Maine Revised Statutes

Title 24-A: MAINE INSURANCE CODE

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Title 24-A: MAINE INSURANCE CODE

Chapter 1: GENERAL DEFINITIONS AND PROVISIONS

§1. SHORT TITLE

This Title shall be known and be cited as the Maine Insurance Code. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2. "PERSON" DEFINED

"Person" includes an individual, firm, partnership, corporation, association, syndicate, organization, society, business trust, attorney-in-fact and every natural or artificial legal entity. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3. "INSURANCE" DEFINED

"Insurance" means a contract under which one undertakes to pay or indemnify another as to loss from certain specified contingencies or perils, to pay or grant a specified amount or determinable benefit or annuity in connection with ascertainable risk contingencies or to act as surety, except that the following types of contracts are not considered insurance: [1997, c. 592, §9 (RPR).]

1. **Charitable gift annuity.** A charitable gift annuity agreement, as defined in section 703-A;

[1997, c. 592, §9 (NEW) .]

2. **Road or tourist service contract.** A road or tourist service contract, other than a contract issued by a licensed insurer, related to the repair, operation and care of automobiles or to the protection and assistance of automobile owners or drivers;

[2011, c. 345, §1 (AMD); 2011, c. 345, §7 (AFF) .]

3. **Home service contract.** A home service contract whereby, for a set fee and specified duration, a person agrees to defray the cost of repair or replacement or provide or arrange for the repair or replacement of all or any part of any structural component, appliance or system of a home necessitated by wear and tear, deterioration or inherent defect or by failure of an inspection to detect the likelihood of any such loss; and

[2011, c. 345, §1 (AMD); 2011, c. 345, §7 (AFF) .]

4. **Service contract.** A service contract as defined in section 7102, subsection 11.

[2011, c. 345, §2 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1995, c. 375, §C1 (AMD). 1997, c. 457, §7 (AMD). 1997, c. 592, §9 (RPR). 2011, c. 345, §§1, 2 (AMD). 2011, c. 345, §7 (AFF).

§4. "INSURER" DEFINED

"Insurer" includes every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§5. SUPERINTENDENT, BUREAU DEFINED

1. **Superintendent.** "Superintendent" means the Superintendent of the Bureau of Insurance.

[1973, c. 585, §6 (RPR) .]

2. **Bureau.** "Bureau" means the Bureau of Insurance.

[1973, c. 585, §6 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §6 (RPR).

§6. "DOMESTIC," "FOREIGN," "ALIEN" INSURER DEFINED

1. **Domestic insurer.** A "domestic" insurer is one formed under the laws of this State.

[1969, c. 132, §1 (NEW) .]

2. **Foreign insurer.** A "foreign" insurer is one formed under the laws of any jurisdiction other than this State.

[1969, c. 132, §1 (NEW) .]

3. **Alien insurer.** An "alien" insurer is a foreign insurer formed under the laws of any country other than the United States of America, its states, districts, commonwealths and possessions.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§7. "STATE" DEFINED

When in context signifying other than this State, "state" means any state, district, territory, commonwealth or possession of the United States of America. [1995, c. 329, §3 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1995, c. 329, §3 (AMD).

§8. "AUTHORIZED," "UNAUTHORIZED" INSURER DEFINED

1. **Authorized insurer.** An "authorized" insurer is one duly authorized to transact insurance in this State by a subsisting certificate of authority issued by the superintendent.

[1973, c. 585, §12 (AMD) .]

2. **Unauthorized insurer.** An "unauthorized" insurer is one not so authorized.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§9. "TRANSACTING INSURANCE" DEFINED

In addition to other aspects of insurance operations to which provisions of this Title by their terms apply, "transact" with respect to a business of insurance includes any of the following, whether by mail or any other means: [1969, c. 132, §1 (NEW).]

1. Solicitation or inducement;

[1969, c. 132, §1 (NEW) .]

2. Negotiations;

[1969, c. 132, §1 (NEW) .]

3. Effectuation of a contract of insurance;

[1969, c. 132, §1 (NEW) .]

4. Transaction of matters subsequent to effectuation and arising out of such a contract.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§10. APPLICATION OF CODE AS TO PARTICULAR TYPES OF INSURERS

No provision of this Title shall apply with respect to: [1969, c. 132, §1 (NEW).]

1. Domestic mutual assessment insurers, as identified in chapter 51, except as stated in such chapter;

[1969, c. 177, §1 (AMD) .]

2. Fraternal benefit societies, except as stated in chapter 55;

[1997, c. 676, §2 (AMD) .]

3.

[1997, c. 457, §9 (RP) .]

4. Unless otherwise expressly provided by this Title, a domestic insurer heretofore formed under a special Act of the Legislature, when inconsistent with such special Act as heretofore amended;

[1997, c. 676, §3 (AMD) .]

5. The government contracting activities of a health care servicing entity, as defined in Title 22, section 3173, contracting, whether directly or as a subcontractor, with the Department of Health and Human Services, unless otherwise expressly provided by this Title. This Title may apply to other insurance or managed care activities of a health care servicing entity; or

[1997, c. 676, §4 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

6. The government contracting activities of a health care servicing entity, as defined in Title 22-A, section 207, subsection 7, contracting, whether directly or as a subcontractor, with the Department of Health and Human Services, unless otherwise expressly provided by this Title. This Title may apply to any other insurance or managed care activities of a health care servicing entity.

[2007, c. 695, Pt. C, §14 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §1 (AMD). 1985, c. 399, §1 (AMD). 1997, c. 457, §§8,9 (AMD). 1997, c. 676, §§2-4 (AMD). 2001, c. 354, §3 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 539, Pt. N, §55 (AMD). 2007, c. 695, Pt. C, §14 (AMD).

§11. PARTICULAR PROVISIONS PREVAIL

Provisions of this Title as to a particular kind of insurance, type of insurer or matter shall prevail over provisions relating to insurance, insurers or matters in general. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§12. GENERAL PENALTY

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§1-A (RPR). 1989, c. 269, §2 (RP).

§12-A. CIVIL PENALTY AND ENFORCEMENT PROVISIONS

1. **Civil penalty.** Civil penalties may be assessed against any person who:

A. Violates any provision of this Title, Title 24 or any other law enforced by the superintendent; [1997, c. 634, Pt. B, §1 (RPR).]

B. Violates any rule lawfully adopted by the superintendent; or [1997, c. 634, Pt. B, §1 (RPR).]

C. Violates any lawful order of the superintendent that has not been stayed by order of the superintendent or the Superior Court. [1997, c. 634, Pt. B, §1 (RPR).]

The Superior Court, upon an action brought by the Attorney General, may assess a civil penalty of not less than $500 and not more than $5,000 for each violation in the case of an individual and not less than $2,000 and not more than $15,000 for each violation in the case of a corporation or other entity other than an individual, unless the applicable law specifies a different civil penalty.

The superintendent, following an adjudicatory hearing, may assess a civil penalty of up to $500 for each violation in the case of an individual and a civil penalty of up to $10,000 for each violation in the case of a corporation or other entity other than an individual, unless the applicable law specifies a different civil penalty. The superintendent shall notify the Attorney General or the Attorney General's designee of

any such adjudicatory hearing at the time that the notice of hearing is issued by the superintendent. The superintendent may not assess a civil penalty if the Attorney General notifies the superintendent that the Attorney General intends to pursue an action in Superior Court to seek civil penalties for the same conduct. If the Attorney General elects to pursue the noticed action in Superior Court, the Attorney General shall notify the superintendent of that decision no later than 7 days prior to the hearing.

[2005, c. 41, §1 (AMD) .]

1-A. **Equitable relief; actual damages.** In addition to a civil penalty awarded pursuant to subsection 1, the Superior Court may award to any injured insured or applicant for insurance who is represented by the Attorney General reasonable equitable relief and actual damages.

[1989, c. 826, (NEW) .]

2. **Cease and desist orders.** The superintendent may issue a cease and desist order following an adjudicatory hearing held in conformance with Title 5, chapter 375, subchapter IV, if the superintendent finds that any person has engaged in or is engaging in any act or practice in violation of any law administered or enforced by the superintendent, any rules promulgated under that law or any lawful order of the superintendent.

A. A cease and desist order is effective when issued, unless the order specifies a later effective date or is stayed pursuant to Title 5, section 11004. [1991, c. 298, §1 (AMD).]

B. In the event an appeal is taken, the court shall issue its own order for compliance to the extent that the superintendent's order is affirmed. [1989, c. 269, §3 (NEW).]

C. Violation of any cease and desist order shall be punishable as a violation of this Title in accordance with this section. [1989, c. 269, §3 (NEW).]

[1991, c. 298, §1 (AMD) .]

2-A. **Emergency cease and desist.** The superintendent may issue an emergency cease and desist order, without prior notice and hearing, if the complaint shows that a person is engaging in unlicensed insurance activities or is engaging in conduct that creates an immediate danger to the public safety or is causing or is reasonably expected to cause significant, imminent and irreparable public injury.

A. A request for an emergency cease and desist order must be in writing in the form of a verified complaint. [1991, c. 298, §2 (NEW).]

B. An emergency cease and desist order is effective immediately and will continue in force and effect until further order by the superintendent or unless stayed by the superintendent or by a court of competent jurisdiction. [1991, c. 298, §2 (NEW).]

C. Upon issuance of an emergency cease and desist order, the superintendent shall serve on the person affected by the order, by registered or certified mail to the person's last known address, an order that contains a statement of the charges and a notice of hearing. The hearing, held in conformance with Title 5, chapter 375, subchapter IV, must be held within 10 days of the effective date of the emergency order, unless a later time is agreed upon by all parties. [1991, c. 298, §2 (NEW).]

D. At the hearing, the superintendent shall affirm, modify or set aside, in whole or in part, the emergency cease and desist order and may combine and employ any other enforcement or penalty provisions available to the superintendent to arrive at a final order. [1991, c. 298, §2 (NEW).]

E. The superintendent's order after hearing is a final order in all respects and is subject to subsection 2, paragraph A and section 236. [1991, c. 298, §2 (NEW).]

[1991, c. 298, §2 (NEW) .]

3. **Reprimand or censure.** The superintendent may issue a letter of reprimand or censure to any licensee, but only after opportunity for hearing has been provided to any and all persons who are subjects of the reprimand.

[1989, c. 269, §3 (NEW) .]

4. **Refunds of overcharges.** In the event that any insurer, fraternal benefit society, nonprofit hospital service plan, nonprofit medical service plan, nonprofit health care plan, health maintenance organization or preferred provider organization makes charges to any person that are not in conformity with a filing that it is required to submit for approval or disapproval by this Title or Title 24, the superintendent may order that refunds of any overcharges be made.

[2009, c. 13, §1 (AMD) .]

5. **Election of enforcement options.** The superintendent may elect to utilize any or all of the enforcement options provided by this section, in combination or in sequence, as the superintendent deems appropriate. The penalties and provisions of this section are in addition to any other penalty provided by law.

[1989, c. 269, §3 (NEW) .]

6. **Restitution.** The superintendent may order restitution for any insured or applicant for insurance injured by a violation for which a civil penalty may be assessed pursuant to this section.

[1989, c. 826, (NEW) .]

SECTION HISTORY
1989, c. 269, §3 (NEW). 1989, c. 826, (AMD). 1991, c. 298, §§1,2 (AMD). 1997, c. 634, §B1 (AMD). 2001, c. 165, §B1 (AMD). 2005, c. 41, §1 (AMD). 2009, c. 13, §1 (AMD).

§13. RETENTION OF UNPAID PREMIUM

Any insurance company, broker or agent may retain an amount equal to any undisputed unpaid premium due on the policy under which a claim is being presented, in connection with claims by and settled with an insured, as long as the unpaid premium remains unpaid 60 days after the effective date of that policy or the date of the original billing for the unpaid premium, whichever occurs later. The unpaid premium may not be retained as against any loss payee or mortgagee named in the policy up to the amount of the unpaid balance owed to that loss payee or mortgagee on the date the loss that gave rise to the claim occurred. This section does not apply to a health insurance policy. [1993, c. 117, §1 (NEW).]

SECTION HISTORY
1993, c. 117, §1 (NEW).

§14. AFFORDABLE CARE ACT DEFINED

As used in this Title, "federal Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts. [2011, c. 90, Pt. D, §1 (NEW).]

SECTION HISTORY
2011, c. 90, Pt. D, §1 (NEW).

Chapter 3: THE INSURANCE SUPERINTENDENT

§200. DEPARTMENT CONTINUED

There is continued a department of State Government known as the Insurance Bureau. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§201. SUPERINTENDENT OF INSURANCE; APPOINTMENT; TERM

1. The Superintendent of Insurance is the head of the Bureau of Insurance.

[1973, c. 585, §7 (RPR) .]

2. The superintendent shall be appointed by the Governor and subject to review by the joint standing committee of the Legislature having jurisdiction over banking and insurance and to confirmation by the Legislature.

[1987, c. 105, §3 (AMD) .]

3. The superintendent shall hold his office for 5 years or until his successor has been appointed and has qualified. Any vacancy occurring shall be filled by appointment for the unexpired portion of the term.

[1981, c. 359, §6 (AMD) .]

4. The superintendent shall be removable for cause by impeachment or by address of the Governor to both branches of the Legislature, and Title 5, section 931, subsection 2, shall not apply.

[1987, c. 402, Pt. A, §151 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §7 (RPR). 1975, c. 771, §259 (AMD). 1981, c. 359, §§5-7 (AMD). 1987, c. 105, §3 (AMD). 1987, c. 402, §A151 (AMD).

§202. SEAL

The superintendent shall have a seal of office of a suitable design, bearing the words "Insurance Superintendent of the State of Maine." The superintendent shall file an impression of the seal, duly certified by him under oath, with the Secretary of State. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§203. COMPENSATION

The State shall pay to the superintendent an annual salary in amount as provided by law as full compensation for all duties required of the superintendent. [1989, c. 702, Pt. E, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 553, §25 (AMD). 1989, c. 702, §E12 (AMD).

§204. PRINCIPAL OFFICE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §2 (AMD). 1973, c. 585, §12 (AMD). 1979, c. 251, (RP).

§205. BUREAU ORGANIZATION

With the approval of the Commissioner of Professional and Financial Regulation, the superintendent shall organize the bureau in a manner the superintendent determines necessary for the discharge of the superintendent's duties. [1995, c. 502, Pt. H, §15 (RPR).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1995, c. 502, §H15 (RPR).

§206. DEPUTY SUPERINTENDENTS

1. The superintendent, with the approval of the Commissioner of Professional and Financial Regulation, may employ, subject to the Civil Service Law, 2 deputy superintendents. Where authorized by another section of this Title, the superintendent may also appoint such special deputies as regulatory responsibilities may necessitate.

[1995, c. 502, Pt. H, §16 (AMD) .]

2. The deputies shall perform such duties and exercise such powers of the superintendent as the superintendent may from time to time authorize. The superintendent shall designate one of the deputy superintendents to perform the duties of the superintendent whenever the superintendent is absent from the State; the deputy superintendent is directed to do so by the superintendent; there is a vacancy in the office of superintendent; or the superintendent is incapacitated by illness.

[1995, c. 502, Pt. H, §16 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §8 (RPR). 1983, c. 553, §46 (AMD). 1985, c. 785, §B106 (AMD). RR 1993, c. 1, §55 (COR). 1995, c. 502, §H16 (AMD).

§207. STAFF

The superintendent may employ personnel as the business of the bureau may require, subject to the Commissioner of Professional and Financial Regulation's approval and in accordance with the Civil Service Law. The qualifications of those personnel must reflect the needs and responsibilities relating to the bureau's regulatory functions pursuant to this Title. The superintendent may authorize senior personnel of the bureau to carry out the superintendent's duties and authority. [1995, c. 502, Pt. H, §17 (RPR).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 785, §B107 (AMD). 1995, c. 502, §H17 (RPR).

§208. INDEPENDENT TECHNICAL, PROFESSIONAL SERVICES

The superintendent may from time to time contract for such additional actuarial, examination, rating and other technical and professional services as he may require for discharge of his duties. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§208-A. COOPERATIVE AGREEMENTS

The superintendent, in the superintendent's discretion, may enter into cooperative agreements with other state, federal or foreign law enforcement or regulatory agencies to facilitate the regulatory functions of the superintendent, including, but not limited to, information sharing, coordination of examinations and investigations and joint examinations and investigations. [1999, c. 184, §18 (NEW).]

SECTION HISTORY
1999, c. 184, §18 (NEW).

§209. PROHIBITED INTERESTS, REWARDS

1. The superintendent, or his deputy, or any examiner or employee of the bureau shall not be connected with the management or be holder of a material number of shares of any insurer, insurance holding company, insurance agency or broker, or be pecuniarily interested in any insurance transaction, except as a policyholder or claimant under a policy; except that as to matters wherein a conflict of interests does not exist on the part of any such individual, the superintendent may employ and retain from time to time insurance actuaries, examiners, accountants, and other technicians who are independently practicing their professions even though from time to time similarly employed or retained by insurers or others.

[1973, c. 585, §12 (AMD) .]

2. Subsection 1 above shall not be deemed to prohibit:

A. Receipt by any such individual of fully vested commissions or fully vested retirement benefits to which he is entitled by reason of services performed prior to becoming superintendent or prior to employment in the bureau; [1973, c. 585, §12 (AMD).]

B. Investment in shares of regulated diversified investment companies; or [1969, c. 132, §1 (NEW).]

C. Mortgage loans made under customary terms and in ordinary course of business. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. The superintendent, or his deputy, or any employee or technician employed or retained by the bureau shall not be given or receive, directly or indirectly, any fee, compensation, loan, gift or other thing of value in addition to the compensation and expense allowance provided by or pursuant to the law of this State, or by contract with the superintendent, for any service rendered or to be rendered as such superintendent, deputy, assistant, employee or technician, or in connection therewith.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§210. DELEGATION OF POWERS

1. The superintendent may delegate to his deputy, examiner or an employee of the bureau the exercise or discharge in the superintendent's name of any power, duty or function, whether ministerial, discretionary or of whatever character, vested in or imposed upon the superintendent.

[1973, c. 585, §12 (AMD) .]

2. The official act of any such person acting in the superintendent's name and by his authority shall be deemed an official act of the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§211. GENERAL POWERS, DUTIES

1. The superintendent shall enforce the provisions of, and execute the duties imposed upon him by, this Title.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall have the powers and authority expressly vested in him by or reasonably implied from this Title.

[1973, c. 585, §12 (AMD) .]

3. The superintendent shall have such additional rights, powers and duties as may be provided by other laws.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§212. RULES AND REGULATIONS

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may adopt, amend and rescind reasonable rules to aid the administration or effectuation of any provisions of this Title or of any other state or federal statutes to the extent administered or enforced by the superintendent. [2001, c. 262, Pt. C, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §386 (AMD). 1989, c. 269, §4 (AMD). 1991, c. 885, §E23 (AMD). 1991, c. 885, §E47 (AFF). 2001, c. 262, §C1 (AMD).

§212-A. PARITY FOR INSURANCE AGENTS AND BROKERS

Notwithstanding any other provision of law, to the extent authorized by the superintendent by rule, a licensed agent or broker has the power to engage in any insurance activity that financial institutions chartered by or otherwise subject to the jurisdiction of the Federal Government are authorized to engage in pursuant

to federal law or regulation or by a court of competent jurisdiction. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 207, §3 (NEW).]

SECTION HISTORY
1997, c. 207, §3 (NEW).

§213. ORDERS, NOTICES IN GENERAL

1. Orders and notices of the superintendent shall be effective only when in writing signed by him or by his authority.

[1973, c. 585, §12 (AMD) .]

2. Every order of the superintendent shall state its effective date, and shall concisely state:

A. Its intent or purpose; [1969, c. 132, §1 (NEW).]

B. The grounds on which based; and [1969, c. 132, §1 (NEW).]

C. The provisions of this Title pursuant to which action is taken or proposed to be taken; but failure to so designate a particular provision shall not deprive the superintendent of the right to rely thereon. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

3. An order or notice may be given by delivery to the person to be ordered or notified, or by mailing it, postage prepaid, addressed to such person at his principal place of business or residence as last of record in the bureau. The order or notice shall be deemed to have been given when deposited in a mail depository of the United States post office, and of which the affidavit of the individual who so mailed the order or notice shall be prima facie evidence. Written notice of the party's rights to review or appeal and of the action required and of the time within which action shall be taken in order to appeal shall be given to each party with the decision.

[1977, c. 694, §387 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §387 (AMD).

§214. ENFORCEMENT

1. The superintendent may, through the Attorney General of this State, invoke the aid of the Superior Court through proceedings instituted in any county of this State to enforce any lawful order made or action taken by him. In such proceedings, the Superior Court may make such orders, either preliminary or final, as it deems proper under the facts established before it.

[1973, c. 585, §12 (AMD) .]

2. If the superintendent has reason to believe that any person has violated any provision of this Title, or of other law as applicable to insurance operations, for which criminal prosecution is provided and would be in order, the superintendent shall give the information relative thereto to the Attorney General. The Attorney General shall promptly institute such action or proceedings, including, but not limited to, actions or proceedings to seek restitution, against that person as in the Attorney General's opinion the information may require or justify.

[2003, c. 310, §1 (AMD) .]

3. The Attorney General upon request of the superintendent is authorized to proceed in the courts of any other state or in any federal court or agency to enforce an order or decision of any court proceeding or in any administrative proceeding before the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2003, c. 310, §1 (AMD).

§215. VIOLATION OF RULES, REGULATIONS, ORDERS; PENALTY

Any person who knowingly violates any rule, regulation or order of the superintendent shall be subject to such suspension or revocation of certificate of authority or license as may be applicable under this Title for violation of the provision to which such rule, regulation or order relates. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§216. RECORDS; INSPECTION; DESTRUCTION

1. The superintendent shall carefully preserve in the bureau and in permanent form a correct account of all his transactions and of all fees and moneys received by him by virtue of his office, together with all financial statements, examination reports, correspondence, filings and documents duly received by the bureau. The superintendent shall hand the same over to his successor in office.

[1973, c. 585, §12 (AMD) .]

2. All records of the bureau are subject to public inspection, except as otherwise expressly provided by law as to particular matters; and except that records, correspondence and reports of investigation in connection with actual or claimed violations of this Title or prosecution or disciplinary action for those violations are confidential. The confidential nature of any such record, correspondence or report may not limit or affect use of the same by the superintendent in any such prosecution or action. This subsection does not preclude participation by the superintendent in the establishment of an interstate complaint handling system that may involve the sharing of information with insurance regulatory officials in other jurisdictions and with the National Association of Insurance Commissioners, as long as the names of the complainant and insured remain confidential. This subsection does not preclude the dissemination of aggregate ratios of consumer complaints to the public by the superintendent. Only complaints received in writing are included in the calculation of the complaint ratio. A complaint received by electronic means is considered a written complaint. For the purposes of this subsection, a "consumer complaint" means any written complaint that results in the need for the bureau to conduct further investigation or to communicate in writing with a regulated entity for a response or resolution to the complaint. The superintendent shall adopt rules necessary to define the method for calculating complaint ratios. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 165, Pt. A, §1 (AMD) .]

3. All records and documents of the bureau are subject to subpoena by a court of competent jurisdiction.

[1973, c. 585, §12 (AMD) .]

4. The superintendent may destroy unneeded or obsolete records and filings in the bureau in accordance with provisions and procedures applicable to administrative agencies of the State in general.

[1973, c. 585, §12 (AMD) .]

5. In order to assist the superintendent in the regulation of insurers in this State, it is the duty of the superintendent to maintain as confidential a document or information received from the National Association of Insurance Commissioners or International Association of Insurance Supervisors, public officials of other jurisdictions and members of supervisory colleges in which the superintendent participates pursuant to section 222, subsection 7-B, agencies of the Federal Government or political subdivisions or other agencies of this State, if the document or the information has been provided to the superintendent with notice that it is confidential under the laws of the jurisdiction that is the source of the document or information.

A. Any information furnished pursuant to this subsection by or to the superintendent that has been designated confidential by the official, agency or other entity furnishing the information remains the property of the agency furnishing the information and must be held as confidential by the recipient of the information, except as authorized by the official, agency or other entity furnishing the information to the superintendent, with prior notice to interested parties and consistent with other applicable laws. The authority of the superintendent, pursuant to paragraph B, to permit further disclosure to a 3rd party or to the public of information shared by the superintendent is subject to the same requirements and conditions that apply if the superintendent discloses the information directly to a 3rd party or to the public. [2013, c. 238, Pt. A, §1 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. The superintendent may share information, including otherwise confidential information, with the National Association of Insurance Commissioners or International Association of Insurance Supervisors, public officials of other jurisdictions and members of supervisory colleges in which the superintendent participates pursuant to section 222, subsection 7-B, agencies of the Federal Government or political subdivisions or other agencies of this State, if the recipient of the information agrees to maintain the same level of confidentiality as is available under Maine law and has demonstrated that it has the legal authority to do so. [2013, c. 238, Pt. A, §1 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. The superintendent may enter into one or more written agreements with the National Association of Insurance Commissioners governing sharing and using information under this subsection that:

(1) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this paragraph, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal or international insurance regulators;

(2) Specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this paragraph remains with the superintendent and that the use of information by the National Association of Insurance Commissioners is subject to the direction of the superintendent;

(3) Require prompt notice to be given by the National Association of Insurance Commissioners to any insurer whose confidential information is in the possession of the National Association of Insurance Commissioners pursuant to this paragraph when that information is the subject of a request or subpoena for disclosure or production; and

(4) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this paragraph. [2013, c. 238, Pt. A, §1 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D. This subsection does not alter prohibitions or restrictions applicable to ex parte contacts in the course of an adjudicatory proceeding in which a state agency is a party. [2013, c. 238, Pt. A, §1 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

E. For purposes of this subsection, "other agencies of this State" includes bureau personnel and consultants designated as serving in an advocacy capacity in an adjudicatory proceeding before the superintendent. [2013, c. 238, Pt. A, §1 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §1 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 269, §5 (AMD). 1995, c. 375, §B1 (AMD). 1997, c. 314, §1 (AMD). 1999, c. 184, §19 (AMD). 2001, c. 165, §A1 (AMD). 2013, c. 238, Pt. A, §1 (AMD). 2013, c. 238, Pt. A, §34 (AFF).

§217. ANNUAL REPORT

1. As soon as practical after the annual financial statements have been received from the authorized insurers, the superintendent may make a written report to the Governor showing with respect to the preceding calendar year:

A. The receipts and expenses of the bureau for the year; [1973, c. 585, §12 (AMD).]

B. A summary of the insurance business transacted in this State; [1969, c. 132, §1 (NEW).]

C. A summary of the financial condition of each authorized insurer, as shown by its most recent financial statement on file with the superintendent; [1973, c. 585, §12 (AMD).]

D. Such recommendations as he deems advisable relative to amendment or supplementation of the insurance laws; and [1969, c. 132, §1 (NEW).]

E. Such other information and matters as he deems to be in the public interest relative to the insurance business in this State. [1969, c. 132, §1 (NEW).]

[1975, c. 771, §260 (AMD) .]

2. If the report is printed, the superintendent shall furnish a copy upon request thereby to the insurance supervisory official of other states and to authorized insurers; and, if copies are available for the purpose, to other persons who so request and upon payment by such persons of such reasonable charge therefor as may be fixed by the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 771, §260 (AMD).

§218. PUBLICATIONS; PRICE

The superintendent may have the directory of authorized insurers, of licensed insurance representatives, license examination material, insurance laws and related laws and regulations under his administration published in pamphlet form from time to time, and may fix a price for each copy to cover cost of printing and mailing. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§219. INTERSTATE COOPERATION

The superintendent may communicate on request of the insurance supervisory official of any state, province or country any information which it is his duty by law to ascertain respecting authorized insurers. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§220. INVESTIGATION OF VIOLATIONS

1. **Discretionary investigations.** In addition to examinations and investigations expressly authorized, the superintendent may conduct investigations of insurance matters as the superintendent considers proper upon reasonable cause to determine whether any person has violated any provision of this Title or to secure information useful in the lawful administration of any such provision. The cost of these investigations must be borne by the State.

[1991, c. 26, (NEW) .]

2. **Response to inquiries.** All insurers and other persons required to be licensed pursuant to this Title shall respond to all lawful inquiries of the superintendent that relate to resolution of consumer complaints involving the licensee within 14 days of receipt of the inquiry and to all other lawful inquiries of the superintendent within 30 days of receipt. If a substantive response can not in good faith be provided within the time period, the person required to respond shall so advise the superintendent and provide the reason for the inability to respond.

[1991, c. 26, (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 26, (RPR).

§221. EXAMINATION OF INSURERS

1. For the purpose of determining its financial condition, fulfillment of its contractual obligations and compliance with the law, the superintendent shall examine the affairs, transactions, accounts, records and assets of each authorized insurer, and of any person as to any matter relevant to the financial affairs of the insurer or to the examination, as often as the superintendent determines advisable. In determining the nature, scope and timing of an examination, the superintendent shall consider criteria, including, but not limited to, the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria adopted by the National Association of Insurance Commissioners and published in its Examiners' Handbook. Except as otherwise expressly provided, domestic insurers must be examined at least once every 3 years, unless the superintendent defers making an examination for a longer period; but in no event may an authorized insurer be examined less frequently than once every 5 years. Examination of an alien insurer is limited to its insurance transactions, assets, trust deposits and affairs in the United States, except as otherwise required by the superintendent.

[1993, c. 313, §2 (AMD) .]

2. The superintendent shall in like manner examine each insurer applying for an initial certificate of authority to transact insurance in this State.

[1973, c. 585, §12 (AMD) .]

3. In lieu of the superintendent making an examination, the superintendent may accept a full report of the last recent examination of a foreign or alien insurer, certified to by the insurance supervisory official of another state.

[1991, c. 828, §2 (AMD) .]

3-A. On or after January 1, 1994 the superintendent may accept a full examination report by the insurance regulatory authority of the insurance company's state of domicile or port-of-entry state for any foreign or alien insurer licensed in this State in lieu of an examination by the superintendent if, at the time of the examination, that regulatory authority was accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program or if the examination was performed under the supervision of an accredited insurance regulatory authority or with the participation of one or more examiners who are employed by an accredited insurance regulatory authority and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by the regulatory authority.

[1993, c. 313, §3 (NEW) .]

4. As far as practical, the examination of a foreign or alien insurer must be made in cooperation with the insurance supervisory officials of other states in which the insurer transacts business. Duties may be divided among the participating states in any manner consistent with the standards established by the laws of this State that are applicable to foreign and alien insurers.

[1993, c. 313, §4 (AMD) .]

5. **Examination of health carriers.** The superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this subsection may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination. In lieu of an examination conducted by the superintendent, the superintendent may participate in a multistate examination, or, in the case of a foreign company, approve an examination by the company's domiciliary regulator upon a finding that the examination and report adequately address relevant aspects of the company's market conduct within this State.

[2009, c. 439, Pt. E, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §§1,2 (AMD). 1993, c. 313, §§2-4 (AMD). 2009, c. 439, Pt. E, §1 (AMD).

§221-A. FINANCIAL AUDIT REQUIREMENTS

1. **Purpose.** The purpose of this section is to provide the superintendent with a means of improved financial monitoring of insurers doing business in this State. This mechanism of increased financial surveillance of insurers shall not be a substitute for financial examinations required or authorized by this Title generally.

[1985, c. 330, §1 (NEW) .]

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

A. "Accountant" and "independent certified public accountant" mean an independent certified public accountant or firm licensed to practice in the State or in any state recognizing similar reciprocal licensing requirements and who is a member in good standing of the American Institute of Certified Public Accountants. It shall also mean, in the case of Canadian and British domiciled companies, a Canadian or British chartered accountant. [1985, c. 330, §1 (NEW).]

B. "Audited financial report" means a written report which meets the requirements of subsection 4. [1985, c. 330, §1 (NEW).]

C. "Insurer" means any insurance company doing business in the State pursuant to this Title and includes, but is not limited to, all life, accident and health, property and casualty, title, direct writing reinsuring companies and surplus lines companies regulated by the Bureau of Insurance. [1985, c. 330, §1 (NEW).]

[1985, c. 330, §1 (NEW) .]

3. **Audits required.** All insurers, excepting insurers transacting business in this State pursuant to the terms of chapter 51, shall cause to be conducted an annual audit by an independent certified public accountant. Each domestic insurer shall file an audited financial report with the superintendent on or before June 1st for the year ending December 31st preceding. An extension of the filing deadline may be granted by the superintendent upon a showing by the insurer or its accountant that there exists valid justification for such an extension. A foreign or alien insurer shall file an audited financial report upon the superintendent's request. A firm of independent certified public accountants engaged to perform an audit of an insurer shall substitute the appointed audit partner in charge with another audit partner in charge at least once every 5 years. An accountant substituted for pursuant to this subsection may not serve as a partner in charge of that audit until 5 years after the date of substitution, unless the superintendent waives this requirement on the basis of unusual circumstances upon application by the insurer.

[2009, c. 511, Pt. A, §1 (AMD) .]

4. **Content of annual audited financial reporting.** Annual audited financial reporting must consist of the following.

A. Financial statements furnished under this section must be examined by independent certified public accountants in accordance with generally accepted auditing standards as prescribed by the American Institute of Certified Public Accountants. The opinion of the accountant must cover all years for which a financial presentation is made.

The opinion expressed concerning the financial statements filed under this section must conform with the accounting practices prescribed or permitted by the superintendent or the insurance supervisory official of the insurer's state of domicile. An insurer, with the approval of the superintendent, may file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that uses a pooling agreement and such an insurer cedes all of its direct and assumed business to the pool or if the insurer has executed a 100% reinsurance agreement with one or more of the insurers in the group and the pooling or reinsurance agreement affects the solvency of the insurer or the integrity of the insurer's reserves. In those cases, a columnar consolidating or combining worksheet must be filed with the report.

The opinion must be expressed to the insurer by the accountant on the accountant's letterhead and show the address of the office issuing that opinion, must be manually executed and dated. [1993, c. 313, §6 (AMD).]

B. Financial statements, as a minimum, must consist of:

(1) Balance sheet;

(2) Statement of gain or loss from operations;

(3) Statement of cash flow;

(4) Statement of change in capital paid-up, gross paid-in and contributed surplus and unassigned funds, surplus funds; and

(5) Notes to financial statements. [1993, c. 313, §6 (AMD).]

C. The statement must include an independent certified public accountant's report respecting evaluation of internal controls. [1993, c. 313, §6 (AMD).]

D. The statement must include an independent certified public accountant's letter, in conformance with standards established by the National Association of Insurance Commissioners, attesting to that certified public accountant's qualifications, possession of license and subscription to the code of professional ethics and pronouncements issued by the American Institute of Certified Public Accountants. [1999, c. 113, §6 (AMD).]

[1999, c. 113, §6 (AMD) .]

5. **Rules authorized.** The superintendent shall promulgate such rules as shall be necessary to effectuate provisions of this section.

[1985, c. 330, §1 (NEW) .]

6. **Application and effective date.** For those insurers doing business in this State that are subject to this section, the filing of the initial annual audited financial reports required under this section are due June 30, 1986, covering the calendar year December 31, 1985. Similar recurring reports are due each June 1st thereafter.

[1999, c. 113, §7 (AMD) .]

7. **Exemptions.** Upon written application of any insurer subject to this section, the superintendent may grant an exemption of the filing requirements under this section if the superintendent finds upon review of the application that compliance would constitute a financial hardship upon the insurer.

An insurer is exempt from the filing requirements of this section for any year in which the insurer’s annual statement reflects:

A. Nationwide business in an amount less than $1,000,000 in written premium plus reinsurance assumed; and [2009, c. 511, Pt. A, §2 (NEW).]

B. Outstanding loss reserves in an amount less than $1,000,000. [2009, c. 511, Pt. A, §2 (NEW).]

[2009, c. 511, Pt. A, §2 (RPR) .]

8. **Required notice concerning adverse financial condition.** Each insurer retaining an independent certified public accountant to represent it with respect to the report which the insurer is required to file pursuant to this section shall, as a condition of its written terms of engagement of the accountant, require that:

A. The accountant immediately notify in writing each member of the board of directors of the insurer and the superintendent upon any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported in the annual statement required under section 423 for the year ending December 31st preceding; and [1989, c. 846, Pt. C, §2 (AMD); 1989, c. 846, Pt. E, §4 (AFF).]

B. If the accountant, subsequent to the date of the audited financial report required by this section, becomes aware of material subsequent facts which would have affected his report, the accountant shall provide the pertinent information upon his determination to the parties identified in this subsection. [1985, c. 636, (NEW).]

[1989, c. 846, Pt. C, §2 (AMD); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1985, c. 330, §1 (NEW). 1985, c. 636, (AMD). 1989, c. 846, §§C1,2,E4 (AMD). 1993, c. 313, §§5,6 (AMD). 1999, c. 113, §§5-7 (AMD). 2009, c. 511, Pt. A, §§1, 2 (AMD).

§222. REGISTRATION, REGULATION, SUPERVISION AND EXAMINATION OF HOLDING COMPANY SYSTEMS, AGENTS, PROMOTERS AND OTHERS

1. **Examination.**

[2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §2 (RP) .]

1-A. **Examination.** For purposes of ascertaining compliance with law, or relationships and transactions between any person as defined hereafter and any insurer or proposed insurer subject to this section, the superintendent may as often as the superintendent determines to be advisable examine the accounts, records, documents and transactions pertaining to or affecting the insurance affairs or proposed insurance affairs, or transactions of the insurer or proposed insurer as may be in the possession of any holding company, its subsidiaries or affiliates as is necessary to ascertain the financial condition, including the enterprise risk to the insurer by the ultimate controlling party, or legality of conduct of the insurer or proposed insurer or the insurance holding company system as a whole or any combination of entities within the insurance holding company system and to verify the accuracy of any information provided or required to be provided to the superintendent pursuant to this section.

A. The superintendent's investigatory and examination authority under this subsection extends to the examination of:

(1) Any business entity structured to hold the stock of an insurance company, or person holding the shares of voting stock or policyholder proxies of an insurer as voting trustee or otherwise, for the purpose of controlling the management thereof;

(2) Any insurance producer, adjuster or consultant or other insurance or reinsurance representative or intermediary or any person acting as or purporting to be any of the foregoing;

(3) Any person having a contract giving that person by its terms or in fact the exclusive or dominant right to manage or control the insurer; and

(4) Any person in this State engaged in or proposing to be engaged in or acting as or purporting to be so engaged or proposing to be engaged in the business of insurance or in this State assisting in the promotion, formation or financing of an insurer or insurance holding corporation or corporation or other group financing an insurer or the production of its business. [2013, c. 238, Pt. A, §3 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. Subject to the limitations contained in this subsection and in addition to the powers that the superintendent has under section 221 and sections 223 to 228 relating to the examination of insurers, the superintendent may order an insurer registered under subsection 8 to produce records, books or papers in the possession of the insurer or affiliates as may be necessary to verify the accuracy of the information required to be provided to the superintendent under this section and any additional information pertinent to transactions between the insurer and affiliates. The books, records, papers and information are subject to examination in the same manner as prescribed in this chapter for an examination conducted under section 221, except that expenses incurred by the superintendent in examining an affiliate that is not an

insurer must be borne by the registered insurer subject to the limitations of section 228, subsection 1. The superintendent may issue subpoenas, administer oaths and examine any person under oath for purposes of determining compliance with this subsection. [2013, c. 238, Pt. A, §3 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. A member of an insurer's insurance holding company system shall comply fully and accurately with a request by the insurer to provide it with information necessary to respond to an examination request by the superintendent pursuant to this section. [2013, c. 238, Pt. A, §3 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D. The superintendent may order an insurer registered under subsection 8 to produce information not in the possession of the insurer if the insurer can obtain access to the information pursuant to contractual relationships, statutory obligations or any other lawful method. If the insurer cannot obtain the information requested by the superintendent, the insurer shall provide the superintendent a written objection with a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of the information. It is a violation of this section to submit an objection to production of information without a reasonable basis or to fail to produce information on the basis of an objection that the superintendent has denied after notice and opportunity for hearing. [2013, c. 238, Pt. A, §3 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §3 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

2. Definitions. As used in this section, unless the context otherwise requires, the following words shall have the following meanings.

A. Affiliate. "Affiliate" of, or a person "affiliated" with, a specific person means a person who directly or indirectly controls, or is controlled by, or is under common control with the person specified. [1975, c. 356, §1 (RPR).]

A-1. Beneficial owner. "Beneficial owner" of a voting security, voting insurance policy or guaranty capital share means any person or group of persons acting in concert who, directly or indirectly, through any contract, arrangement, proxy appointment, understanding, relationship or otherwise, has or shares:

(1) Voting power over the security, policy or guaranty capital share, including the power to vote or to direct the voting of the security, policy or share; or

(2) Investment power over the security, policy or share, including the power to dispose or to direct the disposition of the security, policy or share.

The superintendent may determine that persons are acting in concert, either on the superintendent's own initiative or upon application of an interested person, based upon evidence that actions taken by those persons, if consummated, may permit the exercise of common control, directly or indirectly, over the domestic insurer. The absence of a determination by the superintendent that persons are acting in concert shall not be construed to exempt those persons from compliance with the requirements of this section. [1989, c. 385, §1 (NEW).]

A-2. "Continuing director" means:

(1) Any member of a domestic insurer's board of directors, while that person is a member of the board of directors, who was a member of that board of directors prior to the time that any person acquires control of the domestic insurer or any person controlling the insurer; and

(2) Any successor of a continuing director, while the successor is a member of the board of directors, who is recommended or elected to succeed a continuing director by a number of continuing directors equal to a majority of continuing directors in office immediately preceding the acquisition of control. [1991, c. 37, §1 (NEW).]

B. Control.

(1) "Control," including "controlling," "controlled by" and "under common control with," 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. Control is presumed to exist if any person is the beneficial owner of 10% or more of the voting securities or guaranty capital shares, if applicable, or has the right to cast 10% or more of the votes in the election of directors or other governing body of any other person. A beneficial owner may rely in determining the amount of voting securities of any person outstanding upon information set forth in that person's most recent quarterly or annual report filed with the Securities and Exchange Commission pursuant to the Exchange Act unless the beneficial owner knows or has reason to believe that the information contained in the quarterly or annual report is inaccurate. Two or more domestic mutual insurance companies that have restricted their licensed territories to the State are not considered subject to this section merely because those insurance companies commonly share facilities, incurred expenses or personnel services or otherwise utilize cost allocations based on generally accepted accounting principles including pro rata sharing of assumed risks. A person may have more than one controlling person, even if those controlling persons are not acting in concert.

(2) Notwithstanding the presumption of control contained in subparagraph (1), the superintendent, upon application of the insurance company, may determine that the insurer is not controlled by the person presumed to control it. In addition, the superintendent, after notice and an opportunity to be heard, may determine, notwithstanding the absence of the presumption in subparagraph (1), that a person does control an insurance company or companies.

(3) The presumption of control contained in subparagraph (1) does not apply to a securities broker-dealer holding, in the usual and customary broker's function, less than 20% of the voting securities of another person. [2013, c. 238, Pt. A, §4 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

B-1. Exchange Act. "Exchange Act" means the federal Securities Act of 1933, 15 United States Code, Chapter 2-A, Subchapter 1 and the federal Securities Exchange Act of 1934, 15 United States Code, Chapter 2-B. [2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §5 (RPR).]

B-2. Enterprise risk. "Enterprise risk" means an activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer, or of its insurance holding company system as a whole, including, but not limited to, anything that would cause or exacerbate a risk-based capital event as described in sections 6453 to 6456 or would cause the insurer to be in unsound or hazardous financial condition as determined by the superintendent. [2013, c. 238, Pt. A, §6 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. Insurance holding company system. "Insurance holding company system" shall consist of 2 or more affiliated persons, one or more of whom is an insurer. [1975, c. 356, §1 (RPR).]

D. Insurer. "Insurer" has the same meaning as in section 4 and includes a fraternal benefit society required to be licensed under section 4124 or 4125. [2013, c. 238, Pt. A, §7 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

D-1. [1993, c. 313, §7 (RP).]

D-2. "Net gains from operations" means:

(1) For life insurers, the net income or loss after dividends to policyholders and federal income taxes but before the inclusion of net realized capital gains or losses; and

(2) For nonlife insurers, the net income or loss after dividends to policyholders and federal income taxes and net realized capital gains or losses. [1993, c. 313, §8 (NEW).]

D-3. Own risk and solvency assessment or ORSA. "Own risk and solvency assessment" or "ORSA" means a confidential internal assessment that is conducted by an insurer or insurance holding company system of the material and relevant risks associated with its current business plan and the sufficiency of its capital resources to support those risks and that is appropriate to the nature, scale and complexity of the operations of the insurer or insurance holding company system. [2013, c. 238, Pt. A, §8 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D-4. ORSA guidance manual. "ORSA guidance manual" means the NAIC Own Risk and Solvency Assessment (ORSA) Guidance Manual, as amended from time to time. A change in the ORSA guidance manual is effective with regard to this State on January 1st following the calendar year in which the change has been adopted by the National Association of Insurance Commissioners. [2013, c. 238, Pt. A, §8 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D-5. ORSA summary report. "ORSA summary report" means a confidential high-level summary of an insurer's or insurance holding company system's own risk and solvency assessment and includes a combination of separate reports that collectively meet the requirements of the ORSA guidance manual. [2013, c. 238, Pt. A, §8 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

E. Person. "Person" shall mean an individual, a corporation, a corporation which, pursuant to Title 24, chapter 19, maintains and operates nonprofit hospital service plans, nonprofit medical service plans or nonprofit health care plans or any combination thereof, a partnership, an association, a joint stock company, a business trust, an unincorporated organization or any similar entity, or any combination of the foregoing acting in concert. [1975, c. 356, §1 (RPR).]

F. "Subsidiary" of a specified person means an affiliate controlled by that person directly or through one or more intermediaries. [2001, c. 72, §4 (AMD).]

G. "Surplus regarding policyholders" means admitted assets less all liabilities. [1993, c. 313, §9 (NEW).]

H. "Unassigned funds" means the undistributed and unappropriated amount of surplus remaining on the balance sheet date as the result of all operations of an insurance company from its commencement of business. [1993, c. 313, §9 (NEW).]

I. "Voting security" means any security with voting rights or any security convertible into or evidencing a right to acquire a security with voting rights. [1999, c. 113, §10 (NEW).]

[2013, c. 238, Pt. A, §§4-8 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

3. **Subsidiaries of insurers; investments to acquire interest.** This subsection pertains to insurers and their subsidiaries and affiliates.

A. Any domestic insurer may invest in or otherwise acquire one or more subsidiaries as authorized in section 1115 or section 1157. [1987, c. 399, §1 (AMD).]

A-1. A domestic insurer shall notify the superintendent in writing within 30 days after any investment by the insurer or any of its affiliates in any one corporation if the insurer has invested in that corporation and the total investment in that corporation by the insurance holding company system exceeds 10% of the corporation's voting securities. [1991, c. 828, §4 (AMD).]

B. If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within 3 years from the time of the cessation of control or within such further time as the superintendent may prescribe, unless at any time after the investment was made, the investment met the requirements for investment under any other section of this Title and the insurer has notified the superintendent thereof. [1991, c. 828, §4 (AMD).]

[1991, c. 828, §4 (AMD) .]

4. **Tender offers.**

[1989, c. 385, §4 (RP) .]

4-A. **Tender offers.**

[2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §9 (RP) .]

4-B. **Application for approval.**

[2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §10 (RP) .]

4-C. **Acquisitions; tender offers; divestitures.** The following provisions apply to a transaction or proposed transaction that results or might result in the change of direct or indirect control of a domestic insurer.

A. Except as provided in paragraph B, a person other than the issuer may not make a tender offer for, or a request or invitation for tenders of, or an agreement to exchange securities for, or otherwise acquire any voting security, or any security convertible into a voting security, of a domestic insurer or of any person controlling a domestic insurer if, as a result of the consummation thereof, the person making the tender offer, request or agreement would, directly or indirectly, acquire actual or presumptive control of the insurer or controlling person, and a person may not enter into an agreement to merge with or otherwise acquire actual or presumptive control of a domestic insurer or its controlling person, unless:

(1) The person has filed with the superintendent and has sent the domestic insurer an application containing the information required by paragraph C;

(2) The offer, request, invitation, agreement or acquisition has been approved by the superintendent in the manner prescribed in subsection 7; and

(3) Ten days has elapsed from the date of approval by the superintendent and no injunction or other court order precludes consummation of the offer, request, invitation, agreement or acquisition. [2013, c. 238, Pt. A, §11 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. A controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer in any manner, including any partial divestiture that would cause that person to cease to be a controlling person, shall file with the superintendent, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days before the cessation of control, unless the divestiture transaction consists of the transfer of the divesting person's interest to one or more acquiring persons, all of whom have reported their respective acquisitions pursuant to paragraph A. Unless the superintendent grants an exemption under paragraph D, the divesting person shall file an application substantially similar to the application required under paragraph C, with such modifications as the superintendent determines to be appropriate based on the nature of the transaction. The superintendent shall decide whether to approve the application using the criteria in subsection 7, paragraph A and may hold a public hearing if the superintendent determines that a hearing is in the interests of policyholders or the public. If 20 days has elapsed after the superintendent's receipt of a notice filed under this paragraph and the superintendent has not disapproved the proposed divestiture or postponed its effective date pending further review, the superintendent is deemed to have granted an exemption under paragraph D, subparagraph (2). [2013, c. 238, Pt. A, §11 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. An application required by paragraph A must contain the following information as applicable, made under oath or affirmation, except that if the proposed transaction is subject to regulation under the Exchange Act or Title 32, chapter 135, the superintendent may accept the relevant documents filed with the United States Securities and Exchange Commission or the Department of Professional and Financial Regulation, Office of Securities in lieu of some or all of the documents required by this paragraph:

(1) The name and address of each person by whom or on whose behalf the merger or other acquisition of control is to be effected and:

(a) If the person acquiring control is an individual, the person's principal occupation and all offices and positions held during the past 5 years and any convictions for crimes other than minor traffic violations during the past 10 years; and

(b) If the person acquiring control is not an individual, a report of the nature of its business operations during the past 5 years or for a lesser period the person and any predecessors have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to such positions. The list must include the information required by division (a) for each individual listed;

(2) The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction through which funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing consideration. If a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender is confidential if the person filing the application so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring person for the preceding 5 fiscal years, or for a lesser period if the acquiring person and any predecessors have been in existence for less than 5 years, and similar unaudited information as of a date not earlier than 90 days before the filing of the application;

(4) Any plans or proposals that each acquiring person may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in paragraph A that each acquiring person proposes to acquire, the terms of the offer, request, invitation, agreement or acquisition referred to in paragraph A and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in paragraph A that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring person;

(7) A full description of any contracts, arrangements or understandings with respect to any security referred to in paragraph A in which any acquiring person is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits or the giving or withholding of proxies. The description must identify the persons with whom the contracts, arrangements or understandings have been entered into;

(8) A description of the purchase by any acquiring person of any security referred to in paragraph A during the 12 calendar months preceding the filing of the application, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid;

(9) A description of any recommendations to purchase any security referred to in paragraph A made during the 12 calendar months preceding the filing of the application by any acquiring person or by anyone based upon interviews with or at the suggestion of the acquiring person;

(10) Copies of all tender offers for, requests or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in paragraph A and copies of any additional related soliciting material that has been distributed;

(11) The terms of any agreement, contract or understanding made or proposed to be made with any broker-dealer as to solicitation of securities referred to in paragraph A for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard to the solicitation of securities referred to in paragraph A;

(12) An agreement by the person required to file the application to provide the annual enterprise risk report required by subsection 8, paragraph B-1 for as long as control by the person exists;

(13) An acknowledgement by the person required to file the application that the person and all subsidiaries within its control in the insurance holding company system will provide information to the superintendent upon request as necessary to evaluate enterprise risk to the insurer;

(14) A statement as to whether or not the proposed transaction will result in an increase in market share in this State in any line of insurance as specified in the annual statement required to be filed under section 423 for one or more insurers with combined market share greater than 5% and, if so, such further information on the competitive impact of the proposed transaction as the superintendent requires by rule or order; and

(15) Such additional information as the superintendent may prescribe by rule or order. [2013, c. 238, Pt. A, §11 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D. The superintendent may exempt a person otherwise subject to the requirements of this subsection and subsection 7 from some or all of those requirements if the person demonstrates to the satisfaction of the superintendent that an exemption will not be detrimental to the interests of policyholders in the State or the public and that the transaction satisfies at least one of the following criteria:

(1) The interests of the State in regulating the transaction are minimal relative to the interests of other jurisdictions or are minimal relative to the impact of the transaction as a whole;

(2) The person proposes a divestiture of control under paragraph B and the superintendent determines that the prior approval process is not necessary in the circumstances of the transaction;

(3) A party proposing to acquire presumed control submits a disclaimer fully disclosing all material relationships and bases for affiliation with the insurer and demonstrating to the satisfaction of the superintendent that the person will not be acquiring actual control. As a condition of granting an exemption under this subparagraph, the superintendent may require the person to agree to reasonable restrictions on the exercise of rights or powers that might otherwise tend to result in control;

(4) The superintendent elects to participate in a consolidated approval proceeding conducted under the laws of one or more other states pursuant to subsection 7-A, paragraph E; and

(5) The transaction involves the control of a person that is not primarily engaged in the business of insurance, directly or through its affiliates, and there will be no material impact on the management or operations of a domestic insurer.

A person requesting an exemption under this paragraph must agree to provide additional information if needed by the superintendent and to postpone the effective date of the transaction if ordered by the superintendent while the request for exemption is pending. [2013, c. 238, Pt. A, §11 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

E. A broker-dealer that is exempt from the requirements of this section pursuant to subsection 2, paragraph B, subparagraph (3) shall disclose to the superintendent the identity of any person, or group of persons the broker-dealer knows or reasonably believes to be acting in concert, on whose behalf the broker-dealer knows or reasonably believes that the broker-dealer holds 5% or more of the voting securities of a domestic insurer or of any entity the broker-dealer knows or reasonably believes to be a controlling person of a domestic insurer. A broker-dealer shall disclose to the superintendent on request the beneficial owners of any securities held by the broker-dealer of any entity that is, or that the superintendent believes might be or might become, a member of the insurance holding company system of an insurer subject to registration under subsection 8. [2013, c. 238, Pt. A, §11 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §11 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

5. **Tender offer material.** All requests or invitations for tenders or advertisements making a tender offer or requesting or inviting tenders of such voting securities for control of a domestic insurer or its controlling person made by or on behalf of any such person must contain any information specified in subsection 4-C as the superintendent may prescribe and must be filed with the superintendent at the time that material is first published or sent or given to security holders. Copies of any additional material soliciting or requesting such tender offers subsequent to the initial solicitation or request must contain the information that the superintendent may prescribe as necessary or appropriate in the public interest or for the protection of policyholders and must be filed with the superintendent at the time copies of that material are first published or sent or given to security holders.

[2013, c. 238, Pt. A, §12 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

6. **Information as to applicant.** If a person required to file an application under subsection 4-C is a partnership, limited partnership, syndicate or other group, the superintendent may require that the information called for by subsection 4-C must be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group and each person who controls any such partner or member. If a person required to file an application under subsection 4-C is a corporation, the superintendent may require that the information called for by subsection 4-C must be given with respect to the corporation and each officer and director thereof and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding securities of the corporation.

[2013, c. 238, Pt. A, §13 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

7. **Approval, disapproval of proposed change of control.**

A. The superintendent shall hold a hearing in accordance with the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4, within 30 days after the application required by subsection 4-C has been filed with the superintendent. The superintendent shall make a determination within 30 days after the conclusion of that hearing. The superintendent shall approve any purchase, exchange, merger or other change of control referred to in subsection 4-C unless the superintendent finds that:

(1) After the change of control, the domestic insurer could not satisfy the requirements for the issuance of a certificate of authority according to requirements in force at the time of the issuance or last renewal or continuation of its certificate of authority to do the insurance business that it intends to transact in this State;

(2) The effect of the purchases, exchanges, merger of a controlling person of the insurer or other changes of control may be substantially to lessen competition in insurance in this State or tend to create a monopoly in this State or would violate the laws of this State or of the United States relating to monopolies or restraints of trade;

(3) The financial condition of an acquiring person would jeopardize the financial stability of the insurer or prejudice the interest of its policyholders;

(4) The plans or proposals that the acquiring or divesting person has to liquidate the insurer, to sell its assets or to merge it with any person, or to make any other major change in its business or corporate structure or management, are unfair or prejudicial to policyholders;

(5) The competence, experience and integrity of those persons who would control the operation of the insurer indicate that it would not be in the interest of policyholders or the public to permit them to do so;

(6) Any merger of a domestic insurer does not comply with section 3474; or

(7) The change of control would tend to affect adversely the contractual obligations of the domestic insurer or its ability and tendency to render service in the future to its policyholders and the public.
[2013, c. 238, Pt. A, §14 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

B. Paragraph A, subparagraphs (3) to (7) do not apply to any change of control if and to the extent that the superintendent, by rule or by order, exempts the change of control from the provisions of those subparagraphs as not included within the purpose of this subsection. [2013, c. 238, Pt. A, §14 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

C. Merger, consolidation or bulk reinsurance as to a domestic insurer may be effectuated only pursuant to the applicable provisions of chapter 47, subchapter 4 and sections 3875, 4108 and 4109, as related to organization and powers of insurers. [2013, c. 238, Pt. A, §14 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

D. Violation.

(1) Failure to file the application required under subsection 4-C constitutes a violation of this section.

(2) Effectuation of or any attempt to effectuate an acquisition of control of, divestiture of control of or merger with a domestic insurer earlier than 30 days after the filing of the application required by subsection 4-C, before the superintendent's decision if a hearing is held or after disapproval by the superintendent of the acquisition, divestiture or merger, constitutes a violation of this section. [2013, c. 238, Pt. A, §14 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §14 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

7-A. **Consolidated proceedings.** If a proposed change of control requires, or is part of a series of related transactions that require, the approval of the insurance regulators of more than one state, a person filing an application under subsection 4-C with respect to the change of control may file a request for a consolidated approval proceeding with the National Association of Insurance Commissioners.

A. The applicant shall file a copy of the application made under subsection 4-C with the National Association of Insurance Commissioners within 5 days after making the request for a consolidated approval proceeding. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. Within 10 days after receiving notice from the National Association of Insurance Commissioners of a request for a consolidated approval proceeding, the superintendent shall issue an order, with notice to the applicant and to the National Association of Insurance Commissioners, specifying whether the superintendent elects to participate in the consolidated proceeding or to opt out of the consolidated proceeding. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. If the superintendent opts out of the consolidated approval proceeding pursuant to paragraph B, the superintendent shall hold a public hearing under subsection 7 unless the superintendent grants an exemption under subsection 4-C, paragraph D. Opting out of the consolidated proceeding does not preclude or limit the superintendent’s authority to coordinate a proceeding conducted under subsection 7 with the consolidated proceeding or with other parallel proceedings in other states. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D. With the agreement of the other participating insurance regulators, the superintendent may initiate a consolidated approval proceeding under this paragraph to render decisions on all applications within the scope of the order of consolidation issued by the superintendent. A consolidated approval proceeding convened under this paragraph is a public adjudicatory proceeding. Except as provided in this paragraph, the proceeding must be conducted in the same manner as a proceeding under subsection 7.

(1) A person who would have the right to participate in a proceeding on any of the consolidated applications held under subsection 7 or substantially similar laws of other states has the right to participate in the proceeding.

(2) The chief insurance regulator of a participating state has the right to participate in making the decision or in designating a decision-making panel.

(3) The proceeding is public, except that deliberations of a decision-making panel are not public proceedings and communications in the course of those deliberations among panel members and their advisers, other than the decision itself, are not public records.

(4) The proceeding may be held in any state with a significant connection to the subject transactions or in a nearby location in an adjacent state. Sessions may be held in different states. Provision must be made for parties, witnesses, insurance regulators and members of the public to attend and participate in the proceeding by telecommunication.

(5) The superintendent, decision-making panel or presiding officer may vary the applicable procedural requirements under this Title and Title 5 to the extent the superintendent, panel or presiding officer determines to be reasonably necessary for the fair and effective administration of a consolidated multistate proceeding.

(6) The decision is subject to judicial review in the same manner as a final agency action of the superintendent. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

E. The superintendent may participate, including serving as a decision maker or member of a decision-making panel, in a consolidated approval proceeding conducted under the laws of one or more other states if the consolidated proceeding provides for a public hearing with substantially similar rights of participation and judicial review as a proceeding conducted pursuant to paragraph D. If the superintendent elects under this paragraph to participate in a consolidated proceeding that is conducted under the laws of one or more other states, the application is exempt from further review under this section pursuant to subsection 4-C, paragraph D, subparagraph (4) and the consolidated proceeding, notwithstanding the superintendent's participation, is not subject to any provisions of the law of this State governing adjudicatory proceedings, judicial review, public records or public meetings. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

7-B. **Supervisory colleges.** In order to assess the business strategy, financial position, legal and regulatory position, risk exposure including enterprise risk, risk management and governance processes of a domestic insurer that is part of an insurance holding company system with international operations, the superintendent may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. A supervisory college may be convened as either a temporary or permanent forum for communication and cooperation among the regulators charged with the supervision of the insurer or its affiliates.

A. The superintendent's powers with respect to supervisory colleges include, but are not limited to:

(1) Initiating the establishment of a supervisory college or participating in a supervisory college initiated by one or more other regulators;

(2) Entering into agreements providing the basis for cooperation between the superintendent and the other participating regulators and for the activities of the supervisory college, including but not limited to agreements for sharing confidential information under section 216, subsection 5;

(3) Obtaining and providing assistance in examinations conducted under subsection 1-A or under the examination authority of other participating jurisdictions;

(4) Clarifying the membership and participation of other regulators in the supervisory college;

(5) Clarifying the functions of the supervisory college and the role of other regulators, including the designation of the superintendent or another member of the supervisory college as a group-wide supervisor;

(6) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities and processes for information sharing; and

(7) Establishing a crisis management plan. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. A domestic insurer whose activities are subject to this subsection is liable for and shall pay the reasonable expenses of the superintendent's participation in a supervisory college, including reasonable travel expenses. The superintendent may establish a regular assessment to the insurer for the payment of these expenses. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. This section may not be construed to delegate to a supervisory college the authority of the superintendent to regulate or supervise an insurer or its affiliates within this State. [2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §15 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

8. Registration of holding company system insurers.

A. An insurer that is authorized to do business in this State and that is a member of an insurance holding company system shall register with the superintendent, except that these requirements do not apply to a foreign insurer domiciled in a jurisdiction that in the opinion of the superintendent has adopted by statute or regulation disclosure statements and standards substantially similar to those contained in this section. An insurer domiciled in a jurisdiction that has not adopted by statute or regulation disclosure requirements and standards substantially similar to those contained in this section may be treated as a domestic insurer for purposes of this section. Each insurer that is subject to registration under this subsection shall register within 15 days after it becomes subject to registration, and annually thereafter by May 1st, unless the superintendent, for good cause shown, extends the time for registration and then an insurer shall register within that extended time. This section does not prohibit the superintendent from requesting any authorized insurer that is a member of an insurance holding company system and not subject to registration under this section to provide a copy of the registration statement or other information filed by such insurer with the insurance regulatory authority of its state of domicile. Upon request of the insurer or of the insurance regulatory authority of another jurisdiction in which the insurer is authorized to transact insurance, the superintendent at the insurer's expense shall furnish a copy of the registration statement or other information filed by a domestic insurer with the superintendent pursuant to this section; [2013, c. 238, Pt. A, §16 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

B. An insurer subject to registration shall file a registration statement with the superintendent on a form and in a format prescribed by the National Association of Insurance Commissioners. The registration statement must contain current information about:

(1) The capital structure, general financial condition, ownership and management of the insurer and of any person controlling the insurer;

(1-A) The identity and relationship of every member of the insurance holding company system;

(2) The following transactions currently outstanding between the insurer and its affiliates:

(a) Loans and other investments, and purchases, sales or exchanges of securities of the affiliate by the insurer or of the insurer by its affiliates;

(b) Purchases, sales or exchanges of assets;

(c) Transactions not in the ordinary course of business;

(d) Guarantees or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(e) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles;

(f) Reinsurance agreements;

(g) Dividends and other distributions to shareholders; and

(h) Consolidated tax allocation agreements;

(2-A) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(2-B) If requested by the superintendent, financial statements of or within the insurance holding company system, including all affiliates. The required financial statements may include but are not limited to annual audited financial statements filed with the United States Securities and Exchange Commission pursuant to the Exchange Act. An insurer required to file financial statements pursuant to this subparagraph may satisfy the request by providing the superintendent with the most recently filed parent corporation financial statements that have been filed with the United States Securities and Exchange Commission;

(3) Other matters concerning transactions between the insurer and any affiliate as may be required by the superintendent; and

(4) Any other information required by the superintendent by rule; [2013, c. 238, Pt. A, §17 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

B-1. The controlling person with ultimate control of an insurer subject to registration shall also file an annual enterprise risk report. The report must be appropriate to the nature, scale and complexity of the operations of the insurance holding company system and must, to the best of the controlling person's knowledge and belief, identify the material risks within the insurance holding company system, if any, that could pose enterprise risk to the insurer. The report must be filed with the lead state regulator of the insurance holding company system as determined by the procedures within the financial analysis handbook adopted by the National Association of Insurance Commissioners; [2013, c. 238, Pt. A, §18 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B-2. An insurer subject to registration shall file statements confirming that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved and implemented and continue to maintain and monitor corporate governance and internal control procedures; [2013, c. 238, Pt. A, §18 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B-3. A domestic insurer that is subject to registration, and has annual premium of $500,000,000 or more or is a member of an insurance holding company system with annual premium of $1,000,000,000 or more, shall conduct an own risk and solvency assessment in accordance with the requirements of this paragraph at least annually, and also at any time when there are significant changes to the risk profile of the insurer or its insurance holding company system, except as otherwise provided in subparagraph (1). For purposes of this paragraph, "premium" means direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation within the United States Department of Agriculture, Risk Management Agency and with the National Flood Insurance Program within the United States Department of Homeland Security, Federal Emergency Management Agency.

(1) This paragraph does not apply if:

(a) The insurer is an agency, authority or instrumentality of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia or a state or political subdivision of a state;

(b) The insurer and its insurance holding company system did not meet either of the minimum premium criteria of this paragraph in the financial statements immediately preceding their most recent financial statements and the superintendent has not required compliance with this paragraph under subparagraph (2); or

(c) The superintendent has granted a waiver from the requirements of this paragraph based upon unique circumstances. In deciding whether to grant a waiver, the superintendent may consider the type and volume of business written by the insurer, the ownership and organizational structure of the insurer and its insurance holding company system and any other factor the superintendent considers relevant to the insurer or the insurer's insurance holding company system. If the insurer's insurance holding company system includes insurers domiciled in more than one state, the superintendent shall coordinate with the lead regulator and with other domiciliary regulators in considering whether to grant the insurer's request for a waiver.

(2) The superintendent may require an insurer that does not meet either of the minimum premium criteria of this paragraph to comply with the requirements of this paragraph if:

(a) The superintendent determines that the insurer should be subject to this paragraph due to unique circumstances, including, but not limited to, the type and volume of business written by the insurer, the ownership and organizational structure of the insurer and its insurance holding company system, federal agency requests and international supervisor requests;

(b) The insurer is subject to a corrective order or required to adopt a risk-based capital plan under sections 6453 to 6456;

(c) The superintendent has determined in accordance with rules adopted by the superintendent that the insurer is in hazardous financial condition; or

(d) The superintendent has determined that the insurer otherwise exhibits qualities of a troubled insurer.

(3) If an insurer's insurance holding company system has annual premium of $1,000,000,000 or more, the assessment and reporting required by this paragraph must be conducted for each insurer within the insurance holding company system, either on a systemwide basis or separately for insurers or combinations of insurers within the insurance holding company system.

(4) An insurer subject to this paragraph shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. An insurer may satisfy this requirement by participating in an applicable risk management framework maintained by the insurance holding company system of which the insurer is a member.

(5) An insurer subject to this paragraph shall prepare and submit regular ORSA summary reports that satisfy the requirements of this subparagraph and shall provide additional information to the superintendent upon request.

(a) Beginning no later than 2015, the ORSA summary report must be prepared at least annually, on a timetable consistent with the insurer's internal strategic planning processes, and submitted to the lead regulator of the insurer's insurance holding company system, as determined by the procedures within a financial analysis handbook adopted by the National Association of Insurance Commissioners. If the superintendent is not the lead regulator, the insurer shall submit the insurer's or insurance holding company system's most recent ORSA summary report to the superintendent on request.

(b) The ORSA summary report must be prepared consistent with the ORSA guidance manual. Documentation and supporting information must be maintained and made available upon examination by or upon request of the superintendent.

(c) The insurer's or insurance holding company system's chief risk officer, or other executive having responsibility for the oversight of the insurer's enterprise risk management process, shall sign the ORSA summary report attesting to the best of the signer's belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee of the board.

(d) An insurer may comply with this paragraph by providing the most recent ORSA summary report and a report or reports that are substantially similar to the ORSA summary report that are provided by the insurer or another member of its insurance holding company system to the insurance commissioner of another state or to an insurance supervisor or regulator of a foreign jurisdiction if that report provides information that is comparable to the information described in the ORSA guidance manual. Any report in a language other than English must be accompanied by an English translation.

(6) The superintendent's review of the ORSA summary report, and any additional requests for information, must be consistent with accepted regulatory procedures for the analysis and examination of multistate or global insurers and insurance groups. [2013, c. 238, Pt. A, §18 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. An insurer does not need to disclose on the registration statement filed pursuant to this subsection information that is not material to the purposes of this section. Unless the superintendent by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit or investments involving 1/2 of 1% or less of an insurer's admitted assets as of December 31st immediately preceding are not material for purposes of this section; [2013, c. 238, Pt. A, §19 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

D. Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting on forms provided by the superintendent all material changes or additions on or before the 15th day of the month following that in which it learns of each such change or addition; [1975, c. 356, §1 (NEW).]

E. The superintendent shall terminate the registration of any insurer which demonstrates that it is no longer a member of an insurance holding company system; [1975, c. 356, §1 (NEW).]

F. Two or more affiliated insurers subject to registration hereunder may file a consolidated registration statement or consolidated reports amending their respective consolidated statements or their individual registration statements so long as such consolidated filings correctly reflect the condition of and transactions between such persons; [1975, c. 356, §1 (NEW).]

G. The superintendent may allow or require any insurer, which is authorized to do business in this State and which is part of an insurance holding company system, to register on behalf of any affiliated insurer which is required to register under paragraph A and to file all information and material required to be filed under this section; [1975, c. 356, §1 (NEW).]

H. This section shall not apply to any insurer, information or transaction if and to the extent that the superintendent by rule, regulation or order shall exempt the same from the provisions of this section as not comprehended within the purposes thereof; [1975, c. 356, §1 (NEW).]

I. Any person may file with the superintendent a disclaimer of affiliation with any authorized insurer. A disclaimer of affiliation may be filed by the insurer or any member of an insurance holding company system. The disclaimer must fully disclose all material relationships and bases for affiliation between the disclaiming person and the insurer as well as the bases for disclaiming affiliation.

(1) An approved disclaimer relieves the disclaiming person of the duty to register under this section.

(2) A disclaimer is deemed approved unless the superintendent, within 30 days after receipt of a complete disclaimer, including any additional information required by the superintendent, either disallows the disclaimer or notifies the disclaiming person that a hearing will be held on the disclaimer.

(3) The superintendent may condition the approval of a disclaimer on terms and conditions reasonably designed to ensure that the disclaiming person will not exercise actual control or acquire the right to actual control over the insurer without triggering the prior approval process under subsections 4-C and 7.

(4) If the superintendent takes action on a disclaimer without hearing, including the imposition of conditions not agreed to by the disclaiming person, an aggrieved person has the right to a hearing.

(5) The superintendent may rescind the approval of a disclaimer, after notice and opportunity for hearing, on the basis of new information or changed circumstances demonstrating the existence of control over the insurer. [2013, c. 238, Pt. A, §20 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §§16-20 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

9. **Transactions with affiliates; standards.** Transactions by insurers subject to registration with their affiliates are subject to the following standards.

A. The terms, including any charges or fees for services performed, must be fair and reasonable. [1991, c. 828, §5 (AMD).]

A-1. Agreements for cost-sharing services and management must include any provisions required by the superintendent by rule. [2013, c. 238, Pt. A, §21 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. The books, accounts and records of each party must be so maintained as to disclose clearly and accurately the nature and details of the transaction, including all accounting information necessary to support the reasonableness of any charges or fees. [1991, c. 828, §5 (AMD).]

C. The insurer's surplus to policyholders following any dividends or distributions to stockholder affiliates must be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. [1991, c. 548, Pt. B, §3 (AMD).]

D. Expenses incurred and payment received must be allocated to the insurer in conformity with customary insurance accounting practices consistently applied. [1991, c. 828, §5 (NEW).]

E. A domestic insurer shall notify the superintendent in writing at least 30 days in advance, unless the superintendent authorizes a shorter period, before entering into or materially amending or modifying any of the following kinds of transactions with any member of its holding company system:

(1) Sales, purchases, exchanges, loans or extensions of credit, guarantees or investments that are equal to or exceed:

(a) With respect to nonlife insurers, the lesser of 3% of the insurer's admitted assets as of December 31st of the preceding year and 25% of surplus to policyholders;

(b) With respect to life insurers, 3% of the insurer's admitted assets as of December 31st of the preceding year; or

(c) With respect to nonprofit hospital and medical service organizations and their 100% controlled affiliates that operate as monoline health insurers or health maintenance organizations, the lesser of 5% of the entity's admitted assets as of December 31st of the preceding year and 25% of surplus to policyholders;

(2) Loans or extensions of credit to any person who is not an affiliate, if the insurer makes the loan or extension of credit with the agreement or understanding that the proceeds in whole or in substantial part are to be used to make loans or extensions of credit to, purchase assets of or make investments in any affiliate of the insurer if the loan, extension of credit, purchase or investment is equal to or exceeds:

(a) With respect to nonlife insurers, the lesser of 3% of the insurer's admitted assets as of December 31st of the preceding year and 25% of surplus to policyholders;

(b) With respect to life insurers, 3% of the insurer's admitted assets as of December 31st of the preceding year; or

(c) With respect to nonprofit hospital and medical service organizations and their 100% controlled affiliates that operate as monoline health insurers or health maintenance organizations, the lesser of 5% of the entity's admitted assets as of December 31st of the preceding year and 25% of surplus to policyholders;

(3) All reinsurance pooling agreements, and all reinsurance agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a projected change in the insurer's liabilities in any of the next 3 years, equals or exceeds 5% of the insurer's surplus to policyholders, as of December 31st of the preceding year, including those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(4) All management agreements, cost-sharing arrangements, tax allocation agreements, service contracts and guaranties, with the exception of guaranties that are quantifiable in amount and do not exceed, in the aggregate, the lesser of 0.5% of admitted assets and 10% of surplus as regards policyholders as of December 31st of the preceding year;

(5) Any transactions that are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the superintendent determines that those separate transactions were entered into over any 12-month period for such a purpose, the superintendent may exercise authority under this subsection; and

(6) Any other material transactions specified by rule that the superintendent has determined may adversely affect the interests of the insurer's policyholders.

A notice of amendment or modification of a transaction must include the reasons for the change and the financial impact on the domestic insurer. The insurer shall notify the superintendent within 30 days after terminating an agreement previously reported under this paragraph.

The superintendent shall disapprove a transaction that is subject to this paragraph if the transaction violates the standards of this section or other applicable law or adversely affects the interests of policyholders. The superintendent's failure to make a determination on a proposed transaction within 30 days after it has been submitted for review has the effect of an approval, unless the superintendent has issued a notice of adjudicatory hearing on the proposal in accordance with section 230. [2013, c. 238, Pt. A, §21 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

Any violation of this subsection, in addition to the penalties contained in subsection 14, renders the transactions voidable at the initiative of the superintendent or otherwise under applicable law. The superintendent's approval of a transaction in accordance with this section, whether actual or by acquiescence, may not override any applicable law and does not operate to authorize any transaction that would be contrary to law if it involved an insurer not a member of the same holding company system.

[2013, c. 238, Pt. A, §21 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

10. **Insurer's surplus; adequacy factors.** For the purposes of this section, in determining whether an insurer's surplus to policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, may be considered:

A. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria; [1975, c. 356, §1 (NEW).]

B. The extent to which the insurer's business is diversified among the several lines of insurance; [1975, c. 356, §1 (NEW).]

C. The number and size of the risks insured in each line of business; [1975, c. 356, §1 (NEW).]

D. The extent of the geographical dispersion of the insurer's insured risks; [1975, c. 356, §1 (NEW).]

E. The nature and extent of the insurer's reinsurance program; [1975, c. 356, §1 (NEW).]

F. The quality, diversification and liquidity of the insurer's investment portfolio; [1975, c. 356, §1 (NEW).]

G. The recent past and projected future trend in the size of the insurer's surplus as regards policyholders; [1993, c. 313, §10 (AMD).]

H. The quality and liquidity of investments in subsidiaries or affiliates. The department may discount any such investment or treat any investment as a nonadmitted asset for purposes of determining the adequacy of surplus as regards policyholders whenever the investment so warrants; [1993, c. 313, §10 (AMD).]

I. The adequacy of the insurer's reserves; [1993, c. 313, §10 (AMD).]

J. The surplus as regards policyholders maintained by other comparable insurers in respect of the factors set out in this subsection; and [1993, c. 313, §10 (AMD).]

K. The quality of the company's earnings and the extent to which the reported earnings include extraordinary items. [1993, c. 313, §10 (NEW).]

[2013, c. 238, Pt. A, §22 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

11. **Dividends and distributions.**

[1993, c. 313, §11 (RP) .]

11-A. **Extraordinary dividends.**

[2009, c. 511, Pt. A, §3 (RP) .]

11-B. **All other dividends and distributions.**

[2009, c. 511, Pt. A, §4 (RP) .]

11-C. **Dividends and distributions.** The superintendent shall review all dividends and distributions declared or paid by any insurer registered under subsection 8 at least annually.

A. An insurer shall notify the superintendent within 5 days after the declaration of any dividend or distribution. If the dividend or distribution is not disapproved pursuant to paragraph B and is not an extraordinary dividend as defined in paragraph C, the insurer may pay the dividend or distribution once the superintendent has approved the payment or 10 days have elapsed after the superintendent’s receipt of notice. [2009, c. 511, Pt. A, §5 (NEW).]

B. The superintendent shall issue an order restricting or disallowing the payment of dividends and distributions if the superintendent determines that the insurer's surplus would not be reasonable in relation to the insurance company's outstanding liabilities, that the insurer's surplus would be inadequate to that company's financial needs, that the insurer's financial condition would constitute a condition hazardous to policyholders, claimants or the public or that a violation of subsection 4-C prevents the superintendent from sufficiently understanding the enterprise risk to the insurer posed by its affiliates or by its insurance holding company system. [2013, c. 238, Pt. A, §23 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

C. An extraordinary dividend may not be paid until affirmatively approved by the superintendent or until at least 60 days after the superintendent has received a request to pay an extraordinary dividend.

(1) For purposes of this subsection, "extraordinary dividend" means any dividend or distribution, other than a pro rata distribution of a class of the insurer’s own securities, that:

(a) Exceeds 10% of the insurer's surplus to policyholders as of December 31st of the preceding year or the net gain from operations for the preceding calendar year, whichever is greater;

(b) Is declared within 5 years after any acquisition of control of a domestic insurer or of any person controlling that insurer, unless it has been approved by a number of continuing directors equal to a majority of the directors in office immediately preceding that acquisition of control; or

(c) Is not paid entirely from unassigned funds. For purposes of this division, 50% of the net of unrealized capital gains and unrealized capital losses, reduced, but not to less than zero, by that portion of the asset valuation reserve attributable to equity investments, must be excluded from the calculation of unassigned funds.

(2) An insurer may declare an extraordinary dividend on a conditional basis, subject to the superintendent's approval. A declaration pursuant to this subparagraph does not confer any rights upon stockholders until the superintendent has approved the payment or the 60-day review period has elapsed. [2009, c. 511, Pt. A, §5 (NEW).]

[2013, c. 238, Pt. A, §23 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

12. **Verification of information.**

[2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §24 (RP) .]

13. **Confidential communications.**

[2013, c. 238, Pt. A, §34 (AFF); 2013, c. 238, Pt. A, §25 (RP) .]

13-A. **Confidential information.** This section applies to holding company information that is in the possession or control of the superintendent or that is in the possession or control of the National Association of Insurance Commissioners as a result of a filing under this section or as a result of information sharing by the superintendent as authorized by this section.

A. For purposes of this subsection, "holding company information" means any of the following documents, materials and other information if the document, material or other information has not specifically and expressly been designated as a public record by other applicable law:

(1) Information obtained by the superintendent pursuant to an examination or investigation pursuant to subsection 1-A to the same extent as the information would have been confidential if obtained in an examination or investigation conducted under section 220 or 221;

(2) A registration statement or report filed under subsection 8, including all supporting information;

(3) A report filed under subsection 9, including all supporting information;

(4) A notice of proposed divestiture filed under subsection 4-C, paragraph B, until the divestiture transaction has occurred;

(5) A disclosure of the beneficial owner of securities made by a broker-dealer pursuant to subsection 4-C, paragraph E;

(6) The identity of a lender that is to finance a proposed transaction if declared confidential under subsection 4-C, paragraph C, subparagraph (2);

(7) Information filed in support of any required attestation of risk management or internal controls under subsection 4-C, paragraph C, subparagraph (12) or (13);

(8) A competitive impact statement filed under subsection 4-C, paragraph C, subparagraph (14), including all supporting information;

(9) Information obtained under an information-sharing agreement entered into pursuant to this section to the extent that it is protected by the confidentiality provisions of the agreement;

(10) Information obtained pursuant to this section from a jurisdiction other than this State to the extent that it is confidential under the laws of the jurisdiction in which it is normally maintained; and

(11) Information obtained under this section to the extent that it is confidential under other applicable law, including, but not limited to, section 216, section 225 and Title 1, section 402, subsection 3. [2013, c. 238, Pt. A, §26 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

B. Except as otherwise provided by paragraphs D and E or specifically and expressly provided by other applicable law, holding company information is confidential, is not a public record, is not subject to a subpoena, is not subject to discovery or admissible as evidence in any private civil action and may not be made public by the superintendent without prior written consent of the relevant insurer. The privilege provided under this paragraph does not supersede any other applicable privilege or confidentiality protection, nor does disclosure of confidential holding company information to the superintendent constitute a waiver of any such privilege or protection. Neither the superintendent nor any person who received holding company information from or under the authority of the superintendent under this section may be permitted or required to testify in any private civil action concerning holding company information that is confidential under this subsection. [2013, c. 238, Pt. A, §26 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

C. The superintendent may share holding company information that is confidential under this subsection only in accordance with the requirements of section 216, subsection 5 and the following additional requirements.

(1) The recipient of the information must agree in writing to maintain the same level of confidentiality as is available under Maine law. This requirement may be satisfied through a multilateral confidentiality agreement to which both the superintendent and the recipient are parties.

(2) The superintendent may not share confidential holding company information with or through the National Association of Insurance Commissioners except in accordance with an information-sharing agreement entered into in accordance with section 216, subsection 5, paragraph C.

(3) If the recipient of the information is in the United States, the recipient's state must have statutes or rules that expressly protect holding company information at a level at least equivalent to the protections provided by this subsection and section 216, subsection 5.

(4) ORSA-related information subject to subsection 8, paragraph B-3 may, with the written consent of the insurer, be shared with a 3rd-party consultant under an agreement containing the conditions specified in section 216, subsection 5, paragraph C. In addition, any agreement for sharing ORSA-related information with the National Association of Insurance Commissioners or a 3rd-party consultant must further provide that:

(a) The recipient of the information agrees in writing to maintain the confidentiality and privileged status of the ORSA-related information and has verified in writing the legal authority to maintain confidentiality;

(b) Any preauthorization granted under the agreement for further sharing of information provided by the superintendent must be limited to only the domiciliary regulators of other insurers in the same insurance holding company system; and

(c) The National Association of Insurance Commissioners or a 3rd-party consultant may not store ORSA-related information shared pursuant to this subparagraph in a permanent database after the underlying analysis is completed. [2013, c. 238, Pt. A, §26 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

D. This subsection does not prohibit the superintendent from using holding company information in the furtherance of any regulatory or legal action brought as a part of the superintendent's official duties. [2013, c. 238, Pt. A, §26 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

E. Unless otherwise provided by applicable law, the superintendent may, after giving notice and opportunity for hearing to the insurer and any affiliates, controlling person or other persons that would be affected, order one or more items of holding company information, other than ORSA-related information, to be made a public record in its entirety or in redacted form if the superintendent determines that public disclosure will be in the interest of policyholders, shareholders or the public. [2013, c. 238, Pt. A, §26 (NEW); 2013, c. 238, Pt. A, §34 (AFF).]

[2013, c. 238, Pt. A, §26 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

14. Penalties.

A. Any person who willfully violates any of the provisions of this section, or the rules and regulations promulgated by the superintendent under authority thereof, or any person who willfully, in a filing pursuant to subsection 4-C or a registration pursuant to subsection 8, paragraph B, makes any untrue statement of a material fact or omits to state any material fact required to be stated therein or necessary to make the statements therein not misleading, must upon conviction be fined not more than $1,000 or imprisoned not more than 3 years, or both; [2013, c. 238, Pt. A, §27 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

B. Any person who is found, after notice and opportunity to be heard, to have willfully violated any of the provisions of this section or any rule or regulations promulgated by the superintendent under the authority thereof, shall, in addition to any other penalty provided by law, forfeit to this State the sum of $50 for a first violation and an additional sum of $25 for each day such violation shall continue; [1975, c. 356, §1 (NEW).]

C. In addition to other remedies and penalties provided in this section or otherwise available under the laws of this State, any violation of this section is hereby declared to be an unfair method of competition or an unfair or deceptive act and practice in the business of insurance subject to the provisions of chapter 23 and in addition, the superintendent may, after notice and hearing:

(1) Refuse to issue, refuse to renew or reissue, revoke or suspend for a period not exceeding one year any license or certificate of authority issued or to be issued to any person found to have violated any of the provisions of this section;

(2) After notice and hearing impose by order and administrative forfeiture upon such person, enforceable by such revocation, suspension or refusal to issue, renew or reissue of any such license or licenses or otherwise pursuant to the law of this State, in an amount not to exceed $100 for each such violation and for each day's continuance thereof;

(3) Proceed in a court of competent jurisdiction within or without this State against such person, if an insurer, upon the applicable grounds provided for the rehabilitation, conservatorship or liquidation of an insurer or for an injunction to prevent a violation of this section or to reverse or hold invalid any transaction made in violation of this section;

(4) Issue such administrative orders to require compliance with this section, including the filing of evidence of compliance and periodic reporting as to such compliance, enforceable by such revocation, suspension or refusal to issue, renew or reissue of any such license or licenses or otherwise pursuant to the laws of this State; or

(5) Any or all of the foregoing. [1975, c. 356, §1 (NEW).]

[2013, c. 238, Pt. A, §27 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

14-A. Recovery.

A. If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under that order has the right to recover on behalf of the insurer:

(1) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of any distributions other than distributions of shares of the same class of stock paid by the insurer on its capital stock; or

(2) Any payment in the form of a bonus, termination settlement or extraordinary lump-sum salary adjustment made by the insurer or by any subsidiary of that insurer to a director, officer or employee when the distribution or payment pursuant to this subparagraph or subparagraph (1) is made at any time during the one year preceding the petition for liquidation, conservation or rehabilitation, subject to the limitations of paragraphs B, C and D. [1993, c. 313, §13 (NEW).]

B. Such a distribution is not recoverable if the parent corporation or affiliate shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution could adversely affect the ability of the insurer to fulfill its contractual obligations. [1993, c. 313, §13 (NEW).]

C. Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time distributions were paid is liable up to the amount of distributions or payments under paragraph A that the person received. Any person who otherwise controlled the insurer at the time the distributions were declared is liable up to the amount of the distributions the person would have received if that person had been paid immediately. If 2 or more persons are liable for the same distributions, those persons are jointly and severally liable. [1993, c. 313, §13 (NEW).]

D. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds. [1993, c. 313, §13 (NEW).]

E. To the extent that any person liable under paragraph C is insolvent or fails to pay claims due pursuant to paragraph C, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, is jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it. [1993, c. 313, §13 (NEW).]

[1993, c. 313, §13 (NEW) .]

15. **Additional powers.** The powers, remedies, procedures and penalties provided in this section shall be in addition to, and not in limitation of, any other powers, remedies, procedures and penalties otherwise provided by law.

[1975, c. 356, §1 (NEW) .]

16. **Separability of provisions.** If any provision of this section or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and for this purpose the provisions of this section are separable.

[1975, c. 356, §1 (NEW) .]

17. **Jurisdiction of courts; service of process.** Any person obtaining or attempting to obtain control of a domestic insurer is subject to the jurisdiction of the courts of this State and to service of process in the manner provided in this Title. Unless a valid appointment of an agent for service of process is on file with the superintendent pursuant to another provision of this Title, the person is deemed to have appointed the superintendent as agent for service of process, and service may be made in the same manner as provided in section 2105.

[1999, c. 113, §14 (AMD) .]

18. **Rules.** The superintendent may adopt reasonable rules to carry out provisions of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 238, Pt. A, §28 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

19. **Supplemental to existing provisions.** This section, as to insurance holding company systems, supplements in particular those provisions contained in sections 407, subsection 2; 410, subsection 1, paragraph B; 413; 423-C; 425; 1115; 1136; 3414; 3474; 3475; 3476; 3483; 3875 and 4407; and the provisions of this section are deemed to supersede or modify any such provisions or any other provisions of this Title to the extent inconsistent therewith.

[2013, c. 238, Pt. A, §29 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 356, §1 (RPR). 1977, c. 694, §388 (AMD). 1983, c. 394, §§1, 2 (AMD). 1987, c. 399, §1 (AMD). 1989, c. 385, §§1-9 (AMD). 1989, c. 611, §§1, 4 (AMD). 1991, c. 37, §§1, 2 (AMD). 1991, c. 548, Pt. B, §3 (AMD). 1991, c. 828, §§3-6 (AMD). 1993, c. 313, §§7-13 (AMD). 1999, c. 113, §§8-14 (AMD). 2001, c. 72, §§4, 5 (AMD). 2007, c. 466, Pt. D, §§1-3 (AMD). 2009, c. 511, Pt. A, §§3-5 (AMD). 2013, c. 238, Pt. A, §§2-29 (AMD). 2013, c. 238, Pt. A, §34 (AFF).

§223. CONDUCT OF EXAMINATION; ACCESS TO RECORDS; CORRECTION

1. Whenever the superintendent determines to examine the affairs of any person, the superintendent shall designate one or more examiners and instruct them as to the scope of the examination. The superintendent may designate an examiner outside the bureau if the designee is a competent public accountant or an actuary who is a member of the American Academy of Actuaries and is in active practice. The examiner shall, upon demand, exhibit the examiner's official credentials to the person under examination.

A. An examiner may not be designated by the superintendent if the examiner directly or indirectly has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under sections 221 and 222. This section may not be construed to preclude automatically an examiner from being:

(1) A policyholder or claimant under an insurance policy;

(2) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies; or

(4) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed. [1991, c. 828, §7 (NEW).]

[1991, c. 828, §7 (AMD) .]

2. The superintendent shall conduct each examination in an expeditious, fair and impartial manner, consistent with current guidelines and procedures adopted from time to time by the National Association of Insurance Commissioners and published in its Examiners' Handbook.

[1993, c. 313, §14 (AMD) .]

3. Upon any such examination, the superintendent, or the examiner if specifically so authorized in writing by the superintendent, shall have power to administer oaths, and to examine under oath any individual as to any matter relevant to the affairs under examination or relevant to the examination.

[1973, c. 585, §12 (AMD) .]

4. Every person being examined, its officers, attorneys, employees, agents and representatives shall make freely available to the superintendent or designated examiners the accounts, records, documents, files, information, assets and matters of that person in that person's possession or control relating to the subject of the examination and shall facilitate the examination. The refusal of any insurer to submit to examination is grounds for revocation or refusal of a license or renewal license.

[1991, c. 828, §8 (AMD) .]

5. If the superintendent or examiner finds any accounts or records to be inadequate, or inadequately kept or posted, the superintendent may employ experts to reconstruct, rewrite, post or balance them at the expense of the person being examined, if such person has failed to maintain, complete or correct such records or accounting after the superintendent or examiner has given him written notice and a reasonable opportunity to do so.

[1973, c. 585, §12 (AMD) .]

6. Neither the superintendent nor any examiner shall remove any record, account, document, file or other property of the person being examined from the offices or place of such person, except with the written consent of such person in advance of such removal or pursuant to an order of court duly obtained. This provision shall not be deemed to affect the making and removal of copies or abstracts of any such record, account, document, or file.

[1973, c. 585, §12 (AMD) .]

7. Any individual who refuses without just cause to be examined under oath or who willfully obstructs or interferes with the examiners in the exercise of their authority pursuant to this section shall, upon conviction thereof, be subject to a fine of not more than $2,500 or imprisonment for less than a year, or by both.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §§7,8 (AMD). 1993, c. 313, §14 (AMD).

§224. APPRAISAL OF ASSET

1. If the superintendent considers it necessary to value any asset involved in such an examination, the superintendent may appoint one or more competent disinterested persons as appraisers with authority to appraise the real property of an insurer or any real property on which it holds security.

[1991, c. 828, §9 (AMD) .]

2. Any such appraisal shall be expeditiously made, and a copy thereof furnished to the superintendent and to the person being examined.

[1973, c. 585, §12 (AMD) .]

3. The reasonable expense of the appraisal shall be borne by the person being examined.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §9 (AMD).

§225. EXAMINATION REPORT; CONTENTS; PRIMA FACIE EVIDENCE IN CERTAIN PROCEEDINGS

1. Upon completion of an examination, the examiner in charge shall make a true report thereof which shall comprise only facts appearing upon the books, records or other documents of the person examined, or from an appraisal of assets, or as ascertained from the sworn testimony of its officers or agents or other individuals examined concerning its affairs, and such conclusions and recommendations as may reasonably be warranted from such facts. The report of examination shall be verified by the oath of the examiner in charge thereof.

[1969, c. 132, §1 (NEW) .]

2. Such a report of examination of an insurer so verified shall be prima facie evidence in any delinquency proceeding against the insurer, its officers, employees or agents upon the facts stated therein, and whether or not the report has then been filed in the bureau as provided in section 226.

[1973, c. 585, §12 (AMD) .]

3. All working papers, recorded information, documents and copies of any of these media produced by, obtained by or disclosed to the superintendent or any other person in the course of an examination made under this chapter are confidential, are not subject to subpoena and may not be made public by the superintendent or any other person, except to the extent provided in sections 226 and 227. Access may be granted to the National Association of Insurance Commissioners. Any parties granted access must agree in writing prior to receiving the information to provide the information with the same confidential treatment as required by this section unless prior written consent of the insurer to which the information pertains has been obtained.

[2011, c. 320, Pt. A, §3 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §10 (AMD). 2011, c. 320, Pt. A, §3 (AMD).

§226. EXAMINATION REPORTS; DISTRIBUTION, HEARING; AS EVIDENCE

1. Within 60 days after completion of the examination, the superintendent shall deliver a copy of the verified examination report to the person examined, together with a notice affording that person 20 days or an additional reasonable period as the superintendent for good cause may allow, within which to review the report and recommend changes to the report.

[1999, c. 113, §15 (AMD) .]

2. If requested by the person examined, within the period allowed under subsection 1, or if determined advisable by the superintendent without such request, the superintendent shall hold a hearing relative to the report and may not file the report in the bureau until after the hearing and the superintendent's order on the report; except that the superintendent may furnish a copy of the report to the Governor, Attorney General or Treasurer of State pending final decision and, if the copies are so furnished, they are confidential until the

other requirements of this section with regard to examination reports have been satisfied. In lieu of convening a hearing, the superintendent may reopen the examination or, if supported by the information obtained, may adopt some or all of the modifications proposed by the person examined.

[2011, c. 320, Pt. A, §4 (AMD) .]

3. If no such hearing has been requested or held, the examination report, with such modifications, if any, thereof as the superintendent deems proper, shall be accepted by the superintendent and filed in the bureau upon expiration of the review period provided for in subsection 1. The report shall in any event be so accepted and filed within 6 months after final hearing thereon.

[1973, c. 585, §12 (AMD) .]

4. The superintendent shall forward to the person examined a copy of the examination report as filed, together with any recommendations or statements relating thereto which he deems proper.

[1973, c. 585, §12 (AMD) .]

5. If the report is as to examination of a domestic insurer, a copy of the report, or a summary thereof approved by the superintendent, when filed in the bureau, together with the recommendations or statements of the superintendent or his examiner, shall be presented by the insurer's chief executive officer to the insurer's board of directors or similar governing body at a meeting thereof which shall be held within 30 days next following receipt of the report in final form by the insurer. A copy of the report shall also be furnished by the secretary of the insurer, if incorporated, or by the attorney-in-fact, if a reciprocal insurer, to each member of the insurer's board of directors or board of governors, if a reciprocal insurer, and the certificate of the secretary or attorney-in-fact that a copy of the examination report has been so furnished shall be deemed to constitute knowledge of the contents of the report by each such member.

[1973, c. 585, §12 (AMD) .]

6. The report when so filed in the bureau shall be admissible in evidence in any action or proceeding brought by the superintendent against the person examined, or against its officers, employees or agents. In any such action or proceeding, the superintendent or his examiners may at any time testify and offer proper evidence as to information secured or matters discovered during the course of an examination, whether or not a written report of the examination has been either made, furnished or filed in the bureau.

[1973, c. 585, §12 (AMD) .]

7. The Maine Insurance Code does not prevent and may not be construed to prohibit the superintendent from disclosing the content of an examination report, preliminary examination report or the results, or any matter related to a report or results, to the Bureau of Insurance of this State or the insurance department of any other state or country, or to law enforcement officials of this State, any other state agency or the federal government at any time. Any such disclosure must be subject to a protective order of confidentiality issued by the superintendent.

[1991, c. 828, §11 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 425, §1 (AMD). 1973, c. 585, §12 (AMD). 1991, c. 828, §11 (AMD). 1999, c. 113, §15 (AMD). 2011, c. 320, Pt. A, §4 (AMD).

§227. EXAMINATION REPORT

The report of examination of those persons, partnerships, corporations or other business associations that are subject to examination by the superintendent as provided for in sections 221 and 222 must, upon satisfaction of the requirements of section 226 and so long as no court of competent jurisdiction has stayed its publication, be filed in the bureau as a public record, except that any information relating to an individual insured or individual applicant for insurance is confidential. [2011, c. 320, Pt. A, §5 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 425, §2 (RPR). 1973, c. 585, §12 (AMD). 1991, c. 828, §12 (AMD). 2011, c. 320, Pt. A, §5 (AMD).

§228. EXAMINATION EXPENSE

1. The expense of examination of an insurer or of any person regulated under section 222, shall be borne by the person examined. Such expense shall include only the reasonable and proper hotel and travel expenses of the superintendent and his examiners and assistants, including expert assistance, and examiners furnished for the purpose by other states in which the insurer is authorized to transact insurance, reasonable compensation as to such examiners and assistants and incidental expenses as necessarily incurred in the examination. As to expense and compensation, involved in any such examination the superintendent may give due consideration to scales and limitations recommended by the National Association of Insurance Commissioners and outlined in the examination manual sponsored by that association.

[1975, c. 356, §2 (AMD) .]

2. Such person examined shall promptly pay to the superintendent the expenses of the examination upon presentation by the superintendent of a reasonably detailed written statement thereof. Any insurer with total admitted assets as of the end of the preceding calendar year of $50,000,000 or greater must comply with this section in satisfaction of the examination assessment.

[1997, c. 660, Pt. B, §1 (AMD) .]

3. Except that in lieu of payment of examination expense as above required, a domestic insurer with total admitted assets of less than $50,000,000 has the right, at its option, of making an annual payment to the superintendent of an examination expense allotment in an amount equal to .001 of its total admitted assets as of the end of the preceding calendar year, which must be made on March 1st with the filing of the insurer's annual statement with the superintendent; or, if the insurer's admitted assets exceed $10,000,000, but do not exceed $50,000,000, the insurer has the right, at its further option, to pay to the superintendent with respect to any examination the lesser of:

A. The expense of the examination as determined pursuant to subsections 1 and 2 above; or [1969, c. 132, §1 (NEW).]

B. An annual amount equal to .001 of the first $10,000,000 of the insurer's admitted assets plus .0002 of the remainder of such assets, limited, however, to insurers whose admitted assets do not exceed $25,000,000 as such assets are shown by the insurer's financial statement filed with the superintendent for the year-end next preceding the commencement of the examination, such payment to be made on March 1st with the filing of the insurer's annual statement with the superintendent; or [1997, c. 660, Pt. B, §2 (AMD).]

C. If the admitted assets of the insurer exceed $25,000,000, but do not exceed $50,000,000, an annual payment of an examination expense allotment of an amount equal to .001 of the first $10,000,000 of the insurer's admitted assets, plus .0002 of the next $15,000,000 of such assets, plus .000175 of the

remainder of such assets as are shown by the insurer's financial statement filed with the superintendent for the preceding calendar year. The payment must be made on March 1st with the filing of the insurer's annual statement with the superintendent. [1997, c. 660, Pt. B, §2 (AMD).]

[1997, c. 660, Pt. B, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §3 (AMD). 1973, c. 394, (AMD). 1973, c. 585, §12 (AMD). 1975, c. 356, §2 (AMD). 1975, c. 467, (AMD). 1997, c. 660, §§B1,2 (AMD).

§229. ADMINISTRATIVE PROCEDURES; HEARINGS IN GENERAL

1. The superintendent may hold a hearing without request of others for any purpose within the scope of this Title.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall hold a hearing:

A. If required by any provision of this Title, or [1969, c. 132, §1 (NEW).]

B. Upon written application for a hearing by a person aggrieved by any act or impending act, or by any report or order of the superintendent, other than an order for the holding of a hearing, or order on a hearing, or pursuant to such order, of which hearing such person had notice. [1987, c. 220, §1 (AMD).]

[1987, c. 220, §1 (AMD) .]

3. Any such application must be filed with the superintendent within 30 days after such person knew or reasonably should have known of such act, impending act, failure, report or order, unless a different period is provided for by other applicable law, and in which case such other law shall govern. The application shall briefly state the respects in which the applicant is so aggrieved, together with the ground to be relied upon for the relief to be demanded at the hearing. The superintendent may require that the application be signed and sworn to.

[1987, c. 220, §2 (AMD) .]

4. If the superintendent finds that the application is timely and made in good faith, that the applicant would be so aggrieved if his grounds are established and that such grounds otherwise justify the hearing, he shall hold the hearing within 30 days after filing of the application, or within 30 days after the application has been sworn to, whichever is the later date, unless in either case the hearing is postponed by mutual consent. The hearing shall be held in conformity with the provisions contained in the Maine Administrative Procedure Act, Title 5, chapter 375.

[1977, c. 694, §389 (AMD) .]

5. Failure to hold the hearing upon application therefor of a person entitled thereto as provided shall constitute a denial of the relief sought, and shall be the equivalent of a final order of the superintendent on hearing for the purpose of an appeal under section 236.

[1973, c. 585, §12 (AMD) .]

6. Pending the hearing and decision thereon, the superintendent may suspend or postpone the effective date of his previous action.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §389 (AMD). 1987, c. 220, §§1,2 (AMD).

§230. NOTICE OF HEARING

1. Notice of hearing shall be given in conformity with the Maine Administrative Procedure Act, Title 5, chapter 375.

[1981, c. 501, §38 (RPR) .]

2. Except when a different period is expressly provided by the Maine Administrative Procedure Act, Title 5, chapter 375, or by this Title, the superintendent shall give written notice of hearing not less than 14 days in advance. Notice of hearing may be waived and the hearing held at a time mutually fixed by the superintendent and the parties.

[1981, c. 501, §38 (RPR) .]

3.

[1981, c. 501, §38 (RP) .]

4.

[1981, c. 501, §38 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§390-392 (AMD). 1981, c. 501, §38 (RPR).

§231. CONDUCT OF HEARING

1. The superintendent may hold a hearing in Augusta or any other place of convenience to parties and witnesses, as the superintendent determines. The superintendent or the superintendent's designee shall preside at the hearing and shall expedite the hearing and all procedures involved therein. Adjudicatory hearings shall be governed by the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV.

[1989, c. 269, §6 (AMD) .]

2.

[1989, c. 269, §6 (RP) .]

3.

[1989, c. 269, §6 (RP) .]

4.

[1989, c. 269, §6 (RP) .]

5. The hearing shall be public, unless the superintendent or hearing officer determines that a private hearing would be in the public interest, in which case the hearing shall be private, subject to Title 1, section 405, subsection 6.

[1989, c. 269, §6 (AMD) .]

6.

[1989, c. 269, §6 (RP) .]

7. The validity of any hearing held in accordance with the notice thereof, or waiver of notice, shall not be affected by the failure of any person to attend or remain in attendance.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§393-395 (AMD). 1989, c. 269, §6 (AMD).

§232. WITNESSES AND DOCUMENTARY EVIDENCE

1. As to the subject of any examination, investigation or hearing being conducted by the superintendent, the superintendent may subpoena witnesses and administer oaths or affirmations and examine any individual under oath, or take depositions; and by subpoena duces tecum may require the production of documentary and other evidence. Any delegation by the superintendent of power of subpoena shall be in writing. The procedures of Title 5, section 9060, subsection 1, shall also apply to the issuance of subpoenas.

[1989, c. 269, §7 (AMD) .]

2. Every person subpoenaed to appear at any such hearing, examination or investigation shall obey the subpoena, testify truthfully, conduct himself with decorum and in no way obstruct the proceeding or purpose thereof.

[1969, c. 132, §1 (NEW) .]

3. Witnesses shall be entitled to the same fees and allowances as witnesses in Superior Court; except that no insurer, agent, broker or other person subject to this Title who is a subject of such proceeding, and no officer, director or employee of any of the foregoing, shall be entitled to witness or mileage fees. No person shall be excused from attending and testifying in obedience to a subpoena on the ground that the proper witness fee was not tendered or paid, unless the witness shall have demanded such payment as a condition precedent to attending the hearing, examination or investigation and unless such demand shall not have been complied with.

[1969, c. 132, §1 (NEW) .]

4. Any individual knowingly testifying falsely under oath or making a false affirmation, as to any matter material to any such examination, investigation or hearing, shall upon conviction thereof be guilty of perjury.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 269, §7 (AMD).

§233. WITNESSES; DISCIPLINARY PROCEEDINGS

1. If any individual without reasonable cause fails to appear when summoned as a witness, or refuses to answer a lawful and pertinent question, or refuses to produce documentary evidence when directed to do so by the superintendent, or deports himself in a disrespectful or disorderly manner at the inquiry, or obstructs the proceedings by any means, whether or not in the presence of the superintendent or his designee, he is guilty of contempt and may be dealt with as provided in subsection 2.

[1973, c. 585, §12 (AMD) .]

2. The superintendent or his designee, as the case may be, may file a complaint in the Superior Court, setting forth under oath the facts constituting the contempt and requesting an order returnable in not less than 2 nor more than 5 days, directing the alleged contemner to show cause before the court why he should not be punished for contempt. Upon the return of such order, the court shall examine the alleged contemner under oath and the alleged contemner shall have an opportunity to be heard. If the court determines that the respondent has committed any alleged contempt, the court shall punish the offender as if the contempt had occurred in an action arising in or pending in such court.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§234. WITNESSES; IMMUNITY FROM PROSECUTION

If any individual asks to be excused from testifying or from producing evidence of any kind in connection with any examination, hearing or investigation being conducted by the superintendent on the ground that the testimony or evidence required of that individual may tend to incriminate the individual or subject the individual to a penalty or forfeiture, and the Attorney General directs that individual to give testimony or produce evidence, the individual must comply with the directive. No testimony or other evidence so compelled, or any information directly or indirectly derived from that testimony or other evidence, may be used against the offering individual in any criminal, juvenile or civil violation proceeding, except that the testimony or other evidence may be used in a prosecution for perjury, false swearing, contempt or otherwise failing to comply with the directive to testify or produce evidence, or in a proceeding in which the individual has waived the immunity or privilege. [1989, c. 269, §8 (NEW).]

1.

[1989, c. 269, §8 (RP) .]

2.

[1989, c. 269, §8 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 269, §8 (RPR).

§235. ORDER ON HEARING

1. In the conduct of hearings under this Title and making his order thereon, the superintendent shall act in a quasi-judicial capacity.

[1973, c. 585, §12 (AMD) .]

2. Within 30 days after termination of a hearing, or of any rehearing thereof or reargument thereon, or within such other period as may be specified in this Title as to particular proceedings, or within such further reasonable period as the superintendent for good cause may require, the superintendent shall make his order on hearing covering matters involved in such hearing, and give a copy of the order to each party to the hearing in the same manner as notice of the hearing was given to such party; except that as to hearings held with respect to merger, consolidation, bulk reinsurance, conversion, affiliation or change of control of a domestic insurer as provided in chapter 47 (organization and corporate procedures of domestic stock and mutual insurers), where notice of the hearing was given to all stockholders and/or policyholders of an insurer involved, the superintendent is required to give a copy of the order on hearing to the corporation and insurer parties, to intervening parties, to a reasonable number of such stockholders or policyholders as representative of the class, and to other parties only upon written request of such parties.

[1973, c. 585, §12 (AMD) .]

3. The order must contain:

A. A concise statement of facts found by the superintendent upon the evidence adduced at the hearing; [1973, c. 585, §12 (AMD).]

B. A concise statement of the superintendent's conclusions from the facts so found; [1973, c. 585, §12 (AMD).]

C. The superintendent's order, and the effective date of the order; [2009, c. 2, §64 (COR).]

D. Citation of the provisions of this Title upon which the order is based; but failure to so designate a particular provision does not deprive the superintendent of the right thereafter to rely thereon; and [2009, c. 2, §64 (COR).]

E. Notice of the party's right to appeal or review of the order, of the action required for appeal and of the time within which the action must be taken in order to exercise the right. [2009, c. 2, §64 (COR).]

[2009, c. 2, §64 (COR) .]

4. The order may affirm, modify or rescind action theretofore taken or may constitute taking of new action within the scope of the notice of the hearing.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §396 (AMD). RR 2009, c. 2, §64 (COR).

§236. APPEAL FROM THE SUPERINTENDENT

1. In general, judicial review of actions taken by the superintendent or the superintendent's representatives must occur in conformity with the provisions set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 7.

[2009, c. 2, §65 (COR) .]

2. An appeal from the superintendent shall be taken only from an order on hearing, or as to a matter on which the superintendent has failed to hold a hearing after application thereof under section 229, or regarding a matter as to which the superintendent has failed to issue an order after hearing as required by section 235.

[1977, c. 694, §397 (RPR) .]

3. Any person who was a party to the hearing may appeal from an order of the superintendent within 30 days after receipt of notice. Any person not a party to the hearing whose interests are substantially and directly affected and who is aggrieved by an order of the superintendent may appeal within 40 days from the date the decision was rendered. If the appeal is taken from the superintendent's failure or refusal to act, the petition for review shall be filed within 6 months of the expiration of the time within which the action should reasonably have occurred.

[1977, c. 694, §397 (RPR) .]

4.

[1989, c. 269, §9 (RP) .]

5.

[1989, c. 269, §9 (RP) .]

6.

[1989, c. 269, §9 (RP) .]

7.

[1989, c. 269, §9 (RP) .]

8.

[1989, c. 269, §9 (RP) .]

9.

[1989, c. 269, §9 (RP) .]

10.

[1989, c. 269, §9 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §4 (AMD). 1973, c. 585, §12 (AMD). 1977, c. 694, §397 (RPR). 1989, c. 269, §§9,10 (AMD). RR 2009, c. 2, §65 (COR).

§237. ASSESSMENT FOR EXPENSE OF MAINTAINING THE BUREAU OF INSURANCE

The expense of maintaining the Bureau of Insurance must be assessed annually by the Superintendent of Insurance against all insurers and health maintenance organizations licensed to do business in this State in proportion to their respective direct gross premium written on business in this State during the year ending December 31st immediately preceding the fiscal year for which assessment is made. The annual assessment upon all insurers must be applied to the budget of the bureau for the fiscal year commencing July 1st. For any biennial period, total assessment must be in an amount not exceeding .002 of total direct premiums written. When the superintendent calculates the amount of the annual assessment, the superintendent must consider, among other factors, the staffing level required to administer the responsibilities of the bureau. [1997, c. 79, §2 (AMD).]

1. **Expense of examination.** The expense of examination of an insurer or of any person regulated by section 222 continues to be borne by the person examined. The expense of examination consistent with section 228 may not be considered when determining the assessment for maintaining the Bureau of Insurance.

[1997, c. 79, §2 (AMD) .]

2. **Direct gross premium.** Based on the annual statement filed by each insurer pursuant to section 423 or health maintenance organization pursuant to section 4208, the superintendent shall ascertain the amount of direct gross premium it received in that year. For the purpose of this section only, "direct gross premiums" means and includes policy, membership, annuity considerations and other fees, policy dividends applied in payment for insurance and other considerations for insurance received by insurers or health maintenance organizations, on account of policies or contracts covering subjects of insurance, or risks located, resident or to be performed in this State, after deducting return premiums or dividends actually returned or credited to policyholders.

[1997, c. 79, §2 (AMD) .]

3. **Minimum assessment.** In any year in which an insurer or health maintenance organization has no direct gross premium writings in this State, or in which direct gross premium written is not sufficient to produce at the rate prescribed an amount equal to or in excess of $100, the minimum assessment payable by any insurer or health maintenance organization is $100.

[1997, c. 79, §2 (AMD) .]

4. **Notification of assessment.** On or before July 1st of each year, the superintendent shall forward to each insurer or health maintenance organization an itemized bill of the amount due for the annual assessment, the amount due for filing of the annual statement pursuant to sections 423 and 601 and the amount due for the certificate of authority annual continuation fee pursuant to section 601. When an extension of the time of filing an annual statement is granted for good cause by the superintendent pursuant to section 423, subsection 1, or section 4208, the insurer or health maintenance organization must be assessed a provisional amount of $100. Upon receipt of the insurer's or health maintenance organization's annual statement, the provisional assessment must be adjusted to effect a final assessment for the fiscal year at the same rate utilized by the superintendent and levied upon all insurers by the general assessment of July 1st.

[1997, c. 79, §2 (AMD) .]

5. **Time of payment.** Time of payment for the annual assessment, the annual statement filing fee and the annual continuation fee must be made on or before August 10th.

[1995, c. 544, §1 (AMD) .]

6. **Revocation or suspension.** If the annual assessment, annual statement filing fee or annual continuation fee is not paid to the superintendent on or before the prescribed date, the license or certificate of authority of an insurer or health maintenance organization to transact business in this State may be revoked or suspended by the superintendent after a hearing or upon waiver of hearing by the insurer or health maintenance organization until the annual assessment, annual statement filing fee and annual continuation fee is paid. A reinstatement of certificate of authority may not be made prior to payment of the balance of the annual assessment, annual statement filing fee or continuation fee.

[1997, c. 79, §2 (AMD) .]

7. **Recalculation of assessment.** Immediately following the close of the fiscal year ending June 30, 1987, and at the close of each 2nd succeeding fiscal year, the superintendent shall recalculate the assessment made against each party assessed after giving recognition to actual expenditures of the bureau during the preceding biennial period. On or before October 1st, the superintendent shall render to each party assessed

a statement showing the difference between their respective recalculated assessment and the amount they had paid with respect to the preceding biennium. Any overpayment of annual assessment resulting from complying with the requirements of this section must be refunded or, at the option of the assessed party, applied as a credit against the assessment for the succeeding fiscal year. Any overpayment of $100 or less must be applied as a credit against the assessment for the succeeding fiscal year.

[1997, c. 79, §2 (AMD) .]

8. **Deposit with Treasurer of State.** The superintendent shall deposit all payments made pursuant to this section with the Treasurer of State. The money must be used for the sole purpose of paying the expenses of the Bureau of Insurance.

[1997, c. 79, §2 (AMD) .]

9. **Exclusions.** This section does not apply to fraternal benefit societies, as defined in section 4101; assessment mutual insurance companies, as defined in section 3603; and joint underwriting associations, subject to section 2322.

[1997, c. 79, §2 (AMD) .]

10. **Applicability.** This section applies with respect to insurers for fiscal years commencing on or after July 1, 1986 and to health maintenance organizations for fiscal years commencing on or after July 1, 1997.

[1997, c. 79, §2 (AMD) .]

SECTION HISTORY
1985, c. 446, §2 (NEW). 1991, c. 334, §§3,4 (AMD). 1993, c. 313, §15 (AMD). 1995, c. 544, §§1,2 (AMD). 1997, c. 79, §2 (AMD).

Chapter 5: AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS

Subchapter 1: AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS

§400. "STOCK" INSURER DEFINED

A "stock" insurer is an incorporated insurer with its capital divided into shares and owned by its stockholders. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§401. "MUTUAL" INSURER DEFINED

A "mutual" insurer is an incorporated insurer without permanent capital stock, and the governing body of which is elected by its policyholders or those policyholders specified in its charter, or by any reasonable combination of its policyholders, guaranty fund stockholders, or guaranty fund certificate holders, or by other reasonable method. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§402. "RECIPROCAL"; "LLOYD'S" INSURER DEFINED

1. **Reciprocal insurer.** A "reciprocal" insurer is an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact common to all such persons to provide reciprocal insurance among themselves. Any public self-funded pool operating under Title 30, chapter 203-B is not an insurance company or insurer under the laws of this State. The development, administration and provision of a public self-funded pool's programs and coverages do not constitute doing an insurance business.

[1985, c. 713, §4 (AMD) .]

2. **Lloyd's insurer.** A "Lloyd's" insurer is an unincorporated but formally organized association of individual underwriters, any one or more of whom underwrite and thereby assume as insurer such portion of the risk insured by them as shall be set forth in the contract of insurance issued by such an insurer.

[1969, c. 177, §5 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §5 (RPR). 1985, c. 713, §4 (AMD).

§403. "CHARTER" DEFINED

Except where context requires otherwise, "charter" means certificate of organization, certificate of incorporation, articles of incorporation, articles of agreement, articles of association, corporate charter granted by legislative act, or other basic constituent document of a corporation, or of a Lloyd's insurer, or the power of attorney of the attorney-in-fact of a reciprocal insurer. [1969, c. 177, §6 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §6 (AMD).

§404. CERTIFICATE OF AUTHORITY REQUIRED; ENFORCEMENT; PENALTY

1. No person shall act as an insurer and no insurer shall transact insurance in this State by mail or otherwise, unless as authorized by a certificate of authority issued by the superintendent pursuant to this Title and then in full force and effect, except as to such transactions as are expressly otherwise provided in this Title.

[1973, c. 585, §12 (AMD) .]

2. No insurer formed under the laws of this State, and no foreign insurer from offices or by personnel or facilities located in this State, shall solicit insurance applications or otherwise transact insurance in another state or country unless it holds a subsisting certificate of authority granted to it by the superintendent authorizing it to transact the same kind or kinds of insurance in this State.

[1973, c. 585, §12 (AMD) .]

3. The superintendent shall enforce this section through any and all available and lawful means, including, but not limited to, the enjoining of any violation or threatened violation.

[1973, c. 585, §12 (AMD) .]

4. Any insurer and any officer, director, agent, representative or employee of any insurer, who willfully authorizes, negotiates, makes or issues any insurance contract in violation of this section, is upon conviction thereof subject to a fine not to exceed $5,000 or imprisonment for not over 2 years, or to both.

[2013, c. 2, §36 (COR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). RR 2013, c. 2, §36 (COR).

§405. EXCEPTIONS TO CERTIFICATE OF AUTHORITY REQUIREMENT

A certificate of authority shall not be required of an insurer with respect to any of the following:
[1969, c. 132, §1 (NEW).]

1. Investigation, settlement or litigation of claims under its policies lawfully written in this State, or liquidation of assets and liabilities of the insurer, other than collection of new premiums, all as resulting from its former authorized operations in this State;

[1969, c. 132, §1 (NEW) .]

2. Except as provided in section 404, subsection 2, transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this State at time of issuance, and lawfully solicited, written and delivered outside this State;

[1969, c. 132, §1 (NEW) .]

3. Transactions pursuant to surplus lines coverages lawfully written under chapter 19;

[1969, c. 132, §1 (NEW) .]

4. Reinsurance, except as to domestic reinsurers;

[1969, c. 132, §1 (NEW) .]

5. Transactions relative to its investments in this State;

[1969, c. 132, §1 (NEW) .]

6. Any suit or action by the duly constituted receiver, rehabilitator or liquidator of the insurer, or of the insurer's assignee or successor, under laws similar to those contained in chapter 57; or

[2011, c. 90, Pt. C, §1 (AMD) .]

7. Transactions pursuant to individual health insurance covering residents of this State written by a regional insurer or health maintenance organization, as defined in section 405-A, duly authorized or qualified to transact individual health insurance in the state or country of its domicile if the superintendent certifies that the regional insurer or health maintenance organization meets the requirements of section 405-A.

[2011, c. 90, Pt. C, §2 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2011, c. 90, Pt. C, §§1, 2 (AMD).

§405-A. CERTIFICATION OF REGIONAL INSURERS OR HEALTH MAINTENANCE ORGANIZATIONS TO TRANSACT INDIVIDUAL HEALTH INSURANCE

1. **Regional insurer or health maintenance organization defined.** As used in this section, "regional insurer or health maintenance organization" means an insurer or health maintenance organization that holds a valid certificate of authority to transact individual health insurance in Connecticut, Massachusetts, New Hampshire, Rhode Island or Vermont.

[2013, c. 388, Pt. B, §1 (AMD) .]

2. **Certification of regional insurers or health maintenance organizations.** A regional insurer or health maintenance organization may not transact individual health insurance in this State by mail, the Internet or otherwise unless the superintendent has issued a certification that the regional insurer or health maintenance organization has met the requirements of this subsection. The superintendent shall issue a certification or deny certification within 30 days of a request.

A. A policy, contract or certificate of individual health insurance offered for sale in this State by a regional insurer or health maintenance organization must comply with the applicable individual health insurance laws in the state of domicile of that regional insurer and must be actively marketed in that state. [2011, c. 90, Pt. C, §3 (NEW).]

B. A regional insurer or health maintenance organization shall meet the requirements of section 4302 for reporting plan information with respect to individual health plans offered for sale in this State and disclose to prospective enrollees how the health plans differ from individual health plans offered by domestic insurers in a format approved by the superintendent. Health plan policies and applications for coverage must contain the following disclosure statement or a substantially similar statement on the face page of the policy or application in a type size of at least 14 points and font that is easily readable by a person with average eyesight: "This policy is issued by a regional insurer or health maintenance organization and is governed by the laws and rules of (regional insurer's or health maintenance organization's state of domicile). This policy may not be subject to all the insurance laws and rules of the State of Maine, including coverage of certain health care services or benefits mandated by Maine law. Before purchasing this policy, you should carefully review the terms and conditions of coverage under this policy, including any exclusions or limitations of coverage." [2013, c. 388, Pt. B, §2 (AMD).]

C. A regional insurer or health maintenance organization shall meet the requirements of section 4303, subsection 4 for grievance procedures with respect to health plans offered for sale in this State. [2011, c. 90, Pt. C, §3 (NEW).]

D. A regional insurer or health maintenance organization shall meet the requirements of chapter 56-A for provider network adequacy with respect to health plans offered for sale in this State. [2011, c. 90, Pt. C, §3 (NEW).]

E. A regional insurer or health maintenance organization shall meet the requirements of chapter 33 with respect to rates for individual health plans offered for sale in this State. [2011, c. 90, Pt. C, §3 (NEW).]

F. A regional insurer or health maintenance organization shall designate an agent for receiving service of legal documents or process in the manner provided in this Title. [2011, c. 90, Pt. C, §3 (NEW).]

G. A regional insurer or health maintenance organization shall meet the requirements of this Title with respect to allowing the superintendent access to records of the regional insurer or health maintenance organization. [2011, c. 90, Pt. C, §3 (NEW).]

[2013, c. 388, Pt. B, §2 (AMD) .]

3. **Unfair trade practices.** The provisions of chapter 23 apply to a regional insurer or health maintenance organization permitted to transact individual health insurance under this section or section 405.

[2011, c. 90, Pt. C, §3 (NEW) .]

4. **Taxes; assessments.** A regional insurer or health maintenance organization transacting individual health insurance in this State under this section is subject to applicable taxes or assessments imposed on insurers transacting individual health insurance in this State pursuant to this Title and Title 36.

[2011, c. 90, Pt. C, §3 (NEW) .]

5. **Compliance with court orders.** A regional insurer or health maintenance organization transacting individual health insurance in this State under this section shall comply with lawful orders from courts of competent jurisdiction issued in a voluntary dissolution proceeding or in response to a petition for an injunction by the superintendent asserting that the regional insurer or health maintenance organization is in a hazardous financial condition.

[2011, c. 90, Pt. C, §3 (NEW) .]

6. **Exemption from other requirements.** Except as expressly provided in this section, the requirements of this Title do not apply to a regional insurer or health maintenance organization permitted to transact individual health insurance under this section.

[2011, c. 90, Pt. C, §3 (NEW) .]

7. **Agreement with insurance regulators in other state.** The superintendent shall enter into a memorandum of understanding or other agreement with the insurance department of the state of domicile of a regional insurer or health maintenance organization permitted to transact individual health insurance in this State under this section with respect to enforcement of the provisions of this section.

[2011, c. 90, Pt. C, §3 (NEW) .]

8. **Sale of policies.** An individual health insurance policy, contract or certificate may not be offered for sale in this State pursuant to this section before January 1, 2014.

[2011, c. 90, Pt. C, §3 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. C, §3 (NEW). 2013, c. 388, Pt. B, §§1, 2 (AMD).

§405-B. DOMESTIC INSURERS OR LICENSED HEALTH MAINTENANCE ORGANIZATION; INDIVIDUAL HEALTH INSURANCE APPROVED IN OTHER STATES

Notwithstanding any other provision of this Title, a domestic insurer or licensed health maintenance organization authorized to transact individual health insurance in this State may offer for sale in this State an individual health plan duly authorized for sale in Connecticut, Massachusetts, New Hampshire, Rhode Island or Vermont by a parent or corporate affiliate of the domestic insurer or licensed health maintenance organization if the following requirements are met. [2013, c. 388, Pt. B, §3 (AMD).]

1. **Certificate of authority from state of domicile.** The parent or corporate affiliate of the domestic insurer or licensed health maintenance organization must hold a valid certificate of authority to transact individual health insurance in the state of domicile of the parent or corporate affiliate.

[2011, c. 90, Pt. C, §4 (NEW) .]

2. **Compliance with laws of state of domicile.** A policy, contract or certificate of individual health insurance offered for sale in this State by the domestic insurer or licensed health maintenance organization must comply with the applicable individual health insurance laws in the state of domicile of the parent or corporate affiliate and must be actively marketed in that state.

[2011, c. 90, Pt. C, §4 (NEW) .]

3. **Disclosure and reporting.** The domestic insurer or licensed health maintenance organization shall meet the requirements of section 4302 for reporting plan information with respect to individual health plans offered for sale in this State and disclose to prospective enrollees how the individual health plans of the parent or corporate affiliate differ from individual health plans offered by other domestic insurers or licensed health maintenance organizations in a format approved by the superintendent. Health plan policies and applications for coverage must contain the following disclosure statement or a substantially similar statement on the face page of the policy or application in a type size of at least 14 points and font that is easily readable by a person with average eyesight: "This policy is issued by a domestic insurer or licensed health maintenance organization but is governed by the laws and rules of (state of domicile of parent or corporate affiliate of domestic insurer or licensed health maintenance organization), which is the state of domicile of the parent or corporate affiliate of the domestic insurer or licensed health maintenance organization. This policy may not be subject to all the insurance laws and rules of the State of Maine, including coverage of certain health care services or benefits mandated by Maine law. Before purchasing this policy, you should carefully review the terms and conditions of coverage under this policy, including any exclusions or limitations of coverage."

[2013, c. 388, Pt. B, §4 (AMD) .]

4. **Grievance procedures.** The domestic insurer or licensed health maintenance organization shall meet the requirements of section 4303, subsection 4 for grievance procedures with respect to health plans offered for sale in this State.

[2011, c. 90, Pt. C, §4 (NEW) .]

5. **Sale of policies.** A domestic insurer or licensed health maintenance organization may not offer an individual health plan for sale in this State pursuant to this section before January 1, 2014.

[2011, c. 90, Pt. C, §4 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. C, §4 (NEW). 2013, c. 388, Pt. B, §§3, 4 (AMD).

§405-C. DOMESTIC INSURERS OR LICENSED HEALTH MAINTENANCE ORGANIZATIONS; PARITY WITH REGIONAL INSURERS

Notwithstanding any other provision of this Title, a domestic insurer or licensed health maintenance organization authorized to transact individual health insurance in this State may offer for sale in this State an individual health plan equivalent to any plan offered for sale in this State by a regional insurer or health maintenance organization pursuant to section 405-A. An individual health plan may not be offered for sale pursuant to this section before January 1, 2014. [2011, c. 90, Pt. C, §5 (NEW).]

SECTION HISTORY
2011, c. 90, Pt. C, §5 (NEW).

§406. GENERAL ELIGIBILITY FOR CERTIFICATE OF AUTHORITY

To qualify for and hold authority to transact insurance in this State, an insurer must be otherwise in compliance with this Title and with its charter powers, and must be an incorporated stock or mutual insurer, or a reciprocal or Lloyd's insurer; of the same general type as may be formed as a domestic insurer under this Title; except that: [1969, c. 132, §1 (NEW).]

1. No foreign insurer shall be authorized to transact insurance in this State unless as to insurance written in this State it maintains reserve as required by chapter 11 (assets and liabilities); or which, if other than a property or casualty insurer, transacts business anywhere in the United States on the assessment plan, or stipulated premium plan, or any similar plan;

[1969, c. 132, §1 (NEW) .]

2. No insurer shall be authorized to transact a kind of insurance in this State unless duly authorized or qualified to transact such insurance in the state or country of its domicile;

[1969, c. 132, §1 (NEW) .]

3. No insurer shall be authorized to transact in this State any kind of insurance which is not within the definitions as set forth in chapter 9 (kinds of insurance);

[1969, c. 132, §1 (NEW) .]

4. No such authority shall be granted or continued as to any insurer while in arrears to the State for fees, licenses, taxes, assessments, fines or penalties accrued on business previously transacted in this State;

[1969, c. 132, §1 (NEW) .]

5. A Lloyd's insurer shall be treated as a stock insurer for the purposes of this Title, with net assets over all liabilities to be not less than the capital funds required of a foreign stock insurer transacting the same kinds of insurance.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§407. SAME; OWNERSHIP, MANAGEMENT

1. No foreign insurer which is directly or indirectly owned or controlled in whole or substantial part by any government or governmental agency, other than of the Government of the United States of America, shall be authorized to transact insurance in Maine. Membership in a mutual insurer, or subscribership in a reciprocal insurer, or ownership of stock of an insurer by the alien property custodian or similar official of the United States, or ownership of stock or other security which does not have voting rights with respect to the management of the insurer, or supervision of an insurer by public authority, shall not be deemed to be an ownership or control of the insurer for the purposes of this provision.

[1969, c. 132, §1 (NEW) .]

2. The superintendent shall not grant or continue authority to transact insurance in this State as to any insurer or proposed insurer, any director, officer or other individual materially part of the management of which is found by him after investigation or upon reliable information to be incompetent, or dishonest, or untrustworthy, or of unfavorable business repute, or the managers of which are so lacking in insurance company managerial experience in operations of the kind proposed in this State as to make such operation, currently or prospectively, hazardous to, or contrary to the best interests of, the insurance-buying or investing public of this State; or which he has good reason to believe is affiliated directly or indirectly through ownership, control, management, reinsurance transactions or other business relations, with any person or persons of unfavorable business repute, or whose business operations in this State or elsewhere are or have been marked, to the injury of insurers, stockholders, policyholders, creditors or the public, by illegality, or by manipulation of assets, or of accounts, or of reinsurance or by bad faith.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§408. NAME OF INSURER

1. No insurer shall be formed or authorized to transact insurance in this State which has or uses a name which is the same as or deceptively similar to that of another insurer already so authorized.

[1969, c. 132, §1 (NEW) .]

2. No life insurer shall be so authorized which has or uses a name deceptively similar to that of another insurer, other than a predecessor in interest, authorized to transact insurance in this State within the preceding 10 years, if life insurance policies originally issued by such other insurer are still outstanding in this State.

[1969, c. 132, §1 (NEW) .]

3. No insurer shall be formed or authorized to transact insurance which has or uses a name the same as or deceptively similar to that of any foreign insurer not so authorized if such foreign insurer has within the next preceding 12 months signified its intention to secure an incorporation in this State under such name, or

to do business as a foreign insurer in this State under such name, by filing notice of such intention with the superintendent, unless the written consent to the use of such name or deceptively similar name has been given by such foreign insurer.

[1973, c. 585, §12 (AMD) .]

4. No insurer shall be so authorized which has or uses a name which tends to deceive or mislead as to the type of organization of the insurer.

[1969, c. 132, §1 (NEW) .]

5. In case of conflict of names between 2 insurers, or a conflict otherwise prohibited under this section, the superintendent may permit, or shall require as a condition to the issuance of an original certificate of authority to an applicant insurer, the insurer to use in this State such supplementation or modification of its name or such business name as may reasonably be necessary to avoid the conflict.

[1973, c. 585, §12 (AMD) .]

6. Except as provided in subsection 5, an insurer shall conduct its business in this State in its own corporate, if incorporated, or proper, if a reciprocal, name.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§409. INSURANCE LINES COMBINATIONS

An insurer may be authorized to transact such kinds of insurance as it is qualified for under this Title, except that a reciprocal insurer may not transact life insurance. Qualified insurers may transact combinations of business as follows. [1991, c. 385, §1 (AMD).]

1. **Multiple lines insurer.** A multiple lines insurer is authorized to transact more than one kind of coverage if all kinds of coverage fall within the categories listed in sections 704 to 708.

[1991, c. 385, §1 (NEW) .]

2. **All lines insurer.** An all lines insurer is authorized to transact life insurance and one or more of the kinds of coverage, other than health insurance, that may be transacted by a multiple lines insurer.

[1991, c. 385, §1 (NEW) .]

3. **Life or health insurer.** A life or health insurer is authorized to transact life insurance, life and annuity insurance or health insurance as defined in sections 702 to 704-A. A life insurer, health insurer or a life and health insurer does not become an all lines insurer merely by transacting specific lines of casualty insurance that life or health insurers are expressly authorized by law to transact.

[2007, c. 199, Pt. E, §1 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 385, §1 (AMD). 2007, c. 199, Pt. E, §1 (AMD).

§410. MINIMUM PAID-IN CAPITAL AND SURPLUS REQUIREMENTS

1. To qualify for authority to transact any one kind of insurance, as defined in chapter 9, or combination of kinds of insurance as shown below, an insurer must possess and thereafter maintain unimpaired paid-in capital stock, if a stock insurer, or unimpaired basic surplus, if a foreign mutual or a reciprocal insurer, and when first so authorized must possess initial free surplus, all in amounts not less than as determined from the following table.

A health, life and health or multiple line (as described in section 409) insurer may qualify for a certificate of authority to transact a legal services insurance business, as described in chapter 38, if it is otherwise qualified therefor and possesses and thereafter maintains, in addition to the amounts described in the following table, an additional amount of unimpaired paid-in capital stock, if a stock insurer, or unimpaired basic surplus, if a foreign mutual or reciprocal insurer, of not less than $500,000.

An insurer may qualify for a certificate of authority to transact solely financial guaranty insurance as defined in section 709-A, if it is otherwise qualified therefor and possesses and thereafter maintains paid-in capital stock in the amount of $2,500,000 and initial free surplus in an amount of $47,500,000 or, if the insurer is a foreign mutual or reciprocal insurer, minimum required basic surplus in an amount of $2,500,000 and initial free surplus in an amount of $47,500,000.

	Stock Insurers		Foreign mutual, Reciprocal Insurers	
Kind or Kinds of Insurance	Minimum Required Capital Stock	Initial Free Surplus	Minimum Required Basic Surplus	Initial Free Surplus
Life	$1,500,000	$1,500,000	$1,500,000*	$1,500,000*
Health	1,000,000	1,000,000	1,000,000	1,000,000
Life and Health	2,500,000	2,500,000	2,500,000*	2,500,000*
Casualty	1,500,000	1,500,000	1,500,000	1,500,000
Marine and Transportation	1,500,000	1,500,000	1,500,000	1,500,000
Property	1,000,000	1,000,000	1,000,000	1,000,000
Surety	1,500,000	1,500,000	1,500,000	1,500,000
Title	500,000	500,000	500,000	500,000
Multiple line (as defined in section 409)	2,500,000	2,500,000	2,500,000	2,500,000
All Line (as defined in section 409	5,000,000	5,000,000	5,000,000*	5,000,000*

* Does not apply as to a reciprocal insurer.

Except:

A. An insurer holding a valid certificate of authority to transact insurance in this State on January 1, 1970 may, if otherwise qualified therefor until January 1, 1989, continue to be so authorized while possessing paid-in capital stock, if a stock insurer, or surplus, if a mutual or reciprocal insurer, as required for such authority immediately prior to January 1, 1970. [1991, c. 385, §2 (AMD).]

B. Prior to January 1, 1989, the superintendent may not authorize such an insurer to transact any other kinds of insurance unless it complies with the requirements as to capital stock, if a stock insurer, or basic surplus, if a mutual or reciprocal insurer, as applied to all kinds of insurance it proposes to transact, as provided in the table contained in this paragraph.

A health, life and health or multiple line (as described in section 409) insurer may qualify for a certificate of authority to transact a legal services insurance business, as described in chapter 38, if it is otherwise qualified therefor and possesses and thereafter maintains, in addition to the amounts described in the following table, an additional amount of unimpaired paid-in capital stock, if a stock insurer, or unimpaired basic surplus, if a foreign mutual or reciprocal insurer, of not less than $500,000.

Kind or Kinds of Insurance	Stock Insurers Minimum Required Capital Stock	Stock Insurers Initial Free Surplus	Foreign mutual, Reciprocal Insurers Minimum Required Basic Surplus	Foreign mutual, Reciprocal Insurers Initial Free Surplus
Life	$500,000	$1,000,000	$1,000,000*	$1,000,000*
Health	250,000	250,000	250,000	250,000
Life and Health	500,000	1,000,000	1,000,000*	1,000,000*
Casualty	500,000	500,000	500,000	500,000
Marine and Transportation	500,000	500,000	500,000	500,000
Property	500,000	500,000	500,000	500,000
Surety	500,000	500,000	500,000	500,000
Title	150,000	150,000	150,000	150,000
Multiple line (as defined in section 409)	1,000,000	1,000,000	1,000,000	1,000,000
All Line (as defined in section 409	2,000,000	2,000,000	2,000,000*	2,000,000*

*Does not apply as to a reciprocal insurer. [1991, c. 385, §2 (AMD).]

C. Until January 1, 1989, a domestic mutual insurer formed prior to January 1, 1968, and while possessing surplus of not less than $200,000 may be authorized to transact, in addition to the types of insurance it was transacting prior to July 24, 1984, any other additional kinds of insurance authorized by its charter; subject to those minimum required basic surplus amounts applicable as to foreign mutual insurers as contained in the table in paragraph B, if the insurer is to transact life insurance together with any one or more of property, casualty, surety or marine and transportation insurances. [1987, c. 78, §1 (AMD).]

D. Domestic mutual insurers holding a certificate of authority upon January 1, 1989, if otherwise qualified, and possessed of basic surplus in minimum required amounts as contained in the table in this paragraph may continue to be so authorized, provided those insurers continue to possess and maintain unimpaired basic surplus funds as determined in this paragraph and applicable to those lines or kinds of insurance permitted by its certificate of authority immediately prior to January 1, 1989. Upon application by any such insurer and written approval by the superintendent, the insurer's certificate of authority may be extended to permit the writing of other kinds or lines of insurance if the insurer is qualified and possessed of basic surplus funds in amounts contained in the table in this paragraph. A domestic mutual insurer holding a certificate of authority prior to January 1, 1989, but which does not possess and maintain basic surplus in the minimum required amounts contained in the table in this paragraph, may continue to be authorized to transact insurance in this State and to write other kinds or lines of insurance, subject to the approval of the superintendent, as long as it maintains 100% reinsurance and has no liabilities.

For the purposes of this paragraph, any assuming reinsurer must be a corporation which possesses the ability to exercise control of the ceding insurer, must be an insurance company possessed of a certificate of authority to transact the same kinds of insurance in this State as those assumed and shall file a consolidated annual statement as required by section 423.

A health, life and health or multiple line (as described in section 409) insurer may qualify for a certificate of authority to transact a legal services insurance business, as described in chapter 38, if it is otherwise qualified therefor and possesses and thereafter maintains, in addition to the amounts described in the following table, an additional amount of unimpaired paid-in capital stock, if a stock insurer, or unimpaired basic surplus, if a foreign mutual or reciprocal insurer, of not less than $500,000.

Kind or Kinds of Insurance	Domestic Mutual Insurers
Life	$1,000,000
Health	500,000
Life and Health	1,250,000
Casualty	750,000
Marine and Transportation	1,000,000
Property	500,000
Surety	1,000,000
Title	350,000
Multiple Line (as defined in secton 409)	1,250,000
All line (as defined in section 409)	2,500,000

[1991, c. 385, §2 (AMD).]

E. An insurer that otherwise possesses funds as required under this subsection shall at all times maintain policyholders' surplus, combined paid-in capital stock, if any, and surplus, reasonable in amount, as determined by the superintendent, in relation to the kinds and amount of insurance it has in force, or being written and retained by it, net of applicable reinsurance. In making any such determination, the superintendent shall give due consideration to any applicable standards approved or adopted by the National Association of Insurance Commissioners and to the desirability of substantial uniformity as to such requirements among the respective states. [1991, c. 385, §2 (AMD).]

F. A health maintenance organization as a division or line of business is subject to this paragraph.

(1) An insurer that operates a health maintenance organization as a division or a line of business shall possess and maintain policyholder's surplus, including paid-in capital stock if any, as otherwise required by this section and in addition shall meet the surplus requirements of section 4204-A.

(2) A nonprofit hospital or medical service organization that operates a health maintenance organization as a division or as a line of business shall possess and maintain subscriber reserves as defined in section 2301, subsection 9-A, paragraph H, subparagraph (2) and in an amount required by the superintendent and in addition shall meet the surplus requirements of section 4204-A. [1993, c. 702, Pt. A, §7 (NEW).]

[1993, c. 702, Pt. A, §7 (AMD) .]

2. Capital and surplus requirements are based upon all the kinds of insurance transacted by the insurer in any and all areas in which it operates or proposes to operate, whether or not only a portion of such kinds are to be transacted in this State.

[1969, c. 132, §1 (NEW) .]

3. As to surplus required for authority to transact one or more kinds of insurance and thereafter to be maintained, domestic mutual legal reserve insurers hereafter formed are governed by chapter 47.

[1991, c. 385, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§7,8 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 625, §134 (AMD). 1983, c. 709, §1 (AMD). 1987, c. 78, §§1,2 (AMD). 1987, c. 707, §1 (AMD). 1991, c. 385, §2 (AMD). 1993, c. 702, §A7 (AMD).

§411. INSURING COMBINATIONS WITHOUT ADDITIONAL CAPITAL FUNDS

Without additional paid-in capital stock or additional surplus, an authorized insurer may also be authorized: [1969, c. 132, §1 (NEW).]

1. If a life insurer, to grant annuities;

[1969, c. 132, §1 (NEW) .]

2. If a health insurer, to insure against congenital defects, as defined in section 707;

[1969, c. 132, §1 (NEW) .]

3. If a casualty insurer or multiple line insurer, to transact health insurance; except that this provision does not apply to a domestic insurer authorized to transact casualty insurance only, pursuant to section 410, subsection 1, paragraph A; or

[1991, c. 385, §3 (AMD) .]

4. To transact employee benefit excess insurance to the extent authorized pursuant to section 707, subsection 3.

[1991, c. 385, §4 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 385, §§3,4 (AMD).

§412. DEPOSITS

1. No insurance company other than a domestic real estate title insurance company or a domestic mutual fire insurance company that is transacting only the business of fire, marine or glass on the assessment plan may do so in this State unless it makes and maintains a deposit with the Superintendent of Insurance, as security for all its policyholders, of securities that are determined eligible for deposit under section 1253. The deposit must be maintained in a minimum actual market value that, exclusive of interest, may never be less than $100,000. The deposit must be retained by the superintendent and disposed of as directed by section 1263.

[1999, c. 113, §16 (AMD) .]

2. Any admitted foreign insurance company may file with the superintendent a certificate of the insurance supervisory official of such other jurisdiction that he holds in trust and on deposit for benefit of all the policyholders of the company a deposit of not less than $100,000 in such securities as are required or permitted to be deposited with him by the laws of that jurisdiction. These securities are to be of a character consistent with investment authority in such jurisdiction. Such certificate shall contain a statement by said supervisory official that he is satisfied that the actual market value of these securities is of minimum value of $100,000. No deposit shall be required to be maintained in this State while such a deposit, if so certified, is retained by said supervisory official.

[1975, c. 77, (RPR) .]

3. The superintendent shall receive and hold in trust deposits made under this section by any domestic insurance company in compliance with the laws of this or any other state, to enable it to do business in this or any other state, and in like manner shall hold deposits made by a foreign company under the laws of this

State. The company making such deposit shall be entitled to any investment income thereon and with the superintendent's consent, if not inconsistent with the laws under which such deposit was made, may exchange in whole or in part such securities comprising the deposit for other approved securities of equal value.

[1975, c. 77, (RPR) .]

4. The superintendent shall not authorize an alien insurer to transact insurance in this State unless it makes in this State through the superintendent and thereafter continuously maintains a deposit, representing funds in excess of all the insurer's liabilities under insurance contracts in force in the United States of America, of a fair market value in amount not less than the minimum paid-in capital stock required under this Title of a foreign stock insurer authorized to transact like kinds of insurance in this State. The superintendent may require additional trusteed surplus funds in reasonable amount to secure the interest of beneficiaries under policies insured by the alien insurer. In addition to the foregoing trusteed surplus account, an alien insurer authorized pursuant to this Title shall establish and maintain in one or more states of the United States a deposit or deposits of trust assets of a kind and quality as generally required by this section. The value of the deposit or deposits shall be at least equal to those obligations resulting from insurance in force in the United States. The deposit or deposits shall, if located outside the State, be subject to administration standards comparable to those contained in this Title. The deposit shall be held in trust for the exclusive benefit of the insurer's policyholders and creditors in the United States of America.

A. In lieu of such a deposit made or maintained in this State, the superintendent shall accept the certificate in proper form of the insurance supervisory official having general supervision of insurers in any other state to the effect that a deposit of like quality and amount, or part thereof, by such insurer is being maintained for like purposes in public custody or control pursuant to the laws of such state. [1975, c. 77, (NEW).]

[1985, c. 330, §2 (AMD) .]

5. All such deposits in this State are subject to the provisions of chapter 15 (Administration of Deposits).

[1975, c. 77, (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 77, (RPR). 1985, c. 330, §2 (AMD). 1999, c. 113, §16 (AMD).

§413. APPLICATION FOR CERTIFICATE OF AUTHORITY

To apply for an original certificate of authority an insurer shall file with the superintendent its written application therefor on forms as prescribed and furnished by the superintendent, accompanied by the applicable fees specified in section 601 (fee schedule), stating under the oath of the president or vice-president or other chief officer and the secretary of the insurer, or of the attorney-in-fact, if a reciprocal insurer, the insurer's name, location of its home office or principal office in the United States, if an alien insurer, the kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, and such additional information as the superintendent may reasonably require, together with the following documents, as applicable: [1973, c. 585, §12 (AMD).]

1. If a corporation, or a Lloyd's, a copy of its charter, together with all amendments thereto, or as restated and amended under the laws of its state or country of domicile, currently certified by the public official with whom the originals are on file in such state or country;

[1969, c. 177, §9 (AMD) .]

2. If a domestic incorporated insurer or a mutual insurer, a copy of its bylaws, certified by the insurer's corporate secretary;

[1969, c. 132, §1 (NEW) .]

3. If a reciprocal insurer, a copy of the power of attorney of its attorney-in-fact, certified by the attorney-in-fact; and if a domestic reciprocal insurer, the declaration provided for in section 3856;

[1969, c. 132, §1 (NEW) .]

4. A complete copy of its financial statement as of not earlier than the December 31st next preceding in form as customarily used in the United States by like insurers, sworn to by at least 2 executive officers of the insurer or certified by the public insurance supervisory official of the insurer's state of domicile, or of entry into the United States, if an alien insurer;

[1969, c. 132, §1 (NEW) .]

5.

[1985, c. 330, §3 (RP) .]

5-A. A copy of a current report of examination of the insurer certified by the public insurance supervisory official of the insurer's state of domicile, or of entry into the United States, if an alien insurer. For purposes of this requirement, a report of examination is deemed "current" only if its date of account is within 36 months of filing of the application, except that the superintendent may, in the superintendent's discretion, accept a report of examination within a period reasonably proximate to 36 months from its date of account that is filed by the applicant promptly upon its receipt when issuance of the report by the domiciliary regulator has been delayed for reasons beyond the control of the applicant and that are unrelated to the applicant's financial condition or its compliance with applicable laws;

[1995, c. 570, §1 (AMD) .]

6. Appointment of an agent pursuant to section 421 to receive service of legal process;

[1997, c. 592, §10 (AMD) .]

7. If a foreign or alien insurer, a certificate of the public insurance supervisory official of its state or country of domicile showing that it is authorized or qualified for authority to transact in such state or country the kinds of insurance proposed to be transacted in this State;

[1969, c. 132, §1 (NEW) .]

8. If an alien insurer, certificate as to deposit, if to be tendered pursuant to section 412, and a copy of the trust deed pertaining to such deposit, certified by the trustee;

[1969, c. 132, §1 (NEW) .]

9. If a life or health insurer, a copy of the insurer's rate book and of each form of policy currently proposed to be issued in this State, and of the form of application therefor; or

[1993, c. 637, §1 (AMD) .]

10. If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records.

[1993, c. 637, §1 (AMD) .]

11.

[1993, c. 637, §2 (RP) .]

12.

[1993, c. 637, §2 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §9 (AMD). 1973, c. 585, §12 (AMD). 1985, c. 330, §§3,4 (AMD). 1993, c. 637, §§1,2 (AMD). 1995, c. 570, §1 (AMD). 1997, c. 592, §10 (AMD).

§413-A. ALIEN INSURER; PORT OF ENTRY

1. **Port of entry.** An alien insurer that has been authorized by the superintendent to use the State as its port of entry for the transaction of business in the United States is considered a domestic insurer to the extent provided in this section. An alien insurer that has been approved by another state to use that state as its port of entry is considered to be domiciled in that state in the same manner, if there is a valid reciprocity agreement between that state and this State or if the superintendent has determined that the applicable laws of that state are substantially similar to this section and its implementing rules.

[1999, c. 113, §17 (AMD) .]

2. **Rules.** The superintendent shall adopt rules establishing the terms and conditions of port of entry authorization, which include without limitation:

A. The requirements an alien insurer must satisfy to qualify for port of entry authorization. These requirements must include, at a minimum:

(1) Agreement to adhere to all laws applicable to domestic insurers;

(2) Maintenance of appropriate trust surplus or other adequate security within the State;

(3) Maintenance of records of all United States operations within the State; and

(4) Maintenance of a separate financial reporting system for United States operations; [1995, c. 375, Pt. D, §1 (NEW).]

B. The procedures for obtaining, maintaining and terminating port of entry authorization; and [1995, c. 375, Pt. D, §1 (NEW).]

C. Modifications of the provisions of this Title, and of the rules adopted by the superintendent that apply to domestic insurers, as the superintendent determines necessary for the appropriate regulation of alien insurers with port of entry authorization. [1995, c. 375, Pt. D, §1 (NEW).]

[1995, c. 375, Pt. D, §1 (NEW) .]

SECTION HISTORY
1995, c. 375, §D1 (NEW). 1999, c. 113, §17 (AMD).

§414. ISSUANCE, REFUSAL OF AUTHORITY, OWNERSHIP OF CERTIFICATE

1. If upon completion of its application, the superintendent finds that the insurer has met the requirements therefor under this Title, and that the insurer has furnished evidence satisfactory to him that its methods of operation are not such as would render its proposed operation hazardous to the public or its policyholders in this State, the superintendent shall issue to the insurer a proper certificate of authority; otherwise, the superintendent shall issue his order refusing such certificate.

[1973, c. 585, §12 (AMD) .]

2. The certificate of authority, if issued, shall state the insurer's name, home office address, state or country of organization, and the kinds of insurance the insurer is authorized to transact throughout this State. At the insurer's request, the superintendent may issue a certificate of authority limited to particular types of insurance or coverages within a kind of insurance as defined in chapter 9.

[1973, c. 585, §12 (AMD) .]

3. Although issued and delivered to the insurer, the certificate of authority at all times shall be the property of the State of Maine. Upon any expiration, suspension or termination thereof, the insurer shall promptly deliver the certificate to the superintendent.

[1973, c. 585, §12 (AMD) .]

4. Insurers required to file an annual statement must, as a condition to the issuance or continuance of a certificate of authority, provide the National Association of Insurance Commissioners with all information required for participation in the Insurance Regulatory Information System. This filing must contain the insurer's current annual statement convention blank and, if requested by the superintendent or the National Association of Insurance Commissioners, publicly available financial reports of any affiliated insurers or other entities necessary for analyzing any insurer licensed in this State. Each statement furnished by an insurer must be manually executed by those persons who are required by section 423 to verify an annual statement utilizing the prescribed jurat. Any amendments and addendums to the annual statement subsequently filed with the superintendent must also be filed with the National Association of Insurance Commissioners. Insurers shall provide written certification to the superintendent that they have complied with this subsection when they file their annual statements. This subsection does not apply to any insurer doing business under chapter 51.

In the absence of bad faith, fraud or intentional act, an officer or an employee of the National Association of Insurance Commissioners may not be subject to civil liability for libel, slander or any other cause of action in tort as a result of processing data or other information filed by insurers under this subsection or distribution of reports prepared on the basis of that information to insurance regulatory officials of any state that has subscribed to and used the Insurance Regulatory Information System through the National Association of Insurance Commissioners. Information provided to the superintendent that is held confidential by the National Association of Insurance Commissioners must be held confidential by the superintendent unless that information is relevant to any hearing conducted by the superintendent pursuant to section 229 or an order requiring disclosure is issued by the Superior Court.

[1991, c. 828, §13 (AMD) .]

5. The superintendent may require insurers subject to this section to make available any accountant's work papers created during an audit.

A. The superintendent may review the accountant's work papers upon timely notice to the insurer. The superintendent may photocopy or otherwise record the contents of work papers during the review.
[1989, c. 846, Pt. C, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. Any work papers or copies of work papers under the superintendent's custody or control are confidential and are not subject to public inspection. [1989, c. 846, Pt. C, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. The work papers of an insurer's subsidiaries, parent or other corporate affiliates are deemed to be the insurer's work papers to the extent that the work papers reference transactions between the insurer and the subsidiary, parent or corporate affiliate and affect the insurer's final equity determination. [1989, c. 846, Pt. C, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

D. The insurer shall, as a condition of the accountant's engagement, require accountants:

(1) To retain any work papers prepared in connection with an audit of the insurer for at least 6 years after the close of a reporting period; and

(2) To provide the work papers, or a copy, to the insurer at the insurer's request. [1989, c. 846, Pt. C, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

E. For purposes of this subsection, the term "work papers" includes, but is not limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and the accountant's employees in conducting the examination of the insurer. [1989, c. 846, Pt. C, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

[1989, c. 846, Pt. C, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 846, §§A,C3,E4 (AMD). 1991, c. 828, §13 (AMD).

§415. CONTINUATION OF CERTIFICATE OF AUTHORITY

1. A certificate of authority continues in force as long as the insurer is entitled under this Title and until suspended or revoked by the superintendent or terminated at the insurer's request.

A. [1995, c. 544, §3 (RP).]

B. [1995, c. 544, §3 (RP).]

C. [1995, c. 544, §3 (RP).]

[1995, c. 544, §3 (AMD) .]

2.

[1995, c. 544, §4 (RP) .]

3. The superintendent may, upon the insurer's request made within 3 months after suspension, reinstate a certificate of authority that the superintendent suspended due to the insurer's failure to pay the annual fee upon payment by the insurer of the fee for reinstatement specified in section 601. Otherwise the insurer may be granted another certificate of authority only after filing application therefor and meeting all other requirements as for an original certificate of authority in this State.

[1997, c. 592, §11 (AMD) .]

4.

[1997, c. 592, §11 (RP) .]

5.

[1997, c. 592, §11 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 767, §§10,11 (AMD). 1977, c. 222, §1 (AMD). 1977, c. 694, §398 (AMD). 1981, c. 501, §§39,40 (AMD). 1995, c. 544, §§3,4 (AMD). 1997, c. 592, §11 (AMD).

§415-A. TERMINATION OF CERTIFICATE OF AUTHORITY

An authorized insurer which elects to terminate its license authority in this State, in whole or in part, shall submit a withdrawal plan designed to protect policyholders and claimants which is subject to approval by the superintendent. The insurer shall submit its plan at least 60 days prior to its proposed date of withdrawal. The plan shall include, but not be limited to, requirements and procedures for meeting the insurer's existing contractual obligations, providing security in the event of a subsequent insolvency and meeting any applicable statutory obligations. The plan shall also comply with any further terms and conditions which are prescribed by rules adopted by the superintendent. In order to protect the interest of the people of this State, the superintendent may require the insurer to make a deposit of securities of a nature and type eligible under section 1253, to be held in trust by the treasurer in the name of the superintendent. [1985, c. 330, §5 (NEW).]

If an insurer's license authority is revoked, suspended or otherwise terminated in a manner other than by its election, the superintendent shall issue an order which prescribes terms and conditions related to the license termination which shall, to the extent practicable, conform to the requirements governing withdrawal plans as prescribed by this section and rules promulgated under this section. In the event that an insurer attempts to terminate its license authority in this State without filing a withdrawal plan acceptable to the superintendent, the superintendent shall issue an order prescribing the terms and conditions of the termination. Any order issued pursuant to this section, including an order directing an insurer to produce relevant information, may be enforced as provided by section 214. [1985, c. 330, §5 (NEW).]

SECTION HISTORY
1985, c. 330, §5 (NEW).

§416. PETITION FOR SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY; MANDATORY GROUNDS

1. Notwithstanding Title 4, chapter 5, and Title 5, section 10051, the superintendent shall refuse to continue or shall suspend or revoke an insurer's certificate of authority:

A. If such action is required by any provision of this Title; [1983, c. 419, §1 (AMD).]

B. If a foreign insurer and it no longer meets the requirements for a certificate of authority, on account of deficiency of capital or surplus or otherwise; [1983, c. 419, §1 (AMD).]

C. If a domestic insurer and it has failed to cure an impairment of capital or surplus within the time allowed therefor by the superintendent under this Title or is otherwise no longer qualified for the certificate of authority; [1983, c. 419, §1 (AMD).]

D. If the insurer's certificate of authority to transact insurance therein is suspended or revoked by its state of domicile, or state of entry into the United States, if an alien insurer; or [1969, c. 132, §1 (NEW).]

E. For failure of the insurer to pay taxes on its premiums as required by law. [1969, c. 132, §1 (NEW).]

[1999, c. 547, Pt. B, §44 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

2. Except in case of insolvency or impairment of required capital or surplus, or suspension or revocation by another state as referred to in subsection 1, paragraph D, the superintendent shall give the insurer at least 20 days notice in advance of any such refusal, suspension or revocation under this section and of the particulars of the reasons therefor. If the insurer requests a hearing thereon within the 20 days, the request shall automatically stay the superintendent's proposed action until his order is made on that hearing. Hearings held pursuant to this subsection shall be held in conformity with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV.

[1983, c. 419, §1 (AMD) .]

3. If an action initiated by the superintendent to suspend or revoke an insurer's certificate of authority is based on subsection 1, paragraphs B or C, a sworn statement of financial condition of the insurer signed by an officer of the insurer which indicates that the insurer no longer meets the requirements for a certificate of authority shall be prima facie proof that the requirements for a certificate of authority are not met.

[1983, c. 419, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 544, §83 (AMD). 1973, c. 585, §12 (AMD). 1977, c. 694, §§399,400 (AMD). 1983, c. 419, §1 (AMD). 1999, c. 547, §B44 (AMD). 1999, c. 547, §B80 (AFF).

§417. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY; DISCRETIONARY AND SPECIAL GROUNDS

1. Notwithstanding Title 4, chapter 5 and Title 5, section 10051, the superintendent may refuse to continue or may suspend or revoke an insurer's certificate of authority if the superintendent finds, after a hearing thereon or upon waiver of hearing by the insurer, that the insurer has violated or failed to comply with any lawful order of the superintendent, or has willfully violated or willfully failed to comply with any lawful rule of the superintendent, or has violated any provision of this Title other than those for violation of which suspension or revocation is mandatory.

[1999, c. 547, Pt. B, §45 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

2. The superintendent shall suspend or revoke an insurer's certificate of authority on any of the following grounds, if he finds after a hearing held in conformity with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV, that the insurer:

A. Is in unsound condition, or is being fraudulently conducted, or is in such condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance in this State currently or prospectively hazardous or injurious to policyholders or to the public; [1983, c. 419, §2 (AMD).]

B. With such frequency as to indicate its general business practice in this State, has without just cause failed to pay, or delayed payment of, claims arising under its policies, whether the claim is in favor of an insured or is in favor of a third person; or, with like frequency, without just cause compels insureds or claimants to accept less than the amount due them or to employ attorneys or to bring suit against the insurer or an insured to secure full payment or settlement of such claims; [1983, c. 419, §2 (AMD).]

C. Refuses to be examined, or if its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its accounts, records and files for examination by the superintendent when required, or refuse to perform any legal obligation relative to the examination; or [1973, c. 585, §12 (AMD).]

D. Has failed to pay any final judgment rendered against it in this State upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within 30 days after the judgment became final or within 30 days after dismissal of an appeal before final determination, whichever date is the later. [1969, c. 132, §1 (NEW).]

[1983, c. 419, §2 (AMD) .]

3. Notwithstanding Title 4, chapter 5 and Title 5, section 10051, the superintendent may, without notice or a hearing thereon, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation or other delinquency proceedings have been commenced against the insurer in any state by the public official charged with supervising the insurance industry in that state. Upon suspending a certificate of authority under this subsection, the superintendent shall promptly schedule a hearing on the matter, to be held within 30 days of the suspension. The superintendent shall make a determination within 30 days after the conclusion of that hearing.

[1999, c. 547, Pt. B, §45 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§401-403 (AMD). 1983, c. 419, §2 (AMD). 1999, c. 547, §B45 (AMD). 1999, c. 547, §B80 (AFF).

§418. POWER TO AMEND, MODIFY OR REFUSE TO RENEW CERTIFICATES OF AUTHORITY

Notwithstanding the authority of the District Court, the superintendent may amend, modify or refuse to renew any insurer's certificate of authority for cause pursuant to procedures in conformity with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [1983, c. 419, §3 (AMD); 1999, c. 547, Pt. B, §78 (AMD); 1999, c. 547, Pt. B, §80 (AFF).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §10 (AMD). 1973, c. 585, §12 (AMD). 1977, c. 694, §404 (RPR). 1983, c. 419, §3 (AMD). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF).

§418-A. ORDER, NOTICE OF SUSPENSION OR, REVOCATION; PUBLICATION; EFFECT UPON AGENTS' AUTHORITY

1. All suspensions or revocations of, or refusals to continue, an insurer's certificate of authority shall be by the superintendent's order, given to the insurer by personal delivery or by certified or registered mail, addressed to the insurer at its last address of record with the superintendent. Notice by mail shall be deemed given when so mailed.

[1983, c. 419, §4 (NEW) .]

2. Upon issuance of the order, the superintendent shall forthwith give notice thereof to the insurer's agents in this State of record in the bureau, and shall likewise suspend or revoke the authority of those agents to represent the insurer.

[1983, c. 419, §4 (NEW) .]

SECTION HISTORY
1983, c. 419, §4 (NEW).

§419. DURATION OF SUSPENSION; INSURER'S OBLIGATION DURING SUSPENSION PERIOD; REINSTATEMENT

1. The suspension of an insurer's certificate of authority must be for such period as the superintendent specifies in the order of suspension. During the suspension period, the superintendent may rescind or shorten the suspension period by further order. The superintendent may reinstate the insurer's certificate of authority upon written request of the insurer if the superintendent finds that the causes of the suspension are no longer continuing and that the insurer is otherwise in compliance with the requirements of this Title.

[1995, c. 570, §2 (AMD) .]

2. During the suspension period, the insurer shall not solicit or write any new business in this State, but shall file its annual statement, pay fees, licenses and taxes as required under this Title, and may service its business already in force in this State, as if the certificate of authority had continued in full force.

[1983, c. 419, §5 (AMD) .]

3. Upon expiration of the suspension period, if within that period the certificate of authority has not terminated, the insurer's certificate of authority shall reinstate unless the superintendent finds that the causes of the suspension are continuing, or that the insurer is otherwise not in compliance with the requirements of this Title.

[1983, c. 419, §5 (AMD) .]

4. Upon reinstatement of the insurer's certificate of authority, the authority of its agents in this State to represent the insurer shall likewise reinstate. The superintendent shall promptly notify the insurer and its agents in this State, of record in the bureau, of that reinstatement.

[1983, c. 419, §5 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§405,406 (AMD). 1983, c. 419, §5 (AMD). 1995, c. 570, §2 (AMD).

§420. GENERAL CORPORATION LAWS INAPPLICABLE TO FOREIGN INSURERS

The general corporation laws of this State shall not apply as to foreign insurers holding certificates of authority to transact insurance in this State. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§421. SUPERINTENDENT PROCESS AGENT FOR INSURERS

1. Before the superintendent authorizes it to transact insurance in this State, each insurer shall appoint an agent to receive service of legal process issued against the insurer in this State. The insurer shall file with the superintendent a copy of the appointment. The notice to the superintendent must be accompanied by a copy of a resolution of the board of directors or like governing body of the insurer, if an incorporated insurer, showing that those officers who executed the appointment were duly authorized to do so on behalf of the insurer. The registered agent must consent to the appointment.

[1997, c. 592, §12 (AMD) .]

1-A.

[T. 24-A, §421, sub-§1-A (RP) .]

2.

[1997, c. 457, §12 (RP) .]

3. Service of process against a foreign or alien insurer may be made only by service thereof upon the attorney appointed by the insurer.

[1997, c. 457, §13 (AMD) .]

4. Service of such process against a domestic insurer may be made as provided hereunder, or in any other manner provided by law.

[1969, c. 132, §1 (NEW) .]

5. At the time of application for a certificate of authority the insurer shall file the appointment with the superintendent, together with designation of the person to whom process against it served upon the appointed agent is to be forwarded. The insurer may change such designation by a new filing.

[1997, c. 592, §13 (AMD) .]

6. A copy of such appointment, certified by the superintendent, shall be received in evidence in all courts of this State.

[1973, c. 585, §12 (AMD) .]

7. Any person or entity required by Title 24 or this Title to appoint an agent for service of process who does not have a valid appointment on file with the superintendent or required by applicable law to appoint the superintendent as agent for service of process is deemed to have appointed the superintendent as agent for service of process, and process may be served within this State in the same manner as provided in section 2105. This subsection does not relieve that person or entity from any requirement to appoint an agent for service of process or from the applicable penalties for failure to comply with that requirement.

[2013, c. 238, Pt. E, §1 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §§10-14 (AMD). 1997, c. 592, §§12, 13 (AMD). 1999, c. 113, §18 (AMD). 2013, c. 238, Pt. E, §1 (AMD).

§422. SERVING PROCESS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §15 (RP).

§423. ANNUAL STATEMENT

1. Each authorized insurer shall annually on or before March 1st, or within any reasonable extension of time that the superintendent for good cause may have granted on or before such March 1st, file with the superintendent a full and true statement of its financial condition, transactions and affairs as of December 31st preceding. The statement must be on an annual statement blank of the National Association of Insurance Commissioners, be prepared in accordance with the association's annual statement instructions, and follow practices and procedures prescribed by the association's accounting practices and procedures manual, with any useful or necessary modification or adaptation thereof and as supplemented by additional information required by the superintendent. The statement must be verified by the oath of the insurer's president or vice-president, and secretary or actuary as applicable, or in the absence of the foregoing, by 2 other principal officers; or if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.

[1993, c. 313, §16 (AMD) .]

2. The statement of an alien insurer shall be verified by its United States manager or other officer duly authorized, and shall relate only to the insurer's transactions and affairs in the United States unless the superintendent requires otherwise. If the superintendent requires a statement as to such an insurer's affairs throughout the world, the insurer shall file such statement with the superintendent as soon as reasonably possible.

[1973, c. 585, §12 (AMD) .]

3. The superintendent may refuse to continue, or may suspend or revoke, the certificate of authority of any insurer failing to file its annual statement when due.

[1973, c. 585, §12 (AMD) .]

4. Before August 10th, and at the same time the insurer makes payment for its annual assessment, the insurer shall pay the fee for filing its annual statement as prescribed by section 601 (fee schedule).

[1995, c. 544, §5 (AMD) .]

5. The superintendent may adopt rules that prescribe accounting standards applicable to statements filed pursuant to this section. These rules may permit or require any class or classes of insurers domiciled or authorized to do business in this State to conform its financial presentations to the standards of preparation prescribed in the accounting practices and procedures manual of the National Association of Insurance Commissioners.

[1991, c. 828, §14 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §14 (AMD). 1993, c. 313, §16 (AMD). 1995, c. 544, §5 (AMD).

§423-A. INTERIM FINANCIAL REPORTING REQUIREMENTS

1. **Quarterly report.** Within 45 days following the close of any calendar quarter, except the 4th quarter, an authorized insurer, subject to the requirements of section 423, shall upon the superintendent's request, made to the authorized insurer, not later than the end of the quarter to be reported upon file a quarterly report of financial condition with the Bureau of Insurance.

[1985, c. 330, §6 (NEW) .]

2. **Form and content.** The quarterly report shall be in the form requested by the superintendent and shall contain such information as the superintendent deems necessary or if the superintendent elects shall be conformed to the reporting format developed by the National Association of Insurance Commissioners and which is in customary use in the United States for differing types of authorized insurers.

[1985, c. 330, §6 (NEW) .]

3. **Verification.** The report shall be verified by the oath of the insurer's president or vice-president, and the secretary or actuary as applicable, or in the absence of the foregoing, by 2 other principal officers; or if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.

[1985, c. 330, §6 (NEW) .]

SECTION HISTORY
1985, c. 330, §6 (NEW).

§423-B. PERIODIC FINANCIAL REPORTS OF INSURER-CONTROLLED HEALTH MAINTENANCE ORGANIZATIONS

An authorized insurer that controls and operates a health maintenance organization as a division or line of business shall file on a continuing basis any additional periodic financial reports required by the superintendent by rule. [1993, c. 702, Pt. A, §8 (NEW).]

SECTION HISTORY
1993, c. 702, §A8 (NEW).

§423-C. REPORTS OF MATERIAL TRANSACTIONS

1. **Report required.** Every domestic insurer must file a report with the superintendent, on or before the 15th day of each month, if it has engaged in a material investment or reinsurance transaction during the preceding month that has not already been separately reported to the superintendent or submitted to the superintendent for prior review.

[1995, c. 375, Pt. A, §1 (NEW) .]

2. **Material transactions defined.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Material investment transaction" means an acquisition or disposition of an asset or the aggregate of a series of related acquisitions or related dispositions during a 30-day period that is nonrecurring, not in the ordinary course of business and involving more than 5% of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the superintendent. Asset acquisitions and dispositions include without limitation a purchase, sale, lease, exchange, merger, consolidation, succession, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment or destruction. Asset acquisition does not include the construction or development of real property for the use of the reporting insurer or the acquisition of materials for such construction or development. [1995, c. 375, Pt. A, §1 (NEW).]

B. "Material reinsurance transaction" means:

(1) A transaction involving property and casualty business, including accident and health business written by a property and casualty insurer, that involves more than 50% of either the insurer's total ceded written premium or the insurer's total ceded indemnity and loss adjustment reserves;

(2) A transaction involving life, annuity or accident and health business that causes a change, either positive or negative, in the current total reserve credit taken for all life, annuity and accident and health business of more than 50% from the total reserve credit taken for such business in the insurer's most recent annual statement. "Total reserve credit" includes reserve credit taken for unearned premiums, reserve credit taken other than for unearned premiums and amounts recoverable on paid and unpaid losses for all reinsurance ceded;

(3) Any transaction in which either:

(a) An authorized reinsurer representing more than 10% of the insurer's total reserve credit for business ceded is replaced by one or more unauthorized reinsurers; or

(b) Previously established collateral requirements have been reduced or waived for one or more unauthorized reinsurers representing collectively more than 10% of the insurer's total reserve credit for business ceded; or

(4) Transactions otherwise falling within the scope of this paragraph do not need to be reported if:

(a) In the case of a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than 10% of its total written premium for direct and assumed business;

(b) In the case of a life, annuity and accident and health insurer, the total reserve credit taken for business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement before any cession; or

(c) The transaction falls within the scope of a previously reported reinsurance agreement. [1995, c. 2, §51 (COR).]

[1995, c. 2, §51 (COR) .]

3. **Reporting procedures.** Reports for material investment transactions and material reinsurance transactions must follow the following procedures.

A. A report of a material investment transaction must include the following information:

(1) Date of the transaction;

(2) Manner of acquisition or disposition;

(3) Description of the assets involved;

(4) Nature and amount of the consideration given or received;

(5) Purpose of or reason for the transaction;

(6) Manner by which the amount of consideration was determined;

(7) Gain or loss recognized or realized as a result of the transaction; and

(8) Name of the person from whom the assets were acquired or to whom they were disposed. [1995, c. 375, Pt. A, §1 (NEW).]

B. A report of a material reinsurance transaction must include the following information:

(1) Effective date of the nonrenewal, cancellation or revision of the reinsurance agreement affected by the transaction;

(2) The description of the transaction with an identification of the initiator of the transaction;

(3) Purpose of or reason for the transaction; and

(4) If applicable, the identity of the replacement reinsurers. [1995, c. 375, Pt. A, §1 (NEW).]

C. Material transactions must be reported on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement of 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves, and the insurer has ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1,000,000 total direct and assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus. [1995, c. 375, Pt. A, §1 (NEW).]

[1995, c. 375, Pt. A, §1 (NEW) .]

4. **Confidentiality.** All reports obtained by or disclosed to the superintendent pursuant to this section are confidential, are not subject to subpoena and may not be made public by the superintendent, the National Association of Insurance Commissioners or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains. If the superintendent, after giving the insurer that would be affected notice and an opportunity for hearing, determines that publication is in the interest of policyholders, shareholders or the public, the superintendent may publish all or any part of a report in the manner the superintendent determines to be appropriate.

[1995, c. 375, Pt. A, §1 (NEW) .]

SECTION HISTORY
RR 1995, c. 2, §51 (COR). 1995, c. 375, §A1 (NEW).

§423-D. ANNUAL REPORT SUPPLEMENT

1. **Annual report supplement required.** Each health insurer and health maintenance organization shall file an annual report supplement on or before March 1st of each year, or within any reasonable extension of time that the superintendent for good cause may have granted on or before March 1st. The superintendent shall adopt rules regarding specifications for the annual report supplement. The annual report supplements must provide the public with general, understandable and comparable financial information relative to the in-state operations and results of authorized insurers and health maintenance organizations. Such information must include, but is not limited to, medical claims expense, administrative expense and underwriting gain for each line segment of the market in this State in which the insurer participates. The annual report supplements must contain sufficient detail for the public to understand the components of cost incurred by authorized health insurers and health maintenance organizations as well as the annual cost trends of these carriers. The superintendent shall develop standardized definitions of each reported measure. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2003, c. 469, Pt. E, §2 (NEW) .]

2. **Exemption.** If an insurer is engaged in the type of health insurance business identified as an exception to the definition of health insurance in section 704, subsection 2 and is not engaged in health insurance in this State as defined in that section, then the insurer is not subject to the requirements of this section for the filing of annual report supplements.

[2003, c. 469, Pt. E, §2 (NEW) .]

SECTION HISTORY
2003, c. 469, §E2 (NEW).

§423-E. REPORT TO LEGISLATURE

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §2 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §3 (RP).

§423-F. OWN RISK AND SOLVENCY ASSESSMENT

1. **General requirement.** A domestic insurer that is not subject to registration under section 222, subsection 8 shall comply with the requirements of section 222, subsection 8, paragraph B-3 if the requirements of that paragraph would apply if the insurer were subject to registration. The superintendent is considered the insurer's lead regulator for purposes of this section.

[2013, c. 238, Pt. A, §30 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

2. **Confidentiality.** All documents prepared or filed pursuant to this section are confidential to the same extent and subject to the same terms and procedures as if they were prepared or filed pursuant to section 222, subsection 8, paragraph B-3.

[2013, c. 238, Pt. A, §30 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

SECTION HISTORY
2013, c. 238, Pt. A, §30 (NEW). 2013, c. 238, Pt. A, §34 (AFF).

§424. -- PENALTY FOR LATE OR FALSE STATEMENT

1. An insurer failing, without just cause beyond the reasonable control of the insurer, to file its annual statement as required in section 423 shall forfeit to the State $25 for each day of delinquency, to be collected if necessary, by civil action against the insurer in the District Court, Southern Kennebec Division.

[1969, c. 132, §1 (NEW) .]

2. Any director, officer, agent or employee of any insurer who subscribes to, makes or concurs in making or publishing, any annual or other statement required by law, knowing the same to contain any material statement that is false, commits a Class D crime.

[1991, c. 797, §9 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 797, §9 (AMD).

§425. TRANSACTIONS WITH PARENT CORPORATION, SUBSIDIARIES, AND AFFILIATES

1. No insurer shall engage directly or indirectly in any transaction or agreement with its parent corporation, or with any subsidiary or affiliated person which shall result or tend to result in:

A. Substitution through any method of any asset of the insurer with an asset or assets of inferior quality or lower fair market value; or [1969, c. 132, §1 (NEW).]

B. Deception as to the true operating results of the insurer; or [1969, c. 132, §1 (NEW).]

C. Deception as to the true financial condition of the insurer; or [1969, c. 132, §1 (NEW).]

D. Allocation to the insurer of a proportion of the expense of combined facilities or operations which is unfair and unfavorable to the insurer; or [1969, c. 132, §1 (NEW).]

E. Unfair, unnecessary or excessive charges against the insurer for services, or facilities, or supplies or reinsurance; or [1969, c. 132, §1 (NEW).]

F. Unfair and inadequate charges by the insurer for reinsurance, services, facilities or supplies furnished by the insurer to others; or [1969, c. 132, §1 (NEW).]

G. Payment by the insurer for services, facilities, supplies or reinsurance not reasonably needed by the insurer. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. In all transactions between the insurer and its parent corporation, or involving the insurer and any subsidiary or affiliated person, full recognition shall be given to the paramount duty and obligation of the insurer to protect the interests of policyholders, both existing and future.

[1969, c. 132, §1 (NEW) .]

3. For the purposes of this section a "subsidiary" is a person of which either the insurer or the parent corporation, or both, holds practical control, and an "affiliated person" is a person controlled by any combination of the insurer, the parent corporation, a subsidiary, or the principal stockholders or officers or directors of any of the foregoing.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§425-A. CONTRACT TO PARTICIPATE IN FINANCE PROGRAM

An authorized insurer may enter into a contract or arrangement with a financial institution for the purpose of participating in a finance program with the financial institution. In this case, the financial institution need not be licensed as a producer, as long as the purpose of the arrangement is to authorize an insurer to direct or refer insureds, prospective insureds or other customers to the financial institution for loans, or for the purpose of authorizing an insurer to facilitate arrangements for leases, loans or credit applications with the financial institution. This section does not exempt persons from otherwise complying with applicable state or federal laws relating to entering into such contracts. [1997, c. 457, §16 (NEW).]

SECTION HISTORY
1997, c. 457, §16 (NEW).

§426. RESIDENT AGENT; COUNTERSIGNATURE LAW

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 168, §2 (RP).

§427. -- EXCEPTIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §11 (AMD). 1979, c. 162, (AMD). 1985, c. 524, §§1-4 (AMD). 1987, c. 481, §1 (AMD). 1989, c. 168, §3 (RP).

§428. RETALIATORY PROVISION

1. When by or pursuant to the laws of any other state or foreign country or province any taxes, licenses and other fees, in the aggregate, and any fines, penalties, deposit requirements or other material requirements, obligations, prohibitions or restrictions are or would be imposed upon Maine insurers doing business or that might seek to do business in such state, country or province, or upon the agents or representatives of such insurers or upon brokers, which are in excess of such taxes, licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements or obligations, prohibitions or restrictions directly imposed upon similar insurers, or upon the agents or representatives of such insurers, or upon brokers, of such other state, country or province under the statutes of this State, so long as such laws of such other state, country or province continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties or deposit requirements or other material requirements, obligations, prohibitions or restrictions of whatever kind shall be imposed by the superintendent upon the insurer, or upon the agents or representatives of such insurers, or upon brokers, of such other state, country or province doing business or seeking to do business in Maine. Any tax, license or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state, country or province on Maine insurers or their agents or representatives or upon Maine brokers shall be deemed to be imposed by such state, country or province within the meaning of this section.

[1973, c. 585, §12 (AMD) .]

1-A. Notwithstanding subsection 1, this section does not apply to application fees, examination fees, issuance fees, appointment fees, renewal fees and any other licensing fees associated with agent licenses, broker licenses, consultant licenses, adjuster licenses, managing general agent registrations and reinsurance intermediary licenses.

[1993, c. 637, §3 (NEW) .]

2. This section shall not apply as to personal income taxes, or as to ad valorem taxes on real or personal property, or as to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance; except that deductions, from premium taxes or other taxes otherwise payable, allowed on account of real estate or personal property taxes paid shall be taken into consideration by the superintendent in determining the propriety and extent of retaliatory action under this section.

[1973, c. 585, §12 (AMD) .]

3. For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada or a province thereof, shall be that state designated by the insurer in writing filed with the superintendent at time of admission to this State or within 6 months after January 1, 1970, whichever date is the later, and may be any one of the following states:

A. That in which the insurer was first authorized to transact insurance; [1969, c. 132, §1 (NEW).]

B. That in which is located the insurer's principal place of business in the United States; or [1969, c. 132, §1 (NEW).]

C. That in which is held the largest deposit of trusteed assets of the insurer for the protection of its policyholders in the United States. [1969, c. 132, §1 (NEW).]

If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

[1973, c. 625, §135 (AMD) .]

4. The domicile of an insurer formed under the laws of Canada or a province thereof shall be that province of Canada in which its head office is located.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §135 (AMD). 1993, c. 637, §3 (AMD).

Subchapter 2: INSURANCE EMERGENCIES

§471. PROCLAMATION BY GOVERNOR

Whenever it appears to the Governor that the welfare of the State or any section thereof, or the welfare and security of insurers under the supervision of the superintendent or their insureds or beneficiaries require, the Governor may proclaim that an insurance emergency exists and this subchapter shall thereupon become effective. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§472. RULES AND REGULATIONS

During the period of any insurance emergency described in section 471, the superintendent shall have power to make, amend or rescind such rules and regulations governing the business of any insurers as he deems expedient in order to adopt and maintain sound methods of protecting the interests of insurer, insureds, beneficiaries or the public. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§473. INSURERS REGULATED; SUSPENDED

During any insurance emergency period as described in sections 471 and 472, the superintendent is empowered to suspend for such time or times as he may determine the transaction of insurance functions of any authorized insurer, whether domestic or foreign, solvent or otherwise, and to limit its insurance business in volume or character to such particular amounts or classifications and for such time or times as he may deem advisable. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§474. PAYMENTS DEFERRED

During any insurance emergency period as described in sections 471 and 472, the superintendent shall have authority to postpone or defer, by rules or orders made and issued by him, for such time or times as he may determine, the payment of any amount payable under the terms of any policy of insurance, annuity or pure endowment contract, and the payment of judgments, notes, drafts, checks, bills of exchange or other forms of payment of claims due from insurers to any person, firm or corporation, whether such claim is liquidated or unliquidated, due or to become due at a day certain, and defer the payment of premiums on policies affected by such postponements or suspensions and may direct payment in full or in part whenever in his discretion such payment may be safely consummated. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§475. "INSURER" DEFINED

The words "insurer" or "insurers" as used in this subchapter shall include corporations, interinsurers, associations, societies and orders as well as partnerships and individual agents representing such organizations. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§476. PERSONAL RESPONSIBILITY OF THE SUPERINTENDENT LIMITED

The superintendent shall not be held legally responsible for any act or failure to act in the premises when such act or failure to act shall have been shown to be the result of good faith. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§477. DURATION AT WILL OF GOVERNOR

The authority and power given the superintendent under this subchapter shall terminate and be of no effect when the Governor proclaims that any insurance emergency has ceased to exist. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§478. JURISDICTION OF COURTS

During any emergency insurance period as described in sections 471 and 472, the superintendent is authorized to issue such directions, rules or orders as in his discretion the circumstances may warrant, and any Justice of the Supreme Judicial or Superior Courts shall have full jurisdiction to enforce this chapter by appropriate decrees. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§479. PENALTIES

Any violation of any order issued by virtue of this subchapter or any rule or regulatory provision made by the superintendent pursuant thereto shall be punishable by a fine of not more than $1,000 or by imprisonment for less than one year, or by both. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

Chapter 7: FEES AND TAXES

§601. FEE SCHEDULE

The superintendent shall collect, and persons so served shall pay to the superintendent, the fees and miscellaneous charges as set forth in this section. The superintendent may adopt rules establishing the fees and charges in different amounts from those specified under this section, except that the amount of any such fee or charge may not exceed the cap established in this section. In the absence of such rules, the maximum amounts set forth in this section apply. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2003, c. 203, §1 (AMD).]

1. **Certificate of authority.** Insurer's certificate of authority fees may not exceed:

A. For filing application for initial certificate of authority, including all documents submitted as part of the application. If an applicant requests deferral and new data filings respecting the application are required, a fee in equal amount is required upon the filing of the new information $1,000. [1991, c. 334, §5 (AMD).]

B. Issuance, and each annual continuation $100; and [1995, c. 544, §6 (AMD).]

C. Reinstatement, under section 415 $350; [2003, c. 203, §1 (AMD).]

[2003, c. 203, §1 (AMD) .]

2. **Charter documents, other than those filed with application for certificate of authority.** The fee: for filing by an insurer for a reservation of a name; in addition to any other fee, a late filing of any information required to be filed by a licensee; registration of a branch location; and filing any amendment to certificate of organization, articles or certificate of incorporation, charter, bylaws, power of attorney, as to reciprocal insurers, and other constitutent documents of the insurer may not exceed $25;

[2003, c. 203, §1 (AMD) .]

3. **Annual statement.** Filing annual statement of insurer, payable annually may not exceed $100;

[2003, c. 203, §1 (AMD) .]

4. **Process.**

[1997, c. 592, §15 (RP) .]

5. **Producers.** Producers' license and appointment fees may not exceed:

A. Issuance fee for original resident producer license, including limited license $30; [1997, c. 457, §18 (AMD); 1997, c. 457, §55 (AFF).]

B. Appointment of resident producer, each insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group $30;

Biennial fee for appointment, each insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group $30; [1997, c. 592, §16 (AMD).]

C. Temporary license issuance fee $50; [1993, c. 637, §4 (AMD).]

D. [1997, c. 457, §55 (AFF); 1997, c. 457, §18 (RP).]

E. Issuance fee for original nonresident producer license $70;

Appointment of such producer, each insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group $70;

Biennial fee for appointment, each insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group $70; [2003, c. 1, §20 (COR).]

F. Issuance fee for resident agency license, $30;

Biennial fee, $30;

Biennial fee for appointment, each insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group, $30; and [2011, c. 238, Pt. H, §1 (AMD).]

G. Issuance fee for nonresident agency license, $70;

Biennial fee, $70;

Biennial fee for appointment, each insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group, $70. [2011, c. 238, Pt. H, §2 (AMD).]

H. [2011, c. 238, Pt. H, §3 (RP).]

[2011, c. 238, Pt. H, §§1-3 (AMD) .]

6. **Brokers.**

[1997, c. 457, §55 (AFF); 1997, c. 457, §19 (RP) .]

7. **Consultants.** Consultant license fees may not exceed:

A. Issuance fee for original resident consultant license $50;

Biennial fee $50; [1997, c. 592, §17 (AMD).]

B. Issuance fee for original nonresident consultant license $100;

Biennial fee $100; [1997, c. 592, §17 (AMD).]

C. Issuance fee for resident consultant agency license $50;

Biennial fee $50; and [1997, c. 592, §17 (AMD).]

D. Issuance fee for nonresident consultant agency license $100;

Biennial fee $100. [1997, c. 592, §17 (AMD).]

[2003, c. 203, §1 (AMD) .]

8. **Adjusters.** Adjuster license fees may not exceed:

A. Issuance fee for original resident adjuster license $30;

Biennial fee $30; [1997, c. 592, §18 (AMD).]

B. Issuance fee for original nonresident adjuster license $60;

Biennial fee $60; [1997, c. 592, §18 (AMD).]

C. Temporary license $50; [1993, c. 637, §8 (AMD).]

D. Issuance fee for resident adjuster agency license $30;

Biennial fee $30; and [1997, c. 592, §18 (AMD).]

E. Issuance fee for nonresident adjuster agency license $60;

Biennial fee $60. [1997, c. 592, §18 (AMD).]

[2003, c. 203, §1 (AMD) .]

9. **Examination.**

[1993, c. 221, §1 (RP) .]

9-A. **Application.** Application for license fees may not exceed:

A. Application filing fee, other than consultants $15; and [1993, c. 221, §2 (NEW).]

B. Consultant application filing fee $25. [1993, c. 221, §2 (NEW).]

[2003, c. 203, §1 (AMD) .]

10. **Vending machines.** Insurance vending machines fees may not exceed:

Issuance fee for license, each machine $100; and

Biennial continuation of license, each machine $100.

[2003, c. 203, §1 (AMD) .]

11. **Rating organizations and advisory organizations.** Rating organizations and advisory organizations fees may not exceed:

Original license issuance fee $200; and

Biennial continuation of license $200.

[2003, c. 203, §1 (AMD) .]

12. **Road or tourist service.**

[1997, c. 457, §20 (RP) .]

13. **Copies of certificates.** Certified copy of insurer certificate of authority or other license issued under this Title may not exceed $10.

[2003, c. 203, §1 (AMD) .]

14. **Copies of other documents.** Copies of other documents on file in the bureau: reasonable charge as fixed by the superintendent; and for certifying and fixing official seal may not exceed $10.

[2003, c. 203, §1 (AMD) .]

15.

[1975, c. 767, §15 (RP) .]

16. **Self-insurance authorization.** Fees applicable to each self-insurer, individual or group, seeking authorization or authorized to operate a workers' compensation self-insurance plan, and each self-insurance reinsurance account and each protected cell of a self-insurance reinsurance account, may not exceed:

A. For filing application for initial authorization, including all documents submitted as part of the application, $1,000; [2009, c. 232, §1 (AMD).]

A-1. For filing application for authority to self-insure under Title 39-A, section 403, subsection 16, including all documents submitted as part of the application, $500; [2009, c. 232, §1 (AMD).]

B. For authorization and each annual continuation, $300; and [2009, c. 232, §1 (AMD).]

C. For filing a yearly report of a self-insurer, $100. [2009, c. 232, §1 (AMD).]

If a self-insurer terminates the plan or otherwise does not continue to self-insure, the fee applicable to filing of yearly reports must apply to that period in which the making of these reports is mandated.

[2009, c. 232, §1 (AMD) .]

17. **Rules, rates and forms filings.** Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificate filings may not exceed $20.

[2003, c. 203, §1 (AMD) .]

18. **Third-party administrators.** Third-party administrators license fees may not exceed:

A. Original issuance fee $100; and [1993, c. 637, §12 (AMD).]

B. Annual renewal fee $100. [1993, c. 637, §12 (AMD).]

[2003, c. 203, §1 (AMD) .]

19. **Purchasing group registrations.** Purchasing group registration fees may not exceed:

A. Original issuance fee $100; and [1993, c. 637, §13 (AMD).]

B. Annual renewal fee $100. [1993, c. 637, §13 (AMD).]

[2003, c. 203, §1 (AMD) .]

20. **Preferred provider arrangement administrator.** Preferred provider arrangement administrator fees may not exceed:

A. Original registration issuance fee $100; and [1993, c. 637, §13 (AMD).]

B. Annual renewal fee $100. [1993, c. 637, §13 (AMD).]

[2003, c. 203, §1 (AMD) .]

21. **Reinsurance intermediary.** Reinsurance intermediary issuance fees and renewal fees may not exceed:

A. Original license issuance fee $50; and [1993, c. 637, §14 (RPR).]

B. Annual continuation $50. [1997, c. 457, §21 (AMD).]

[2003, c. 203, §1 (AMD) .]

22. **Managing general agents.** Managing general agents fees may not exceed:

A. Original registration fee $100; and [1993, c. 221, §4 (NEW).]

B. Annual continuation of registration fee $100. [1993, c. 221, §4 (NEW).]

[2003, c. 203, §1 (AMD) .]

23. **Continuing education vendors and courses.** Filing fees for continuing education courses and vendors may not exceed:

A. Filing fee for each continuing education vendor $100; [1993, c. 637, §15 (NEW).]

B. Biennial continuation of approval $100; and [1993, c. 637, §15 (NEW).]

C. Filing fee for original approval of each continuing education course $20. [1993, c. 637, §15 (NEW).]

[2003, c. 203, §1 (AMD) .]

24. **Multiple-employer welfare arrangements.** Applications for authorization may not exceed $500.

[2003, c. 203, §1 (AMD) .]

25. **Transferees of structured settlement payment rights.** Transferees of structured settlement payment rights registration fees may not exceed:

A. Original issuance fee $100; and [1999, c. 268, §1 (NEW).]

B. Annual renewal fee $100. [1999, c. 268, §1 (NEW).]

[2003, c. 203, §1 (AMD) .]

26. **Accredited reinsurers.** Application fees for accreditation of reinsurers may not exceed $500.

[2013, c. 238, Pt. B, §1 (AMD) .]

26-A. **Certified reinsurers.** Application fees for certification of reinsurers may not exceed $1,000.

[2013, c. 238, Pt. B, §2 (NEW) .]

27. **Viatical or life settlement provider.** Settlement provider license issuance fees and renewal fees may not exceed:

A. Original license issuance fee $400; and [2003, c. 636, §1 (NEW).]

B. Annual renewal fee $400. [2003, c. 2, §85 (COR).]

[2003, c. 2, §85 (COR) .]

28. **Pharmacy benefits manager.** Pharmacy benefits manager registration fees may not exceed:

A. Original issuance fee, $100; and [2009, c. 581, §3 (NEW).]

B. Annual renewal fee, $100. [2009, c. 581, §3 (NEW).]

[2009, c. 581, §3 (NEW) .]

29. **Portable electronic device insurance vendor.** Portable electronic device insurance vendor licensing fees may not exceed:

A. Original license issuance fee, $1,000; and [2011, c. 297, §1 (NEW).]

B. Annual renewal fee, $500. [2011, c. 297, §1 (NEW).]

(Subsection 29 as enacted by PL 2011, c. 345, §3 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 601, SUBSECTION 30)

[2011, c. 297, §1 (NEW) .]

30. (REALLOCATED FROM T. 24-A, §601, sub-§29) **Service contract providers and administrators.** Service contract provider or administrator annual registration fees may not exceed $200.

[2011, c. 1, §37 (RAL) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §1 (AMD). 1973, c. 150, §1 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 726, §§1-6 (AMD). 1975, c. 767, §§12-15 (AMD). 1977, c. 222, §2 (AMD). 1979, c. 658, §1 (AMD). 1981, c. 225, §§1-4 (AMD). 1981, c. 501, §41 (AMD). 1989, c. 435, §1 (AMD). 1989, c. 846, §§D1,E4 (AMD). 1991, c. 334, §5 (AMD). 1991, c. 828, §15 (AMD). 1993, c. 153, §§1-8 (AMD). 1993, c. 221, §§1-4 (AMD). 1993, c. 637, §§4-15 (AMD). 1995, c. 544, §6 (AMD). 1995, c. 594, §1 (AMD). 1995, c. 618, §1 (AMD). 1997, c. 457, §§17-21 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 592, §§14-18 (AMD). 1999, c. 268, §1 (AMD). 1999, c. 609, §1 (AMD). 2001, c. 47, §1 (AMD). RR 2003, c. 1, §20 (COR). RR 2003, c. 2, §85 (COR). 2003, c. 203, §1 (AMD). 2003, c. 636, §1 (AMD). 2009, c. 232, §1 (AMD). 2009, c. 581, §3 (AMD). RR 2011, c. 1, §37 (COR). 2011, c. 238, Pt. H, §§1-3 (AMD). 2011, c. 297, §1 (AMD). 2011, c. 345, §3 (AMD). 2011, c. 345, §7 (AFF). 2013, c. 238, Pt. B, §§1, 2 (AMD).

§602. TAX ON PREMIUMS AND ANNUITY CONSIDERATIONS

As to returns and taxes on premiums and annuity considerations refer to Title 36, chapter 357. [1989, c. 502, Pt. A, §92 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 502, §A92 (AMD).

§603. RECORD, REMITTANCE OF FEES

The superintendent shall keep a correct account of all fees and moneys received by him by virtue of his office, and shall pay the same over to the Treasurer of State forthwith. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§604. INSURANCE REGULATORY FUND

1. There is created in the State Treasury a dedicated account to be designated the "Insurance Regulatory Fund," the funds of which are hereby appropriated for the partial support and maintenance of the Insurance Bureau.

[1973, c. 585, §12 (AMD) .]

2. The Treasurer of State shall credit the following funds to the Insurance Regulatory Fund:

A. The balance, if any, remaining on January 1, 1970 of funds allocated to the bureau pursuant to Title 24, section 372; [1973, c. 625, §136 (AMD).]

B. Fees, licenses and other charges collected and remitted by the superintendent under section 601 (fee schedule), or as increased pursuant to section 428 (retaliatory provision); [1985, c. 446, §3 (AMD).]

C. [1997, c. 457, §22 (RP).]

D. Amounts assessed by the superintendent under Title 24, section 2332; [1985, c. 446, §3 (AMD).]

E. Amounts assessed by the superintendent under section 237; [1985, c. 446, §3 (NEW).]

F. Amounts assessed by the superintendent under Title 39-A, section 409; and [1991, c. 885, Pt. E, §24 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

G. Such other amounts as may be expressly required by law to be so credited. [1985, c. 446, §3 (NEW).]

[2001, c. 559, §1 (AMD); 2001, c. 559, §2 (AFF) .]

3. Expenditures by the bureau from the Insurance Regulatory Fund shall be subject to budget control in the same manner as applies to departments of State in general.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§12,13 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 625, §136 (AMD). 1985, c. 446, §3 (AMD). 1991, c. 885, §E24 (AMD). 1991, c. 885, §E47 (AFF). 1997, c. 457, §22 (AMD). 2001, c. 559, §Z1 (AMD). 2001, c. 559, §Z2 (AFF).

§605. IN LIEU, PRE-EMPTION PROVISION

1. Payment by the insurer of the taxes as required by Title 25, section 2399 and Title 36, chapter 357 is in lieu of all taxes imposed by the State upon the insurer, or any subsidiary referred to in section 1157, subsection 5, paragraph B, subparagraph (1), upon premiums or upon income, and of any franchise, privilege or other taxes measured by income of the insurer or the subsidiary.

[1993, c. 502, §1 (AMD); 1993, c. 502, §5 (AFF) .]

2. The State preempts the field of regulating, or of imposing excise, privilege, franchise, income, license, permit, registration and similar taxes, licenses and fees upon, insurers, any subsidiary referred to in section 1157, subsection 5, paragraph B, subparagraph (1), their general agents, agents and other representatives as such; and on the intangible property of insurers, any subsidiary referred to in section 1157, subsection 5, paragraph B, subparagraph (1) or such representatives; and all political subdivisions or agencies in this State are prohibited from regulating insurers, any subsidiary referred to in section 1157, subsection 5, paragraph B, subparagraph (1) or their general agents, agents and other representatives as such, and from imposing upon them any such tax, license or fee. This provision does not prohibit the imposition by political subdivisions of taxes upon real and tangible personal property.

[1993, c. 502, §2 (AMD); 1993, c. 502, §5 (AFF) .]

3. This section shall not be modified or repealed by any law of general application hereafter enacted, unless expressly referred to or expressly repealed therein.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §14 (AMD). 1989, c. 502, §A93 (AMD). 1993, c. 502, §§1,2 (AMD). 1993, c. 502, §5 (AFF).

Chapter 9: KINDS OF INSURANCE; LIMITS OF RISK; REINSURANCE

Subchapter 1: KINDS OF INSURANCE

§701. DEFINITIONS NOT MUTUALLY EXCLUSIVE

It is intended that certain insurance coverages may come within the definitions of 2 or more kinds of insurance as defined in this chapter, and the inclusion of such coverage within one definition shall not exclude it as to any other kind of insurance within the definition of which such coverage is likewise reasonably includable. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§702. "LIFE INSURANCE" DEFINED

Life insurance is insurance on human lives. The transaction of life insurance includes also the granting endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, and optional modes of settlement of proceeds of life insurance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§703. "ANNUITY" DEFINED

For the purposes of this Title, an "annuity" is a contract under which obligations are assumed with respect to periodic payments for a specific term or terms or where the making or continuance of all or of some of the payments, or the amount of a payment, is dependent upon the continuance of human life, except payments made pursuant to optional modes of settlement under the authority of section 702. A contract that includes extra benefits of the kinds defined in sections 702 and 704 is deemed to be an annuity, if the extra benefits constitute a subsidiary or incidental part of the entire contract. A charitable gift annuity agreement, as defined in section 703-A, is not insurance. [1995, c. 375, Pt. C, §2 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1995, c. 375, §C2 (AMD).

§703-A. CHARITABLE GIFT ANNUITY AGREEMENT

1. **Charitable gift annuity agreement defined.** For the purposes of this Title, a "charitable gift annuity agreement" is a written contract in which a qualified organization receives money or other property conditioned upon the organization's agreement to pay an annuity to one or more individuals; as long as, with respect to the organization, the annuity meets the requirements for exclusion from the definition of "acquisition indebtedness" under the Internal Revenue Code, Section 514(c)(5) or a successor provision.

[1995, c. 375, Pt. C, §3 (NEW) .]

2. **Qualified organization defined.** For the purposes of this Title, a "qualified organization" is an organization that is privately and specially established as an instrumentality of the State for a nonprofit purpose or an organization that meets the following requirements.

A. The organization is a nonprofit organization that is either:

(1) An organization to which the Maine Nonprofit Corporation Act applies; or

(2) Organized under the laws of a jurisdiction within the United States and qualified as a foreign corporation pursuant to Title 13-B, chapter 12. [1995, c. 375, Pt. C, §3 (NEW).]

B. The organization qualifies as a tax-exempt organization under the Internal Revenue Code, Section 501(c)(3) or a successor provision. [1995, c. 375, Pt. C, §3 (NEW).]

C. The organization:

(1) Has been operating continuously for 5 or more years;

(2) Is a parent or subsidiary of a qualified organization; or

(3) Is the successor to an organization that meets the requirements of paragraphs A and B and both organizations together have operated continuously for 5 or more years. [1995, c. 375, Pt. C, §3 (NEW).]

[1995, c. 375, Pt. C, §3 (NEW) .]

SECTION HISTORY
1995, c. 375, §C3 (NEW).

§704. "HEALTH INSURANCE" DEFINED

1. **Health insurance.** For purposes of this Title, except as provided in subsection 2 and subsection 3, "health insurance" means insurance of human beings against bodily injury, disablement or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto, including provision for the mental and emotional welfare of human beings by defraying the costs of legal services only to the extent provided for in chapter 38.

[2011, c. 192, §1 (AMD) .]

2. **Exceptions.** As used in this Title and Title 24 in any law enacted after the effective date of this subsection that mandates medical benefits or coverage in individual or group health insurance policies under chapter 33 or chapter 35 for certain specific health services or diseases or certain providers of health care services or that mandates rights and obligations under chapter 56-A, unless the context otherwise indicates, the use of "health insurance" and related terms such as "accident and health insurance," "accident and sickness insurance," "carrier," "health," "health benefit plan," "health care," "health insurer" or "insurer" does not include, unless specifically provided otherwise in the law, the following types of insurance or any combination of those types of insurance: accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

[2001, c. 79, §1 (NEW) .]

3. **Health care sharing ministry.** As used in this Title and Title 24, the use of "health insurance" and related terms such as "accident and health insurance," "accident and sickness insurance," "carrier," "health," "health benefit plan," "health care," "health insurer" or "insurer" does not include, unless specifically provided otherwise in the law, a health care sharing ministry, and a health care sharing ministry may not be considered to be engaged in the business of insurance for the purposes of this Title. For the purposes of this section, "health care sharing ministry" means a faith-based, nonprofit organization that is exempt from taxation under the federal Internal Revenue Code and that:

A. Has been in existence continuously since December 31, 1999 and has facilitated the sharing of medical expenses of participants without interruption since December 31, 1999; [2011, c. 192, §2 (NEW).]

B. Limits participation in the health care sharing ministry to individuals who have a particular religious affiliation; [2011, c. 192, §2 (NEW).]

C. Acts as a facilitator among participants who have financial and medical needs and matches those participants with other participants with the present ability to assist those with financial and medical needs in accordance with criteria established by the health care sharing ministry; [2011, c. 192, §2 (NEW).]

D. Provides for the financial and medical needs of a participant through monetary contributions from one participant to another; [2011, c. 192, §2 (NEW).]

E. Provides amounts that participants may contribute without any assumption of risk or promise to pay among the participants and requires no assumption of risk or promise to pay by the health care sharing ministry to the participants; [2011, c. 192, §2 (NEW).]

F. Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution; [2011, c. 192, §2 (NEW).]

G. Conducts an annual audit that is performed by an independent certified public accountant in accordance with generally accepted accounting principles and that is made available to the public upon request; and [2011, c. 192, §2 (NEW).]

H. Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills." [2011, c. 192, §2 (NEW).]

[2011, c. 192, §2 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 801, §1 (AMD). 2001, c. 79, §1 (RPR). 2011, c. 192, §§1, 2 (AMD).

§704-A. HEALTH MAINTENANCE ORGANIZATION

For purposes of this Title, "health maintenance organization" is defined in section 4202-A, subsection 10. [1993, c. 702, Pt. A, §9 (NEW).]

SECTION HISTORY
1993, c. 702, §A9 (NEW).

§705. "PROPERTY INSURANCE" DEFINED

Property insurance is insurance on real or personal property of every kind and of every interest therein against loss or damage from any and all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage. Property insurance does not include title insurance, as defined in section 709. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§706. "BONDS" DEFINED

The definition of "bonds" includes: [1995, c. 329, §4 (AMD).]

1. Fidelity insurance, which is insurance guaranteeing the honesty of persons holding positions of public or private trust;

[1995, c. 329, §4 (AMD) .]

2. Surety insurance guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings and contracts of suretyship; and

[1995, c. 329, §4 (AMD) .]

3. Insurance indemnifying banks, bankers, brokers, financial or moneyed corporations or associations against loss, resulting from any cause, of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts or other valuable papers, documents, money, precious metals and articles made therefrom, jewelry, watches, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles, or by messenger, but not including any other risks of transportation or navigation; also insurance against loss or damage to such an insured's premises or to his furnishings, fixtures, equipment, safes and vaults therein, caused by burglary, robbery, theft, vandalism or malicious mischief, or any attempt thereat.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1995, c. 329, §4 (AMD).

§707. "CASUALTY INSURANCE" DEFINED

1. Casualty insurance includes:

A. Vehicle insurance. Insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any hazard or cause, and against any loss, liability or expense resulting from or incidental to ownership, maintenance or use of any such vehicle, aircraft or animal; together with insurance against accidental injury to individuals, irrespective of legal liability of the insured, including the named insured, while in, entering, alighting from, adjusting, repairing, cranking or caused by being struck by a vehicle, aircraft or draft or riding animal, if such insurance is issued as an incidental part of insurance on the vehicle, aircraft or draft or riding animal; [1969, c. 132, §1 (NEW).]

B. Liability insurance. Insurance against legal liability for the death, injury or disability of any human being, or for damage to property; and provision of medical, hospital, surgical, disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance; [1969, c. 132, §1 (NEW).]

C. Workers' compensation and employer's liability. Insurance, written on a primary basis, of the obligations accepted by, imposed upon or assumed by employers under law for death, disablement or injury of employees; [1991, c. 872, §1 (AMD).]

C-1. Employee benefit excess insurance. Insurance, protecting an employer against higher than expected obligations under an employee benefit plan, at retention levels that do not have the effect of making the plan an insured plan. Reinsurance provided to employers that self-insure their workers' compensation exposures pursuant to Title 39-A, section 403 does not constitute employee benefit excess insurance. The transaction of employee benefit excess insurance does not constitute the conduct of the business of reinsurance; [2007, c. 466, Pt. D, §4 (AMD).]

D. Burglary and theft. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation or wrongful conversion, disposal or concealment, or from any attempt at any of the foregoing; including supplemental coverage for medical, hospital, surgical

and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery or theft by another; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers and documents, resulting from any cause; [1969, c. 132, §1 (NEW).]

E. Personal property floater. Insurance upon personal effects against loss or damage from any cause; [1969, c. 132, §1 (NEW).]

F. Glass. Insurance against loss or damage to glass, including its lettering, ornamentation and fittings; [1969, c. 132, §1 (NEW).]

G. Boiler and machinery. Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery or apparatus, and to make inspection of and issue certificates of inspection upon boilers, machinery and apparatus of any kind, whether or not insured; [1969, c. 132, §1 (NEW).]

H. Leakage and fire extinguishing equipment. Insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus, water pipes or containers, or by water entering through leaks or openings in buildings, and insurance against loss or damage to such sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus; [1969, c. 132, §1 (NEW).]

I. Credit. Insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured; [1969, c. 132, §1 (NEW).]

J. Malpractice. Insurance against legal liability of the insured, and against loss, damage or expense incidental to a claim of such liability, and including medical hospital, surgical and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury or disablement of any person, or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary or professional service; [1969, c. 132, §1 (NEW).]

K. Elevator. Insurance against loss of or damage to any property of the insured, resulting from the ownership, maintenance or use of elevators, except loss or damage by fire, and to make inspection of and issue certificates of inspection upon elevators; [1969, c. 132, §1 (NEW).]

L. Congenital defects. Insurance against congenital defects in human beings; [1969, c. 132, §1 (NEW).]

M. Livestock. Insurance against loss or damage to livestock, and services of a veterinary for such animals; [1969, c. 132, §1 (NEW).]

N. Entertainments. Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment or similar production, event or exhibition against loss from interruption, postponement or cancellation thereof due to death, accidental injury or sickness of performers, participants, directors or other principals; [1969, c. 132, §1 (NEW).]

N-1. Involuntary unemployment. Insurance against the loss of income due to a permanent or temporary job loss or job change. Involuntary unemployment insurance may include labor dispute coverage. Governmental benefit programs are not considered involuntary unemployment insurance for purposes of this Title; and [2001, c. 138, §2 (NEW).]

O. Miscellaneous. Insurance against any other kind of loss, damage or liability properly a subject of insurance and not within any other kind of insurance as defined in this subchapter, if such insurance is not disapproved by the superintendent as being contrary to law or public policy. [1973, c. 585, §12 (AMD).]

[2007, c. 466, Pt. D, §4 (AMD) .]

2. Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under subsection 1, paragraphs A (vehicle), B (liability), D (burglary), G (boiler and machinery), J (malpractice) and K (elevator) shall for all purposes be deemed to be the same kind of insurance to which it is so incidental, and shall not be subject to provisions of this Title applicable to life and health insurances.

[1969, c. 132, §1 (NEW) .]

3. An insurer other than a casualty insurer may transact employee benefit excess insurance only if that insurer is authorized to insure the class of risk assumed by the underlying benefit plan. Employee benefit excess insurance, even if written by a life or health insurer, is not subject to chapters 29 and 31 to 37, except to the extent that particular provisions are made expressly applicable by rule or law. No later than July 1, 1997, the superintendent shall by rule set standards distinguishing excess insurance from basic insurance. In developing these standards, the superintendent may consider the analysis supporting the recommendations of the National Association of Insurance Commissioners.

[1995, c. 673, Pt. B, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 385, §§5-7 (AMD). 1991, c. 872, §§1,2 (AMD). 1995, c. 375, §C4 (AMD). 1995, c. 673, §B2 (AMD). 2001, c. 138, §2 (AMD). 2007, c. 466, Pt. D, §4 (AMD).

§708. MARINE AND TRANSPORTATION, "WET MARINE" INSURANCE DEFINED

1. "Marine and transportation insurance" includes:

A. Insurance against any kinds of loss or damage to:

(1) Vessels, craft, aircraft, cars, automobiles and vehicles of every kind, as well as all goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks, and

(2) Person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of such insurance, but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles, and

(3) Precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise; and

(4) Bridges, tunnels and other instrumentalities of transportation and communication, excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage, unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion are the only hazards to be covered; piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion; other aids to navigation and transportation, including dry docks and marine railways, against all risks; [1969, c. 132, §1 (NEW).]

B. "Marine protection and indemnity insurance," meaning insurance against, or against legal liability of the insured for, loss, damage or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. For the purposes of this Title, "wet marine and transportation" insurance is that part of "marine and transportation" insurance which includes only:

A. Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto; [1969, c. 132, §1 (NEW).]

B. Insurance of marine builders' risks, marine war risks and contracts of marine protection and indemnity insurance; [1969, c. 132, §1 (NEW).]

C. Insurance of freights and disbursements pertaining to a subject of insurance coming within this definition; and [1969, c. 132, §1 (NEW).]

D. Insurance of personal property and interests therein, in course of exportation from or importation into any country, or in course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in respect to, appertaining to or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any delays, storage, transshipment or reshipment incident thereto. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§709. "TITLE INSURANCE" DEFINED

Title insurance is insurance of owners of property or others having an interest therein, or liens or encumbrances thereon, against loss by encumbrance, or defective titles, or invalidity, or adverse claim to title. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§709-A. FINANCIAL GUARANTY INSURANCE DEFINED

The term "financial guaranty insurance" includes any insurance under which loss is payable upon proof of occurrence of any of the following events to the damage of an insured claimant or obligee: [1987, c. 707, §2 (NEW).]

1. Failure of any obligor or obligors on any debt instrument or other monetary obligation, including common or preferred stock, to pay when due the principal, interest, dividend or purchase price of the instrument or obligation, whether the failure is the result of a financial default or insolvency and whether or not the obligation is incurred directly or as guarantor by, or on behalf of, another obligor which has also defaulted;

[1987, c. 707, §2 (NEW) .]

2. Changes in the level of interest rates,whether short term or long term, or in the difference between interest rates existing in various markets;

[1987, c. 707, §2 (NEW) .]

3. Changes in the rate of exchange of currency, or from the inconvertibility of one currency into another for any reason; or

[1987, c. 707, §2 (NEW) .]

4. Changes in the value of specific assets, including the residual value of property at the termination of a lease.

[1987, c. 707, §2 (NEW) .]

SECTION HISTORY
1987, c. 707, §2 (NEW).

§710. "MULTIPLE LINE" INSURERS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 385, §8 (RP).

Subchapter 2: LIMITS OF RISK

§721. LIMITS OF RISK

1. No insurer shall retain any risk on any one subject of insurance, whether located or to be performed in this State or elsewhere, in an amount exceeding 10% of its surplus to policyholders.

[1969, c. 132, §1 (NEW) .]

2. A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake and other catastrophic hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of any other hazard insured against.

[1969, c. 132, §1 (NEW) .]

3. Reinsurance ceded as authorized by section 731 shall be deducted in determining risk retained. As to surety risks, deduction shall be made of the amount assumed by any authorized cosurety and the value of any security deposited, pledged or held subject to the surety's consent and for the surety's protection.

[1969, c. 132, §1 (NEW) .]

4. As to alien insurers, this section shall relate only to risks and surplus to policyholders of the insurer's United States branch.

[1969, c. 132, §1 (NEW) .]

5. "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, shall be deemed to include any voluntary reserves which are not required pursuant to law, and shall be determined from the last sworn statement of the insurer on file with the superintendent, or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

[1973, c. 585, §12 (AMD) .]

6. This section shall not apply to life or health insurance, annuities, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employers' liability coverages, nor to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

[1987, c. 769, Pt. A, §89 (AMD) .]

7. Limits of risk as to newly formed domestic mutual insurers shall be as provided in section 3352.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1987, c. 769, §A89 (AMD).

Subchapter 3: REINSURANCE

§731. REINSURANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §15 (AMD). 1973, c. 585, §12 (AMD). 1985, c. 330, §§7-9 (AMD). 1989, c. 846, §§E1,4 (RP).

§731-A. ACCEPTANCE OF REINSURANCE

An insurer may accept reinsurance only of such kinds of risks, and retain risk thereon within such limits, as the insurer is otherwise authorized to insure. [1989, c. 846, Pt. E, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

SECTION HISTORY
1989, c. 846, §§E2,4 (NEW).

§731-B. CREDIT FOR REINSURANCE

1. Credit for reinsurance is allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurance is ceded to a solvent assuming insurer that:

A. Is licensed to transact insurance or reinsurance in this State, provided the assuming insurer maintains surplus as regards policyholders in an amount not less than the sum of paid-in capital stock, if any, and surplus as otherwise required for a certificate of authority for the kinds and amount of insurance and assumed reinsurance the insurer has in force net of any applicable ceded reinsurance. If the assuming insurer is licensed as a special purpose reinsurance vehicle pursuant to section 782 and maintains capital and surplus in accordance with the requirements of section 787, credit for reinsurance under a special purpose reinsurance vehicle contract, as defined in section 781, subsection 15, is allowed only to the extent that:

(1) The fair value of the assets held by or for the benefit of the ceding insurer equals or exceeds the obligations due and payable to the ceding insurer by the special purpose reinsurance vehicle under the special purpose reinsurance vehicle contract;

(2) The assets are held in accordance with the requirements in subchapter 6;

(3) The assets are administered in the manner and pursuant to arrangements under subchapter 6;

(4) The assets are held or invested in one or more of the forms allowed in section 795; and

(5) The contract complies with all other relevant requirements of subchapter 6; [2007, c. 386, §1 (AMD).]

B. Is domiciled and licensed in a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this section, if the insurer:

(1) Submits to the authority of this State to examine its books and records; and

(2) Except where reinsurance is ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system, maintains a surplus regarding policyholders in an amount not less than $20,000,000; [1991, c. 828, §16 (AMD).]

B-1. Is accredited as a reinsurer in this State, in accordance with the following standards.

(1) To apply for accreditation, a reinsurer shall file with the superintendent a written application on a form prescribed by the superintendent, accompanied by the fee prescribed in section 601, subsection 26 and an agreement to submit to the jurisdiction of the courts of this State and to the authority of the superintendent to examine the reinsurer's books and records.

(2) An accredited reinsurer must be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien reinsurer, that reinsurer must be entered through and licensed to transact insurance or reinsurance in at least one state.

(3) An accredited reinsurer shall file with the superintendent, as part of its application and annually thereafter, a copy of its annual statement filed with the insurance department of its state of domicile or United States port of entry and a copy of its most recent audited financial statement.

(4) A reinsurer applying for accreditation that maintains a surplus as regards to policyholders in an amount not less than $20,000,000 is deemed to be accredited if the reinsurer's application is not denied by the superintendent within 90 days after submission of the application. The superintendent has the discretion to grant accreditation to an applicant with a surplus less than $20,000,000 subject to such terms and conditions as the superintendent determines to be necessary and appropriate for the protection of domestic ceding insurers and their policyholders. [2013, c. 238, Pt. B, §3 (AMD).]

B-2. Is certified as a reinsurer in this State and secures its obligations in accordance with this paragraph.

(1) To be eligible for certification, the assuming insurer must meet the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a jurisdiction determined by the superintendent to be a qualified jurisdiction pursuant to subparagraph (3);

(b) The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the superintendent pursuant to rules adopted under subsection 7;

(c) The assuming insurer must maintain financial strength ratings from 2 or more rating agencies determined by the superintendent to be acceptable pursuant to rules adopted under subsection 7;

(d) The assuming insurer must agree to submit to the jurisdiction of this State and to appoint an agent for service of process in the same manner as provided for authorized insurers under section 421 and agree to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final United States judgment;

(e) The assuming insurer must agree to meet applicable information filing requirements as determined by the superintendent, both with respect to an initial application for certification and on an ongoing basis;

(f) The assuming insurer must pay the application fee prescribed in section 601, subsection 26-A and, to the extent provided in rules adopted under subsection 7, must agree to pay reasonable costs of review; and

(g) The assuming insurer must satisfy any other requirements for certification established by the superintendent.

(2) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying the requirements of subparagraph (1):

(a) The association may satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which must include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the superintendent to provide adequate protection;

(b) The incorporated members of the association may not be engaged in any business other than underwriting as a member of the association and must be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(c) Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the superintendent an annual certification by the association's domiciliary regulator of the solvency of each underwriter member of the association or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(3) The superintendent shall create and publish a list of jurisdictions that are qualified to serve as the domiciliary regulators of certified reinsurers.

(a) In order to determine whether the domiciliary jurisdiction of an alien assuming insurer is eligible to be recognized as a qualified jurisdiction, the superintendent shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled in the United States. To be recognized as qualified, a jurisdiction must agree to share information and cooperate with the superintendent with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the superintendent has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. The superintendent may consider additional factors.

(b) If the National Association of Insurance Commissioners has published a list of recommended qualified jurisdictions, the superintendent shall consider that list in determining qualified jurisdictions. If the superintendent recognizes a jurisdiction as qualified that does not appear on the list published by the National Association of Insurance Commissioners, the superintendent shall make detailed findings of fact supporting the recognition in accordance with criteria to be developed in rules adopted under subsection 7.

(c) United States jurisdictions that are accredited by the National Association of Insurance Commissioners must be recognized as qualified jurisdictions.

(d) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the superintendent may suspend the reinsurer's certification indefinitely, in lieu of revocation.

(4) The superintendent shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies determined to be acceptable pursuant to rules adopted under subsection 7. The superintendent shall publish a list of all certified reinsurers and their ratings.

(5) A certified reinsurer shall secure all obligations assumed from United States ceding insurers under this subsection, and under comparable laws of other states, at a level consistent with its rating and in a form acceptable to the superintendent, in compliance with rules adopted under subsection 7.

(a) If the security is insufficient, the superintendent shall reduce the allowable credit by an amount proportionate to the deficiency and may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(b) The reinsurer may secure its obligations as a certified reinsurer through a multibeneficiary trust that meets the requirements of paragraph C and subsection 2-A, with the following modifications.

(i) The maximum credit allowable may exceed the value of the qualifying security to the extent provided in this subparagraph.

(ii) The minimum trusteed surplus is $10,000,000, rather than the amount specified in paragraph C.

(iii) If the certified reinsurer also maintains a multibeneficiary trust for obligations required to be fully secured under paragraph C or comparable laws of other states, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed with reduced security as permitted by this paragraph or comparable laws of other United States jurisdictions and for its obligations that are required to be fully secured. The trust accounts may not be approved as qualifying security unless the reinsurer has bound itself, by the language of the trust and by agreement with the insurance regulator with principal oversight of each such trust account, to apply, upon termination of any such trust account, the remaining surplus of that trust to the extent necessary to fund any deficiency of any other such trust account.

(c) If a certified reinsurer does not secure its obligations through a qualifying multibeneficiary trust, it must secure its obligations to the ceding insurer consistent with the requirements of subsection 3, except that the maximum credit allowable may exceed the value of the qualifying security to the extent provided in this subparagraph.

(d) For purposes of this subparagraph, a certified reinsurer whose certification has been terminated for any reason must be treated as a certified reinsurer required to secure 100% of its obligations, unless the superintendent has continued to assign a higher rating, as permitted by other provisions of this section, to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(6) If an applicant for certification has been certified as a reinsurer in a jurisdiction accredited by the National Association of Insurance Commissioners, the superintendent may defer to that jurisdiction's certification to grant certification in this State and may defer to the rating assigned by that jurisdiction.

(7) A certified reinsurer that ceases to assume new business in this State may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable

requirements of this subsection, and the superintendent shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business. [2013, c. 238, Pt. B, §4 (NEW).]

C. Maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States ceding insurers, their assigns and successors in interest.

(1) The assuming insurer shall report annually to the superintendent information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by licensed insurers to enable the superintendent to determine the sufficiency of the trust fund.

(2) In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and, in addition, unless the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, must include a trusteed surplus of at least $20,000,000. The trust must provide that after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, the insurance regulator with principal oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and must consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(3-A) A group including incorporated and individual unincorporated underwriters may secure its obligations with funds held in trust in compliance with the following standards.

(a) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust must consist of a trusteed account in an amount at least equal to the respective underwriters' several liabilities attributable to reinsurance ceded by United States domiciled ceding insurers to any underwriter that is a member of the group.

(b) Notwithstanding the other provisions of this section, for reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992 and not amended or renewed after that date, the trust must consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States.

(c) In addition, the group shall maintain a trusteed surplus of at least $100,000,000 held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

An incorporated member of the group may not be engaged in any business other than underwriting as a member of the group and is subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members. Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the superintendent an annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group or, if a certification is unavailable, financial statements prepared by independent public accountants.

(4-A) The superintendent in rules adopted pursuant to subsection 7 may establish alternative criteria for approval of a reinsurance trust if the superintendent determines that the criteria provide adequate protection to policyholders of United States ceding insurers and are in substantial conformance with standards approved by the National Association of Insurance Commissioners.

(5) The trust must be established in a form approved by the superintendent and consistent with any rules adopted by the superintendent pursuant to this section. The form of the trust and any amendments to the trust must also have been approved by the insurance regulatory official of the state where the trust is domiciled or of another state that, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest. The trust and the assuming insurer are subject to examination, as determined by the superintendent, at the assuming insurer's expense. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(6) The trustees of the trust shall report to the superintendent in writing by February 28th of each year, setting forth the balance of the trust and listing the trust's investments at the end of the preceding year and certifying the date of termination of the trust, if so planned, or certifying that the trust does not expire before December 31st of the current year.

(7) The corpus of the trust is to be valued as any other admitted asset or assets; [2013, c. 238, Pt. B, §5 (AMD).]

D. Does not meet the requirements of paragraph A, B, B-1, B-2 or C, but only with respect to risks located in a jurisdiction where that reinsurance is required by law. The superintendent for good cause after notice and opportunity for hearing may disallow or reduce the credit otherwise permitted under this paragraph. [2013, c. 238, Pt. B, §6 (AMD).]

[2013, c. 238, Pt. B, §§3-6 (AMD) .]

1-A. The superintendent may suspend or revoke a reinsurer's accreditation or certification under subsection 1, after notice and opportunity for hearing, for failure to meet the applicable requirements of subsection 1 or on any ground that would warrant similar action against the certificate of authority of an authorized insurer.

A. A suspension or revocation under this subsection may not take effect until after the superintendent's order following a hearing, unless:

(1) The reinsurer waives its right to a hearing;

(2) The superintendent's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subsection 1, paragraph B-2, subparagraph (6); or

(3) The superintendent finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the superintendent's action. [2013, c. 238, Pt. B, §7 (NEW).]

B. While a reinsurer's accreditation or certification is suspended pursuant to this subsection, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit under subsection 1 except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection 3. If a reinsurer's accreditation or certification is revoked pursuant to this subsection, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection 1, paragraph B-2, subparagraph (5) or subsection 3. [2013, c. 238, Pt. B, §7 (NEW).]

C. The superintendent may deny an application for accreditation or certification under subsection 1, or may impose conditions or restrictions on a reinsurer's accreditation or certification, on any ground for which accreditation or certification may be suspended or revoked. [2013, c. 238, Pt. B, §7 (NEW).]

[2013, c. 238, Pt. B, §7 (NEW) .]

2. The credit permitted by subsection 1 is not to be allowed unless the assuming insurer agrees in the reinsurance agreements:

A. That, if the assuming insurer fails to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer:

(1) Will submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(2) Will comply with all requirements necessary to give the court jurisdiction; and

(3) Will abide by the final decision of the court or of any Appellate Court in the event of an appeal; and [1989, c. 846, Pt. E, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. To designate the superintendent or an attorney as its attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company, as required in section 421. [1989, c. 846, Pt. E, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

This provision is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

[1989, c. 846, Pt. E, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

2-A. Credit for reinsurance may not be allowed on the basis of a trust maintained pursuant to subsection 1, paragraph C unless the assuming insurer agrees in the trust agreements to the following conditions.

A. Notwithstanding any other provisions in the trust instrument, if the trust fund contains an amount less than the amount required by this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund. [2001, c. 47, §5 (NEW).]

B. The assets must be distributed by and claims must be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies. [2001, c. 47, §5 (NEW).]

C. If the commissioner with regulatory oversight determines that the assets of the trust fund or any part of the assets of the trust fund are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part of the assets of the trust fund must be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement. [2001, c. 47, §5 (NEW).]

D. The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection. [2001, c. 47, §5 (NEW).]

[2001, c. 47, §5 (NEW) .]

3. An asset or a reduction from liability for the reinsurance ceded to an assuming insurer not meeting the requirements of subsection 1 is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must equal the value of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the contract, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of:

A. Cash; [1989, c. 846, Pt. E, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those designated as exempt from filing in the purposes and procedures manual of the Securities Valuation Office, and qualifying as admitted assets; or [2013, c. 238, Pt. B, §8 (AMD).]

C. Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution no later than December 31st of the year for which filing is being made and in the possession of the ceding company on or before the filing date of its annual statement.

(1) A letter of credit from an issuer determined to be acceptable as of the date of issuance or the date of confirmation of the letter, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continues to be acceptable as security until its expiration, extension, renewal, modification or amendment, whichever first occurs. The ceding insurer shall replace a nonqualifying letter of credit at its earliest opportunity.

(2) The letter of credit must indicate that it is not subject to any condition or qualification outside the letter of credit, and that the beneficiary need only draw a sight draft under the letter and present the letter to obtain funds and that no other document need be presented. [1993, c. 313, §18 (AMD).]

[2013, c. 238, Pt. B, §8 (AMD) .]

4. For purposes of this section, a "qualified United States financial institution" means an institution that:

A. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state of the United States; [1991, c. 828, §17 (AMD).]

B. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and [1991, c. 828, §17 (AMD).]

C. Has been determined by the superintendent or the Securities Valuation Office of the National Association of Insurance Commissioners to meet standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the superintendent. [1991, c. 828, §17 (NEW).]

[1991, c. 828, §17 (AMD) .]

4-A. "Qualified United States financial institution" means for purposes of those provisions of this section specifying those institutions that are eligible to act as a fiduciary of a trust an institution that:

A. Is organized or in the case of a United States branch or agency office of a foreign banking organization licensed under the laws of the United States or any state of the United States and has been granted authority to operate with fiduciary powers; and [1991, c. 828, §18 (NEW).]

B. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies. [1993, c. 1, §56 (COR).]

[1993, c. 1, §56 (COR) .]

5. Credit is allowed as an asset or deduction from liability to any ceding insurer only for reinsurance ceded to an assuming insurer qualified under this section, except that no credit is allowed, unless the reinsurance contract provides, in substance, that in the event of the insolvency of the ceding insurer, the reinsurance is payable under a contract or contracts reinsured by the assuming insurer on the basis of reported claims allowed by the court, without diminution because of the insolvency of the ceding insurer. The payments must be made directly to the ceding insurer or to the ceding insurer's domiciliary receiver unless the contract or other written agreement specifically provides another payee in the event of the insolvency of the ceding insurer or unless the assuming insurer, with the consent of the direct insured or insureds, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the reinsured policies and in substitution for the obligations of the ceding insurer to those payees.

The reinsurance agreement may condition the payments upon written notice by the ceding insurer's domiciliary receiver to the assuming insurer of the pendency of a claim on the contract reinsured within a reasonable time after the claim is filed in the proceeding where the claim is to be adjudicated. During the pendency of such a claim, any assuming insurer may investigate the claim and interpose, at the assuming insurer's own expense, any defenses in the proceeding that the assuming insurer determines available to the ceding insurer or to the ceding insurer's receiver. The expenses may be filed as a claim against the insolvent ceding insurer to the extent of its proportionate share of the benefit that may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer. When 2 or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to the claim, the expense must be apportioned in accordance with the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer.

[2001, c. 47, §7 (AMD) .]

6.

[1999, c. 113, §21 (RP) .]

7. The superintendent may adopt rules, subject to Title 5, chapter 375, to implement this section. Rules adopted under this section are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

[2001, c. 47, §8 (AMD) .]

SECTION HISTORY
1989, c. 846, Pt. E, §§2, 4 (NEW). 1991, c. 38, (AMD). 1991, c. 828, §§16-18 (AMD). RR 1993, c. 1, §56 (COR). 1993, c. 313, §§17, 18 (AMD). 1993, c. 666, Pt. C, §1 (AMD). 1999, c. 113, §§19-21 (AMD). 2001, c. 47, §§2-8 (AMD). 2003, c. 249, §1 (AMD). 2007, c. 386, §1 (AMD). 2013, c. 238, Pt. B, §§3-8 (AMD).

§731-C. BULK REINSURANCE

The cession of bulk reinsurance by a domestic insurer is subject to section 3483. [1989, c. 846, Pt. E, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

SECTION HISTORY
1989, c. 846, §§E2,4 (NEW).

§731-D. NOTIFICATION OF REINSURANCE CHANGES

The superintendent may by rule or order require an insurer to promptly inform the superintendent in writing of the cancellation or any other material change of any of the insurer's reinsurance treaties or arrangements. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2013, c. 238, Pt. B, §9 (AMD).]

SECTION HISTORY
1989, c. 846, Pt. E, §2 (NEW). 1989, c. 846, Pt. E, §4 (AFF). 2013, c. 238, Pt. B, §9 (AMD).

§731-E. REINSURANCE CONCENTRATION RISK

1. **Reinsurance claim exposure.** An insurer shall manage its reinsurance recoverables proportionate to its own book of business. A domestic insurer shall notify the superintendent within 30 days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceed 50% of the insurer's last reported surplus to policyholders or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, are likely to exceed this limit.

[2013, c. 238, Pt. B, §10 (NEW) .]

2. **Diversification.** An insurer shall diversify its reinsurance program to the extent reasonably necessary to avoid imprudent concentrations of risk. A domestic insurer shall notify the superintendent within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20% of the insurer's gross written premium in the prior calendar year or after the insurer has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit.

[2013, c. 238, Pt. B, §10 (NEW) .]

3. **Risk management.** A notice provided by an insurer under subsection 1 or 2 must include a demonstration that the insurer is safely managing the exposure.

[2013, c. 238, Pt. B, §10 (NEW) .]

SECTION HISTORY
2013, c. 238, Pt. B, §10 (NEW).

§732. DEPOSITS AND FUNDS WITHHELD UNDER REINSURANCE TREATIES

Any ceding insurer must report in its annual statement all funds withheld and deposit funds established pursuant to contracts of ceded reinsurance. Ceding insurers must report this and related information as required by reporting rules established by the National Association of Insurance Commissioners. [1991, c. 828, §19 (NEW).]

SECTION HISTORY
1991, c. 828, §19 (NEW).

§733. EXAMINATION OF REINSURANCE AGREEMENTS

The superintendent may examine the reinsurance agreements or deposit arrangements of a ceding insurer at any time. [1991, c. 828, §19 (NEW).]

SECTION HISTORY
1991, c. 828, §19 (NEW).

§734. MINIMUM SURPLUS REGARDING POLICYHOLDERS TO ASSUME PROPERTY AND CASUALTY REINSURANCE

1. **Prohibition.** Notwithstanding section 731-B, subsection 1, paragraph B, a domestic property or domestic casualty insurer, other than mutual assessment insurers operating pursuant to chapter 51, possessing less than $10,000,000 in surplus regarding policyholders may not, without the prior written approval of the superintendent, assume reinsurance on any risk that it is otherwise permitted to assume except when the reinsurance is:

A. Required by applicable law or rule; or [1991, c. 828, §19 (NEW).]

B. Assumed pursuant to pooling arrangements among members of the same holding company system. [1991, c. 828, §19 (NEW).]

[1991, c. 828, §19 (NEW) .]

2. **Application.** This section applies to contracts of reinsurance entered into or renewed after the effective date of this section.

[1991, c. 828, §19 (NEW) .]

3. **Effect.** The performance of an activity prohibited by this section does not invalidate any reinsurance contract between the parties to the contract.

[1991, c. 828, §19 (NEW) .]

SECTION HISTORY
1991, c. 828, §19 (NEW).

Subchapter 4: REINSURANCE INTERMEDIARIES
HEADING: PL 1991, C. 828, §20 (NEW)

§741. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 828, §20 (NEW).]

1. **Actuary.** "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

[1991, c. 828, §20 (NEW) .]

2. **Cession.** "Cession" means a transfer by a policy originating insurer to a reinsurer of the whole or a portion of a single risk, defined policy or defined division of business as set out in a reinsurance contract.

[1991, c. 828, §20 (NEW) .]

3. **Controlling person.** "Controlling person" means any person who directly or indirectly has the power to direct or cause to be directed the management, control or activities of the reinsurance intermediary.

[1991, c. 828, §20 (NEW) .]

4. **Insurer.** "Insurer" means every person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance who holds an existing certificate of authority to transact insurance in this State pursuant to section 404.

[1991, c. 828, §20 (NEW) .]

5. **Reinsurance intermediary.** "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager as these terms are defined in subsections 6 and 7.

[1991, c. 828, §20 (NEW) .]

6. **Reinsurance intermediary-broker.** "Reinsurance intermediary-broker" means any person, other than an officer or employee of the ceding insurer who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

[1991, c. 828, §20 (NEW) .]

7. **Reinsurance intermediary-manager.** "Reinsurance intermediary-manager" means any person who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for such a reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term. The term does not include:

A. An employee of the reinsurer; [1991, c. 828, §20 (NEW).]

B. A manager of a branch of an alien reinsurer that is located in the United States; [1991, c. 828, §20 (NEW).]

C. An underwriting manager that, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer subject to section 222 and whose compensation is not based on the volume of premiums written; and [1991, c. 828, §20 (NEW).]

D. The manager of a group, association, pool or organization of insurers that engages in joint underwriting or joint reinsurance and who is subject to examination by the public insurance regulatory official of the state or country in which the manager's principal business office is located. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

8. **Reinsurer.** "Reinsurer" means any person who operates as an insurer in any manner under applicable provisions of this Title in the assumption of reinsurance risks.

[1991, c. 828, §20 (NEW) .]

9. **Retrocession.** "Retrocession" means a transfer by a reinsurer to another reinsurer of those risks defined in subsection 2.

[1991, c. 828, §20 (NEW) .]

10. **Retrocessionaire.** "Retrocessionaire" means an insurer or reinsurer assuming reinsurance risks under a retrocession.

[1991, c. 828, §20 (NEW) .]

11. **Qualified United States financial institution.** For purposes of this section, a "qualified United States financial institution" means an institution that:

A. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state of the United States and has been granted authority to operate with fiduciary powers; [1991, c. 828, §20 (NEW).]

B. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and [1991, c. 828, §20 (NEW).]

C. Has been determined by the superintendent or the Securities Valuation Office of the National Association of Insurance Commissioners to meet standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the superintendent. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

12. **Qualified United States financial institution.** "Qualified United States financial institution" means for the purposes of those provisions of this section specifying those institutions that are eligible to act as a fiduciary of a trust an institution that:

A. Is organized or in the case of a United States branch or agency office of a foreign banking organization licensed under laws of the United States or any state of the United States and has been granted authority to operate with fiduciary powers; and [1991, c. 828, §20 (NEW).]

B. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§742. REINSURANCE INTERMEDIARIES; LICENSING

1. **Qualifications for license.** For the protection of the people of this State, the superintendent may not issue, continue or permit to exist any reinsurance intermediary license except in compliance with this subchapter.

[1995, c. 544, §7 (AMD) .]

2. **License requirement.**

[1995, c. 544, §7 (RP) .]

2-A. **License requirement.** A person or organization may be authorized by the superintendent to act as a reinsurance intermediary under the following circumstances.

A. A person or organization acting in this State as a reinsurance intermediary broker who has an office in this State must be licensed as a resident agent, broker or reinsurance intermediary broker in order to do business in this State. [1995, c. 544, §7 (NEW).]

B. A person or organization acting in this State as a reinsurance intermediary broker who does not maintain an office in this State must either:

(1) Be licensed in this State as a nonresident agent, broker or reinsurance intermediary broker; or

(2) Be licensed in another state with substantially similar laws. [1995, c. 544, §7 (NEW).]

C. A person or organization acting in this State as a reinsurance intermediary manager, by representing a domestic insurer or by maintaining an office in this State, must be licensed as a resident agent, broker or reinsurance intermediary broker in order to do business in this State. [1995, c. 544, §7 (NEW).]

D. A person or organization acting in this State as a reinsurance intermediary manager who does not maintain an office in this State and who does not represent a domestic insurer must either:

(1) Be licensed as a nonresident agent, broker or reinsurance intermediary manager in this State; or

(2) Be licensed as an agent, broker or reinsurance intermediary manager in another state with substantially similar laws. [1995, c. 544, §7 (NEW).]

[1995, c. 544, §7 (NEW) .]

3. **License forms.** The superintendent shall prescribe, consistent with the applicable requirements of this subchapter, and furnish all printed forms required under this subchapter in connection with application for and issuance of licenses.

[1991, c. 828, §20 (NEW) .]

4. **Application for licensure.** Application for licensure is governed by this subsection.

A. Written application for a reinsurance intermediary license must be made to the superintendent by the applicant and be accompanied by the applicable license application and issuance fee shown in section 601. The application must be signed and duly sworn to by the applicant. [1991, c. 828, §20 (NEW).]

A-1. Prior to filing an application with the superintendent, the superintendent may require each applicant to take a written examination to test the applicant's competence to act as a reinsurance intermediary. [1995, c. 544, §7 (NEW).]

B. If the applicant is an individual, the application must include full answers to questions reasonably necessary to determine the applicant's identity, age, residence, present occupation, financial responsibility and insurance experience. The application must contain any other facts as the superintendent may require relative to the applicant's qualifications for the license as those qualifications are stated in this subchapter. [1995, c. 544, §7 (AMD).]

C. If the applicant is a firm, association, partnership or corporation, the application must include, in addition, the names and residence addresses of all members, officers and directors and designate the name and residence address of each individual who is to exercise the license powers. Each individual shall furnish information concerning that individual for an individual license. Every individual named in the application is authorized to act in the name of the organization licensed as a reinsurance intermediary in this State. [1995, c. 544, §7 (AMD).]

D. The application must indicate whether any insurance license was ever refused, suspended, revoked or continuance refused and whether any insurer, general agent, individual or organization claims that the applicant is indebted to it and, if so, the details of the indebtedness and the applicant's defense to that indebtedness. [1995, c. 544, §7 (AMD).]

[1995, c. 544, §7 (AMD) .]

5. **Additional requirements.** The superintendent may require a reinsurance intermediary manager to:

A. File a surety bond issued by a licensed insurer, in an amount and format acceptable to the superintendent, for the protection of the reinsurer; or [1991, c. 828, §20 (NEW).]

B. Maintain an errors and omissions policy issued by an insurer licensed in this State in an amount acceptable to the superintendent. [1991, c. 828, §20 (NEW).]

[1995, c. 544, §7 (AMD) .]

6. **Nonresident applicant.** If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, must designate the superintendent as agent for service of process in the manner and with the same legal effect provided for by this Title for designation of service of process upon unauthorized insurers. The applicant shall furnish the superintendent with the name and address of a resident of this State upon whom notices or orders of the superintendent or process affecting the nonresident reinsurance intermediary may be served. If a nonresident applicant becomes licensed, the licensee shall promptly notify the superintendent in writing of every change in its designated agent for service of process. Such a change is not effective until acknowledged by the superintendent.

[1991, c. 828, §20 (NEW) .]

7. **Attorneys exempted.** Licensed attorneys-at-law of this State when acting in their professional capacity are exempt from this section.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW). 1995, c. 329, §5 (AMD). 1995, c. 544, §7 (AMD).

§743. GENERAL PROVISIONS

The superintendent may issue a reinsurance intermediary license to any person or organization that complies with the requirements of this subchapter. [1995, c. 544, §8 (AMD).]

1. **Licensing; persons that are not individuals.** Licensing of a firm, association, partnership or corporation is subject to this subsection.

A. A license issued to a firm, association, partnership or corporation authorizes all the members of the firm, association, partnership or corporation and employees of those entities to act as reinsurance intermediaries if each individual is named in the application and registered with the superintendent. Those individuals exercise the license power only for and in the name of the organization. This paragraph does not prevent an individual from being separately licensed and acting in that individual's own behalf and name. [1995, c. 544, §8 (AMD).]

B. The superintendent may not license a firm, association, partnership or corporation unless the license is within purposes stated in the partnership agreement or articles of incorporation. All licensees are subject to the applicable standards of section 407, subsection 2. [2013, c. 299, §1 (AMD).]

C. All licensees under this subsection are subject to the same restrictions with regard to business names as applied to insurers under section 408. [1995, c. 544, §8 (AMD).]

[2013, c. 299, §1 (AMD) .]

2. **Advertising.** Licensees may advertise only in the name under which they are licensed.

[1991, c. 828, §20 (NEW) .]

3. **Notice of change.** Licensees shall promptly notify the superintendent of every change in address and notify the superintendent of every change among its members, directors and officers and of other individuals designated in or registered to the license.

[1995, c. 544, §8 (AMD) .]

4. **Refusal.** The superintendent may refuse to issue a license to a reinsurance intermediary if, in the superintendent's judgment, the applicant, any person named on the application, or a member, principal, officer or director of the applicant, is not trustworthy, has given cause for revocation or suspension of such license or has failed to comply with any prerequisite for the issuance of such license, or that any controlling person of an applicant is not trustworthy to act as a reinsurance intermediary.

[1995, c. 544, §8 (AMD) .]

5. **Superintendent review.** If the superintendent finds that the application is complete and that the applicant is otherwise qualified for the license applied for, the superintendent shall promptly issue the license. Otherwise, the superintendent shall refuse to issue the license, promptly notify the applicant of the refusal and state the grounds for refusal.

[1991, c. 828, §20 (NEW) .]

6. **Refund.** If the license is refused, the superintendent shall promptly refund to the applicant all fees received for application for a reinsurance intermediary license.

[1991, c. 828, §20 (NEW) .]

7. **Duration.** Unless revoked or suspended, a reinsurance intermediary license remains in effect as long as the licensee pays the annual fee required by section 601 before the anniversary date of the license.

[1995, c. 544, §8 (AMD) .]

SECTION HISTORY
1991, c. 828, §20 (NEW). 1995, c. 544, §8 (AMD). 2013, c. 299, §1 (AMD).

§744. REQUIRED CONTRACT PROVISIONS; REINSURANCE INTERMEDIARY-BROKER

Transactions between a reinsurance intermediary-broker and the insurer it represents in such a capacity may be entered into only pursuant to a written authorization specifying the responsibilities of each party. The authorization must, at a minimum, provide that: [1991, c. 828, §20 (NEW).]

1. **Termination.** The insurer may terminate the reinsurance intermediary-broker's authority at any time upon 5 days' written notice to the reinsurance intermediary-broker;

[1991, c. 828, §20 (NEW) .]

2. **Accounting.** The reinsurance intermediary-broker shall render timely accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by or owed, to the reinsurance intermediary-broker and remit all funds due to the insurer within 30 days of receipt;

[1991, c. 828, §20 (NEW) .]

3. **Bank as fiduciary.** All funds collected for the insurer's account must be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank that is a qualified United States financial institution;

[1991, c. 828, §20 (NEW) .]

4. **Compliance with law.** The reinsurance intermediary-broker shall comply with section 745;

[1991, c. 828, §20 (NEW) .]

5. **Compliance with standards.** The reinsurance intermediary-broker shall comply with the written standards established by the insurer for the cession or retrocession of all risks; and

[1991, c. 828, §20 (NEW) .]

6. **Disclosure.** The reinsurance intermediary-broker shall disclose to the insurer any relationship with any reinsurer or insurer to which business will be ceded or retroceded.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§745. BOOKS AND RECORDS; REINSURANCE INTERMEDIARY-BROKERS

1. **Records required.** For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction showing:

A. The type of contract, limits, underwriting restrictions, classes of risks and territory; [1991, c. 828, §20 (NEW).]

B. Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation; [1991, c. 828, §20 (NEW).]

C. Reporting and settlement requirements of balances; [1991, c. 828, §20 (NEW).]

D. Rate used to compute the reinsurance premium; [1991, c. 828, §20 (NEW).]

E. Names and addresses of assuming reinsurers; [1991, c. 828, §20 (NEW).]

F. Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker; [1991, c. 828, §20 (NEW).]

G. Related correspondence and memoranda; [1991, c. 828, §20 (NEW).]

H. Proof of placement; [1991, c. 828, §20 (NEW).]

I. Details regarding retrocessions handled by the reinsurance intermediary-broker, including the identity of retrocessionaires and percentage of each contract assumed or ceded; [1991, c. 828, §20 (NEW).]

J. Financial records, including, but not limited to, premium and loss accounts; and [1991, c. 828, §20 (NEW).]

K. When the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(1) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(2) Placed through a representative of the assuming reinsurer that is not an employee, written evidence that the reinsurer has delegated binding authority to the representative. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

2. **Access.** The insurer must have access and may copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§746. DUTIES OF INSURERS UTILIZING THE SERVICES OF A REINSURANCE INTERMEDIARY-BROKER

1. **License requirements.** An insurer may not engage the services of any person to act as a reinsurance intermediary-broker on the insurer's behalf unless that person is licensed as required by this subchapter.

[1991, c. 828, §20 (NEW) .]

2. **Status of intermediary-broker.** An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which the insurer transacts business, unless such reinsurance intermediary-broker is under common control with the insurer and subject to section 222.

[1991, c. 828, §20 (NEW) .]

3. **Financial statements.** The insurer shall annually obtain a copy of statements of current origin of the financial condition of each reinsurance intermediary-broker with which the insurer transacts business. These statements must be certified reports or reviews performed by a certified public accountant.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§747. REQUIRED CONTRACT PROVISIONS; REINSURANCE INTERMEDIARY-MANAGERS

Transactions between a reinsurance intermediary-manager and the reinsurer it represents in such capacity may be entered into only pursuant to a written contract, specifying the responsibilities of each party, that must be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through the reinsurance intermediary-manager, a true copy of the approved contract must be filed with the superintendent for approval. The contract must, at a minimum, contain the following terms and conditions. [1991, c. 828, §20 (NEW).]

1. **Termination.** The reinsurer may terminate the contract for cause upon 5 days' written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

[1991, c. 828, §20 (NEW) .]

2. **Accounting.** The reinsurance intermediary-manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by or owed, to the reinsurance intermediary-manager and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

[1991, c. 828, §20 (NEW) .]

3. **Bank as fiduciary.** All funds collected for the reinsurer's account must be held in trust by the reinsurance intermediary-manager in a fiduciary capacity in a bank that is a qualified United States financial institution. The reinsurance intermediary-manager may retain no more than 3 months' estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.

[1991, c. 828, §20 (NEW) .]

4. **Compliance with law.** The reinsurance intermediary-manager shall comply with section 748.

[1991, c. 828, §20 (NEW) .]

5. **Access.** The reinsurer must have access to and may copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer.

[1991, c. 828, §20 (NEW) .]

6. **Nonassignable.** The contract may not be assigned in whole or in part by the reinsurance intermediary-manager.

[1991, c. 828, §20 (NEW) .]

7. **Compliance with standards.** The reinsurance intermediary-manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

[1991, c. 828, §20 (NEW) .]

8. **Commissions; fees.** The contract must set forth the rates, terms and purposes of commissions, charges and other fees that the reinsurance intermediary-manager may levy against the reinsurer.

[1991, c. 828, §20 (NEW) .]

9. **Settlement.** If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

A. All claims must be reported to the reinsurer in a timely manner; [1991, c. 828, §20 (NEW).]

B. A copy of each claim file must be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(1) Has the potential to exceed the lesser of an amount determined by the superintendent or the limit set by the reinsurer;

(2) Involves a coverage dispute;

(3) May exceed the reinsurance intermediary-manager's claims settlement authority;

(4) Is open for more than 6 months; or

(5) Is closed by payment of the lesser of an amount set by a court of competent jurisdiction or an amount agreed by the reinsurer; [1991, c. 828, §20 (NEW).]

C. All claim files must be the joint property of the reinsurer and the reinsurance intermediary-manager; except that, upon an order of liquidation of the reinsurer, the files become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager must have reasonable access to and may copy the files on a timely basis; and [1991, c. 828, §20 (NEW).]

D. Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

10. **Interim profits.** If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, interim profits may not be paid until one year after the end of each underwriting period for property business and 5 years after the end of each underwriting period for casualty business or other period set by the superintendent for other specified kinds of insurance and not until the adequacy of reserves on remaining claims has been verified pursuant to section 750, subsection 3.

[1991, c. 828, §20 (NEW) .]

11. **Financial statements.** The reinsurance intermediary-manager shall annually provide the reinsurer with a statement of current origin of its financial condition prepared by an independent certified accountant. These statements must be certified reports or review statements prepared by a certified public accountant.

[1991, c. 828, §20 (NEW) .]

12. **On-site review.** The reinsurer shall periodically and no less than semiannually conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

[1991, c. 828, §20 (NEW) .]

13. **Disclosure.** The reinsurance intermediary-manager shall disclose to the reinsurer any relationship the reinsurer has with any insurer prior to ceding or assuming any business with the insurer pursuant to this contract.

[1991, c. 828, §20 (NEW) .]

14. **Scope of authority.** Within the scope of its actual or apparent authority the acts of the reinsurance intermediary-manager are deemed to be the acts of the reinsurer on whose behalf it is acting.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§748. BOOKS, RECORDS AND POWERS; REINSURANCE INTERMEDIARY-MANAGERS

1. **Records required.** For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager shall keep a complete record for each transaction showing:

A. The type of contract, limits, underwriting restrictions, classes of risks and territory; [1991, c. 828, §20 (NEW).]

B. Period of coverage, including effective and expiration dates, cancellation provisions and notice required for cancellation, and status of disposition of outstanding reserves on covered risks; [1991, c. 828, §20 (NEW).]

C. Reporting and settlement requirements of balances; [1991, c. 828, §20 (NEW).]

D. Rate used to compute the reinsurance premium; [1991, c. 828, §20 (NEW).]

E. Names and addresses of reinsurers; [1991, c. 828, §20 (NEW).]

F. Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager; [1991, c. 828, §20 (NEW).]

G. Related correspondence and memoranda; [1991, c. 828, §20 (NEW).]

H. Proof of placement; [1991, c. 828, §20 (NEW).]

I. Details regarding retrocessions handled by the reinsurance intermediary-manager including the identity of retrocessionaires and the percentage of each contract assumed or ceded; [1991, c. 828, §20 (NEW).]

J. Financial records, including but not limited to, premium and loss accounts; and [1991, c. 828, §20 (NEW).]

K. When the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(1) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(2) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§749. PROHIBITED ACTS

The reinsurance intermediary-manager may not: [1991, c. 828, §20 (NEW).]

1. **Retrocession.** Retrocede business on behalf of the reinsurer; except that, the reinsurance intermediary-manager may facultatively retrocede business pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for any such retrocession. The guidelines must include a list of reinsurers with which automatic agreements are in effect, commission schedules and for each reinsurer, the coverages and amounts or percentages that may be reinsured;

[1991, c. 828, §20 (NEW) .]

2. **Use of syndicates.** Commit the reinsurer to participate in reinsurance syndicates;

[1991, c. 828, §20 (NEW) .]

3. **Use of other licensees.** Make use of any agent or broker without ensuring that the agent or broker is lawfully licensed to transact the kind of reinsurance for which the agent or broker is being used;

[1991, c. 828, §20 (NEW) .]

4. **Claim payment.** Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholder surplus as of December 31st of the next preceding calendar year;

[1991, c. 828, §20 (NEW) .]

5. **Claim recovery.** Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer;

[1991, c. 828, §20 (NEW) .]

6. **Joint employment.** Jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary-manager is under common control with the reinsurer subject to section 222; or

[1991, c. 828, §20 (NEW) .]

7. **Subcontract.** Assign duties under a contract to a subcontracting manager.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§750. DUTIES OF REINSURERS UTILIZING THE SERVICES OF A REINSURANCE INTERMEDIARY-MANAGER

1. **License required.** A reinsurer may not engage the services of any person to act as a reinsurance intermediary-manager on its behalf unless that person is licensed as required by this subchapter.

[1991, c. 828, §20 (NEW) .]

2. **Financial statements.** The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager that the reinsurer has engaged prepared by an independent certified public accountant in a form acceptable to the superintendent.

[1991, c. 828, §20 (NEW) .]

3. **Actuarial review.** If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary who specializes in the type of insurance under consideration attesting to the adequacy of loss reserves including losses incurred and outstanding on business produced by the reinsurance intermediary-manager. This opinion is in addition to any other required loss reserve certification.

[1991, c. 828, §20 (NEW) .]

4. **Binding authority.** Binding authority for all retrocessional contracts or participation in reinsurance syndicates rests with an officer of the reinsurer who may not be affiliated with the reinsurance intermediary-manager.

[1991, c. 828, §20 (NEW) .]

5. **Notice of termination.** Within 30 days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of termination to the superintendent.

[1991, c. 828, §20 (NEW) .]

6. **Board member qualifications.** A reinsurer may not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its reinsurance intermediary-manager. This subsection does not apply to relationships governed by section 222 or chapter 77.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§751. EXAMINATION AUTHORITY

1. **Authority.** A reinsurance intermediary is subject to examination by the superintendent. The superintendent must have access to all books, bank accounts and records of the reinsurance intermediary in a usable form.

[1991, c. 828, §20 (NEW) .]

2. **Status.** A reinsurance intermediary-manager may be examined as if it were the reinsurer.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§752. PENALTIES AND LIABILITIES

1. **Violation.** A reinsurance intermediary, insurer or reinsurer found by the superintendent, after a hearing conducted in accordance with the Maine Administrative Procedure Act, to be in violation of any provision of this Title, is subject to the following.

A. For each separate violation, a violator must pay a penalty of not less than $5,000 and not more than $100,000 for each separate violation. [1991, c. 828, §20 (NEW).]

B. A violator is subject to revocation or suspension of its license. [1991, c. 828, §20 (NEW).]

C. If a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation. [1991, c. 828, §20 (NEW).]

[1991, c. 828, §20 (NEW) .]

2. **Final agency action.** The decision, determination or order of the superintendent pursuant to this section is a final agency action and may be appealed pursuant to section 236.

[1991, c. 828, §20 (NEW) .]

3. **Nonexclusivity of penalties.** Nothing contained in this section affects the right of the superintendent to impose any other penalties provided in this Title.

[1991, c. 828, §20 (NEW) .]

4. **Rights of others.** Nothing contained in this subchapter limits or restricts the rights of policyholders, claimants, creditors or other 3rd parties or confers any rights to those persons.

[1991, c. 828, §20 (NEW) .]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§753. RULES

The superintendent may adopt reasonable rules for the implementation and administration of the provisions of this subchapter. [1991, c. 828, §20 (NEW).]

SECTION HISTORY
1991, c. 828, §20 (NEW).

§754. EFFECTIVE DATE

This subchapter takes effect January 1, 1993. An insurer or reinsurer may not continue to utilize the services of a reinsurance intermediary on and after February 1, 1993 unless utilization is in compliance with this subchapter. [1991, c. 828, §20 (NEW).]

SECTION HISTORY
1991, c. 828, §20 (NEW).

Subchapter 5: ASSUMPTION REINSURANCE

§761. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [1993, c. 603, (NEW).]

1. **Assuming insurer.** "Assuming insurer" means the insurer that acquires an insurance obligation or risk from the transferring insurer pursuant to an assumption reinsurance agreement.

[1993, c. 603, (NEW) .]

2. **Assumption reinsurance agreement.** "Assumption reinsurance agreement" means a contract that both:

A. Transfers insurance obligations or risks of existing or in-force contracts of insurance from a transferring insurer to an assuming insurer; and [1993, c. 603, (NEW).]

B. Is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks under the contracts are extinguished. [1993, c. 603, (NEW).]

[1993, c. 603, (NEW) .]

3. **Contract of insurance.** "Contract of insurance" means a written agreement between an insurer and policyholder pursuant to which the insurer, in exchange for premium or other consideration, agrees to assume an obligation or risk of the policyholder or to make payments on behalf of, or to, the policyholder or its beneficiaries. Contract of insurance may include property, casualty, life, health, accident, surety, title and annuity business authorized to be written pursuant to the insurance laws of this State.

[1993, c. 603, (NEW) .]

4. **Home service business.** "Home service business" means insurance business on which premiums are collected on a weekly or monthly basis by an agent of the insurer.

[1993, c. 603, (NEW) .]

5. **Notice of transfer.** "Notice of transfer" means the written notice to policyholders required by section 764, subsection 1.

[1993, c. 603, (NEW) .]

6. **Policyholder.** "Policyholder" means an individual or entity that has the right to terminate or otherwise alter the terms of a contract of insurance. It includes a certificateholder whose certificate is in force on the proposed effective date of the assumption, if the certificateholder has the right to keep the certificate in force without change in benefit following termination of the group policy.

The right to keep the certificate in force referred to in this section does not include the right to elect individual coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, COBRA, of the Employee Retirement Income Security Act of 1974, as amended, 29 United States Code, Section 1161 to 1168.

[1993, c. 603, (NEW) .]

7. **Transferring insurer.** "Transferring insurer" means the insurer that transfers an insurance obligation risk to an assuming insurer pursuant to an assumption reinsurance agreement.

[1993, c. 603, (NEW) .]

SECTION HISTORY
1993, c. 603, (NEW).

§762. SCOPE

1. **Application.** This subchapter applies to an insurer authorized in this State that either assumes or transfers the obligations or risks on contracts of insurance pursuant to an assumption reinsurance agreement.

[1993, c. 603, (NEW) .]

2. **Exceptions.** This subchapter does not apply to the following:

A. A reinsurance agreement or transaction in which the ceding insurer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement; [1993, c. 603, (NEW).]

B. The substitution of one insurer for another upon the expiration of insurance coverage pursuant to statutory or contractual requirements and the issuance of a new contract of insurance by another insurer; [1993, c. 603, (NEW).]

C. The transfer of contracts of insurance pursuant to mergers or consolidations of 2 or more insurers to the extent that those transactions are regulated by law; [1993, c. 603, (NEW).]

D. An insurer subject to a judicial order of liquidation or rehabilitation; [1993, c. 603, (NEW).]

E. A reinsurance agreement or transaction to which a state insurance guaranty association is a party, except that policyholders do not lose any rights or claims afforded under their original policies pursuant to chapter 57, subchapter III and chapter 62; or [1993, c. 603, (NEW).]

F. The transfer of liabilities from one insurer to another under a single group policy upon the request of the group policyholder, unless the certificateholder pays all or substantially all of the premium. [1993, c. 603, (NEW).]

[1993, c. 603, (NEW) .]

SECTION HISTORY
1993, c. 603, (NEW).

§763. NOTICE REQUIREMENTS OF INTENT TO TRANSFER INSURANCE CONTRACT

1. **Notice to policyholders, agents and brokers.** Notice to policyholders, agents and brokers is required as follows.

A. The transferring insurer shall provide or cause to be provided to each policyholder a notice of transfer by first class mail, addressed to the policyholder's last known address or to the address to which premium notices or other policy documents are sent or, with respect to home service business, by personal delivery with acknowledged receipt. A notice of transfer must also be sent to the transferring insurer's agents or brokers of record on the affected policies. [1993, c. 603, (NEW).]

B. The notice of transfer must state or provide:

(1) The date the transfer and novation of the policyholder's contract of insurance is proposed to take place;

(2) The names and addresses and telephone numbers of the assuming and transferring insurers;

(3) That the policyholder has the right to either consent to or reject the transfer and novation;

(4) The procedures and time limit for consenting to or rejecting the transfer and novation;

(5) A summary of an effect that consenting to or rejecting the transfer and novation has on the policyholder's rights;

(6) A statement that the assuming insurer is licensed to write the type of business being assumed in the state where the policyholder resides or is otherwise authorized, as provided in this subchapter, to assume the business;

(7) The name and address of the person at the transferring insurer to whom the policyholder should send a written statement of acceptance or rejection of the transfer and novation;

(8) The address and phone number of the Bureau of Insurance so that the policyholder may write or call for further information regarding the financial condition of the assuming insurer; and

(9) The following financial data for both companies:

(a) Ratings for the last 5 years if available or for a lesser period as are available from 2 nationally recognized insurance rating services acceptable to the superintendent including the rating service's explanation of the meaning of the ratings. If ratings are unavailable for a year of the 5-year period, this must also be disclosed;

(b) A balance sheet as of December 31st for the previous 3 years if available or for a lesser period as is available and as of the date of the most recent quarterly statement;

(c) A copy of the Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and

(d) An explanation of the reason for the transfer. [1993, c. 603, (NEW).]

C. Notice must be given in a manner that conforms to the following form:

NOTICE OF TRANSFER

IMPORTANT: THIS NOTICE AFFECTS
YOUR CONTRACT RIGHTS.
PLEASE READ IT CAREFULLY.

Transfer of Policy

The [name of assuming insurer] has agreed to replace us as your insurer under [policy or certificate name and number] effective [date]. The [name of assuming insurer] principal place of business is [address]. Certain financial information concerning both companies is attached, including (1) ratings for the time period required by the Bureau of Insurance from 2 nationally recognized insurance rating services; (2) balance sheets for the time period required by the Bureau of Insurance and as of the date of the most recent quarterly statement; (3) a copy of the Management's Discussion and Analysis that was filed as a supplement to the previous year's annual statement; and (4) an explanation of the reason for the transfer. You may obtain additional information concerning [name of assuming insurer] from reference materials in your local library or by contacting the Superintendent of Insurance at [address and phone number].

The [name of assuming insurer] is licensed to write this coverage in your state. The Superintendent of Insurance in your state has reviewed the potential effect of the proposed transaction and has approved the transaction.

Your Rights

You may choose to consent to or reject the transfer of your policy to [name of assuming insurer]. If you want your policy transferred, you may notify us in writing by signing and returning the enclosed preaddressed, postage-paid card or by writing to us at:

[name, address and facsimile number of contact person]

Payment of your premium to the assuming company constitutes acceptance of the transaction. A method is provided to allow you to pay the premium while reserving the right to reject the transfer.

If you reject the transfer, you may keep your policy with us or exercise an option under your policy. If we do not receive a written rejection you have, as a matter of law, consented to the transfer. Before this consent is final you will be provided a second notice of the transfer 24 months from now. After the second notice is provided, you have one month to reply. If you have paid your premium to the [name of assuming insurer], without reserving your right to reject the transfer, you will not receive a second notice.

( ) This is your first notice. Please respond within 24 months.

( ) This is your second notice. You must respond within one month to reject the transfer of your policy. If we do not hear from you by [date], your policy will be transferred to [name of assuming insurer].

Effect of Transfer

If you accept this transfer, [name of assuming insurer] will be your insurer. The insurer has direct responsibility to you for the payment of all claims, benefits and for all other policy obligations. We no longer have an obligation to you.

If you accept this transfer, you must make all premium payments and claims submissions to [name of assuming insurer] and direct all questions to [name of assuming insurer].

For your convenience, we have enclosed a preaddressed postage-paid response card. Please take time now to read the enclosed notice and complete and return the response card to us.

If you have further questions about this agreement, you may contact [name of transferring insurer] or [name of assuming insurer].

Sincerely,

. . . . . .

[name of transferring insurer
address

[name of assuming insurer
address

phone] phone]
[Notice Date]

RESPONSE CARD

____ Yes, I accept the transfer of my policy from [name of transferring insurer] to [name of assuming insurer].

____ No, I reject the proposed transfer of my policy from [name of transferring insurer] to [name of assuming insurer] and wish to retain my policy with [name of transferring insurer].

Date: Signature:
Name:

Address:

[1993, c. 603, (NEW).]

D. The notice of transfer must include a preaddressed, postage-paid response card that a policyholder may return as the written statement of acceptance or rejection of the transfer and novation. [1993, c. 603, (NEW).]

E. The notice of transfer must be filed as part of the prior approval requirement set forth in subsection 2, paragraph A. [1993, c. 603, (NEW).]

[1993, c. 603, (NEW) .]

2. **Notification and prior approval.** The requirements for notification and prior approval are as follows:

A. Prior approval by the superintendent is required for a transaction when an insurer domiciled in this State assumes or transfers obligations or risks on contracts of insurance under an assumption reinsurance agreement. An insurer licensed in this State may not transfer obligations or risks on contracts of insurance issued to or owned by residents of this State to an insurer that is not licensed in this State. An insurer domiciled in this State may not assume obligations or risks on contracts of insurance issued to or owned by policyholders residing in another state unless it is licensed in the other state or the insurance regulatory official of that state has approved the assumption. [1993, c. 603, (NEW).]

B. A licensed foreign insurer that enters into an assumption reinsurance agreement that transfers the obligations or risks on contracts of insurance issued to or owned by residents of this State shall file or cause to be filed the assumption certificate with the superintendent a copy of the notice of transfer and an affidavit that the transaction is subject to substantially similar requirements in the state of domicile of both the transferring and assuming insurer. [1993, c. 603, (NEW).]

C. A licensed foreign insurer that enters into an assumption reinsurance agreement that transfers the obligations or risks on contracts of insurance issued to or owned by residents of this State shall obtain prior approval of the superintendent and be subject to all other requirements of this subchapter unless the transferring and assuming insurers are subject to assumption reinsurance requirements adopted by law or rule in the jurisdiction of their domicile, which are substantially similar to those contained in this subchapter. [1993, c. 603, (NEW).]

D. The following factors, along with such factors as the superintendent determines appropriate under the circumstances, must be considered by the superintendent in reviewing a request for approval:

(1) The financial condition of the transferring and assuming insurers and the effect the transaction has on the financial condition of each company;

(2) The competence, experience and integrity of those persons who control the operation of the assuming insurer;

(3) The plans or proposals the assuming party has with respect to the administration of the policies subject to the proposed transfer;

(4) Whether the transfer is fair and reasonable to the policyholders of both companies; and

(5) Whether the notice of transfer to be provided by the insurer is fair, adequate and not misleading. [1993, c. 603, (NEW).]

[1993, c. 603, (NEW) .]

SECTION HISTORY
1993, c. 603, (NEW). 1993, c. 603, (NEW).

§764. RIGHTS OF POLICYHOLDER

1. **Right to reject.** Every policyholder has the right to reject the transfer and novation of the contracts of insurance. A policyholder electing to reject the assumption transaction shall return to the transferring insurer the preaddressed, postage-paid response card or other written notice and indicate on the response card that the assumption is rejected.

[1993, c. 603, (NEW) .]

2. **Payment of premium.** Payment of the next premium to the assuming company after notice is received is determined to indicate the policyholder's acceptance of the transfer to the assuming insurer and a novation is determined to have been effected if the premium notice clearly states that payment of the premium to the assuming insurer constitutes acceptance of the transfer. The premium notice must also provide a method for the policyholder to pay the premium while reserving the right to reject the transfer. With respect to a home service business or any other business not using premium notices, the disclosures and procedural requirements of this subsection are to be set forth in the notice of transfer required by section 763, subsection 1, paragraph A and in the assumption certificate.

[1995, c. 329, §6 (AMD) .]

3. **Additional notice.** No fewer than 24 months after the mailing of the initial notice of transfer required under section 763, if positive consent to the transfer and assumption has not been received or consent has not been determined to have occurred under subsection 1, the transferring company shall send to the policyholder a 2nd and final notice of transfer as specified in section 763, subsection 1. If the policyholder does not reject the transfer during the one-month period immediately following the date on which the transferring insurer mailed the 2nd and final notice of transfer, the policyholder's consent is determined to have occurred and novation of the contract is effected. With respect to the home service business, the 24 and one-month periods must be measured from the date of delivery of the notice of transfer pursuant to section 763, subsection 1, paragraph A.

[1993, c. 603, (NEW) .]

4. **Response cards.** The transferring insurer is deemed to have received the response card on the date it is postmarked. A policyholder may also send a response card by facsimile or other electronic transmission or by registered mail, express delivery or courier service, in which case the response card is determined to have been received by the assuming insurer on the date of actual receipt by the transferring insurer.

[1993, c. 603, (NEW) .]

SECTION HISTORY
1993, c. 603, (NEW). 1995, c. 329, §6 (AMD).

§765. EFFECT OF CONSENT BY THE POLICYHOLDER

If a policyholder consents to the transfer pursuant to section 764 or if the transfer is effected under section 766, there is a novation of the contract of insurance subject to the assumption reinsurance agreement with the result that the transferring insurer is relieved of all insurance obligations or risks transferred under the assumption reinsurance agreement and the assuming insurer is directly and solely liable to the policyholder for those insurance obligations or risks. [1993, c. 603, (NEW).]

SECTION HISTORY
1993, c. 603, (NEW).

§766. AUTHORITY OF THE INSURANCE REGULATORY OFFICIAL

1. **Transfer in the best interest of the policyholders.** If an insurer domiciled in this State or in a jurisdiction having a substantially similar law is determined by the domiciliary insurance regulatory official to be in hazardous financial condition or an administrative proceeding has been instituted against it for the purpose of reorganizing or conserving the insurer, and the transfer of the contracts of insurance is in the best interest of the policyholders, as determined by the domiciliary insurance regulatory official, a transfer and novation may be effected notwithstanding the provisions of this subchapter. This may include a form of implied consent and adequate notification to the policyholder of the circumstances requiring the transfer as approved by the insurance regulatory official.

[1993, c. 603, (NEW) .]

2. **Protection.** Notwithstanding any other provision of law, in the event that a transfer and novation is effected by a decision of a domiciliary insurance regulatory official under this section, the residents of this State whose policies are transferred to an unlicensed insurer are entitled to full protection under chapter 57, subchapter III and chapter 62.

[1993, c. 603, (NEW) .]

SECTION HISTORY
1993, c. 603, (NEW).

Subchapter 6: SPECIAL PURPOSE REINSURANCE VEHICLE HEADING: PL 2003, C. 249, §2 (NEW)

§781. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [2003, c. 249, §2 (NEW).]

1. **Aggregate limit.** "Aggregate limit" means the maximum sum payable to the ceding insurer under a special purpose reinsurance vehicle contract.

[2003, c. 249, §2 (NEW) .]

2. **Catastrophe excess of loss property reinsurance.** "Catastrophe excess of loss property reinsurance" means excess of loss reinsurance for a catastrophe layer of a reinsurance program, written on either a per occurrence or aggregate basis.

[2003, c. 249, §2 (NEW) .]

3. **Catastrophe life or health reinsurance.** "Catastrophe life or health reinsurance" means reinsurance of life, health or annuity products that transfers mortality, morbidity, survival or other related risks in excess of existing proportional or nonproportional automatic and facultative treaties newly placed or in force on the same risks.

[2003, c. 249, §2 (NEW) .]

4. **Ceding insurer.** "Ceding insurer" means an insurer that enters into a special purpose reinsurance vehicle contract with a special purpose reinsurance vehicle and includes a reinsurer retroceding assumed reinsurance to a special purpose reinsurance vehicle. A group of affiliated insurers under common control entering into a special purpose reinsurance vehicle contract on a coordinated basis is considered a single ceding insurer.

[2003, c. 249, §2 (NEW) .]

5. **Control.** "Control," including the terms "controlling," "controlled by" and "under common 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 the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing 10% or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist. Notwithstanding this subsection, for the purposes of this subchapter, the fact that a special purpose reinsurance vehicle exclusively provides reinsurance to a ceding insurer under a special purpose reinsurance vehicle contract is not by itself sufficient grounds for a finding that the reinsurance vehicle or the special purpose reinsurance vehicle organizer or owner is controlled by or under common control with the ceding insurer.

[2003, c. 249, §2 (NEW) .]

6. **Fair value.** "Fair value" means:

A. As to cash, the amount of cash; and [2003, c. 249, §2 (NEW).]

B. As to an asset other than cash:

(1) The amount at which that asset could be bought or sold in a current transaction between arms-length, willing parties;

(2) The quoted market price for the asset in active markets must be used if available; and

(3) If quoted market prices are not available, a value determined using the best information available considering values of like assets and other valuation methods, such as present value of future cash flows, historical value of the same or similar assets or comparison to values of other asset classes the value of which have been historically related to the subject asset. [2003, c. 249, §2 (NEW).]

[2003, c. 249, §2 (NEW) .]

7. **Fully funded.** "Fully funded" means, with respect to a special purpose reinsurance vehicle contract, that the fair value of the assets under the control of the ceding insurer or held in trustfor the benefit of the ceding insurer under the special purpose reinsurance vehicle contract on the date on which the special purpose reinsurance vehicle contract is effected, equals or exceeds the aggregate limit as defined in subsection 1.

[2007, c. 386, §2 (AMD) .]

7-A. **Impairment.** "Impairment" or "impaired" means, with respect to a special purpose reinsurance vehicle or any of its protected cells, that either:

A. The available capital of the special purpose reinsurance vehicle or protected cell has fallen below the applicable initial capital requirement without the approval of the superintendent; or [2007, c. 386, §3 (NEW).]

B. The fair value of the assets under the control of the ceding insurer or held in trust for the benefit of the ceding insurer under a special purpose reinsurance vehicle contract is less than the aggregate limit remaining under the contract as of the time the determination is made. [2007, c. 386, §3 (NEW).]

[2007, c. 386, §3 (NEW) .]

8. **Indemnity trigger.** "Indemnity trigger" means a transaction term by which the special purpose reinsurance vehicle's obligation to pay the ceding insurer for losses covered by a special purpose reinsurance vehicle contract is triggered by the ceding insurer incurring a specified level of losses.

[2003, c. 249, §2 (NEW) .]

9. **Insolvency.** "Insolvency" or "insolvent" means that the special purpose reinsurance vehicle or one or more of its protected cells is unable to pay its obligations when they are due unless the obligations are the subject of a bona fide dispute.

[2007, c. 386, §4 (AMD) .]

10. **Nonindemnity trigger.** "Nonindemnity trigger" means a transaction term by which the special purpose reinsurance vehicle's obligation to pay the ceding insurer under a special purpose reinsurance vehicle contract arises from the occurrence or existence of some event or condition other than the ceding insurer incurring a specified level of losses under its insurance or reinsurance contracts.

[2003, c. 249, §2 (NEW) .]

11. **Permitted investments.** "Permitted investments" means those investments that meet the qualifications under section 795.

[2003, c. 249, §2 (NEW) .]

11-A. **Protected cell.** "Protected cell" means a separate account established and maintained by a special purpose reinsurance vehicle for one special purpose reinsurance vehicle contract and the accompanying insurance securitization with a ceding insurer as further provided for in section 784-A.

[2007, c. 386, §5 (NEW) .]

12. **Qualified United States financial institution.** "Qualified United States financial institution" means for purposes of meeting the requirements of a trustee as specified in section 784 a financial institution that is eligible to act as a fiduciary of a trust and:

A. Is organized or, in the case of a United States branch or agency office of a foreign banking organization, is licensed under the laws of the United States or any state; and [2003, c. 249, §2 (NEW).]

B. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies. [2003, c. 249, §2 (NEW).]

[2003, c. 249, §2 (NEW) .]

13. **Reinsurance vehicle.** "Reinsurance vehicle" means a special purpose reinsurance vehicle.

[2003, c. 249, §2 (NEW) .]

14. **Special purpose reinsurance vehicle.** "Special purpose reinsurance vehicle" means an entity domiciled in and organized under the laws of this State that has received a limited certificate of authority from the superintendent under this subchapter exclusively for the limited purpose of entering into and effectuating special purpose reinsurance vehicle insurance securitizations, special purpose reinsurance vehicle contracts and other related transactions permitted by this subchapter.

[2003, c. 249, §2 (NEW) .]

15. **Special purpose reinsurance vehicle contract; contract.** "Special purpose reinsurance vehicle contract" or "contract" means a contract between the special purpose reinsurance vehicle and the ceding insurer pursuant to which the special purpose reinsurance vehicle agrees to pay the ceding insurer an agreed amount upon the occurrence of a triggering event.

[2003, c. 249, §2 (NEW) .]

16. **Special purpose reinsurance vehicle insurance securitization; insurance securitization.** "Special purpose reinsurance vehicle insurance securitization" or "insurance securitization" means a package of related risk transfer instruments, capital market offerings and facilitating administrative agreements by which proceeds are obtained by a special purpose reinsurance vehicle directly or indirectly through the issuance of securities and are held in trust or under the control of the ceding insurer pursuant to the requirements of this subchapter to secure the obligations of the special purpose reinsurance vehicle under one or more special purpose reinsurance vehicle contracts with one or more ceding insurers, when investment risk to the holders of these securities is contingent upon the obligations of the special purpose reinsurance vehicle to the ceding insurer or ceding insurers under the special purpose reinsurance vehicle contract in accordance with the transaction terms.

[2007, c. 386, §6 (AMD) .]

17. **Special purpose reinsurance vehicle organizer; organizer.** "Special purpose reinsurance vehicle organizer" or "organizer" means one or more persons that have organized or intend to organize a special purpose reinsurance vehicle under authority obtained as specified in this subchapter.

[2003, c. 249, §2 (NEW) .]

18. **Special purpose reinsurance vehicle securities; securities.** "Special purpose reinsurance vehicle securities" or "securities" means the securities issued by a special purpose reinsurance vehicle.

[2003, c. 249, §2 (NEW) .]

19. **Triggering event.** "Triggering event" means an event or condition that if and when it occurs or exists obligates the special purpose reinsurance vehicle to make a payment to the ceding insurer under the provisions of a special purpose reinsurance vehicle contract.

[2003, c. 249, §2 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §§2-6 (AMD).

§782. LIMITED CERTIFICATE OF AUTHORITY REQUIRED

1. **Limited certificate of authority.** In order to securitize one or more ceding insurers' risks, a special purpose reinsurance vehicle shall obtain a limited certificate of authority from the superintendent according to the provisions of this section.

[2003, c. 249, §2 (NEW) .]

2. **Application.** A special purpose reinsurance vehicle organizer seeking to obtain a limited certificate of authority for a special purpose reinsurance vehicle shall file an application for a limited certificate of authority with the superintendent and pay the application fee specified in section 601, subsection 1. A complete application must include the following:

A. An affidavit verifying that each prospective organizer meets the requirements of this subchapter; [2003, c. 249, §2 (NEW).]

B. A representation that the prospective organizer intends to form a special purpose reinsurance vehicle that operates in accordance with the requirements under this subchapter; [2003, c. 249, §2 (NEW).]

C. The proposed name of the special purpose reinsurance vehicle; [2003, c. 249, §2 (NEW).]

D. Biographical affidavits of all organizers setting forth their legal names, any names under which they have conducted or are conducting their affairs and any names of any person affiliated, as defined in section 222, with any organizer, together with such other biographical information as the superintendent may request; [2003, c. 249, §2 (NEW).]

E. The source and form of the minimum capital to be contributed to the special purpose reinsurance vehicle; [2003, c. 249, §2 (NEW).]

F. Any persons with which the special purpose reinsurance vehicle is or upon formation will be affiliated as defined in section 222; [2003, c. 249, §2 (NEW).]

G. The names and biographical affidavits of the proposed members of the board of directors and principal officers of the special purpose reinsurance vehicle pursuant to section 790, setting forth their legal names, any names under which they have conducted or are conducting their affairs and any names of any person affiliated, as defined in section 222, with any proposed director or officer, together with such other biographical information as the superintendent may request; [2003, c. 249, §2 (NEW).]

H. A plan of operation, consisting of a description of the contemplated insurance securitization or securitizations, the special purpose reinsurance vehicle contract and related transactions, which must include:

(1) Draft documentation or at the discretion of the superintendent a written summary of all material agreements that are planned in order to effectuate the insurance securitization or securitizations and the related contract, including the names of the ceding insurers, the nature of the risks being assumed and the maximum amounts, purpose and nature and the interrelationships of the various transactions required to effectuate the insurance securitization or securitizations;

(2) The investment strategy of the special purpose reinsurance vehicle and a representation that the investment strategy complies with the investment requirements set forth in this subchapter and that the strategy includes investment practices or other provisions to preserve asset values that facilitate attainment of full funding during the term of the insurance securitization or securitizations with assets that can be monetized in response to a triggering event without a substantial loss in value;

(3) A description of the method by which losses covered by the contract that may develop after the termination of the contract period are to be addressed under the provisions of the contract;

(4) If applicable, a representation that the special purpose reinsurance vehicle contract with the ceding insurer, the security agreement or trust agreement under section 784, subsection 4, paragraph D-1 or E and any trusts holding assets that secure the obligations of the special purpose reinsurance vehicle under the contract are structured in accordance with the requirements under this subchapter ; and

(5) If protected cells are to be used, a description of the procedures for maintaining and safeguarding separate accounts as required by section 784-A, subsection 1 and an application for approval of each initial protected cell as required by section 784-A, subsection 2. [2007, c. 386, §7 (AMD).]

[2007, c. 386, §7 (AMD) .]

3. **Additional information.** The superintendent shall notify the special purpose reinsurance vehicle organizer if any additional information is needed in order to review the application and shall approve or deny the application within 60 days after determining that the application is complete.

A. The superintendent shall approve the application and issue a limited certificate of authority under this section if the superintendent finds that:

(1) The proposed plan of operation provides a reasonable expectation of a successful operation;

(2) The terms of the contract and related transactions comply with this subchapter and any applicable rules adopted by the superintendent;

(3) The proposed plan of operation is not hazardous to any ceding insurer or to policyholders; and

(4) The insurance regulator of the state of domicile of each ceding insurer has notified the superintendent in writing that it has not disapproved the transaction. The superintendent may waive this requirement for a ceding insurer whose domiciliary state does not have a substantially similar law if the superintendent finds that the domiciliary regulator has had notice and adequate opportunity to review the proposal and has not objected. [2003, c. 249, §2 (NEW).]

B. In evaluating the expectation of a successful operation, the superintendent shall consider, among other factors, whether the proposed organizer, directors and officers of the proposed special purpose reinsurance vehicle are of good character and not reasonably believed to be affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions or other insurance or business relations, with any person known to have been involved in the improper manipulation of assets, accounts or reinsurance. [2003, c. 249, §2 (NEW).]

C. If the superintendent denies the application or if the superintendent withholds consent to a proposed transaction involving a domestic ceding insurer under a similar law of another jurisdiction the proposed organizer or ceding insurer has the right to a hearing upon a timely request filed pursuant to section 229. [2003, c. 249, §2 (NEW).]

[2003, c. 249, §2 (NEW) .]

4. **Approval.** Upon approval of the application by the superintendent and the issuance of a limited certificate of authority, the special purpose reinsurance vehicle may be acquired or formed and, in accordance with the approved plan of operation, the special purpose reinsurance vehicle may enter into contracts and conduct other activities within the scope of the filed plan of operation.

[2003, c. 249, §2 (NEW) .]

5. **Reinsurance activities.** The limited certificate of authority must state that the special purpose reinsurance vehicle's authorization to be involved in the business of insurance is limited only to the reinsurance activities that the special purpose reinsurance vehicle is allowed to conduct pursuant to this subchapter.

[2003, c. 249, §2 (NEW) .]

6. **Documentation of insurance securitization.** The special purpose reinsurance vehicle organizer shall provide a complete set of the documentation of the insurance securitization to the superintendent upon closing of any transactions, including an opinion of legal counsel with respect to compliance with this subchapter and any other applicable laws as of the effective date of any transaction.

[2007, c. 386, §8 (AMD) .]

7. **Changes in plan of operation.** Any material change to the special purpose reinsurance vehicle's plan of operation filed pursuant to subsection 2, including, but not limited to, the initiation of a new insurance securitization to continue the activities of the special purpose reinsurance vehicle pursuant to this subchapter after expiration and full satisfaction of the initial securitization transactions, requires prior approval of the superintendent. A change in the counterparty to swap transactions for an existing insurance securitization as allowed under this subchapter is not considered a material change unless the special purpose reinsurance vehicle's managers know or should know that the new counterparty presents a substantial risk of default.

[2007, c. 386, §9 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §§7-9 (AMD).

§783. LIMITED PURPOSE OF SPECIAL PURPOSE REINSURANCE VEHICLE

Special purpose reinsurance vehicles authorized under this subchapter are created for the limited purpose of entering into insurance securitization transactions with investors and related agreements to pay one or more ceding insurers agreed-upon amounts under a special purpose reinsurance vehicle contract upon the occurrence of triggering events related to the insurance business of the ceding insurer. A special purpose reinsurance vehicle may not issue a contract for assumption of risk or indemnification of loss other than a special purpose reinsurance vehicle contract. [2003, c. 249, §2 (NEW).]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§784. APPROVED TRANSACTIONS AND OPERATION OF SPECIAL PURPOSE REINSURANCE VEHICLES

1. **Contracts.** Special purpose reinsurance vehicles authorized under this subchapter may enter into and effectuate special purpose reinsurance vehicle contracts with one or more ceding insurers as long as the contracts:

A. Obligate the reinsurance vehicle to indemnify the ceding insurer for losses; [2003, c. 249, §2 (NEW).]

B. Are securitized in full through a single special purpose reinsurance vehicle insurance securitization or, if protected cells are used, through a single special purpose reinsurance vehicle insurance securitization for each protected cell; and [2007, c. 386, §10 (AMD).]

C. Are fully funded and secured with assets held in trust in accordance with the requirements of this section pursuant to agreements proposed under this subchapter, and invested in a manner that meets the criteria set forth in section 795. [2003, c. 249, §2 (NEW).]

[2007, c. 386, §10 (AMD) .]

2. **Eligible lines of business.** A special purpose reinsurance vehicle contract may only provide catastrophe excess of loss property reinsurance coverage or catastrophe life or health reinsurance coverage, unless the superintendent adopts rules pursuant to section 797 specifying additional lines of business that may be reinsured by a special purpose reinsurance vehicle or approves a waiver of the requirement of this subsection for good cause shown with respect to a particular application.

[2007, c. 386, §11 (AMD) .]

3. **Multiple ceding insurers.** A special purpose reinsurance vehicle may enter into contracts with multiple ceding insurers only if each contract is attributable to a different protected cell or if:

A. The special purpose reinsurance vehicle reinsures no more than 10 ceding insurers; and [2003, c. 249, §2 (NEW).]

B. Each ceding insurer has no more than $50,000,000 in surplus as reported in its most recent financial statement filed with its domiciliary regulator, as of the date the special purpose reinsurance vehicle is licensed. A group of ceding insurers under common control may elect to be treated as separate insurers for purposes of this subsection, but only if each insurer in the group that is reinsured by the same special purpose reinsurance vehicle is counted separately for purposes of the 10-cedent limit. [2003, c. 249, §2 (NEW).]

[2007, c. 386, §12 (AMD) .]

4. **Terms of operation.** A special purpose reinsurance vehicle may enter into agreements with 3rd parties and conduct business necessary to fulfill its obligations and administrative duties incident to the insurance securitization and the special purpose reinsurance vehicle contract. The agreements may include entering into swap agreements or other transactions that have the objective of leveling timing differences in funding upfront or ongoing transaction expenses or managing credit or interest rate risk of the investments in trust to ensure that the assets held in trust are sufficient to satisfy payment or repayment of the securities issued pursuant to an insurance securitization transaction and any other obligations of the special purpose reinsurance vehicle. In fulfilling its function, the special purpose reinsurance vehicle shall adhere to the following requirements and shall, to the extent of its powers, ensure that contracts obligating other parties to perform certain functions incident to its operations are substantively and materially consistent with the following requirements and guidelines.

A. A special purpose reinsurance vehicle must have a distinct name, which must include the designation "SPRV" or "Special Purpose Reinsurance Vehicle." The name of the reinsurance vehicle may not be deceptively similar to, or likely to be confused with or mistaken for, any other existing business name registered in this State. [2003, c. 249, §2 (NEW).]

B. Unless otherwise provided in the plan of operation, the principal place of business and office of any reinsurance vehicle organized under this subchapter must be located in this State. [2003, c. 249, §2 (NEW).]

C. The assets of a reinsurance vehicle must be preserved and administered by or on behalf of the reinsurance vehicle to satisfy the liabilities and obligations of the reinsurance vehicle incident to the insurance securitization and other related agreements including the contract. [2003, c. 249, §2 (NEW).]

D. Except as provided in paragraph D-1, assets of the reinsurance vehicle that are pledged to secure obligations of the reinsurance vehicle to a ceding insurer under a contract must be held in trust and administered by a qualified United States financial institution serving as trustee. The qualified United States financial institution may not control, be controlled by or be under common control with the reinsurance vehicle or any ceding insurer. [2007, c. 386, §13 (AMD).]

D-1. If approved by the superintendent, the reinsurance vehicle and the ceding insurer may enter into a written agreement, in compliance with the ceding insurer's applicable domiciliary credit for reinsurance laws, under which the assets pledged as security, in lieu of being held in trust, are held in the United

States subject to withdrawal solely by the ceding insurer and under its exclusive control. The security agreement may not be approved unless the superintendent determines that the agreement is consistent with the purposes of this subsection, that the ceding insurer has unconditional access to the funds necessary to fulfill the reinsurance vehicle's obligations to the ceding insurer and that the assets withheld under the control of the ceding insurer are never less than the amount that would otherwise be required to be held in trust. [2007, c. 386, §13 (NEW).]

E. The trust described in paragraph D must be governed by a written agreement between the reinsurance vehicle and the ceding insurer that creates one or more trust accounts into which all pledged assets must be deposited and held until distributed in accordance with the trust agreement. The pledged assets must be held by the trustee at the trustee's office in the United States and may be held in certificated or electronic form. [2007, c. 386, §13 (AMD).]

F. The provisions for withdrawal by the ceding insurer of funds from the trust must comply with the ceding insurer's applicable domiciliary credit for reinsurance laws and be clean and unconditional, subject only to the following requirements:

(1) The ceding insurer has the right to withdraw assets from the trust account at any time without notice to the reinsurance vehicle subject only to written notice to the trustee from the ceding insurer that funds in the amount requested are due and payable by the reinsurance vehicle;

(2) No other statement or document need be presented in order to withdraw assets, except that the ceding insurer may be required to acknowledge receipt of withdrawn assets;

(3) The trust agreement described in paragraph E must indicate that it is not subject to any conditions or qualifications outside of the trust agreement;

(4) The trust agreement described in paragraph E may not contain references to any other agreements or documents; and

(5) Reference may not be made to the fact that these funds may represent reinsurance premiums or that the funds have been deposited for any specific purpose. [2007, c. 386, §13 (AMD).]

G. The trust agreement described in paragraph E must be established for the sole use and benefit of the ceding insurer at least to the full extent of the reinsurance vehicle's obligations to the ceding insurer under the contract. In the case of more than one ceding insurer or more than one reinsurance contract with the same ceding insurer, a separate trust agreement must be entered into with each ceding insurer and a separate trust account must be maintained for each ceding insurer. [2007, c. 386, §13 (AMD).]

H. The trust agreement described in paragraph E must provide for the trustee to:

(1) Receive assets and hold all assets in a safe place;

(2) Determine that all assets are in a form that the ceding insurer or the trustee, upon direction by the ceding insurer, may whenever necessary negotiate the assets, without consent or signature from the reinsurance vehicle or any other person or entity;

(3) Furnish to the reinsurance vehicle, the superintendent and the ceding insurer a statement of all assets in the trust account referred to in paragraph E reported at fair value upon its inception and at intervals no less frequent than the end of each calendar quarter;

(4) Notify the reinsurance vehicle and the ceding insurer within 10 days of any deposits to or withdrawals from the trust account referred to in paragraph E;

(5) Upon written demand of the ceding insurer, immediately take steps necessary to transfer absolutely all right, title and interest in the assets held in the trust account referred to in paragraph E to the ceding insurer and deliver physical custody of the assets to the ceding insurer; and

(6) Allow no substitutions or withdrawals of assets from the trust account referred to in paragraph E except on written instructions from the ceding insurer. [2003, c. 249, §2 (NEW).]

I. The trust agreement described in paragraph E must provide that at least 30 days but not more than 45 days before termination of the trust account written notification of termination must be delivered by the trustee to the ceding insurer. [2007, c. 386, §13 (AMD).]

J. The trust agreement described in paragraph E may be made subject to and governed by the laws of any state in addition to the requirements for the trust as provided in this subchapter as long as the state is disclosed in the plan of operation filed with and approved by the superintendent. [2003, c. 249, §2 (NEW).]

K. The trust agreement described in paragraph E must prohibit invasion of the trust account referred to in paragraph E for the purpose of paying compensation to or reimbursing the expenses of the trustee. [2003, c. 249, §2 (NEW).]

L. The trust agreement described in paragraph E must provide that the trustee be liable for the trustee's own negligence, willful misconduct or lack of good faith.

(1) Notwithstanding the provisions of paragraph F, subparagraphs (3) to (5) and paragraph M, subparagraph (5), when a trust agreement described in paragraph E is established in conjunction with a contract, then the trust agreement may provide that the ceding insurer shall undertake to use and apply any amounts drawn upon the trust account without diminution because of the insolvency of the ceding insurer or the reinsurance vehicle for the following purposes:

(a) To pay or reimburse the ceding insurer amounts due to the ceding insurer under the contract, including, but not limited to, unearned premiums due to the ceding insurer if not otherwise paid by the reinsurance vehicle in accordance with the terms of that trust agreement; or

(b) When the ceding insurer has received notification of termination of the trust account referred to in paragraph E and when some or all of the reinsurance vehicle's obligations under the specific contract remain unliquidated and undischarged 10 days before the termination date, to withdraw amounts equal to the undischarged obligations and deposit the amounts in a separate account in the name of the ceding insurer in any qualified United States financial institution apart from its general assets in trust for the sole purpose of discharging any contractual obligations of the reinsurance vehicle that may remain executory after the withdrawal and for any period after the termination date. Assets so held must revert to the reinsurance vehicle when they are no longer necessary to secure the obligations of the reinsurance vehicle and may not exceed the sum of the following amounts as determined in good faith by the ceding insurer:

(i) Losses and loss expenses paid by the ceding insurer but not recovered from the reinsurance vehicle;

(ii) Reserves for losses reported and outstanding;

(iii) Reserves for losses incurred but not reported;

(iv) Reserves for loss expenses;

(v) Reserves for unearned premiums; and

(vi) Any additional amount necessary to maintain full funding of the aggregate limit remaining under the contract if the period of coverage or the agreed-upon period of loss development has yet to expire.

(2) The provisions to be included in the trust agreement described in paragraph E pursuant to this paragraph may instead be included in the underlying contract. [2003, c. 249, §2 (NEW).]

M. A special purpose reinsurance vehicle contract must contain provisions that:

(1) Require the reinsurance vehicle to :

(a) Enter into a trust agreement described in paragraph E and establish a trust account referred to in paragraph E for the benefit of the ceding insurer; or

(b) Enter into a security agreement described in paragraph D-1.

The trust agreement or security agreement must specify what recoverables or reserves or both the agreement is to cover;

(2) Stipulate that assets pledged as security be valued according to their current fair value for purposes of the contract and may consist only of permitted investments;

(3) If applicable, require the reinsurance vehicle, before depositing assets with the trustee, to execute assignments or endorsements in blank or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments in order that the ceding insurer or the trustee upon the direction of the ceding insurer may whenever necessary negotiate any such assets without consent or signature from the reinsurance vehicle or any other entity;

(4) Require that all settlements of account between the ceding insurer and the reinsurance vehicle be made in cash or its equivalent; and

(5) Stipulate that the reinsurance vehicle and the ceding insurer agree that the assets in any trust account referred to in paragraph E and established pursuant to the provisions of the contract may be withdrawn by the ceding insurer at any time notwithstanding any other provisions in the contract and must be used and applied by the ceding insurer or any successor by operation of law of the ceding insurer, including, but not limited to, and subject to the provisions of section 793, any liquidator, rehabilitator, receiver or conservator of the ceding insurer, without diminution because of insolvency on the part of the ceding insurer or the reinsurance vehicle, only for the following purposes:

(a) To transfer all such assets into one or more trust accounts pursuant to paragraph L for the benefit of the ceding insurer pursuant to the terms of the contract and in compliance with this subchapter; and

(b) To pay any other amounts that the ceding insurer claims are due under the contract. [2007, c. 386, §13 (AMD).]

N. The contract entered into by the reinsurance vehicle may contain provisions that give the reinsurance vehicle the right to seek approval from the ceding insurer to withdraw from the trust account referred to in paragraph E all or part of the assets contained in the trust account and to transfer the assets to the reinsurance vehicle as long as:

(1) The reinsurance vehicle shall at the time of the withdrawal replace the withdrawn assets with other qualified assets having a fair value equal to the fair value of the assets withdrawn and that meet the requirements of section 795; and

(2) After the withdrawals and transfer, the fair value of the assets in the trust account referred to in paragraph E securing the obligations of the reinsurance vehicle under the contract is no less than an amount needed to satisfy the full funding requirement of the contract. The ceding insurer has the sole discretion to determine whether these provisions have been satisfied but may not unreasonably nor arbitrarily withhold its approval. [2003, c. 249, §2 (NEW).]

O. The contract must provide that investors in the reinsurance vehicle agree that any obligation to repay principal, interest or dividends on the securities issued by the reinsurance vehicle must be reduced upon the occurrence of a triggering event, to the extent that the assets of the reinsurance vehicle held in trust for the benefit of the ceding insurer are remitted to the ceding insurer in fulfillment of the obligations of the reinsurance vehicle under the contract. [2003, c. 249, §2 (NEW).]

P. Assets held by a reinsurance vehicle in trust must be valued at their fair value. [2003, c. 249, §2 (NEW).]

Q. The proceeds from the sale of securities by the reinsurance vehicle to investors must be deposited with the trustee or under the control of the ceding insurer as described in this subchapter and must be held or invested in accordance with the requirements of section 795. [2007, c. 386, §13 (AMD).]

R. A reinsurance vehicle organized under this subchapter may engage only in fully funded contracts to support in full the ceding insurer's exposures assumed by the reinsurance vehicle. A contract must be indemnity-triggered unless the superintendent adopts rules pursuant to section 797 authorizing nonindemnity-triggered contracts and addressing the treatment of the portion of the risk that is nonindemnity-based, including accounting, disclosure, risk-based capital treatment and the manner in which risks associated with a nonindemnity-based contract may be evaluated and managed. Assets of the reinsurance vehicle may be used to pay interest or other consideration on any outstanding debt or other obligation of the reinsurance vehicle and nothing in this paragraph may be construed or interpreted to prevent a reinsurance vehicle from entering into a swap agreement or other transaction that has the effect of guaranteeing interest or other consideration. [2003, c. 249, §2 (NEW).]

S. In the special purpose reinsurance vehicle insurance securitization, the contracts or other relating documentation must contain provisions identifying the reinsurance vehicle that enters into the reinsurance securitization and the contracts or other documentation must clearly disclose that the assets of the reinsurance vehicle and only those assets are available to pay the obligations of that reinsurance vehicle. Notwithstanding this paragraph, and subject to the provisions of this subchapter and any other applicable law, the failure to include such language in the contracts or other documentation may not be used as the sole basis by creditors, reinsurers or other claimants to circumvent the provisions of this subchapter. [2003, c. 249, §2 (NEW).]

T. A reinsurance vehicle is not authorized to:

(1) Issue or otherwise administer primary insurance policies;

(2) Have any obligation to the policyholders or reinsureds of the ceding insurer;

(3) Enter into a contract with a person that is not licensed or otherwise authorized to conduct the business of insurance or reinsurance in at least its state or country of domicile; or

(4) Assume or retain exposure to insurance or reinsurance losses for its own account that is not initially fully funded by proceeds from an insurance securitization that meets the requirements of this subchapter. [2003, c. 249, §2 (NEW).]

U. At the cessation of business of a reinsurance vehicle, the limited certificate of authority granted by the superintendent under section 782 expires and the reinsurance vehicle may no longer be authorized to conduct activities pursuant to this subchapter until a new certificate of authority is issued pursuant to a new filing in accordance with section 782. The completion of a reinsurance vehicle's securitization activities does not constitute the cessation of business for purposes of this paragraph if the reinsurance vehicle's approved business plan contemplates additional securitizations. [2007, c. 386, §13 (AMD).]

V. It is unlawful for a reinsurance vehicle to lend or otherwise invest or place in custody, trust or under management any of its assets with or to borrow money or receive a loan or advance from, other than by issuance of the securities pursuant to an insurance securitization, from anyone convicted of a felony, anyone who is untrustworthy or of known bad character or anyone convicted of a criminal offense involving the conversion or misappropriation of fiduciary funds or insurance accounts, theft, deceit, fraud, misrepresentation or corruption. [2003, c. 249, §2 (NEW).]

W. A special purpose reinsurance vehicle may purchase reinsurance with the approval of the superintendent to retrocede risks assumed through a special purpose reinsurance vehicle contract. Reinsurance purchased by the reinsurance vehicle does not reduce the aggregate limit of the reinsurance vehicle or the covered protected cell and may only be credited toward the funding requirements of the reinsurance vehicle or the covered protected cell to the extent that the ceding insurer has a direct right

of recovery against the retrocessionaire that is secured by assets deposited with the trustee or under the control of the ceding insurer in accordance with this section and held or invested in accordance with the requirements of section 795. [2007, c. 386, §13 (NEW).]

[2007, c. 386, §13 (AMD) .]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §§10-13 (AMD).

§784-A. PROTECTED CELLS

1. **Establishment of protected cells.** A special purpose reinsurance vehicle may establish and maintain one or more protected cells with the prior written approval of the superintendent, subject to compliance with the provisions of this section.

A. A protected cell may be established only for the purpose of insuring or reinsuring risks of one or more special purpose reinsurance vehicle contracts with the intent of facilitating an insurance securitization. The establishment of a protected cell in compliance with this section in connection with a lawful insurance securitization does not constitute a fraudulent conveyance, a scheme to defraud creditors or a transaction of business for a fraudulent purpose. [2007, c. 386, §14 (NEW).]

B. Each protected cell must be accounted for separately on the books and records of the special purpose reinsurance vehicle to reflect the financial condition and results of operations of the protected cell, net income or loss, dividends or other distributions for the special purpose reinsurance vehicle contract with each cell and other factors as may be provided in the special purpose reinsurance vehicle contract, insurance securitization transaction documents, plan of operation or business plan, or as required by the superintendent. The special purpose reinsurance vehicle must establish administrative and accounting procedures necessary for the proper attribution of protected cell assets and protected cell liabilities to each protected cell. The directors of a special purpose reinsurance vehicle shall keep the protected cell assets and liabilities attributable to each protected cell separate and separately identifiable from the assets and liabilities of the special purpose reinsurance vehicle's general account and from the protected cell assets and liabilities attributable to any other protected cell. [2007, c. 386, §14 (NEW).]

C. Amounts attributed to a protected cell under this section, including assets transferred to a protected cell account, are owned by the special purpose reinsurance vehicle, and the special purpose reinsurance vehicle is not and may not hold itself out to be a trustee with respect to those protected cell assets of that protected cell account. [2007, c. 386, §14 (NEW).]

D. All attributions of assets and liabilities between a protected cell and the general account must be in accordance with the plan of operation approved by the superintendent. No other attribution of assets or liabilities may be made by a special purpose reinsurance vehicle between the special purpose reinsurance vehicle's general account and its protected cell or cells. The special purpose reinsurance vehicle must attribute all insurance obligations, assets and liabilities relating to a special purpose reinsurance vehicle contract and the related insurance securitization transaction, including any securities issued by the special purpose reinsurance vehicle as part of the insurance securitization and any taxes or other obligations arising by operation of law, to the associated protected cell. [2007, c. 386, §14 (NEW).]

E. The assets of a protected cell are not chargeable with liabilities arising out of a special purpose reinsurance vehicle contract related to or associated with another protected cell. More than one special purpose reinsurance vehicle contract may not be attributed to the same protected cell unless those special purpose reinsurance vehicle contracts are intended to be, and ultimately are, part of a single securitization transaction. [2007, c. 386, §14 (NEW).]

F. A sale, exchange or other transfer of assets may not be made by the special purpose reinsurance vehicle between or among any of its protected cells without the consent of the superintendent, the ceding insurer or insurers and the holders of the securities issued by each protected cell. [2007, c. 386, §14 (NEW).]

G. A sale, exchange, transfer of assets, dividend or distribution may not be made from a protected cell without the superintendent's approval except as authorized in advance under the special purpose reinsurance vehicle contract or related insurance securitization transaction documents and may not be approved if the sale, exchange, transfer, dividend or distribution would result in insolvency or impairment with respect to a protected cell. [2007, c. 386, §14 (NEW).]

H. A special purpose reinsurance vehicle may pay interest or repay principal, or both, and make distributions or repayments in respect of any securities attributed to a particular protected cell from assets or cash flows relating to or emerging from the special purpose reinsurance vehicle contract and the insurance securitization transactions that are attributable to that particular protected cell in accordance with the provisions of this subchapter or as otherwise approved by the superintendent. [2007, c. 386, §14 (NEW).]

[2007, c. 386, §14 (NEW) .]

2. **Approval of protected cells.** A special purpose reinsurance vehicle contract with or attributable to a protected cell does not take effect without the superintendent's prior written approval, and the addition of each new protected cell constitutes a change in the business plan requiring the superintendent's prior written approval and the amendment of the special purpose reinsurance vehicle's limited certificate of authority. The superintendent may retain legal, financial and examination services from outside the bureau to examine and investigate the application for a protected cell, the reasonable cost of which may be charged against the applicant, or the superintendent may use internal resources to examine and investigate the application, the reasonable cost of which may be charged against the applicant up to a maximum of $12,000, or both. The application for approval of a protected cell must include a plan of operation for the protected cell consistent with the requirements of section 782, subsection 2, paragraph H.

[2007, c. 386, §14 (NEW) .]

3. **Minimum capital requirements.** A special purpose reinsurance vehicle with protected cells shall possess and maintain capitalization in each protected cell in the amount and manner required for a special purpose reinsurance vehicle in section 787 and, in addition, shall possess and maintain minimum capitalization separate and apart from the capitalization of its protected cell or cells in an amount determined by the superintendent after giving due consideration of the special purpose reinsurance vehicle's business plan, feasibility study and proforma financial statements, including the nature of the risks to be insured or reinsured.

[2007, c. 386, §14 (NEW) .]

4. **Status of protected cells.** A protected cell is not a legal person separate from the special purpose reinsurance vehicle. However, a protected cell must have its own distinct name or designation that includes the words "protected cell" and all protected cells must be identified by name in the special purpose reinsurance vehicle's limited certificate of authority. The special purpose reinsurance vehicle shall hold all assets attributable to the protected cell in one or more separately established and identified protected cell accounts bearing the name or designation of that protected cell.

A. The assets of a protected cell are available only to the ceding insurer and other creditors of that protected cell and may not be used to pay expenses or claims other than those attributable to the protected cell. Creditors with respect to a protected cell are not entitled to any recourse against the protected cell assets of other protected cells or the assets of the special purpose reinsurance vehicle's

general account. If an obligation of a special purpose reinsurance vehicle relates only to the general account, the creditor is entitled to have recourse with respect to that obligation only to the assets of the general account. [2007, c. 386, §14 (NEW).]

B. Protected cell assets may not be pledged or otherwise encumbered except for the benefit of creditors of that protected cell in furtherance of the securitization in accordance with the approved plan of operation. [2007, c. 386, §14 (NEW).]

C. All contracts or other documentation reflecting protected cell liabilities must clearly indicate that only the protected cell assets are available for the satisfaction of those protected cell liabilities. In all special purpose reinsurance vehicle insurance securitizations involving a protected cell, the contracts or other documentation effecting the transaction must contain provisions identifying the protected cell to which the transaction is attributed. In addition, the contracts or other documentation must clearly disclose that the assets of that protected cell, and only those assets, are available to pay the obligations of that protected cell. However, failure to include express language attributing obligations under a contract to a protected cell does not give a party the right to void or reform the contract if the party had notice that the contract related to a protected cell. [2007, c. 386, §14 (NEW).]

D. If the special purpose reinsurance vehicle enters into a contract involving more than one protected cell, the rights and obligations relating to each protected cell must be several rather than joint and the contract must make clear provisions for their apportionment between protected cells. [2007, c. 386, §14 (NEW).]

E. In any action or proceeding involving the potential for monetary recovery by or against a special purpose reinsurance vehicle with protected cells, or for nonmonetary relief relating to a particular protected cell or cells, any process, pleading or order must name the specific cell or cells affected, including if applicable the general account. [2007, c. 386, §14 (NEW).]

[2007, c. 386, §14 (NEW) .]

5. **Separate administrative services.** A special purpose reinsurance vehicle may contract with or arrange for an investment advisor, commodity trading advisor or other 3rd party to manage the assets or administer the obligations of a protected cell, if all remuneration, expenses and other compensation arising out of services performed with respect to that protected cell are payable only from the assets of that protected cell or, with the approval of the superintendent, from the assets of the special purpose reinsurance vehicle's general account.

[2007, c. 386, §14 (NEW) .]

6. **Notice of impairment or insolvency.** A special purpose reinsurance vehicle with protected cells shall notify the superintendent in writing within 10 business days after the special purpose reinsurance vehicle or any protected cell becomes impaired or insolvent.

[2007, c. 386, §14 (NEW) .]

7. **Conversion to protected cell framework.** A special purpose reinsurance vehicle without protected cells may apply to the superintendent in accordance with subsection 2 to revise its plan of operation to establish one or more protected cells. If there is an existing insurance securitization in force at the time of the application, the revised plan of operation must provide for the establishment of a protected cell for that securitization and the transfer to the protected cell of all assets and liabilities relating to the securitization.

[2007, c. 386, §14 (NEW) .]

8. **Termination of protected cell.** At the cessation of business of a protected cell in accordance with the plan approved by the superintendent, the special purpose reinsurance vehicle shall close out the protected cell account and the superintendent shall modify the limited certificate of authority to reflect the termination.

[2007, c. 386, §14 (NEW) .]

SECTION HISTORY
2007, c. 386, §14 (NEW).

§785. POWERS

1. **Powers.** A special purpose reinsurance vehicle authorized under this subchapter has the powers to enter into contracts and to conduct other commercial activities necessary to fulfill the purposes of this subchapter. These activities may include, but are not limited to, entering into contracts, issuing securities of the special purpose reinsurance vehicle and complying with the terms of the contracts, entering into trust agreements, swap agreements and any other agreements necessary to effectuate an insurance securitization in compliance with the limitations and pursuant to the authorities granted to the reinsurance vehicle under this subchapter or the plan of operation approved by the superintendent.

[2003, c. 249, §2 (NEW) .]

2. **Bylaws.** A special purpose reinsurance vehicle organized or doing business under this subchapter is capable of suing or being sued and may make or enforce contracts in relation to the business of the reinsurance vehicle; may have and use a common seal and in the name of the reinsurance vehicle or by a trustee chosen by the board of directors is capable of taking, purchasing, holding and disposing of real and personal property for carrying into effect the purposes of its organization; and may by its board of directors, trustees, officers or managers make bylaws and amendments to the bylaws not inconsistent with the laws or the constitution of this State or of the United States. The bylaws must define the manner of electing directors, trustees or managers and officers of the reinsurance vehicle, together with their qualifications, duties and term of office.

[2003, c. 249, §2 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§786. AFFILIATION

Notwithstanding the provisions of section 222, the special purpose reinsurance vehicle, the special purpose reinsurance vehicle organizer or subsequent debt or equity investors in special purpose reinsurance vehicle securities are not deemed affiliates of the ceding insurer by virtue of the special purpose reinsurance vehicle contract between the ceding insurer and the reinsurance vehicle, the securities of the reinsurance vehicle or related agreements necessary to implement the special purpose reinsurance vehicle insurance securitization. [2007, c. 386, §15 (AMD).]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §15 (AMD).

§787. CAPITALIZATION

A special purpose reinsurance vehicle must have minimum initial capital of not less than $5,000. All of the initial capital must be received by the reinsurance vehicle in cash. The minimum initial capital required and all other funds of the reinsurance vehicle in excess of its minimum initial capital, including funds held in trust to secure the obligations of the reinsurance vehicle pursuant to its special purpose reinsurance vehicle contracts, must be invested as provided in section 795. [2003, c. 249, §2 (NEW).]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§788. DIVIDENDS

The special purpose reinsurance vehicle may not declare or pay dividends in any form to its owners unless the dividends do not cause the reinsurance vehicle or any of its protected cells to become impaired and, after giving effect to the dividends, the assets of the reinsurance vehicle, including assets held in trust pursuant to the terms of the insurance securitization, must be sufficient to meet its obligations. Except for dividends specifically provided for in the approved plan of operation under section 782, subsection 2, paragraph H, the prior approval of the superintendent is required for any dividend paid during the term of coverage or while the reinsurance vehicle has undischarged obligations to the ceding insurer. The dividends may be declared by the board of directors of the reinsurance vehicle if the dividends would not violate the provisions of this subchapter or the approved plan of operation and would not jeopardize the fulfillment of the obligations of the reinsurance vehicle or the trustee pursuant to the special purpose reinsurance vehicle insurance securitization, the special purpose reinsurance vehicle contract or any related transaction. The provisions of section 222, subsection 11-C do not apply to such dividends. [2009, c. 511, Pt. A, §6 (AMD).]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §16 (AMD). 2009, c. 511, Pt. A, §6 (AMD).

§789. RECORDS AND FINANCIAL REPORTS

1. **Records.** The records of the special purpose reinsurance vehicle must be maintained in this State and must be available for examination by the superintendent at any time. No later than 5 months after the end of the fiscal year of the reinsurance vehicle, the reinsurance vehicle shall file with the superintendent an audit by a certified public accounting firm of the financial statements of the reinsurance vehicle and the trust accounts referred to in section 784, subsection 2, paragraph E.

[2003, c. 249, §2 (NEW) .]

2. **Statement of operation.** Each special purpose reinsurance vehicle organized under this subchapter shall file with the superintendent no later than March 1st of each year a statement of operations, including a statement of income, a balance sheet and a detailed listing of invested assets, including identification of assets held in trust to secure the reinsurance vehicle's obligations under the special purpose reinsurance vehicle contract, for the year ending the prior December 31st. The statements must be prepared in accordance with statutory accounting principles consistent with section 901-A on forms required by the superintendent. If one or more protected cells have been established, the statement must detail the financial experience of the general account and each protected cell separately, in addition to providing the combined financial experience of the special purpose reinsurance vehicle and all protected cells.

[2007, c. 386, §17 (AMD) .]

3. **Financial statement.** The special purpose reinsurance vehicle shall keep its books and records in such manner that its financial condition, affairs and operations can be ascertained and so that its financial statements filed with the superintendent can be readily verified and its compliance with the provisions of this subchapter determined. The books and records may be photographed, reproduced on film or stored and reproduced electronically.

[2003, c. 249, §2 (NEW) .]

4. **Preservation.** All books, records, documents, accounts and vouchers must be preserved and kept available in this State for the purpose of examination and until authority to destroy or otherwise dispose of the records is secured from the superintendent. The original records may, however, be kept and maintained outside this State if, according to a plan adopted by the special purpose reinsurance vehicle's board of directors and approved by the superintendent, it maintains suitable records in lieu of the original records.

[2003, c. 249, §2 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §17 (AMD).

§790. OFFICERS AND DIRECTORS

The directors of a special purpose reinsurance vehicle shall elect officers that they consider necessary to carry out the purposes of the reinsurance vehicle pursuant to this subchapter. The provisions of Title 13-C, section 857 apply to the indemnification of officers and directors of reinsurance vehicles organized under this subchapter. [2003, c. 249, §2 (NEW).]

1. **Appointment; election of officers; directors.** Each special purpose reinsurance vehicle authorized to do business in this State shall notify the superintendent within 30 days after the appointment or election of any new officers or directors.

[2003, c. 249, §2 (NEW) .]

2. **Removal of officer; director.** When the superintendent determines that an officer or director does not meet the standards set forth in this section, the superintendent shall, after notice and opportunity for hearing afforded to the officer or director, and after a finding that the officer or director is incompetent or untrustworthy or of known bad character, order the removal of the person. If the reinsurance vehicle does not comply with a removal order within 30 days, the superintendent may suspend that reinsurance vehicle's limited certificate of authority until such time as the order is complied with.

[2003, c. 249, §2 (NEW) .]

3. **Loans with affiliate.** The reinsurance vehicle may make no loans to any special purpose reinsurance vehicle organizer, owner, director, officer, manager or affiliate of the reinsurance vehicle.

[2003, c. 249, §2 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§791. FEES AND TAXES

A special purpose reinsurance vehicle application under section 782, subsection 2 is subject to the application fee specified in section 601, subsection 1. A reinsurance vehicle is also responsible for expenses and costs incurred by the bureau in accordance with section 228. The reinsurance vehicle is not subject to state premium or other taxes incidental to the operation of its business as long as the business remains within the limitations of this subchapter. [2003, c. 249, §2 (NEW).]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§792. DISSOLUTION

A special purpose reinsurance vehicle operating under this subchapter may be dissolved at any time by a vote of its directors under section 790 and after the action has been approved by the superintendent. Voluntary dissolution may not be effected or allowed until and unless all of the obligations of the reinsurance vehicle pursuant to the insurance securitization or securitizations have been fully and finally satisfied pursuant to their terms. In the case of voluntary dissolution, the disposition of the affairs of the reinsurance vehicle, including the settlement of all outstanding obligations, must be made by the officers or directors of the reinsurance vehicle and when the liquidation has been completed and a final statement in acceptable form has been filed with and approved by the superintendent the provisions for voluntary dissolution under section 3484 must be followed to dissolve the reinsurance vehicle. [2007, c. 386, §18 (AMD).]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §18 (AMD).

§793. CONSERVATION, REHABILITATION OR LIQUIDATION

1. **Authorized insurer.** A special purpose reinsurance vehicle is considered an authorized insurer for purposes of section 4351, subsection 1, and the provisions of chapter 57 apply to a reinsurance vehicle or to any of a reinsurance vehicle's protected cells, except to the extent modified by this section.

[2007, c. 386, §19 (AMD) .]

2. **Grounds for action.** Notwithstanding the provisions of sections 4356 and 4357, the Superior Court may issue an order authorizing the superintendent to conserve, rehabilitate or liquidate a special purpose reinsurance vehicle domiciled in this State, or one or more of its protected cells, only if the superintendent proves by clear and convincing evidence or the reinsurance vehicle stipulates after notice and opportunity for hearing that:

A. There has been embezzlement, wrongful sequestration, dissipation or diversion of the assets of the reinsurance vehicle or protected cell intended to be used to pay amounts owed to the ceding insurer or the holders of special purpose reinsurance vehicle securities; or [2007, c. 386, §19 (AMD).]

B. The reinsurance vehicle or protected cell is insolvent and the holders of a majority in outstanding principal amount of each class of special purpose reinsurance vehicle securities request or consent to conservation, rehabilitation or liquidation under this subchapter. [2007, c. 386, §19 (AMD).]

[2007, c. 386, §19 (AMD) .]

3. **Receiver.** Notwithstanding any contrary provision of this Title, rules adopted under this Title or any other applicable law, upon any order of conservation, rehabilitation or liquidation of the special purpose reinsurance vehicle or one or more of its protected cells, a receiver is bound to deal with the reinsurance vehicle's assets and liabilities in accordance with the requirements under this subchapter.

[2007, c. 386, §19 (AMD) .]

3-A. **Protected cells.** The following provisions apply to the insolvency of a special purpose reinsurance vehicle with protected cells or to the insolvency of a protected cell.

A. The insolvency of one protected cell does not constitute the insolvency of any other protected cell or of the special purpose reinsurance vehicle itself. The insolvency of a special purpose reinsurance vehicle does not constitute the insolvency of any of its solvent protected cells and is not a basis for the receivership of any solvent protected cell capable of independent operation. [2007, c. 386, §19 (NEW).]

B. Notwithstanding the insolvency of the special purpose reinsurance vehicle or of any other protected cell, the obligations attributed to any solvent protected cell must continue to be paid as they come due. [2007, c. 386, §19 (NEW).]

C. The assets attributed to a protected cell may not be applied to the liabilities attributed to another protected cell or to the reinsurance vehicle generally, except that:

(1) If the insolvency of the special purpose reinsurance vehicle renders a protected cell incapable of being managed independently, a receiver may, after consultation with the creditors of the protected cell, contract for the management of the protected cell and charge to the protected cell a reasonable amount for those services;

(2) A general liability of an insolvent special purpose reinsurance vehicle may be apportioned equitably in whole or in part to one or more of its protected cells if the Superior Court determines that the liability arises out of the operations of the protected cell or cells and that the interests of innocent creditors of the protected cell or cells are not unreasonably impaired; and

(3) If assets or liabilities have been commingled, or have been wrongfully transferred between protected cells or between a protected cell and the general account, the Superior Court shall trace the assets and attribute them to the proper accounts, giving due consideration to the terms of any relevant governing instrument or contract. [2007, c. 386, §19 (NEW).]

D. The plan of rehabilitation or liquidation of any special purpose reinsurance vehicle with protected cells must make reasonable provision for the continued operation of all solvent protected cells, which may involve the formation of one or more new special purpose reinsurance vehicles or the transfer of one or more protected cells. [2007, c. 386, §19 (NEW).]

[2007, c. 386, §19 (NEW) .]

4. **Recoverable amounts.** With respect to amounts recoverable under a special purpose reinsurance vehicle contract, the amount recoverable by the receiver may not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation or liquidation with respect to the ceding insurer, notwithstanding any provisions to the contrary in the contracts or other documentation governing the special purpose reinsurance vehicle insurance securitization.

A. Notwithstanding the provisions of chapter 57, an application or petition in any delinquency proceeding relating to a ceding insurer or any temporary restraining order or injunction issued in any such proceeding may not prohibit the transaction of any business by a reinsurance vehicle, including any payment by a reinsurance vehicle made pursuant to a special purpose reinsurance vehicle security or any action or proceeding against a reinsurance vehicle or its assets. [2003, c. 249, §2 (NEW).]

B. Notwithstanding the provisions of chapter 57, subchapter 2, the commencement of a summary proceeding or other interim proceeding commenced prior to a formal delinquency proceeding with respect to a reinsurance vehicle and any order issued by the court in such proceeding may not prohibit a reinsurance vehicle from making a payment pursuant to a special purpose reinsurance vehicle security or contract or from taking any action required to make the payment. [2003, c. 249, §2 (NEW).]

[2003, c. 249, §2 (NEW) .]

5. **Nonfraudulent transfer.** Notwithstanding any other provision of chapter 57 or other state law:

A. A receiver of a ceding insurer may not void a nonfraudulent transfer by a ceding insurer to a special purpose reinsurance vehicle of money or other property made pursuant to a special purpose reinsurance vehicle contract; and [2007, c. 386, §19 (AMD).]

B. A receiver of a special purpose reinsurance vehicle may not void a nonfraudulent transfer by the reinsurance vehicle of money or other property made to a ceding insurer pursuant to a special purpose reinsurance vehicle contract or made to or for the benefit of any holder of a special purpose reinsurance vehicle security on account of the special purpose reinsurance vehicle security. [2003, c. 249, §2 (NEW).]

[2007, c. 386, §19 (AMD) .]

6. **Fulfillment of obligations.** With the exception of the fulfillment of the obligations under a special purpose reinsurance vehicle contract and notwithstanding any other provisions of this subchapter or other law of this State to the contrary, the assets of a special purpose reinsurance vehicle including assets held in trust may not be consolidated with or included in the estate of a ceding insurer in any delinquency proceeding against the ceding insurer under this subchapter for any purpose, including, without limitation, distribution to creditors of the ceding insurer.

[2003, c. 249, §2 (NEW) .]

7. **Domiciliary receiver.** Notwithstanding any other provision of this subchapter:

A. The domiciliary receiver of a special purpose reinsurance vehicle domiciled in another state is vested by operation of law with the title to all of the assets, property, contracts and rights of action and all of the books, accounts and other records of the reinsurance vehicle located in this State. The domiciliary receiver has the immediate right to recover all such vested property, assets and causes of action of the reinsurance vehicle located in this State ; and [2007, c. 386, §19 (AMD).]

B. An ancillary proceeding may not be commenced or prosecuted in this State against a special purpose reinsurance vehicle domiciled in another state. [2003, c. 249, §2 (NEW).]

[2007, c. 386, §19 (AMD) .]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §19 (AMD).

§794. NOT SUBJECT TO GUARANTY FUNDS; RESIDUAL MARKET OR SIMILAR ARRANGEMENTS

1. **Guaranty funds.** The special purpose reinsurance vehicle or the activities, assets and obligations relating to the reinsurance vehicle are not subject to the provisions of chapter 57, subchapter 3 or chapter 62 and a reinsurance vehicle may not be assessed by or otherwise be required to contribute to any guaranty fund or guaranty association in this State with respect to the activities, assets or obligations of a reinsurance vehicle or the ceding insurer.

[2003, c. 249, §2 (NEW) .]

2. **Residual market.** The special purpose reinsurance vehicle may not be required to participate in any residual market, so-called "FAIR" plan or other similar plan to provide insurance coverage, take out policies, assume risks, make capital contributions, pay or be otherwise obligated for assessments, surcharges or fees or otherwise support or participate in such plans or arrangements.

[2003, c. 249, §2 (NEW) .]

SECTION HISTORY

2003, c. 249, §2 (NEW).

§795. ASSET AND INVESTMENT LIMITATIONS

1. **Assets.** Assets of the special purpose reinsurance vehicle held in trust to secure obligations under the special purpose reinsurance vehicle contract must at all times be held in:

A. Cash and cash equivalents; [2003, c. 249, §2 (NEW).]

B. Securities listed by the Securities Valuation Office of the National Association of Commissioners or its successor organization and qualifying as admitted assets under statutory accounting principles pursuant to section 901-A; or [2003, c. 249, §2 (NEW).]

C. Any other form of security acceptable to the superintendent. [2003, c. 249, §2 (NEW).]

[2003, c. 249, §2 (NEW) .]

2. **Investment practices.** In addition, the special purpose reinsurance vehicle may enter into swap agreements or other transactions that have the objective of leveling timing differences in funding of upfront or ongoing transaction expenses or managing credit or interest rate risk of the investments in the trust to ensure that the investments are sufficient to ensure payment or repayment of the securities and related interest or principal payments issued pursuant to a special purpose reinsurance vehicle insurance securitization transaction or the reinsurance vehicle's obligations under the special purpose reinsurance vehicle contract.

[2003, c. 249, §2 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§796. NO TRANSACTION OF INSURANCE BUSINESS BY INVESTORS IN SECURITIES

The securities issued by the special purpose reinsurance vehicle pursuant to a special purpose reinsurance vehicle insurance securitization are not deemed to be insurance or reinsurance contracts. An investor in such securities issued pursuant to insurance securitization or any holder of such securities may not by sole means of this investment or holding be deemed to be transacting an insurance business in this State. The underwriters or selling agents and their partners, directors, officers, members, managers, employees, agents, representatives and advisors involved in an insurance securitization are not deemed to be acting as insurance or reinsurance producers, intermediaries or consultants by virtue of their activities in connection with the special purpose reinsurance vehicle or with the insurance securitization. [2007, c. 386, §20 (AMD).]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §20 (AMD).

§796-A. CONFIDENTIALITY OF PROPRIETARY INFORMATION

Any requirement established by this subchapter to file proprietary business information with the superintendent does not in and of itself make that information a public record. Information filed with the superintendent pursuant to this subchapter is entitled to any privileges and confidentiality protections that would apply if the special purpose reinsurance vehicle were a captive insurance company licensed by the superintendent pursuant to section 6702. [2007, c. 386, §21 (NEW).]

SECTION HISTORY
2007, c. 386, §21 (NEW).

§797. AUTHORITY TO ADOPT RULES

The superintendent may adopt rules necessary to effectuate the purposes of this subchapter. Any rules so adopted do not affect a special purpose reinsurance vehicle insurance securitization in effect at the time of adoption. Rules adopted pursuant to this subchapter are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2003, c. 249, §2 (NEW).]

SECTION HISTORY
2003, c. 249, §2 (NEW).

§798. EXEMPTION FROM INSURANCE LAWS WITHIN LIMITATIONS

1. **Titles consistent.** A special purpose reinsurance vehicle is subject to chapters 1, 3 and 5 to the extent consistent with this subchapter.

[2003, c. 249, §2 (NEW) .]

2. **Provisions not applicable.** No other provisions of this Title are applicable to a special purpose reinsurance vehicle organized under this subchapter, except as expressly provided in this subchapter or in rules adopted by the superintendent pursuant to section 797.

[2003, c. 249, §2 (NEW) .]

3. **Variance.** The superintendent may issue an order exempting a special purpose reinsurance vehicle or a protected cell from provisions of this subchapter upon a finding that the variance is necessary for conformance to the laws or regulatory requirements of a ceding insurer's state of domicile and that the variance is consistent with the purposes of this subchapter given the nature of the risks to be insured.

[2007, c. 386, §22 (NEW) .]

SECTION HISTORY
2003, c. 249, §2 (NEW). 2007, c. 386, §22 (AMD).

Chapter 11: ASSETS AND LIABILITIES

Subchapter 1: ASSETS

§901. "ASSETS" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 501, §42 (AMD). 1991, c. 828, §21 (AMD). 2001, c. 72, §6 (RP).

§901-A. STATUTORY ACCOUNTING PRINCIPLES; RESERVES

1. **Principles; admitted assets.** In evaluating the financial condition of an insurer, the superintendent shall determine which assets may be recognized as admitted assets and shall value the insurer's admitted assets and the insurer's liabilities:

A. In accordance with recognized statutory accounting principles as codified by the National Association of Insurance Commissioners or its successor organization and reflected in the association's accounting practices and procedures manual and valuation of securities manual and their successor publications; and [2001, c. 524, §1 (NEW).]

B. In accordance with any additional accounting practices permitted by the superintendent upon the request of the insurer. [2001, c. 524, §1 (NEW).]

[2001, c. 524, §1 (RPR) .]

2. **Reserve required.** If the superintendent finds, in view of the character of investments held by a domestic insurer, that it would be prudent for the insurer to establish a special reserve for possible losses or fluctuations in the value of its investments, including realty holdings acquired by mortgage loan default, the superintendent may permit or require the insurer to establish such a reserve, reasonable in amount, and may require that the reserve be maintained and reported in any statement or report of the financial condition of the insurer.

[2001, c. 72, §7 (NEW) .]

3. **Rules.** The superintendent may adopt rules to implement 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.

[2001, c. 72, §7 (NEW) .]

SECTION HISTORY
2001, c. 72, §7 (NEW). 2001, c. 524, §1 (AMD).

§902. ASSETS NOT ALLOWED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §2 (AMD). 2001, c. 72, §8 (RP).

Subchapter 2: LIABILITIES HEADING: PL 2001, C. 72, §9 RP)

§921. LIABILITIES, IN GENERAL

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 432, §1 (AMD). 2001, c. 72, §9 (RP).

§922. DISALLOWANCE OF "WASH" TRANSACTIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2001, c. 72, §9 (RP).

§923. UNEARNED PREMIUM RESERVE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 72, §9 (RP).

§924. UNEARNED PREMIUM RESERVE FOR MARINE AND TRANSPORTATION INSURANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2001, c. 72, §9 (RP).

§925. HEALTH INSURANCE POLICY RESERVES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 124, (AMD). 1973, c. 585, §12 (AMD). 1979, c. 453, §1 (RPR). 1979, c. 663, §§140,141 (AMD). 2001, c. 72, §9 (RP).

§926. TITLE INSURANCE RESERVES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 72, §9 (RP).

§927. MORTGAGE GUARANTY CONTINGENCY RESERVE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §16 (AMD). 1973, c. 585, §12 (AMD). 1981, c. 501, §43 (AMD). 2001, c. 72, §9 (RP).

Subchapter 2-A: PROPERTY CASUALTY INSURANCE RESERVES HEADING: PL 1991, C. 128 (NEW)

§941. DEFINITIONS

(REPEALED)

SECTION HISTORY
1991, c. 128, (NEW). 2007, c. 281, §3 (AFF). 2007, c. 281, §1 (RP).

§942. PROPERTY AND CASUALTY INSURANCE RESERVES; REQUIRED ANNUAL CERTIFICATIONS

(REPEALED)

SECTION HISTORY
1991, c. 128, (NEW). 2007, c. 281, §3 (AFF). 2007, c. 281, §1 (RP).

§943. STATEMENT OF CERTIFYING ACTUARY

(REPEALED)

SECTION HISTORY
1991, c. 128, (NEW). 2007, c. 281, §3 (AFF). 2007, c. 281, §1 (RP).

§945. TRANSITION PERIOD

(REPEALED)

SECTION HISTORY
1991, c. 128, (NEW). 2007, c. 281, §3 (AFF). 2007, c. 281, §1 (RP).

§946. REQUIRED NOTICE

(REPEALED)

SECTION HISTORY
1991, c. 128, (NEW). 2007, c. 281, §3 (AFF). 2007, c. 281, §1 (RP).

§947. RULES AUTHORIZED

(REPEALED)

SECTION HISTORY
1991, c. 128, (NEW). 2007, c. 281, §3 (AFF). 2007, c. 281, §1 (RP).

Subchapter 3: LIFE INSURANCE RESERVES

§951. SHORT TITLE

This subchapter may be known and cited as "the Standard Valuation Law." [2013, c. 238, Pt. C, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 346, §1 (AMD). 2013, c. 238, Pt. C, §1 (RPR).

§951-A. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [2013, c. 238, Pt. C, §2 (NEW).]

1. **Appointed actuary.** "Appointed actuary" means the actuary appointed by an insurer pursuant to section 952-A, subsection 1.

[2013, c. 238, Pt. C, §2 (NEW) .]

2. **NAIC.** "NAIC" means the National Association of Insurance Commissioners or its successor organization.

[2013, c. 238, Pt. C, §2 (NEW) .]

3. **Operative date.** "Operative date," with respect to the initial adoption of the valuation manual, means January 1st of the first calendar year beginning at least 6 months after all of the following events have occurred:

A. The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members or 3/4 of the members voting, whichever is greater; [2013, c. 238, Pt. C, §2 (NEW).]

B. The NAIC's model standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions has been enacted by states representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements; and [2013, c. 238, Pt. C, §2 (NEW).]

C. The NAIC's model standard valuation law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions has been enacted by at least 42 of the following 55 jurisdictions: the 50 states of the United States, American Samoa, the District of Columbia, Guam, the Commonwealth of Puerto Rico and the United States Virgin Islands. [2013, c. 238, Pt. C, §2 (NEW).]

[2013, c. 238, Pt. C, §2 (NEW) .]

4. **Policyholder behavior.** "Policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this subchapter, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization or benefit elections prescribed by the policy or contract, but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

[2013, c. 238, Pt. C, §2 (NEW) .]

5. **Principle-based valuation.** "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is subject to section 960.

[2013, c. 238, Pt. C, §2 (NEW) .]

6. **Qualified actuary.** "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets all applicable requirements specified in the valuation manual or by rule adopted by the superintendent.

[2013, c. 238, Pt. C, §2 (NEW) .]

7. **Subject lines of insurance.** "Subject lines of insurance" means life insurance, accident and health insurance and deposit-type contracts, as those terms are defined in the valuation manual.

[2013, c. 238, Pt. C, §2 (NEW) .]

8. **Tail risk.** "Tail risk" means a risk for which the frequency of low-probability events is higher than expected under a normal probability distribution or the risk of events of very significant magnitude.

[2013, c. 238, Pt. C, §2 (NEW) .]

9. **Valuation manual.** "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in section 959.

[2013, c. 238, Pt. C, §2 (NEW) .]

SECTION HISTORY
2013, c. 238, Pt. C, §2 (NEW).

§952. CALCULATION OF RESERVE LIABILITIES

1. The superintendent shall annually value, or cause to be valued, the reserve liabilities, hereinafter called reserves, for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer transacting business in this State in accordance with this subchapter, except that in the case of an alien insurer, such valuation must be limited to its United States business; and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest and methods, net level premium method or other, used in the calculation of such reserves. In calculating such reserves, the superintendent may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of any foreign or alien insurer, the superintendent may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard herein provided. For policies and contracts issued before the operative date of the valuation manual or not addressed by the valuation manual, reserves must be determined according to sections 953 to 958-A. For policies and contracts issued after the operative date of the valuation manual, reserves must be determined according to sections 959 and 960 and as specified by the valuation manual.

[2013, c. 238, Pt. C, §3 (AMD) .]

2. Any such insurer which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the superintendent, adopt any lower standard of valuation, but not lower than the minimum herein provided.

[1973, c. 585, §12 (AMD) .]

3. Beginning on the operative date of the valuation manual, a life or health insurer and a casualty or multiple lines insurer transacting health insurance shall comply with the applicable requirements of this subchapter if the insurer is required to hold a certificate of authority to write one or more subject lines of insurance in this State or if the insurer has written, issued or reinsured contracts of one or more subject lines of insurance in this State and has at least one such policy in force or on claim.

[2013, c. 238, Pt. C, §4 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 238, Pt. C, §§3, 4 (AMD).

§952-A. ACTUARIAL OPINION OF RESERVES

1. **General.** An insurer doing business in this State subject to this subchapter shall appoint a qualified actuary, in accordance with any applicable requirements of the valuation manual or rules adopted by the superintendent, and annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items of that insurer held in support of the policies and contracts specified by the superintendent by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this State. Before the operative date of the valuation manual, the superintendent by rule shall define the specifics of the opinion. On and after the operative date of the valuation manual, if the valuation manual has prescribed specific requirements applicable to the opinion, the opinion must comply with those requirements. The superintendent by rule may add any other items considered necessary to the scope of the opinion.

[2013, c. 238, Pt. C, §5 (AMD) .]

2. **Actuarial analysis of reserves and assets supporting those reserves.** Except as otherwise authorized or required in accordance with rules adopted by the superintendent or applicable provisions of the valuation manual, an insurer subject to this subchapter shall include in the opinion required by subsection 1 an opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the superintendent by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, adequately provide for the insurer's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

The superintendent may provide by rule for a transition period for establishing any higher reserves that the appointed actuary may consider necessary in the opinion required by this subsection.

[2013, c. 238, Pt. C, §5 (AMD) .]

3. **Requirement for opinion under subsection 2.** An opinion required by subsection 2 is governed by the following provisions.

A. A memorandum, in form and substance acceptable to the superintendent as specified in the valuation manual or by rule, must be prepared to support the actuarial opinion. [2013, c. 238, Pt. C, §5 (AMD).]

B. If the insurer fails to provide a supporting memorandum at the request of the superintendent within a period specified in the valuation manual or by rule or the superintendent determines that the supporting memorandum provided by the insurer fails to meet the prescribed standards or is otherwise unacceptable to the superintendent, the superintendent may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare a supporting memorandum as required by the superintendent. [2013, c. 238, Pt. C, §5 (AMD).]

[2013, c. 238, Pt. C, §5 (AMD) .]

4. **Requirement for all opinions.** An opinion required pursuant to subsection 1 or 2 is governed by the following provisions.

A. The opinion must be submitted with the annual statement reflecting the valuation of reserve liabilities for each year ending on or after December 31, 1995. [1993, c. 634, Pt. B, §1 (NEW); 1993, c. 634, Pt. B, §4 (AFF).]

B. The opinion must apply to all business in force, including individual and group health insurance plans, in a form and substance acceptable to the superintendent. [2013, c. 238, Pt. C, §5 (AMD).]

B-1. The opinion must comply with the requirements of any applicable rules and, on and after the operative date of the valuation manual, must comply with all applicable requirements of the valuation manual. [2013, c. 238, Pt. C, §5 (NEW).]

C. The opinion must be based on standards adopted by the Actuarial Standards Board or its successor and, to the extent applicable, on any additional standards prescribed by the valuation manual or prescribed by the superintendent by rule. [2013, c. 238, Pt. C, §5 (AMD).]

D. In the case of an opinion required to be submitted by a foreign or alien insurer, the superintendent may accept the opinion filed by that insurer with the insurance supervisory official of another state if the superintendent determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this State. [1993, c. 634, Pt. B, §1 (NEW); 1993, c. 634, Pt. B, §4 (AFF).]

E. [2013, c. 238, Pt. C, §5 (RP).]

F. Except in cases of fraud or willful misconduct, the appointed actuary is not liable for damages to any person, other than the insurer and the superintendent, for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion. [2013, c. 238, Pt. C, §5 (AMD).]

G. The superintendent may take disciplinary action against the insurer or the appointed actuary pursuant to section 12-A for knowing violations of this section and may establish additional grounds for disciplinary action by rule. [2013, c. 238, Pt. C, §5 (AMD).]

H. [2013, c. 238, Pt. C, §5 (RP).]

I. [2013, c. 238, Pt. C, §5 (RP).]

J. [2013, c. 238, Pt. C, §5 (RP).]

K. [2013, c. 238, Pt. C, §5 (RP).]

L. [2013, c. 238, Pt. C, §5 (RP).]

M. [2013, c. 238, Pt. C, §5 (RP).]

[2013, c. 238, Pt. C, §5 (AMD) .]

5. **Applicability to health carriers.** A health carrier not otherwise subject to this section or section 993 shall file an actuarial opinion in accordance with the applicable National Association of Insurance Commissioners annual statement instructions. For purposes of this section, "health carrier" means an insurer, health maintenance organization, nonprofit corporation subject to Title 24 or fraternal benefit society that provides health insurance or comparable health benefits. This section and rules adopted pursuant to this section apply to health carriers to the extent provided in the valuation manual. Before the operative date of the valuation manual, this section and rules adopted pursuant to this section apply to health carriers to the extent that they specifically refer to health carriers or impose requirements that are consistent with and no more stringent than the annual statement instructions.

[2013, c. 238, Pt. C, §5 (AMD) .]

SECTION HISTORY
1993, c. 634, Pt. B, §1 (NEW). 1993, c. 634, Pt. B, §4 (AFF). 2001, c. 89, §§1, 2 (AMD). 2009, c. 511, Pt. B, §1 (AMD). 2011, c. 320, Pt. A, §6 (AMD). 2013, c. 238, Pt. C, §5 (AMD).

§952-B. APPLICABILITY OF RESERVING METHODOLOGIES

Sections 953 to 958-A do not apply to a policy or contract that is issued on or after the operative date of the valuation manual and is subject to section 959, unless those sections are made applicable by reference in whole or part in the valuation manual. [2013, c. 238, Pt. C, §6 (NEW).]

SECTION HISTORY
2013, c. 238, Pt. C, §6 (NEW).

§953. MINIMUM STANDARDS

1. This subsection applies only to policies and contracts issued prior to January 1, 1948, or such earlier date after July 21, 1945, as shall have been elected by an insurer as the date on and after which it would comply with the standard nonforfeiture law.

Except as otherwise provided in subsection 3, the legal minimum standard of value for such life insurance policies issued on or after the first day of September, 1931, by any life insurer chartered by this State, shall be the American Experience Table of Mortality with interest at 3 1/2% per year. Any such life insurer may, at its option, value its insurance policies issued on and after such day, in accordance with their terms on the basis of the American Men Ultimate Table of Mortality with interest not higher than 3 1/2% per year by the net level premium method. Reserves for all such policies and contracts may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by this subsection.

[1975, c. 342, §1 (AMD) .]

2. This subsection applies only to policies and contracts issued on and after January 1, 1948, or the earlier date after July 21, 1945, as shall have been elected by an insurer as the date on and after which it would comply with the standard nonforfeiture law.

Except as otherwise provided in subsection 3 and section 953-A, the minimum standard for the valuation of all those policies and contracts shall be the commissioners reserve valuation method defined in section 954, 3 1/2% interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after December 31, 1975, 4% interest, and the following tables, or in the case of these policies and contracts, other than annuity and pure endowment contracts, issued on or after January 1, 1980, 4 1/2% interest, and the following tables.

A. Standard Ordinary Mortality Table. For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in these policies, -- the Commissioners 1941 Standard Ordinary Mortality Table; provided that the Commissioners 1958 Standard Ordinary Mortality Table shall be the table for the minimum standard for those policies issued on and after January 1, 1966, or such earlier date after September 12, 1959, as shall have been elected by an insurer as the date on and after which it would use such table as the basis for minimum cash surrender values and nonforfeiture benefits under the standard nonforfeiture law and prior to the operative date of the Standard Nonforfeiture Law for Life Insurance, section 2532-A; provided that for any category of those policies issued on female risks all modified net premiums and present values referred to in sections 951 to 957 may be calculated according to an age not more than 3 years younger than the actual age of the insured, or in the case of those policies issued on or after January 1, 1980, according to an age not more than 6 years younger than the actual age of the insured. For those policies issued on or after the operative date of the Standard Nonforfeiture Law for Life Insurance, section 2532-A, the Commissioners 1980 Standard Ordinary Mortality Table, or at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors or any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for the policies. [1983, c. 346, §2 (AMD).]

B. Standard Industrial Mortality Table. For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies, -- the 1941 Standard Industrial Mortality Table; provided that the Commissioners 1961 Standard Industrial Mortality Table, or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for those policies, shall be the table for the minimum standard for those policies issued on and after January 1, 1968, or such earlier date after September 1, 1963, as shall have been elected by the insurer as the date on and after which it would use such table as the basis for minimum cash surrender values and nonforfeiture benefits under the standard nonforfeiture law. [1983, c. 346, §2 (AMD).]

C. Standard Annuity Mortality Table or Annuity Mortality Table. For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in those policies -- the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the superintendent. [1983, c. 346, §2 (AMD).]

D. Group Annuity Mortality Table. For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in those policies -- the Group Annuity Mortality Table for 1951, any modification of the table approved by the superintendent, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts. [1983, c. 346, §2 (AMD).]

E. Class (3) Disability Table. For total and permanent disability benefits in or supplementary to ordinary policies or contracts -- for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for those policies; for policies or contracts issued on or after January 1, 1961 and prior to January 1, 1966, either those tables or, at the option of the insurer, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies. [1983, c. 346, §2 (AMD).]

F. Inter-Company Double Indemnity Mortality Table. For accidental death benefits in or supplementary to policies -- for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for those policies; for policies issued on or after January 1, 1961 and prior to January 1, 1966, either that table or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies. [1983, c. 346, §2 (AMD).]

G. Group Life Insurance Tables. For group life insurance, life insurance issued on the substandard basis and other special benefits -- such table as may be approved by the superintendent. [1983, c. 346, §2 (AMD).]

[1983, c. 346, §2 (AMD) .]

3. Except as provided in section 953-A, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the effective date of this subsection, as defined herein, and for all annuities and pure endowments purchased on or after the effective date under group annuity and pure endowment contracts, shall be the commissioners reserve valuation method defined in section 954 and the following tables and interest rates.

A. 1971 Individual Annuity Mortality Table. For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in those contracts -- the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for those contracts, or any modification of these tables approved by the superintendent, and 6% interest for single premium immediate annuity contracts, and 4% interest for all other individual annuity and pure endowment contracts, or in the case of these contracts issued on or after January 1, 1980, 7 1/2% interest for individual single premium immediate annuity contracts, 5 1/2% interest for single premium deferred annuity and pure endowment contracts and 4 1/2% interest for all other individual annuity and pure endowment contracts. [1983, c. 346, §2 (AMD).]

B. 1971 Group Annuity Mortality Table. For all annuities and pure endowments purchased under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts -- the 1971 Group Annuity Mortality Table, or any group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the superintendent for use in determining the minimum standard of valuation for those annuities and pure endowments, or any modification of these tables approved by the superintendent, and 6% interest, or in the case of annuities and pure endowments purchased under those contracts on or after January 1, 1980, 7 1/2% interest. [1983, c. 346, §2 (AMD).]

This subsection shall not apply to any insurer before January 1, 1979, unless the insurer shall have filed with the superintendent an election to comply with the provisions of this subsection after a specified date before January 1, 1979, provided that an insurer may elect different dates on which this subsection shall apply to individual and pure endowment contracts and to group annuity and pure endowment contracts. If an insurer makes no such election, this subsection shall apply to that insurer on January 1, 1979.

[1983, c. 346, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 342, §§1-3 (AMD). 1979, c. 453, §§2-4 (AMD). 1983, c. 346, §2 (AMD).

§953-A. APPLICABLE INTEREST RATES

1. The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates, as defined in this section:

A. All life insurance policies issued in a particular calendar year, on or after the operative date of the Standard Nonforfeiture Law for Life Insurance, section 2532-A; [1983, c. 346, §3 (NEW).]

B. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984, or January 1, 1983, at the election of the insurer; [1983, c. 346, §3 (NEW).]

C. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, or January 1, 1983, at the election of the insurer, under group annuity and pure endowment contracts; and [1983, c. 346, §3 (NEW).]

D. The net increase, if any, in a particular calendar year after January 1, 1984, or January 1, 1983, at the election of the insurer, in amounts held under guaranteed interest contracts. [1983, c. 346, §3 (NEW).]

An insurer electing January 1, 1983, in lieu of January 1, 1984, in paragraph B, C or D, shall notify the superintendent of its election by written notice no later than December 31, 1983.

[1983, c. 346, §3 (NEW) .]

2. The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearest 1/4 of 1%:

A. For life insurance:

I = .03 + W (R*1* -.03) + W (R*2*-.09)
2

[1983, c. 346, §3 (NEW).]

B. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

I=.03 + W (R -.03)

where R1 is the lesser of R and .09,

R*2* is the greater of R and .09,
R is the reference interest rate defined in this section, and W is the weighting factor defined in this section;

[1983, c. 346, §3 (NEW).]

C. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in paragraph B, the formula for life insurance stated in paragraph A shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single premium immediate annuities stated in paragraph B shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less; [1983, c. 346, §3 (NEW).]

D. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium annuities stated in paragraph B shall apply; and [1983, c. 346, §3 (NEW).]

E. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in paragraph B shall apply. [1983, c. 346, §3 (NEW).]

If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year, determined without reference to this sentence, differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 1/2 of 1%, the calendar year statutory valuation interest rate for those life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, by using the reference interest rate defined for 1979, and shall be determined for each subsequent calendar year, regardless of when the Standard Nonforfeiture Law for Life Insurance, section 2532-A, becomes operative.

[1983, c. 346, §3 (NEW) .]

3. The weighting factors in the formulas in subsection 2 are given in the following tables:

A. Weighting Factors for Life Insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy; [1983, c. 346, §3 (NEW).]

B. Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:.80; [1983, c. 346, §3 (NEW).]

C. Weighting factors for other annuities and for guaranteed interest contracts, except as stated in paragraph B, shall be as specified in subparagraphs (1), (2) and (3), according to the rules and definitions in subparagraphs (4), (5) and (6):

(1) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Types A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

(2) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in subparagraph (1) increased by:

Plan Type A	B	C
.15	.25	.05;

(3) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in subparagraph (1) or derived in subparagraph (2) increased by:

Plan Type A	B	C
.05	.05	.05;

(4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence;

(5) Plan type as used in the subparagraphs (1), (2) and (3) tables is defined as follows.

(a) Plan Type A. At any time policyholder may withdraw funds, only: With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; without that adjustment, but in installments over 5 years or more; as an immediate life annuity; or no withdrawal permitted.

(b) Plan Type B. Before expiration of the interest rate guarantee, policyholder may withdraw funds, only: With an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; without that adjustment, but in installments over 5 years or more; or no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without that adjustment in a single sum or installments over less than 5 years.

(c) Plan Type C. Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than 5 years, either: Without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund; and

(6) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund. [1983, c. 346, §3 (NEW).]

[1983, c. 346, §3 (NEW) .]

4. The reference interest rate referred to in subsection 2 is defined as follows:

A. For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30th of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; [1983, c. 346, §3 (NEW).]

B. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30th of the calendar year of issue or year of purchase, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; [1983, c. 346, §3 (NEW).]

C. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph B, with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30th of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average-Monthly Average Corporates,as published by Moody's Investors Service, Inc.; [1983, c. 346, §3 (NEW).]

D. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in paragraph B, with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30th of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; [1983, c. 346, §3 (NEW).]

E. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30th of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc.; and [1983, c. 346, §3 (NEW).]

F. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in paragraph B, the average over a period of 12 months, ending on June 30th of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc. [1983, c. 346, §3 (NEW).]

[1983, c. 346, §3 (NEW) .]

5. In the event that Moody's Corporate Bond Yield Average-Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or in the event that the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the superintendent, may be substituted.

[1983, c. 346, §3 (NEW) .]

SECTION HISTORY
1983, c. 346, §3 (NEW).

§954. COMMISSIONERS RESERVE VALUATION METHOD DEFINED

1. **Policies providing for uniform insurance and uniform premiums.** Except as otherwise provided in subsection 2 and section 957, reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of paragraph A over paragraph B as follows:

A. A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of such policy on which a premium falls due. Such net level annual premium shall not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy; [1979, c. 453, §5 (NEW).]

B. A net one-year term premium for those benefits provided in the first policy year. [1983, c. 346, §4 (AMD).]

[1983, c. 346, §4 (AMD) .]

1-A. **Reserve.** For any life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the 2nd year and for which no comparable additional benefit is provided in the first year for that excess and which provides an endowment benefit or a cash surrender value, or a combination thereof, in an amount greater than that excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date, defined in this subsection as the first policy anniversary on which the sum of any endowment

benefit and any cash surrender value then available is greater than that excess premium, shall, except as otherwise provided in section 957, be the greater of the reserve as of that policy anniversary calculated as described in subsection 1 and the reserve as of that policy anniversary calculated as described in subsection 1, but with the value defined in subsection 1, paragraph A, being reduced by 15% of the amount of that excess first year premium, all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, the policy being assumed to mature on that date as an endowment, and the cash surrender value provided on that date being considered as an endowment benefit. In making this comparison, the mortality and interest bases stated in sections 953 and 953-A shall be used.

Reserves according to the commissioners reserve valuation method for:

A. Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; [1983, c. 346, §5 (NEW).]

B. Group annuity and pure endowment contracts, purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under the United States Internal Revenue Code, Section 408, as now or hereafter amended; [1983, c. 346, §5 (NEW).]

C. Disability and accidental death benefits in all policies and contracts; and [1983, c. 346, §5 (NEW).]

D. All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, [1983, c. 346, §5 (NEW).]

shall be calculated by a method consistent with the principles of the preceding provisions of this section, except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

[1983, c. 346, §5 (NEW) .]

2. **Annuity and pure endowment contracts.** This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under the United States Internal Revenue Code, Section 408, as now or hereafter amended.

Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability or accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using 20e mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

[1979, c. 453, §5 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 453, §5 (RPR). 1983, c. 346, §§4,5 (AMD).

§955. MINIMUM RESERVES

1. **Minimum aggregate reserves for life insurance policies.** An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, that are subject to section 953, subsection 2 may not be less than the aggregate reserves calculated in accordance with the method set forth in sections 954 and 957-A and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for these policies.

[1993, c. 634, Pt. B, §2 (NEW) .]

2. **Minimum aggregate reserves for all policies.** The aggregate reserves for all policies, contracts and benefits may not be less than the aggregate reserves determined necessary by the appointed actuary in the opinion required by section 952-A.

[2013, c. 238, Pt. C, §7 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 346, §6 (AMD). 1993, c. 634, Pt. B, §2 (RPR). 2013, c. 238, Pt. C, §7 (AMD).

§956. OPTIONAL RESERVE CALCULATION

1. **Reserve calculation.** Reserves for any category of policies, contracts or benefits as established by the superintendent that are subject to section 953, subsection 2, may be calculated at the option of the insurer according to any standards that produce greater aggregate reserves for that category than those calculated according to the minimum standard provided in section 955, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided.

[1993, c. 634, Pt. B, §3 (NEW) .]

2. **Lower standard of valuation.** Any insurer that adopts any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in section 955 may adopt, with the approval of the superintendent, any lower standards of valuation, but not lower than the minimum required, except that for the purposes of this section the holding of additional reserves previously determined necessary by the appointed actuary in the opinion required by section 952-A may not be determined to be the adoption of a higher standard of valuation.

[2013, c. 238, Pt. C, §8 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 453, §6 (AMD). 1993, c. 634, Pt. B, §3 (RPR). 2013, c. 238, Pt. C, §8 (AMD).

§957. DEFICIENCY RESERVE

If the gross premium charged by any life insurer on any policy or contract which is subject to section 953, subsection 2, is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for that policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest and method actually used for that policy or contract, or the reserve calculated by the method actually used for that policy or contract, but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by

the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in sections 953 and 953-A. [1983, c. 346, §7 (AMD).]

For any life insurance policy issued on or after January 1, 1987, for which the gross premium in the first policy year exceeds that of the 2nd year and for which no comparable additional benefit is provided in the first year for that excess and that provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than that excess premium, the foregoing provisions of this section must be applied as if the method actually used in calculating the reserve for that policy were the method described in section 954, ignoring the 2nd paragraph of section 954. The minimum reserve at each policy anniversary of such a policy is the greater of the minimum reserve calculated in accordance with section 954, including the 2nd paragraph of that section, and the minimum reserve calculated in accordance with this section. [2011, c. 420, Pt. A, §22 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 453, §7 (RPR). 1983, c. 346, §7 (AMD). 2011, c. 420, Pt. A, §22 (AMD).

§957-A. SUPERINTENDENT'S AUTHORITY TO APPROVE CERTAIN PLANS

1. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in sections 954 and 957, the reserves which are held under any plan of that type must:

A. Be appropriate in relation to the benefits and the pattern of premiums for that plan; and [1983, c. 346, §8 (NEW).]

B. Be computed by a method which is consistent with the principles of this Standard Valuation Law, [1983, c. 346, §8 (NEW).]

as determined by regulations promulgated by the superintendent.

[1983, c. 346, §8 (NEW) .]

SECTION HISTORY
1983, c. 346, §8 (NEW).

§958. INTEREST RATES

All changes in the interest rates specified in this subchapter and in sections 2528 to 2534, which were made by the Amendatory Acts of 1979, shall become ineffective as to contracts or policies issued on or after November 1, 1987, unless expressly extended by law. [1979, c. 453, §8 (NEW).]

SECTION HISTORY
1979, c. 453, §8 (NEW).

§958-A. INTEREST RATES EXTENDED

Notwithstanding section 958, the changes in the interest rates for life insurance specified in this subchapter and in sections 2528 to 2534, which were made by the Amendatory Acts of 1979, shall continue to apply to life insurance policies issued on or after January 1, 1980 and prior to the operative date of the Standard Nonforfeiture Law for Life Insurance, section 2532-A. [1983, c. 346, §9 (NEW).]

SECTION HISTORY
1983, c. 346, §9 (NEW).

§959. RESERVES SUBJECT TO VALUATION MANUAL

1. **General requirement.** On and after the operative date of the valuation manual, reserves on policies and contracts of subject lines of insurance must be valued as follows, except as otherwise specifically provided in this section or in rules adopted by the superintendent:

A. For policies and contracts issued on and after the operative date of the valuation manual, in accordance with the valuation manual; [2013, c. 238, Pt. C, §9 (NEW).]

B. For policies and contracts described in sections 953 to 958-A and issued before the operative date of the valuation manual, in accordance with those sections; and [2013, c. 238, Pt. C, §9 (NEW).]

C. For health insurance policies and contracts issued before the operative date of the valuation manual, and any other policies and contracts outside the scope of paragraphs A and B, in accordance with rules adopted by the superintendent. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

2. **Necessary provisions.** The valuation manual must specify all of the following:

A. Definitions of the policies and contracts subject to this section; [2013, c. 238, Pt. C, §9 (NEW).]

B. The following minimum valuation standards for all policies and contracts subject to this section:

(1) The commissioners reserve valuation method for life insurance contracts, other than annuity contracts;

(2) The commissioners annuity reserve valuation method for annuity contracts; and

(3) Minimum reserves for all other policies or contracts; [2013, c. 238, Pt. C, §9 (NEW).]

C. Provisions specifying which policies and contracts or types of policies and contracts are subject to section 960 and specifying the minimum valuation standards consistent with those provisions; [2013, c. 238, Pt. C, §9 (NEW).]

D. For policies and contracts subject to section 960:

(1) Requirements for the format of reports to the superintendent under section 960, subsection 3, paragraph C, which must include information necessary to determine whether the valuation is appropriate and in compliance with this subchapter;

(2) Assumptions to be prescribed for risks over which the insurer does not have significant control or influence; and

(3) Procedures for corporate governance and oversight of the actuarial function and a process for appropriate waiver or modification of such procedures; [2013, c. 238, Pt. C, §9 (NEW).]

E. For policies and contracts not subject to section 960, a minimum valuation standard that either:

(1) Is consistent with the minimum standard of valuation for policies and contracts issued before the operative date of the valuation manual; or

(2) Develops reserves that quantify the benefits and guarantees, and the funding, associated with the policies and contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring; [2013, c. 238, Pt. C, §9 (NEW).]

F. Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of insurer experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules and internal controls; and [2013, c. 238, Pt. C, §9 (NEW).]

G. The data and form of the data required under section 961. The requirements must specify to whom the data must be submitted and may specify other requirements, including requirements with respect to data analyses and reporting of analyses. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

3. **Supplementation and resolution of conflicts.** In the absence of a specific valuation requirement or if the superintendent determines that a specific valuation requirement in the valuation manual is not consistent with the requirements or purposes of this subchapter, an insurer shall comply with minimum valuation standards prescribed by the superintendent by rule or order.

[2013, c. 238, Pt. C, §9 (NEW) .]

4. **Examination.** For an insurer subject to this section, the superintendent may hire, contract with or otherwise engage a qualified actuary, at the insurer's expense, to perform an actuarial examination of the insurer and provide an opinion on the appropriateness of any reserve assumption or method used by the insurer or to review and provide an opinion on the insurer's compliance with any requirement of this subchapter. The superintendent may rely on any actuarial opinion issued on behalf of another insurance regulator in the United States that is relevant to an insurer's compliance with this subchapter.

[2013, c. 238, Pt. C, §9 (NEW) .]

5. **Corrections.** The superintendent may require an insurer to change any assumption or method as determined necessary by the superintendent to comply with the requirements of the valuation manual or this subchapter, and the insurer shall adjust the reserves as required by the superintendent.

[2013, c. 238, Pt. C, §9 (NEW) .]

6. **Violations.** Violations of this subchapter are subject to all remedies specified in section 12-A or otherwise available by law.

[2013, c. 238, Pt. C, §9 (NEW) .]

7. **Changes to valuation manual.** Unless a later effective date is specified or the superintendent has disapproved the change by rule, a change to the valuation manual is effective on January 1st following the adoption of the change by an affirmative vote of the NAIC representing:

A. At least 3/4 of the NAIC members voting; [2013, c. 238, Pt. C, §9 (NEW).]

B. At least a majority of the total NAIC membership; and [2013, c. 238, Pt. C, §9 (NEW).]

C. Jurisdictions totaling greater than 75% of the aggregate written direct premiums reported in the most recently available life, accident and health annual statements; health annual statements; and fraternal annual statements. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

SECTION HISTORY
2013, c. 238, Pt. C, §9 (NEW).

§960. REQUIREMENTS FOR PRINCIPLE-BASED RESERVES

1. **Scope.** This section applies to all policies and contracts for which principle-based reserving is required by the valuation manual, unless exempted by the superintendent in accordance with the following standards:

A. An exemption under this subsection may not be granted unless the insurer is licensed and doing business exclusively in this State; [2013, c. 238, Pt. C, §9 (NEW).]

B. The exemption must be in writing; [2013, c. 238, Pt. C, §9 (NEW).]

C. The superintendent may rescind or modify the exemption in writing at any time, with reasonable notice to the insurer; [2013, c. 238, Pt. C, §9 (NEW).]

D. The exemption may apply to all business written by the insurer or to specific policy or contract forms or product lines; and [2013, c. 238, Pt. C, §9 (NEW).]

E. An insurer granted an exemption under this subsection shall value its reserves using the assumptions and methods used before the operative date of the valuation manual, in addition to any requirements established by the superintendent by rule or by the terms of the order granting the exemption. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

2. **Standards.** An insurer shall establish reserves for policies and contracts subject to this section using a valuation methodology that meets all applicable requirements of the valuation manual and that:

A. Quantifies the benefits and guarantees, and the funding, associated with the policies and contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the policies and contracts. For polices and contracts with significant tail risk, the methodology must reflect conditions appropriately adverse to quantify the tail risk; [2013, c. 238, Pt. C, §9 (NEW).]

B. Incorporates assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those used within the insurer's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods; [2013, c. 238, Pt. C, §9 (NEW).]

C. Incorporates assumptions that are derived in one of the following manners:

(1) The assumption is prescribed in the valuation manual; or

(2) For assumptions that are not prescribed in the valuation manual, the assumptions are:

(a) Established using the insurer's available experience, to the extent that it is relevant and statistically credible; or

(b) To the extent that insurer-specific data is not available, relevant or statistically credible, established using other relevant, statistically credible experience; and [2013, c. 238, Pt. C, §9 (NEW).]

D. Provides margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

3. **Oversight and controls.** An insurer using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

A. Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual; [2013, c. 238, Pt. C, §9 (NEW).]

B. Provide to the superintendent and the insurer's board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls must be designed to ensure that all material risks inherent in the liabilities and associated assets subject to principle-based valuation are included in the valuation and that valuations are made in accordance with the valuation manual. The certification must be based on the controls in place as of the end of the preceding calendar year; and [2013, c. 238, Pt. C, §9 (NEW).]

C. Develop, and file with the superintendent upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

4. **Formulaic components.** A principle-based valuation may include a formulaic reserve component and must do so when prescribed by the valuation manual or required by the superintendent.

[2013, c. 238, Pt. C, §9 (NEW) .]

5. **Applicability of rules.** Rules adopted by the superintendent pursuant to this subchapter before January 1, 2014 do not apply to policies, contracts or actuarial opinions issued on or after the operative date of the valuation manual unless expressly made applicable by rule or order of the superintendent.

[2013, c. 238, Pt. C, §9 (NEW) .]

SECTION HISTORY
2013, c. 238, Pt. C, §9 (NEW).

§961. EXPERIENCE REPORTING

For all policies and contracts in force on or after the operative date of the valuation manual, an insurer shall submit mortality, morbidity, policyholder behavior and expense experience data, as applicable, and other data as prescribed in the valuation manual. [2013, c. 238, Pt. C, §9 (NEW).]

SECTION HISTORY
2013, c. 238, Pt. C, §9 (NEW).

§962. CONFIDENTIALITY

1. **Information subject to this section.** For purposes of this section, "protected valuation information" means:

A. A memorandum in support of an opinion submitted under section 952-A and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the superintendent or any other person in connection with the memorandum; [2013, c. 238, Pt. C, §9 (NEW).]

B. All documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the superintendent or any other person in the course of an examination made under section 959, subsection 4 that would be confidential under section 225, subsection 3 if they had been prepared or obtained under section 221; [2013, c. 238, Pt. C, §9 (NEW).]

C. Any reports, documents, materials and other information developed by an insurer in support of, or in connection with, an annual certification of internal controls under section 960, subsection 3, paragraph B and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the superintendent or any other person in connection with such reports, documents, materials and other information; [2013, c. 238, Pt. C, §9 (NEW).]

D. Any principle-based valuation report developed under section 960, subsection 3, paragraph C and any other documents, materials and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the superintendent or any other person in connection with such a report; [2013, c. 238, Pt. C, §9 (NEW).]

E. Any documents, materials, data and other information submitted by an insurer under section 961, referred to in this paragraph as "experience data," and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data that include any potentially insurer-identifying or personally identifiable information and that are provided to or obtained by the superintendent or any other person and any other documents, materials, data and other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the superintendent or any other person in connection with such experience data and materials; and [2013, c. 238, Pt. C, §9 (NEW).]

F. Any information received by the superintendent from the Actuarial Board for Counseling and Discipline or its successor related to a memorandum or report described in paragraph A or D, if the information has been provided with notice or the understanding that it is confidential or privileged under applicable law. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

2. **Confidentiality of information subject to this section.** Except as provided in this subsection, all protected valuation information is confidential, must be kept confidential by the superintendent, is not a public record and is not subject to subpoena or discovery or admissible in evidence in any private civil action. The superintendent may use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the superintendent's official duties, including sharing the information on a confidential basis under section 216, subsection 5.

A. Neither the superintendent nor any person who receives documents, materials or other information while acting under the authority of the superintendent is permitted or required to testify in any private civil action concerning any protected valuation information. [2013, c. 238, Pt. C, §9 (NEW).]

B. Disclosure to the superintendent under this section or as a result of sharing of documents, materials or other information pursuant to section 216 does not constitute a waiver of any applicable privilege or claim of confidentiality with regard to the documents, materials or other information. [2013, c. 238, Pt. C, §9 (NEW).]

C. The superintendent may share protected valuation information described in subsection 1, paragraphs A and D with the Actuarial Board for Counseling and Discipline or its successor upon a request stating that the information is required for the purpose of professional disciplinary proceedings and that the disciplinary entity agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of the information in the same manner and to the same extent as required for the superintendent. The superintendent may request and receive confidential information described in subsection 1, paragraph F from the Actuarial Board for Counseling and Discipline or its successor. The superintendent may enter into information-sharing agreements to facilitate the exchange of information under this paragraph. [2013, c. 238, Pt. C, §9 (NEW).]

D. For protected valuation information described in subsection 1, paragraphs A and D, the confidentiality provided by this subsection may be limited or terminated as follows:

(1) The information may be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the actuarial memorandum or principle-based valuation report;

(2) The information may be released with the written consent of the insurer; and

(3) If any portion of an actuarial memorandum or principle-based valuation report is cited by the insurer in its marketing or is publicly volunteered by the insurer before a governmental agency other than a state insurance agency or is released by the insurer to the news media, all portions of the memorandum or report become public records. [2013, c. 238, Pt. C, §9 (NEW).]

[2013, c. 238, Pt. C, §9 (NEW) .]

SECTION HISTORY
2013, c. 238, Pt. C, §9 (NEW).

Subchapter 4: VALUATION OF ASSETS HEADING: PL 2001, C. 72, §10 (RP)

§981. VALUATION OF BONDS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §22 (AMD). 1993, c. 313, §19 (AMD). 2001, c. 72, §10 (RP).

§982. VALUATION OF OTHER SECURITIES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 622, §§78-A (AMD). 1973, c. 585, §12 (AMD). 1977, c. 432, §2 (AMD). 1993, c. 313, §20 (AMD). 2001, c. 72, §10 (RP).

§983. VALUATION OF PROPERTY

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2001, c. 72, §10 (RP).

§984. VALUATION OF PURCHASE MONEY MORTGAGES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 72, §10 (RP).

Subchapter 5: PROPERTY AND CASUALTY ACTUARIAL OPINION

§991. SHORT TITLE

This Act may be known and cited as "the Property and Casualty Actuarial Opinion Act." [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

SECTION HISTORY
2007, c. 281, §2 (NEW). 2007, c. 281, §3 (AFF).

§992. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

1. **Covered kinds of insurance.** "Covered kinds of insurance" means property insurance as defined in section 705 and casualty insurance as defined in section 707 and does not include health insurance as defined in section 704, unless required by the applicable NAIC annual statement instructions to be included in the property and casualty actuarial opinion of a casualty insurer or multiple lines insurer, or property insurance written by domestic mutual assessment insurers pursuant to chapter 51.

A. [2013, c. 238, Pt. C, §10 (RP).]

B. [2013, c. 238, Pt. C, §10 (RP).]

[2013, c. 238, Pt. C, §10 (RPR) .]

2. **NAIC.** "NAIC" means the National Association of Insurance Commissioners.

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

3. **Qualified actuary.** "Qualified actuary" means a person who is a member of the American Academy of Actuaries who has obtained a designation either as a fellow or an associate in the Casualty Actuarial Society and, if an associate, has at least 5 years' experience in actuarial practice obtained in the covered kinds of insurance.

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

SECTION HISTORY
2007, c. 281, §2 (NEW). 2007, c. 281, §3 (AFF). 2013, c. 238, Pt. C, §10 (AMD).

§993. ACTUARIAL OPINION OF RESERVES AND SUPPORTING DOCUMENTATION

1. **Statement of actuarial opinion.** Every property and casualty insurance company doing business for covered kinds of insurance in this State, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed qualified actuary entitled “Statement of Actuarial Opinion.” This opinion must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions.

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

2. **Actuarial opinion summary.** An actuarial opinion summary is required pursuant to this subsection.

A. Every property and casualty insurance company domiciled in this State that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary, written by the company’s appointed qualified actuary. This actuarial opinion summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions and must be considered as a document supporting the actuarial opinion required in subsection 1. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

B. A property and casualty insurance company licensed but not domiciled in this State shall provide an actuarial opinion summary upon request of the superintendent. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

3. **Actuarial report and work papers.** An actuarial report is required pursuant to this subsection.

A. An actuarial report and underlying work papers as required by the appropriate NAIC property and casualty annual statement instructions must be prepared to support each actuarial opinion. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

B. If a property and casualty insurance company fails to provide a supporting actuarial report or work papers at the request of the superintendent or the superintendent determines that the supporting actuarial report or work papers provided by the company are otherwise unacceptable to the superintendent, the superintendent may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or work papers. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

4. **Liability.** The appointed qualified actuary is not liable for damages to any person, other than the property and casualty insurance company and the superintendent, for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud, willful misconduct or reckless disregard on the part of the actuary.

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

SECTION HISTORY
2007, c. 281, §2 (NEW). 2007, c. 281, §3 (AFF).

§994. CONFIDENTIALITY

1. **Statement of actuarial opinion.** The statement of actuarial opinion under section 993, subsection 1 must be provided with the annual statement under section 423 in accordance with the appropriate NAIC property and casualty annual statement instructions and is a public record subject to disclosure pursuant to Title 1, chapter 13.

[2009, c. 511, Pt. B, §2 (AMD) .]

2. **Documents in possession of bureau.** The confidentiality of documents in the possession of the bureau is governed by this subsection.

A. Documents, materials or other information in the possession or control of the bureau that are considered an actuarial report, work papers or actuarial opinion summary provided in support of the opinion, as described in section 993, and any other material provided by the property and casualty insurance company to the superintendent in connection with the actuarial report, work papers or actuarial opinion summary are confidential and not subject to disclosure pursuant to Title 1, chapter 13. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

B. This subsection may not be construed to limit the superintendent’s authority to release documents to the Actuarial Board for Counseling and Discipline or successor organization as long as the material is required for the purpose of professional disciplinary proceedings and the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the superintendent for preserving the confidentiality of the documents. This section may not be construed to limit the superintendent’s authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the superintendent’s official duties. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

3. **Testimony.** Neither the superintendent nor any person who received documents, materials or other information while acting under the authority of the superintendent is permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection 2.

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

4. **Sharing of documents.** In order to assist in the performance of the superintendent's duties, the superintendent may:

A. Share documents, materials or other information, including confidential and privileged documents, materials or information subject to subsection 2, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries and with state, federal and international law enforcement authorities, as long as the recipient agrees to maintain the confidentiality of the document, material or other information and has the legal authority to maintain confidentiality; [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

B. Receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions. The superintendent shall maintain as confidential any document, material or information received with notice or the understanding that it is confidential under the laws of the jurisdiction that is the source of the document, material or information; and [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

C. Enter into agreements governing sharing and use of information consistent with this subsection and subsections 2 and 3. [2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF).]

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

5. **Waiver.** No waiver of a claim of confidentiality in the documents, materials or information may occur as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in subsection 4.

[2007, c. 281, §2 (NEW); 2007, c. 281, §3 (AFF) .]

SECTION HISTORY
2007, c. 281, §2 (NEW). 2007, c. 281, §3 (AFF). 2009, c. 511, Pt. B, §2 (AMD).

Chapter 13: INVESTMENTS

§1101. SCOPE OF CHAPTER

1. Subject to subsection 2 and section 1137, this chapter applies to all insurers except life or health insurers that transact business of a type described in section 409, subsection 3.

[1991, c. 385, §9 (NEW) .]

2. Each domestic all lines insurer, as defined in section 409, subsection 2, shall, for accounting and financing purposes, establish and maintain distinct accounts dedicated exclusively to the insurance it transacts under its life or health insurance authority and to the remainder of its business. Each account must include reserves and surplus funds adequate to financially support the underwriting activity. All assets allocated to life accounts and health accounts are subject to chapter 13-A rather than this chapter. The books and records of any insurer writing more than one kind of business must reflect the assets and operations relating to each underwriting activity in detail sufficient to demonstrate compliance with this chapter and chapter 13-A.

[1991, c. 385, §9 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §3 (AMD). 1989, c. 846, §§B1,E4 (AMD). 1991, c. 385, §9 (RPR).

§1102. ELIGIBLE INVESTMENTS

1. Insurers shall hereafter invest in or lend their funds on the security of and shall hold as eligible investments only those as prescribed in this chapter.

[1969, c. 177, §17 (AMD) .]

2. Any particular investment held by an insurer on January 1, 1970, which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to such effective date, shall be deemed to be an eligible investment.

[1973, c. 625, §137 (AMD) .]

3. Eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in subsection 2, or in section 1131, subsection 2, or section 1134.

[1979, c. 458, §1 (AMD) .]

4. Any investment limitation or diversification requirement based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of the December 31st next preceding the date of acquisition of the investment by the insurer or as shown by a current applicable financial statement, prepared on the same basis as that annual statement, resulting from merger with another insurer, bulk reinsurance or change in capitalization.

[1987, c. 399, §4 (AMD) .]

5. Nothing in this chapter shall be deemed to prohibit an insurer from advancing funds to another insurer upon the type of agreement provided for in section 3415 (borrowed capital funds), and subject to the terms of such section 3415.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §17 (AMD). 1973, c. 625, §137 (AMD). 1979, c. 458, §1 (AMD). 1987, c. 399, §4 (AMD).

§1103. GENERAL QUALIFICATIONS

1. No security or investment, other than real and personal property acquired under section 1125 (real estate), shall be eligible for acquisition unless it is interest bearing or interest accruing or entitled to dividends, if declared, or is otherwise income-entitled, is not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing thereon.

Notwithstanding this subsection, nothing in this chapter may be deemed to prohibit an insurer from effecting or maintaining bona fide hedging transactions in foreign currency in connection with the purchase and sale of securities eligible for investment under this chapter or in contracts for future delivery of options, calls and other rights to purchase and puts and other rights to require another person to purchase, securities eligible for investment under this chapter, provided that those contracts, options, calls, puts and rights are traded on a national securities exchange or board of trade regulated under the laws of the United States and provided that the aggregate amount of those investments, as valued for all purposes in accordance with generally accepted accounting principles, shall not exceed 1% of the insurer's assets. For purposes of this subsection, a "bona fide hedging transaction" means a purchase or sale of foreign currency or of a contract, option, call, put or right, as the case may be, entered into for the purchase of offsetting changes in foreign currency exchange rates or in the market value of a security held or proposed to be acquired by the insurer.

[1983, c. 442, §1 (AMD) .]

2. No provision of this chapter shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets, or upon a debt or judgment, or under a lawful and bona fide agreement of bulk reinsurance, merger or consolidation. Any security or property so acquired which is not otherwise an eligible investment under this chapter shall be disposed of pursuant to section 1133 if real estate, or pursuant to section 1134 if personal property or securities.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 442, §1 (AMD).

§1104. AUTHORIZATION, RECORD OF INVESTMENTS

1. An insurer shall not make any investment or loan unless the same is authorized or approved by the insurer's board of directors or by a committee thereof charged with supervision of investments and loans.

[1987, c. 399, §5 (AMD) .]

2. The insurer shall maintain a full record of each investment, showing, among other pertinent information, the name of any officer, director or principal stockholder of the insurer having any direct, indirect or contingent interest in the securities, loan or property constituting the investment, or in the person in whose behalf the investment is made, and the nature of such interest.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §5 (AMD).

§1105. DIVERSIFICATION -- LIFE, LIFE/HEALTH INSURERS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§18-20 (AMD). 1983, c. 442, §§2,3 (AMD). 1987, c. 399, §6 (RP).

§1106. DIVERSIFICATION; PROPERTY, CASUALTY AND OTHER NONLIFE INSURERS

The investments of an insurer are subject to the following diversification requirements and limitations. [1993, c. 313, §21 (AMD).]

1. Not less than 30% of the insurer's assets in aggregate amount may consist of cash funds, agents' balances less than 90 days past due and investments eligible under the following sections:

A. 1107 (public obligations); [1969, c. 132, §1 (NEW).]

B. 1108 (obligations, stock of certain federal and international agencies); [1969, c. 132, §1 (NEW).]

C. 1109 (investment grade corporate obligations); [1989, c. 846, Pt. B, §3 (AMD); 1989, c. 846, Pt. E, §4 (AFF).]

D. 1112 (preferred or guaranteed stocks); [1969, c. 132, §1 (NEW).]

E. 1116 (trustees' or receivers' obligations); [1969, c. 132, §1 (NEW).]

F. 1117 (equipment trust certificates); [1969, c. 132, §1 (NEW).]

G. 1118 (acceptances, bills of exchange); [1969, c. 132, §1 (NEW).]

H. 1119 (savings and loan institutions); [1969, c. 177, §21 (AMD).]

I. 1120 (common trust funds, mutual funds); [1969, c. 132, §1 (NEW).]

J. 1124 (mortgage loans); and [1969, c. 132, §1 (NEW).]

K. 1126 (housing developments). [1969, c. 132, §1 (NEW).]

[1993, c. 313, §21 (AMD) .]

2. The insurer may not invest in aggregate amount in excess of its surplus as to policyholders in all investments eligible under the following sections:

A. 1113 (common stocks); [1969, c. 132, §1 (NEW).]

B. 1114 (insurance stocks); [1969, c. 132, §1 (NEW).]

C. 1115 (stocks of subsidiaries); and [1993, c. 313, §21 (AMD).]

D. 1120, subsection 2 (mutual funds). [1993, c. 313, §21 (AMD).]

E. [1993, c. 313, §21 (RP).]

[1993, c. 313, §21 (AMD) .]

3. The insurer may not invest in aggregate amount over 20% of its assets in all investments in real estate eligible under sections 1125 (real estate) and 1127 (leased property).

[1993, c. 313, §21 (AMD) .]

4. Except as otherwise expressly provided, an insurer may not invest more than 10% of its assets in the securities of any one person, other than investments eligible under the following sections:

A. 1107 (public obligations); [2001, c. 524, §2 (AMD).]

B. 1108 (obligations, stock of certain federal and international agencies); and [2001, c. 524, §2 (AMD).]

C. 1120 (common trust funds, mutual funds), but as to this exception, only with the prior approval of the superintendent and only in index mutual funds in an amount up to 20% of the insurer's assets. [2001, c. 524, §2 (NEW).]

[2001, c. 524, §2 (AMD) .]

5. The insurer's investments in common stock, preferred stock, debt obligations and other securities of subsidiaries other than insurance subsidiaries are limited to the lesser of 10% of the insurer's admitted assets or 50% of the insurer's surplus as to policyholders except in instances when a greater investment has been approved by the superintendent.

[1993, c. 313, §21 (NEW) .]

6. The assets of an insurer may be invested in obligations issued, assumed, guaranteed or accepted by domestic institutions, or trustees or receivers of those institutions and preferred shares of any of those institutions, except that, without the prior approval of the superintendent, a domestic insurer may not acquire any high-yield or medium grade obligations of any institution if:

A. The aggregate amount of all medium grade obligations and all high-yield obligations then held by the insurer exceeds the lesser of 20% of its admitted assets or its surplus as to policyholders; [1993, c. 313, §21 (NEW).]

B. The aggregate amount of all high-yield obligations then held by the insurer exceeds 10% of its admitted assets; [1993, c. 313, §21 (NEW).]

C. The aggregate amount of all high-yield obligations rated 5 or 6 by the Securities Valuation Office of the National Association of Insurance Commissioners or, if not rated by the National Association of Insurance Commissioners, rated at the equivalent of 5 or 6 by Moody's Investors Service, Inc., Standard and Poor's Corporation, Fitch Investors Service, Inc. or Duff and Phelps, Inc. exceeds 3% of admitted assets; [1993, c. 313, §21 (NEW).]

D. The aggregate amount of all high-yield obligations rated 6 by the Securities Valuation Office of the National Association of Insurance Commissioners or, if not rated by the National Association of Insurance Commissioners, rated the equivalent of 6 by Moody's Investors Service, Inc., Standard and Poor's Corporation, Fitch Investors Service, Inc. or Duff and Phelps, Inc., exceeds 1% of admitted assets; [1993, c. 313, §21 (NEW).]

E. The aggregate amount of medium grade obligations issued, guaranteed or insured by any one institution then held by the insurer exceeds 1% of its admitted assets; or [1993, c. 680, Pt. C, §3 (AMD).]

F. The aggregate amount of high-yield obligations issued, guaranteed, or insured by any one institution then held by the insurer would exceed 1/2 of 1% of its admitted assets. [1993, c. 313, §21 (NEW).]

[1993, c. 680, Pt. C, §3 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§21-23 (AMD). 1989, c. 846, §§B2-5,E4 (AMD). 1993, c. 313, §21 (AMD). 1993, c. 680, §C3 (AMD). 2001, c. 524, §2 (AMD).

§1107. PUBLIC OBLIGATIONS

An insurer may invest in bonds or other evidences of indebtedness, not in default as to principal or interest, which are valid and legally authorized obligations issued, assumed or guaranteed by the United States or by any state thereof, or by Canada or any of the provinces thereof, or by any county, city, town, village, municipality or district therein or by any political subdivision thereof or by a public instrumentality of one or more of the foregoing, if, by statutory or other legal requirements applicable thereto, such obligations are payable, as to both principal and interest, from: [1969, c. 132, §1 (NEW).]

1. Taxes levied or by law required to be levied upon all taxable property or all taxable income within the jurisdiction of such governmental unit, or from

[1969, c. 132, §1 (NEW) .]

2. Adequate special revenues pledged or otherwise appropriated or by law required to be provided for the purpose of such payment; but not including any obligation payable solely out of special assessments on properties benefited by local improvements unless adequate security is evidenced by the ratio of assessment to the value of the property or the obligation is additionally secured by an adequate guaranty fund required by law.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1108. OBLIGATIONS, STOCK OF CERTAIN FEDERAL AND INTERNATIONAL AGENCIES

An insurer may invest in the obligations, or stock where stated, issued, assumed or guaranteed by the following agencies of the government of the United States of America, or in which such government is a participant, whether or not such obligations are guaranteed by such government: [1969, c. 132, §1 (NEW).]

1. Farm Loan Bank.

[1969, c. 132, §1 (NEW) .]

2. Commodity Credit Corporation.

[1969, c. 132, §1 (NEW) .]

3. Federal Intermediate Credit Banks.

[1969, c. 132, §1 (NEW) .]

4. Federal Land Banks.

[1969, c. 132, §1 (NEW) .]

5. Central Bank for Cooperatives.

[1969, c. 132, §1 (NEW) .]

6. Federal Home Loan Banks, and stock thereof.

[1969, c. 132, §1 (NEW) .]

7. Federal National Mortgage Association, and stock thereof when acquired in connection with sale of mortgage loans to such association.

[1969, c. 132, §1 (NEW) .]

8. International Bank for Reconstruction and Development.

[1969, c. 132, §1 (NEW) .]

9. Inter-American Development Bank.

[1969, c. 132, §1 (NEW) .]

10. Asian Development Bank.

[1969, c. 132, §1 (NEW) .]

10-A. African Development Bank; and

[1987, c. 405, §36 (NEW) .]

11. Any other similar agency of, or participated in by, the government of the United States of America and of similar financial quality.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 405, §36 (AMD).

§1109. INVESTMENT GRADE OBLIGATIONS

An insurer may invest in obligations, other than those eligible for investment under section 1124 (mortgage loans), issued, assumed or guaranteed by any solvent institution created or existing under the laws of the United States or of Canada, or of any state, province, district or territory thereof, provided that the obligations are not in default as to principal or interest, are investment grade obligations as defined in section 1110, subsection 1-A, paragraph I, and are qualified under any of the following. [1999, c. 715, §2 (AMD).]

1. Obligations secured by adequate collateral security and bearing fixed interest and if during each of any 3, including either of the last 2, fiscal years of a period of not less than 3 nor more than 5 fiscal years next preceding the date of acquisition by the insurer, the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges, as defined in section 1110, shall have been not less than 1 1/4 times the total of its fixed charges for such year, or obligations which, at the date of acquisition by the insurer, are

adequately secured and have investment qualities and characteristics wherein the speculative elements are not predominant. In determining the adequacy of collateral security, not more than 1/3 of the total value of such required collateral shall consist of stock other than stock meeting the requirements of section 1112 (preferred or guaranteed stock).

[1969, c. 132, §1 (NEW) .]

2. Obligations secured by one or more leases, whether or not additionally secured by one or more mortgages, provided the following conditions are met:

A. The leases are assigned to the insurer or to a trustee acting on behalf of the insurer and are noncancellable by either party, except under provisions specified in the leases and designed to give adequate protection to the insurer's investment. [1979, c. 458, §2 (AMD).]

B. The aggregate rentals due under all such leases are sufficient to provide

(1) For all expenses (including taxes other than the borrower's income tax) of operation of the leased property during the initial term of such leases and

(2) For amortization during the initial term of such leases of not less than 90% of the investment (or 100% thereof if the investment is not also secured by a mortgage) with interest thereon. [1969, c. 132, §1 (NEW).]

C. The leases make suitable provisions for continuation of adequate payments throughout the life of the investment. [1969, c. 132, §1 (NEW).]

D. The lessees under such leases, or any corporation or instrumentality of government which has assumed or guaranteed the lessees' performance thereunder is such that its obligations would be eligible for investment by an insurer in accordance with section 1107 or the aggregate net earnings of such lessees available for fixed charges, as defined in section 1110, is at least equal to that required by subsection 1. [2009, c. 2, §66 (COR).]

[2009, c. 2, §66 (COR) .]

3. Fixed interest bearing obligations, other than those described in subsection 1, if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than 1 1/2 times its annual fixed charges applicable to such period and if during either of the last 2 years of such period such net earnings have been not less than 1 1/2 times its fixed charges for such year.

[1969, c. 132, §1 (NEW) .]

4. Adjustment, income or other contingent interest obligations if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than 1 1/2 times the sum of its average annual fixed charges and its average annual maximum contingent interest applicable to such period and if during either of the last 2 years of such period such net earnings have been not less than 1 1/2 times the sum of its fixed charges and maximum contingent interest for such year.

[1969, c. 132, §1 (NEW) .]

5. Fixed interest bearing obligations, other than those described in subsections 1 and 3, if:

A. Net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer have averaged per year not less than 1 1/4 times its average annual fixed charges applicable to such period and if during each of any 4 fiscal years of such period such net earnings have been not less than 1 1/4 times its fixed charges for such year; [1969, c. 132, §1 (NEW).]

B. The net earnings of such institution available for its fixed charges during a period of not less than 7 nor more than 10 fiscal years next preceding the date of acquisition by the insurer have been such that for each of any 7 fiscal years of such period such net earnings have been not less than 1 1/4 times its fixed charges for such year; and [1969, c. 132, §1 (NEW).]

C. The liquid assets of such institution have been not less than 105% of its liabilities, other than capital stock and surplus. For the purposes of this subsection, "liquid assets" and "liabilities" shall be determined in reliance upon the latest regular financial statement of the issuing, assuming or guaranteeing institution prepared as of a date not more than 15 months prior to the date of acquisition by the insurer; if net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions, "liquid assets" and "liabilities" shall be determined in reliance upon a consolidated financial statement of parent and subsidiary institutions after treating any minority stock interest in such subsidiary institutions as a liability; and the term "liquid assets" shall mean the sum of cash, receivables or portions thereof, as the case may be, payable on demand or not more than 10 years after the date as of which the determination thereof is made for the purposes of this subsection, and readily marketable securities, in each case less applicable reserves and unearned income. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

6. Fixed interest bearing obligations of financial companies, other than those eligible under subsections 1, 3 and 5, if either:

A.

(1) Net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges during each of the 5 fiscal years next preceding the date of acquisition by that insurer shall not have been less than 1 1/4 times its fixed charges for that year; and

(2) The liquid assets of that institution as of the end of the fiscal year covered in the latest regular financial statement of that institution prepared as of a date not more than 15 months prior to the date of acquisition by that insurer and as of the end of each of the 4 fiscal years next preceding that fiscal year shall have not been less than 95% of its liabilities, other than deferred income taxes, deferred investment tax credits, capital stock and surplus; or [1979, c. 458, §3 (NEW).]

B.

(1) Net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges during each of the 5 fiscal years next preceding the date of acquisition by that insurer shall have been not less than 1.15 times its fixed charges for that year; and

(2) The liquid assets of that institution as of the end of the fiscal year covered in the latest regular financial statement of that institution prepared as of a date not more than 15 months prior to the date of acquisition by that insurer and as of the end of each of the 4 fiscal years next preceding that fiscal year shall have been not less than 105% of its liabilities, other than deferred income taxes, deferred investment tax credits, capital stock and surplus. [1979, c. 458, §3 (NEW).]

A "financial company" is one having an average of at least 50% of its net income, including income derived from subsidiaries, over its last 5 fiscal years next preceding the date of acquisition by that insurer derived from the business of wholesale, retail, installment, mortgage, commercial, industrial or consumer financing, or from banking or factoring or similar or related lines of business.

For purposes of paragraph A, subparagraph (2) and paragraph B, subparagraph (2), if net earnings are determined in reliance upon consolidated financial statements of parent and subsidiary institutions, "liquid assets" and "liabilities" shall be determined in reliance upon a consolidated financial statement of parent and subsidiary institution after treating any minority stock interest in that subsidiary institution as a liability;

and the term "liquid assets" shall mean the sum of cash, receivables or portions thereof, as the case may be, payable on demand or not more than 12 years following the close of the applicable fiscal year, and readily marketable securities, in each case less applicable reserves and unearned income.

[1979, c. 458, §3 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 458, §§2,3 (AMD). 1989, c. 846, §§B6,E4 (AMD). 1993, c. 313, §22 (AMD). 1999, c. 715, §2 (AMD).
RR 2009, c. 2, §66 (COR).

§1109-A. HIGH-YIELD CORPORATE OBLIGATIONS

(REPEALED)

SECTION HISTORY
1989, c. 846, §§B7,E4 (NEW). 1993, c. 313, §23 (RP).

§1110. -- CERTAIN TERMS DEFINED; NET EARNINGS

1.

[1999, c. 715, §3 (RP) .]

1-A. **Definitions.** As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

A. "Admitted assets" means assets recognized by the superintendent pursuant to section 901-A. [2001, c. 72, §11 (AMD).]

B. "Aggregate amount of investments" means the aggregate value of those investments as determined in accordance with statutory accounting principles pursuant to section 901-A and any rules adopted under that section. [2001, c. 72, §11 (AMD).]

C. "Asset value" is that value that may be contained in the annual statement of the corporation filed pursuant to section 423. [1999, c. 715, §4 (NEW).]

D. "Bona fide hedging transaction" means a purchase or sale of foreign currency or of a contract, option, call, put or right entered into for the purpose of offsetting changes in foreign currency exchange rates, in the market value of investments held or proposed to be acquired by the insurer or in the market value of liabilities that the insurer has or expects to incur, pursuant to a duly adopted resolution of the insurer's board of directors and written operations procedure submitted to the superintendent before making any such purchases and sales, as long as:

(1) There is a high correlation between changes in the market value of those hedging purchases and sales and the market value of the assets and liabilities to be hedged; and

(2) Books and records regarding all such purchases and sales are maintained by the insurer in accordance with generally accepted accounting principles.

The superintendent may adopt further rules regarding the form and content of resolutions, operation procedures, books and accounts and further accounting treatment and valuation methods necessary to ensure compliance with this definition. [1999, c. 715, §4 (NEW).]

E. "Domestic institution" means an institution created or existing under the laws of the United States or any state, district or territory. [1999, c. 715, §4 (NEW).]

F. "Fixed charges" includes interest on funded and unfunded debt and amortization of debt discount, but in the case of a bank or trust company, interest paid by that institution upon any deposit or any certificate or other evidence of a deposit may not be deemed a fixed charge of such an institution. [1999, c. 715, §4 (NEW).]

G. "High-yield obligations" means obligations that are neither investment grade nor medium grade obligations. [1999, c. 715, §4 (NEW).]

H. "Institution" means a corporation, a joint-stock association, a business trust, a business partnership, a business joint venture or any other similar entity. [1999, c. 715, §4 (NEW).]

I. "Investment grade obligation" means an obligation that at the time of acquisition by the insurer is rated "1" or "2" by the Securities Valuation Office of the National Association of Insurance Commissioners. If not valued by the Securities Valuation Office of the National Association of Insurance Commissioners, "investment grade obligation" means an obligation that at the time of acquisition by the insurer is rated the equivalent of "1" or "2" by one of the following nationally recognized independent rating agencies: Moody's Investors Service, Inc., Standard and Poor's Division of The McGraw-Hill Companies, Inc., Fitch Investors Service, Inc., or Duff and Phelps Credit Rating Company. [1999, c. 715, §4 (NEW).]

J. "Medium grade obligation" means an obligation that at the time of acquisition by the insurer is rated by the Securities Valuation Office of the National Association of Insurance Commissioners as "Class 3" quality. If not valued by the Securities Valuation Office of the National Association of Insurance Commissioners, "medium grade obligation" means an obligation that at the time of acquisition by the insurer is rated the equivalent of "3" by Moody's Investors Service, Inc., Standard and Poor's Division of The McGraw-Hill Companies, Inc., Fitch Investors Service, Inc., or Duff and Phelps Credit Rating Company. [1999, c. 715, §4 (NEW).]

K. "Net earnings available for fixed charges" means net income after deducting operating and maintenance expenses, taxes other than federal, state and other income taxes, depreciation and depletion, but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of the issuing, assuming or guaranteeing institutions. [1999, c. 715, §4 (NEW).]

L. "Not acquired by the insurer from an issuer, underwriter or dealer" means acquired by the insurer in an exempt transaction described in the United States Securities Act of 1933, Section 4(1) or Section 4(3), 15 United States Code, Section 77d(1) or Section 77d(3), as from time to time amended. [1999, c. 715, §4 (NEW).]

M. "Obligations" includes bonds, debentures, notes or other evidences of indebtedness. [1999, c. 715, §4 (NEW).]

N. "Qualified broker or dealer" means a broker or dealer that is organized under the laws of a state, is registered under the United States Securities Exchange Act of 1934, 15 United States Code, Sections 78a to 78kk and has net capital in excess of $250,000,000. [1999, c. 715, §4 (NEW).]

O. "Qualified financial institution" means a bank or a trust company that is organized under the laws of a state or the United States, has assets in excess of $5,000,000,000, has, or its parent corporation has, senior obligations outstanding rated "AA" or better and has a ratio of primary capital to total assets of at least 5 1/2% and a ratio of total capital to total assets of at least 6%. [1999, c. 715, §4 (NEW).]

P. "Qualified for public sale" means registered under the United States Securities Act of 1933, 15 United States Code, Sections 77a to 77aa. [1999, c. 715, §4 (NEW).]

Q. "Subsidiary" has the same meaning as defined in section 222, subsection 2, paragraph F. The term "subsidiary" does not include a separate account established under section 2537. [1999, c. 715, §4 (NEW).]

R. "United States" when used to signify place includes those geographical areas and the lands and waters adjacent to those geographical areas under the jurisdiction of the United States. [1999, c. 715, §4 (NEW).]

[2001, c. 72, §11 (AMD) .]

2. If net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions, such net earnings shall be determined after provisions for income taxes of only those subsidiaries in which the parent institution owns directly or indirectly less than 90% of all classes of voting stock, and after proper allowance for minority stock interest, if any; and the required coverage of fixed charges shall be computed on a basis including fixed charges and preferred dividends of subsidiaries other than those payable by such subsidiaries to the parent corporation or to any other of such subsidiaries, except that if the minority common stock interest in the subsidiary corporation is substantial, the fixed charges and preferred dividends may be apportioned in accordance with regulations prescribed by the superintendent.

[1973, c. 585, §12 (AMD) .]

3.

[1999, c. 715, §5 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 458, §§4,5 (AMD). 1983, c. 759, §1 (AMD). 1993, c. 313, §§24,25 (AMD). 1999, c. 715, §§3-5 (AMD). 2001, c. 72, §11 (AMD).

§1111. -- APPLICATION OF EARNINGS TEST

In applying the earnings tests under this chapter to any institution for any period, whether or not in legal existence at the beginning of such period: [1969, c. 132, §1 (NEW).]

1. Earnings from the beginning of such period may include, as determined in accordance with adjusted or pro forma consolidated earnings statements, earnings of any other institution the assets of which have been acquired substantially as an entirety by purchase, merger, consolidation or otherwise after the beginning of such period. If less than substantially all the assets of another institution have been so acquired, and such assets constitute either substantially all the assets of the acquiring institution immediately after such acquisition or substantially all the assets theretofore employed by such other institution in a divisional, branch or other unit operation, the earnings determined to be properly attributable to the assets so acquired may be so included, if certified by an independent accountant approved by the insurer to be earnings so attributable. If any such acquisition of assets has been made from a business enterprise other than an institution, the earnings determined to be attributable to the assets so acquired may likewise be so included if so certified. In the case of any such inclusion of earnings of assets so acquired, fixed charges, contingent interest or dividends for the period of such inclusion shall be either

A. The fixed charges, contingent interest or dividends for such period determined in accordance with adjusted or pro forma consolidated statements for such period giving effect to any additional fixed charges or contingent interest existing or dividends on stock or shares outstanding, immediately after such acquisition, properly attributable to such acquisition, as certified by an independent accountant approved by the insurer to be such fixed charges, contingent interest or dividends so determined, or [1969, c. 132, §1 (NEW).]

B. The fixed charges or contingent interest existing or dividends on stock or shares outstanding immediately after such acquisition. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. If any institution has been reorganized pursuant to the bankruptcy law after the beginning of such period, earnings prior to such reorganization of the institution so reorganized may be so included. In the case of the inclusion of earnings prior to such a reorganization, fixed charges, contingent interest or dividends for the period of such inclusion shall be fixed charges or contingent interest existing or dividends on stock or shares outstanding immediately after such reorganization.

[1969, c. 132, §1 (NEW) .]

3. If earnings are determined in reliance on consolidated earnings statements of parent and subsidiary institutions,

A. The provisions of this section may also be applied in determining earnings of any subsidiary institution and [1969, c. 132, §1 (NEW).]

B. Any institution which has become a subsidiary institution after the beginning of such period may be included as a subsidiary institution from the beginning of such period. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

In the case of any such inclusion of a subsidiary institution, fixed charges, contingent interest or dividends for the period of such inclusion shall be either

A. The fixed charges, contingent interest or dividends for such period determined in accordance with adjusted or pro forma consolidated statements for such period which give effect to any additional fixed charges or contingent interest existing or dividends on stock or shares outstanding, immediately after such subsidiary institution shall have become a subsidiary, properly attributable to the acquisition of stock or shares of such subsidiary institution, during such period and before it became a subsidiary, as certified by an independent accountant approved by the insurer to be such fixed charges, contingent interest or dividends so determined, or

B. The fixed charges or contingent interest existing or dividends on stock or shares outstanding immediately after such subsidiary institution became a subsidiary.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1112. PREFERRED OR GUARANTEED STOCKS

An insurer may invest in the preferred or guaranteed stocks or shares of any solvent institution created or existing under the laws of the United States or of Canada, or of any state, province, district or territory thereof, if all of the prior obligations and prior preferred stocks, if any, of such institution at the date of acquisition by the insurer are eligible as investments under this chapter; and if qualified under subsection 1 or subsection 2 following: [1969, c. 132, §1 (NEW).]

1. Preferred stocks or shares shall be deemed qualified if both of the following requirements are met:

A. The earnings of such institution available for its fixed charges for a period of 5 fiscal years next preceding the date of acquisition by the insurer shall have averaged per year not less than 1 1/2 times the sum of its average annual fixed charges, if any, its average annual maximum contingent interest, if any, and its average annual preferred dividend requirements applicable to such period; and [1969, c. 132, §1 (NEW).]

B. During either of the last 2 years of such period such net earnings shall have been not less than 1 1/2 times the sum of its fixed charges, contingent interest and preferred dividend requirements for such year. The term "preferred dividend requirements" shall be deemed to mean cumulative or noncumulative dividends whether paid or not. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. Guaranteed stocks or shares shall be deemed qualified if the assuming or guaranteeing institution meets the requirements of section 1109, subsection 3, (corporate obligations), construed so as to include as a fixed charge the amount of guaranteed dividends of such issue or the rental covering the guarantee of such dividends.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1113. COMMON STOCKS

An insurer may invest in nonassessable, except as to bank or trust company stocks, and except for taxes, common stocks, other than insurance stocks, of any solvent corporation organized and existing under the laws of the United States or Canada, or of any state or province thereof, if such corporation has had net earnings available for dividends on such stock in at least 5 of the 7 fiscal years next preceding acquisition by the insurer. If the issuing corporation has not been in legal existence for the whole of such 7 fiscal years but was formed as a consolidation or merger of 2 or more businesses of which at least one was in operation on a date 7 years prior to the investment, eligibility of its common stock under this section shall be based upon consolidated pro-forma statements of the predecessor or constituent institutions. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1114. INSURANCE STOCKS

1. An insurer may invest in the stocks of other solvent insurers formed under the laws of this or another state, which stocks meet the applicable requirements of section 1112 (preferred or guaranteed stocks) or 1113 (common stocks).

[1969, c. 132, §1 (NEW) .]

2. With the superintendent's advance written consent an insurer may acquire and hold the controlling interest in the outstanding voting stock of a stock insurer formed under the laws of this or another state. The superintendent shall not give his consent if he finds that such acquisition would not be in the best interests of the insurers involved, or of their respective policyholders or stockholders, or that it would materially tend to lessen competition or to result in any monopoly in the insurance business.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1115. STOCKS OF SUBSIDIARIES

1. An insurer may invest in the stock of its subsidiary insurance corporation formed or acquired by it; or in the stock of its subsidiary business corporation or corporations formed and engaged solely in any one or more of the following businesses:

A. In any business necessary and incidental to the convenient operation of the insurer's insurance business, or to the administration of any of its lawful affairs, or to the service or benefit of its policyholders; [1969, c. 132, §1 (NEW).]

B. Providing any of actuarial, computer, data processing, accounting, claims, appraisal, collection, loss prevention or safety engineering and similar services; [1969, c. 132, §1 (NEW).]

C. Real estate management and development; [1969, c. 132, §1 (NEW).]

D. Premium financing; [1969, c. 132, §1 (NEW).]

E. Financing of agents of the insurer; [1969, c. 132, §1 (NEW).]

F. Acting as investment adviser or principal underwriter of an investment company or companies, registered as such under the Investment Companies Act of 1940; [1969, c. 132, §1 (NEW).]

G. Financial and investment counseling services; [1969, c. 132, §1 (NEW).]

H. Administration of self-insurance plans; [1969, c. 132, §1 (NEW).]

I. Administration of self-insured pension and similar plans, or the self-insured portions of such plans; [1969, c. 132, §1 (NEW).]

J. Acting as administrative agent for a government instrumentality which is performing an insurance function; [1969, c. 132, §1 (NEW).]

K. Securities broker-dealer; [1969, c. 132, §1 (NEW).]

L. Escrow services; [1969, c. 132, §1 (NEW).]

M. Trust services with respect to funds payable or paid by it under its insurance contracts; or [1999, c. 715, §6 (AMD).]

N. A depository institution, or any company that controls such an institution, that is subject to the federal Gramm-Leach-Bliley Act, Sections 104(c) and 306(2), 113 Stat. 1338 as long as the insurer's total investment in all such subsidiaries does not exceed 5% of the insurer's admitted assets. [1999, c. 715, §7 (NEW).]

[1999, c. 715, §§6, 7 (AMD) .]

2. For the purposes of this section a "subsidiary" is a corporation of which the insurer owns sufficient stock to give it effective control.

[1969, c. 132, §1 (NEW) .]

3.

[1987, c. 399, §7 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 759, §2 (AMD). 1987, c. 399, §7 (AMD). 1999, c. 715, §§6,7 (AMD).

§1116. TRUSTEES' OR RECEIVERS' OBLIGATIONS

An insurer may invest in certificates, notes or other obligations issued by trustees or receivers of any institution created or existing under the laws of the United States or of any state, district or territory thereof, which, or the assets of which, are being administered under the direction of any court having jurisdiction, if such obligation is adequately secured as to principal and interest. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1117. EQUIPMENT TRUST CERTIFICATES

An insurer may invest in equipment trust obligations or certificates which are adequately secured, or in other adequately secured instruments evidencing an interest in transportation equipment wholly or in part within the United States of America and a right to receive determined portions of rental, purchase or other fixed obligatory payments for the use or purchase of such transportation equipment. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1118. ACCEPTANCES, BILLS OF EXCHANGE

An insurer may invest in bank and bankers' acceptances and other bills of exchange of the kind and maturities made eligible, pursuant to law, for purchase in the open market by federal reserve banks. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1119. SAVINGS AND LOAN INSTITUTIONS

An insurer may invest in the shares of savings and loan or buildings and loan associations or in the savings accounts of federal savings and loan associations, to the extent that the investment or account is insured by the Federal Savings and Loan Insurance Corporation pursuant to the National Housing Act of 1934, as amended. [1969, c. 177, §24 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §24 (AMD).

§1120. COMMON TRUST FUNDS, MUTUAL FUNDS

An insurer may invest in: [1969, c. 132, §1 (NEW).]

1. A bank's common trust fund as defined in section 584 of the United States Internal Revenue Code of 1954; and

[1969, c. 132, §1 (NEW) .]

2. The securities of any open-end management type investment company or investment trust registered with the federal Securities and Exchange Commission under the Investment Company Act of 1940 as from time to time amended, if such investment company or trust, other than one of which a subsidiary of the insurer is investment adviser or principal underwriter, has a net asset value of not less than $25,000,000 as at the date of investment by the insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1121. HYDROCARBON PRODUCTION PAYMENTS

An insurer may invest in production payments, or interests therein evidenced by trust certificates or other instruments, payable from oil, gas or other hydrocarbons in producing properties located in the United States or the adjacent continental shelf if an obligation secured by and payable from such production payment or interest therein would qualify for investment under section 1109, subsection 1, (corporate obligations) as an obligation which is adequately secured and has investment qualities and characteristics wherein the speculative elements are not predominant. "Production payments" means rights to oil, gas or other hydrocarbons in place or as produced which entitle the owner thereof to a specified fraction or percentage of production until a specified sum of money has been received. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1122. POLICY LOANS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §8 (RP).

§1123. COLLATERAL LOANS

An insurer may lend and thereby invest its funds upon the pledge of securities eligible for investment under this chapter. As at date made, no such loan shall exceed in amount 90% of the market value of such collateral pledged. The amount so loaned shall be included pro rata in determining the maximum percentage of funds permitted under this chapter to be invested in the respective categories of securities so pledged. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1124. MORTGAGE LOANS

1. An insurer may invest in bonds, notes or evidences of indebtedness other than those described in section 1109 (corporate obligations), which are secured by first or 2nd mortgages, or deeds of trust upon improved real property located in the United States or Canada, including leasehold estates having an unexpired term of not less than 21 years, inclusive of the term or terms which may be provided by enforceable options of renewal, if the underlying real property is not subject to any prior lien, and subject to the following requirements.

A. The security for the loan must be a first or 2nd lien upon such real property; and [1979, c. 458, §6 (AMD).]

B. In the case of leaseholds, there must not be any condition or right of reentry or forfeiture not insured against under which the insurer is unable to continue the lease in force for the duration of the loan. [1969, c. 132, §1 (NEW).]

[1979, c. 458, §6 (AMD) .]

2. Nothing herein shall prohibit any investment by reason of the existence of any prior lien for ground rents, taxes, assessments, common area maintenance charges or other similar charges not yet delinquent.

[1979, c. 458, §7 (AMD) .]

3. A loan secured by a 2nd mortgage or deed of trust may be made or acquired if, although junior in lien to a prior existing mortgage covering the same real property or leasehold interest thereof, the net amount actually advanced by the insurer under its mortgage plus the balance of principal and accrued interest then remaining unpaid under such prior mortgage does not exceed the amount which the insurer otherwise could have invested in such mortgage loan. The total loans or investments made under this subsection by an insurer shall not exceed 2% of its total admitted assets, and no such loan or investment shall be made or acquired by an insurer if the mortgagor, without the approval of the insurer, may increase the principal amount of the indebtedness secured by the prior mortgage except to the extent that the amount of that increase is applied in reduction of the loan or investment held by the insurer.

[1979, c. 458, §8 (AMD) .]

4. Such a mortgage loan or loans made or acquired by an insurer on any one property shall not at time of investment by the insurer be in amount in excess of 80% of the fair market value of the property or permit amortization over a period in excess of 40 years, or, in the case of leasehold interest, be in excess of 75% of the fair market value of such interest or permit amortization over a period exceeding 4/5 of the lease term remaining at the time of the loan inclusive of the term or terms which may be provided by enforceable options of renewal, provided that this provision shall not be deemed to prohibit an insurer from investing in a nonamortizing mortgage loan so long as the period of nonamortization does not exceed 5 years and the aggregate amount of nonamortizing mortgage loans made under this subsection shall not exceed 30% of the insurer's assets. Prior to the investment, the value of the property or of the leasehold interest shall be determined, for the purposes of the investment, by a competent appraiser.

[1981, c. 257, (AMD) .]

5. In applying the limitations under subsection 4, there may be excluded from the amount invested that portion guaranteed by the Administrator of Veterans' Affairs pursuant to the Servicemen's Readjustment Act of 1944, as amended, or insured by the Federal Housing Administration under the National Housing Act, as amended, or by other United States or Canadian government agency.

[1969, c. 132, §1 (NEW) .]

6. An insurer may invest in purchase money mortgages or like securities received by it upon the sale or exchange of real property acquired pursuant to section 1125. Subsection 4 shall not apply as to such investments.

[1969, c. 132, §1 (NEW) .]

7. An insurer may invest in a mortgage participation, which for this purpose shall mean a bond, note or other evidence of indebtedness forming part of an issue of bonds, notes or other evidences of indebtedness which are secured by the same mortgage or deed of trust and shall also mean an instrument evidencing a participation in a bond, note or other evidence of indebtedness so secured, provided that the following requirements are met:

A. The underlying mortgage or deed of trust otherwise qualifies for investment as a mortgage loan under this section; and [1979, c. 458, §10 (NEW).]

B. Either:

(1) The entire indebtedness secured by the same mortgage or deed of trust is held by the insurer;

(2) The insurer holds a senior participation giving it substantially the rights of a first or 2nd mortgagee, and a position of priority over the other holders of participations in that indebtedness; or

(3) Each participation is of equal rank. [1979, c. 458, §10 (NEW).]

[1979, c. 458, §10 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 458, §§6-10 (AMD). 1981, c. 257, (AMD).

§1125. REAL ESTATE

1. Except as provided in section 1127 (leased property), a domestic insurer may invest in real estate only if used for the purposes or acquired in the manners, and within the limits, as follows:

A. The building in which it has its principal office, the land upon which the building stands, and such other real estate as may be requisite for the insurer's convenient accommodation in the transaction of its business. The amount so invested shall not aggregate more than 15% of the insurer's assets. [1987, c. 399, §9 (AMD).]

B. Real estate acquired in satisfaction of loans, mortgages, liens, judgments, decrees or debts previously owing to the insurer in the due course of its business. [1969, c. 132, §1 (NEW).]

C. Real estate acquired in part payment of the consideration on the sale of other real estate owned by it, if such transaction shall have effected a net reduction in the insurer's investments in real estate. [1969, c. 132, §1 (NEW).]

D. Real estate acquired by gift or devise, or through merger, consolidation or bulk reinsurance of another insurer under this Title. [1969, c. 132, §1 (NEW).]

E. The seller's interest in real estate subject to an agreement of purchase or sale, but the sum invested in any such interest shall not exceed 2/3 of the fair value of such parcel. [1969, c. 132, §1 (NEW).]

F. Additional real estate and equipment incident thereto, if necessary or convenient for the purpose of enhancing the sale or other value of real estate previously acquired or held under this section. Such real estate and equipment, together with the real estate for the enhancement of which it was acquired, shall be included, for the purpose of applicable investment limits, and shall be subject to disposal under section 1133 at the same time and under the same conditions as apply to such enhanced real estate. [1969, c. 132, §1 (NEW).]

G. Improved real estate, or any interest therein, acquired or held by purchase, lease or otherwise, acquired as an investment for production of income, or acquired to be improved or developed for such investment purposes pursuant to an existing program therefor. The insurer may hold, mortgage, improve, develop, maintain, manage, lease, sell, convey and otherwise dispose of real estate acquired by it under this provision. [1969, c. 132, §1 (NEW).]

[1987, c. 399, §9 (AMD) .]

2. For the purposes of section 1124 (mortgage loans) and this section, "improved" real property means:

A. Farmland used for tillage, crop or pasture; [1969, c. 132, §1 (NEW).]

B. Real estate on which permanent improvements, or improvements under construction or in process of construction, suitable for residence, residential, recreational, institutional, commercial or industrial use, are situated; and [1969, c. 132, §1 (NEW).]

C. Real estate to be developed for the use or uses set forth in paragraph B, on which improvements, or improvements under construction or in process of construction, such as streets, sidewalks, sewers and utilities which will become an integral part of such development, are situated or abut. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §9 (AMD).

§1126. HOUSING DEVELOPMENTS

To the extent and upon such conditions as may be authorized by the superintendent, an insurer may invest in stock and evidences of indebtedness of any housing company or redevelopment company organized under the private housing finance law of this or any other state, or of any corporation organized for the purpose of owning and operating any housing project under laws expressly designed to promote the provision of housing for persons of low and moderate income, or in the securities of any corporation organized under the laws of this or any other state for the purpose of owning, acquiring or holding real property or any interest therein as an investment for the production of income or to be developed or improved for such investment purpose, if all of the stock other than directors' qualifying shares of such housing company, redevelopment company or corporation has been or is to be originally issued to one or more insurers, whether domestic or foreign. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1127. LEASED PROPERTY AND NONCORPORATE OBLIGATIONS

1. An insurer may invest in personal or real property owned either by the insurer, or a trustee, while under lease to a lessee able to meet any one of the earnings tests provided by section 1109.

[1979, c. 458, §11 (NEW) .]

2. In addition to investments otherwise permitted under this chapter, an insurer may invest in obligations, other than those of institutions as defined in section 1110, subsection 1-A, paragraph H, which are secured by:

A. An assignment of a right to receive rental, charter, hire, purchase or other payments for the use or purchase of real or personal property adequate to return the investments and payable or guaranteed by one or more governmental units or instrumentalities, whose obligations would qualify for investment under section 1107 or section 1108, or by one or more institutions whose obligations would qualify for investment under section 1109. The aggregate amount of investments made or acquired under this subsection may not exceed 2% of an insurer's total admitted assets; and [2001, c. 471, Pt. B, §13 (AMD).]

B. A mortgage or a security interest in that real or personal property. [1979, c. 458, §11 (NEW).]

[2001, c. 471, Pt. B, §13 (AMD) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1979, c. 458, §11 (RPR). 2001, c. 471, §B13 (AMD).

§1128. SPECIAL INVESTMENTS; SEPARATE ACCOUNTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 560, §1 (RPR). 1973, c. 585, §12 (AMD). 1987, c. 399, §10 (RP).

§1129. SPECIAL INVESTMENTS OF TITLE INSURERS

1. A title insurer may also have invested funds in an amount not exceeding 50% of its paid-in capital stock and its surplus, in its abstract plant and equipment and in stocks of abstract companies.

[1969, c. 132, §1 (NEW) .]

2. Investments authorized under subsection 1 shall not be credited against required reserves.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1130. INVESTMENTS IN FOREIGN COUNTRIES

1. An insurer authorized to transact insurance in a foreign country or which has outstanding insurance or reinsurance contracts on risks resident or located in a foreign country may invest in or otherwise acquire or loan upon securities and investments in such foreign country which are substantially of the same kinds, classes and investment grades as those eligible for investment under other sections of this chapter; but the aggregate amount of such investments in a foreign country and of cash in the currency of such country shall not, except as to Canadian investments otherwise authorized under this chapter, exceed 1 1/2 times the amount of its reserves and other obligations under such contracts or the amount which the insurer is required by law to invest in such country, whichever is the greater.

[1987, c. 399, §11 (AMD) .]

2. In addition to the foreign investments otherwise permitted under this chapter, an insurer may invest in or otherwise acquire or loan upon securities and investments in foreign countries which are substantially of the same kinds, classes and investment grades as those otherwise eligible for investment under this chapter; but the aggregate amount of such investments under this subsection shall not exceed 1% of the insurer's assets.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §11 (AMD).

§1131. MISCELLANEOUS INVESTMENTS

1. An insurer may make loans or investments, not otherwise eligible, qualified or expressly permitted under this chapter, in an aggregate amount not over 10% of the insurer's assets and not over 1% of those assets as to any one such loan or investment. The investment limitations contained in this chapter, qualitative or quantitative or otherwise, shall not apply to loans or investments under this section, provided that all loans or investments made or acquired under this section shall meet the following requirements.

A. The loan or investment must fulfill the requirements of section 1103 and otherwise qualify as a sound investment. [2001, c. 72, §12 (AMD).]

B. No such loan or investment may be represented by:

(1) Any asset determined to be nonadmitted pursuant to section 901-A or rules adopted under that section;

(2) Any loan or investment expressly prohibited under section 1136; or

(3) Agents' balances, or amounts advanced to or owing by agents, except as to mortgage loans and collateral loans to those agents otherwise authorized under this chapter. [2001, c. 72, §12 (AMD).]

C. No loan or investment may cause the insurer to exceed the specific diversification requirements enumerated in section 1106. [1987, c. 399, §12 (RPR).]

[2001, c. 72, §12 (AMD) .]

2. The insurer shall keep a separate record of all loans and investments made under this section. Any such loan or investment that subsequent to the date of making or acquisition thereof has attained the standard of eligibility and qualifies under any other section of this chapter may thereupon be deemed to have been made or acquired under and in compliance with that section and shall no longer be considered to have been made or acquired under this section.

[1979, c. 458, §12 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 458, §12 (RPR). 1983, c. 759, §3 (AMD). 1987, c. 399, §12 (AMD). 2001, c. 72, §12 (AMD).

§1132. CONVERSION AND INCIDENTAL RIGHTS

Nothing in this chapter shall be deemed to prohibit an insurer from making an investment otherwise authorized under this chapter, because the investment is convertible into other securities in which the insurer is not permitted to invest under this chapter, or because the insurer receives in connection with such investment stock warrants, whether or not detachable, stock options, stock, property interests or other assets of any kind. Anything so received by the insurer and in which the insurer is otherwise not authorized to invest shall be carried on its books at no value. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1133. TIME LIMIT FOR DISPOSAL OF REAL ESTATE

1. Except as stated in subsection 2, or unless the insurer elects to hold the real estate as an investment under section 1125, subsection 1, paragraph G:

A. An insurer shall dispose of real estate acquired under section 1125, subsection 1, paragraph A, within 5 years after it has ceased to be necessary for the convenient accommodation of the insurer in the transaction of its business. [1969, c. 132, §1 (NEW).]

B. An insurer shall dispose of real estate acquired under section 1125, subsection 1, paragraphs B, C or E, within 5 years after the date of acquisition, unless used or to be used for the insurer's accommodation under section 1125, subsection 1, paragraph A. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. Upon proof satisfactory to him that the interests of the insurer will suffer materially by the forced sale thereof, the superintendent may by order grant a reasonable extension of the period, as specified in such order, within which the insurer shall dispose of any particular parcel of such real estate.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1134. TIME LIMIT FOR DISPOSAL OF OTHER INELIGIBLE PROPERTY AND SECURITIES

Any personal property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at the time of such acquisition, shall be disposed of within 3 years from date of acquisition unless within such period the security has attained to the standard of eligibility; except, that any security or personal property acquired under any agreement of bulk reinsurance, merger or consolidation, may be retained for a longer period if so provided in the plan for such reinsurance, merger, or consolidation as approved by the superintendent under chapter 47. Upon application by the insurer and proof that forced sale of any such property or security would materially injure the interests of the insurer, the superintendent may extend the disposal period for an additional reasonable time. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1135. FAILURE TO DISPOSE OF REAL ESTATE OR SECURITIES; EFFECT, PENALTY

1. Any real estate, personal property or securities lawfully acquired, and held by an insurer after expiration of the period for disposal thereof or any extension of such period granted by the superintendent as provided in sections 1133 and 1134 shall not be allowed as an asset of the insurer.

[1973, c. 585, §12 (AMD) .]

2. The insurer shall forthwith dispose of any ineligible investment unlawfully acquired by it, and the superintendent shall suspend or revoke the insurer's certificate of authority if the insurer fails to dispose of the investment within such reasonable time as the superintendent may, by his order, specify.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1136. PROHIBITED INVESTMENTS AND INVESTMENT UNDERWRITING

1. In addition to investments excluded pursuant to other provisions of this Title, an insurer shall not invest in or lend its funds upon the security of:

A. Issued shares of its own capital stock, except:

(1) For the purpose of mutualization under chapter 47, or

(2) For retirement, or

(3) Pursuant to a plan for such investment or loan submitted in writing by the insurer to the superintendent in advance, and which the superintendent has not, within 20 days after such submission or within such additional reasonable period as the superintendent may request, disapproved as being unfair or inequitable to the insurer's policyholders or stockholders. [1973, c. 585, §12 (AMD).]

B. Securities issued by any corporation or enterprise the controlling interest of which is, or will after such acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, subsidiaries, or controlling stockholders, and the spouses and children of any of the foregoing individuals. Investments in controlled insurance corporations or subsidiaries under sections 1114 and 1115 are not subject to this provision. [1969, c. 132, §1 (NEW).]

C. Any note or other evidence of indebtedness of any director, officer or controlling stockholder of the insurer or of the spouse or child of any of the foregoing. [1987, c. 399, §13 (AMD).]

[1987, c. 399, §13 (AMD) .]

2. No insurer shall underwrite or participate in the underwriting of an offering of securities or property of any other person. This provision shall not be deemed to prohibit:

A. The acquisition and ownership by the insurer of its subsidiary corporation acting as investment adviser or principal underwriter of a management company or investment company registered with the Securities and Exchange Commission under the Investment Company Act of 1940, as amended. [1969, c. 132, §1 (NEW).]

B. The registration by the insurer, under the Securities Act of 1933 or other applicable law, of restricted or other securities acquired and owned by it in regular course of business. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. No insurer shall enter into any agreement to withhold from sale any of its securities or property, and the disposition of its assets shall at all times be within the control of the insurer. This provision shall not be deemed to affect any right or obligation of the insurer under a contract or agreement referred to in section 2537 (separate accounts), and shall not be deemed to prohibit an insurer from lending any of its publicly traded portfolio securities or bond investments to a financial institution, to a securities broker or securities dealer under a program which provides adequate collateral security for the return of the value of the loaned portfolio securities or bond investments and which provides that any such loan of securities may be terminated by the insurer on not more than 10 days' notice. These programs shall conform to provisions contained in a regulation promulgated by the Superintendent of Insurance on a prospective basis covering those programs and which sets consistent standards for the collateral security deposits.

[1979, c. 458, §13 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 458, §13 (AMD). 1987, c. 399, §13 (AMD).

§1137. INVESTMENTS OF FOREIGN INSURERS

The investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially equal to that required under this chapter for similar funds of like domestic insurers. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

Chapter 13-A: INVESTMENTS OF LIFE INSURERS AND LIFE AND HEALTH INSURERS

§1151. SCOPE OF CHAPTER

Except as provided in sections 1101 and 1161, this chapter applies only to a domestic life or health insurer that transacts business of a type described in section 409, subsection 3. [1991, c. 385, §10 (AMD).]

SECTION HISTORY
1987, c. 399, §14 (NEW). 1989, c. 846, §§B8,E4 (RPR). 1991, c. 385, §10 (AMD).

§1151-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 715, §8 (NEW).]

1. **Acceptable collateral.** "Acceptable collateral" means:

A. As to securities lending transactions, repurchase transactions and reverse repurchase transactions and for the purpose of calculating counter-party exposure amount: cash, cash equivalents, letters of credit or direct obligations of, or securities that are fully guaranteed as to principal and interest by the government of the United States, by any agency of the United States, by the Federal National Mortgage Association or by the Federal Home Loan Mortgage Corporation; and [1999, c. 715, §8 (NEW).]

B. As to foreign securities lending transactions: sovereign debt rated "1" by the Securities Valuation Office of the National Association of Insurance Commissioners. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

2. **Admitted assets.** "Admitted assets" means assets recognized by the superintendent pursuant to section 901-A.

[2001, c. 72, §13 (AMD) .]

3. **Aggregate amount of investments.** "Aggregate amount of investments" means the aggregate value of those investments, as determined in accordance with statutory accounting principles pursuant to section 901-A and any rules adopted under that section, except as provided in section 1157, subsection 5.

[2001, c. 72, §13 (AMD) .]

4. **Business entity.** "Business entity" means a sole proprietorship, corporation, limited liability company, association, general or limited partnership, joint stock company, joint venture, mutual fund, bank, trust, real estate investment trust, joint tenancy or other similar form of business organization, whether organized as a for-profit or nonprofit organization.

[1999, c. 715, §8 (NEW) .]

5. **Cap.** "Cap" means an agreement obligating the seller to make payments to the buyer with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number, sometimes called the "strike rate" or "strike price."

[1999, c. 715, §8 (NEW) .]

6. **Cash equivalents.** "Cash equivalents" means highly rated, highly liquid and readily marketable obligations that are readily convertible into known amounts of cash without a penalty and have a remaining term to maturity of one year or less. For purposes of this definition, "highly rated" means an investment rated "P-1" by Moody's Investors Service, Inc., "A-1" by the Standard and Poor's Division of The McGraw-Hill Companies, Inc., or an equivalent rating by a nationally recognized statistical rating organization recognized by the Securities Valuation Office of the National Association of Insurance Commissioners.

[1999, c. 715, §8 (NEW) .]

7. **Collar.** "Collar" means an agreement to receive payments as the buyer of an option, cap or floor and to make payments as the seller of a different option, cap or floor.

[1999, c. 715, §8 (NEW) .]

8. **Counter-party.** "Counter-party" means a business entity that is the other party to an investment practices transaction with an insurer or, as to a securities lending transaction, the custodian bank or agent, if any, acting on behalf of an insurer.

[1999, c. 715, §8 (NEW) .]

9. **Counter-party exposure; counter-party exposure amount.** "Counter-party exposure" or "counter-party exposure amount" means:

A. For an over-the-counter derivative instrument not entered into pursuant to a written master agreement that provides for netting of payments owed by the respective parties:

(1) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(2) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer; and [1999, c. 715, §8 (NEW).]

B. For an over-the-counter derivative instrument entered into pursuant to a written master agreement that provides for netting of payments owed by the respective parties, if the domiciliary jurisdiction of the counter-party is either within the United States or within a foreign jurisdiction listed as eligible for netting in the purposes and procedures manual of the Securities Valuation Office of the National Association of Insurance Commissioners or its successor publication, the greater of zero or the net sum payable to the insurer in connection with all derivative instruments subject to the written master agreement upon their liquidation in the event of default by the counter-party pursuant to the master agreement, assuming there are no conditions precedent to the obligations of the counter-party to make such a payment and no setoff of amounts payable pursuant to any other instrument or agreement. [1999, c. 715, §8 (NEW).]

For purposes of this definition, "market value" or the "net sum payable" is determined at the end of the most recent quarter of the insurer's fiscal year and must be reduced by the market value of acceptable collateral held by the insurer or a custodian on the insurer's behalf.

[1999, c. 715, §8 (NEW) .]

10. **Derivative instrument.** "Derivative instrument" means any agreement, option or instrument or any series or combination of those agreements, options or instruments:

A. To make or take delivery of, assume or relinquish a specified amount of one or more underlying interests, or to make a cash settlement in lieu thereof; or [1999, c. 715, §8 (NEW).]

B. That has a price, performance, value or cash flow based primarily upon the actual or expected price, yield, level, performance, value or cash flow of one or more underlying interests. [1999, c. 715, §8 (NEW).]

For purposes of this definition, "derivative instrument" includes options, warrants not attached to another financial instrument purchased by the insurer, caps, floors, collars, swaps, forwards, futures and any other substantially similar agreements, options or instruments, or any series or combinations of those agreements, options or instruments. "Derivative instrument" does not include collateralized mortgage obligations, other asset-backed securities, principal-protected structured securities, floating rate securities or instruments in which an insurer is otherwise authorized to invest or that an insurer is otherwise authorized to receive under this chapter other than under section 1153, subsection 4, and any debt obligations of the insurer.

[1999, c. 715, §8 (NEW) .]

11. **Derivative transaction.** "Derivative transaction" means a transaction involving the use of one or more derivative instruments. For purposes of section 1153, subsection 4, dollar roll transactions, repurchase transactions, reverse repurchase transactions and securities lending transactions are not considered derivative transactions.

[1999, c. 715, §8 (NEW) .]

12. **Dollar roll transaction.** "Dollar roll transaction" means 2 simultaneous transactions with settlement dates no more than 96 days apart so that in one transaction an insurer sells to a counter-party and in the other transaction the insurer is obligated to purchase from the same counter-party substantially similar securities of the following types:

A. Mortgage-backed securities issued, assumed or guaranteed by the Government National Mortgage Association, the Federal National Mortgage Association, the Federal Home Loan Mortgage Corporation or their respective successors; and [1999, c. 715, §8 (NEW).]

B. Other mortgage-backed securities referred to the Secondary Mortgage Market Enhancement Act of 1984, 15 United States Code, Section 77r-1, as amended. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

13. **Domestic institution.** "Domestic institution" means an institution created or existing under the laws of the United States or any state, district or territory.

[1999, c. 715, §8 (NEW) .]

14. **Floor.** "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the "floor rate" or "price," exceeds a reference price, level, performance or value of one or more underlying interests.

[1999, c. 715, §8 (NEW) .]

15. **Foreign investment; foreign investment practice.** "Foreign investment" or "foreign investment practice" means an investment or investment practice in a foreign jurisdiction, an investment practice with a person domiciled in a foreign jurisdiction or an investment in a person, real estate or asset domiciled in a foreign jurisdiction. An investment or investment practice is not considered a foreign investment or foreign investment practice if the issuing person, counter-party, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction unless:

A. The counter-party or the issuing person is a shell business entity; and [1999, c. 715, §8 (NEW).]

B. The investment or investment practice is not assumed, accepted, guaranteed, insured or otherwise backed by a domestic jurisdiction or a person that is not a shell business entity, domiciled in a domestic jurisdiction. [1999, c. 715, §8 (NEW).]

For purposes of this subsection, "shell business entity" means a business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned or previously owned by a person domiciled in a foreign jurisdiction; "qualified guarantor" means a guarantor against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction; and "qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

[1999, c. 715, §8 (NEW) .]

16. **Foreign jurisdiction.** "Foreign jurisdiction" means a jurisdiction other than the United States, any state or any political subdivision of the United States or any state.

[1999, c. 715, §8 (NEW) .]

17. **Forward.** "Forward" means an agreement other than a future to make or take delivery in the future of one or more underlying interests, or effect a cash settlement based on the actual or expected price, level, performance or value of such underlying interests. "Forward" does not mean spot transactions effected within customary settlement periods, when-issued purchases or other similar cash market transactions.

[1999, c. 715, §8 (NEW) .]

18. **Future.** "Future" means an agreement traded on a futures exchange to make or take delivery of or effect a cash settlement based on the actual or expected price, level, performance or value of one or more underlying interests.

[1999, c. 715, §8 (NEW) .]

19. **Futures exchange.** "Futures exchange" means a qualified foreign exchange or an exchange, contract market or board of trade on which trading in futures is conducted that has been authorized for futures trading in the United States by the Commodities Futures Trading Commission or its successor.

[1999, c. 715, §8 (NEW) .]

20. **Hedging transaction.** "Hedging transaction" means a derivative transaction that is entered into and maintained to reduce:

A. The risk of a change in the value, yield, price, cash flow or quantity of assets or liabilities or a portfolio of assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring; or [1999, c. 715, §8 (NEW).]

B. The currency exchange rate risk related to assets or liabilities or a portfolio of assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

21. **High-yield obligations.** "High-yield obligations" means obligations that are neither investment grade nor medium grade obligations.

[1999, c. 715, §8 (NEW) .]

22. **Income generation transaction.** "Income generation transaction" means a derivative transaction that is entered into to generate income. A derivative transaction that is entered into as a hedging transaction or a replication or synthetic asset transaction is not considered an income generation transaction.

[1999, c. 715, §8 (NEW) .]

23. **Institution.** "Institution" means a corporation, joint-stock association, business trust, business partnership, business joint venture or any other similar entity.

[1999, c. 715, §8 (NEW) .]

24. **Investment grade obligation.** "Investment grade obligation" means an obligation that at the time of acquisition by the insurer is rated "1" or "2" by the Securities Valuation Office of the National Association of Insurance Commissioners. If not valued by the Securities Valuation Office of the National Association of Insurance Commissioners, "investment grade obligation" means an obligation that at the time of acquisition by the insurer is rated the equivalent of "1" or "2" by one of the following nationally recognized independent rating agencies: Moody's Investors Service, Inc., Standard and Poor's Division of The McGraw-Hill Companies, Inc., Fitch Investors Service, Inc. or Duff and Phelps Credit Rating Company.

[1999, c. 715, §8 (NEW) .]

25. **Investment practices.** "Investment practices" means transactions of the types described in section 1153, subsection 4 and section 1160, subsection 6.

[1999, c. 715, §8 (NEW) .]

26. **Market value.** "Market value" means the price for the security or derivative instrument obtained from a generally recognized source or the most recent quotation from such a source or, to the extent no generally recognized source exists, the price for the security or derivative instrument as determined pursuant to the terms of the instrument or in good faith by the insurer as can be reasonably demonstrated to the superintendent upon request, plus accrued but unpaid income thereon to the extent not included in the price as of the date that market value is determined.

[1999, c. 715, §8 (NEW) .]

27. **Medium grade obligation.** "Medium grade obligation" means an obligation that at the time of acquisition by the insurer is rated by the Securities Valuation Office of the National Association of Insurance Commissioners as Class "3" quality. If not valued by the Securities Valuation Office of the National Association of Insurance Commissioners, "medium grade obligation" means an obligation that at the time of acquisition by the insurer is rated the equivalent of "3" by Moody's Investors Service, Inc., Standard and Poor's Division of The McGraw-Hill Companies, Inc., Fitch Investors Service, Inc. or Duff and Phelps Credit Rating Company.

[1999, c. 715, §8 (NEW) .]

28. **Obligation.** "Obligation" means a bond, note, debenture, trust certificate including an equipment certificate, production payment, negotiable bank certificate of deposit, banker's acceptance, credit tenant loan as that term is defined in the practices and procedures manual of the National Association of Insurance Commissioners or its successor publication, loan secured by financing net leases and other evidence of indebtedness for the payment of money, or participations, certificates or other evidence of an interest in any of the foregoing, whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

[1999, c. 715, §8 (NEW) .]

29. **Option.** "Option" means an agreement giving the buyer the right to buy or receive, sell or deliver, enter into, extend or terminate or effect a cash settlement based on the actual or expected price, spread, level, performance or value of one or more underlying interests, including, without limitation, an option to purchase or sell a swap at a given price and time or at a series of prices and times.

[1999, c. 715, §8 (NEW) .]

30. **Over-the-counter derivative instrument.** "Over-the-counter derivative instrument" means a derivative instrument entered into with a counter-party other than through a qualified exchange or futures exchange or cleared through a qualified clearinghouse.

[1999, c. 715, §8 (NEW) .]

31. **Person.** "Person" means an individual, business entity, multilateral development bank or a government or quasi-governmental body, such as a political subdivision or a government-sponsored enterprise.

[1999, c. 715, §8 (NEW) .]

32. **Potential exposure.** "Potential exposure" means:

A. As to a futures position, the amount of initial margin required for that position; or [1999, c. 715, §8 (NEW).]

B. As to swaps, collars and forwards, 0.5% times the notional amount times the square root of the remaining years to maturity. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

33. **Qualified bank.** "Qualified bank" means:

A. A national bank, state-chartered bank or trust company that is adequately capitalized at all times as determined by standards adopted by federal banking regulators and that either is regulated by state banking laws or is a member of the Federal Reserve System; or [1999, c. 715, §8 (NEW).]

B. A bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as a bank or trust company by that country's government or an agency of that country's government and that is adequately capitalized at all times as determined by standards adopted by international banking regulators. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

34. **Qualified broker or dealer.** "Qualified broker or dealer" means a broker or dealer that is organized under the laws of a state, is registered under the United States Securities Exchange Act of 1934, 15 United States Code, Sections 78a to 78kk and has net capital in excess of $250,000,000.

[1999, c. 715, §8 (NEW) .]

35. **Qualified business entity.** "Qualified business entity" means:

A. An issuer of preferred stock or obligations that are rated "1" or "2" by the Securities Valuation Office of the National Association of Insurance Commissioners or an issuer of obligations, preferred stock or derivative instruments that are rated the equivalent of "1" or "2" by the Securities Valuation Office of the National Association of Insurance Commissioners or by a nationally recognized statistical rating organization recognized by the Securities Valuation Office of the National Association of Insurance Commissioners; or [1999, c. 715, §8 (NEW).]

B. A primary dealer in United States Government securities that is recognized by the Federal Reserve Bank of New York. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

36. **Qualified clearinghouse.** "Qualified clearinghouse" means a clearinghouse subject to the rules of a qualified exchange or a futures exchange that provides clearing services, including acting as a counter-party to each of the parties to a transaction such that the parties no longer have credit risk to each other.

[1999, c. 715, §8 (NEW) .]

37. **Qualified exchange.** "Qualified exchange" means:

A. A securities exchange registered as a national securities exchange or a securities market regulated under the federal Securities Exchange Act of 1934, 15 United States Code, Section 78 et seq., as amended; [1999, c. 715, §8 (NEW).]

B. A board of trade or commodities exchange designated as a contract market by the Commodity Futures Trading Commission or any successor; [1999, c. 715, §8 (NEW).]

C. Any computerized or Internet-based market for private offerings, resales and trading of obligations or other securities that is maintained under the auspices of a federally regulated, self-governing securities dealers organization, registered as a securities exchange or regulated as a securities market under the federal Securities Exchange Act of 1934, 15 United States Code, Section 78 et seq., as amended; [1999, c. 715, §8 (NEW).]

D. A designated offshore securities market as defined in Securities Exchange Commission Regulation S, 17 Code of Federal Regulations, Part 230, as amended; or [1999, c. 715, §8 (NEW).]

E. A qualified foreign exchange. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

38. **Qualified foreign exchange.** "Qualified foreign exchange" means a foreign exchange, board of trade or contract market located outside the United States, its territories or possessions:

A. That has received regulatory comparability relief under Commodity Futures Trading Commission Rule 30.10 as set forth in Appendix C to Part 30 of the Commodity Futures Trading Commission's Regulations, 17 Code of Federal Regulations, Part 30, as amended; [1999, c. 715, §8 (NEW).]

B. That is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under Commodity Futures Trading Commission Rule 30.10, as set forth in Appendix C to Part 30 of the Commodity Futures Trading Commission's Regulations, 17 Code of Federal Regulations, Part 30, as amended, as to futures transactions in the jurisdiction where the exchange, board of trade or contract market is located; or [1999, c. 715, §8 (NEW).]

C. Upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the Commodity Futures Trading Commission's Office of General Counsel; however, an exchange, board of trade or contract market that qualifies as a "qualified foreign exchange" only under this paragraph may only be a "qualified foreign exchange" as to foreign stock index futures contracts that are the subject of no-action relief. [1999, c. 715, §8 (NEW).]

[1999, c. 715, §8 (NEW) .]

39. **Qualified for public sale.** "Qualified for public sale" means registered under the United States Securities Act of 1933, 15 United States Code, Sections 77a to 77aa.

[1999, c. 715, §8 (NEW) .]

40. **Replication or synthetic asset transaction.** "Replication or synthetic asset transaction" means a derivative transaction entered into in conjunction with other permissible investments held by the insurer in order to reproduce the investment characteristics of other permissible investments. A derivative transaction entered into by the insurer as a hedging transaction or an income generation transaction is not considered a replication or synthetic asset transaction.

[1999, c. 715, §8 (NEW) .]

41. **Repurchase transaction.** "Repurchase transaction" means a transaction in which an insurer purchases securities from a counter-party that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

[1999, c. 715, §8 (NEW) .]

42. **Reverse repurchase transaction.** "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a qualified bank or a qualified business entity or a bank or a business entity whose obligations with respect to such transaction are guaranteed by a qualified bank or a qualified business entity and the insurer is obligated to repurchase the sold securities or equivalent securities from the bank or business entity at a specified price, either within a specified period of time or upon demand.

[1999, c. 715, §8 (NEW) .]

43. **Securities lending transaction.** "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a qualified bank or a qualified business entity or a bank or a business entity whose obligations with respect to such transaction are guaranteed by a qualified bank or a qualified business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

[1999, c. 715, §8 (NEW) .]

44. **Subsidiary.** "Subsidiary" has the meaning as prescribed in section 222, subsection 2, paragraph F. The term "subsidiary" does not include a separate account established under section 2537.

[1999, c. 715, §8 (NEW) .]

45. **Swap.** "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, yield, level, performance or value of one or more underlying interests.

[1999, c. 715, §8 (NEW) .]

46. **Underlying interest.** "Underlying interest" means the assets, liabilities or other interests, or a combination of those assets, liabilities or interests, underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities or derivative instruments that are or relate to investments or investment practices that an insurer is permitted to acquire or engage in pursuant to this chapter.

[1999, c. 715, §8 (NEW) .]

47. **United States.** "United States" when used to signify place means those lands and waters under the jurisdiction of the United States.

[1999, c. 715, §8 (NEW) .]

48. **Warrant.** "Warrant" means an instrument that gives the holder the right to purchase or sell the underlying interest at a given price and time or at a series of prices and times outlined in the warrant agreement.

[1999, c. 715, §8 (NEW) .]

SECTION HISTORY
1999, c. 715, §8 (NEW). 2001, c. 72, §13 (AMD).

§1152. ELIGIBILITY OF INVESTMENTS

1. **Eligible investments.** Insurers shall invest in or lend their funds on the security of and shall hold as eligible investments only those as prescribed or permitted in this chapter.

[1987, c. 399, §14 (NEW) .]

2. **Prior investments.** Any particular investment held by an insurer on the effective date of this chapter, which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately before the effective date of this chapter, shall be considered an eligible investment.

[1987, c. 399, §14 (NEW) .]

3. **Eligibility date.** Eligibility of an investment shall be determined as of the date of its making or acquisition, except as stated in subsection 2, or in section 1153, subsection 3, or in section 1156, subsection 2, paragraph H, subparagraph (4).

[1987, c. 399, §14 (NEW) .]

4. **Basis for limitation or diversification.** Any investment limitation or diversification requirement based upon the amount of the insurer's assets or particular funds shall relate to such assets or funds as shown by the insurer's annual statement as of the December 31st next preceding the date of acquisition of the investment by the insurer, or as shown by a current applicable financial statement, prepared on the same basis as that annual statement, resulting from merger with another insurer, bulk reinsurance or change in capitalization.

[1987, c. 399, §14 (NEW) .]

5. **Capital loans.** Nothing in this chapter prohibits an insurer from advancing funds to another insurer upon the type of agreement provided for in section 3415, borrowed capital funds, and subject to the terms of that section.

[1987, c. 399, §14 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW).

§1153. GENERAL QUALIFICATIONS

1. **Eligible investments.** No investment, other than real property acquired under section 1156, subsection 2, paragraph D, and personal property incident to that real property or acquired under section 1156, subsection 2, paragraph E, and other than investments acquired under section 1156, subsection 2, paragraph

H, subparagraph (2), may be eligible for acquisition unless it is interest bearing, interest accruing, entitled to dividends, if declared, or is otherwise income entitled and is not then in default in any respect and the insurer is entitled to receive for its exclusive account and benefit that interest or those dividends or that income.

[1987, c. 399, §14 (NEW) .]

2. **Bona fide hedging transactions.**

[1999, c. 715, §9 (RP) .]

3. **Permitted acquisitions.** Nothing in this chapter prohibits the acquisition by an insurer of:

A. Securities or property received as a dividend or pursuant to a lawful judicial or nonjudicial plan of reorganization or dissolution or pursuant to a lawful and bona fide agreement of bulk reinsurance, merger or consolidation or through the exercise of rights of conversion, stock warrants or stock options received by it in accordance with this subsection or section 1156; [1987, c. 399, §14 (NEW).]

B. An investment permitted under section 1156 because that investment is convertible into other securities or stock in which the insurer is not permitted to invest under this chapter or because the insurer receives in connection with that investment stock warrants, whether detachable or nondetachable, stock options, shares of stock, property interests or other assets of any kind; or [1987, c. 399, §14 (NEW).]

C. Real or personal property or any interest in that property received in satisfaction of a debt previously owing to that insurer. If any securities received by any insurer in accordance with paragraph A consist in whole or in part of stock or shares of any institution, as defined in section 1156, or of bonds or other obligations which do not meet the requirements specified in section 1156, then any of that stock or shares and any bond or obligation of that type so received shall be disposed of within 5 years from the time of its acquisition or before the expiration of any further period or periods of time as may be prescribed in writing by the superintendent or treated as a nonadmitted asset thereafter unless, at any time after acquisition, those securities have met the relevant requirements and the insurer has notified the superintendent of that fact. [1987, c. 399, §14 (NEW).]

[1987, c. 399, §14 (NEW) .]

4. **Derivative transactions.** This chapter does not prohibit an insurer from engaging in hedging transactions, income generation transactions and replication or synthetic asset transactions under the following conditions.

A. Before entering into any derivative transaction, the board of directors of the insurer shall determine that the insurer, directly or through an investment management subsidiary or affiliate, has adequate professional personnel, technical expertise and systems to implement investment practices involving derivative transactions and approve a derivative instruments use plan that:

(1) Describes investment objectives and risk constraints, such as counter-party exposure amounts;

(2) Defines permissible transactions including identification of the risks that may be hedged, the assets or liabilities that may be replicated and permissible types of income generation transactions; and

(3) Requires compliance with internal control procedures. [1999, c. 715, §10 (NEW).]

B. The insurer shall establish written internal control procedures that provide for:

(1) A quarterly report to the board of directors that reviews:

(a) All derivative transactions entered into, outstanding or closed out;

(b) The results and effectiveness of the insurer's implementation of its derivative instruments use plan; and

(c) The credit risk exposure to each counter-party for over-the-counter derivative transactions based upon the counter-party exposure amount;

(2) A system for determining whether hedging, income generation or replication strategies used by the insurer have been effective;

(3) A system of regular reports on at least a monthly basis to management that include:

(a) A description of all derivative transactions entered into, outstanding or closed out during the period since the last report;

(b) The purpose of each outstanding derivative transaction;

(c) A performance review of the derivative instruments program; and

(d) The counter-party exposure amounts for over-the-counter derivative transactions;

(4) Written authorizations that identify the responsibilities and limitations of authority of persons authorized to effect and maintain derivative transactions; and

(5) Documentation appropriate for each transaction including:

(a) The purpose of the transaction;

(b) The assets or liabilities to which the transaction relates;

(c) The specific derivative instrument used in the transaction;

(d) For over-the-counter derivative instrument transactions, the name of the counter-party and the counter-party exposure amount; and

(e) For exchange-traded derivative instruments, the name of the exchange and the name of the firm that handled the transaction. [1999, c. 715, §10 (NEW).]

C. Whenever the derivative transactions entered into under this subsection are not in compliance with this subsection or, if continued, may now or subsequently create a hazardous financial condition of the insurer that affects its policyholders, creditors or the general public, the superintendent may, after notice and an opportunity for a hearing, order the insurer to take such action as may be reasonably necessary to rectify the noncompliance or hazardous financial condition or prevent an impending hazardous financial condition from occurring. [1999, c. 715, §10 (NEW).]

D. An insurer may enter into hedging transactions under this subsection if as a result of and after giving effect to each such transaction:

(1) The aggregate statutory financial statement value of all outstanding caps, floors, warrants not attached to another financial instrument and options other than collars purchased by the insurer pursuant to this subsection does not exceed 7.5% of its admitted assets;

(2) The aggregate statutory financial statement value of all outstanding warrants, caps, floors and options other than collars written by the insurer pursuant to this subsection does not exceed 3% of its admitted assets; and

(3) The aggregate potential exposure of all outstanding collars, swaps, forwards and futures entered into or acquired by the insurer pursuant to this subsection does not exceed 6.5% of its admitted assets.

With respect to hedging transactions, an insurer shall demonstrate to the superintendent upon request the intended hedging characteristics and effectiveness of the hedging transaction or combination of hedging transactions through cash-flow testing, duration analysis or other appropriate analysis. [1999, c. 715, §10 (NEW).]

E. An insurer may enter into an income generation transaction if:

(1) As a result of and after giving effect to the transaction, the aggregate statutory financial statement value of admitted assets that are then subject to call or that generate the cash flows for payments required to be made by the insurer under caps and floors sold by the insurer and then

outstanding under this paragraph, plus the statutory financial statement value of admitted assets underlying derivative instruments then subject to calls sold by the insurer and outstanding under this paragraph, plus the purchase price of assets subject to puts then outstanding under this paragraph does not exceed 10% of its admitted assets; and

(2) The transaction is one of the following types and meets the other requirements specified in this subparagraph that are applicable to that type of transaction:

(a) Sales of call options on assets, if the insurer holds or has a currently exercisable right to acquire the underlying assets during the entire period that the option is outstanding;

(b) Sales of put options on assets, if the insurer holds sufficient cash, cash equivalents or interests in a short-term investment pool to purchase the underlying assets upon exercise during the entire period that the option is outstanding, and has the ability to hold the underlying assets in its portfolio. If the total market value of all put options sold by the insurer exceeds 2% of the insurer's admitted assets, the insurer shall set aside pursuant to a custodial or escrow agreement cash or cash equivalents having a market value equal to the amount of its put option obligations in excess of 2% of the insurer's admitted assets during the entire period the option is outstanding;

(c) Sales of call options on derivative instruments if the insurer holds or has a currently exercisable right to acquire assets generating the cash flow to make any payments for which the insurer is liable pursuant to the underlying derivative instruments during the entire period that the call options are outstanding and has the ability to enter into the underlying derivative transactions for its portfolio; or

(d) Sales of caps and floors, if the insurer holds or has a currently exercisable right to acquire assets generating the cash flow to make any payments for which the insurer is liable pursuant to the caps and floors during the entire period that the caps and floors are outstanding. [1999, c. 715, §10 (NEW).]

F. An insurer may enter into replication or synthetic asset transactions in accordance with the requirements of the purposes and procedures manual of the National Association of Insurance Commissioners or its successor publication concerning replication or synthetic asset transactions on or after the date on which the National Association of Insurance Commissioners adopts such requirements. [1999, c. 715, §10 (NEW).]

G. An insurer may purchase or sell one or more derivative instruments to offset, in whole or in part, any derivative instrument previously purchased or sold, without regard to the quantitative limitations of this subsection as long as the transaction may be recognized as an offsetting transaction in accordance with generally accepted accounting principles. [1999, c. 715, §10 (NEW).]

H. Each derivative instrument must be:

(1) Traded on a qualified exchange;

(2) Entered into with, or guaranteed by, a qualified bank or a qualified business entity;

(3) Issued or written by or entered into with the issuer of the underlying interest on which the derivative instrument is based; or

(4) In the case of futures, traded through a broker that is registered as a futures commission merchant under the federal Commodity Exchange Act or that has received exemptive relief from such registration under rule 30.10 promulgated under the federal Commodity Exchange Act. [1999, c. 715, §10 (NEW).]

[1999, c. 715, §10 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW). 1999, c. 715, §§9,10 (AMD).

§1154. AUTHORIZATION; RECORD OF INVESTMENTS

1. **Authorization required.** An insurer shall not make any investment or loan, other than policy loans or annuity contract loans, unless it is authorized or approved by the insurer's board of directors or by a committee of the board of directors charged with supervision of investments and loans.

[1987, c. 399, §14 (NEW) .]

2. **Records.** The insurer shall maintain a full record of each investment, showing, among other things, the name of any officer, director or principal stockholder of the insurer having any direct, indirect or contingent interest in the securities, loan or property constituting the investment, or in the person in whose behalf the investment is made, and the nature of that interest.

[1987, c. 399, §14 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW).

§1155. DIVERSIFICATION

Investments of an insurer shall be subject to the following diversification requirements and limitations. [1987, c. 399, §14 (NEW).]

1. **Real estate; personal property; equity interests; subsidiaries.** Not more than 40% of the insurer's assets in aggregate amount may consist of investments described in the following subdivisions:

A. Real estate, section 1156, subsection 2, paragraph D, subparagraph (1); [1987, c. 399, §14 (NEW).]

B. Personal property, section 1156, subsection 2, paragraph E; [1987, c. 399, §14 (NEW).]

C. Equity interests, section 1156, subsection 2, paragraph F; and [1987, c. 399, §14 (NEW).]

D. Subsidiaries, section 1157, except as provided in that section. [1987, c. 399, §14 (NEW).]

If, on or after the effective date of this subsection, the insurer makes investments of those types in institutions or property located within the State aggregating 1% or more of its assets, the 40% limitation in this subsection shall be increased by an equal amount up to 45%, exclusive of those investments in institutions or property located within the State, thus providing for a maximum limit on the investments described in those subdivisions of 50% of the insurer's assets.

[1987, c. 399, §14 (NEW) .]

2. **Government obligations; policy loans; other limitations.** Except as otherwise expressly provided, an insurer may not invest in or may not incur counter-party exposure to any one person if, after giving effect to those investments and that counter-party exposure, the aggregate of those investments in and that counter-party exposure to that person would exceed 10% of the insurer's admitted assets, with the following exceptions:

A. Government obligations pursuant to section 1156, subsection 2, paragraph A; [2001, c. 524, §3 (AMD).]

B. Policy loans pursuant to section 1158; and [2001, c. 524, §3 (AMD).]

C. Index mutual funds, but as to this exception, only with the prior approval of the superintendent and limited to 20% of the insurer's admitted assets. [2001, c. 524, §3 (NEW).]

[2001, c. 524, §3 (AMD) .]

3. Other investment limitations shall be as provided in particular sections of this chapter.

[1987, c. 399, §14 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW). 1999, c. 715, §11 (AMD). 2001, c. 524, §3 (AMD).

§1156. RESERVE AND OTHER INVESTMENTS

1. **Standard of care.** When investing the assets of an insurer, the directors and officers of the insurer shall perform their duties in good faith and with that degree of care that an ordinarily prudent person in a like position would use under similar circumstances.

[1987, c. 399, §14 (NEW) .]

2. **Investment classes.** Subject to section 1155, the assets of an insurer may be invested in the following classes, subject to the percentage limitations contained in this subsection:

A. Obligations issued, assumed, guaranteed or insured by the United States or by any state or by the District of Columbia, or any other governmental unit in the United States, its territories or possessions, or by any agency or instrumentality of any of those, provided that those obligations are by law payable, as to both principal and interest, from taxes upon all property or income within the jurisdiction of that governmental unit, or from adequate special revenues pledged or appropriated or otherwise by law required to be provided for the purpose of that payment, but not including special assessments on properties benefitted by local improvements unless adequate security is evidenced by the ratio of assessment to the value of those properties, or unless the obligation is additionally secured by an adequate guaranty fund required by law; [1987, c. 399, §14 (NEW).]

B. Obligations issued, assumed, guaranteed or accepted by domestic institutions or by trustees or receivers of those institutions, and preferred shares of any of those institutions, provided that without the prior approval of the superintendent, no domestic insurer may acquire any high-yield or medium grade obligations of any institution if:

(1) The aggregate amount of all medium grade obligations and all high-yield obligations then held by the insurer exceeds 20% of its admitted assets;

(2) The aggregate amount of all high-yield obligations then held by the insurer exceeds 10% of its admitted assets;

(3) The aggregate amount of all high-yield obligations rated 5 or 6 by the Securities Valuation Office of the National Association of Insurance Commissioners or, if not valued by the National Association of Insurance Commissioners, rated the equivalent of 5 or 6 by Moody's Investors Service, Inc., Standard and Poor's Corporation, Fitch Investors Service, Inc. or Duff and Phelps, Inc., exceeds 3% of admitted assets;

(4) The aggregate amount of all high-yield obligations rated 6 by the Securities Valuation Office of the National Association of Insurance Commissioners or, if not valued by the National Association of Insurance Commissioners, rated the equivalent of 6 by Moody's Investors Service, Inc., or rated D by Standard and Poor's Corporation, Fitch Investors Service, Inc., or Duff and Phelps, Inc., exceeds 1% of admitted assets;

(5) The aggregate amount of medium grade obligations issued, guaranteed or insured by any one institution then held by the insurer exceeds 1/2 of 1% of its admitted assets; or

(6) The aggregate amount of high-yield obligations issued, guaranteed or insured by any one institution then held by the insurer exceeds 1/2 of 1% of its admitted assets. [1993, c. 313, §26 (RPR).]

C. Obligations secured by liens on real property or interests in real property located within the United States and not eligible under paragraph A or B acquired directly or indirectly through limited partnership interests, general partnership interests, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates or other similar instruments if, at the time of the acquisition, the obligation does not exceed:

(1) Ninety percent of the fair market value of the real estate, if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(2) Eighty percent of the fair market value of the real estate, if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period of 30 years or less and requires periodic payments made no less frequently than annually. Each periodic payment must be sufficient to ensure that at all times the outstanding principal balance of the mortgage loan may not be greater than the outstanding principal balance that would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans that are otherwise permitted under this subparagraph may provide for a payment of the principal balance before the end of the period of amortization of the loan. For residential mortgage loans, the 80% limitation may be increased to 97% if acceptable private mortgage insurance has been obtained; or

(3) Seventy-five percent of the fair market value of the real estate for mortgage loans that do not meet the requirements of subparagraph (1) or (2).

A mortgage loan that is secured by other than a first lien may not be acquired under this paragraph unless the insurer is the holder of the first lien. For purposes of this paragraph, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the Administrator of Veterans' Affairs, or their successors. A mortgage loan that is acquired under this paragraph and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the National Association of Insurance Commissioners accounting practices and procedures manual or successor publication continues to qualify as a mortgage loan under this paragraph. [1999, c. 715, §12 (AMD).]

D. Investments in real property or interests therein located in the United States, held directly or evidenced by partnership interests, stock of corporations, trust certificates or other instruments and acquired:

(1) As an investment for the production of income or to be improved or developed for that investment purpose; or

(2) For the convenient accommodation of the insurer's business.

After giving effect to any of those types of investments, the aggregate amount of investments made under subparagraph (1) may not exceed 20% of the insurer's total admitted assets; the aggregate amount of investments made under subparagraph (2) may not exceed 10% of the insurer's total admitted assets; and the aggregate amount of investments made under this paragraph may not exceed 25% of the insurer's total admitted assets. Investments under subparagraph (1) in any single property, including improvements on that property, may not in the aggregate exceed 2% of the insurer's total admitted assets; [1993, c. 313, §27 (AMD).]

E. Investments in personal property or interests in that property located or used wholly or in part within the United States, held directly or evidenced by partnership interests, stock of corporations, trust certificates or other instruments, provided that, after giving effect to any investment of that type, the aggregate amount of those investments will not exceed 10% of the insurer's total admitted assets and provided that investments under this paragraph in any single item of personal property will not in the aggregate exceed 1% of the insurer's total admitted assets; [1987, c. 399, §14 (NEW).]

F. Investments, other than investments described in paragraph D or E and in addition to investments authorized by section 1157, in common stock, partnership interests, trust certificates or other equity interests, other than preferred shares, of domestic institutions, provided that, after giving effect to any investment of that type under this paragraph, the aggregate amount of those investments will not exceed 20% of the insurer's total admitted assets; [1987, c. 399, §14 (NEW).]

F-1. Investment practices entered into under section 1153, subsection 4 or section 1160, subsection 6; [2001, c. 471, Pt. D, §24 (NEW).]

G. The following foreign investments in and investment practices with persons domiciled in foreign jurisdictions:

(1) Canadian securities and investments substantially of the same classes as those eligible for investment under paragraphs A to F, but the aggregate amount of those investments that are held at any time by any insurer may not exceed 10% of total admitted assets, except when a greater amount is permitted pursuant to subparagraph (2), in which case this subparagraph is not applicable;

(2) In the case of any insurer that is authorized to do business in a foreign country or possession of the United States or that has outstanding insurance, annuity or reinsurance contracts on lives or risks resident or located in a foreign country or possession of the United States, securities and investments in that foreign country or possession that are substantially of the same classes as those eligible for investment under paragraphs A to F, but the aggregate amount of such investments in a foreign country or a possession of the United States and of cash in the currency of that country or possession that is at any time held by that insurer may not, except as provided in paragraph H, exceed 1 1/2 times the amount of its reserves and other obligations under those contracts or the amount that that insurer is required by law to invest in that country or possession, whichever is greater;

(3) Foreign investments in and foreign investment practices with persons domiciled in foreign jurisdictions that are substantially of the same classes as those eligible for investment under this chapter, if after giving effect to the investment or transaction:

(a) The aggregate amount of foreign investments then held by the insurer and foreign investment practices then engaged in by the insurer under this subparagraph does not exceed 20% of its admitted assets; and

(b) The aggregate amount of foreign investments then held by the insurer and foreign investment practices then engaged in by the insurer under this subparagraph in a single foreign jurisdiction does not exceed 10% of its admitted assets if the foreign jurisdiction has a sovereign debt rating of "1" from the Securities Valuation Office of the National Association of Insurance Commissioners or 3% of its admitted assets if the foreign jurisdiction has a sovereign debt rating other than "1" from the Securities Valuation Office of the National Association of Insurance Commissioners; and

(4) Investments and investment practices denominated in foreign currencies whether or not they are foreign investments acquired or foreign investment practices engaged in pursuant to subparagraphs (1) or (3), or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments or investment practices denominated in a foreign currency if:

(a) The aggregate amount of investments then held by the insurer and investment practices then engaged in by the insurer under this subparagraph denominated in foreign currencies does not exceed 10% of its admitted assets; and

(b) The aggregate amount of investments then held by the insurer and investment practices then engaged in by the insurer under this subparagraph denominated in the currency of a single foreign jurisdiction does not exceed 10% of its admitted assets if the foreign jurisdiction has a sovereign debt rating of "1" from the Securities Valuation Office of the National Association

of Insurance Commissioners or 3% of its admitted assets if the foreign jurisdiction has a sovereign debt rating other than "1" from the Securities Valuation Office of the National Association of Insurance Commissioners.

An investment or an investment practice is not considered denominated in a foreign currency if the insurer enters into one or more hedging transactions permitted under section 1153, subsection 4 to hedge the foreign currency exchange rate risk associated with such investment or investment practice; and [1999, c. 715, §13 (AMD).]

H. Investments that do not qualify or are not permitted under any other paragraph of this subsection; as long as:

(1) After giving effect to any investment made under this paragraph, the aggregate amount of those investments does not exceed 14% of total admitted assets, except that investments made under this paragraph in institutions or property not located within the State may not exceed 10% of total admitted assets; and, if the insurer makes investments described in paragraphs A to G and elects to charge those investments against the quantitative limits in this paragraph instead of the quantitative limits in paragraphs A to G, then the aggregate amount invested under this paragraph in those types of investments may not exceed 5% of total admitted assets for any one of those types of investments;

(2) Investments that are neither interest bearing nor income entitled are subject to all of the provisions of this paragraph; and the aggregate amount of those investments held at any one time may not exceed 3% of total admitted assets;

(3) The investment limitations contained in this chapter, qualitative or otherwise, do not apply to loans or investments made or acquired under this paragraph, provided that no loan or investment made or acquired under this paragraph may be represented by any asset determined to be nonadmitted pursuant to section 901-A or rules adopted under that section; any loan or investment expressly prohibited under section 1160; or agents' balances, or amounts advanced to or owing by agents, except as to policy loans, mortgage loans and collateral loans to those agents otherwise authorized under this chapter; or

(4) The insurer shall keep a separate record of all loans and investments made or acquired under this paragraph. Any such loan or investment that, subsequent to the date of making or acquisition, has attained the standard of eligibility and qualifies under any other provision of this chapter may be considered to have been made or acquired under and in compliance with that provision and may no longer be considered to have been made or acquired under this paragraph. [2001, c. 471, Pt. A, §27 (AMD).]

[2001, c. 471, Pt. A, §27 (AMD); 2001, c. 471, Pt. D, §24 (AMD) .]

3. Determination of eligibility. The eligibility of any investment under any paragraph of subsection 2 must be determined at the time of acquisition, except that investments qualified under subsection 2, paragraph H, may be requalified at a later date under another provision of this chapter, if the relevant conditions are satisfied at the time of such requalification.

[1993, c. 313, §28 (AMD) .]

SECTION HISTORY
1987, c. 399, §14 (NEW). 1993, c. 313, §§26-28 (AMD). 1999, c. 715, §§12,13 (AMD). 2001, c. 72, §14 (AMD). 2001, c. 471, §§A27,D24 (AMD).

§1157. INVESTMENT IN SUBSIDIARIES

1. **Investment or acquisition.** Subject to the limitations contained in subsection 5, an insurer may invest in, or otherwise acquire, subsidiaries engaged or organized to engage in any businesses lawful under the laws of the jurisdictions in which those subsidiaries are organized.

[1987, c. 399, §14 (NEW) .]

2. **Authorization.** Except as provided in section 1153, subsection 3, investments in subsidiaries authorized by this section may not be authorized under any other section of this chapter.

[1987, c. 399, §14 (NEW) .]

3. **Superintendent; order of disposition.** At any time after the acquisition by the insurer of any subsidiary, other than a holding company engaged solely in the ownership or control of other subsidiaries, or a subsidiary referred to in subsection 5, paragraph B, subparagraphs (1) or (2), the superintendent may order its disposition if he finds, after notice and an opportunity to be heard, that its continued retention is materially adverse to the interests of the insurer's policyholders. The insurer shall have at least 36 months to effect the disposition. If that disposition is not so effected, the subsidiary may not thereafter be allowed as an asset of the insurer.

[1987, c. 399, §14 (NEW) .]

4. **Name.** The name of any subsidiary may not be such as to mislead or deceive the public.

[1987, c. 399, §14 (NEW) .]

5. **Limitations.** Subject to the exceptions in paragraph B, investments in subsidiaries of an insurer are limited as follows.

A. Except with the approval of the superintendent, that insurer may not make, directly or indirectly, an investment in any subsidiary if that investment would bring the aggregate net cost of investments in all subsidiaries to an amount in excess of the lesser of 10% of the insurer's total admitted assets or 50% of the insurer's surplus as regards policyholders or if that investment would bring the aggregate net investment in that subsidiary to an amount in excess of 2% of those total admitted assets. [1993, c. 313, §29 (AMD).]

B. Investments made directly or indirectly in the following subsidiaries are not subject to the limitations contained in paragraph A or in section 1155 or 1156, nor are these investments to be counted in determining compliance with those limitations:

(1) Subsidiaries, all of whose stock is owned by one or more insurers, engaged or organized to engage exclusively in the ownership or management of assets authorized under this chapter as investments for the insurer;

(2) Subsidiaries engaged or organized to engage in the kinds of business in which the insurer may engage, provided that the aggregate net cost of the insurer's investments in all such subsidiaries may not exceed 50% of its surplus as to policyholders; and

(3) A subsidiary that is a depository institution, or any company that controls such an institution, that is subject to the federal Gramm-Leach-Bliley Act, Sections 104(c) and 306(2), 113 Stat. 1338, as long as the insurer's total investment in all such subsidiaries does not exceed 5% of the insurer's admitted assets.

An investment described in section 3415 is not considered as an investment in a subsidiary in determining compliance with the limitations of this subsection. [1999, c. 715, §14 (AMD).]

C. Subject to paragraph B, the "net cost of investment" is defined to be the sum of: The total money or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of that subsidiary; and all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation; less returns of capital, repayments of principal and any other payments reducing the investment in the subsidiary. [1987, c. 399, §14 (NEW).]

D. Investments made or acquired by subsidiaries referred to in paragraph B, subparagraph (1) are considered to be made or acquired directly by the insurer, pro rata, in the case of a subsidiary not wholly owned and, to such extent, are subject to all the provisions and limitations on the making of investments specified in this chapter with respect to investments by the insurer; must be valued in accordance with the provisions of section 901-A and any other applicable provisions of this Title and any applicable rules adopted by the superintendent; and must be located pursuant to section 3408. Those subsidiaries are subject to examination by the superintendent under section 221, subsection 1 and section 222, subsection 1-A. [2013, c. 238, Pt. A, §31 (AMD); 2013, c. 238, Pt. A, §34 (AFF).]

E. There shall be excluded from all computations under paragraph A any investment by an insurer in any subsidiary, or by one subsidiary in another subsidiary, to the extent that such investment is reinvested in another subsidiary, but amounts so reinvested shall thereafter be included in such computations unless further excluded or exempted by this chapter. [1987, c. 399, §14 (NEW).]

[2013, c. 238, Pt. A, §31 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

6. **Valuation of subsidiary stock.** In determining the financial condition of an insurer, all investments made directly or indirectly in the stock of its subsidiaries must be valued in accordance with section 901-A and any rules adopted under that section.

[2001, c. 72, §16 (AMD) .]

7. **Application of law.** Except as provided in section 1155, investments in subsidiaries made pursuant to this section are not subject to any other restrictions or prohibitions contained in this chapter.

[1987, c. 399, §14 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW). 1993, c. 313, §29 (AMD). 1993, c. 502, §3 (AMD). 1993, c. 502, §5 (AFF). 1999, c. 715, §14 (AMD). 2001, c. 72, §§15, 16 (AMD). 2013, c. 238, Pt. A, §31 (AMD). 2013, c. 238, Pt. A, §34 (AFF).

§1158. POLICY LOANS

A life insurer may lend to its policyholder, upon pledge of the policy as collateral security, any sum not exceeding the cash surrender value of the policy; or may lend against pledge or assignment of any of its supplementary contracts or other contracts or obligations, as long as the loan is adequately secured by that pledge or assignment. Loans so made are eligible investments of the insurer. [1987, c. 399, §14 (NEW).]

SECTION HISTORY
1987, c. 399, §14 (NEW).

§1159. SPECIAL INVESTMENTS; SEPARATE ACCOUNTS

1. **Special investments.** Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subsection 2:

A. Amounts allocated to any separate account established by the insurer pursuant to section 2537, separate accounts and accumulations on those accounts may be invested and reinvested without regard to any requirements or limitations prescribed by this chapter except for the provisions of section 1156, subsection 1; and [1987, c. 399, §14 (NEW).]

B. Except as provided in subsection 2, paragraph B, the investments in that separate account or accounts may not be taken into account in applying the investment limitations otherwise applicable to the investments of the insurer. [1987, c. 399, §14 (NEW).]

[1987, c. 399, §14 (NEW) .]

2. **Separate accounts.** Except with the approval of the superintendent and under such conditions as to investments and other matters as he may prescribe, which shall recognize the guaranteed nature of the benefits provided, no insurer may guarantee the value of the assets allocated to a separate account, or any interest in that account, or the investment results of that account, or the income from that account, to a contract holder, without limitation of liability under all those guarantees to the extent of the interest of the contract holder in assets allocated to that separate account, unless:

A. To the extent that the applicable agreements provide that the assets in that separate account shall not be chargeable with liabilities arising out of any other business of the insurer, the assets allocated to that separate account are invested subject to the requirements and limitations on investments imposed by section 1156, subsection 2, as though the aggregate assets allocated to that separate account were the insurer's total admitted assets; or [1987, c. 399, §14 (NEW).]

B. The assets allocated to that separate account are invested subject to the requirements and limitations on investments imposed by section 1156, subsection 2, as though they were part of the general assets of the insurer. [1987, c. 399, §14 (NEW).]

[1987, c. 399, §14 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW).

§1160. PROHIBITED TRANSACTIONS AND INVESTMENT UNDERWRITING

1. **Purchase of own common stock.** A stock insurer may not purchase its own common stock, except for the purpose of mutualization under chapter 47; for retirement; or pursuant to a plan for investment or loan submitted in writing by the insurer to the superintendent in advance, and which the superintendent has not disapproved within 20 days after the submission or within any additional reasonable period as the superintendent may request, as being unfair or inequitable to the insurer's policyholders or stockholders.

[1987, c. 769, Pt. A, §90 (AMD) .]

2. **Underwriting.** No insurer may underwrite or participate in the underwriting of an offering of securities or property of any person. This provision may not be considered to prohibit:

A. The acquisition and ownership by the insurer of its subsidiary corporation acting as an investment adviser or principal underwriter of a management company or investment company registered with the United States Securities and Exchange Commission under the Investment Company Act of 1940, United States Code, Title 11, Section 72 and 102, and Title 15, Sections 80a-1 to 80a-52, as amended; [1987, c. 399, §14 (NEW).]

B. The registration by the insurer, under the United States Securities Act of 1933, United States Code, Title 15, Sections 77a to 77aa or other applicable law, of restricted or other securities acquired and owned by it in the regular course of business; and [1987, c. 399, §14 (NEW).]

C. The underwriting by an insurer individually or on its account jointly with one or more of its subsidiaries of the securities of any company that is engaged primarily in the business of investing in or holding securities or real property and to which the insurer or any of its subsidiaries renders management, investment advisory or sales services nor from participating in sales or purchases of those securities jointly with any person in the insurer's holding company system, as defined in section 222. [1987, c. 399, §14 (NEW).]

[1987, c. 399, §14 (NEW) .]

3. **Investments in affiliates.** No insurer may purchase the stock of or otherwise invest in or lend its funds upon the security of any note or other evidence of indebtedness of any affiliate in the insurer's holding company system, except as authorized by section 222 or 1157, or lend its funds to any director or officer of the insurer or the spouse or child of any director or officer. This provision does not prohibit:

A. Policy loans authorized under section 1158. [1999, c. 715, §15 (AMD).]

B. [1999, c. 715, §15 (RP).]

C. [1999, c. 715, §15 (RP).]

[1999, c. 715, §15 (AMD) .]

4. **Encumbrance of securities.**

[1999, c. 715, §16 (RP) .]

5. **Disposition of property.** An insurer may enter into any agreement to sell or withhold from sale any of its property, as long as the insurer is not participating in a prohibited underwriting. The disposition of an insurer's property shall be the responsibility of its board of directors, in accordance with its charter and bylaws.

[1987, c. 399, §14 (NEW) .]

6. **Encumbrance of securities.** An insurer may enter into securities lending transactions that are conducted directly, through a custodian bank that is a qualified bank, or through an agent, and may enter into repurchase transactions, reverse repurchase transactions and dollar roll transactions, subject to the following requirements.

A. The insurer's board of directors shall adopt a written plan regarding such transactions that specifies guidelines and objectives to be followed, such as:

(1) A description of how cash received will be invested or used for general corporate purposes of the insurer;

(2) Operational procedures to manage interest rate risk, counter-party default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(3) The extent to which the insurer may engage in these transactions. [1999, c. 715, §17 (NEW).]

B. The insurer shall enter into a written agreement for all transactions authorized in this subsection other than dollar roll transactions. The written agreement must require each transaction to terminate no more than one year from its inception. The agreement must be made with the counter-party, except that, for securities lending transactions, the agreement may be through a custodian bank that is a qualified bank

or the agreement may be with an agent acting on behalf of the insurer if the agent or the guarantor of the agent's obligations under the agreement is a qualified bank or a qualified business entity and if the agreement with the agent requires the agent to enter into separate agreements with each counter-party that are consistent with the requirements of this subsection and prohibits securities lending transactions under the agreement with the agent or its affiliates. [1999, c. 715, §17 (NEW).]

C. Cash received in a transaction under this subsection, if not used by the insurer for its general corporate purposes in accordance with the plan adopted by the board of directors pursuant to paragraph A, must be invested in accordance with this chapter and in a manner that recognizes the liquidity needs of the transaction. For so long as any transaction under this subsection remains outstanding, the insurer, its agent or custodian shall maintain either physically or through the book entry systems of the Federal Reserve, Depository Trust Company, Participants Trust Company or other securities depositories approved by the superintendent:

(1) Possession of acceptable collateral for the transaction;

(2) A perfected security interest in acceptable collateral for the transaction; or

(3) In the case of a foreign jurisdiction, title to, or rights of a secured creditor to, acceptable collateral for the transaction.

The amount of acceptable collateral required for the purposes of subparagraphs (1), (2) and (3) is the amount required pursuant to the provisions of the purposes and procedures manual of the Securities Valuation Office of the National Association of Insurance Commissioners or its successor publication. [1999, c. 715, §17 (NEW).]

D. An insurer may not enter into a transaction under this subsection if, as a result of and after giving effect to the transaction:

(1) The aggregate amount of securities then loaned to, sold to or purchased from any one counter-party under this subsection would exceed 5% of its admitted assets. In calculating the amount sold to or purchased from a counter-party under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a written master agreement; or

(2) The aggregate amount of all securities then loaned to, sold to or purchased from all counter-parties under this subsection would exceed 40% of its admitted assets. [1999, c. 715, §17 (NEW).]

[1999, c. 715, §17 (NEW) .]

SECTION HISTORY
1987, c. 399, §14 (NEW). 1987, c. 769, §A90 (AMD). 1999, c. 715, §§15-17 (AMD).

§1161. INVESTMENTS OF FOREIGN INSURERS

The investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile, if of a quality substantially equal to that required under this chapter for similar funds of like domestic insurers. [1987, c. 399, §14 (NEW).]

SECTION HISTORY
1987, c. 399, §14 (NEW).

§1162. DEFINITIONS

(REPEALED)

SECTION HISTORY
1987, c. 399, §14 (NEW). 1993, c. 313, §30 (RP).

§1162-A. DEFINITIONS

(REPEALED)

SECTION HISTORY
RR 1993, c. 1, §§57,58 (COR). 1993, c. 313, §31 (NEW). 1999, c. 715, §18 (RP).

Chapter 15: ADMINISTRATION OF DEPOSITS

§1251. AUTHORIZED DEPOSITS OF INSURERS

The following deposits of insurers when made through the superintendent shall be accepted and held in trust, subject to the provisions of this chapter: [1973, c. 585, §12 (AMD).]

1. Deposits required under this Title for authority to transact insurance in this State.

[1969, c. 132, §1 (NEW) .]

2. Deposits of domestic insurers when made pursuant to its charter; or pursuant to the laws of other states, provinces, and countries as requirement for authority to transact insurance in such state, province or country.

[1969, c. 132, §1 (NEW) .]

3. Deposits in such additional amounts as are permitted to be made under section 1259.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1252. PURPOSE OF DEPOSIT

1. Deposits made in this State under section 412 (deposit requirement) shall be held in trust for the respective purposes stated in that section.

[1969, c. 132, §1 (NEW) .]

2. A deposit made in this State by a domestic insurer transacting insurance in another state, province or country, and as required by the laws of such other state, province or country, shall be held for the protection of all the insurer's policyholders or all its policyholders and creditors or for such other purpose or purposes as may be specified pursuant to such laws.

[1969, c. 132, §1 (NEW) .]

3. Deposits required under the retaliatory provision, section 428, shall be held for such purposes as is required by such provision, and as specified by the superintendent's order requiring such deposit to be made.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §25 (AMD). 1973, c. 585, §12 (AMD).

§1253. SECURITIES ELIGIBLE FOR DEPOSIT

1. All such deposits required under section 412 for authority to transact insurance in this State and hereafter made shall consist of securities in negotiable form of kinds eligible for investment of funds of domestic insurers under chapter 13, other than real estate mortgages, and approved by the superintendent for deposit. Deposits heretofore made shall consist of such assets as were then eligible for deposit.

[1973, c. 585, §12 (AMD) .]

2. All other deposits of a domestic insurer held in this State pursuant to the laws of another state, province or country shall be comprised of securities of the kinds described in subsection 1, and of such additional kind or kinds of securities required or permitted by the laws of such state, province or country.

[1969, c. 132, §1 (NEW) .]

3. Deposits of foreign insurers made in this State under the retaliatory provision, section 428, shall consist of such assets as are required by the superintendent pursuant to such provision.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §26 (AMD). 1973, c. 585, §12 (AMD).

§1254. DEPOSITARY; RECORDS

1. Deposits made in this State under this Title shall be made through the superintendent with the Treasurer of State.

[1973, c. 585, §12 (AMD) .]

2. The Treasurer of State shall furnish the superintendent, for delivery to the depositing insurer, his official certificate identifying the securities deposited, the amount and par value of each, and his opinion of their value.

[1973, c. 585, §12 (AMD) .]

3. The superintendent shall keep a record of the securities comprising the deposit of each insurer, showing as far as practical the amount and market value of each item, and all his transactions relative thereto.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1255. RESPONSIBILITY FOR SAFEKEEPING

The State shall be responsible for the safekeeping of all securities and receipts delivered to the superintendent under authority of this chapter. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1256. CUSTODIAL ARRANGEMENTS

1. In lieu of deposit with the Treasurer of State as provided in section 1254, upon the insurer's written request and for its greater convenience, the superintendent may in his discretion permit the insurer to make and maintain the deposit under custodial arrangements with the trust department of an established bank located in Maine.

[1973, c. 585, §12 (AMD) .]

2. Where of convenience to the insurer in the buying, selling and exchange of securities comprising its deposit, and in the collection of accruals thereon, the insurer may, with the superintendent's advance written approval, deposit certain of its securities under custodial arrangements with an established bank or trust company located outside this State.

[1973, c. 585, §12 (AMD) .]

3. The insurer shall deposit with the Treasurer of State through the superintendent the original receipts issued by the custodian institution for all securities held under such custodial arrangements.

[1973, c. 585, §12 (AMD) .]

4. The form and terms of all such custodial arrangements shall be as prescribed or approved by the superintendent consistent with the applicable provisions of this Title.

[1973, c. 585, §12 (AMD) .]

5. The insurer shall bear the costs of custodial arrangements, and the State of Maine shall not be responsible for the safekeeping of securities so held.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1257. ASSIGNMENT, TRANSFER OF SECURITIES OR ASSETS

All assets deposited by an insurer and not negotiable by delivery shall be duly assigned or transferred to the superintendent and his successors in office. Upon release of any such security to the insurer, the superintendent shall reassign or transfer the same to the insurer. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1258. APPRAISAL

The superintendent may, in his discretion, prior to acceptance for deposit of any particular security, or at any time thereafter while so deposited, have the same appraised or valued by competent appraisers. The reasonable cost of any such appraisal or valuation shall be borne by the insurer. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1259. EXCESS DEPOSITS

1. If securities deposited by an insurer under this chapter are subject to material fluctuations in market value, the superintendent may, in his discretion, require the insurer to deposit and maintain on deposit additional securities in amount reasonably necessary to assure that the deposit at all times has a market value of not less than the amount specified under the law by which the deposit is required.

[1973, c. 585, §12 (AMD) .]

2. An insurer may otherwise at its option deposit securities in amount exceeding its deposit required or otherwise permitted under this Title by not more than 20% of such required or permitted deposit, or $20,000, whichever is the larger amount, for the purpose of absorbing fluctuations in the value of securities deposited and to facilitate exchange and substitution of such securities. During the solvency of the insurer any such excess shall be released to the insurer upon its request. During the insolvency of the insurer, such excess deposit shall be released only as provided in section 1263, subsection 4.

[1969, c. 177, §27 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §27 (AMD). 1973, c. 585, §12 (AMD).

§1260. RIGHTS OF INSURER DURING SOLVENCY

So long as the insurer remains solvent and is in compliance with this Title it may: [1969, c. 132, §1 (NEW).]

1. Demand, receive, sue for and recover the income from the securities deposited;

[1969, c. 132, §1 (NEW) .]

2. Exchange and substitute for the deposited securities, eligible securities of equivalent or greater fair market value; and

[1969, c. 132, §1 (NEW) .]

3. At any reasonable time inspect any such deposit.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§1261. LEVY UPON DEPOSIT

No judgment creditor or other claimant of an insurer shall have the right to levy upon any of the assets held in this State as a deposit for the protection of the insurer's policyholders or policyholders and creditors. As to deposits made pursuant to the retaliatory provision, section 428, levy thereupon shall be permitted if so provided in the superintendent's order under which the deposit is required. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1262. DEFICIENCY OF DEPOSIT

If for any reason the market value of securities of an insurer held on deposit in this State as required under this Title falls below the required amount, the insurer shall promptly deposit other or additional assets eligible for deposit sufficient to cure the deficiency. If the insurer has failed to cure the deficiency within 20 days after receipt of notice thereof by registered mail from the superintendent, the superintendent shall forthwith revoke the insurer's certificate of authority. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§1263. DURATION AND RELEASE OF DEPOSIT, IN GENERAL

1. Every deposit made in this State by an insurer pursuant to this Title shall be held as long as there is outstanding any liability of the insurer as to which the deposit was so required; or, if a deposit required under the retaliatory provision, section 428, the deposit shall be held for so long as the basis of such retaliation exists.

[1969, c. 132, §1 (NEW) .]

2. Upon the request of a domestic insurer, the superintendent shall return to the insurer the whole or any portion of the assets and securities of the insurer held on deposit when the superintendent is satisfied that the securities so to be returned are subject to no liability and are not required to be longer held by any provision of law or the purposes of the original deposit. If the insurer has reinsured all its outstanding risks in another insurer or insurers authorized to transact insurance in this State, and if so provided in the reinsurance agreement, the superintendent shall deliver such securities to such insurer or insurers so assuming such risks, upon proof to his satisfaction:

A. That the assuming insurer has assumed and agreed to discharge all liabilities of every kind due and to become due which the deposit was to secure, [1969, c. 132, §1 (NEW).]

B. That the assuming insurer has on deposit in this State or with a State official in the United States, securities in an amount and value not less than the deposit required of the reinsured insurer and which will subsist for the security of the obligations of the reinsured insurer so assumed, and [1969, c. 132, §1 (NEW).]

C. That such assets and securities have been duly assigned, transferred and set over to such assuming insurer or insurers. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. The superintendent shall return to a foreign insurer any deposit made in this State by the insurer, when the insurer has ceased transacting insurance in this State, or in the United States, and the insurer is not subject to any liability in this State on account of which the deposit was held.

[1973, c. 585, §12 (AMD) .]

4. If the insurer is subject to delinquency proceedings as defined in section 4353 upon the order of a court of competent jurisdiction the superintendent shall yield the insurer's assets held on deposit to the receiver, conservator, rehabilitator or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

[1973, c. 585, §12 (AMD) .]

5. No release of deposited assets shall be made except upon application to and the written order of the superintendent. The superintendent shall have no personal liability for any release of any such deposit or part thereof so made by him in good faith.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

Chapter 16: PRODUCERS, ADJUSTERS AND CONSULTANTS

Subchapter 1: SCOPE OF CHAPTER AND DEFINITIONS HEADING: PL 1997, C. 457, §23 (NEW)

§1401. SCOPE OF CHAPTER

1. **Producers, consultants and adjusters.** This chapter governs the qualifications, licensing and general requirements for producers, consultants and adjusters as to any and all kinds of insurance and types of insurers, nonprofit hospital or medical service organizations, health maintenance organizations, fraternal benefit societies, viatical settlement providers and risk retention groups, except reinsurers.

[2001, c. 259, §2 (AMD) .]

2. **Agents and brokers.**

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF); T. 24-A, §1401, sub-§2 (RP) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §2 (AMD).

§1402. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following words have the following meanings. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

1. **Adjuster.** "Adjuster" means any individual who, as an independent contractor or as an employee of an independent contractor, or as an employee of another organization, for fee, commission or other compensation, investigates for, settles on behalf of and reports to an insurer, fraternal benefit society, workers' compensation self-insurer or insured relative to claims arising under the workers' compensation laws or other types of insurance contracts. "Adjuster" does not include:

A. Attorneys admitted to practice in this State; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. Property and casualty insurance adjusters who are employees of insurers; [2009, c. 511, Pt. C, §1 (AMD).]

C. Licensed producers authorized by contract to settle and pay claims within a specified limit established by the insurer or fraternal benefit society not to exceed $5,000; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. Persons excepted from licensure as adjusters pursuant to Title 5, section 1727-A and persons acting as adjusters solely on behalf of the State or counties, cities and towns; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

E. Persons adjusting only life and health insurance claims; [2011, c. 554, §1 (AMD).]

F. Adjuster trainees; or [2011, c. 554, §1 (AMD).]

G. An individual who satisfies the following with regard to portable electronic device insurance as defined under section 7001, subsection 6, paragraph A:

(1) The individual collects claim information from, or furnishes claim information to, insureds or claimants and conducts data entry including entering data into an automated claims adjudication system; and

(2) The individual is an employee of an adjuster licensed under this chapter or the adjuster's affiliate.

No more than 25 individuals under the supervision of one licensed adjuster or insurance producer described under paragraph C may be exempt pursuant to this paragraph.

For purposes of this paragraph, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of portable electronic device insurance claims that is used by an adjuster, insurance producer or supervised individual operating pursuant to this paragraph; complies with all claims payment requirements of the Maine Insurance Code; and is certified as compliant with this paragraph by a licensed adjuster that is an officer of a business entity licensed under this chapter. [2011, c. 2, §29 (COR).]

[2011, c. 2, §29 (COR) .]

2. **Adjuster trainee.** "Adjuster trainee" means any individual with less than one year total experience handling loss claims under insurance contracts or the workers' compensation laws who is not licensed in this State as an adjuster and who is employed by and subject to the immediate personal supervision of an adjuster who is licensed in this State and who has been established in the business of adjusting for 3 years or more.

[1997, c. 592, §19 (AMD) .]

3. **Agency.**

[2001, c. 259, §3 (RP) .]

3-A. **Business entity.** "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

[2001, c. 259, §4 (NEW) .]

4. **Consultant.** "Consultant" means any individual who, for a fee, advises or offers to advise any person insured or seeking insurance or named or to be named as beneficiary, or having or to have any interest in or insured under any property and casualty or life and health insurance contract or annuity contract, existing or proposed.

A. "To advise" means to provide information relative to coverage, rights or interests under insurance or annuity contracts, or relative to the retention, exchange, surrender, exercise of rights or other disposition of insurance or annuity contracts. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. [1999, c. 225, §1 (RP).]

C. [1999, c. 225, §1 (RP).]

D. "Consultant" does not include:

(1) An attorney licensed to practice who is actively practicing law in this State;

(2) An insurance actuary and member or associate of the Society of Actuaries or American Academy of Actuaries;

(3) A public accountant certified under Title 32, chapter 113 or a certified public accountant who is certified under Title 32, chapter 113 and in active public practice;

(4) A licensed insurance producer who receives a fee in lieu of a commission pursuant to section 1450 if the insurance producer receives a fee for the insurance transaction and not for other services provided;

(5) A financial institution or a financial institution holding company if the insurance advice is given as part of its trust department rendering insurance advice in a fiduciary capacity; or

(6) A person authorized to act as or on behalf of an investment advisor in accordance with Title 32, section 16403 and 16404 to the extent such activities entail providing insurance advice incidental to financial planning advice. [2005, c. 65, Pt. C, §10 (AMD).]

[2005, c. 65, Pt. C, §10 (AMD) .]

5. **Insurance producer.** "Insurance producer" means a person required to be licensed under subchapter II-A to sell, solicit or negotiate insurance.

A. [1997, c. 457, §23 (NEW); T. 24-A, §1402, sub-§5, ¶ A (RP).]

[2001, c. 259, §5 (RPR) .]

6. **Insurance producer activities.**

[2001, c. 259, §6 (RP) .]

7. **License.** "License" means a document issued by the superintendent authorizing a person to act as an insurance producer, adjuster or consultant for kinds of insurance specified in the document as authorized in this chapter. The license itself does not create any authority, actual, apparent or inherent, in the licensee to represent or commit any particular insurer, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group.

[1997, c. 592, §19 (AMD) .]

8. **Life and health consultant.** "Life and health consultant" means a person licensed as a consultant to advise on life contracts, annuity contracts and health insurance contracts.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

9. **Limited insurance producer license.**

[2001, c. 259, §7 (RP) .]

9-A. **Multiple peril crop insurance adjuster.** “Multiple peril crop insurance adjuster” means a person who adjusts crop insurance claims under the federal crop insurance program administered by the United States Department of Agriculture.

[2009, c. 511, Pt. C, §2 (NEW) .]

10. **Nonresident.** "Nonresident" means a person other than a resident of this State.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

11. **Property and casualty consultant.** "Property and casualty consultant" means a person licensed as a consultant to advise on any one or more of the following kinds of insurance:

A. Casualty insurance; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. Property insurance; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. Surety insurance; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. Marine and transportation insurance; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

E. Title insurance; or [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

F. Legal services insurance. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

11-A. **Property and casualty insurance adjuster.** "Property and casualty insurance adjuster" means a person who adjusts property and casualty claims of any kind except for multiple peril crop insurance claims.

[2009, c. 511, Pt. C, §3 (NEW) .]

12. **Resident.** "Resident" means any of the following:

A. An individual who is domiciled in this State and who is not licensed elsewhere as a resident producer, consultant or adjuster; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. An individual whose principal place of business is located in this State and who is not licensed elsewhere as a resident producer, consultant or adjuster; or [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. A business entity either incorporated in this State or having its principal place of business in this State that is not licensed as a resident business entity elsewhere. [2001, c. 259, §8 (AMD).]

[2001, c. 259, §8 (AMD) .]

13. **Service representative.**

[2001, c. 259, §9 (RP) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §19 (AMD). 1999, c. 225, §§1,2 (AMD). 1999, c. 270, §§1,2 (AMD). 2001, c. 259, §§3-9 (AMD). 2005, c. 65, §C10 (AMD). 2009, c. 511, Pt. C, §§1-3 (AMD). RR 2011, c. 2, §29 (COR). 2011, c. 554, §§1, 2 (AMD). MRSA T.24A ., §1402/5/A (AMD).

Subchapter 2: GENERAL LICENSING REQUIREMENTS FOR PRODUCERS, ADJUSTERS, CONSULTANTS AND BUSINESS ENTITIES HEADING: PL 1997, C. 457, §23 (NEW); 2001, C. 259, §10 (RPR)

§1410. PRELICENSING REQUIREMENTS

1. **Written examination.** Unless exempt, prior to filing an application for a license with the superintendent, an individual applying for a resident insurance producer, adjuster or consultant license must pass a written examination. The examination must test the knowledge of the individual concerning the kinds of insurance for which the application is made, the duties and responsibilities of an insurance producer, adjuster or consultant and the insurance laws and rules of this State.

[2001, c. 259, §11 (NEW) .]

2. **Examination content.** The examination may be administered as a 2-part examination. If a 2-part examination is administered, one part of the examination must test the applicant's knowledge as to the kinds of insurance for which the application is made and the other part must test the individual's knowledge of the duties and responsibilities of an insurance producer, adjuster or consultant and the insurance laws and

rules of this State. The producer examination must be administered in accordance with subchapter II-A, the consultant examination in accordance with subchapters III and V and the adjuster examination in accordance with subchapters III and VI.

[2001, c. 259, §11 (NEW) .]

3. **Outside testing service.** The superintendent may make arrangements, including contracting with an outside testing service, for administering examinations. The applicant shall pay any fees for the services of any independent testing service designated by the superintendent. An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

[2001, c. 259, §11 (NEW) .]

4. **Education requirements.**

[2007, c. 51, §1 (RP) .]

5. **Experience required.** An applicant for examination for a consultant license must have had not less than 5 years of actual experience with respect to the kinds of insurance and contracts to be covered by the license.

[2001, c. 259, §11 (NEW) .]

6. **Examination results.** Within 30 days after an individual completes the examination, the superintendent or any independent testing service designated by the superintendent shall inform the individual whether or not the individual has passed. An individual who fails the examination must remit the required fees before being rescheduled for another examination. An individual who fails one part of a 2-part examination must pay the full examination fee but need only be examined on the part of the examination that the individual failed. An individual who does not apply for a license within 2 years after passing one part or all of an examination must register and pay the fee for a subsequent examination.

[2001, c. 259, §11 (NEW) .]

7. **Separate examination for each category.** An applicant for more than one kind of license or for more than one authority under a license must be separately examined for each category of license or authority and shall pay a separate examination fee for each examination. Nothing in this section prohibits the giving of all required examinations to a particular applicant on the same day.

[2001, c. 259, §11 (NEW) .]

8. **Variable contract license.** An applicant for a variable contract license, in addition to passing an examination required for a resident producer's license with life authority in accordance with subchapter II-A, must have successfully completed the minimum requirements of a national association of securities dealers for the sale of variable contracts.

[2001, c. 259, §11 (NEW) .]

9. **Multiple peril crop insurance adjuster examination.** An individual applying for a resident multiple peril crop insurance adjuster license must either pass a crop adjuster examination administered by the superintendent under this section or provide proof of federal crop insurance certification pursuant to a process that includes passing a crop adjuster proficiency examination.

[2009, c. 511, Pt. C, §4 (NEW) .]

SECTION HISTORY
2001, c. 259, §11 (NEW). 2007, c. 51, §1 (AMD). 2009, c. 511, Pt. C, §4 (AMD).

§1411. LICENSE REQUIRED

1. **Producer.** A person may not act as or purport to be an insurance producer or limited insurance producer or engage in producer activities with respect to insurance risks resident, located or to be performed in this State or elsewhere for any kind or kinds of insurance unless licensed for such a kind or kinds in accordance with subchapter II-A.

[2001, c. 259, §12 (AMD) .]

2. **Consultant; adjuster.** A person may not act as or purport to be a consultant with respect to insurance risks resident, located or to be performed in this State or elsewhere unless licensed as a consultant under this chapter. A person may not act as or purport to be an adjuster unless licensed as an adjuster under this chapter, except as provided in section 1475.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

3. **Insurance business.** A person may not for a fee or commission engage in the business of offering any advice, counsel, opinion or similar service with respect to the benefits, advantages or disadvantages under any policy of insurance that is issued in this State unless that person is:

A. Engaged or employed as an attorney licensed in this State to practice law; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. A licensed insurance producer offering advice concerning a kind of insurance for which the insurance producer is licensed to transact business and does not receive a separate fee for rendering such advice other than commissions or fees for the sale of an insurance or annuity policy, except that this paragraph does not apply to a licensed insurance producer who is also authorized to act as or on behalf of an investment advisor pursuant to section 1402, subsection 4, paragraph D, subparagraph (6); [1999, c. 225, §3 (AMD).]

C. An actuary or a certified public accountant engaged or employed in a consulting capacity, performing duties incidental to that position; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. A licensed adjuster acting within the scope of the license; or [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

E. A licensed insurance consultant acting within the scope of the license. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1999, c. 225, §3 (AMD) .]

4. **Liability.** A licensee is personally liable under any insurance contract made by or through the licensee that is outside the scope of the license authority. An insurance contract issued on an application solicited, received or forwarded by an unlicensed person and otherwise valid is not thereby rendered invalid.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1999, c. 225, §3 (AMD). 2001, c. 259, §12 (AMD).

§1412. PROHIBITED ACTIVITIES

1. **License revocation.** A person whose license as an insurance producer, consultant or adjuster has been revoked, suspended, denied for cause or voluntarily surrendered to avoid prosecution in this State may not participate in any manner in the conduct of an insurance business entity, whether an agency or insurance brokerage or consulting or adjusting business.

[2001, c. 259, §13 (AMD) .]

2. **Compensation.** A person whose license as an insurance producer, consultant or adjuster has been revoked, suspended, denied for cause or voluntarily surrendered to avoid prosecution may not derive any compensation, by whatever name called, based on the operation of the insurance business entity in which the person was engaged or employed prior to the revocation, suspension, denial or surrender of license. This subsection does not prohibit a person from receiving compensation for activities that the person engaged in prior to any loss of license referred to in this section, nor does it prohibit any person from divesting an interest in an insurance company or agency for value.

[2001, c. 259, §13 (AMD) .]

3. **Relicensure.** Nothing in this section prohibits any rights a person may have to seek relicensure under section 1418.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

4. **Violations.** Any person violating this section is guilty of a Class E crime and may be punished upon conviction, by a fine of not less than $100 nor more than $1,000, or by imprisonment for not more than 6 months, or by both.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §13 (AMD).

§1413. LICENSE REQUIREMENT FOR BUSINESS ENTITIES

1. **License required.** A business entity, whether it has a location in this State or not, must be licensed as an insurance producer, adjuster or consultant business entity in order to authorize individual licensees to act on the entity's behalf by engaging in insurance producer, adjuster or consultant activities or in order to use the name of the business entity in insurance-related advertising in the State. A business entity has no authority to act on its own without an individual licensee. A license authority held by an individual licensee employed by a business entity does not transfer to other employees within that business entity. Licensure of a

nonresident business entity does not depend upon the entity's maintaining a business entity license in another state. Business entity licensees are subject to the standards of section 407, subsection 2, when applicable, and section 408, subsections 1 and 4.

[2001, c. 259, §14 (AMD) .]

2. **Officers; directors; members; partners.** A business entity shall notify the superintendent of its members, directors, officers or partners, and of all executive officers and directors of entities owning and individuals owning, directly or indirectly, 51% or more of the outstanding voting securities of the applicant, within 14 days of a request for such information by the superintendent.

[2011, c. 554, §3 (AMD) .]

3. **Responsible person.** Each officer or director of a corporation, each officer and member of a limited liability company and each partner of a partnership who is acting as an insurance producer, adjuster or consultant shall obtain an insurance producer, adjuster, or consultant license. Officers, members and partners do not have to be individually licensed if they are not engaging in producer activities, are not acting as consultants or adjusters and are not being compensated based upon the volume of insurance business transacted. At least one individual licensee must be designated responsible for the business entity's compliance with the insurance laws and rules of this State. The responsible person shall ensure that every individual acting in the name of the entity does not act beyond the scope of that individual's license. The designated responsible person for each business entity shall maintain a list of all current home addresses and home telephone numbers for each individual designated to act in the name of the entity. The business entity shall notify the superintendent, within 14 days of every change of the designated licensed person responsible for the entity's compliance with laws and rules of this State. The designated responsible person is responsible for all correspondence with the business entity from the superintendent. If the responsible person in a business entity loses that person's license, the business entity license terminates if a new person is not designated as responsible for the business entity within 14 days.

[2001, c. 259, §14 (AMD) .]

4. **Authority.** Whenever a business entity changes the individuals designated to act in the name of the entity, the entity shall notify the superintendent within 30 days of those changes.

[2001, c. 259, §14 (AMD) .]

5. **Resident branch offices.** A resident business entity establishing more than one place of business in this State must procure a business entity branch registration for each location within the State. A resident branch office is any office location other than the location of the licensed business entity that regularly conducts insurance business or that is advertised as a location where the public may contact the business entity or its employees concerning insurance services. An office location that meets this definition that is itself a separate legal entity from the licensed business entity must obtain a separate business entity license and can not be registered as a branch office. The licensed person designated as responsible for the business entity is responsible for all branch locations.

[2001, c. 259, §14 (AMD) .]

6. **Nonresident branch locations.** A nonresident business entity doing business in this State shall procure a business entity license for its principal location and a branch office registration for each location doing business in the State. The licensed person designated as responsible for the business entity is responsible for all such branch locations.

[2001, c. 259, §14 (AMD) .]

7. **Applications.**

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF); T. 24-A, §1413, sub-§7 (RP) .]

8. **Motor vehicle rental company.** A rental company that primarily provides rental of motor vehicles to the public under a rental agreement that includes travel, baggage, liability or other related insurance coverage purchased by an individual in connection with and incidental to the rental of a motor vehicle, whether at the rental office or by preselection of coverage by the individual, shall obtain a limited insurance producer license under this chapter, and at least one employee at each office of the rental company located in the State shall obtain a limited insurance producer license.

[1999, c. 270, §3 (NEW) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §20 (AMD). 1999, c. 270, §3 (AMD). 2001, c. 259, §14 (AMD). 2011, c. 554, §3 (AMD).

§1414. TRADE NAMES

A licensee doing business under any name other than the licensee's legal name is required to notify the superintendent prior to using the trade name. [2001, c. 259, §15 (RPR).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §15 (RPR).

§1415. LICENSE AUTHORITIES

1. **Producer authorities.** An individual resident or nonresident insurance producer may receive any of the full license authorities pursuant to section 1420-F, subsection 1, paragraphs A to F and surplus lines authority in accordance with chapter 19.

A. [2001, c. 259, §16 (RP).]

B. [2001, c. 259, §16 (RP).]

C. [2001, c. 259, §16 (RP).]

D. [2001, c. 259, §16 (RP).]

E. [2001, c. 259, §16 (RP).]

[2011, c. 238, Pt. H, §4 (AMD) .]

2. **Consultant categories.** A resident or nonresident consultant may receive the following authorities under the license:

A. Property and casualty; or [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. Life and health. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

3. **Adjuster authorities.** A resident or nonresident adjuster may receive the following authorities under the license:

A. Property and casualty insurance adjuster; and [2009, c. 511, Pt. C, §5 (NEW).]

B. Multiple peril crop insurance adjuster. [2009, c. 511, Pt. C, §5 (NEW).]

[2009, c. 511, Pt. C, §5 (AMD) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §21 (AMD). 2001, c. 259, §16 (AMD). 2009, c. 511, Pt. C, §5 (AMD). 2011, c. 238, Pt. H, §4 (AMD).

§1416. LIMITED INSURANCE LICENSES

1. **Limited license.** The superintendent may issue to an applicant qualified under this chapter a limited insurance producer license, in the areas of authority listed as such in section 1420-F.

[2001, c. 259, §17 (AMD) .]

2. **Fee.** The fee for a limited insurance producer license is specified in section 601.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §17 (AMD).

§1416-A. LICENSE CONTINUATION OR TERMINATION

1. **License for indefinite term.** Each license issued under this chapter continues in force continuously, unless suspended, revoked or otherwise terminated by the superintendent, as long as any applicable fee set forth in section 601 is paid and education requirements for resident licensees are met by the due date.

[2001, c. 259, §18 (NEW) .]

2. **Biennial license continuation fees.** Each nonresident adjuster and consultant must be billed by the superintendent a biennial fee as provided in section 601 and shall pay the fee due by January 1st of even-numbered years. Each nonresident business entity must be billed by the superintendent a biennial fee as provided in section 601 and shall pay the fee due by April 1st of odd-numbered years. Each resident adjuster and consultant must be billed by the superintendent a biennial fee as provided in section 601 and shall pay the fee due by October 1st of even-numbered years. Each resident business entity must be billed by the superintendent a biennial fee as provided in section 601 and shall pay the fee due by December 1st of even-numbered years.

[2005, c. 43, §1 (AMD) .]

3. **Suspension or revocation.** Failure to pay the required fees by a licensee within 90 days from the due date results in suspension or revocation of the license pursuant to section 1417, for violating the insurance laws pursuant to section 1420-K, subsection 1, paragraph B.

[2001, c. 259, §18 (NEW) .]

SECTION HISTORY
2001, c. 259, §18 (NEW). 2005, c. 43, §1 (AMD).

§1417. SUSPENSION; REVOCATION; REFUSAL OF LICENSE

1. **Suspension, revocation, probation, denial.** Notwithstanding Title 5, chapter 375, subchapter VI, the superintendent may, after notice and opportunity for hearing, deny, revoke, suspend, place on probation or limit the permissible activities under any license issued under this chapter, including business entity licenses, or any surplus lines broker license if the superintendent finds that, as to the applicant or licensee, any of the causes exist that are listed in section 1420-K, and that for purposes of this section apply to adjusters and consultants as well as producers.

A. [2001, c. 259, §19 (RP).]

B. [2001, c. 259, §19 (RP).]

C. [2001, c. 259, §19 (RP).]

D. [2001, c. 259, §19 (RP).]

E. [2001, c. 259, §19 (RP).]

F. [2001, c. 259, §19 (RP).]

G. [2001, c. 259, §19 (RP).]

H. [2001, c. 259, §19 (RP).]

[2001, c. 259, §19 (AMD) .]

2. **Agency suspension.**

[2001, c. 259, §20 (RP) .]

3. **Voluntary surrender.** The superintendent may, after notice and opportunity for a hearing under this section, deem the license suspended or revoked of a previously licensed person who voluntarily surrendered an insurance license.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

4. **Exceptional circumstances.**

[2001, c. 259, §21 (RP) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §§22,23 (AMD). 2001, c. 259, §§19-21 (AMD).

§1418. RELICENSING AFTER REVOCATION; REFUSAL OF LICENSE

1. **Relicensing.** The superintendent may not issue a license under this Title to a person whose license has been revoked until at least one year has expired from the effective date of that revocation. If the licensee pursues an appeal from the superintendent's decision, the superintendent may not consider issuance of a new license until at least one year from the date of a final court order affirming that revocation. The license applicant shall reestablish qualification for the license in accordance with the applicable provisions of this Title. The superintendent may refuse any such new license applications unless the applicant shows good cause why the prior revocation should not be deemed a bar to the issuance of a new license.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Ineligibility for relicensing.** A person whose license has been revoked twice pursuant to section 1417 or section 1420-K may not again be eligible for any license under this Title.

[2001, c. 259, §22 (AMD) .]

3. **Business entity relicensing.** If the license of a business entity is suspended or revoked pursuant to section 1417 or section 1420-K, an officer, director or member of that entity may not be licensed as an insurance producer, adjuster or consultant during the period of that suspension or revocation unless the superintendent determines that member, officer or director was not personally at fault and did not acquiesce in the matter for which the license was suspended or revoked.

[2001, c. 259, §22 (AMD) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §22 (AMD).

§1419. DUTY TO NOTIFY OF CHANGES; PAYMENT OF LATE FEE

Unless a different time is set by another provision of law, any change of business address, business telephone number, name or other material change in the conditions or qualifications set forth in the original application of a licensee must be reported to the superintendent no later than 30 days after the change. This requirement includes any conviction of a crime other than a traffic violation or any disciplinary action brought by an insurance regulatory official of any other jurisdiction against the licensee or against any officer, director, member or partner in a business entity. A licensee shall report to the superintendent any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this State within 30 days of the final disposition of the matter. This report must include a copy of the order, consent to order or other relevant legal documents. Within 30 days of the initial pretrial hearing date, a licensee shall report to the superintendent any criminal prosecution of the licensee taken in any jurisdiction. The report must include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents. If any notice required under this section is received after the prescribed time period, the licensee shall pay the late fee for filing as prescribed in section 601. [2001, c. 259, §23 (AMD).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §24 (AMD). 2001, c. 259, §23 (AMD).

Subchapter 2-A: MAINE PRODUCER LICENSING ACT HEADING: PL 2001, C. 259, §24 (NEW)

§1420. SHORT TITLE; SCOPE AND APPLICATION

1. **Short title.** This subchapter may be known and cited as the "Maine Producer Licensing Act."

[2001, c. 259, §24 (NEW) .]

2. **Scope and application.** This subchapter governs the qualifications and procedures for the licensing of insurance producers. It simplifies and organizes some statutory language to improve efficiency, permits the use of new technology and reduces costs associated with issuing and renewing insurance licenses. This subchapter does not apply to excess and surplus lines agents and brokers required to be licensed as producers with surplus lines authority pursuant to chapter 19, except as provided in sections 1420-G and 1420-O.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-A. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [2001, c. 259, §24 (NEW).]

1. **Business entity.** "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

[2001, c. 259, §24 (NEW) .]

2. **Home state.** "Home state" means the District of Columbia and any state or territory of the United States that is the location of an insurance producer's principal place of residence or principal place of business, and in which that person is licensed to act as an insurance producer.

[2001, c. 259, §24 (NEW) .]

3. **Insurance.** "Insurance" has the same meaning as in section 3, and as the context may require, means any of the lines of authority in chapter 9, subchapter I.

[2001, c. 259, §24 (NEW) .]

4. **Insurance producer.** "Insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance.

[2001, c. 259, §24 (NEW) .]

5. **Insurer.** "Insurer" means a person engaged in the business of entering into contracts of insurance, as defined in section 3, and includes a health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization, viatical settlement provider or risk retention group.

[2001, c. 259, §24 (NEW) .]

6. **License.** "License" means a document issued by the superintendent authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

[2001, c. 259, §24 (NEW) .]

7. **Limited line credit insurance.** "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the superintendent determines should be designated a form of limited line credit insurance.

[2001, c. 259, §24 (NEW) .]

8. **Limited line credit insurance producer.** "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy.

[2001, c. 259, §24 (NEW) .]

9. **Limited lines insurance.** "Limited lines insurance" means those lines of insurance defined as limited lines in section 1420-F, subsection 1 or any other line of insurance that the superintendent determines necessary to recognize for the purposes of complying with section 1420-G, subsection 5.

[2001, c. 259, §24 (NEW) .]

10. **Limited lines producer.** "Limited lines producer" means a person authorized by the superintendent to sell, solicit or negotiate limited lines insurance.

[2001, c. 259, §24 (NEW) .]

11. **Negotiate.** "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

[2001, c. 259, §24 (NEW) .]

12. **Person.** "Person" means an individual or a business entity.

[2001, c. 259, §24 (NEW) .]

13. **Sell.** "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

[2001, c. 259, §24 (NEW) .]

14. **Solicit.** "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

[2001, c. 259, §24 (NEW) .]

15. **Terminate.** "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

[2001, c. 259, §24 (NEW) .]

16. **Uniform business entity application.** "Uniform business entity application" means the uniform business entity application for resident and nonresident business entities authorized by the National Association of Insurance Commissioners, or its successor organization.

[2001, c. 259, §24 (NEW) .]

17. **Uniform application.** "Uniform application" means the uniform application for resident and nonresident producer licensing authorized by the National Association of Insurance Commissioners or its successor organization.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-B. LICENSE REQUIRED

A person may not sell, solicit or negotiate insurance in this State for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this subchapter. [2001, c. 259, §24 (NEW).]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-C. EXCEPTIONS TO LICENSING

1. **Insurers.** This subchapter may not be construed to require an insurer to obtain an insurance producer license. In this section, "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

[2001, c. 259, §24 (NEW) .]

2. **Exceptions.** A license as an insurance producer is not required of the following:

A. An officer, director or employee of an insurer or of an insurance producer, only if that officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this State and:

(1) The activities of the officer, director or employee are executive, administrative, managerial, clerical or a combination of these and are only indirectly related to the sale, solicitation or negotiation of insurance;

(2) The functions of officer, director or employee relate to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(3) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers when the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance; [2001, c. 259, §24 (NEW).]

B. A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; a person who secures and furnishes information for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or a person who performs administrative services related to mass marketed property and casualty insurance without being paid a commission for the service; [2001, c. 259, §24 (NEW).]

C. An employer or association or its officers, directors or employees, or the trustees of an employee trust plan, to the extent that the employer, officers, employees, directors or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employer, association, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts; [2001, c. 259, §24 (NEW).]

D. Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers, and who are not individually engaged in the sale, solicitation or negotiation of insurance; [2001, c. 259, §24 (NEW).]

E. A person whose activities in this State are limited to advertising without the intent to solicit insurance in this State through communications in printed publications or other forms of electronic mass media, whose distribution is not limited to residents of the State, if the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this State; [2001, c. 259, §24 (NEW).]

F. A person who is not a resident of this State who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, if that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; [2011, c. 297, §2 (AMD).]

G. A salaried full-time employee who counsels or advises that person's employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer if the employee does not sell or solicit insurance or receive a commission; or [2011, c. 297, §3 (AMD).]

H. A person who offers to sell or sells portable electronic device insurance pursuant to a license issued by the superintendent under chapter 89. [2011, c. 297, §4 (NEW).]

[2011, c. 297, §§2-4 (AMD) .]

SECTION HISTORY
2001, c. 259, §24 (NEW). 2011, c. 297, §§2-4 (AMD).

§1420-D. APPLICATION FOR EXAMINATION

1. **Written examination.** A resident individual applying for an insurance producer license must pass a written examination unless exempt pursuant to section 1420-H. The examination must test the knowledge of the individual concerning the lines of authority applied for, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this State. The superintendent may adopt rules regarding the development and administration of examinations required by this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 259, §24 (NEW) .]

2. **Outside testing service.** The superintendent may make arrangements, including contracting with an outside testing service, for administering examinations and collecting any applicable fee set forth in section 601.

[2001, c. 259, §24 (NEW) .]

3. **Fees.** Each individual applying for an examination shall remit any applicable fee as prescribed by the superintendent as set forth in section 601.

[2001, c. 259, §24 (NEW) .]

4. **Rescheduling.** An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and must remit all required fees and forms before being rescheduled for another examination.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-E. APPLICATION FOR LICENSE

1. **Uniform application.** An individual applying for a resident insurance producer license shall apply to the superintendent on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the superintendent must find that the individual:

A. Is at least 18 years of age; [2001, c. 259, §24 (NEW).]

B. Has not committed any act that is a ground for denial, suspension or revocation set forth in section 1420-K; [2001, c. 259, §24 (NEW).]

C. [2007, c. 51, §2 (RP).]

D. Has paid any required fees set forth in section 601; and [2001, c. 259, §24 (NEW).]

E. Has successfully passed the examinations for the lines of authority for which the person has applied. [2001, c. 259, §24 (NEW).]

[2007, c. 51, §2 (AMD) .]

2. **Uniform business entity application.** A business entity acting as an insurance producer is required to obtain an insurance producer license. Application must be made using the uniform business entity application. Before approving the application, the superintendent must find that:

A. The business entity has paid any required fees set forth in section 601; and [2001, c. 259, §24 (NEW).]

B. The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of this State. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

3. **Verification.** The superintendent may require any documents reasonably necessary to verify the information contained in an application.

[2001, c. 259, §24 (NEW) .]

4. **Instruction.** Each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited line credit insurance a program of instruction that may be approved by the superintendent.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW). 2007, c. 51, §2 (AMD).

§1420-F. LICENSE

1. **Issuance; lines of authority.** Unless denied licensure pursuant to section 1420-K, a person who has met the requirements of sections 1420-D and 1420-E must be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority, as designated in this subsection for the purposes of this subchapter:

A. Life, which is insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income; [2001, c. 259, §24 (NEW).]

B. Accident and health or sickness, which is insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income; [2001, c. 259, §24 (NEW).]

C. Property, which is insurance coverage for the direct or consequential loss of or damage to property of every kind; [2001, c. 259, §24 (NEW).]

D. Casualty, which is insurance coverage against legal liability, including coverage for death, injury or disability or damage to real or personal property; [2001, c. 259, §24 (NEW).]

E. Variable life and variable annuity products, which is insurance coverage provided under variable life insurance contracts and variable annuities; [2001, c. 259, §24 (NEW).]

F. Personal lines, which is property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes; [2001, c. 259, §24 (NEW).]

G. Credit, which is limited line credit insurance; [2001, c. 259, §24 (NEW).]

H. Travel accident and baggage insurance contracts, which are a limited line; [2001, c. 259, §24 (NEW).]

I. Title insurance contracts, which are a limited line; [2001, c. 259, §24 (NEW).]

J. [2005, c. 43, §2 (RP).]

K. Automobile mechanical breakdown contracts, which are a limited line; and [2001, c. 259, §24 (NEW).]

L. Insurance offered, sold or solicited in connection with and incidental to the rental of rental cars for a period of no more than 60 days, whether at the rental office or by preselection of coverage in master, corporate, group or individual agreements, that is nontransferable, applies only to the rental car that is the subject of the rental agreement and is limited to the following kinds of insurance:

(1) Personal accident insurance for renters and other rental car occupants for accidental death or dismemberment and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(2) Liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period;

(3) Personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period;

(4) Roadside assistance and emergency sickness protection insurance; and

(5) Any other coverage designated by the superintendent. [2007, c. 51, §3 (RPR).]

[2007, c. 51, §3 (AMD) .]

2. **Duration.** An insurance producer license remains in effect, unless revoked or suspended, as long as any applicable fee set forth in section 601 is paid and education requirements pursuant to subchapter VII for resident individual producers are met by the due date.

[2001, c. 259, §24 (NEW) .]

3. **Lapse.** An individual insurance producer whose license lapses may, within 12 months, reinstate the same license without the necessity of passing a written examination.

[2001, c. 259, §24 (NEW) .]

4. **Waiver.** A licensed insurance producer who is unable to comply with license continuation procedures due to military service or some other extenuating circumstance, such as a long-term medical disability, may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with continuation procedures.

[2001, c. 259, §24 (NEW) .]

5. **Contents.** The license must contain the licensee's name, address, personal identification number, the date of issuance, the lines of authority and any other information required by the superintendent.

[2001, c. 259, §24 (NEW) .]

6. **Change of name or address.** A licensee shall inform the superintendent by any means acceptable to the superintendent of a change of address within 30 days of the change. Failure to timely inform the superintendent of a change in legal name or address results in a penalty pursuant to section 601.

[2001, c. 259, §24 (NEW) .]

7. **Contract with other entities.** In order to assist in the performance of the superintendent's duties, the superintendent may contract with nongovernmental entities, including the National Association of Insurance Commissioners, its affiliates or subsidiaries or its successor organization, to perform any ministerial functions, including the collection of fees, related to producer licensing that the superintendent and the nongovernmental entity determine appropriate.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW). 2005, c. 43, §2 (AMD). 2007, c. 51, §3 (AMD).

§1420-G. NONRESIDENT LICENSING

1. **Qualifications.** Unless denied licensure pursuant to section 1420-K, a nonresident person must be issued a nonresident producer license if:

A. The person is currently licensed as a resident and in good standing in that person's home state; [2001, c. 259, §24 (NEW).]

B. The person has submitted the proper request for licensure and has paid any fees required by section 601; [2001, c. 259, §24 (NEW).]

C. The person has submitted or transmitted to the superintendent the application for licensure submitted to that person's home state, or in lieu of the same, a completed uniform application; and [2001, c. 259, §24 (NEW).]

D. The person's home state awards nonresident producer licenses to residents of this State on the same basis. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

2. **Verification.** The superintendent may verify the producer's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries or any successor organization.

[2001, c. 259, §24 (NEW) .]

3. **Change of address.** A nonresident producer who moves from one state to another state or a resident producer who moves from this State to another state shall file a change of address and provide certification from the new resident state within 30 days of the change of legal residence. A fee or license application is not required.

[2001, c. 259, §24 (NEW) .]

4. **Surplus lines; license in home state.** Notwithstanding any other provision of this subchapter, a person licensed as a surplus lines producer in that person's home state must be issued a nonresident surplus lines producer license pursuant to subsection 1. Except as provided in subsection 1, nothing in this section otherwise amends or supersedes any other provision of chapter 19.

[2001, c. 259, §24 (NEW) .]

5. **Limited lines; license in home state.** Notwithstanding any other provision of this subchapter, a person licensed as a limited line credit insurance or other type of limited lines producer in that person's home state must be issued a nonresident limited lines producer license, pursuant to subsection 1, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this section, limited line insurance is any authority granted by the home state that restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to section 1420-F, subsection 1, paragraphs A to F.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-H. EXEMPTION FROM EXAMINATION

1. **Exemption.** An individual who applies for an insurance producer license in this State who was previously licensed for the same lines of authority in another state is not required to complete any examination pursuant to section 1410. This exemption is only available if the person is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state, or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries or any successor organization, indicate that the producer is or was licensed in good standing for the line of authority requested.

[2007, c. 51, §4 (AMD) .]

2. **Application.** A person licensed as an insurance producer in another state who moves to this State shall make application within 90 days of establishing legal residence to become a resident licensee pursuant to section 1420-E. An examination pursuant to section 1410 is not required of that person to obtain any line of authority previously held in the prior state except when the superintendent determines otherwise by rule. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2007, c. 51, §4 (AMD) .]

3. **Additional exemptions.** An examination is also not required of:

A. An applicant for a license covering the same kind or kinds of insurance for which the applicant was licensed under a similar license in this State within the past 2 years, other than a temporary license issued pursuant to section 1420-J. This exemption applies only to persons who have met the applicable continuing education requirements during the 2-year period, who voluntarily terminated their previous license and who continue to be fully qualified for the license. A person whose previous license was revoked or suspended may not become relicensed pursuant to this paragraph; [2001, c. 259, §24 (NEW).]

B. An applicant for a license as a limited insurance producer who solicits or sells travel and baggage insurance; [2001, c. 259, §24 (NEW).]

C. An applicant for a license as a resident title insurance producer who is an attorney at law duly licensed to practice law in this State; [2001, c. 259, §24 (NEW).]

D. An applicant for a license as a limited insurance producer who solicits or sells mechanical breakdown insurance; or [2001, c. 259, §24 (NEW).]

E. An applicant for a license as a limited insurance producer employed by a motor vehicle rental company who solicits or sells insurance in connection with and incidental to the rental of a motor vehicle for a period not to exceed 60 days in accordance with section 1420-F, subsection 1, paragraph L. [2007, c. 51, §4 (AMD).]

[2007, c. 51, §4 (AMD) .]

SECTION HISTORY
2001, c. 259, §24 (NEW). 2007, c. 51, §4 (AMD).

§1420-I. ASSUMED NAMES

An insurance producer doing business under any name other than the producer's legal name is required to notify the superintendent prior to using the assumed name. [2001, c. 259, §24 (NEW).]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-J. TEMPORARY LICENSING

1. **License authorized.** The superintendent may issue a temporary insurance producer license for a period not to exceed 180 days without requiring an examination if the superintendent determines that the temporary license is necessary for the servicing of an insurance business in the following cases:

A. To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business; [2001, c. 259, §24 (NEW).]

B. To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license; [2001, c. 259, §24 (NEW).]

C. To the designee of a licensed insurance producer entering active service in the Armed Forces of the United States; or [2001, c. 259, §24 (NEW).]

D. In any other circumstance when the superintendent determines that the public interest will best be served by the issuance of this license. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

2. **Limitations.** The superintendent may by order limit the authority of any temporary licensee in any way determined necessary to protect insureds and the public. The superintendent may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The superintendent may by order revoke a temporary license if the interest of insureds or the public is endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-K. LICENSE DENIAL, NONRENEWAL OR REVOCATION

1. **Causes.** The superintendent may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or may levy a civil penalty in accordance with section 12-A or take any combination of such actions, for any one or more of the following causes:

A. Providing incorrect, misleading, incomplete or materially untrue information in the license application; [2001, c. 259, §24 (NEW).]

B. Violating any insurance laws, or violating any rule, regulation, subpoena or order of the superintendent or of another state's insurance commissioner; [2001, c. 259, §24 (NEW).]

C. Obtaining or attempting to obtain a license through misrepresentation or fraud; [2001, c. 259, §24 (NEW).]

D. Improperly withholding, misappropriating or converting any money or properties received in the course of doing insurance business; [2001, c. 259, §24 (NEW).]

E. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance; [2001, c. 259, §24 (NEW).]

F. Having been convicted of a criminal offense as provided in Title 5, section 5301. Any revocation, suspension or denial of license under this paragraph must be in accordance with Title 5, sections 5302 to 5304; [2001, c. 259, §24 (NEW).]

G. Having admitted to or been found to have committed any insurance unfair trade practice or fraud; [2001, c. 259, §24 (NEW).]

H. Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this State or elsewhere; [2001, c. 259, §24 (NEW).]

I. Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory; [2001, c. 259, §24 (NEW).]

J. Forging another's name to an application for insurance or to any document related to an insurance transaction; [2001, c. 259, §24 (NEW).]

K. Improperly using notes or any other reference material to complete an examination for an insurance license; [2001, c. 259, §24 (NEW).]

L. Knowingly accepting insurance business from an individual who is not licensed; [2001, c. 259, §24 (NEW).]

M. Failing to comply with an administrative or court order imposing a child support obligation; or [2001, c. 259, §24 (NEW).]

N. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

2. **Notification.** If the superintendent does not renew or denies an application for a license, the superintendent shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the superintendent within 30 days for a hearing before the superintendent to determine the reasonableness of the superintendent's action. The hearing must be held within 30 days of that written demand and pursuant to section 229.

[2001, c. 259, §24 (NEW) .]

3. **Effect on business entity.** The license of a business entity may be suspended, revoked or refused if the superintendent finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the superintendent nor corrected.

[2001, c. 259, §24 (NEW) .]

4. **Civil penalties.** In addition to or in lieu of any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil penalty according to section 12-A.

[2001, c. 259, §24 (NEW) .]

5. **Enforcement powers.** The superintendent retains the authority to enforce the provisions of and impose any penalty or remedy authorized by this Title, Title 24 or any other law enforced by the superintendent against any person who is under investigation for or charged with a violation of this Title, Title 24 or any other law enforced by the superintendent, even if the person's license has been surrendered or has lapsed by operation of law.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-L. COMMISSIONS

1. **License required to pay.** An insurance company or insurance producer may not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this State if that person is required to be licensed under this subchapter and is not so licensed.

[2001, c. 259, §24 (NEW) .]

2. **License required to accept.** A person may not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this State if that person is required to be licensed under this subchapter and is not so licensed.

[2001, c. 259, §24 (NEW) .]

3. **Deferral.** Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this State if the person was required to be licensed under this subchapter at the time of the sale, solicitation or negotiation and was so licensed at that time.

[2001, c. 259, §24 (NEW) .]

4. **Assignments.** An insurer or insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this State, unless the payment would violate chapter 23 or any other applicable provision of this Title.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-M. APPOINTMENTS

1. **Appointment.** An insurance producer may not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

[2001, c. 259, §24 (NEW) .]

2. **Notice.** To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the superintendent, a notice of appointment within 15 days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

[2001, c. 259, §24 (NEW) .]

3. **Fee.** An insurer shall pay an appointment fee, in the amount and method of payment set forth in section 601, for each insurance producer appointed by the insurer.

[2001, c. 259, §24 (NEW) .]

4. **Renewal.** An insurer shall remit, in a manner prescribed by the superintendent, a renewal appointment fee in the amount set forth in section 601.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-N. NOTIFICATION TO SUPERINTENDENT OF TERMINATION

1. **Termination for cause.** An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the superintendent within 30 days following the effective date of the termination, using a format prescribed by the superintendent, if the reason for termination is one of the reasons set forth in section 1420-K or the insurer has knowledge the producer was found by a court, government body or self-regulatory organization authorized by law to have engaged in any of the activities in section 1420-K. Upon the written request of the superintendent, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

[2001, c. 259, §24 (NEW) .]

2. **Termination without cause.** An insurer or authorized representative of the insurer that terminates the appointment, employment or contract with a producer for any reason not set forth in section 1420-K shall notify the superintendent within 30 days following the effective date of the termination, using a format prescribed by the superintendent. Upon written request of the superintendent, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

[2001, c. 259, §24 (NEW) .]

3. **Ongoing notification requirement.** The insurer or the authorized representative of the insurer shall promptly notify the superintendent in a format acceptable to the superintendent if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the superintendent in accordance with subsection 1 had the insurer then known of its existence.

[2001, c. 259, §24 (NEW) .]

4. **Copy of notification to be provided to producer.** Notification to the producer and comments by the producer must be as follows.

A. Within 15 days after making the notification required by subsections 1, 2 and 3, the insurer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for cause for any of the reasons listed in section 1420-K, the insurer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier. [2001, c. 259, §24 (NEW).]

B. Within 30 days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the superintendent. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer and the comments become a part of the superintendent's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection 6. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

5. **Immunities.** This subsection governs immunities.

A. In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the superintendent or an organization of which the superintendent is a member that compiles the information concerning the termination and makes it available to other insurance commissioners or regulatory or law enforcement agencies is not subject to civil liability for making this information available, and a civil cause of action may not arise against these entities or their respective agents or employees as a result of reporting or providing information under this section. [2001, c. 259, §24 (NEW).]

B. In any action brought against a person that may have immunity under paragraph A for making any statement required by this section or providing any information relating to any statement that may be requested by the superintendent, the party bringing the action shall plead specifically in any allegation that paragraph A does not apply because the person making the statement or providing the information did so with actual malice. [2001, c. 259, §24 (NEW).]

C. Paragraph A or B does not abrogate or modify any existing statutory or common law privileges or immunities. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

6. **Confidentiality.** Subject to limitations set out in this subsection, any documents, materials or other information in the control or possession of the bureau that is furnished by an insurer or producer or an employee or agent acting on behalf of the insurer or producer or that is obtained by the superintendent in an investigation pursuant to this section is confidential, is not subject to subpoena and is not subject to discovery or admissible in evidence in any private civil action except by a court order for good cause.

A. The superintendent is, however, authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the superintendent's duties. [2001, c. 259, §24 (NEW).]

B. Neither the superintendent nor any person who received documents, materials or other information while acting under the authority of the superintendent may be permitted or required to testify in any private civil action concerning any confidential documents, materials or information except as ordered by a court for good cause. [2001, c. 259, §24 (NEW).]

C. In order to assist in the performance of the superintendent's duties under this subchapter, the superintendent:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph A, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries or any successor organization, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality of the documents, materials or other information;

(2) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries or any successor organization, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials or information; and

(3) May enter into agreements governing sharing and use of information consistent with this subsection. [2001, c. 259, §24 (NEW).]

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information occurs as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in paragraph C. [2001, c. 259, §24 (NEW).]

E. Nothing in this subchapter prohibits the superintendent from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to Title 1, chapter 13, subchapter I to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries or any successor organization. [2001, c. 259, §24 (NEW).]

[2001, c. 259, §24 (NEW) .]

7. **Penalties for failing to report.** An insurer, producer or an employee or agent acting on behalf of the insurer or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license suspended or revoked and may be fined in accordance with section 12-A.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-O. RECIPROCITY

1. **Reciprocity.** The superintendent shall waive any requirements for a nonresident license applicant with a valid license from that person's home state, except the requirements imposed by section 1420-G, if the applicant's home state awards nonresident licenses to residents of this State on the same basis.

[2001, c. 259, §24 (NEW) .]

2. **Continuing education.** Satisfaction of a nonresident producer's home state's continuing education requirements for licensed insurance producers constitutes satisfaction of this State's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this State on the same basis.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

§1420-P. REPORTING OF ACTIONS

1. **Administrative actions.** A producer shall report to the superintendent any administrative action taken against the producer in another jurisdiction or by another governmental agency in this State within 30 days of the final disposition of the matter. This report must include a copy of the order, consent to order or other relevant legal documents.

[2001, c. 259, §24 (NEW) .]

2. **Criminal actions.** Within 30 days of the initial pretrial hearing date, a producer shall report to the superintendent any criminal prosecution of the producer taken in any jurisdiction. The report must include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

[2001, c. 259, §24 (NEW) .]

SECTION HISTORY
2001, c. 259, §24 (NEW).

Subchapter 3: APPLICATION PROCEDURE FOR ADJUSTERS AND CONSULTANTS HEADING: PL 1997, C. 457, §23 (NEW); 2001, C. 259, §25 (RPR)

§1421. LICENSING FORMS

The superintendent or an independent licensing service designated by the superintendent shall prescribe, consistent with the applicable requirements of this chapter, and furnish all forms required under this chapter in connection with applications for and issuance of licenses. The superintendent or an independent testing service designated by the superintendent shall prescribe and furnish all forms required in connection with examinations for licenses. [1997, c. 592, §24 (AMD).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §24 (AMD).

§1422. LICENSE TO BE ISSUED ONLY ON COMPLIANCE

The superintendent may not issue or permit any license of an applicant who is not in compliance with or who has not established qualifications in accordance with the applicable provisions of this chapter. [2001, c. 259, §26 (AMD).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §26 (AMD).

§1423. APPLICATION FOR EXAMINATION

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §§25,26 (AMD). 2001, c. 259, §27 (RP).

§1424. APPLICATION FOR LICENSE

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §§27,28 (AMD). 2001, c. 259, §28 (RP).

§1424-A. APPLICATION FOR LICENSE

1. **Application.** An individual applying for an insurance adjuster or consultant license shall apply to the superintendent on a form as determined by the superintendent and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the superintendent must find that the individual:

A. Has complied with the requirements of subchapter V in the case of consultants and subchapter VI in the case of adjusters; [2001, c. 259, §29 (NEW).]

B. Has not committed any act that is a ground for denial, suspension or revocation set forth in sections 1417 and 1420-K; [2001, c. 259, §29 (NEW).]

C. Has completed any prelicensing requirements for the license for which the person has applied, as specified in subchapter II; [2001, c. 259, §29 (NEW).]

D. Has paid any required fees set forth in section 601; and [2001, c. 259, §29 (NEW).]

E. Has successfully passed the examinations for the license for which the person, if a resident, has applied. [2001, c. 259, §29 (NEW).]

[2001, c. 259, §29 (NEW) .]

2. **Business entity.** A business entity acting as an insurance adjuster or consultant is required to obtain an adjuster or consultant license. Application must be made using the uniform business entity application. Before approving the application, the superintendent must find that:

A. The business entity has paid any required fees set forth in section 601; and [2001, c. 259, §29 (NEW).]

B. The business entity has designated a licensed person responsible for the business entity's compliance with the insurance laws, rules and regulations of this State. [2001, c. 259, §29 (NEW).]

[2001, c. 259, §29 (NEW) .]

3. **Verification.** The superintendent may require any documents reasonably necessary to verify the information contained in an application.

[2001, c. 259, §29 (NEW) .]

SECTION HISTORY
2001, c. 259, §29 (NEW).

§1425. INVESTIGATION OF LICENSE APPLICANTS

When an application for license under this chapter is submitted, the superintendent may investigate the applicant's character, financial responsibility, experience, background and fitness for the license applied for. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1426. ISSUANCE; REFUSAL OF LICENSE; REFUNDS OF FEES

1. **Issuance.** If the superintendent finds that the application is complete, the applicant has passed any required examination and that the applicant is otherwise qualified for the license applied for, the superintendent shall promptly issue the license; otherwise, the superintendent may not issue the license and shall promptly notify the applicant of such refusal stating the grounds for denial.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Fees.**

[2001, c. 259, §30 (RP) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §29 (AMD). 2001, c. 259, §30 (AMD).

§1427. EXEMPTION FROM EXAMINATION REQUIREMENT

(REPEALED)

SECTION HISTORY

1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §§30,31 (AMD). 1999, c. 270, §§4-6 (AMD). 2001, c. 259, §31 (RP).

§1427-A. EXEMPTION FROM EXAMINATION REQUIREMENT

1. **Exemption.** An individual who applies for an adjuster or consultant license in this State who was previously licensed as such in another state is not required to complete any prelicensing education or examination pursuant to section 1410. This exemption is only available if the person is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state, or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries or any successor organization, indicate that the adjuster or consultant is or was licensed in good standing for the type of license requested.

[2001, c. 259, §32 (NEW) .]

2. **Application.** A person licensed as an adjuster or consultant in another state who moves to this State must apply within 90 days of establishing legal residence to become a resident licensee. Prelicensing education or examination is not required of that person to obtain the adjuster or consultant license type previously held in the prior state except when the superintendent determines otherwise by rule. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 259, §32 (NEW) .]

3. **Other exemptions.** An examination is not required of an applicant for the same type of license that the applicant previously held in this State within the past 2 years, other than a temporary license. This exemption applies only to persons who have met the applicable continuing education requirements during the 2-year period, who voluntarily terminated their previous license, and who continue to be fully qualified for the license. A person whose previous license was revoked or suspended may not become relicensed pursuant to this subsection.

[2001, c. 259, §32 (NEW) .]

SECTION HISTORY
2001, c. 259, §32 (NEW).

§1428. TEMPORARY LICENSE AS INSURANCE PRODUCER

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §33 (RP).

§1429. INSURANCE VENDING MACHINES

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §33 (RP).

§1430. LICENSE CONTINUATION OR TERMINATION

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §§32-37 (AMD). 2001, c. 259, §34 (RP).

§1431. APPOINTMENT OF INSURANCE PRODUCERS OR AGENCIES *(REPEALED)*

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §38 (RP).

§1432. TERMINATION OF PRODUCER OR AGENCY APPOINTMENT *(REPEALED)*

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §38 (RP).

Subchapter 4: PRODUCERS HEADING: PL 1997, C. 457, §23 (NEW)

§1441. APPLICABILITY

1. **Licensed resident producers.**

[1997, c. 592, §39 (RP) .]

1-A. **Licensed producers.** This subchapter applies to licensed resident and nonresident producers.

[1997, c. 592, §40 (NEW) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §§39,40 (AMD).

§1441-A. APPOINTMENT OF INSURANCE PRODUCERS OR AGENCIES *(REPEALED)*

SECTION HISTORY
1997, c. 592, §41 (NEW). 2001, c. 259, §35 (RP).

§1441-B. TERMINATION OF PRODUCER OR AGENCY APPOINTMENT *(REPEALED)*

SECTION HISTORY
1997, c. 592, §41 (NEW). 2001, c. 259, §35 (RP).

§1442. AUTHORITY OF INSURANCE PRODUCER

1. **Licensed insurance producer.** A licensed insurance producer in this State may:

A. Engage in insurance producer activities throughout this State within the authority granted the insurance producer by the insurer, health maintenance organization, fraternal benefit society, or nonprofit hospital or medical service organization and the scope of the producer's license; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. Adjust the losses of the insurer or fraternal benefit society within the authority granted the insurance producer by the insurer or fraternal benefit society; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. Not place or seek to place insurance coverage, other than with an insurer, health maintenance organization, fraternal benefit society or nonprofit hospital association for which the insurance producer holds an appointment, except as provided under section 1450, subsection 2. A licensed resident or a nonresident insurance producer may not place or seek to place insurance coverage other than in an authorized insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization, except as provided in chapter 19; and [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. Enter into a contract or arrangement with a financial institution for the purpose of participating in a finance program with the financial institution. In this case, the financial institution need not be licensed as a producer, as long as the purpose of the arrangement is to authorize an insurance producer to facilitate, direct or refer insureds, prospective insureds or other customers to the financial institution for loans or for the purpose of authorizing an insurance producer to facilitate arrangements for leases, loans or credit applications with the financial institution. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1443. EXCEPTIONS TO LICENSING REQUIREMENT

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §36 (RP).

§1443-A. LICENSING OF FINANCIAL INSTITUTIONS AND RELATED PARTIES

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

A. "Affiliate" means any of the following entities:

(1) A subsidiary of a financial institution or credit union authorized to do business in this State or of a financial institution holding company;

(2) An employee, an officer other than a director, or licensed 3rd-party producer of a financial institution or credit union authorized to do business in this State, a financial institution holding company or any institution listed in subparagraph (1);

(3) A person or entity possessing 5% or more of the ownership interests of a financial institution or credit union authorized to do business in this State, or of a financial institution holding company or of any institution listed in subparagraph (1); or

(4) An insurer or insurance producer or consultant utilizing space in the retail area of a financial institution or credit union authorized to do business in this State or of a financial institution holding company or an institution listed in subparagraph (1) in order to engage in the transaction

of insurance when payments for use of the space are made to the that institution pursuant to a space-sharing agreement based directly or indirectly upon a percentage of the volume of business conducted by the insurer, insurance agent, broker or consultant. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. "Credit union authorized to do business in this State" or "credit union" has the same meaning as defined in Title 9-B, section 131, subsection 12-A. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. "Financial institution authorized to do business in this State" or "financial institution" has the same meaning as defined in Title 9-B, section 131, subsection 17-A. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. "Financial institution holding company" has the same meaning as defined in Title 9-B, section 1011 and includes a mutual holding company as defined in Title 9-B, section 1052. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

E. "Licensed 3rd-party producer" means a licensed insurance producer or consultant who engages in authorized insurance activities related to insurance products directly on behalf of a specified licensed insurance entity through an independent contractor relationship. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

F. "Ownership interest" includes general partnership shares, limited partnership shares and shares of stock that possess any voting rights. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

G. "Subsidiary" means any corporation, partnership, association or other business entity in which either:

(1) One or more financial institutions or credit unions authorized to do business in this State, financial institution holding companies or any officers, employees, agents or representatives of the financial institutions or credit unions authorized to do business in this State or financial institution holding companies possess directly or indirectly, singly or in the aggregate, an ownership interest of at least 25%; or

(2) It is determined by the superintendent after notice and opportunity for hearing that one or more financial institutions or credit unions authorized to do business in this State, financial institution holding companies or any officers, employees, agents or representatives of financial institutions or credit unions authorized to do business in this State or financial institution holding companies, singly or in the aggregate, exercise a controlling influence over the management and policies of the entity. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Licensing.** A financial institution or credit union authorized to do business in this State, financial institution holding company or the subsidiary or affiliate of any of those entities or an officer, employee, agent or representative of a financial institution, credit union, financial institution holding company or the subsidiary of any of those entities may be licensed as an insurance producer or consultant in this State or may act as an insurance producer or consultant in this State. These organizations are not required to become licensed as insurance producers or consultants with respect to: credit life and credit health insurance to the extent authorized by chapter 37 when the insured is enrolled in the policy; group health insurance to the extent authorized by chapter 35 when the insured is enrolled in the policy; and group life insurance to the extent authorized by chapter 31 when the insured is enrolled in the policy; credit property insurance; credit involuntary unemployment insurance; forced placed property insurance; a vendor's single interest policy; and any other insurance product as determined by the superintendent. In addition, a financial institution, credit union, financial institution holding company or a subsidiary or employee of any such entity may sell annuities, arrange for the sale of annuities or share commissions in connection with the sale of annuities to the extent authorized by Title 9-B, section 443, subsection 11, if the entity has been licensed pursuant to this

chapter and if that activity includes the sale of variable annuity contracts, a national association of securities dealers registration form must be submitted to the superintendent as required by the provisions of section 1410, subsection 8.

[2001, c. 259, §37 (AMD) .]

3. **Rulemaking.** The superintendent, the Superintendent of Financial Institutions and the Superintendent of Consumer Credit Protection may, pursuant to this subsection, Title 9-A, section 4-407 and Title 9-B, section 448, subsection 5, undertake joint rulemaking to carry out the purpose of this section, including issues regarding signs, the physical location of sales of insurance and identification of producers affiliated with financial institutions, credit unions, financial institution holding companies or supervised lenders. In adopting rules pursuant to this section, the superintendent, the Superintendent of Financial Institutions and the Superintendent of Consumer Credit Protection shall consider the possibility of confusion and perception of coercion among the insurance-consuming public, the need for cost-effective delivery of insurance products to insurance consumers and the importance of parity among producers affiliated with federally chartered and state-chartered financial institutions and credit unions. Any rule adopted may not interfere significantly with the ability of a producer to solicit or negotiate the sale of an insurance product, whether or not that producer is affiliated with a financial institution, credit union, financial institution holding company or supervised lender, except when no other reasonable alternative exists to protect the insurance-consuming public. Rules adopted under this section are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. Nothing in this section is intended to restrict or interfere with the ability of the bureau, the Bureau of Financial Institutions or the Bureau of Consumer Credit Protection to adopt rules with respect to areas in which the respective agencies have independent jurisdiction.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF); 2001, c. 44, §11 (AMD); 2001, c. 44, §14 (AFF); 2007, c. 273, Pt. B, §§5, 6 (REV); 2007, c. 695, Pt. A, §47 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 44, §11 (AMD). 2001, c. 44, §14 (AFF). 2001, c. 259, §37 (AMD). 2007, c. 273, Pt. B, §7 (AFF). 2007, c. 273, Pt. B, §§5, 6 (REV). 2007, c. 695, Pt. A, §47 (AFF).

§1444. APPOINTMENT REQUIRED; REPORT AND FEES REQUIRED

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §38 (RP).

§1444-A. INSURANCE VENDING MACHINES

1. **Vending machines.** A licensed insurance producer may solicit and issue personal travel accident insurance policies by means of a mechanical vending machine supervised by the insurance producer and placed at an airport or similar place of convenience to the traveling public if the superintendent finds:

A. That the policy to be sold provides reasonable coverage and benefits, is reasonably suited for sale and issuance through a vending machine and that use of such a machine in a proposed location would be of convenience to the public; [2001, c. 259, §39 (NEW).]

B. That the type of vending machine proposed to be used is reasonably suitable for the purpose; [2001, c. 259, §39 (NEW).]

C. That reasonable means are provided for informing prospective purchasers of policy coverages and restrictions; and [2001, c. 259, §39 (NEW).]

D. That reasonable means are provided for refund of money inserted in a defective machine when no insurance or a lesser amount than that paid for is actually received. [2001, c. 259, §39 (NEW).]

[2001, c. 259, §39 (NEW) .]

2. **Special license.** For each machine to be used, the superintendent may issue to the insurance producer a special vending machine license. The license must specify the name and address of the insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization and the name and address of the insurance producer, the name of the policy to be sold, the serial number of the machine and the place where the machine is to be in operation. The license is subject to termination, suspension or revocation coincidentally with the license of the insurance producer. The superintendent shall also revoke the license for any machine for which the superintendent finds that the license qualifications no longer exist. The license fee for each respective vending machine is established in section 601. Proof of the existence of a license must be displayed on or about each machine in use in the manner that the superintendent reasonably requires.

[2001, c. 259, §39 (NEW) .]

SECTION HISTORY
2001, c. 259, §39 (NEW).

§1445. RESPONSIBILITY OF INSURER, HEALTH MAINTENANCE ORGANIZATION, FRATERNAL BENEFIT SOCIETY, OR NONPROFIT HOSPITAL OR MEDICAL SERVICE ORGANIZATION; PROHIBITED ACTIVITIES

1. **Responsibilities for training and supervision.** In addition to any other applicable provisions of law, the insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization:

A. Shall ensure adequate training for its appointed producers; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. Shall provide supervision of its appointed producers who sell insurance on its behalf; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. Is responsible for injuries to consumers resulting from the actions of its appointed producers to the extent of restitution, reimbursement of money or payment of interest to the consumer; and [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. Is accountable and may be penalized by the superintendent, as provided for in this Title, for the actions of its producers. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Prohibited activities.** A licensed insurance producer in this State may not:

A. Use knowledge gained as a result of the producer's insurance relationship with the insurance consumer for the producer's own personal gain, other than the receipt of fees or commissions allowed under section 1450, or use knowledge gained as a result of the relationship for the purpose of investing the insurance consumer's money in property or assets in which the insurance producer or the producer's relatives have or will have a personal ownership interest unless that activity is otherwise authorized under insurance, banking or securities laws or rules; or [1999, c. 225, §4 (AMD).]

B. Receive a fee for rendering advice on financial or estate planning or for selling trust packages, if the producer also recommends the purchase of an insurance policy upon which the producer will receive commissions, unless the producer is licensed as a consultant acting in compliance with consultant licensing laws or provides the required documentation in accordance with section 1466, subsection 2. [1999, c. 225, §4 (AMD).]

[1999, c. 225, §4 (AMD) .]

3. **Common law principles.** Nothing in this chapter abrogates the common law principles of apparent or implied authority as available remedies or defenses.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1999, c. 225, §4 (AMD).

§1446. PLACE OF BUSINESS

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §40 (RP).

§1447. RECORDS

1. **Records.** The insurance producer or business entity shall keep or make accessible at the producer's or business entity's place of business a copy of the written appointment or designation from each insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization with which the insurance producer or business entity has an appointment. The insurance producer or business entity shall keep at the producer's or business entity's place of business complete records of transactions under the license. If a producer engages in transactions on behalf of a business entity and subsequently maintains a different place of business, the business entity shall maintain the records of those transactions. If a producer engages in transactions independent of any business entity, the producer shall maintain the records of those transactions. For the purpose of examination or investigation by the superintendent, records may be maintained in electronic form. As to each insurance policy or contract placed through or sold by the licensee, the records must show:

A. The names of the insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. The number and expiration date of the policy or contract; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. The premium payable as to the policy or contract; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

D. The name and address of the insured; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

E. The date and time of every binder made by the insurance producer; and [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

F. Such other information as the superintendent may reasonably require. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[2001, c. 259, §41 (AMD) .]

2. **Retention.** The records must be kept available for inspection by the superintendent for a period of at least 3 years after completion of the respective transactions.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1999, c. 50, §1 (AMD). 2001, c. 259, §41 (AMD).

§1448. QUALIFICATIONS FOR INSURANCE PRODUCER LICENSE

(REPEALED)

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §42 (RP).

§1449. REPORTING AND ACCOUNTING FOR PREMIUMS

All premiums and return premiums received by an insurance producer are trust funds received by the licensee in a fiduciary capacity in accordance with this section. [2003, c. 35, §1 (RPR).]

1. **Return premiums; accounting and payment to an insured.** The licensee shall account for and pay the return premiums to the insured or apply the return premiums to outstanding balances of any insured within 30 days from the date of receipt. The date of receipt is the date the money is actually received or the date the credit is posted by the insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization to the licensee's account.

[2003, c. 35, §1 (NEW) .]

2. **Premiums; accounting and payment to an insurer.** The licensee shall promptly account for and pay premiums to the insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization in accordance with the contract between the insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization and the licensee.

[2003, c. 35, §1 (NEW) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2003, c. 35, §1 (RPR).

§1450. COMMISSIONS; PAYMENT; ACCEPTANCE

1. **Commissions.** Except as provided in section 1420-L, an insurer, health maintenance organization, fraternal benefit society or nonprofit hospital or medical service organization may not pay to any unlicensed person, either directly or indirectly, any commission on a sale of a contract of insurance issued on a risk located or to be performed within this State unless at the time of the taking of the application for the insurance

the person was duly licensed by this State as an insurance producer as to the kind or kinds of insurance involved. An unlicensed person or business entity may not receive or accept any commission or compensation for insurance unless licensed pursuant to this chapter.

[2001, c. 259, §43 (AMD) .]

2. **Shared commissions.** If an insurance producer does not have an appointment with an insurer, the insurance producer may place with that insurer, through a duly licensed and appointed producer of such insurer, an insurance coverage necessary for the adequate protection of a subject of insurance and share in the commission on that insurance, if each producer is licensed as to the kinds of insurance involved.

A. [2011, c. 238, Pt. H, §5 (RP).]

B. [2011, c. 238, Pt. H, §5 (RP).]

C. [2011, c. 238, Pt. H, §5 (RP).]

D. [2011, c. 238, Pt. H, §5 (RP).]

E. [2011, c. 238, Pt. H, §5 (RP).]

[2011, c. 238, Pt. H, §5 (AMD) .]

3. **Rules.** With respect to the sale of property and casualty insurance sold to large commercial insurance risks, producers may be compensated by fees paid by or on behalf of the insured, by commissions paid by an insurer or by a combination of both. The superintendent may adopt rules to establish standards for determining large commercial insurance risks. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 2001, c. 259, §43 (AMD). 2011, c. 238, Pt. H, §5 (AMD).

Subchapter 5: CONSULTANTS HEADING: PL 1997, C. 457, §23 (NEW)

§1461. SCOPE OF SUBCHAPTER

1. **Scope.** This subchapter applies to consultants as defined in section 1402.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Definition.** Unless the context otherwise requires, "consultant," as used in this subchapter, means both property and casualty consultants and life and health consultants as defined in section 1402.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1462. LICENSE REQUIRED

A person may not act as a consultant in this State without first obtaining a license from the superintendent in accordance with this subchapter. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY

1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1463. QUALIFICATIONS FOR LICENSE

A license may not be issued pursuant to this subchapter unless the applicant has satisfactorily passed a written examination administered by the superintendent and has filed a bond as required by section 1464.
[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1464. CONSULTANT'S BOND

1. **Bond.** Every applicant for license as a consultant shall file with the license application and maintain in effect while licensed a bond issued by an authorized surety insurer in this State, continuous in form and providing for aggregate liability of $20,000.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Indemnification.** The bond must indemnify any person damaged by any fraudulent act or conduct of the licensee in transactions under the license, and must likewise be conditioned upon faithful accounting and application of all money coming into the licensee's possession in connection with activities as such a licensee.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

3. **Release.** The bond remains in force until released by the superintendent or until canceled by the surety. Without prejudice to any liability previously incurred, the surety may cancel the bond upon 30 days advance written notice to the licensee and the superintendent. Upon cancellation by the surety and failure to procure a satisfactory replacement bond prior to cancellation, the consultant's license terminates.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1465. CONSULTING CONTRACT REQUIRED

A licensee may not act in any further capacity for which a license is required without having first entered into a written contract with a client. The contract must include, without limitation, the amount and basis of any consulting fee and the duration of employment and must be in a form approved by the superintendent.
[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1466. COMMISSIONS AND FEES

1. **Property and casualty consultant.** A property and casualty consultant and any person in which the consultant has an interest may not, directly or indirectly, charge a consultant fee and receive or share in any commission for the sale of insurance as a producer on any policy or certificate of insurance unless the advice given by the producer for the insurance occurs at least 12 months before or after the period of employment as

a consultant as specified in the contract required by section 1465. This subsection does not prevent a licensed property and casualty insurance producer from receiving a fee rather than commission on the sale of property and casualty insurance in accordance with section 1450 and rules adopted by the superintendent.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Life and health consultant.** A life and health consultant may charge a consulting fee and receive commissions for the sale of insurance as an insurance producer if both the consulting fee and the insurance commissions are provided for in a written agreement, in a form approved by the superintendent, signed by the client and the consultant.

[1999, c. 225, §5 (AMD) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1999, c. 225, §5 (AMD).

§1467. OBLIGATION TO SERVE INTEREST OF CLIENT

A consultant is obligated, under the license, to serve with objectivity and complete loyalty the interests of the client and to render to the client such information, counsel and service that, within the knowledge, understanding and opinion in good faith of the consultant, best serves the client's insurance or annuity needs and interests. A consultant may not use knowledge gained as a result of the consultant's insurance relationship with the client for the consultant's own personal gain, other than the receipt of fees or commissions allowed under section 1450, or use knowledge gained as a result of the relationship for the purpose of investing the client's money in property or assets in which the consultant, or any person in which the consultant has a pecuniary interest or a familial relationship, has or will have a personal ownership interest unless such activity is otherwise specifically authorized under insurance, banking, or securities laws. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1468. RECORDS

The consultant shall keep at the consultant's place of business all contracts with clients for a period of 3 years from the termination of the contracts. For the purpose of investigation or examination by the superintendent, contracts may be maintained in electronic form. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

Subchapter 6: ADJUSTERS HEADING: PL 1997, C. 457, §23 (NEW)

§1471. SCOPE OF THIS SUBCHAPTER

This subchapter applies only to insurance adjusters as defined in section 1402. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1472. QUALIFICATIONS FOR ADJUSTER LICENSE

1. **Issuance of license.** The superintendent may not issue, continue or permit to exist any license as an adjuster, except in compliance with this chapter or unless the person meets the requirements of subsection 2.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Qualifications.** In order to be licensed as an insurance adjuster, a person:

A. Must be at least 18 years of age; [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. Must be competent, trustworthy, financially responsible, and of good personal and business reputation; and [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

C. Must pass any written examination required for the license under subchapter 2 or maintain federal crop insurance certification in the case of multiple peril crop insurance adjusters who established license qualification through such certification. [2009, c. 511, Pt. C, §6 (AMD).]

[2009, c. 511, Pt. C, §6 (AMD) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §42 (AMD). 2001, c. 259, §44 (AMD). 2009, c. 511, Pt. C, §6 (AMD).

§1473. ADOPTION OF RULES

The superintendent may adopt rules to establish the standards for performance of the duties of the adjuster. In addition to the causes set forth in section 1417, the superintendent may suspend, revoke or refuse a license of an adjuster for failure to perform the duties of the adjuster in accordance with the standards in this subchapter and in accordance with the standards adopted by rules. Rules adopted pursuant to this subchapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1474. RECORDS

1. **Record of each transaction.** Each adjuster shall keep at the adjuster's business address shown on the license a record of all transactions under the license. For the purpose of investigation or examination by the superintendent, records may be maintained in electronic form.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

2. **Information.** The record must include:

A. A copy of all investigations or adjustments undertaken or consummated; and [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

B. A statement of any fee, commission or other compensation received or to be received by the adjuster on account of the investigation or adjustment. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

3. **Retention.** The adjuster shall make records available for examination by the superintendent at all times and shall retain the records for at least 3 years.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1475. CATASTROPHE INVESTIGATIONS AND ADJUSTMENTS

An adjuster license is not required for an adjuster sent into this State on behalf of an authorized insurer or fraternal benefit society for the investigation or adjustment of a particularly unusual or extraordinary loss or of a series of losses resulting from a catastrophe common to all such losses. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1476. ACTIVITIES OF INSURANCE ADJUSTERS

The following requirements govern the activities of insurance adjusters. [1997, c. 592, §43 (NEW).]

1. **Solicitation.** An adjuster seeking to provide adjusting services to an insured for a fee to be paid by the insured may not solicit or offer an adjustment services contract to any person for at least 36 hours after an accident or occurrence as a result of which the person might have a potential claim.

[1997, c. 592, §43 (NEW) .]

2. **Contract provision.** Any such adjustment services contract must contain a provision, prominently printed on the first page of the contract, stating that the person contracting with the adjuster has the option to rescind the contract within 2 business days after the contract is signed.

[1997, c. 592, §43 (NEW) .]

SECTION HISTORY
1997, c. 592, §43 (NEW).

Subchapter 7: CONTINUING EDUCATION
HEADING: PL 1997, C. 457, §23 (NEW)

§1481. CONTINUING EDUCATION ADVISORY COMMITTEE

The Continuing Education Advisory Committee is established and consists of 6 members appointed by the superintendent for terms of 3 years each, on a staggered-term basis to prevent the terms of more than 2 members from expiring in any one year. A person may not be reappointed to the committee for more than one 3-year term. A person is ineligible for appointment to the committee unless that person is an active, full-time insurance producer or consultant. Committee members are eligible for reimbursement of expenses. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

§1481-A. APPLICABILITY OF SUBCHAPTER

1. **Applicability.** This subchapter applies to licensed producers and licensed consultants.

[1997, c. 592, §44 (NEW) .]

2. **Exceptions.** Except for limited licenses for the sale of annuities, this subchapter does not apply to persons holding only limited licenses under section 1416.

[1997, c. 592, §44 (NEW) .]

SECTION HISTORY
1997, c. 592, §44 (NEW).

§1482. EDUCATIONAL REQUIREMENTS

As a prerequisite to maintaining a license, licensees must complete a continuing education requirement every 2 years in programs or courses approved by the superintendent. The superintendent may establish by rule the amount of continuing education credit hours, not to exceed 30 hours, required under this section. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A. The superintendent may, for good cause shown, grant an extension of time to any person to allow that person to comply with this subchapter. [2005, c. 43, §3 (AMD).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §45 (AMD). 2005, c. 43, §3 (AMD).

§1483. APPLICATION FOR APPROVAL OF PROGRAM

1. **Application.** Each application for approval of a continuing education program must be submitted according to the guidelines prescribed by the superintendent accompanied by the appropriate fee in section 601. The fee is nonrefundable. A fee is required only for original course submissions. Subsequent or renewal filings of approved courses are considered original if modified in any manner.

[1997, c. 592, §46 (AMD) .]

2. **Review.** Courses and programs must be approved or disapproved by the superintendent, subject to prior review and nonbinding recommendations of the Continuing Education Advisory Committee or another 3rd-party selected by the superintendent. After review and approval or disapproval, the submissions need not be maintained by the superintendent and may be destroyed. The superintendent may, by rule, establish criteria for the review and approval of courses and for the determination of the number of continuing education hours to be credited for completion of each course or program. Rules adopted pursuant to this subchapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §46 (AMD).

§1484. FAILURE TO COMPLY

The license of any insurance producer or consultant who is out of compliance with this subchapter for at least 60 days, is subject to suspension or revocation pursuant to section 1420-K, subsection 1, paragraph B. [2001, c. 259, §45 (AMD).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 592, §47 (AMD). 2001, c. 259, §45 (AMD).

§1485. RULE-MAKING AUTHORITY

The superintendent may establish by rule reasonable procedures and standards to fulfill the purposes of this subchapter and may contract with third parties for the purpose of fulfilling responsibilities under this subchapter. Rules adopted pursuant to this subchapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 457, §23 (NEW); 1997, c. 457, §55 (AFF).]

SECTION HISTORY
1997, c. 457, §23 (NEW). 1997, c. 457, §55 (AFF).

Subchapter 8: MANAGING GENERAL AGENTS
HEADING: PL 1997, C. 573, §1 (NEW)

§1491. SHORT TITLE

This subchapter may be known and cited as the "Managing General Agents Act." [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

§1492. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

1. **Actuary.** "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

2. **Insurer.** "Insurer" means a person engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance who holds an existing certificate of authority to transact insurance in this State pursuant to section 404.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

3. **Managing general agent or MGA.** "Managing general agent" or "MGA" means a person who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office, and acts as a producer for the insurer, whether known as a managing general agent, manager or other similar term; and who, with or without the authority, either separately or together with affiliates, directly or indirectly, produces and underwrites an amount of gross direct written premium equal to or more than 5% of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter of the year following the last annual statement and adjusts or pays claims in excess of an amount determined by the superintendent or negotiates reinsurance on behalf of the insurer, or both. The term does not include:

A. An employee of the insurer; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

B. A manager of a branch of an alien insurer that is located in the United States; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

C. An underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to section 222 and whose compensation is not based on the volume of premiums written; and [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

D. The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

4. **Underwrite.** "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

§1493. LICENSE AND REGISTRATION REQUIREMENT

1. **In-state risks.** A person may not act in the capacity of an MGA with respect to risks located in this State for an insurer licensed in this State unless that person holds a valid Maine producer license and appointment authorizing the producer to sell the applicable kinds of insurance and unless registered with the superintendent as a managing general agent pursuant to subsection 5.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

2. **Out-of-state risks.** A person may not act in the capacity of an MGA representing an insurer domiciled in this State with respect to risks located outside this State unless that person holds a valid Maine producer license and appointment in this State and unless registered with the superintendent as a managing general agent pursuant to subsection 5.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

3. **Bond.** The superintendent may require a bond in an amount acceptable to the superintendent for the protection of the insurer.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

4. **Errors and omissions policy.** The superintendent may require the MGA to maintain an errors and omissions policy.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

5. **Application.** Each managing general agent shall file with the superintendent an application for registration as a managing general agent and shall pay the fee in section 601.

A. The superintendent shall prescribe, consistent with the applicable requirements of this subchapter, and furnish forms required under this subchapter in connection with application for an issuance of registration certificates and for notification of termination of contracts pursuant to section 1495. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

B. The application for registration must include the name and address of the insurer with whom the producer has an appointment pursuant to section 1420-M and with whom the producer has a written contract pursuant to section 1494, a statement of the duties that the producer is expected to perform on behalf of the insurer, the lines of insurance for which the producer is to be authorized to act and any other information the superintendent requests. [2001, c. 259, §46 (AMD).]

C. If the superintendent finds that the application is complete, the superintendent shall promptly issue a certificate of registration to the producer; otherwise, the superintendent shall refuse to issue the registration and promptly notify the producer and the insurer of the refusal, stating the grounds for refusal. The producer may request a hearing on the superintendent's denial pursuant to section 229. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

[2001, c. 259, §46 (AMD) .]

6. **Duration.** Unless notification of termination of contract is received pursuant to section 1495, the certificate of registration remains in effect as long as the registrant continues to hold a valid Maine producer license and as long as the registrant complies with the provisions of this subchapter. A certificate of registration expires upon receipt by the superintendent of notification of termination of contract pursuant to section 1495 or pon notification of termination of the producer's license and the registrant shall promptly deliver the certificate of registration to the superintendent.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF). 1999, c. 127, §A37 (AMD). 1999, c. 127, §A38 (AFF). 2001, c. 259, §46 (AMD).

§1494. REQUIRED CONTRACT PROVISIONS

A person acting in the capacity of an MGA may not place business with an insurer unless there is in force a written contract between the parties that sets forth the responsibilities of each party and, when both parties share responsibility for a particular function, specifies the division of those responsibilities. The contract must contain the following minimum provisions. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

1. **Termination.** The insurer may terminate the contract for cause upon written notice to the MGA. The insurer may suspend the underwriting authority of the MGA during the pendency of any dispute regarding the cause for termination. However, the suspension of an MGA does not relieve the MGA of the responsibility to service business in existence at the time of the suspension.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

2. **Accounting.** The MGA shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

3. **Bank as fiduciary.** All funds collected for the account of an insurer must be held by the MGA in a fiduciary capacity in a bank that is a member of the Federal Reserve System. This account must be used for all payments on behalf of the insurer. The MGA may retain no more than 3 months' estimated claims payments and allocated loss adjustment expenses.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

4. **Records.** Separate records of business written by the MGA must be maintained. The insurer must have access and may copy all accounts and records related to its business in a form usable by the insurer. The superintendent must have access to all books, bank accounts and records of the MGA in a form usable to the superintendent. These records must be retained according to section 3408.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

5. **Nonassignable.** The contract may not be assigned in whole or part by the MGA.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

6. **Guidelines.** The contract must include appropriate underwriting guidelines including:

A. The maximum annual premium volume; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

B. The basis of the rates to be charged; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

C. The types of risks that may be written; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

D. Maximum limits of liability; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

E. Applicable exclusions; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

F. Territorial limitations; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

G. Policy cancellation provisions; and [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

H. The maximum policy period. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

The insurer has the right to cancel or not to renew any policy of insurance subject to all applicable laws and rules regarding the cancellation and nonrenewal of insurance policies.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

7. **Settlement authority.** If the contract permits the MGA to settle claims on behalf of the insurer:

A. All claims must be reported to the insurer in a timely manner; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

B. A copy of the claim file must be sent to the insurer at its request or as soon as it becomes known that the claim:

(1) Has the potential to exceed an amount determined by the superintendent or exceeds the limit set by the insurer, whichever is less;

(2) Involves a coverage dispute;

(3) May exceed the MGA's claims settlement authority;

(4) Is open for more than 6 months; or

(5) Is closed by payment of an amount awarded as a result of a judicial proceeding or an amount set by the insurer, whichever is less; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

C. All claim files must be the joint property of the insurer and MGA; except that, upon an order of liquidation of the insurer, the files become the sole property of the insurer or its estate. The MGA must have reasonable access to and may copy the files on a timely basis; and [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

D. Any settlement authority granted to the MGA may be terminated for cause upon written notice by the insurer to the MGA or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination. Upon termination of the MGA's authority to settle claims, the MGA shall desist from any draw on funds of the insurer and shall immediately forward to the insurer all claims files with the MGA's immediate possession and any claims received thereafter. The MGA shall promptly transfer to the insurer any funds owed to the insurer or to any policyholder and shall transfer to the insurer any property of the insurer that is within the MGA's actual or constructive possession. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

8. **Transmission.** When electronic claims files are in existence, the contract must address the timely transmission of the data.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

9. **Interim profits.** If the contract provides for a sharing of interim profits by the MGA and the MGA has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other manner, interim profits may not be paid to the MGA until one year after they are earned for property insurance business and 5 years after they are earned on casualty business and not until the profits have been verified pursuant to section 1495.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

10. **Prohibitions.** The MGA may not:

A. Bind reinsurance or retrocessions on behalf of the insurer, except that the MGA may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for reinsurance both assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

B. Commit the insurer to participate in insurance or reinsurance syndicates; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

C. Make use of any producer without ensuring that the producer is lawfully licensed in this State to transact the kind of insurance for which the producer is used; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

D. Without prior approval of the insurer, pay or commit the insurer to pay a claim over an amount specified by the insurer, net of reinsurance, which may not exceed 1% of the insurer's policyholder surplus as of December 31st of the preceding year; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

E. Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

F. Make use of any producer who serves on the insurer's board of directors; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

G. Jointly employ an individual who is employed with the insurer; or [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

H. Assign specific duties under a contract with an insurer to other parties. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

§1495. DUTIES OF INSURERS

1. **Records for each MGA.** The insurer shall require and maintain on file an independent financial examination of current origin prepared on the basis of statutory accounting prescribed or permitted by the superintendent respecting each MGA with which the insurer has done business.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

2. **Actuarial review.** If an MGA establishes loss reserves, the insurer shall annually obtain the opinion of an actuary or actuaries who specialize in the type of insurance under consideration, attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the MGA. This requirement is in addition to any other required loss reserve certification.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

3. **On-site review.** The insurer shall periodically and at least semiannually conduct an on-site review of the underwriting and claims processing operations of the MGA.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

4. **Binding authority.** Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates rests with an officer of the insurer, who may not be affiliated with the MGA.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

5. **Notice of termination.** Within 30 days of termination of a contract with an MGA, the insurer shall provide written notification of that termination to the superintendent.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

6. **Quarterly review.** An insurer shall review its books and records each quarter to determine if any producer has become, by operation of section 1492, subsection 3, an MGA as defined in that section. If the insurer determines that its producer has become an MGA, the insurer shall promptly notify the producer and the superintendent of that determination and the insurer and producer must fully comply with the provisions of this subchapter within 30 days.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

7. **Board member qualifications.** An insurer may not appoint to its board of directors an officer, director, employee, producer or controlling shareholder of its managing general agents. This subsection does not apply to relationships governed by section 222 or chapter 77 to the extent that control of an insurer is permissible under section 222 or chapter 77.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

§1496. ACTS OF MGA CONSIDERED ACTS OF INSURER; EXAMINATION AUTHORITY

The acts of the MGA are deemed to be the acts of the insurer on whose behalf it is acting. An MGA may be examined as if it were the insurer. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

§1497. PENALTIES AND LIABILITIES

1. **Penalties.** If the superintendent finds after a hearing conducted in accordance with section 229 that any person has violated any provision of this subchapter, the superintendent may order:

A. For each separate violation, any penalty provided for by section 12-A; [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

B. Revocation or suspension of the producer's license or the insurer's certificate of authority; and [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

C. The MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this subchapter committed by the MGA. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

2. **Effect of order.** The decision, determination or order of the superintendent pursuant to subsection 1 is subject to judicial review as provided by section 236.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

3. **Penalties.** Nothing contained in this section affects the right of the superintendent to impose any other penalties provided for in this Title.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

4. **Rights of others.** Nothing contained in this subchapter limits or restricts the rights of policyholders, claimants and auditors.

[1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF) .]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

§1498. RULES

The superintendent may adopt reasonable rules for the implementation and administration of this subchapter. Rules adopted pursuant to this subchapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 573, §1 (NEW); 1997, c. 573, §2 (AFF).]

SECTION HISTORY
1997, c. 573, §1 (NEW). 1997, c. 573, §2 (AFF).

Chapter 17: AGENTS, BROKERS, CONSULTANTS AND ADJUSTERS

Subchapter 1: LICENSING PROCEDURES AND GENERAL REQUIREMENTS HEADING: PL 1997, C. 457, §27 (RP)

§1501. SCOPE OF CHAPTER

(REPEALED)

SECTION HISTORY
1969, c. 132, §§1,37,39 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1502. "AGENT" DEFINED, IN GENERAL

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1503. "GENERAL LINES AGENT" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 801, §§2,3 (AMD). 1995, c. 329, §7 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1504. "LIFE AGENT" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 151, (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1505. "HEALTH AGENT" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1506. "BROKER" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 801, §§4,5 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1507. "SERVICE REPRESENTATIVE" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§27-A (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1508. "CONSULTANT" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 696, §§1,2 (AMD). 1977, c. 351, §1 (AMD). 1983, c. 801, §§6,7 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP). 1997, c. 457, §24 (RPR).

§1509. "ADJUSTER" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 168, §4 (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1509-A. "ADJUSTER TRAINEE" DEFINED

(REPEALED)

SECTION HISTORY
1989, c. 168, §5 (NEW). 1995, c. 329, §8 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1510. "ORGANIZATION" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 153, §9 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1511. "RESIDENT," "NONRESIDENT" DEFINED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1995, c. 329, §9 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1512. LICENSE REQUIRED; LIABILITY; VALIDITY OF CONTRACT; PENALTY

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 168, §6 (AMD). 1993, c. 221, §5 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1512-A. PROHIBITED ACTIVITIES

(REPEALED)

SECTION HISTORY
1983, c. 419, §6 (NEW). 1997, c. 457, §25 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1512-B. REPORT OF SUPERINTENDENT

(REPEALED)

SECTION HISTORY
1989, c. 168, §7 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1513. EXCEPTIONS TO LICENSE REQUIREMENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§27-B (AMD). 1989, c. 168, §§8,9 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1514. PURPOSE OF LICENSE; "CONTROLLED BUSINESS"

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 315, §18 (RP). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1514-A. PROHIBITION AS TO FINANCIAL INSTITUTIONS AND RELATED PARTIES

(REPEALED)

SECTION HISTORY
1971, c. 407, (NEW). 1985, c. 731, (RPR). 1993, c. 322, §§3,4 (AMD). 1995, c. 329, §10 (AMD). 1997, c. 315, §19 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1515. LICENSING FORMS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 366, §1 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1516. LICENSE TO BE ISSUED ONLY ON COMPLIANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1517. LICENSING OF ORGANIZATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §2 (AMD). 1973, c. 585, §12 (AMD). 1979, c. 301, (AMD). 1993, c. 153, §10 (AMD). 1993, c. 322, §5 (AMD). 1995, c. 329, §§11-14 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1518. APPLICATION FOR LICENSE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 67, (AMD). 1993, c. 221, §6 (AMD). 1993, c. 637, §§16-18 (AMD). 1995, c. 570, §3 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1519. INVESTIGATION OF LICENSE APPLICANTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §3 (AMD). 1973, c. 585, §12 (AMD). 1993, c. 637, §19 (AMD). 1995, c. 329, §15 (AMD). 1995, c. 462, §A46 (AMD). 1995, c. 625, §A24 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1520. WRITTEN EXAMINATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 560, §12 (AMD). 1973, c. 585, §12 (AMD). 1985, c. 366, §2 (AMD). 1989, c. 168, §10 (AMD). 1993, c. 221, §§7,8 (AMD). 1993, c. 637, §20 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1521. EXEMPTION FROM EXAMINATION REQUIREMENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §4 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 625, §138 (AMD). 1993, c. 153, §11 (AMD). 1995, c. 570, §4 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1522. SCOPE OF EXAMINATION; REFERENCE MATERIAL

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 366, §3 (AMD). 1989, c. 168, §11 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1523. TIME, PLACE AND CONDUCT OF EXAMINATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 260, (AMD). 1985, c. 366, §4 (AMD). 1993, c. 153, §§12,13 (AMD). 1993, c. 637, §21 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1524. FAILURE TO TAKE EXAMINATION; REEXAMINATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 366, §§5-7 (AMD). 1993, c. 637, §22 (RP).

§1525. EXAMINATION ADVISORY BOARDS; DESIGNATION, APPOINTMENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 812, §149 (AMD). 1985, c. 366, §8 (AMD). 1989, c. 168, §§12-14 (AMD). 1995, c. 329, §§16,17 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1526. -- FUNCTIONS, REPORTS, EXPENSES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 812, §150 (AMD). 1989, c. 168, §15 (AMD). 1995, c. 329, §18 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1527. ISSUANCE, REFUSAL OF LICENSE; REFUNDABILITY OF FEES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1528. LICENSE CATEGORIES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §5 (RPR). 1973, c. 560, §13 (AMD). 1973, c. 585, §12 (AMD). 1975, c. 159, §§1,2 (AMD). 1989, c. 168, §§16,17 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1529. LICENSE CONTENTS; NUMBER OF LICENSES REQUIRED

(REPEALED)

SECTION HISTORY

1969, c. 132, §1 (NEW). 1971, c. 435, §§6,7 (AMD). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1530. MULTIPLE LICENSING, LIFE OR HEALTH INSURANCE AGENTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 152, §§1,2 (AMD). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1531. LIMITED LICENSES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 253, (AMD). 1971, c. 435, §§8,9 (AMD). 1973, c. 585, §12 (AMD). 1983, c. 298, §§1,2 (AMD). 1993, c. 322, §6 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP). 2007, c. 466, Pt. A, §45 (RP).

§1532. CONTINUATION, EXPIRATION OF LICENSES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §§10,11 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 726, §7 (AMD). 1975, c. 159, §3 (AMD). 1975, c. 767, §§16,17 (AMD). 1977, c. 222, §§3,4 (AMD). 1977, c. 682, §§3,4 (AMD). 1983, c. 419, §7 (RP).

§1532-A. LICENSE CONTINUATION OR TERMINATION

(REPEALED)

SECTION HISTORY
1983, c. 419, §8 (NEW). 1985, c. 366, §§9,10 (AMD). 1989, c. 31, §§2,3 (AMD). 1989, c. 168, §§18,19 (AMD). 1989, c. 878, §A66 (AMD). 1993, c. 153, §14 (AMD). 1995, c. 570, §5 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1533. APPOINTMENT OF AGENTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §12 (RPR). 1973, c. 585, §12 (AMD). 1973, c. 726, §8 (AMD). 1975, c. 767, §18 (AMD). 1993, c. 221, §§9,10 (AMD). 1993, c. 637, §23 (AMD). 1995, c. 570, §6 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1534. BIENNIAL CONTINUATION OF APPOINTMENT

(REPEALED)

SECTION HISTORY

1969, c. 132, §1 (NEW). 1971, c. 435, §13 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 726, §9 (RPR). 1975, c. 767, §19 (RPR). 1993, c. 221, §11 (AMD). 1993, c. 637, §§24-26 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1535. TERMINATION OF AGENT APPOINTMENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 112, §§1,2 (AMD). 1993, c. 221, §§12,13 (AMD). 1993, c. 637, §§27,28 (AMD). 1995, c. 329, §19 (AMD). 1995, c. 694, §D50 (AMD). 1995, c. 694, §E2 (AFF). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1536. TEMPORARY LICENSE AS AGENT OR BROKER

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §14 (AMD). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1537. -- RIGHTS, LIMITATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1538. INSURANCE VENDING MACHINES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 726, §10 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1539. SUSPENSION, REVOCATION, REFUSAL OF LICENSE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§407,408 (AMD). 1983, c. 419, §9 (AMD). 1989, c. 269, §§11-13 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1540. PROCEDURES UPON SUSPENSION OR REVOCATION; POWERS OF SUPERINTENDENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §409 (RPR). 1991, c. 298, §3 (RP).

§1541. RETURN OF LICENSE TO SUPERINTENDENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1542. RELICENSING AFTER REVOCATION; REFUSAL OF LICENSE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §410 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1543. DUTY TO HAVE AGENT OR BROKER AT EACH PLACE OF BUSINESS

(REPEALED)

SECTION HISTORY
1987, c. 292, (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1544. CHANGE OF ADDRESS

(REPEALED)

SECTION HISTORY
1993, c. 221, §14 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1545. AUTHORITY OF AGENT; LIMITATION AS TO SURETY BONDS

(REPEALED)

SECTION HISTORY
1993, c. 221, §14 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1546. BROKER'S AUTHORITY; COMMISSIONS

(REPEALED)

SECTION HISTORY
1993, c. 221, §14 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1547. PLACE OF BUSINESS

(REPEALED)

SECTION HISTORY
1993, c. 221, §14 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1548. RECORDS

(REPEALED)

SECTION HISTORY
1993, c. 221, §14 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

Subchapter 2: GENERAL LINES AGENTS AND BROKERS -- QUALIFICATIONS AND REQUIREMENTS HEADING: PL 1997, C. 457, §27 (RP)

§1601. SHORT TITLE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1602. SCOPE OF SUBCHAPTER

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1603. QUALIFICATIONS FOR GENERAL LINES AGENT AND BROKER LICENSE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 433, §59 (AMD). 1971, c. 598, §47 (AMD). 1973, c. 585, §12 (AMD). 1993, c. 637, §29 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1604. EDUCATIONAL REQUIREMENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §139 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1605. AUTHORITY OF AGENT; LIMITATION AS TO SURETY BONDS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1985, c. 564, §1 (AMD). 1993, c. 221, §15 (RP).

§1606. BROKER'S BOND

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 366, §11 (AMD). 1995, c. 329, §20 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1607. BROKER'S AUTHORITY, COMMISSIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1985, c. 564, §2 (AMD). 1993, c. 221, §16 (RP).

§1608. BROKER, AGENT LICENSE COMBINATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1609. PLACE OF BUSINESS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1993, c. 221, §17 (RP).

§1610. RECORDS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1993, c. 221, §17 (RP).

§1611. SIGNATURE, COUNTERSIGNATURE OF POLICIES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 435, §15 (AMD). 1973, c. 585, §12 (AMD). 1989, c. 168, §20 (RP).

§1612. COUNTERSIGNATURE FEE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 168, §21 (RP).

§1613. REPORTING AND ACCOUNTING FOR PREMIUMS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1614. COMMISSIONS; PAYMENT, ACCEPTANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1615. SHARING COMMISSIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1616. NONRESIDENT AGENTS, BROKERS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 168, §22 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1617. -- SERVICE OF PROCESS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1618. -- NONRESIDENT MUST PLACE BUSINESS THROUGH RESIDENT AGENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 548, §D1 (RP).

§1619. INITIAL LICENSE; GENERAL LINES AGENTS

(REPEALED)

SECTION HISTORY
1973, c. 248, (NEW). 1975, c. 159, §4 (AMD). 1989, c. 168, §23 (RP).

Subchapter 3: LIFE AGENTS AND BROKERS QUALIFICATIONS AND REQUIREMENTS HEADING: PL 1997, C. 457, §27 (RP)

§1671. SHORT TITLE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 221, §18 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1672. APPLICABILITY OF LIFE AND HEALTH AGENT AND BROKER LAW

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 221, §18 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1673. QUALIFICATIONS FOR LIFE AGENT, HEALTH AGENT AND LIFE BROKER LICENSES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 433, §60 (AMD). 1971, c. 598, §48 (AMD). 1973, c. 585, §12 (AMD). 1993, c. 221, §19 (AMD). 1993, c. 637, §30 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1674. INITIAL LICENSE -- LIFE AGENTS, BROKERS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 159, §5 (AMD). 1989, c. 168, §24 (RP).

§1675. BROKERS; BOND, AUTHORITY, COMMISSIONS, COMBINATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 221, §§20,21 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1676. COMMISSIONS: LIFE AGENTS, LIFE BROKERS AND HEALTH AGENTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 221, §22 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1677. EXCESS OR REJECTED RISKS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 221, §23 (RP).

§1677-A. SHARED COMMISSIONS

(REPEALED)

SECTION HISTORY
1993, c. 221, §24 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1678. FIDUCIARY RESPONSIBILITY: LIFE AGENTS, LIFE BROKERS AND HEALTH AGENTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 221, §25 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1679. COUNTERSIGNATURE OF HEALTH POLICIES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 548, §D1 (RP).

§1680. NONRESIDENT LIFE AGENTS, HEALTH AGENTS AND LIFE BROKERS; SERVICE OF PROCESS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 168, §25 (AMD). 1993, c. 221, §26 (AMD). 1995, c. 329, §21 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1681. CHANGE OF ADDRESS, NOTICE TO SUPERINTENDENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1993, c. 221, §27 (RP).

Subchapter 4: INSURANCE CONSULTANTS QUALIFICATIONS AND REQUIREMENTS HEADING: PL 1997, C. 457, §27 (RP)

§1801. SHORT TITLE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1802. SCOPE OF SUBCHAPTER IV

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1803. LICENSE REQUIRED

(REPEALED)

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1804. QUALIFICATIONS FOR LICENSE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 341, (RPR). 1983, c. 419, §10 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1805. CONSULTANT'S BOND

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 341, (RPR). 1985, c. 366, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1806. RECORDS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 351, §2 (AMD). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1807. CONSULTING CONTRACT REQUIRED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 351, §3 (AMD). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1807-A. CONSULTING FEE

(REPEALED)

SECTION HISTORY
1977, c. 351, §4 (NEW). 1979, c. 341, (RP).

§1808. COMMISSIONS AND FEES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1809. OBLIGATION TO SERVE INTEREST OF CLIENT

(REPEALED)

SECTION HISTORY

1969, c. 132, §1 (NEW). 1979, c. 341, (RPR). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP). 1997, c. 457, §26 (RPR).

§1810. NONRESIDENT CONSULTANTS; SERVICE OF PROCESS

(REPEALED)

SECTION HISTORY
1979, c. 341, (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

Subchapter 5: INSURANCE ADJUSTERS QUALIFICATIONS AND REQUIREMENTS HEADING: PL 1997, C. 457, §27 (RP)

§1851. SHORT TITLE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1852. SCOPE OF THIS SUBCHAPTER

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1853. QUALIFICATIONS FOR ADJUSTER LICENSE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §28 (AMD). 1969, c. 433, §61 (AMD). 1971, c. 598, §49 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 625, §140 (AMD). 1989, c. 168, §§26,27 (AMD). 1991, c. 615, §A2 (AMD). 1993, c. 221, §28 (AMD). 1995, c. 329, §§22-24 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1854. ADJUSTER'S BOND

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 366, §13 (AMD). 1989, c. 168, §28 (AMD). 1993, c. 637, §§31,32 (AMD). 1995, c. 329, §25 (RP).

§1855. RECORDS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1856. NONRESIDENT ADJUSTERS; PROCESS; SPECIAL CATASTROPHE LOSSES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1857. TEMPORARY LICENSE AS ADJUSTER

(REPEALED)

SECTION HISTORY
1973, c. 150, §2 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1858. ACTIVITIES OF INSURANCE ADJUSTERS

(REPEALED)

SECTION HISTORY
1997, c. 86, §1 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP). 1997, c. 683, §B13 (RP).

Subchapter 6: CONTINUING EDUCATIONAL REQUIREMENTS FOR LICENSED AGENTS, BROKERS AND CONSULTANTS
HEADING: PL 1989, C. 31, §4 (NEW); 1997, C. 457, §27 (RP)

§1875. APPLICABILITY

(REPEALED)

SECTION HISTORY
1989, c. 31, §4 (NEW). 1989, c. 878, §§H5,6 (AMD). 1993, c. 322, §7 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1876. CONTINUING EDUCATION ADVISORY COMMITTEE

(REPEALED)

SECTION HISTORY
1989, c. 31, §4 (NEW). 1995, c. 329, §26 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1877. EDUCATIONAL REQUIREMENTS

(REPEALED)

SECTION HISTORY
1989, c. 31, §4 (NEW). 1989, c. 625, (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1878. APPLICATION FOR APPROVAL OF PROGRAM

(REPEALED)

SECTION HISTORY

1989, c. 31, §4 (NEW). 1993, c. 637, §33 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1879. PENALTY

(REPEALED)

SECTION HISTORY
1989, c. 31, §4 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1880. RULE-MAKING AUTHORITY

(REPEALED)

SECTION HISTORY
1989, c. 31, §4 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

Subchapter 7: MANAGING GENERAL AGENTS HEADING: PL 1991, C. 828, §23 (NEW); 1997, C. 457, §27 (RP)

§1881. SHORT TITLE

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1882. DEFINITIONS

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1883. LICENSE AND REGISTRATION REQUIREMENT

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1993, c. 221, §29 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1884. REQUIRED CONTRACT PROVISIONS

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1885. DUTIES OF INSURERS

(REPEALED)

SECTION HISTORY

1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1886. ACTS OF MGA CONSIDERED ACTS OF INSURER; EXAMINATION AUTHORITY

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1887. PENALTIES AND LIABILITIES

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1888. RULES

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

§1889. EFFECTIVE DATE

(REPEALED)

SECTION HISTORY
1991, c. 828, §23 (NEW). 1997, c. 457, §55 (AFF). 1997, c. 457, §27 (RP).

Chapter 18: INSURANCE ADMINISTRATORS

§1901. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

1. "Administrator" means any person who, on behalf of a plan sponsor, health care service plan, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on residents of this State in connection with any type of life, annuity, health, workers' compensation or employee benefit excess insurance benefit provided in or as an alternative to insurance as defined by sections 702 to 704, former Title 39 or Title 39-A, other than any of the following:

A. An employer on behalf of the employer's employees or the employees of one or more subsidiary or affiliated corporations of the employer; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. A union on behalf of its members; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. A plan sponsor administering its own plan; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

D. An insurance company that is:

(1) Authorized to transact insurance business in this State; or

(2) Acting as an insurer with respect to a policy lawfully issued and delivered by that company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

E. A nonprofit hospital, medical or health care services plan, health maintenance organization, professional service plan corporation or person in the business of providing continuing care, possessing a valid certificate of authority issued by the Bureau of Insurance, and the sole representative of that person, plan, organization or corporation, if the activities of the plan, organization, corporation or person are limited to the activities permitted under the certificate of authority; [1993, c. 702, Pt. A, §10 (AMD).]

F. An insurance agent or broker licensed in this State, whose activities are limited to the scope of that license; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

G. An adjuster licensed in this State, whose activities are limited to the adjustment of claims; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

H. A creditor on behalf of the creditor's debtors with respect to insurance covering a debt between the creditor and its debtors; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

I. A trust and its trustees, agents, and employees acting pursuant to a trust established in conformity with 29 United States Code, Section 186; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

J. A trust exempt from taxation under the federal Internal Revenue Code of 1986, Section 501(a), and the trustees and employees acting pursuant to that trust, or a custodian and its agents and employees, including individuals representing the trustees in overseeing the activities of a service company or administrator, acting pursuant to a custodial account that meets the requirements of the federal Internal Revenue Code of 1986, Section 401(f); [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

K. A financial institution or a mortgage lender that collects and remits premiums to licensed insurance agents or authorized insurers concurrently or in connection with mortgage loan payments; [1997, c. 457, §28 (AMD).]

L. A credit card issuing company that advances for and collects premiums or charges from its credit card holders who have authorized that collection if the company does not adjust or settle claims; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

M. A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or health insurance coverage; [1995, c. 673, Pt. A, §1 (AMD).]

N. A person acting as a trustee, named fiduciary or plan official of an employee benefit plan within the meaning of the federal Employee Retirement Income Security Act of 1974, as amended, 29 United States Code, Section 1001, et seq.; and [1995, c. 673, Pt. A, §1 (AMD).]

O. A private purchasing alliance licensed in accordance with chapter 18-A. [1995, c. 673, Pt. A, §2 (NEW).]

Notwithstanding any other provision of this subsection, "administrator" includes any administrator of a preferred provider arrangement required to register under this chapter pursuant to section 2674-A.

[2003, c. 428, Pt. C, §1 (AMD) .]

2. "ATF" means an administrator trust fund that is a special fiduciary account, established and maintained by an administrator under section 1909, in which contributions and premiums are deposited.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

3. "CASA" means a claims administration services account that is a special fiduciary account, established and maintained by an administrator under section 1909, from which claims and claims adjustment expenses are disbursed.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

4. "Charges" means any compensation paid by a plan sponsor, health care service plan, health maintenance organization or insurer for services performed by the administrator.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

5. "Contributions" means the value of funds that have been provided or are to be applied by a plan sponsor or other entity to fund the self-insured portion of any plan, or premiums charged to a plan sponsor or other entity by an insurer for coverage under contracts of insurance or excess insurance. Contributions include administrative fees charged to a covered individual. "Administrative fee" means any compensation paid by a covered individual for services performed by the administrator.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

6. "Covered individual" means any individual eligible for life, annuity, workers' compensation or health benefits under a plan.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

7. "Plan" means any plan, fund or program established or maintained by a plan sponsor, health care service plan, health maintenance organization or insurer to the extent that the plan, fund or program was established or is maintained to provide through insurance or alternatives to insurance any type of life, annuity, health or workers' compensation benefit within the scope of sections 702 to 704, former Title 39 or Title 39-A.

[1991, c. 885, Pt. E, §26 (AMD); 1991, c. 885, Pt. E, §47 (AFF) .]

8. "Plan sponsor" means any person, other than an insurer, who establishes or maintains a plan covering residents of this State, including, but not limited to, plans established or maintained by 2 or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

9. "Premium" means any money charged a covered individual, plan sponsor or other entity to provide life, accident, workers' compensation or health insurance under a plan. The term "premium" includes amounts paid by or charged to a covered individual plan sponsor or other entity for stop loss or excess insurance.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

10. "Quasi-resident" means a nonresident licensee who receives or collects 50% or more of calendar year contributions, premium volume or other funds subject to administration from plan sponsors or insureds resident in this State.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 1991, c. 885, §§E25,26 (AMD). 1991, c. 885, §E47 (AFF). 1993, c. 702, §A10 (AMD). 1995, c. 673, §§A1,2 (AMD). 1997, c. 457, §28 (AMD). 1999, c. 609, §2 (AMD). 2003, c. 428, §C1 (AMD).

§1902. LICENSE REQUIRED

A person may not act as or profess to be an administrator after August 1, 1990, unless licensed under this chapter. An administrator doing business in this State on August 1, 1990, shall apply for a license by November 1, 1990. In addition to any other penalty that may be imposed for violation of this Title, any person violating this section shall, upon conviction, be punished by a fine of not less than $100 nor more than $1,000 or by imprisonment for less than one year, or both. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

An administrator licensed under this chapter on or before December 31, 2003 shall submit information by March 21, 2004 as to the types of business conducted by that administrator in this State on a form prescribed by the superintendent. [2003, c. 469, Pt. E, §3 (NEW).]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 2003, c. 469, §E3 (AMD).

§1903. APPLICATION

An applicant for a license shall file with the superintendent an application, on a form prescribed by the superintendent, that must include or have attached the following: [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

1. The names, addresses and official positions of the individuals who are responsible for the conduct of the affairs of the administrator, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation or the partners in the case of a partnership;

[2003, c. 469, Pt. E, §4 (AMD) .]

2. An application fee, as specified in section 601, that the superintendent shall apply toward the initial administrator annual fee if an administrator's license is granted to the applicant; and

[2003, c. 469, Pt. E, §4 (AMD) .]

3. The specific type of business in which the 3rd-party administrator will or intends to engage.

[2003, c. 469, Pt. E, §5 (NEW) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 2003, c. 469, §§E4,5 (AMD).

§1904. BOND REQUIREMENTS FOR ADMINISTRATORS

1. Every applicant for an administrator's license shall file with the application, and shall maintain in force while licensed, a fidelity bond, and at the superintendent's discretion, a surety bond, in favor of the Treasurer of State, for the benefit of covered persons or plan sponsors as their interest may appear, executed by a surety company authorized to do business in this State and payable to any party injured under the terms of the bond. The bond must be continuous in form and in one of the following amounts:

A. For an administrator that maintains an ATF but does not maintain a CASA, the greater of $50,000 or 5% of contributions and premiums projected to be received or collected in the ATF for the following plan year from residents of the State, but not to exceed $1,000,000; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. For an administrator that maintains a CASA but does not maintain an ATF, the greater of $50,000 or 5% of the claims and claim expenses projected to be held in the CASA for the following year to pay claims and claim expenses for residents of the State, but not to exceed $1,000,000; or [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. For an administrator that maintains an ATF and a CASA, the greater of $50,000 or 5% of contributions and premiums projected to be received or collected in the ATF for the following plan year from residents of the State plus 5% of the claims and claim expenses projected to be held in the CASA accounts for the following year to pay claims and claim expenses for residents of the State, but not to exceed $1,000,000. [1993, c. 171, Pt. A, §1 (AMD).]

This subsection applies to an administrator who is required to maintain funds in a fiduciary capacity as set forth in section 1909.

[1995, c. 329, §27 (AMD) .]

2. The bond must remain in force and effect until the surety is released from liability by the superintendent or until the bond is cancelled by the surety. The surety may cancel the bond and be released from further liability under the bond upon 30 days' written notice in advance to the superintendent. The cancellation does not affect any liability incurred or accrued under the bond before the 30-day period expires. Upon receiving any notice of cancellation, the superintendent shall immediately notify the licensee.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

3. The administrator's license automatically terminates if the bond required by this section is not in force. Within 30 days after the bond ceases to be in force, the administrator shall return the license to the superintendent for cancellation.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 1993, c. 171, §A1 (AMD). 1995, c. 329, §27 (AMD).

§1905. LICENSE

1. Upon receipt of a complete application for an administrator license, the superintendent shall investigate, to the extent the superintendent considers advisable, the applicant's experience, background and fitness for the license. The superintendent may obtain a credit and investigative report relative to the applicant from a recognized and established independent investigation and reporting agency. The superintendent may establish from time to time a reasonable uniform flat amount that the applicant must pay for the report. The report cost must be included with the application. The contents of the report are confidential.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

2. If the superintendent finds that the applicant is qualified for an administrator license, the superintendent shall promptly issue the license, which identifies the types of business in which the applicant may engage; otherwise the superintendent shall refuse to issue the license and promptly notify the applicant.

[2003, c. 469, Pt. E, §6 (AMD) .]

3. Sections 1417 and 1418 apply to licenses issued under this chapter.

[1997, c. 457, §29 (AMD); 1997, c. 457, §55 (AFF) .]

4. Unless revoked or suspended under section 1907, an administrator license remains in effect as long as the holder of the license maintains in force and effect the bond required by section 1904 and pays the annual fee required by section 601 before the anniversary date of the license.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

5. An administrator shall submit an application to amend its license if the administrator desires to amend the types of business on its then-current license.

[2003, c. 469, Pt. E, §7 (NEW) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 1997, c. 457, §29 (AMD). 1997, c. 457, §55 (AFF). 2003, c. 469, §§E6,7 (AMD).

§1906. ADMINISTRATOR REQUIREMENTS

1. Each administrator shall identify to the superintendent any ownership interest or affiliation of any kind with any plan sponsor, health care service plan, health maintenance organization or insurer responsible directly or through reinsurance for providing benefits to any plan for which the administrator provides services as an administrator.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

2. An administrator shall provide services as an administrator only pursuant to a written agreement between the administrator and the plan sponsor, health care service plan, health maintenance organization or insurer. The administrator shall retain the written agreement as part of its records for the duration of the agreement and for 7 years after the agreement expires.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

3. An administrator shall maintain, in its principal office for the duration of the written agreement with any plan sponsor or insurer and for 7 years after the agreement expires, adequate books and records of all transactions involving a plan sponsor, health care service plan, health maintenance organization or insurer and covered individuals and beneficiaries. These books and records must be maintained in accordance with generally accepted standards of business recordkeeping. An administrator is not required to maintain copies of books and records if the originals are returned to the plan sponsor, health care service plan, health maintenance organization or insurer before the end of the 7-year period. The administrator shall maintain evidence of the return of the originals for the balance of the 7-year period.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

4. The administrator shall file with the superintendent the names and addresses of the insurers, health care service plans, health maintenance organizations and plan sponsors with whom the administrator has entered into written agreements. If an insurer, health care service plan, health maintenance organization or plan sponsor does not assume or bear the risk, the administrator must disclose the name and address of the ultimate risk bearer. In addition, at the time of a license renewal, the administrator shall also file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid by the administrator by each plan sponsor and the total dollar amount of claims paid by each plan sponsor. This subsection applies to the initial application for an administrator's license and any renewal of a license.

[2001, c. 457, §20 (AMD) .]

5. An administrator may use advertising pertaining to the plan only if that advertising has been approved in advance by the plan sponsor, health care service plan, health maintenance organization or insurer.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

6. Upon receiving instructions from the plan sponsor, health care service plan, health maintenance organization or insurer, an administrator shall deliver promptly to covered individuals or beneficiaries all policies, certificate booklets, termination notices or other written communications.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

7. An administrator may not receive compensation from a plan sponsor, health care service plan, health maintenance organization or insurer that is contingent upon the loss ratio of the plan. This subsection does not, however, prevent the administrator from engaging in cost containment activities with a plan sponsor, health care service plan, health maintenance organization or insurer.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

8. An administrator may not receive from any plan sponsor, health care service plan, health maintenance organization, insurer, covered individual or beneficiary under a plan any compensation or other payments except as expressly set forth in the written agreement between the administrator and the plan sponsor, health care service plan, health maintenance organization or insurer.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

9. Upon request of the superintendent, an administrator shall make available for examination, either at the Bureau of Insurance or at the licensee's principal place of business, all basic organizational documents, including, but not limited to, articles of incorporation, articles of association, partnership agreements, trade name certificates, trust agreements, shareholder agreements and other applicable documents and all amendments to those documents, bylaws, rules and regulations or similar documents regulating the conduct of the administrator's internal affairs.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

10. When acting as an administrator, the acts of an insurance administrator are deemed to be the acts of the plan sponsor, health care service plan, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization or insurer.

[1997, c. 457, §30 (NEW) .]

11. In addition to any other applicable provisions of law, the plan sponsor, health care service plan, health maintenance organization, fraternal benefit society, nonprofit hospital or medical service organization or insurer is accountable and may be penalized by the superintendent, as provided for in this Title, for the actions of its administrators.

[1997, c. 457, §30 (NEW) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 1997, c. 457, §30 (AMD). 2001, c. 457, §20 (AMD).

§1907. LICENSE SUSPENSION, REVOCATION OR DENIAL

Any license issued under this chapter may be suspended or revoked after notice to the licensee and an opportunity for hearing and any application for license may be denied after notice and opportunity for hearing: [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

1. For any of the grounds for suspension or revocation of a license set forth in section 1417; or

[1997, c. 457, §31 (AMD); 1997, c. 457, §55 (AFF) .]

2. If the licensee or applicant:

A. Is using any method or practice in conducting business that renders further transaction of business in this State hazardous or injurious to covered individuals or the public; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. Is affiliated with and is under the same general management as another administrator that transacts business in this State without being licensed under this chapter; or [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. Has failed to report a conviction as required by section 1908. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW). 1997, c. 457, §31 (AMD). 1997, c. 457, §55 (AFF).

§1908. CRIMINAL CONVICTIONS

Any administrator and any individual listed on the application, as required by section 1903, who is convicted of a crime punishable by imprisonment for more than one year shall report that conviction to the superintendent within 30 days after judgment is entered. Within that 30-day period, the administrator shall also provide the superintendent with a copy of the judgment and any commitment order and any other relevant documents relating to disposition of the criminal action. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW).

§1909. FIDUCIARY ACCOUNTS AND DUTIES

1. Administrators shall hold in a fiduciary capacity all contributions and premiums received or collected on behalf of a plan sponsor or insurer, except service fees owed to the administrator pursuant to the written agreement between the plan sponsor, insurer, health care service plan or health maintenance organization and the administrator. These funds may not be used as general operating funds of the administrator. All contributions and premiums received or collected by the administrator from residents of this State that the administrator holds more than 30 days or deposits into an account that is not under the control of the plan sponsor, health care service plan, health maintenance organization or insurer, must be placed in a special fiduciary account, designated as an ATF. All resident and quasi-resident licensees required to maintain an ATF under this section shall maintain the ATF with one or more financial institutions located within the State and subject to jurisdiction of the courts of this State. Funds belonging to 2 or more plans may be held in the same ATF, provided the administrator's records clearly indicate the funds belonging to each plan. Checks drawn on the ATF must indicate on the face of the checks that the checks are drawn on the administrator's ATF.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

2. The administrator may make the following disbursements from the ATF:

A. Contributions and premiums due insurers or other persons providing life, accident and health, or workers' compensation coverage for a plan; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. Return contributions and premiums to a plan or covered individual; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. Commissions or administrative fees due to the administrator when earned under a written agreement; and [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

D. Transfers into the CASA of the administrator. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

3. For each plan for which an ATF is required, the balance in the ATF must at all times be the amount deposited plus accrued interest, if any, less authorized disbursements. If the balance at the financial institution, with respect to the ATF, is less than the amount deposited plus accrued interest, if any, less authorized disbursements, the administrator is presumed, for purposes of license revocation or suspension, to have misappropriated funds and to have acted in a financially irresponsible manner.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

4. Before establishing an ATF that is interest bearing or income producing, the administrator shall disclose the nature of the account to the plan sponsor, health care service plan, health maintenance organization or insurer on whose behalf the funds are to be held. The administrator shall secure written consent and authorization from the plan sponsor, health care service plan, health maintenance organization or insurer for the investment of the money and disposition of the interest or earnings. An administrator may not make any investment that assumes a risk other than the risk that the obligor might not pay the principal when due. The administrator may not use specialized techniques or strategies that incur additional risks to generate higher returns or to extend maturities. Such techniques include, but are not limited to, the use of financial futures or options, buying on margins and pledging of ATF balances.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

5. Administrators may place ATF funds in interest bearing or income producing investments and retain the interest or income on the funds, provided the administrator obtains the prior written authorization of the plan sponsors, health care service plans, health maintenance organizations or insurers on whose behalf the funds are to be held. In addition to savings and checking accounts, an administrator may invest in the following:

A. Direct obligations of the United States or government agency securities with maturities of not more than one year; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. Certificates of deposit, with a maturity of not more than one year, issued by financial institutions insured by the Federal Deposit Insurance Corporation (FDIC) or Federal Savings and Loan Insurance Corporation (FSLIC), provided any such deposit does not exceed the maximum level of insurance protection provided to certificates of deposit held by those institutions; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. Repurchase agreements with financial institutions or government securities dealers recognized as primary dealers by the Federal Reserve System provided:

(1) The value of the repurchase agreement is collateralized with assets that are allowable investments for ATF funds;

(2) The collateral has a market value, at the time the repurchase agreement is entered into, at least equal to the value of the repurchase agreement; and

(3) The repurchase agreement does not exceed 30 days; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

D. Commercial paper, provided the commercial paper is rated at least P-1 by Moody's Investors Service, Inc. or at least A-1 by Standard & Poor's Corporation; or [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

E. Money market funds, provided the money market fund invests exclusively in assets that are allowable investments pursuant to paragraphs A to D for ATF funds. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

Each investment transaction must be made in the name of the administrator's ATF. The administrator shall maintain evidence of any such investments. Each investment transaction must flow through the administrator's ATF.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

6. The administrator shall hold in a fiduciary capacity all money that the administrator receives to pay claims and claim adjustment expenses. All resident and quasi-resident licensees shall place all such money for claims and claim adjustment expenses for residents of this State, whether received from a plan sponsor, health care service plan, health maintenance organization or insurer or from the administrator's ATF, in a special fiduciary account in a financial institution located in this State. The account must be designated a CASA.

Funds belonging to 2 or more plans may be held in the same CASA, provided the administrator's records clearly indicate the funds belonging to each plan. Checks drawn on the CASA must indicate on the face of the checks that the checks are drawn on the administrator's CASA.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

7. No deposit may be made into a CASA and no disbursement may be made from a CASA except for claims and claim adjustment expenses. For each plan for which a CASA is required, the balance in the CASA must at all times be the amount deposited less claims and claims adjustment expenses paid. If the CASA balance is less than that amount, the administrator shall be presumed, for purposes of license revocation or suspension, to have misappropriated funds and to have acted in a financially irresponsible manner.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

8. Administrators shall maintain detailed books and records that reflect all transactions involving the receipt and disbursement of:

A. Contributions and premiums received on behalf of a plan sponsor, health care service plan, health maintenance organization or insurer; and [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. Claims and claim adjustment expenses received and paid on behalf of a plan sponsor, health care service plan, health maintenance organization or insurer. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

9. The detailed preparation, journalizing and posting of books and records required by subsection 8 must be maintained on a timely basis and all journal entries for receipts and disbursements must be supported by evidential matter that must be referenced in the journal entry so that receipts and disbursements may be traced for verification. Administrators shall prepare and maintain monthly financial institution account reconciliations of any ATF and CASA established by the administrator. Reconciliation of accounts is timely if accomplished not more than 45 days after the end of the month in which the transaction occurred. The reconciliation must include, at a minimum, the following:

A. The source and amount of any money received and deposited by the administrator, and the date of receipt and deposit; [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

B. The date each disbursement was made, the person to whom the disbursement was made and a written explanation of any difference between the amount disbursed and the amount billed or authorized; and [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

C. A description of the disbursement in sufficient detail to identify the source document substantiating the purpose of the disbursement. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

10. Failure to accurately maintain the required books and records in a timely manner is deemed to be untrustworthy, hazardous or injurious to participants in the plan or the public and financially irresponsible.

[1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW).

§1910. UNAUTHORIZED ACTIVITIES

Nothing in this chapter may be construed to permit any person or entity to receive or collect charges, contributions or premiums for, or adjust or settle claims in connection with, any type of life or accident or health benefit, unless the person or entity is authorized through the insurance laws of a state or the Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, et seq. as amended, to provide those benefits. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW).

§1911. AUDITS AND EXAMINATIONS

The superintendent may designate examiners or consultants, as appropriate, to perform an audit of an administrator when the superintendent considers an audit necessary. Administrators shall make all records and books of account available to the examiners or consultants, and shall otherwise facilitate the performance of the audit. All claims information respecting individual claimants must be kept confidential. [1989, c. 846, Pt. D, §2 (NEW); 1989, c. 846, Pt. E, §4 (AFF).]

SECTION HISTORY
1989, c. 846, §§D2,E4 (NEW).

§1912. STANDARDIZED CLAIM FORMS

All administrators who administer claims and who provide 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 administrators who administer claims and who provide 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 administrator 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 administrator 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. [2005, c. 97, §1 (AMD).]

SECTION HISTORY
1993, c. 477, §D8 (NEW). 1993, c. 477, §F1 (AFF). 2003, c. 218, §2 (AMD). 2003, c. 469, §D3 (AMD). 2003, c. 469, §D9 (AFF). 2005, c. 97, §1 (AMD).

§1913. REGISTRATION OF PHARMACY BENEFITS MANAGERS

Beginning April 1, 2011, a person may not act as a pharmacy benefits manager in this State without first paying the registration fee required under section 601, subsection 28. [2011, c. 443, §4 (RPR).]

1. **Definitions.** As used in this section, the following terms have the following meanings.

A. "Pharmacy benefits manager" means a person or entity that contracts with a plan sponsor, health care service plan, health maintenance organization or insurer to manage or administer a contract, agreement or arrangement between a carrier or administrator and a pharmacy, as defined in Title 32, section 13702-

A, subsection 24, in which the pharmacy agrees to provide services to a health plan enrollee whose plan benefits include incentives for the enrollee to use the services of that pharmacy. [2011, c. 443, §4 (NEW).]

[2011, c. 443, §4 (NEW) .]

2. **Rules.** The superintendent may adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A to administer and enforce the registration requirements of this section.

[2011, c. 443, §4 (NEW) .]

3. **Enforcement.** The superintendent may enforce this section under sections 220 and 223 and other provisions of this Title.

[2011, c. 443, §4 (NEW) .]

SECTION HISTORY
2009, c. 581, §4 (NEW). 2011, c. 443, §4 (RPR).

Chapter 18-A: PRIVATE PURCHASING ALLIANCES

§1951. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1995, c. 673, Pt. A, §3 (NEW).]

1. **Carrier.** "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue health plans in this State. For the purposes of this chapter, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this chapter apply as if all health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this chapter, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

[1995, c. 673, Pt. A, §3 (NEW) .]

2. **Private purchasing alliance.** "Private purchasing alliance" or "alliance" means a corporation established under former Title 13-A, Title 13-B or Title 13-C to provide health insurance to its members through one or more participating carriers.

[2003, c. 428, Pt. H, §1 (AMD) .]

SECTION HISTORY
1995, c. 673, §A3 (NEW). 1997, c. 616, §1 (AMD). RR 2001, c. 2, §B58 (AFF). RR 2001, c. 2, §B42 (COR). 2001, c. 369, §1 (AMD). 2003, c. 428, §H1 (AMD).

§1952. LICENSURE

A private purchasing alliance may not market, sell, offer or arrange for a package of one or more health benefit plans underwritten by one or more carriers without first being licensed by the superintendent. The superintendent shall specify by rule standards and procedures for the issuance and renewal of licenses for private purchasing alliances. A rule may require an application fee of not more than $400 and an annual license fee of not more than $100. A license may not be issued until the rulemaking required by this chapter has been undertaken and all required rules are in effect. Dirigo Health, as established in chapter 87, is exempt from the licensure requirements of this section as an independent executive agency of the State. [2003, c. 469, Pt. E, §8 (AMD).]

SECTION HISTORY
1995, c. 673, §A3 (NEW). 2003, c. 428, §H2 (AMD). 2003, c. 469, §E8 (AMD).

§1953. POWERS

In addition to the powers granted in Title 13-B or Title 13-C, an alliance may do any of the following: [2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §43 (COR).]

1. **Membership fees.** Set reasonable fees for membership in the alliance for financing reasonable and necessary costs incurred in administering the alliance;

[1995, c. 673, Pt. A, §3 (NEW) .]

2. **Premium collection.** Provide premium collection services for health benefit plans offered through the alliance if the insurer or health maintenance organization offering the plan gives express written authorization to the alliance or any other person or entity acting on behalf of the alliance to act as the insurer's or the health maintenance organization's agent for that purpose;

[1995, c. 673, Pt. A, §3 (NEW) .]

3. **Contracts.** Contract with qualified independent 3rd parties for any service necessary to carry out the powers and duties authorized or required by this chapter;

[1995, c. 673, Pt. A, §3 (NEW) .]

4. **Standards.** Exclude a carrier or freeze enrollment in a carrier for failure to achieve established quality, access or information reporting standards of the alliance;

[1995, c. 673, Pt. A, §3 (NEW) .]

5. **Data collection.** Develop uniform standards for data to be provided by participating carriers and providers. The alliance may collect data necessary for evaluation of the performance of participating carriers and their provider networks by consumers, providers, employers and the superintendent;

[1995, c. 673, Pt. A, §3 (NEW) .]

6. **Negotiation.** Negotiate with participating carriers the premium rates charged for coverage offered through the alliance, consistent with rules adopted by the superintendent; or

[1995, c. 673, Pt. A, §3 (NEW) .]

7. **Risk adjustment.** Establish procedures, subject to approval by the superintendent, for adjusting payments within each risk pool to participating carriers if the alliance finds that some carriers have a significantly disproportionate share of high-risk or low-risk enrollees.

[1995, c. 673, Pt. A, §3 (NEW) .]

SECTION HISTORY
1995, c. 673, §A3 (NEW). 1997, c. 616, §2 (AMD). RR 2001, c. 2, §B58 (AFF). RR 2001, c. 2, §B43 (COR).

§1954. DUTIES

An alliance shall: [1995, c. 673, Pt. A, §3 (NEW).]

1. **Carrier eligibility.** Develop and make available a list of objective criteria, subject to rules adopted by the superintendent, that participating carriers must meet in order to be eligible to participate in the alliance;

[1995, c. 673, Pt. A, §3 (NEW) .]

2. **Enrollee choice.** Ensure that enrollees have a choice among a reasonable number of competing carriers and types of health benefit plans.

A. [2001, c. 369, §2 (RP).]

B. [T. 24-A, §1954, sub-§2, ¶ B (RP).]

C. [1997, c. 370, Pt. A, §2 (RP).]

[2001, c. 369, §2 (AMD) .]

3. **Enrollment.** Develop standard enrollment procedures in accordance with rules adopted by the superintendent;

[1995, c. 673, Pt. A, §3 (NEW) .]

4. **Plan descriptions.** Publish educational materials, plan descriptions and comparison sheets describing participating carriers and the health benefit plans available through the alliance for use in enrolling eligible members. The information may include an assessment of utilization management procedures and the level of quality and cost-effective care;

[1995, c. 673, Pt. A, §3 (NEW) .]

5. **Enrollee eligibility.** Establish eligibility standards for membership in accordance with rules adopted by the superintendent. Eligibility standards may not relate to health status;

[1995, c. 673, Pt. A, §3 (NEW) .]

6. **Acceptance of enrollees.** Accept all applicants for membership that meet the alliance's eligibility standards;

[1995, c. 673, Pt. A, §3 (NEW) .]

7. **Risk pools.** Develop standards for classifying groups of participating members into risk pools. The risk pools may include one or more risk pools for enrolled employees and their dependents and a risk pool for enrolled individuals and their dependents;

[1995, c. 673, Pt. A, §3 (NEW) .]

8. **Annual report.** Prepare an annual report on the operations of the alliance to the superintendent, which must include an accounting of all outside revenues received by the alliance and internal and independent audits and any other information the superintendent may require;

[1995, c. 673, Pt. A, §3 (NEW) .]

9. **Trust account.** Maintain a trust account or accounts for deposit of all money received and collected for the operation of the alliance. An alliance and its board members, employees and agents have a fiduciary duty with respect to all money received or owed to it to ensure payments of its obligations and a full accounting to its members and the superintendent; and

[1995, c. 673, Pt. A, §3 (NEW) .]

10. **Violations.** Report to the superintendent any suspected or alleged law violations.

[1995, c. 673, Pt. A, §3 (NEW) .]

The superintendent may specify further duties by rule. [1995, c. 673, Pt. A, §3 (NEW).]

SECTION HISTORY
1995, c. 673, §A3 (NEW). 1997, c. 370, §§A1,2 (AMD). 2001, c. 369, §2 (AMD). MRSA T.24A, §1954/1/B (AMD).

§1955. RESTRICTIONS

1. **Restricted activities.** An alliance may not purchase health care services, assume risk for the cost or provision of health care services or otherwise contract with health care providers for the provision of health care services to enrollees without the prior approval of the superintendent.

[1997, c. 616, §3 (AMD) .]

2. **Licensing.** A person who solicits applications for insurance, negotiates insurance contracts or takes applications for insurance from enrollees on behalf of an alliance or on behalf of insurance carriers or health maintenance organizations that have contracted with the alliance must be licensed with the bureau in compliance with chapter 16.

[1997, c. 457, §32 (AMD); 1997, c. 457, §55 (AFF) .]

3. **Conflict of interest.** A person may not be a board member, officer or employee of an alliance if that person is employed as or by, is a member of the board of directors of, is an officer of, or has a material direct or indirect ownership interest in a carrier or health care provider. A person may not be a board member or officer of an alliance if a member of that person's household is a member of the board of directors of, is an officer of or has a material direct or indirect ownership interest in a carrier or health care provider. An employee of an alliance who is licensed as an agent, broker or consultant may act under that license only on behalf of the alliance and only within the scope of that person's duties as an employee.

[1997, c. 616, §3 (AMD) .]

4. **Commissions.** All commissions or other payments to the alliance from or on behalf of carriers must inure to the benefit of the alliance and alliance members. An employee of an alliance may not receive compensation that is contingent upon the amount of coverage sold or upon the health carrier that is chosen. This subsection does not prohibit an alliance from arranging coverage through an unaffiliated agent or broker who is paid on a commission basis in the ordinary course of business.

[1995, c. 673, Pt. A, §3 (NEW) .]

5. **Rulemaking.** The superintendent may specify further restrictions by rule.

[1995, c. 673, Pt. A, §3 (NEW) .]

SECTION HISTORY
1995, c. 673, §A3 (NEW). 1997, c. 457, §32 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 616, §3 (AMD).

§1956. AUTHORITY OF SUPERINTENDENT

1. **Alliance conduct.** The superintendent has the authority to regulate the establishment and conduct of alliances as set forth in this chapter.

[1995, c. 673, Pt. A, §3 (NEW) .]

2. **Representations.** A person or entity not licensed by the superintendent as a private purchasing alliance and engaged in the purchase, sale, marketing or distribution of health insurance or health care benefit plans may not represent itself as an alliance, health insurance purchasing alliance, purchasing alliance, health insurance purchasing cooperative or purchasing cooperative, or otherwise use a confusingly similar name.

[1995, c. 673, Pt. A, §3 (NEW) .]

3. **Conflict.** Nothing in this chapter may be considered in conflict with or limit the duties and powers granted to the superintendent under the laws of this State.

[1995, c. 673, Pt. A, §3 (NEW) .]

4. **Penalties.** Violations of this chapter are subject to the penalties contained in section 12-A.

[1995, c. 673, Pt. A, §3 (NEW) .]

SECTION HISTORY
1995, c. 673, §A3 (NEW).

§1957. RULEMAKING

The superintendent shall adopt rules necessary to carry out the requirements of this chapter before January 1, 1997. All rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter II-A. [1995, c. 673, Pt. A, §3 (NEW).]

SECTION HISTORY
1995, c. 673, §A3 (NEW).

Chapter 19: SURPLUS LINES

§2001. SHORT TITLE

This chapter constitutes and may be cited as the "Surplus Lines Law." [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2001-A. SCOPE

This chapter applies exclusively to transactions when this State is the home state of the applicant or insured. Nothing in this chapter applies to the sale, solicitation, negotiation, placement or writing of contracts of insurance for any applicant or insured whose home state is in a jurisdiction other than in this State. [2011, c. 331, §1 (NEW); 2011, c. 331, §§16, 17 (AFF).]

SECTION HISTORY
2011, c. 331, §1 (NEW). 2011, c. 331, §§16, 17 (AFF).

§2002. EXEMPTIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 769, §A92 (AMD). 1993, c. 153, §15 (RP).

§2002-A. EXEMPTIONS FROM PROVISIONS

1. The following kinds of insurance must be procured from authorized insurers and are not eligible for export in the surplus lines market:

A. Life insurance; [1993, c. 153, §16 (NEW).]

B. Health insurance; or [1993, c. 153, §16 (NEW).]

C. Employee benefit excess insurance. [1993, c. 153, §16 (NEW).]

[1993, c. 153, §16 (NEW) .]

2. This surplus lines law may not be used to place reinsurance. Nothing in this subsection prohibits the cession or assumption of reinsurance as otherwise permitted by this Title.

[1993, c. 153, §16 (NEW) .]

3. Producers with surplus lines authority may procure the following kinds of insurance from eligible surplus lines insurers without adherence to the procedures set forth in section 2004 or any other requirement to determine whether the full amount or type of insurance sought can be obtained from admitted insurers:

A. Wet marine and transportation insurance; [1993, c. 153, §16 (NEW).]

B. Insurance on subjects located, resident or to be performed wholly outside of this State, or on vehicles or aircraft owned and principally garaged outside this State; [1993, c. 153, §16 (NEW).]

C. Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in such operations; [2011, c. 331, §2 (AMD); 2011, c. 331, §§16, 17 (AFF).]

D. Insurance on aircraft owned or operated by manufacturers of aircraft or of aircraft operated in commercial interstate flight, or cargo of such aircraft, or against liability other than workers' compensation and employer's liability arising out of the ownership, maintenance or use of such aircraft; or [2011, c. 331, §2 (AMD); 2011, c. 331, §§16, 17 (AFF).]

E. Insurance placed by a producer with surplus lines authority for an exempt commercial purchaser if:

(1) The producer has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that provides greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing for the producer to procure or place such insurance from a nonadmitted insurer. [2011, c. 331, §2 (NEW); 2011, c. 331, §§16, 17 (AFF).]

[2011, c. 331, §2 (AMD); 2011, c. 331, §§16, 17 (AFF) .]

SECTION HISTORY
1993, c. 153, §16 (NEW). 1997, c. 592, §48 (AMD). 2011, c. 331, §2 (AMD). 2011, c. 331, §§16, 17 (AMD).

§2003. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF).]

1. "Producer" means a producer with surplus lines authority duly licensed as such under this chapter.

[2011, c. 331, §3 (AMD); 2011, c. 331, §§16, 17 (AFF) .]

2. To "export" means to place insurance in a nonadmitted insurer under this Surplus Lines Law.

[2011, c. 331, §3 (AMD); 2011, c. 331, §§16, 17 (AFF) .]

3. "Admitted insurer" means an insurer licensed to engage in the business of insurance in this State.

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

4. "Affiliate" means, with respect to an insured, any entity that controls, is controlled by or is under common control with the insured.

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

5. "Affiliated group" means any group of affiliates.

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

6. "Exempt commercial purchaser" means an exempt commercial purchaser as defined by the federal Nonadmitted and Reinsurance Reform Act of 2010, Public Law 111-203, Section 527.

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

7. "Home state" means:

A. With respect to an insured:

(1) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(2) If 100% of the insured risk is located out of the state referred to in subparagraph 1, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or [2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF).]

B. With respect to an affiliated group, if more than one of the insureds from an affiliated group are named insureds on a single nonadmitted insurance contract, the home state, as determined pursuant to paragraph A, of the member of the affiliated group that has the largest percentage of premium attributed to it under that insurance contract. [2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF).]

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

8. "Nonadmitted insurance" means any property and casualty insurance permitted to be placed through a surplus lines broker with a nonadmitted insurer eligible to accept that insurance.

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

9. "Nonadmitted insurer" means an insurer not licensed to engage in the business of insurance in this State. "Nonadmitted insurer" does not include a risk retention group, as that term is defined in section 6093, subsection 13.

[2011, c. 331, §3 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 592, §49 (AMD). 2011, c. 331, §3 (AMD). 2011, c. 331, §§16, 17 (AFF).

§2004. CONDITIONS FOR EXPORT

If certain insurance coverages cannot be procured from authorized insurers, such coverages, hereinafter designated "surplus lines," may be procured from unauthorized insurers, subject to the following conditions: [1969, c. 132, §1 (NEW).]

1. The insurance must be procured through a licensed producer with surplus lines authority.

[1997, c. 592, §50 (AMD) .]

2. The desired coverage is necessary for the adequate protection of a risk in the State.

[1969, c. 132, §1 (NEW) .]

3. It may be written under the laws of this State by an authorized insurer.

[1969, c. 132, §1 (NEW) .]

4. The insurance is not available after diligent effort has been made to place the coverage with authorized insurers.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 592, §50 (AMD).

§2005. REPORT OF COVERAGE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §29 (RPR). 1973, c. 585, §12 (AMD). 1997, c. 592, §51 (RP).

§2006. OPEN LINES FOR EXPORT

1. The superintendent may by order declare eligible for export generally and without compliance with section 2004, subsections 2, 3 and 4, any class or classes of insurance coverage or risk for which the superintendent finds, after a hearing of which notice was given to each insurer authorized to transact such class or classes in this State, that there is not a reasonable or adequate market among authorized insurers either as to acceptance of the risk, contract terms, or premium or premium rate. Any such order shall continue in effect during the existence of the conditions upon which predicated, but subject to earlier termination by the superintendent.

[1997, c. 592, §52 (AMD) .]

2. The producer shall file with or as directed by the superintendent a memorandum as to each such coverage placed by the producer in an unauthorized insurer, in such form and context as the superintendent may reasonably require for the identification of the coverage and determination of the tax payable to the State relative thereto.

[1997, c. 592, §52 (AMD) .]

3. A producer may also place with authorized insurers any insurance coverage made eligible for export generally under subsection 1, and without regard to rate or form filings that may otherwise be applicable as to the authorized insurer. As to coverages so placed in an authorized insurer the premium tax thereon must be reported and paid by the insurer as required generally under the law of this State.

[1997, c. 592, §53 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §30 (AMD). 1973, c. 585, §12 (AMD). 1997, c. 592, §§52,53 (AMD).

§2007. ELIGIBLE SURPLUS LINES INSURERS

1. A producer may not knowingly place surplus lines insurance with an insurer that is unsound financially or that is ineligible under this section.

[1997, c. 592, §54 (AMD) .]

2. The superintendent shall from time to time publish a list of all surplus lines insurers determined by the superintendent to be eligible currently, and shall mail a copy of such list to each producer at the producer's office last of record with the superintendent. This subsection may not be construed to cast upon the superintendent the duty of determining the actual financial condition or claims practices of any unauthorized insurer; and the status of eligibility, if granted by the superintendent, may indicate only that the insurer appears to be sound financially and to have satisfactory claims practices, and that the superintendent has no credible evidence to the contrary. While any such list is in effect, the producer shall restrict to the insurers so listed all surplus lines business placed by the producer.

[1997, c. 592, §54 (AMD) .]

3. The superintendent shall approve a United States insurer's request for eligibility if the insurer:

A. Is authorized to write such insurance in its domiciliary jurisdiction; [2011, c. 331, §4 (NEW); 2011, c. 331, §§16, 17 (AFF).]

B. Has established satisfactory evidence of good repute and financial integrity; and [2011, c. 331, §4 (NEW); 2011, c. 331, §§16, 17 (AFF).]

C. Maintains capital and surplus, or its equivalent under the laws of its state of domicile, in an amount at least equal to the greater of:

(1) The minimum capital and surplus that would be required if the insurer were licensed in this State; and

(2) $15,000,000. [2011, c. 331, §4 (NEW); 2011, c. 331, §§16, 17 (AFF).]

[2011, c. 331, §4 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

4. The superintendent may list an insurer as eligible if it does not meet the minimum capital and surplus requirements of subsection 3 upon an affirmative finding of acceptability by the superintendent. The finding must be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. The superintendent may not make an affirmative finding of acceptability if the nonadmitted insurer's capital and surplus is less than $4,500,000.

[2011, c. 331, §4 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

5. A non-United States insurer is considered eligible to write insurance on an unauthorized basis in this State if it is listed on the quarterly listing of alien insurers maintained by the National Association of Insurance Commissioners.

[2011, c. 331, §4 (NEW); 2011, c. 331, §§16, 17 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 592, §54 (AMD). 2011, c. 331, §4 (AMD). 2011, c. 331, §§16, 17 (AFF).

§2008. EVIDENCE OF THE INSURANCE; CHANGES; PENALTY

1. Upon placing a surplus lines coverage, the producer shall promptly issue and deliver to the insured evidence of the insurance consisting either of the policy as issued by the insurer, or, if such policy is not then available, the surplus lines producer's certificate. Such a certificate must be executed by the producer and show the description and location of the subject of the insurance, coverage, conditions and term of the insurance, the premium and rate charged and taxes collected from the insured, and the name and address of the insured and insurer. If the direct risk is assumed by more than one insurer, the certificate must state the name and address and proportion of the entire direct risk assumed by each such insurer.

[1997, c. 592, §55 (AMD) .]

2. A producer may not issue any such certificate or any cover note, or purport to insure or represent that insurance will be or has been granted by any unauthorized insurer, unless the producer has prior written authority from the insurer for the insurance, or has received information from the insurer in the regular course of business that such insurance has been granted, or an insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

[1997, c. 592, §55 (AMD) .]

3. If, after the issuance and delivery of any such certificate, there is any change as to the identity of the insurers, or the proportion of the direct risk assumed by an insurer as stated in the producer's original certificate, or in any other material respect as to the insurance evidenced by the certificate, the producer shall promptly issue and deliver to the insured a substitute certificate accurately showing the current status of the coverage and the insurers responsible under the certificate.

[1997, c. 592, §55 (AMD) .]

4. If a policy issued by the insurer is not available upon placement of the insurance and the producer has issued and delivered the certificate as provided in this section, upon request of the insured the producer shall as soon as reasonably possible procure from the insurer its policy evidencing the insurance and deliver the policy to the insured in replacement of the producer's certificate.

[1997, c. 592, §55 (AMD) .]

5. Any producer with surplus lines authority who knowingly or negligently issues a false certificate of insurance or who fails promptly to notify the insured of any material change with respect to such insurance by delivery to the insured of a substitute certificate as provided in subsection 3, upon conviction, is subject to the penalty provided by section 12-A or to any greater applicable penalty otherwise provided by law.

[2007, c. 466, Pt. D, §5 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 592, §55 (AMD). 2007, c. 466, Pt. D, §5 (AMD).

§2009. IDENTIFICATION AND NOTICE ON CONTRACT

Every insurance contract procured and delivered as a surplus lines coverage pursuant to this chapter shall have stamped upon it, and bearing the name of the producer with surplus lines authority who procured it, the following: [1997, c. 592, §56 (AMD).]

"This insurance contract is issued pursuant to the Maine Insurance Laws by an insurer neither licensed by nor under the jurisdiction of the Maine Bureau of Insurance." [1997, c. 592, §56 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 592, §56 (AMD).

§2009-A. CANCELLATION AND NONRENEWAL OF SURPLUS LINES COVERAGE

1. **Notice.** Cancellation and nonrenewal by an insurer of surplus lines coverage subject to this chapter shall not be effective unless received by the named insured at least 14 days prior to the effective date of cancellation or, when the cancellation is for nonpayment of premium, at least 10 days prior to the effective date of cancellation. A postal service certificate of mailing to the named insured at the insured's last known address shall be conclusive proof of receipt on the 5th calendar day after mailing.

[1989, c. 172, §1 (NEW) .]

2. **Exemption.** Cancellation and nonrenewal by an insurer of surplus lines coverage subject to this chapter shall not be subject to sections 2908 and 3007.

[1989, c. 172, §1 (NEW) .]

SECTION HISTORY
1989, c. 172, §1 (NEW).

§2010. SURPLUS LINES INSURANCE VALID

Insurance contracts procured as surplus line coverage from unauthorized insurers in accordance with this chapter shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2011. INSURER'S LIABILITY FOR LOSSES AND UNEARNED PREMIUMS

1. As to a surplus lines risk that has been assumed by an unauthorized insurer pursuant to this chapter, and if the premium has been received by the producer with surplus lines authority who placed such insurance, in all questions arising under the coverage as between the insurer and the insured the insurer is deemed to have received the premium due to it for such coverage; and the insurer is liable to the insured as to losses covered by such insurance, and for unearned premiums that may become payable to the insured upon cancellation of such insurance, whether or not in fact the producer is indebted to the insurer with respect to the insurance or for any other cause.

[1997, c. 592, §57 (AMD) .]

2. Each unauthorized insurer assuming a surplus lines risk under this chapter is deemed to have subjected itself to the terms of this section.

[1997, c. 592, §57 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 592, §57 (AMD).

§2012. SURPLUS LINES AUTHORITY

1. Any person while licensed in this State as a resident producer who is determined by the superintendent to be competent and trustworthy with respect to the handling of surplus lines, and while maintaining an office at a designated location in this State, may be licensed as a producer with surplus lines authority.

[1997, c. 592, §58 (AMD) .]

2. Application for the authority must be made to the superintendent on forms as designated and furnished by the superintendent.

[1997, c. 592, §58 (AMD) .]

3. The application and authority fee must be as specified in section 601.

[1997, c. 592, §58 (AMD) .]

4. The producer with surplus lines authority is subject to the applicable provisions of chapter 16.

[1997, c. 592, §58 (AMD) .]

5. A nonresident producer who is considered by the superintendent to be competent and trustworthy with respect to the handling of surplus lines may apply for surplus lines authority under the following circumstances:

A. If the nonresident maintains a business location within this State and maintains all records of surplus lines transactions within this State; [2001, c. 259, §47 (AMD).]

B. If the nonresident transacts only liability insurance business and only on behalf of a purchasing group registered with the superintendent and the nonresident agrees to produce surplus lines records in this State within 14 days from a request of the superintendent; or [2001, c. 259, §47 (AMD).]

C. The license is to be issued on a reciprocal basis pursuant to sections 1420-G and 1420-O. [2001, c. 259, §48 (NEW).]

[2001, c. 259, §§47, 48 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §§33,34 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 592, §58 (AMD). 2001, c. 259, §§47,48 (AMD).

§2013. LICENSE SUSPENSION OR REVOCATION

1. Notwithstanding Title 5, chapter 375, subchapter VI, the superintendent may, after notice and opportunity for hearing, deny, revoke, suspend or limit the permissible activities under any surplus lines authority:

A. If the producer fails to remit the tax as required by section 2018; [2001, c. 259, §49 (AMD).]

B. If a producer who is required to maintain an office in this State fails to do so, or to keep the records, or to allow the superintendent to examine those records as required by this law, or if the producer removes those records from the State when prohibited; [2001, c. 259, §49 (AMD).]

C. If the producer places a surplus lines coverage in an insurer other than as authorized under section 2007; [1997, c. 592, §59 (AMD).]

D. For any other applicable cause for which a producer's license may be suspended or revoked; or [2001, c. 259, §50 (AMD).]

E. If the producer assists any person or persons not licensed as producers with surplus lines authority by serving as a reporting producer for purposes of section 2015 or 2016 with respect to insurance coverage not procured by the producer. [1997, c. 592, §59 (AMD).]

[2001, c. 259, §§49, 50 (AMD) .]

2. The procedures provided by chapter 16 for suspension or revocation of licenses apply to suspension or revocation of a surplus lines authority.

[1997, c. 592, §59 (AMD) .]

3. Upon a ruling by the superintendent suspending or revoking a producer's surplus lines authority the superintendent may suspend or revoke all other licenses or authorities held by the same individual under this Title.

[1997, c. 592, §59 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§411,412 (AMD). 1985, c. 564, §3 (AMD). 1991, c. 298, §4 (AMD). 1995, c. 329, §§28,29 (AMD). 1997, c. 457, §35 (AMD). 1997, c. 457, §55 (AFF). 1997, c. 592, §59 (AMD). 2001, c. 259, §§49,50 (AMD).

§2014. PRODUCER'S SURETY BOND

A licensed producer with surplus lines authority may accept and place surplus line business for any insurance producer licensed in this State for the kind of insurance involved, and may compensate the producer for the business. [1997, c. 592, §60 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 592, §60 (AMD).

§2015. RECORD OF PROCURED COVERAGES

1. Each producer shall keep in the producer's office a full and true record of each surplus lines coverage procured by the producer, including a copy of each daily report, if any, a copy of each certificate of insurance issued, books of account in which financial entries are recorded respecting these transactions and such of the following items as may be applicable:

A. Amount of the insurance; [1969, c. 132, §1 (NEW).]

B. Gross premium charged; [1969, c. 132, §1 (NEW).]

C. Return premium paid, if any; [1969, c. 132, §1 (NEW).]

D. Rate of premium charged upon the several items of property; [1969, c. 132, §1 (NEW).]

E. Effective date of the contract and the terms of the contract; [1997, c. 592, §61 (AMD).]

F. Name and address of each insurer on the direct risk and the proportion of the entire risk assumed by such insurer, if less than the entire risk; [1997, c. 592, §61 (AMD).]

G. Name and address of the insured; [1969, c. 132, §1 (NEW).]

H. Brief general description of the property or risk insured and where located or to be performed; and [1969, c. 132, §1 (NEW).]

I. Other information as may be required by the superintendent. [1969, c. 132, §1 (NEW).]

[2007, c. 51, §5 (AMD) .]

2. The record may not be removed from this State in the case of a resident producer with surplus lines authority and in the case of both resident and nonresident licensees must be made available and open to examination by the superintendent at all times within 5 years after issuance of the coverage to which it relates. For the purpose of investigation or examination by the superintendent, records may be maintained in electronic form.

[2007, c. 51, §5 (AMD) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 564, §4 (AMD). 1997, c. 457, §36 (AMD). 1997, c. 592, §61 (AMD). 2007, c. 51, §5 (AMD).

§2016. PERIODIC REPORTS AND TAX PAYMENTS

1. Each producer with surplus lines authority shall maintain in the producer's office a monthly report showing the amount of insurance placed for any person or organization, the location of each risk, the gross premium charged, the name of each insurer with which the insurance was placed, the date and term of each insurance contract issued during the preceding month and any other pertinent information required by the superintendent. The report must show in the same detail each contract cancelled during the month covered by the report and the return premium on it. The monthly report must be made available to the superintendent for examination at the producer's office location at any time or by delivery to the bureau upon 5 days' notice by the superintendent.

[2007, c. 51, §6 (AMD) .]

2.

[2011, c. 331, §§16, 17 (AFF); 2011, c. 331, §5 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 674, §1 (RPR). 1997, c. 457, §37 (AMD). 1997, c. 592, §62 (AMD). 1997, c. 660, §B3 (AMD). 2007, c. 51, §6 (AMD). 2011, c. 331, §5 (AMD). 2011, c. 331, §§16, 17 (AFF).

§2017. ANNUAL REPORT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 674, §1 (RPR). 1995, c. 329, §30 (RP).

§2018. FAILURE TO PAY TAX

If any producer fails to remit the tax provided by section 2016 within 30 days after the tax is due, the superintendent may, following an adjudicatory hearing, assess a penalty of not less than $25 for each day of delinquency. Any fine collected by the superintendent must be paid to the Treasurer of State and credited to the Insurance Regulatory Fund. [1997, c. 592, §63 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 541, §A162 (AMD). 1991, c. 298, §5 (AMD). 1991, c. 674, §2 (AMD). RR 1997, c. 2, §49 (COR). 1997, c. 592, §63 (AMD).

§2019. LEGAL PROCESS AGAINST SURPLUS LINE INSURER

1. An unauthorized insurer shall be sued, upon any cause of action arising in the State under any contract issued by it as a surplus lines contract pursuant to this law, in the Superior Court.

[1969, c. 132, §1 (NEW) .]

2. Before the surplus lines insurer may do business in this State, each insurer shall appoint an agent to receive service of legal process issued against it in this State. The insurer shall file with the superintendent a copy of the appointment. The notice to the superintendent must be accompanied by a copy of a resolution of the board of directors or like governing body of the insurer, if an incorporated insurer, showing that those officers who executed the appointment were duly authorized to do so on behalf of the insurer. Service of legal process against the insurer may be made in any such action by service of 2 copies upon the designated agent. If no agent is designated, service of legal process against the insurer may be made by mailing a copy of the process to the producer through whom such insurance was procured, or to the insurer at its principal place of business, addressed to the address of the producer or insurer, as the case may be, last of record with the superintendent. Upon service of process in accordance with this provision, the court is deemed to have jurisdiction in personam of the insurer.

[1997, c. 592, §64 (AMD) .]

3. An unauthorized insurer issuing such policy is deemed thereby to have authorized service of process against it in the manner and to the effect as provided in this section. Any such policy must contain a provision stating the substance of this section, and designating the person to whom process must be served as provided in subsection 2.

[1997, c. 592, §64 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 592, §64 (AMD).

§2020. PRODUCER'S SURETY BOND

1. Every applicant for a surplus lines producer's authority shall file with the superintendent evidence of a bond in favor of the State executed by an authorized surety insurer. The bond is conditioned upon full accounting and due payment to the person entitled to the bond of funds coming into the surplus lines producer's possession through insurance transactions under the license. The bond may be continuous in force and aggregate liability on the bond is limited to payment of not less than $20,000.

[1997, c. 592, §65 (AMD) .]

2. The bond must remain in force until released by the superintendent or until canceled by the surety. Without prejudice to liability previously incurred, the surety may cancel the bond upon 30 days' advance written notice to both the producer and the superintendent. Upon notice to the superintendent of cancellation by the surety and failure of the surplus lines producer to procure a satisfactory replacement bond prior to cancellation, the surplus lines producer's authority terminates.

[1997, c. 592, §65 (AMD) .]

SECTION HISTORY
1993, c. 153, §17 (NEW). 1995, c. 329, §31 (AMD). 1997, c. 592, §65 (AMD).

Chapter 21: UNAUTHORIZED INSURERS -- PROHIBITIONS, PROCESS AND ADVERTISING

§2101. REPRESENTING OR AIDING UNAUTHORIZED INSURER PROHIBITED

1. No person shall in this State directly or indirectly act as agent for, or otherwise represent or aid on behalf of another, any insurer not then authorized to transact such business in this State, in the solicitation, negotiation, procurement or effectuation of insurance or annuity contracts, or renewal thereof, or forwarding of applications for insurance or annuities, or the dissemination of information as to coverage or rates, or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or collection or forwarding of premiums, or in any other manner represent or assist such an insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this State.

[1969, c. 132, §1 (NEW) .]

2. This section does not apply to:

A. Matters authorized to be done by the superintendent under the Unauthorized Insurers Process Act, sections 2102 to 2108; [1973, c. 625, §141 (AMD).]

B. Transactions as to which the insurer is not required to have a certificate of authority pursuant to section 405 (exceptions to certificate of authority requirement); [1969, c. 132, §1 (NEW).]

C. A licensed adjuster or attorney at law representing such an insurer from time to time in his professional capacity; [1969, c. 132, §1 (NEW).]

D. Transactions in this State relating to a policy of wet marine and transportation insurance delivered or issued for delivery outside this State; [1969, c. 132, §1 (NEW).]

E. The employee, compensated on salary only, of a Maine employer who on behalf of the employer assists in the procurement or administration of insurance coverages on the property, risks and insurable interests of the employer; or [2011, c. 331, §6 (AMD); 2011, c. 331, §§16, 17 (AFF).]

F. Transactions outside this State arising from the unsolicited application of the insured, if the transaction is lawful in the jurisdiction in which it occurs and the applicable premium tax has been paid in compliance with Title 36, section 2513. [2011, c. 331, §7 (NEW); 2011, c. 331, §§16, 17 (AFF).]

[2011, c. 331, §§6, 7 (AMD); 2011, c. 331, §§16, 17 (AFF) .]

3. If the superintendent has reason to believe that any insurer or other person is acting in violation of this section or section 404, the superintendent shall commence proceedings in accordance with sections 12-A and 404. Section 2105 applies to all process, notices and statements of charges to be served on the unauthorized insurer or insurers.

[1991, c. 298, §6 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §141 (AMD). 1991, c. 298, §6 (AMD). 2011, c. 331, §§6, 7 (AMD). 2011, c. 331, §§16, 17 (AFF).

§2102. PURPOSES AS RELATED TO UNAUTHORIZED INSURERS

The purpose of section 12-A and sections 2102 to 2108 (Unauthorized Insurers Process Act) is to subject certain insurers to the jurisdiction of the superintendent and the courts of this State in suits and disciplinary proceedings as provided therein, by or on behalf of insureds or beneficiaries under insurance contracts or the superintendent. The Legislature declares its concern that many Maine residents hold insurance policies delivered in this State by unauthorized insurers, other than as to surplus lines coverages written pursuant to chapter 19, thus presenting to such residents the often insuperable obstacle of resort to distant courts for the assertion of legal rights under their policies; and that such insurers may induce residents to purchase insurance through false advertising sent into this State. In furtherance of such state interest, the Legislature herein provides a method of substituted service of process upon such insurers, declares that in so doing it exercises its power to protect Maine residents, to define, for the purposes of this chapter, what constitutes doing business in this State, and also exercises powers and privileges available to the State under Public Law 15, 79th Congress of the United States, chapter 20, 1st Session, S. 340, as amended, which declares that the business of insurance and every person engaged therein are subject to the laws of the several states. [1991, c. 298, §7 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §142 (AMD). 1991, c. 298, §7 (AMD).

§2103. UNAUTHORIZED INSURERS PROCESS ACT; TITLE; INTERPRETATION

1. Sections 2102 to 2108 constitute and may be cited as the Unauthorized Insurers Process Act.

[1969, c. 177, §31 (AMD) .]

2. The Act shall be so interpreted as to effectuate its general purpose to make uniform the laws of those states which enact it.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §31 (AMD).

§2104. SUPERINTENDENT PROCESS AGENT

Solicitation, effectuation, or delivery of any insurance contract, by mail or otherwise, within this State by an unauthorized insurer, or the performance within this State of any other service or transaction connected with such insurance by or on behalf of such insurer, shall be deemed to constitute an appointment by such insurer of the superintendent and his successors in office as its attorney, upon whom may be served all lawful process issued within this State in any action or proceeding against such insurer arising out of any such contract or transaction; and shall be deemed to signify the insurer's agreement that any such service of process shall have the same legal effect and validity as personal service of process upon it in this State. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2105. SERVICE OF PROCESS

1. Service of process upon any such insurer pursuant to section 2104 shall be made by delivering to and leaving with the superintendent or some person in apparent charge of his office 2 copies thereof and the payment to him of the fees as prescribed by section 601. The superintendent shall forthwith mail by registered or certified mail one of the copies of such process to the defendant at its principal place of business last known to the superintendent, and shall keep a record of all process so served upon him. Such service of process is sufficient, provided notice of such service and a copy of the process are sent within 10 days thereafter by registered or certified mail by plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt or receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

[1973, c. 585, §12 (AMD) .]

2. Service of process in any such action, suit or proceeding shall in addition to the manner provided in subsection 1 be valid if served upon any person within this State, who in this State on behalf of such insurer, is:

A. Soliciting insurance; or [1969, c. 132, §1 (NEW).]

B. Making any contract of insurance or issuing or delivering any policies or written contracts of insurance; or [1969, c. 132, §1 (NEW).]

C. Collecting or receiving any premium for insurance; and a copy of such process is sent within 10 days thereafter by registered or certified mail by the plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. No plaintiff or complainant shall be entitled to a judgment or to have his complaint taken pro confesso under this section until the expiration of 30 days from the date of the filing of the affidavit of compliance.

[1969, c. 132, §1 (NEW) .]

4. Nothing in this section shall limit or abridge the right to serve any process, notice or demand upon any insurer in any other manner now or hereafter permitted by law.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2106. EXEMPTIONS FROM SERVICE OR PROCESS PROVISIONS

Sections 2104 and 2105 shall not apply to surplus lines insurance lawfully effectuated under chapter 19, or to reinsurance, or to any action or proceeding against an unauthorized insurer arising out of any of the following where the policy or contract contains a provision designating the superintendent as its attorney for

the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such policy, or where the insurer enters a general appearance in any such action: [1973, c. 585, §12 (AMD).]

1. Wet marine and transportation insurance;

[1969, c. 132, §1 (NEW) .]

2. Insurance on or with respect to subjects located, resident, or to be performed wholly outside this State, or on vehicles or aircraft owned and principally garaged outside this State;

[1969, c. 132, §1 (NEW) .]

3. Insurance on property or operations of railroads engaged in interstate commerce; or

[1969, c. 132, §1 (NEW) .]

4. Insurance on aircraft or cargo of such aircraft, or against liability, other than employer's liability, arising out of the ownership, maintenance, or use of such aircraft.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2107. DEFENSE OF ACTION BY UNAUTHORIZED INSURER

1. Before an unauthorized insurer files or causes to be filed any pleading in any action or proceeding instituted against it under sections 2104 and 2105, such insurer shall:

A. Procure a certificate of authority to transact insurance in this State; or [1969, c. 132, §1 (NEW).]

B. Deposit with the clerk of the court in which such action or proceeding is pending cash or securities, or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action. The court may in its discretion make an order dispensing with such deposit or bond where the insurer makes a showing satisfactory to the court that it maintains in a state of the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in such action or proceeding, and that the insurer will pay final judgment entered therein without requiring suit to be brought on such judgment in the state where such funds or securities are located. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. The court in any action or proceeding in which service is made in the manner provided in section 2105 may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection 1, and to defend such action.

[1969, c. 132, §1 (NEW) .]

3. Nothing in subsection 1 is to be construed to prevent an unauthorized insurer from filing a motion to quash or to set aside the service of any process made in the manner provided in section 2105 on the ground either:

A. That such unauthorized insurer has not done any of the acts enumerated in section 2104; or [1969, c. 132, §1 (NEW).]

B. That the person on whom service was made pursuant to subsection 2 of section 2105 was not doing any of the acts therein enumerated. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2108. ATTORNEY FEES

In any such action against an unauthorized insurer, if the insurer has failed for 30 days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court shall allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action, and in no event shall such fee be less than $100. Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2109. UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT; TITLE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 541, §A163 (AMD). 1991, c. 298, §8 (RP).

§2110. NOTICE TO DOMICILIARY SUPERVISORY OFFICIAL

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 298, §9 (RP).

§2111. ACTION BY SUPERINTENDENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §32 (AMD). 1973, c. 585, §12 (AMD). 1977, c. 694, §413 (AMD). 1991, c. 298, §10 (RP).

§2112. RECIPROCAL JUDGMENT

The Attorney General upon request of the superintendent may proceed in the courts of this State or any reciprocal state or in any federal court or agency to enforce an order or decision in any court proceeding or in any administrative proceeding before the superintendent. [1973, c. 585, §12 (AMD).]

1. **Definitions.** In this section:

A. "Reciprocal state" means any state the laws of which contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders in equity issued by courts located in other states, against insurers incorporated or authorized to do business in such state. [1969, c. 132, §1 (NEW).]

B. "Foreign decree" means any decree or order in equity of a court located in a "reciprocal state," including a court of the United States located therein, against a "domestic insurer" obtained by a "qualified party." [1969, c. 132, §1 (NEW).]

C. "Domestic insurer" means any insurer incorporated or authorized to do business in this State. [1969, c. 132, §1 (NEW).]

D. "Qualified party" means a state regulatory agency acting in its capacity to enforce the insurance laws of its state. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. **List of reciprocal states.** The superintendent shall determine which states qualify as reciprocal states and shall maintain at all times an up-to-date list of such states.

[1973, c. 585, §12 (AMD) .]

3. **Filing and status of foreign decrees.** A copy of any foreign decree authenticated in accordance with the Act of Congress or the statutes of this State may be filed in the office of the clerk of any Superior Court of this State. The clerk, upon verifying with the superintendent that the decree or order qualifies as a foreign decree shall treat the foreign decree in the same manner as a decree of a Superior Court of this State. A foreign decree so filed has the same effect and shall be deemed as a decree of a Superior Court of this State, and is subject to the same procedures, defenses and proceedings for reopening, vacating, or staying as a decree of a Superior Court of this State and may be enforced or satisfied in like manner.

[1973, c. 585, §12 (AMD) .]

4. **Notice of filing.**

A. At the time of the filing of the foreign decree, the Attorney General shall make and file with the clerk of the court an affidavit setting forth the name and last known post office address of the defendant. [1969, c. 132, §1 (NEW).]

B. Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given, and to the superintendent, and shall make a note of the mailing in the docket. In addition, the Attorney General may mail a notice of the filing of the foreign decree to the defendant and to the superintendent and may file proof of mailing with the clerk. Lack of mailing notice or filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the Attorney General has been filed. [1973, c. 585, §12 (AMD).]

C. No execution or other process for enforcement of a foreign decree filed hereunder shall issue until 30 days after the date the decree is filed. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

5. **Stay.**

A. If the defendant shows the Superior Court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree rquired by the state in which it was rendered; [1969, c. 132, §1 (NEW).]

B. If the defendant shows the Superior Court any ground upon which enforcement of a decree of any Superior Court of this State would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this State. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

6. **Fees.** Any person filing a foreign decree shall pay to the clerk of court the applicable fee. Fees for docketing, transcription or other enforcement proceedings shall be as provided for decrees of the Superior Court.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2113. REPORT AND TAX OF INDEPENDENTLY PROCURED COVERAGES. *(REPEALED)*

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §33 (AMD). 1973, c. 585, §12 (AMD). RR 2001, c. 2, §A39 (COR). 2011, c. 331, §§16, 17 (AFF). 2011, c. 331, §8 (RP).

§2114. PENALTY

Any person who in this State represents an unauthorized insurer in the transaction of business in this State in violation of law, shall, in addition to any other applicable penalty, be liable for the full amount of any loss sustained on any insurance contract made by or through him, directly or indirectly, and for any premium taxes which may become due under any law of this State by reason of such contract. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

Chapter 23: TRADE PRACTICES AND FRAUDS

§2151. PURPOSE

The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945, Public Law 15, 79th Congress, by defining or providing for the determination of all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices, by defining or providing for the determination of all such practices in other states by residents of this State which constitute unfair methods of competition or unfair or deceptive acts or practices, and by prohibiting the trade practices so defined or determined. [1985, c. 648, §4 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1985, c. 648, §4 (AMD).

§2151-A. HEARINGS

All hearings held under this chapter shall be in accordance with the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [1977, c. 694, §414 (NEW).]

SECTION HISTORY
1977, c. 694, §414 (NEW).

§2151-B. RULES

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may promulgate rules defining, limiting or prescribing acts and practices which are deemed to be in violation of this chapter. [1985, c. 648, §5 (NEW).]

SECTION HISTORY
1985, c. 648, §5 (NEW).

§2152. UNFAIR METHODS; DECEPTIVE ACTS PROHIBITED

No person shall engage in this State in any trade practice which is defined in this chapter, as, or determined pursuant to this chapter, to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. No resident of this State shall engage in any other state in any trade practice which is defined in this chapter as, or determined pursuant to this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2152-A. LIFE INSURANCE SOLICITATION

It shall be an unfair practice under this chapter for any insurer, agent or broker to solicit, negotiate or procure the purchase of life insurance within this State, except in compliance with life insurance cost disclosure rules which shall be adopted in accordance with the Maine Administrative Procedure Act Title 5, chapter 375, by the superintendent by July 1, 1980. [1979, c. 447, (NEW).]

SECTION HISTORY
1979, c. 447, (NEW).

§2152-B. UNFAIR SOLICITATION METHODS

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

A. "Cold lead advertising" means making use directly or indirectly of a method of marketing that fails to disclose in a conspicuous manner that a purpose of the marketing is insurance sales solicitation and that contact will be made by an insurance producer or insurance company. [2007, c. 53, §1 (NEW).]

B. "Medicare products" includes Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D, Medicare Advantage and Medicare supplement plans. [2007, c. 53, §1 (NEW).]

[2007, c. 53, §1 (NEW) .]

2. **Unfair solicitation methods.** It is an unfair trade practice under this chapter for an insurer or producer to:

A. Sell, solicit or negotiate the purchase of health insurance in this State through the use of cold lead advertising; [2007, c. 53, §1 (NEW).]

B. Use an appointment that was made to discuss Medicare products or to solicit the sale of Medicare products in order to solicit sales of life insurance, health insurance or annuity products unless the consumer requests such solicitation and the products to be discussed are clearly identified to the consumer in writing at least 48 hours in advance of the appointment; and [2007, c. 53, §1 (NEW).]

C. Solicit the sale of Medicare products door-to-door prior to receiving an invitation from a consumer. [2007, c. 53, §1 (NEW).]

[2007, c. 53, §1 (NEW) .]

SECTION HISTORY
2007, c. 53, §1 (NEW).

§2153. MISREPRESENTATION; FALSE ADVERTISING OF POLICIES

No person shall make, issue, circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or make any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or use any name or title on any policy or class of policies misrepresenting the true nature thereof. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2154. FALSE INFORMATION; ADVERTISING

A person may not make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication or on a business card, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or

statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of that person's insurance business or with respect to the name of a financial institution in a manner that is untrue, deceptive or misleading. [2007, c. 118, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2005, c. 46, §1 (AMD). 2007, c. 32, §1 (AMD). 2007, c. 118, §1 (AMD).

§2155. "TWISTING" PROHIBITED

No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, borrow against, surrender, retain, exchange, modify, convert, or otherwise affect or dispose of any insurance policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2155-A. DUMPING PROHIBITED

The guaranteed issue requirements of section 2736-C may not be used by insurers, health maintenance organizations, agents, brokers, consultants or any other persons to provide separate coverage to an employee or dependent with a health condition to improve the claims experience of an employer-sponsored group health benefit plan. [1997, c. 370, Pt. B, §1 (NEW).]

SECTION HISTORY
1997, c. 370, §B1 (NEW).

§2156. FALSE OR MISLEADING FINANCIAL STATEMENTS

1. No person shall file with any supervisory or other public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive.

[1969, c. 132, §1 (NEW) .]

2. No person shall make any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

[1969, c. 132, §1 (NEW) .]

3. No person shall advertise the capital or assets of an insurer without in the same advertisement setting forth the amount of the insurer's liabilities.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2157. DEFAMATION

No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to an insurer, or of an organization proposing to become an insurer, and which is calculated to injure any person engaged or proposing to engage in the business of insurance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2158. BOYCOTT, COERCION AND INTIMIDATION

No person shall: [1969, c. 132, §1 (NEW).]

1. Enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance.

[1969, c. 132, §1 (NEW) .]

2. Enter into any agreement to commit any act of boycott, coercion or intimidation, or in pursuance thereof monopolize or attempt to monopolize any part of the business of insurance.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2159. UNFAIR DISCRIMINATION -- LIFE INSURANCE, ANNUITIES AND HEALTH INSURANCE

1. No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

[1969, c. 132, §1 (NEW) .]

2. No person may make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. Nothing in this provision prohibits an insurer from providing incentives for insureds to use the services of a particular provider.

[1985, c. 704, §3 (AMD) .]

3. It shall be an unfair trade practice in the business of insurance for any insurer to discriminate unfairly against any person who has tested positive for the presence of the human immunodeficiency antigen or the presence of an antibody to the human immunodeficiency virus or who has Acquired Immune Deficiency Syndrome or AIDS, AIDS Related Complex (ARC) or HIV related diseases provided that nothing in this subsection prohibits an insurer from treating individuals of different classes and of unequal expectations of life, or essentially different hazards, differently in accordance with subsection 1 or 2.

[1989, c. 176, §2 (NEW) .]

4. It shall not be unfair discrimination for group life insurance policies or contracts subject to chapter 31 to contain an exclusion or restriction for death caused by Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases which existed 6 months prior to the individual's effective date of insurance if an actuarial justification is filed and approved by the superintendent. The exclusion or restriction may run for no longer than the incontestable period of the policy within the meaning of section 2615.

[1989, c. 176, §2 (NEW) .]

5. **Definitions.** As used in this section, "HIV" and "antibody to HIV" have the same meanings as set out in Title 5, section 19201.

[1991, c. 3, §3 (NEW) .]

6. **Test results.** No insurer may request any person to reveal whether the person has obtained a test for the presence of antibodies to HIV or a test to measure the virus or to reveal the results of such tests taken prior to an application for insurance coverage.

[1991, c. 3, §3 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1985, c. 704, §3 (AMD). 1989, c. 176, §2 (AMD). 1991, c. 3, §3 (AMD).

§2159-A. INSURANCE DISCRIMINATION SOLELY ON ACCOUNT OF BLINDNESS PROHIBITED

No insurer authorized to transact business in this State may refuse to insure or continue to insure, limit the amount, extent or kind of coverage available to an individual or charge an individual a rate different from that normally charged for the same coverage solely because the insured or the applicant for insurance is blind or partially blind. [1985, c. 445, (RPR).]

No insurer authorized to transact business in this State may refuse to insure or continue to insure, limit the amount, extent or kind of coverage available to an individual or charge an individual a rate different from that normally charged for the same coverage solely because the insured or the applicant for insurance has a physical or mental handicap, as defined in Title 5, section 4553, subsection 7-A, other than blindness or partial blindness, unless the basis for that action is clearly demonstrated through sound actuarial evidence. [1985, c. 445, (RPR).]

1. **Deaf.**

[1985, c. 445, (RP) .]

2. **Developmentally disabled.**

[1985, c. 445, (RP) .]

SECTION HISTORY
1975, c. 255, (NEW). 1975, c. 675, (AMD). 1977, c. 279, (RPR). 1979, c. 127, §156 (AMD). 1979, c. 663, §142 (AMD). 1985, c. 445, (RPR).

§2159-B. DISCRIMINATION AGAINST VICTIMS OF DOMESTIC ABUSE PROHIBITED

1. **Discrimination prohibited.** An insurer, nonprofit hospital and medical service organization or health maintenance organization that issues life, health or disability coverage may not deny, cancel, refuse to renew or restrict coverage of any person or require the payment of additional charges based on the fact or perception that the person is, or may become, the victim of domestic abuse, under Title 19-A, section 4002. This subsection does not prohibit applying an underwriting or rating criterion to a victim of domestic abuse based on physical or mental history or other factors of general applicability regardless of the underlying cause and in accordance with the requirements of section 2159, subsections 1 and 2. An insurer, nonprofit hospital and medical service organization or health maintenance organization may not be held criminally or civilly liable for any cause of action that may result from compliance with this subsection. This subsection does not prohibit an insurer, nonprofit hospital and medical service organization or health maintenance organization from declining to issue coverage to an applicant known to be, or to have been, an abuser of the proposed insured.

[2001, c. 16, §1 (NEW) .]

2. **Justification of adverse insurance decisions.** An insurer, nonprofit hospital and medical service organization or health maintenance organization that issues life, health or disability coverage that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer, nonprofit hospital and medical service organization or health maintenance organization knows or has reason to know is related to domestic abuse shall explain the reasons for its action to the applicant or insured in writing and shall demonstrate that its action, and any applicable policy provision:

A. Does not have the purpose or effect of treating abuse status as a medical condition or underwriting or rating criterion; [2001, c. 16, §1 (NEW).]

B. Is not based upon any actual or perceived correlation between a medical condition and domestic abuse; [2001, c. 16, §1 (NEW).]

C. Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or disability without regard to whether the medical condition or disability is related to domestic abuse; and [2001, c. 16, §1 (NEW).]

D. Except for claims actions, is based on a determination made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience that there is a correlation between the medical condition or disability and a material increase in insurance risk. [2001, c. 16, §1 (NEW).]

[2001, c. 16, §1 (NEW) .]

SECTION HISTORY
1995, c. 553, §1 (NEW). RR 1997, c. 2, §50 (COR). 2001, c. 16, §1 (RPR).

§2159-C. DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR TESTING

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

A. "Genetic characteristic" means any inherited gene or chromosome, or alteration of a gene or chromosome, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome. [1997, c. 677, §2 (NEW).]

B. "Genetic information" means the information concerning genes, gene products or inherited characteristics that may be obtained from an individual or family member. [1997, c. 677, §2 (NEW).]

C. "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids, such as deoxyribonucleic acid, or DNA, ribonucleic acid, or RNA, or mitochondrial DNA, and tests of chromosomes or proteins in order to identify a predisposing genetic characteristic. [1997, c. 677, §2 (NEW).]

D. "Carrier" means an insurer, nonprofit hospital and medical service organization or health maintenance organization. [2009, c. 244, Pt. D, §1 (NEW).]

[2009, c. 244, Pt. D, §1 (AMD) .]

2. **Discrimination in health, hospital and dental insurance.** A carrier that issues individual or group hospital, health or dental insurance is subject to the requirements of this subsection. This subsection does not apply to accidental injury, specified disease, hospital indemnity, disability, long-term care and other limited benefit health insurance policies and contracts.

A. A carrier may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, as defined by the superintendent, by rule, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance. [2009, c. 244, Pt. D, §2 (NEW).]

B. Except as provided in this paragraph, a carrier may not request or require an individual to undergo a genetic test.

(1) Nothing in this subsection limits the authority of a health care professional who is providing health care services to an individual to request that that individual undergo a genetic test.

(2) A carrier may request, but not require, that an individual undergo a genetic test if the conditions described in this subparagraph are met:

(a) The request is made pursuant to research that complies with 45 Code of Federal Regulations, Part 46 or equivalent federal regulations and any applicable state or local laws, rules or regulations for the protection of human subjects in research;

(b) The carrier clearly indicates to the individual to whom the request is made, or in the case of a minor child to the legal guardian of the individual, that compliance with the request is voluntary and noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) Genetic information collected or acquired under this subparagraph is not used for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract; and

(d) The carrier complies with all applicable federal laws and regulations. [2009, c. 244, Pt. D, §2 (NEW).]

C. A carrier may not request, require or purchase genetic information for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract. [2009, c. 244, Pt. D, §2 (NEW).]

D. A carrier may not request, require or purchase genetic information with respect to an individual prior to the individual's enrollment under the plan or coverage in connection with the enrollment. [2009, c. 244, Pt. D, §2 (NEW).]

E. If a carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning an individual, the request, requirement or purchase is not considered a violation of paragraph D if the request, requirement or purchase is not in violation of paragraph C. [2009, c. 244, Pt. D, §2 (NEW).]

F. A reference in this subsection to genetic information concerning an individual includes:

(1) With respect to an individual who is a pregnant woman, genetic information of any fetus carried by that individual; and

(2) With respect to an individual using an assisted reproductive technology, genetic information of any embryo legally held by the individual. [2009, c. 244, Pt. D, §2 (NEW).]

[2009, c. 244, Pt. D, §2 (RPR) .]

3. **Discrimination in life, disability and long-term care insurance.** An insurer may not make or permit any unfair discrimination against an individual in the application of genetic information or the results of a genetic test in the issuance, withholding, extension or renewal of an insurance policy for life, credit life, disability, long-term care, accidental injury, specified disease, hospital indemnity or credit accident insurance or an annuity. For the purposes of this subsection, "unfair discrimination" includes, but is not limited to, the application of the results of a genetic test in a manner that is not reasonably related to anticipated claims experience.

A. If the superintendent has reason to believe that unfair discrimination has occurred and that a proceeding by the superintendent is in the interest of the public, the superintendent, in accordance with chapter 3, shall serve upon the insurer a statement of the charges. Upon a determination that the practice or act of the insurer is in conflict with this subsection, the superintendent shall issue an order requiring the insurer to cease and desist from engaging in the practice or act and may order payment of a penalty consistent with the provisions of section 12-A. [1997, c. 677, §2 (NEW).]

B. If, in the issuance, withholding, extension or renewal of an insurance policy covered by this subsection, an insurer uses the results of a genetic test in compliance with this subsection, the insurer shall notify the individual who is the subject of the genetic test that such a test is required and shall obtain the individual's authorization in accordance with the requirements of chapter 24. If a genetic test is required, the insurer shall ensure that the individual states in writing whether the individual wishes to be informed of the test results and, if authorized by the individual, shall provide a copy of the test results, along with a written interpretation of the results by a qualified professional, to the individual or to a physician or other health care practitioner designated by the individual. [1997, c. 677, §2 (NEW).]

[1997, c. 677, §2 (NEW) .]

SECTION HISTORY
1997, c. 677, §2 (NEW). 2009, c. 244, Pt. D, §§1, 2 (AMD).

§2160. REBATES -- LIFE, HEALTH AND ANNUITY CONTRACTS

1. **Limitation.** Except as otherwise provided by law, no person may:

A. Knowingly permit or offer to make or make any contract of life insurance, life annuity or health insurance or agreement concerning that contract that is not plainly expressed in the contract issued; [1997, c. 457, §38 (NEW).]

B. Pay or allow or give or offer to pay, allow or give directly or indirectly as inducement to life or health insurance or life annuity:

(1) Any rebate of premiums payable on the contract;

(2) Any special favor or advantage in the dividends or other benefits;

(3) Any paid employment or contract for services of any kind; or

(4) Any valuable consideration or inducements not specified in the contract; or [1997, c. 457, §38 (NEW).]

C. Directly or indirectly give or sell or purchase or offer or agree to give, sell, purchase or allow as inducement to life or health insurance or life annuity or in connection with the insurance or annuity or any agreement, whether or not specified in the policy or contract, of any form or nature promising:

(1) Returns or profits;

(2) Any stocks, bonds or other securities;

(3) Interest present in or contingent on or measured by the agreement of any insurer or other corporation, association or partnership; or

(4) Any dividends or profits accrued or to accrue on an agreement. [1997, c. 457, §38 (NEW).]

[1997, c. 457, §38 (NEW) .]

2. **Benefit not associated with indemnification or loss.** Unless otherwise provided by law, a provision may not be included within an insurance policy if the sole intent of the provision is to give to the insured a benefit that is not associated with indemnification or loss. This subsection does not apply to annuities.

[1997, c. 592, §66 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §38 (RPR). 1997, c. 592, §66 (AMD).

§2161. EXCEPTIONS TO DISCRIMINATION, REBATES, STOCK INDUCEMENTS PROVISION -- LIFE, HEALTH AND ANNUITY CONTRACTS

1. Nothing in sections 2159 and 2160 shall be construed as including within the definition of discrimination or rebates any of the following practices:

A. In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses, or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer and its policyholders; [1969, c. 132, §1 (NEW).]

B. In the case of life insurance policies issued on the debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; [1969, c. 132, §1 (NEW).]

C. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; [1969, c. 132, §1 (NEW).]

D. Reduction of premium rate for policies of large amount, but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plan issued in smaller amounts; [1969, c. 132, §1 (NEW).]

E. Reduction in premium rates for life or health insurance policies or annuity contracts on salary savings, payroll deduction, preauthorized check, bank draft or similar plans in amounts reasonably commensurate with the savings made by the use of such plans; [1969, c. 132, §1 (NEW).]

F. The issuance of policies of group insurance with or without annuities at rates less than the usual rate of premiums for individual policies or contracts as otherwise provided for by law; [1969, c. 132, §1 (NEW).]

G. Allowance to an agent or broker, and receipt by the agent or broker, of commissions with respect to insurance written on himself. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. Nothing in this chapter shall be construed as including within the definition of securities as inducements to purchase insurance the selling or offering for sale, contemporaneously with life insurance or annuities, of mutual fund shares or face amount certificates of regulated investment companies under offerings registered with the Securities and Exchange Commission where such shares or such face amount certificates or such insurance or annuities may be purchased independently of and not contingent upon purchase of the other, at the same price and upon the same terms and conditions as where purchased independently.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2162. UNFAIR DISCRIMINATION, REBATES PROHIBITED -- PROPERTY, CASUALTY, SURETY INSURANCE

1. No property, casualty or surety insurer or any employee or representative thereof, and no broker, agent or solicitor as to such insurance shall pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified or provided for in the policy, except to the extent provided for in an applicable filing with the superintendent as provided by law.

A. Unless otherwise provided by law, a provision may not be included within an insurance policy if the sole intent of the provision is to give to the insured a benefit that is not associated with indemnification or loss. [1997, c. 457, §39 (NEW).]

B. Notwithstanding any other provision of law, the superintendent may approve filings allowing reductions in premium associated with savings in issuance and administrative expenses except that, if a filing affecting surety bonds for construction projects financed in whole or in part with public funds allows for any reduction in premium to be given, paid, allowed or offered after execution of the bond, including, without limitation, any rebate, discount, consideration or inducement of any kind, the filing must ensure that the entire amount of the reduction will be paid directly to the governmental department or agency administering the public funds for the project. In the case of a project financed only in part with public funds, the governmental department or agency may be paid a percentage of the reduction equal to the percentage of the project that is financed with public funds. [1997, c. 457, §39 (NEW).]

[1997, c. 457, §39 (AMD) .]

2. No such insurer shall make or permit any unfair discrimination between insureds or property having like insuring or risk characteristics in the premium or rates charged for insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the insurance.

[1969, c. 132, §1 (NEW) .]

3. Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents, brokers or solicitors, or as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits. As used in this section the word "insurance" includes suretyship and the word "policy" includes bond. This section does not apply as to wet marine and transportation insurance.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §39 (AMD).

§2162-A. PAYMENT OF DIVIDEND CONDITIONED UPON RENEWAL; UNFAIR TRADE PRACTICE

It is an unfair trade practice to make the payment of a policy dividend or any portion of a dividend conditioned upon renewal of the policy or contracts. This section does not apply to the first year dividend on life insurance policies. [1985, c. 548, (NEW).]

SECTION HISTORY
1985, c. 548, (NEW).

§2163. RECEIPT OF REBATE, ILLEGAL INDUCEMENT PROHIBITED

1. **Limitations.** No person may knowingly receive or accept, directly or indirectly:

A. Any rebate of premium or part of a premium; [1997, c. 457, §40 (NEW).]

B. Any producer's commission on a premium or part of a premium payable on any policy of insurance or annuity contract; [1997, c. 457, §40 (NEW).]

C. Any special favor or advantage in the dividend or other benefits to accrue; or [1997, c. 457, §40 (NEW).]

D. Anything of value as inducement to any policy of insurance or annuity contract or in connection with any policy of insurance or annuity contract that is not specified, promised or provided for in the policy or contract, except as otherwise provided by law. [1997, c. 457, §40 (NEW).]

[1997, c. 457, §40 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §40 (RPR).

§2163-A. PERMITTED ACTIVITIES

Notwithstanding any other provision in sections 2160 to 2163, an insurer, employee of an insurer or producer may offer to give gifts in connection with marketing for the sale or retention of contracts of insurance provided the cost does not exceed $20 per year per policy or quote, and conduct raffles or drawings, so long as there is no participation costs to entrants, in which case prizes may be valued in excess of $20 but not more than $100. Nothing in sections 2160 to 2163 may be construed to prohibit an insurance producer from receiving a fee rather than commission on the sale of property and casualty insurance in accordance with section 1450 and rules adopted by the superintendent. [1999, c. 8, §1 (AMD).]

Gifts and prizes given pursuant to this section may not be in the form of cash, check or other cash equivalent. [1999, c. 8, §1 (NEW).]

SECTION HISTORY

1997, c. 457, §41 (NEW). 1999, c. 8, §1 (AMD).

§2164. STOCK OPERATIONS AND ADVISORY BOARD CONTRACTS

No person shall issue or deliver or permit its agents, officers, or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2164-A. DIRECT BILLING, NOTICE

No insurer, domestic or foreign, shall, except upon the written request of the insured, convert or convert upon renewal any contract of property or casualty insurance, excluding accident and health insurance and life insurance, to a direct billing basis until it has given 90 days advance written notice thereof to its resident agents. [1969, c. 548, (NEW).]

SECTION HISTORY
1969, c. 548, (NEW).

§2164-B. CONFLICTS OF INTEREST IN APPRAISALS

(REPEALED)

SECTION HISTORY
1979, c. 171, (NEW). 1979, c. 471, (NEW). 1979, c. 663, §143 (RAL).
1995, c. 522, §1 (RP).

§2164-C. FREE COMPETITION

1. **Appraisals or repairs to motor vehicle glass.** A domestic or foreign insurer or its agent or employee may not require, directly or indirectly, that appraisals or repairs to motor vehicle glass be made or not be made in a specified place of business.

A domestic or foreign insurer or its agent or employee may not contract with any person to act as its agent for purposes of managing, handling or arranging repair or replacement of motor vehicle glass when that person is compensated by payment of a portion of the difference between the list price of the product or services provided and the amount paid to the person providing repair and replacement service.

[2005, c. 101, §1 (NEW) .]

2. **Appraisals or repairs to motor vehicles for collision damage.** A domestic or foreign insurer or its agent or employee may not require, directly or indirectly, that appraisals or repairs to motor vehicles with collision damage be made or not be made in a specified place of business.

A domestic or foreign insurer or its agent or employee may not contract with any person to act as its agent for purposes of managing, handling or arranging repair or replacement of motor vehicles for collision damage when that person is compensated by payment of a portion of the difference between the list price of the product or services provided and the amount paid to the person providing repair and replacement service.

A domestic or foreign insurer or its agent or employee may not recommend the use of a particular motor vehicle repair service or network of repair services without informing the claimant that the claimant is under no obligation to use the recommended repair service or network of repair services.

[2005, c. 101, §1 (NEW) .]

SECTION HISTORY
1979, c. 663, §143 (RAL). 1993, c. 203, §1 (AMD). 2005, c. 101, §1 (RPR).

§2164-D. UNFAIR CLAIMS PRACTICES

1. **Definition.** As used in this section, "insurer" means any person, reciprocal exchange, Lloyd's insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, including, but not limited to, producers, adjusters and 3rd-party administrators. "Insurer" also means nonprofit hospital or medical service organizations, as described in Title 24, section 2301.

A. [1997, c. 634, Pt. A, §1 (RP).]

B. [1997, c. 634, Pt. A, §1 (RP).]

C. [1997, c. 634, Pt. A, §1 (RP).]

D. [1997, c. 634, Pt. A, §1 (RP).]

E. [1997, c. 634, Pt. A, §1 (RP).]

[1997, c. 634, Pt. A, §1 (RPR) .]

2. **Prohibited activities.** It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to commit any act under subsection 3 if:

A. It is committed in conscious disregard of this section and any rules adopted under this section; or [1997, c. 634, Pt. A, §1 (NEW).]

B. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct. [1997, c. 634, Pt. A, §1 (NEW).]

[1997, c. 634, Pt. A, §1 (RPR) .]

3. **Unfair practices.** Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions related to coverages at issue; [1997, c. 634, Pt. A, §1 (NEW).]

B. Failing to acknowledge with reasonable promptness pertinent written communications with respect to claims arising under its policies; [1997, c. 634, Pt. A, §1 (NEW).]

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; [1997, c. 634, Pt. A, §1 (NEW).]

D. Failing to develop and maintain documented claim files supporting decisions made regarding liability; [1997, c. 634, Pt. A, §1 (NEW).]

E. Refusing to pay claims without conducting a reasonable investigation; [1997, c. 634, Pt. A, §1 (NEW).]

F. Failing to affirm coverage or deny coverage, reserving any appropriate defenses, within a reasonable time after having completed its investigation related to a claim; [1997, c. 634, Pt. A, §1 (NEW).]

G. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured; [1997, c. 634, Pt. A, §1 (NEW).]

H. Making claim payments to an insured or beneficiary without indicating the coverage under which each payment is being made; [1997, c. 634, Pt. A, §1 (NEW).]

I. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss and subsequent verification when subsequent verification would result in duplication of information appearing in the formal proof of loss; [1997, c. 634, Pt. A, §1 (NEW).]

J. Failing, in the case of claims denials or offers of compromise settlement, to promptly provide an accurate written explanation of the basis for those actions; [1997, c. 634, Pt. A, §1 (NEW).]

K. Failing to provide forms, accompanied by reasonable explanations for their use, necessary to present claims within 15 calendar days of such a request. This paragraph does not apply when there is an extraordinary loss or series of losses resulting from a catastrophe as determined by the superintendent; or [1997, c. 634, Pt. A, §1 (NEW).]

L. Failing to adopt and implement reasonable standards to ensure that the repairs of a repairer owned by or required to be used by the insurer are performed in a professional manner. [1997, c. 634, Pt. A, §1 (NEW).]

[1997, c. 634, Pt. A, §1 (NEW) .]

4. **Compelling insureds to institute suits.** It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to compel insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them with such frequency as to indicate a general business practice; except that this provision does not apply when the insurer has a reasonable basis to contest liability or dispute the amount of any damages or the extent of any injuries claimed.

[1997, c. 634, Pt. A, §1 (NEW) .]

5. **Resolution of claims.** It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to fail to deal with insureds in good faith to resolve claims made against policies of insureds without just cause and with such frequency as to indicate a general business practice.

[1997, c. 634, Pt. A, §1 (NEW) .]

6. **Chapter 56-A.** The superintendent shall ensure that the provisions of chapter 56-A and any rules adopted pursuant to that chapter are enforced consistent with this section.

[1997, c. 634, Pt. A, §1 (NEW) .]

7. **Rules.** The superintendent may adopt rules necessary to carry out the provisions of this section. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

[1997, c. 634, Pt. A, §1 (NEW) .]

8. **Private action.** This section may not be construed as abridging an insurer's duty to its insured or altering policy provisions. This section may not be construed to create or imply a private cause of action for violation of this section.

[1997, c. 634, Pt. A, §1 (NEW) .]

9. **Applicability.** This section does not apply to claims involving workers' compensation, medical malpractice, fidelity, suretyship or boiler and machinery insurance.

[1997, c. 634, Pt. A, §1 (NEW) .]

SECTION HISTORY
1987, c. 291, §1 (NEW). 1997, c. 634, §A1 (RPR).

§2164-E. DISCLOSURE OF COVERAGE LIMITS TO CLAIMANT; PENALTY

Upon written request by a claimant or the claimant's attorney, an insurer doing business in this State shall provide the claimant or the claimant's attorney with the liability coverage limits of that insurer's insured. The insurer must provide the liability coverage limits within 60 days of receipt of the written request. [2009, c. 189, §1 (NEW).]

An insurer who fails to comply with this section is subject to a penalty of $500, plus reasonable attorney's fees and expenses incurred in obtaining the liability coverage limits. [2009, c. 189, §1 (NEW).]

SECTION HISTORY
2009, c. 189, §1 (NEW).

§2165. DESIST ORDERS FOR PROHIBITED PRACTICES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 394, §3 (AMD). 1985, c. 648, §§6,7 (AMD). 1991, c. 298, §11 (RP).

§2165-A. CEASE AND DESIST ORDERS; ACTIONS AGAINST DEFINED AND UNDEFINED UNFAIR AND DECEPTIVE PRACTICES

1. Emergency cease and desist orders issued pursuant to section 12-A, subsection 2-A may not be imposed for violations under this section.

[1991, c. 298, §12 (NEW) .]

2. The superintendent may issue a cease and desist order pursuant to section 12-A, subsection 2 if, after a hearing, the superintendent finds that any person in this State has engaged or is engaging in any act or practice defined or prohibited under this chapter or rules adopted pursuant to this chapter or that a resident of this State has so engaged or is so engaging in another state.

[1991, c. 298, §12 (NEW) .]

3. The superintendent may issue a cease and desist order pursuant to section 12-A, subsection 2 if, after a hearing, the superintendent finds that any person in the State has engaged or is engaging, or that a resident of the State has engaged or is engaging in another state, in an unfair or deceptive practice not defined in this chapter or in rules adopted pursuant to this chapter. For any undefined practice, the civil penalties set forth in section 12-A, subsection 1 may not be imposed for practice engaged in prior to the issuance and service of a valid cease and desist order.

[1991, c. 298, §12 (NEW) .]

SECTION HISTORY

1991, c. 298, §12 (NEW).

§2166. PROCEDURES AS TO UNDEFINED PRACTICES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 648, §8 (AMD). 1991, c. 298, §13 (RP).

§2167. SERVICE UPON UNAUTHORIZED INSURERS

Provisions of this chapter applicable to insurers apply fully to unauthorized insurers. If an action under this chapter is brought against an unauthorized insurer, section 2105 applies to all process, notices and statements of charges. [1991, c. 298, §14 (NEW).]

1.

[1991, c. 298, §14 (RP) .]

2.

[1991, c. 298, §14 (RP) .]

3.

[1991, c. 298, §14 (RP) .]

4.

[1991, c. 298, §14 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 298, §14 (RPR).

§2167-A. NOTICE TO DOMICILIARY SUPERVISORY OFFICIAL

Whenever the superintendent has reason to believe that a foreign or alien insurer or licensed insurance professional is acting in violation of this chapter or chapter 21, the superintendent shall notify the insurance supervisory official of that person's domiciliary jurisdiction. [1991, c. 298, §15 (NEW).]

SECTION HISTORY
1991, c. 298, §15 (NEW).

§2168. COERCION IN REQUIRING INSURANCE

1. **Prohibition against certain requirements.** A person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property may not require, as a condition to the financing or lending, or as a condition to the renewal or extension of any such loan or to the performance of any other act in connection with the financing or lending, that the purchaser or borrower, or the successors of the purchaser or borrower negotiate through a particular insurer or insurers, insurance agent or agents, broker or brokers, type of insurer or types of insurers, any policy of insurance or renewal thereof issued in connection with the extension of credit. For purposes of this section, the term

"policy" includes, but is not limited to, any temporary contract or binder, by whatever name known, under the terms of which insurance coverage commences at a specified time, and continues until a finished policy is issued or the risk is declined and coverage is terminated.

[1997, c. 315, §21 (AMD) .]

1-A. **Prohibition against unreasonable burdens.** A creditor or lender may not, in connection with the extension of credit, interfere with the free choice of a borrower or purchaser under subsection 1 by imposing any unreasonable time or burden on an insurance agent or broker not affiliated with the lender or creditor that is not also imposed on an insurance agent or broker who is affiliated with the lender or creditor. "Affiliate" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A with respect to financial institutions and credit unions and in Title 9-A, section 4-403, with respect to supervised lenders.

[1999, c. 127, Pt. A, §39 (AMD) .]

2. **Approval of insurer; written criteria.** This section does not prevent the exercise by any lender or creditor of its right to approve the insurer selected by the borrower on a reasonable nondiscriminatory basis related to the solvency and assessment policies of the insurer and its ability to service the policy. A lender or creditor who exercises its rights under this subsection shall establish written criteria for approving the insurer selected by the borrower and in the event the creditor or lender actually denies an insurer under that criteria the lender or creditor must provide verbal notice to the customer within 3 business days and written notice within 10 business days. Upon request by a licensed insurer, agent, broker or consultant, a customer, a lender or creditor must within 10 business days of receiving the request provide a copy of its written criteria for approving an insurer.

[1997, c. 315, §23 (AMD) .]

2-B. **Change of insurance carrier.** A purchaser or borrower may change insurance carriers in connection with the extension of credit by a lender or creditor if the change does not violate a condition of the extension of credit regarding adequacy of coverage or other proper basis under subsection 2 or is otherwise prohibited by law.

[1997, c. 315, §24 (NEW) .]

3. **Violation.** A person who violates this section commits a civil violation and is subject to civil penalties and other remedies as provided in section 12-A. The Superior Court, on complaint by any person that this section is being violated, may issue an injunction against the violation and may hold in contempt and punish therefor in case of disregard of the injunction.

[2001, c. 421, Pt. B, §90 (AMD); 2001, c. 421, Pt. C, §1 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 394, §4 (AMD). 1997, c. 315, §§21-24 (AMD). 1999, c. 127, §A39 (AMD). 2001, c. 421, §B90 (AMD). 2001, c. 421, §C1 (AFF).

§2168-A. TIE-IN SALES OF INSURANCE

1. **Definition.** As used in this section, "tie-in sales" means the practice of tying the sale of one product to another.

[1991, c. 49, (NEW) .]

2. **Prohibited tie-in sales.** In the purchase of insurance, tie-in sales are an unfair trade practice when:

A. The consumer is required to place additional coverage with an insurer not of the consumer's choice in order to obtain a desired coverage; and [1991, c. 49, (NEW).]

B. The consumer's alternative opportunities to purchase the desired coverage are severely limited or nonexistent. [1991, c. 49, (NEW).]

[1991, c. 49, (NEW) .]

3. **Penalties.** An insurance contract sold in violation of the provisions of this section is voidable at the option of the consumer. Violations of this section are enforceable through section 12-A.

[1991, c. 49, (NEW) .]

SECTION HISTORY
1991, c. 49, (NEW).

§2168-B. SOLICITATION OR NEGOTIATION INVOLVING PURCHASERS OR BORROWERS

A licensed agent or broker affiliated with a lender or creditor may not solicit an application for an insurance contract in connection with the extension of credit or negotiate such a contract from a purchaser or borrower whom the agent or broker knows, or should have known, has applied to receive an extension of credit from that lender or creditor until such time as the creditor or lender has provided by hand or sent written notice to the purchaser or borrower of its action on the application or has documented in writing in the lender's or creditor's records its action on the application. This section does not limit the ability of a lender or creditor to do any of the following: [1997, c. 315, §25 (NEW).]

1. **Marketing activities.** To engage at any time in marketing activities and solicitations for the sale of insurance, including through the mail or by telephone, that are not specifically directed toward purchasers or borrowers who have applied to receive an extension of credit.

[1997, c. 315, §25 (NEW) .]

This section does not apply to group health and group life insurance to the extent authorized by chapters 31 and 35 when the insured is enrolled in the insurance policy, credit life and credit health insurance to the extent authorized by chapter 37, credit property insurance, credit involuntary unemployment insurance, forced placed property insurance, a vendor's single interest policy or any other insurance product as determined by the superintendent. [1997, c. 315, §25 (NEW).]

"Affiliate" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A with respect to financial institutions and credit unions and in Title 9-A, section 4-403 with respect to supervised lenders. [1999, c. 127, Pt. A, §40 (AMD).]

SECTION HISTORY
1997, c. 315, §25 (NEW). 1999, c. 127, §A40 (AMD).

§2169. NOTICE OF FREE CHOICE OF AGENT OR INSURER

The creditor or lender at the time of application for the loan or at the outset of negotiations regarding the loan or sale shall inform the purchaser or borrower of that person's right of free choice in the selection of the agent and insurer through or by which the insurance in connection with the loan is to be placed, including the right to choose an agent or broker whether or not that agent or broker is affiliated with a creditor or lender. For purposes of this section, "affiliated" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A, with respect to financial institutions and credit unions or in Title 9-A, section 4-403 with respect to supervised lenders. In conjunction with this notice, a creditor or lender shall inform its purchasers or borrowers that obtaining insurance products from a particular agent or broker does not affect credit decisions

by the creditor or lender regarding the purchaser or borrower, unless the insurance product selected violates the terms of the extension of credit regarding adequacy of coverage or is otherwise not approved under section 2168, subsection 2. Another person may not interfere either directly or indirectly with the borrower's, debtor's or purchaser's free choice of an agent and of an insurer that complies with the requirements set out in section 2168 and the creditor or lender may not refuse an adequate policy so tendered by the borrower, debtor or purchaser. A creditor or lender may not reject an insurance product selected by a purchaser or borrower because the product was not obtained from or through an insurance agent or broker affiliated with the institution. For purposes of this section, the term "policy" includes, but is not limited to, any temporary contract or binder, by whatever name known, under the terms of which insurance coverage commences at a specified time, and continues until a finished policy is issued or the risk is declined and coverage is terminated. Upon notice of any refusal of this tendered policy, the superintendent shall order the creditor or lender to accept the tendered policy, if the superintendent determines that the refusal is not in accordance with the requirements set out in section 2168. Failure to comply with such an order of the superintendent is a violation of this section. [1999, c. 127, Pt. A, §41 (AMD).]

This section does not apply to group health and group life insurance to the extent authorized by chapters 31 and 35 when the insured is enrolled in the insurance policy, credit life and credit health insurance to the extent authorized by chapter 37, credit property insurance, credit involuntary unemployment insurance, forced placed property insurance, a vendor's single interest policy or any other insurance product as determined by the superintendent. [1997, c. 315, §26 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 394, §5 (AMD). 1993, c. 208, §1 (AMD). 1997, c. 315, §26 (AMD). 1999, c. 127, §A41 (AMD).

§2169-A. CONFIDENTIALITY OF INSURANCE INFORMATION OBTAINED BY LENDERS

1. **Prohibited use of information.** If a lender or creditor requires a purchaser or borrower to provide insurance information in connection with the extension of credit, an insurance agent or broker affiliated with that lender or creditor may not later use the information obtained to solicit or offer insurance directly to the purchaser or borrower. "Insurance information" means copies of insurance policies, binders, rates and expiration dates not otherwise in the possession of the agent or broker. "Affiliate" has the same meaning as set forth in section 1443-A, subsection 1, paragraph A with respect to financial institutions and credit unions or in Title 9-A, section 4-403 with respect to supervised lenders.

[1999, c. 127, Pt. A, §42 (AMD) .]

2. **Use of information with consent.** Notwithstanding subsection 1, an insurance agent or broker affiliated with a lender or creditor may use the insurance information obtained from the purchaser or borrower to solicit or offer insurance to the customer if the customer consents in writing to the use of the information. This consent may not be a condition of the extension of credit to the customer.

[1997, c. 315, §27 (NEW) .]

3. **Information permitted under Fair Credit Reporting Act.** Notwithstanding subsection 1, a lender or creditor may exchange insurance information with its affiliates as permitted under the Fair Credit Reporting Act pursuant to Title 10, chapter 209-B or 15 United States Code, Chapter 41.

[2013, c. 588, Pt. C, §6 (AMD) .]

SECTION HISTORY

1997, c. 315, §27 (NEW). 1999, c. 127, §A42 (AMD). 2013, c. 588, Pt. C, §6 (AMD).

§2169-B. USE OF CONSUMER REPORTS IN INSURANCE UNDERWRITING

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

A. "Adverse action" means a denial or cancellation of, an increase in any charge for or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of personal insurance. [2003, c. 223, §1 (NEW).]

B. "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer. [2003, c. 223, §1 (NEW).]

C. "Consumer" means an individual insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for a personal insurance policy. [2003, c. 223, §1 (NEW).]

D. "Consumer report" has the same meaning as in 15 United States Code, Section 1681a(d). [2013, c. 588, Pt. C, §7 (AMD).]

E. "Consumer reporting agency" has the same meaning as in Title 10, section 1308, subsection 3. [2013, c. 588, Pt. C, §7 (AMD).]

F. "Credit information" means any credit-related information derived from a consumer report, found on a consumer report itself or provided on an application for personal insurance. "Credit information" does not include information that is not credit-related regardless of whether it is contained in a credit report or application or used to calculate an insurance score. [2003, c. 223, §1 (NEW).]

G. "Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit information for the purposes of predicting the future loss exposure of an individual applicant or insured. [2003, c. 223, §1 (NEW).]

H. "Personal insurance" means private passenger automobile, homeowners, motorcycle, mobile home owners and noncommercial dwelling fire insurance policies and boat, personal watercraft, snowmobile and recreational vehicle policies that are individually underwritten for personal, family or household use. [2003, c. 223, §1 (NEW).]

[2013, c. 588, Pt. C, §7 (AMD) .]

2. **Use of consumer reports.** Notwithstanding this subsection, an insurer may use a consumer report as permitted under the Fair Credit Reporting Act pursuant to Title 10, chapter 209-B and 15 United States Code, Chapter 41. An insurer may use information obtained from a consumer reporting agency to calculate an insurance score for underwriting and rating purposes, except that an insurer may not:

A. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status or nationality of a consumer as a factor; [2003, c. 223, §1 (NEW).]

B. Deny, cancel or refuse to renew a policy of personal insurance solely on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by paragraph A; [2003, c. 223, §1 (NEW).]

C. Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information; [2003, c. 223, §1 (NEW).]

D. Take an adverse action against a consumer solely because that consumer does not have a credit card account, without consideration of any other applicable factor independent of credit information; [2003, c. 223, §1 (NEW).]

E. Consider an absence of credit information, the number of inquiries or an inability to calculate an insurance score in underwriting or rating personal insurance unless the insurer has demonstrated to the superintendent that an absence of credit information, the number of inquiries or an inability to calculate an insurance score is a relevant factor to the risk underwritten or rated by the insurer and the insurer applies this factor in a manner approved by the superintendent; or [2003, c. 223, §1 (NEW).]

F. Take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days before the date the policy is first written or renewal is issued. [2003, c. 223, §1 (NEW).]

[2013, c. 588, Pt. C, §8 (AMD) .]

3. **Notice of use of credit information.** If credit information is used by an insurer, an insurer shall disclose, either on the insurance application or at the time the insurance application is taken, that credit information may be obtained by the insurer in connection with the application. The disclosure must be written or provided to an applicant in the same medium as the application for insurance. The insurer is not required to provide the disclosure statement required under this subsection to any insured on a renewal policy if such consumer has previously been provided a disclosure statement. An insurer may demonstrate compliance with this subsection by using the following example disclosure statement: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a 3rd party in connection with the development of your insurance score."

[2003, c. 223, §1 (NEW) .]

4. **Notice of adverse action.** If an insurer makes an adverse action based on credit information, the insurer shall provide the consumer with notice as required by this subsection. The insurer shall provide:

A. Notice to the consumer that an adverse action has been taken in accordance with the requirements of the Fair Credit Reporting Act pursuant to Title 10, chapter 209-B and 15 United States Code, Chapter 41; and [2013, c. 588, Pt. C, §9 (AMD).]

B. Notice to the consumer explaining the reason for the adverse action. The reason or reasons must be provided in sufficiently clear and specific language so that an individual can identify the basis for the insurer's decision to take an adverse action. The notice must include a description of up to 4 factors that were the primary influences of the adverse action. The use of a generalized term such as "poor credit history," "poor credit rating" or "poor insurance score" does not meet the explanation requirements of this paragraph. Standardized credit explanations provided by consumer reporting agencies or other 3rd-party vendors are deemed to comply with this paragraph. [2003, c. 223, §1 (NEW).]

[2013, c. 588, Pt. C, §9 (AMD) .]

5. **Dispute resolution and error correction.** If it is determined through the dispute resolution process set forth in 15 United States Code, Section 1681i(a)(5) that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within 30 days of receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

[2013, c. 588, Pt. C, §10 (AMD) .]

5-A. **Rescoring.** An insurer that uses insurance scores to underwrite or rate risks, upon request of the insured but no more often than once every 12 months, shall obtain an updated credit report and recalculate the insurance score and shall reunderwrite and rerate the consumer within 30 days of receiving the request. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines, on the anniversary date or the effective date of the renewal of the policy.

[2007, c. 74, §1 (NEW) .]

6. **Filing of insurance scoring models.** An insurer that uses insurance scores to underwrite and rate risks shall file the scoring model or other scoring processes used by the insurer with the superintendent. A 3rd party may file scoring models on behalf of insurers. A filing that includes insurance scoring must include loss experience justifying the use of credit information if required by the superintendent. The insurance scoring model contained in a filing required under this subsection is confidential and not a public record within the meaning of Title 1, section 402, subsection 3.

[2003, c. 223, §1 (NEW) .]

7. **Indemnification.** An insurer shall indemnify, defend and hold agents harmless from and against all liability, fees and costs arising out of or relating to the actions, errors or omissions of a producer who obtains or uses credit information or insurance scores for an insurer, provided the producer, in the exercise of reasonable care, follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. This subsection may not be construed to provide a consumer or other insured with a cause of action that does not otherwise exist in the absence of this subsection. This subsection may not be construed to indemnify a producer for the producer's omission when a producer elects not to obtain a credit-related insurance score in connection with an application for personal insurance coverage from an insurer that the producer represents if that insurer uses credit information as permitted under this section to underwrite that coverage.

[2003, c. 223, §1 (NEW) .]

8. **Applicability.** This section applies only to personal insurance. This section does not apply to commercial insurance.

[2003, c. 223, §1 (NEW) .]

SECTION HISTORY
2003, c. 223, §1 (NEW). 2007, c. 74, §1 (AMD). 2013, c. 588, Pt. C, §§7-10 (AMD).

§2170. CERTAIN FEES FOR HANDLING INSURANCE TRANSACTIONS IN CONNECTION WITH LOANS PROHIBITED

1. No person who makes a loan on real or personal property shall in connection with such a transaction make any separate charge to or require any fee from or require the payment of any money for handling insurance papers for an insurer, insurance agency, borrower, mortgagor or purchaser, other than the insurance premium on insurance written as additional security for the loan. This prohibition includes any separate charge or fee or payment of any money for the substitution by a borrower or a mortgagor or a purchaser of one insurance policy on the property for an existing policy on the property when the existing or substituted policy is provided through an insurer or insurance agent or broker licensed to do business in the State.

[1969, c. 132, §1 (NEW) .]

2. This section does not prohibit fees paid to a lender for handling or processing credit accident and health or credit life insurance not exceeding 10% of prima facie premiums as set forth by rules adopted by the superintendent.

[1993, c. 208, §2 (AMD) .]

3. Nothing in this section prevents the payment of the interest which may be charged on premium loans or premium advances in accordance with the security agreement, or the payment of dividends to group policyholders provided that the payment of dividends to group credit life and group credit health policyholders shall be subject to such rules and regulations as shall be promulgated by the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §34 (AMD). 1973, c. 585, §12 (AMD). 1993, c. 208, §2 (AMD).

§2171. USING INSURANCE INFORMATION TO DETRIMENT OF ANOTHER

Whenever the instrument requires that the purchaser, mortgagor or borrower furnish insurance of any kind on real or personal property being conveyed or as collateral security to a loan, the mortgagee or lender shall refrain from selling, transferring or otherwise disclosing or using any and all such insurance information to the mortgagee's or lender's own advantage and to the detriment of either the borrower, purchaser, mortgagor, insurer or company or agency complying with the requirements relating to insurance. [1989, c. 449, (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 449, (AMD).

§2172. FICTITIOUS GROUPS PROHIBITED

1. No insurer or person on behalf of any insurer shall offer, make or permit any preference or distinction for purposes of any property, casualty or, surety insurance coverage, as to form of policy, certificate, premium, rates, benefits or conditions of insurance, whether by master policy, individual policies, certificates of insurance or by any other means, based upon membership, nonmembership, or employment of any person or persons in or by, any group, association, corporation, organization or other combination of persons, based upon marketing through groups, associations, corporations, organizations or other combination of persons, or based upon a group or mass merchandising program of any kind; and shall not make any such preference or distinction available in any event based upon any fictitious grouping of persons. For the purposes of this section a fictitious grouping is defined as any grouping by other than a common insurable interest as to the subject of the insurance and the risk to be insured.

[1969, c. 402, §4 (AMD) .]

2. This section shall not apply as to any grouping placed in effect prior to January 1, 1968.

[1969, c. 402, §4 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 402, §4 (AMD).

§2173. INTERLOCKING OWNERSHIP; MANAGEMENT

1. Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this Title, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create any monopoly therein.

[1969, c. 132, §1 (NEW) .]

2. Any person otherwise qualified may be a director of 2 or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create any monopoly.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2174. ILLEGAL DEALING IN PREMIUMS; EXCESS CHARGES FOR INSURANCE

1. No person shall knowingly collect any sum as premium or charge for insurance, which insurance is not then provided or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as authorized by this Title.

[1969, c. 132, §1 (NEW) .]

2. No person shall willfully collect as premium or charge for insurance any sum in excess of the premium or charge applicable to such insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the superintendent; or, in cases where classifications, premiums, or rates are not required by this Title to be so filed and approved, such premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer. This provision shall not be deemed to prohibit the charging and collection, by surplus lines brokers licensed under chapter 19, of the amount of applicable state and federal taxes and nominal service charge to cover communication expenses, in addition to the premium required by the insurer. This provision shall not be deemed to prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2174-A. PUBLIC WORKS EMPLOYEES' INSURANCE RATES

1. **Definitions.** For the purposes of this section, "public works employee" means a government employee, as defined by Title 14, section 8102, subsection 1, whose employment involves the care, maintenance or construction of municipally or state-owned buildings, open space, parks, parking facilities, waste water treatment systems, sewers or other property, roads, highways or other public ways. For purposes

of this section, "public works employee" also includes an individual who is an independent contractor or employee of an independent contractor, under contract to the governmental entity and whose employment involves the functions listed in this subsection.

[1989, c. 362, (NEW) .]

2. **Public works employees.** No insurer may increase the premium for a personal insurance policy providing motor vehicle liability or collision insurance to a public works employee on the basis of one or more accidents involving a motor vehicle operated by that employee if:

A. The accident occurred while the employee was operating a motor vehicle in the course and scope of employment; and [1989, c. 362, (NEW).]

B. There is a policy of insurance other than the personal insurance policy providing motor vehicle liability or collision coverage for the accident or accidents. [1989, c. 362, (NEW); 1989, c. 737, §1 (AMD).]

[1989, c. 362, (NEW); 1989, c. 737, §1 (AMD) .]

3. **Governmental entity.** This section in no way restricts the premium an insurer may charge a governmental entity, as defined in Title 14, section 8102, subsection 2, for an insurance policy providing motor vehicle liability or collision insurance covering public works employees.

[1989, c. 362, (NEW) .]

SECTION HISTORY
1989, c. 362, (NEW). 1989, c. 737, §1 (AMD).

§2174-B. LAW ENFORCEMENT OFFICERS' AND EMERGENCY RESPONDERS' INSURANCE RATES

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

A. "Law enforcement officer" means any person employed by a governmental entity who by virtue of that employment is vested by law with a duty to investigate and prosecute violators of the laws of this State and to arrest the offenders of the laws. [1989, c. 737, §2 (NEW).]

B. "Emergency responder" means:

(1) A municipal firefighter, as defined in Title 30-A, section 3151, subsection 2; or a volunteer firefighter, as defined in Title 30-A, section 3151, subsection 4, who is operating a municipal vehicle; or

(2) An operator of a vehicle under Title 29-A, section 2054 that is licensed or authorized pursuant to Title 32, chapter 2-B as an ambulance or emergency medical services vehicle, when that operator is acting with the approval of an ambulance service or nontransporting service licensed pursuant to Title 32, chapter 2-B. [2011, c. 493, §1 (NEW).]

[2011, c. 493, §1 (AMD) .]

2. **Law enforcement officers; emergency responders.** An insurer may not increase the premium for a personal insurance policy providing motor vehicle liability or collision insurance to a law enforcement officer or an emergency responder on the basis of one or more accidents involving a motor vehicle operated by the officer or emergency responder if:

A. The accident occurred while the officer or emergency responder was operating a motor vehicle in the course and scope of employment; and [2011, c. 493, §1 (AMD).]

B. There is a policy of insurance other than the personal policy providing motor vehicle liability or collision coverage for the accident or accidents. [1989, c. 737, §2 (NEW).]

[2011, c. 493, §1 (AMD) .]

3. **Governmental entity.** This section in no way restricts the premium an insurer may charge a governmental entity for an insurance policy providing motor vehicle liability or collision insurance covering law enforcement officers or emergency responders.

[2011, c. 493, §1 (AMD) .]

4. **Penalty.** An insurer who violates this section commits a civil violation pursuant to section 12-A.

[1997, c. 114, §1 (NEW) .]

SECTION HISTORY
1989, c. 737, §2 (NEW). 1997, c. 114, §1 (AMD). 2011, c. 493, §1 (AMD).

§2175. INSURER'S OWNERSHIP OF FUNERAL ESTABLISHMENT OR CEMETERY PROHIBITED

No insurer may own or manage or supervise or operate or maintain a mortuary establishment , a funeral establishment, a cemetery, a cemetery corporation or association, a crematorium, a mausoleum or a columbarium. [1989, c. 206, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 206, §1 (AMD).

§2176. FUNERAL AND BURIAL SERVICE CONTRACTS PROHIBITED

An insurer may not contract or agree with any funeral director, funeral establishment, mortuary establishment, cemetery, cemetery corporation or association, crematorium, mausoleum or columbarium or any representative of any of these directors or establishments to the effect that the director or establishment shall conduct the funeral, burial, or cremation or other disposal of the remains of any individual insured by the insurer. An insurer may not retain, utilize or employ any director or establishment as a producer or agency of the insurer and a director or establishment may not act as or purport to be an insurance producer or engage in insurance producer activities. Nothing in this section prevents compliance with Title 39-A, section 216, or the use of an insurance policy, including, subject to the provisions of section 2420, the assignment of rights under life insurance contracts, to provide security for the payment for a funeral, burial or cremation or, subject to chapter 27, the naming of a funeral home or funeral director as beneficiary under a life insurance policy to provide payment for a funeral, burial or cremation. Nothing in this section prohibits the use of an insurance policy as an investment by a mortuary trustee pursuant to Title 32, section 1401. [1999, c. 258, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 206, §2 (AMD). 1991, c. 885, §E27 (AMD). 1991, c. 885, §E47 (AFF). 1999, c. 258, §1 (AMD).

§2177. INSURER NAME -- DECEPTIVE USE PROHIBITED

No person who is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2178. FALSE APPLICATIONS, CLAIMS, PROOFS OF LOSS; PENALTY

No agent, broker, solicitor, examining physician, applicant or other person may knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any application for insurance; or for the purpose of obtaining any money or benefit, knowingly or wilfully present or cause to be presented a false or fraudulent claim; or any proof in support of such a claim for the payment of the loss upon a contract of insurance; or prepare, make, or subscribe a false or fraudulent account, certificate, affidavit or proof of loss, or other document or writing, with intent that the same may be presented or used in support of such a claim. Persons who violate this section are subject to the penalty provided in section 12-A, or as provided by any other applicable law that provides a greater penalty. [1991, c. 824, Pt. A, §50 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 824, §A50 (AMD).

§2179. INQUESTS INTO INSURANCE FRAUDS

On application in writing to the superintendent by an officer of any insurer doing business in the State, stating that he has reason to believe and does believe that any person has, by false representations, procured from the insurer an insurance, or that the insurer has sustained a loss by the fraudulent act of the insured or with his knowledge or consent, and requesting an investigation thereof, the superintendent shall summon and examine, under oath, at a time and place designated by him, any persons and require the production of all books and papers necessary for a full investigation of the facts and make report thereof, with the testimony by him taken, to the insurer making such application. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2180. UNFAIR AND COERCIVE INSURANCE REQUIREMENTS

No officer or employee of this State, or of any political subdivisions or quasi-municipal corporations, or of any public authority, and no person acting or purporting to act on behalf of such officer, employee or public agency or authority, except a public agency or authority created pursuant to agreement or compact with another state, shall, with respect to any public building or construction contract which is about to be or which has been competitively bid, require the bidder to make application to, or furnish financial data to, or to obtain or procure any surety bond or contract of insurance specified in connection with such contract, or specified by any law, ordinance or regulation, from a particular surety or insurance company, agent or broker. No such officer or employee, or person, firm or corporation acting or purporting to act on behalf of such officer or employee, shall negotiate, make application for, obtain or procure any such surety bond or contract of insurance, except contracts of insurance for builder's risk or owner's protective liability, which can be obtained or procured by the bidder, contractor or subcontractor. [1975, c. 623, §33 (AMD).]

The same prohibition shall extend to and include any and all construction projects which are wholly or in part financed by federal, state or municipal funds. [1969, c. 504, §40-A (NEW).]

This section shall not apply to any project under design or construction on January 3, 1970, by or on behalf of a public agency or authority if such agency or authority was then engaged in insurance activity with respect to such project that otherwise would be prohibited by this section. [1969, c. 504, §40-A (NEW).]

SECTION HISTORY
1969, c. 504, §§40-A (NEW). 1975, c. 623, §33 (AMD).

§2181. EXCEPTIONS

This section shall not prevent the exercise by such officer or employee on behalf of the State or such public agency or public authority of the right to approve the form, sufficiency or manner of execution of the surety bonds or contracts of insurance furnished by the surety or insurance company selected by the bidder to underwrite said bonds or contracts of insurance. [1969, c. 504, §40-A (NEW).]

SECTION HISTORY
1969, c. 504, §§40-A (NEW).

§2182. APPLICATION

All provisions in any invitation for bids, or in any of the contract documents, in conflict with sections 2180 and 2181 are declared to be contrary to the public policy of this State. [1969, c. 504, §40-A (NEW).]

SECTION HISTORY
1969, c. 504, §§40-A (NEW).

§2183. IMMUNITY FROM LIABILITY

(REPEALED)

SECTION HISTORY
1987, c. 345, (NEW). 1997, c. 341, §§1,2 (AMD). 1997, c. 675, §1 (RP).

§2184. CREDIT CARD CHARGES OF INSURANCE PURCHASES

(REPEALED)

SECTION HISTORY
1991, c. 727, §1 (NEW). 1993, c. 135, §2 (RP).

§2185. CALCULATION OF HEALTH BENEFITS BASED ON ACTUAL COST

All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. [1997, c. 197, §1 (NEW).]

SECTION HISTORY
1997, c. 197, §1 (NEW).

§2186. INSURANCE FRAUD PREVENTION

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

A. "Fraudulent insurance act" means any of the following acts or omissions when committed knowingly and with intent to defraud:

(1) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

(a) An application for the issuance or renewal of an insurance policy;

(b) The rating of an insurance policy;

(c) A claim for payment or benefit pursuant to an insurance policy;

(d) Payments made in accordance with an insurance policy; or

(e) Premiums paid on an insurance policy;

(2) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented to or by an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

(a) A document filed with the superintendent or the insurance regulatory official or agency of another jurisdiction;

(b) The financial condition of an insurer;

(c) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance in all or part of this State by an insurer;

(d) The issuance of written evidence of insurance; or

(e) The reinstatement of an insurance policy;

(3) Soliciting or accepting new or renewal insurance risks on behalf of an insurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(4) Removing, concealing, altering or destroying the assets or records of an insurer or other person engaged in the business of insurance;

(5) Embezzling, abstracting, purloining or converting money, funds, premiums, credits or other property of an insurer or other person engaged in the business of insurance;

(6) Transacting the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance; or

(7) Attempting to commit, aiding or abetting in the commission of, or conspiring to commit the acts or omissions described in this subsection. [1997, c. 675, §2 (NEW).]

B. "Insurer" means an authorized insurance company, fraternal benefit society, reinsurer, surplus lines insurer, unauthorized insurer, nonprofit hospital and medical service organization, health maintenance organization, risk retention group or multiple employer welfare organization. "Insurer" also includes an insurance producer or other person acting on the behalf of an insurer. For the purposes of this section, "insurer" also means the state Medicaid program. [2009, c. 13, §2 (AMD).]

[2009, c. 13, §2 (AMD) .]

2. **Fraudulent insurance acts prohibited.** A person may not commit a fraudulent insurance act.

[1997, c. 675, §2 (NEW) .]

3. **Fraud warning required.** Fraud warnings are required in accordance with the following.

A. All applications and claim forms for insurance used by insurers in this State, regardless of the form of transmission, must contain the following statement or a substantially similar statement permanently affixed to the application or claim form: "It is a crime to knowingly provide false, incomplete or

misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits." [1997, c. 675, §2 (NEW).]

B. The lack or omission of the statement required in paragraph A does not constitute a defense in any criminal prosecution or civil action for a fraudulent insurance act. [1997, c. 675, §2 (NEW).]

C. This subsection applies to all insurers except reinsurers. The statement required in paragraph A must be included in all applications and claim forms filed and approved for use by the superintendent on or after January 1, 1999. [1997, c. 675, §2 (NEW).]

[1997, c. 675, §2 (NEW) .]

4. **Reporting of fraudulent insurance acts.** Fraudulent insurance acts must be reported in accordance with this subsection.

A. An insurer shall, annually on or before March 1st or within any reasonable extension of time granted by the superintendent, file with the superintendent a report relating to fraudulent insurance acts that the insurer knew or reasonably believed had been committed during the previous calendar year. The report must contain information required by the superintendent in the manner prescribed by the superintendent. The information must be reported on an aggregate basis and may not contain any information identifying any individuals or entities. The superintendent shall adopt by January 1, 1999 rules necessary to define the information that must be reported. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 675, §2 (NEW).]

B. On the July 1st following the filing of the initial reports required by paragraph A, and annually thereafter, the superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters. The report must include aggregate information detailing the fraudulent insurance activity experienced by insurers in this State. [1997, c. 675, §2 (NEW).]

[1997, c. 675, §2 (NEW) .]

5. **Insurer antifraud plans.** Within 6 months of the effective date of this Act, every insurer writing direct insurance shall prepare and implement an antifraud plan. This subsection does not apply to any agency, producer or other person acting on behalf of an insurer. The superintendent may review an insurer's antifraud plan to determine if the plan complies with the requirements of this subsection. The antifraud plan must outline specific procedures, appropriate to the lines of insurance the insurer writes in the State, to:

A. Prevent, detect and investigate all forms of insurance fraud; [1997, c. 675, §2 (NEW).]

B. Educate appropriate employees on the antifraud plan and fraud detection; [1997, c. 675, §2 (NEW).]

C. Provide for the hiring of or contracting for fraud investigators; and [1997, c. 675, §2 (NEW).]

D. Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud. [1997, c. 675, §2 (NEW).]

[1997, c. 675, §2 (NEW) .]

6. **Civil penalties.** Any violation of this section is subject to civil penalties and other remedies as provided in section 12-A. Notwithstanding section 2165-A, subsection 1, the superintendent may issue emergency cease and desist orders on the basis of conduct involving fraudulent insurance acts.

[1997, c. 675, §2 (NEW) .]

7. **Recovery costs.** In a civil action in which it is proven that a person committed a fraudulent insurance act, the court may award reasonable attorney's fees and costs to the insurer. In a civil action in which the insurer alleges that a party committed a fraudulent insurance act that is not established at trial, the court may award reasonable attorney's fees and costs to the party if the allegation is not supported by any reasonable basis of law or fact.

[1997, c. 675, §2 (NEW) .]

SECTION HISTORY
1997, c. 675, §2 (NEW). 1999, c. 5, §1 (AMD). 1999, c. 5, §2 (AFF). 2009, c. 13, §2 (AMD).

§2187. INSURANCE FRAUD REPORTING IMMUNITY

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

A. "Action" includes nonaction or the failure to take action. [1997, c. 675, §2 (NEW).]

B. "Authorized agency" or "authorized agencies" means:

(1) The Attorney General;

(2) A district attorney responsible for prosecution in the municipality where the fraud occurred;

(3) The Federal Bureau of Investigation, or any other federal agency, only for the purposes of subsection 2;

(4) The State Fire Marshal;

(5) The Superintendent of Insurance;

(6) The Superintendent of Financial Institutions;

(7) The United States Attorney's office when authorized or charged with investigation or prosecution of the insurance fraud in question, only for the purposes of subsection 2;

(8) The State Police, state law enforcement officials or local law enforcement officials; or

(9) The National Association of Insurance Commissioners. [2005, c. 433, §1 (AMD); 2005, c. 433, §28 (AFF).]

C. "Fraudulent insurance act" has the same meaning as in section 2186, subsection 1, paragraph A. [1997, c. 675, §2 (NEW).]

D. "Insurer" has the same meaning as in section 2186, subsection 1, paragraph B. [1997, c. 675, §2 (NEW).]

[2005, c. 433, §1 (AMD); 2005, c. 433, §28 (AFF) .]

2. **Information disclosed.** An authorized agency investigating insurance fraud may, in writing, require the insurance company at interest to release to the requesting agency any relevant information or evidence determined to be important to the authorized agency that the company may have in its possession relating to the insurance fraud in question. This information includes, but is not limited to:

A. A history of previous claims made by the insured; [1997, c. 675, §2 (NEW).]

B. Insurance policy information relevant to fraud under investigation and any application for that policy; [1997, c. 675, §2 (NEW).]

C. Material relating to the investigation of the loss including statements and proof of loss; and [1997, c. 675, §2 (NEW).]

D. Policy premium payment records. [1997, c. 675, §2 (NEW).]

[1997, c. 675, §2 (NEW) .]

3. **Exchange of information.** An authorized agency or insurer provided with information pursuant to this section may release or provide that information to any other authorized agency or insurer with an interest in the insurance fraud under investigation.

[1997, c. 675, §2 (NEW) .]

4. **Right to receive upon request.** Any insurer providing information to an authorized agency pursuant to this section has the right, upon request, to receive other information relevant to the fraud from that authorized agency within 30 days.

[1997, c. 675, §2 (NEW) .]

5. **Immunity.** In the absence of fraud, malice or bad faith, any person, including, but not limited to, an insurer or authorized agency, that furnished information relating to suspected, anticipated or completed fraudulent insurance acts is not liable for any damages in any civil action for furnishing the information if that information is furnished to or received from an authorized agency. Nothing in this subsection is intended to abrogate or modify in any way any common law or statutory privilege or immunity previously enjoyed by any person.

[1997, c. 675, §2 (NEW) .]

6. **Confidentiality.** An authorized agency or insurer that receives any information pursuant to this section shall hold it in confidence and may not release the information, except to another authorized agency, until its release is required for a criminal or civil proceeding.

[1997, c. 675, §2 (NEW) .]

SECTION HISTORY
1997, c. 675, §2 (NEW). 2001, c. 44, §11 (AMD). 2001, c. 44, §14 (AFF). 2005, c. 433, §1 (AMD). 2005, c. 433, §28 (AFF).

§2188. PERMITTED ACTIVITIES OF INSURANCE PRODUCERS; NAVIGATORS; REQUIREMENTS

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

A. "Exchange" means a health benefit exchange established or operated in this State, including a health benefit exchange established or operated by the Secretary of the United States Department of Health and Human Services, pursuant to Section 1311 of the federal Affordable Care Act. [2011, c. 631, §1 (NEW).]

B. "Navigator" means a person selected to perform the activities and duties identified in Section 1311(i) of the federal Affordable Care Act. For the purposes of this section, if an organization or business entity serves as a navigator, an individual performing navigator duties for that organization or business entity is considered to be acting in the capacity of a navigator within the meaning of subsection 4. [2011, c. 631, §1 (NEW).]

[2011, c. 631, §1 (NEW) .]

2. **Prohibited activities.** Certification as a navigator under this section does not authorize a person who is not licensed as an insurance producer or consultant in this State in accordance with chapter 16 to act as an insurance producer or consultant. Regardless of whether a navigator certified under this section is also licensed as an insurance producer or consultant in this State in accordance with chapter 16, a navigator may not, while acting as a navigator for an individual, enrollee, potential enrollee or employer:

A. Sell, solicit or negotiate insurance; [2013, c. 388, Pt. A, §1 (AMD).]

B. Make recommendations to purchasers, enrollees or employers or prospective purchasers or enrollees to choose or reject a particular health plan; or [2013, c. 388, Pt. A, §1 (AMD).]

C. Enroll an individual or employee in a qualified health plan offered through an exchange or act as an intermediary between an employer and an insurer that offers a qualified health plan offered through an exchange, except that the actions of a navigator to provide assistance to an individual or employee to facilitate that individual's or employee's enrollment in a qualified health plan is not considered enrolling an individual or employee in a qualified health plan under this paragraph. [2013, c. 388, Pt. A, §1 (AMD).]

[2013, c. 388, Pt. A, §1 (AMD) .]

3. **Certification of navigators.** Prior to any exchange becoming operational in this State, the superintendent shall:

A. [2013, c. 388, Pt. A, §1 (RP).]

B. Adopt rules to establish a certification program for individual navigators who are not licensed as insurance producers and training requirements for all individual navigators and prospective individual navigators that include initial and continuing education requirements and an examination. [2013, c. 388, Pt. A, §1 (AMD).]

C. [2013, c. 388, Pt. A, §1 (RP).]

[2013, c. 388, Pt. A, §1 (AMD) .]

4. **Navigator requirements.** An individual may not act in the capacity of a navigator unless the individual is either licensed as an insurance producer under chapter 16 or certified by the superintendent as a navigator under this section. To be certified as a navigator, an individual must:

A. Be at least 18 years of age; [2013, c. 388, Pt. A, §1 (AMD).]

B. Have completed and submitted a disclosure form, which must be developed by the superintendent and which may include such information as the superintendent determines necessary, and have declared under penalty of refusal, suspension or revocation of the navigator certification that the statements made in the form are true, correct and complete to the best of the individual’s knowledge and belief; [2013, c. 388, Pt. A, §1 (AMD).]

C. Have submitted to any criminal history record check or regulatory background check required by the superintendent by rule; [2013, c. 388, Pt. A, §1 (AMD).]

D. [2013, c. 388, Pt. A, §1 (RP).]

E. Have successfully completed the initial training requirements and any other certification requirements adopted by the superintendent in accordance with subsection 3; and [2013, c. 388, Pt. A, §1 (AMD).]

F. Have paid any fees required by the superintendent. [2013, c. 388, Pt. A, §1 (AMD).]

[2013, c. 388, Pt. A, §1 (AMD) .]

5. **Unfair practices.** The provisions of this chapter and any rules adopted pursuant to this chapter apply to navigators. This subsection may not be construed to create or imply a private cause of action for a violation of any provision of this chapter.

[2013, c. 388, Pt. A, §1 (AMD) .]

5-A. **Privacy.** A navigator may not collect, use, disclose or retain personal information, as defined in section 2204, subsection 20, except for the purposes of performing the duties of a navigator or as permitted by an exchange under privacy standards adopted in accordance with the federal Affordable Care Act. A navigator is a regulated insurance entity for purposes of chapter 24 only if the navigator collects, uses, discloses or retains personal information for purposes other than performing the duties of a navigator.

[2013, c. 388, Pt. A, §1 (NEW) .]

6. **Denial, suspension or revocation.** The superintendent may deny certification and may suspend or revoke the authority of a navigator certified pursuant to this section for any ground specified in section 1420-K, subsection 1. The superintendent may assess civil penalties in accordance with section 12-A for violations of laws regulating the activities of navigators.

[2013, c. 388, Pt. A, §1 (AMD) .]

7. **Rules.** The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 631, §1 (NEW) .]

8. **Construction.** This section may not be construed to prevent the application of any provisions of the federal Affordable Care Act relating to the duties of a navigator.

[2013, c. 388, Pt. A, §1 (NEW) .]

SECTION HISTORY
2011, c. 631, §1 (NEW). 2013, c. 388, Pt. A, §1 (AMD).

Chapter 24: INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

§2201. SHORT TITLE

This chapter may be known and cited as the "Insurance Information and Privacy Protection Act." [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2202. PURPOSE

The purpose of this chapter is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions; to maintain a balance between insurance carriers' need for information and the public's need for fair information practices that respect privacy; to establish a regulatory mechanism to enable insurance consumers to ascertain what information is being collected about them and to verify its accuracy; to limit the distribution of information collected in connection with insurance transactions; and to enable consumers to obtain the reasons for adverse underwriting decisions. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2203. SCOPE

1. **Scope.** This chapter applies to all persons and other entities required to be licensed by the superintendent under this Title, or Title 24, and to all insurance support organizations, as defined in section 2204, that collect, maintain or distribute information on residents of this State or arising out of insurance transactions in this State. With respect to particular insurance transactions, this chapter applies if the transaction arises out of a policy, contract or certificate delivered, issued for delivery or renewed in this State or arises out of an application for such coverage. With respect to information practices, this chapter applies if information is collected or maintained in connection with an insurance transaction subject to this chapter or if personal information about residents of this State is collected or maintained in such a manner as to be accessible by the name of the insurance consumer referred to.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Residents.** For purposes of this chapter, a person is considered a resident of this State if the person's last known mailing address, as shown in the records of the regulated insurance entity or insurance support organization, is in this State.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Exception.** Except to the extent expressly provided in rules adopted by the superintendent pursuant to section 2220, this chapter does not apply to insurance transactions arising out of workers' compensation, medical malpractice, fidelity, suretyship or boiler and machinery insurance or information collected from public records for the purpose of title insurance.

[2001, c. 262, Pt. C, §2 (AMD) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF). 2001, c. 262, §C2 (AMD).

§2204. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

1. **Adverse underwriting decision.** "Adverse underwriting decision" means any of the following actions with respect to consumer insurance transactions involving insurance coverage that is individually underwritten:

A. A declination, cancellation or nonrenewal of insurance coverage, in whole or part; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Failure of a producer or agency to apply for insurance coverage with a specific insurance institution that the producer or agency represents and that is requested by an applicant; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. An offer to insure at higher than standard rates; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. Any other increase in any charge for, any reduction in or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Affiliate; affiliated.** "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Applicant.** "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

4. **Confidential investigative information.** "Confidential investigative information" means any information that:

A. Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving an individual; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Has not been disclosed to 3rd parties in violation of section 2215. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

5. **Consumer insurance transaction.** "Consumer insurance transaction" means an insurance transaction involving insurance primarily for personal, family or household needs rather than business or professional needs.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

6. **Consumer report.** "Consumer report" has the same meaning as in 15 United States Code, Section 1681a(d).

[2013, c. 588, Pt. C, §11 (AMD) .]

7. **Consumer reporting agency.** "Consumer reporting agency" has the same meaning as in Title 10, section 1308, subsection 3.

[2013, c. 588, Pt. C, §11 (AMD) .]

8. **Control; controlled by; under common control with.** "Control," including the terms "controlled by" and "under common control with," 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 the result of an official position with or a corporate office held by the person.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

9. **Health care.** "Health care" means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or affects the structure or function of the human body or any part of the human body. "Health care" includes prescribing, dispensing, furnishing or providing to a patient drugs, biologicals, medical devices, health care equipment and supplies or hospice services and the banking of blood, sperm, organs or any other tissue.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

10. **Health care facility.** "Health care facility" means a facility, institution or entity licensed pursuant to Title 22 that offers health care to persons in this State, including a home health care entity and a hospice program, or a pharmacy licensed pursuant to Title 32. For the purposes of this chapter, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

11. **Health care information.** "Health care information" means information that:

A. Relates to an individual's physical, mental or behavioral condition, personal or family medical history or health care; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Is obtained from a health care provider, from the individual or from the individual's spouse, parent or legal guardian. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

12. **Health care practitioner.** "Health care practitioner" means a person licensed in this State to provide or otherwise lawfully providing health care, and includes a partnership or corporation made up of health care practitioners, or an officer, employee, agent or contractor of a health care practitioner acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to an individual.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

13. **Health care provider.** "Health care provider" means a health care practitioner or health care facility.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

14. **Institutional source.** "Institutional source" means any person or governmental entity that provides information about an individual to a regulated insurance entity or insurance support organization other than:

A. A producer or producer agency; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. The individual who is the subject of the information; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. An individual acting in a personal capacity rather than in a business or professional capacity. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

15. **Insurance carrier; carrier.** "Insurance carrier" or "carrier" means:

A. Any person or entity required to be licensed by the superintendent to assume risk, including without limitation an insurer, nonprofit hospital, medical or health care service organization, health maintenance organization or multiple-employer welfare arrangement; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. A self-funded plan subject to state regulation as described in section 2848-A; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. A preferred provider arrangement administrator as defined in section 2671; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. A 3rd-party administrator, as described in section 1901, that provides administrative services for an entity that is not a carrier. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

"Carrier" does not include other nonrisk-bearing regulated insurance entities, such as producers or agencies.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

16. **Insurance consumer; consumer.** "Insurance consumer" or "consumer" means any individual who resides or obtains insurance in this State and:

A. Is a past, present or proposed principal insured or certificate holder; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Is a past, present or proposed policyowner; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Is a past or present applicant; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. Is a past or present claimant; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

E. Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate subject to this chapter. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

17. **Insurance support organization.** "Insurance support organization" means any person, other than a regulated insurance entity, health care provider or governmental agency, who regularly engages, in whole or in part, in the practice of assembling or collecting information for the primary purpose of providing the information to carriers, producers or agencies for insurance transactions, including:

A. Furnishing consumer reports or investigative consumer reports for use in connection with insurance transactions; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Collecting personal information from regulated insurance entities or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

18. **Insurance transaction.** "Insurance transaction" means any transaction that entails:

A. The determination of an individual's eligibility for an insurance coverage, benefit or payment; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. The servicing of an insurance application, policy, contract or certificate. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

19. **Investigative consumer report.** "Investigative consumer report" has the same meaning as in 15 United States Code, Section 1681a(e).

[2013, c. 588, Pt. C, §11 (AMD) .]

20. **Personal information.** "Personal information" means any information that identifies an individual gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. "Personal information" includes but is not limited to an individual's name and address and health care information.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

21. **Policyholder.** "Policyholder" means any person who:

A. Is a present policyowner; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. In the case of group insurance that is individually underwritten, is a present group certificate holder. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

22. **Pretext interview.** "Pretext interview" means an interview wherein a person, in an attempt to obtain information, performs one or more of the following acts:

A. Pretends to be someone the person is not; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Pretends to represent a person that person is not in fact representing; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Misrepresents the true purpose of the interview; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. Refuses to provide that person's identity upon request. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

23. **Regulated insurance entity.** "Regulated insurance entity" means any person or entity required to be licensed by the superintendent under this Title or Title 24, including without limitation a carrier, producer, producer agency or administrator.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

24. **Residual market.** "Residual market" means any special-purpose insurer, association, organization or other entity that provides insurance coverage to persons who are unable to obtain it in the voluntary market.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF). 2013, c. 588, Pt. C, §11 (AMD).

§2205. PRETEXT INTERVIEWS

A regulated insurance entity or insurance support organization may not use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction unless that entity or organization does not have a generally or statutorily recognized privileged relationship with the insurance consumer about whom the information is related, the interview is conducted for the purpose of investigating a claim and there is a reasonable basis, supported by specific information available for review by the superintendent, for suspecting criminal activity, fraud, material misrepresentation or material nondisclosure. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2206. NOTICE OF INSURANCE INFORMATION PRACTICES

The following requirements apply to notices provided by regulated insurance entities. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

1. **Written notice.** A regulated insurance entity shall provide a written notice of information practices to the applicant, policyholder or claimant in connection with all consumer insurance transactions in accordance with the following.

A. In the case of an application for insurance, the notice must be provided no later than:

(1) The time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records;

(2) The time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records; or

(3) The time of initial notification to the consumer when the insurance transaction is not initiated by the consumer and the consumer was selected based on specific criteria derived from personal information obtained from any source. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. In the case of a policy renewal, the notice must be provided no later than the policy renewal date, unless:

(1) Personal information is collected only from the policyholder or from public records; or

(2) A notice meeting the requirements of this section has been given within the previous 24 months. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. In the case of a policy reinstatement or change in insurance benefits, the notice must be provided no later than the time the request for reinstatement or change in benefits is received by the carrier, unless personal information is collected only from the policyholder or from public records. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Required provisions.** The notice must state:

A. Whether personal information may be collected from persons other than the insurance consumer or consumers proposed for coverage; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. The types of disclosures that may be made without prior authorization under section 2215 and the circumstances under which any such disclosures may be made without prior authorization, except that only those circumstances need be described that occur with such frequency as to indicate a general business practice; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. A description of the rights established under sections 2210 and 2211 and the manner in which those rights may be exercised; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

E. That information obtained from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

F. A description of the types of persons who may have access to the insurance consumer's personal information. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Abbreviated notice.** In lieu of the notice prescribed in subsection 2, the regulated insurance entity may provide an abbreviated notice informing the applicant or policyholder that:

A. Personal information may be collected from persons other than the insurance consumer or consumers proposed for coverage; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Information described in paragraph A as well as other personal information subsequently collected by the regulated insurance entity may in certain circumstances be disclosed to 3rd parties without authorization pursuant to section 2215; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. A right of access and correction exists with respect to all personal information collected; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. The notice prescribed in subsection 2 will be furnished to the applicant or policyholder upon request. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

4. **Satisfaction by other carrier, producer or administrator.** The notice requirements imposed by this section upon a regulated insurance entity may be satisfied by a carrier, producer or administrator authorized to act on the entity's behalf.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

5. **Standard notice forms.** All carriers shall develop and use standard notice forms, but are not required to use the same form as other carriers.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2207. MARKETING AND RESEARCH SURVEYS

A regulated insurance entity that asks questions in connection with an insurance transaction shall clearly identify any questions that are designed to obtain information solely for marketing or research purposes and shall inform consumers that answering the questions is voluntary. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2208. CONTENT OF DISCLOSURE AUTHORIZATION FORMS

Notwithstanding any other provision of law, a regulated insurance entity or insurance support organization may not use a disclosure authorization form unless the form or statement: [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

1. **Signed.** Is signed by the insurance consumer except that:

A. A consumer's spouse, family member or other authorized individual may sign the disclosure authorization form if:

(1) The individual is acting under a valid written power of attorney or acting pursuant to the Uniform Health-care Decisions Act; or

(2) The individual is the consumer's parent or legal guardian, in which case the authorization is valid only insofar as that parent or legal guardian has the exclusive authority to consent for the health care services received by a minor for which the authorization for payment is sought and only as to those disclosures when the holder of the information can reasonably infer that the parent's or legal guardian's interest in disclosure is not adverse to the consumer's; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. A consumer may authorize disclosure in electronic or telephonic form if a unique identifier of the insurance consumer is provided and the insurance consumer authenticates the electronic or telephonic authorization; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Plain language.** Is written in plain language;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Dated.** Is dated;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

4. **Persons authorized to disclose.** Specifies the types of persons authorized to disclose information about the consumer;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

5. **Nature of information.** Specifies the nature of the information authorized to be disclosed;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

6. **Name of regulated insurance entity.** Names the regulated insurance entity and identifies by generic reference representatives of the carrier to whom the consumer is authorizing information to be disclosed;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

7. **Purpose.** Specifies the purposes for which the information is collected;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

8. **Time period of authorization.** Specifies the period of time the authorization remains valid. The period of time may be no longer than:

A. In the case of life, disability or long-term care insurance:

(1) Thirty months from the date the authorization is signed if the authorization is signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits; or

(2) The duration of the claim if the authorization is signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy; or [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. In the case of health or medical insurance, the term of coverage of the policy and any renewals of that policy; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

9. **Right to copy.** Advises the consumer or a person authorized to act on behalf of the consumer that the consumer or the consumer's authorized representative is entitled to receive a copy of the authorization form;

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

10. **Revocation.** Advises the consumer how to revoke the authorization and that the revocation may be a basis for denying insurance benefits; and

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

11. **Failure to sign.** Advises the consumer that failure to sign an authorization form may impair the ability of a regulated insurance entity to evaluate or process an application or claim and may be a basis for denying an application or claims for benefits.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2209. INVESTIGATIVE CONSUMER REPORTS

1. **Required notice.** A regulated insurance entity or insurance support organization may not prepare or request an investigative consumer report about an insurance consumer in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the regulated insurance entity complies with Title 10, section 1314 and informs the consumer in writing that the consumer may request to be interviewed in connection with the preparation of the investigative consumer report.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Personal interview.** If an investigative consumer report is to be prepared by the regulated insurance entity, the regulated insurance entity shall institute reasonable procedures to conduct a personal interview when requested by a consumer.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Insurance support organization.** If an investigative consumer report is to be prepared by an insurance support organization, the regulated insurance entity requesting the report shall inform the insurance support organization whether a personal interview has been requested by the consumer. The insurance support organization shall institute reasonable procedures to conduct such interviews.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2210. ACCESS TO RECORDED PERSONAL INFORMATION

1. **Recorded personal information.** If any insurance consumer, after proper identification, submits a written request to a regulated insurance entity or insurance support organization for access to recorded personal information about the consumer that is reasonably described by the consumer and reasonably locatable and retrievable by the regulated insurance entity or insurance support organization, the regulated insurance entity or insurance support organization shall, within 30 days after the date the request is received:

A. Inform the consumer of the nature and substance of the recorded personal information in writing or by telephone or other oral communication; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Permit the consumer to see and copy, in person, the recorded personal information or to obtain a copy of the recorded personal information by mail, whichever method the consumer prefers, unless the recorded personal information is in coded form, in which case an accurate translation in plain language must be provided in writing; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Disclose to the consumer the identity, if recorded, of those persons to whom the regulated insurance entity or insurance support organization has disclosed the information described or similar personal information about the consumer during the 2 years preceding the request and, if the identity is not recorded, the names of those carriers, producers, agencies, insurance support organizations or other persons to whom any such information is normally disclosed; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. Provide the consumer with a summary of the procedures by which the consumer may request correction, amendment or deletion of recorded personal information. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Resident considered consumer.** For purposes of this section and section 2211, as applied to insurance support organizations, any resident of this State is considered an insurance consumer.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Institutional source.** Any personal information provided pursuant to subsection 1 must identify the source of the information if it is an institutional source.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

4. **Election relating to health care information.** In lieu of disclosure directly to the consumer, the carrier or producer may elect to disclose health care information, together with the identity of the health care provider who provided the information, to a person designated by the consumer who is licensed to provide health care with respect to the condition to which the information relates. The regulated insurance entity or insurance support organization shall notify the consumer at the time of the disclosure that it has provided the information to the health care practitioner.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

5. **Fee.** Except for personal information provided under section 2212, a regulated insurance entity or insurance support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to consumers.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

6. **Satisfaction by other carrier, producer or administrator.** The obligations imposed by this section upon a regulated insurance entity may be satisfied by another carrier, producer or administrator authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection 1, a regulated insurance entity or insurance support organization may make arrangements with an insurance support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

7. **Confidential investigative information.** Confidential investigative information and personal information in which a 3rd person has a nondisclosure right pursuant to section 2215 are not subject to the provisions of this section.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

8. **Applicability.** This section does not apply to a consumer reporting agency except to the extent that this section imposes more stringent requirements on a consumer reporting agency than other state or federal law.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2211. CORRECTION, AMENDMENT OR DELETION OF RECORDED PERSONAL INFORMATION

1. **Action by regulated insurance entity.** Within 30 days after receiving a written request from an insurance consumer to correct, amend or delete any recorded personal information within its possession about the consumer, a regulated insurance entity or insurance support organization shall:

A. In the case of recorded personal information contained within a consumer report, provide the consumer with the name and address of the consumer reporting agency that furnished the report and notify the consumer of the rights under 15 United States Code, Section 1681i governing the correction of inaccurate personal information contained in a consumer report; or [2013, c. 588, Pt. D, §5 (AMD).]

B. In the case of other recorded personal information, either:

(1) Correct, amend or delete the portion of the recorded personal information in dispute; or

(2) Notify the consumer of its refusal to make the requested correction, amendment or deletion; the reasons for the refusal; and the consumer's right to file a statement as provided in subsection 3. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[2013, c. 588, Pt. D, §5 (AMD) .]

2. **Notice to others.** If the regulated insurance entity or insurance support organization corrects, amends or deletes recorded personal information in accordance with subsection 1, paragraph B, the regulated insurance entity or insurance support organization shall notify the consumer in writing and furnish the correction, amendment or fact of deletion to:

A. Any person specifically designated by the consumer who may have, within the preceding 2 years, received that recorded personal information; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. Any insurance support organization whose primary source of personal information is insurance carriers, if the insurance support organization has systematically received recorded personal information from the carrier within the preceding 7 years. However, the correction, amendment or fact of deletion need not be furnished if the insurance support organization no longer maintains recorded personal information about the consumer; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Any insurance support organization that furnished the personal information that has been corrected, amended or deleted. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Consumer statement.** When a consumer disagrees with a regulated insurance entity's or insurance support organization's refusal to correct, amend or delete recorded personal information, or when the regulated insurance entity or insurance support organization has not made all relevant recorded personal information available for verification by the consumer, the consumer must be permitted to file with the regulated insurance entity or insurance support organization:

A. A concise statement setting forth what the consumer thinks is the correct, relevant or fair information; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. A concise statement of the reasons why the consumer disagrees with the regulated insurance entity's or insurance support organization's refusal to correct, amend or delete recorded personal information. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

4. **Filing of statement.** In the event a consumer files a statement as described in subsection 3, the regulated insurance entity or insurance support organization shall:

A. File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the consumer's statement and have access to it; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. In any subsequent disclosure by the regulated insurance entity or insurance support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the consumer's statement along with the recorded personal information being disclosed; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Furnish the statement to the persons and in the manner specified in subsection 2. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

5. **Applicability.** This section does not apply to a consumer reporting agency except to the extent that this section imposes more stringent requirements on a consumer reporting agency than other state or federal law.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF). 2013, c. 588, Pt. D, §5 (AMD).

§2212. REASONS FOR ADVERSE UNDERWRITING DECISIONS

1. **Notice to consumer.** In the event of an adverse underwriting decision, the carrier or producer responsible for the decision shall:

A. Comply with the federal Fair Credit Reporting Act, 15 United States Code, Section 1681m if the decision is based in whole or in part on any information contained in a consumer report; [2013, c. 588, Pt. D, §6 (AMD).]

B. Either provide the consumer with the specific reason or reasons for the adverse underwriting decision in writing or advise the consumer that upon written request the consumer may receive the specific reason or reasons in writing; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. Provide the consumer with a summary of the rights established under subsection 2 and sections 2210 and 2211. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[2013, c. 588, Pt. D, §6 (AMD) .]

2. **Request for explanation.** If a consumer makes a written request for explanation of an adverse underwriting decision within 90 days after receiving written notice of the decision, the carrier or producer shall furnish to the consumer within 21 days after receiving the request:

A. The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to subsection 1, paragraph A or B; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. The specific items of personal information that support those reasons, except that:

(1) The carrier or producer is not required to furnish confidential investigative information if it has a reasonable suspicion, based upon specific information available for review by the superintendent, that the consumer has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure; and

(2) In lieu of disclosure directly to the consumer, the carrier or producer may elect to disclose health care information to a person designated by the consumer who is licensed to provide health care with respect to the condition to which the information relates; and [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. The names and addresses of the institutional sources that supplied the specific items of information pursuant to paragraph B, except that the carrier may elect to disclose the identity of any health care provider to the consumer's designated health care practitioner. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **Satisfaction by other carrier, producer or administrator.** The obligations imposed by this section upon a carrier or producer may be satisfied by another carrier, producer or administrator authorized to act on its behalf.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF). 2013, c. 588, Pt. D, §6 (AMD).

§2213. INFORMATION CONCERNING PREVIOUS ADVERSE UNDERWRITING DECISIONS

Unless an inquiry of a regulated insurance entity or insurance support organization also requests the reasons for the underwriting decision or placement, a regulated insurance entity or insurance support organization may not seek information in connection with an insurance transaction concerning: [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

1. **Previous adverse decision.** Any previous adverse underwriting decision experienced by an insurance consumer; or

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Residual market, surplus lines or substandard risk carrier.** Any previous insurance coverage obtained by a consumer through a residual market, a surplus lines insurer or a carrier that specializes in substandard risks.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2214. PREVIOUS ADVERSE UNDERWRITING DECISIONS

A carrier, producer or producer agency may not base an adverse underwriting decision in whole or in part: [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

1. **Previous adverse underwriting decisions.** On the fact of a previous adverse underwriting decision or on the fact that a consumer previously obtained insurance coverage through a residual market, a surplus lines insurer or a carrier that specializes in substandard risks. However, a carrier or producer may base an adverse underwriting decision on further information obtained from a carrier, producer or producer agency responsible for a previous adverse underwriting decision; or

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Information from insurance support organizations.** On personal information received from an insurance support organization whose primary source of information is insurance carriers. However, a carrier or producer may base an adverse underwriting decision on further personal information obtained as a result of information received from the insurance support organization, including primary source information confirming the information received from the insurance support organization.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2215. DISCLOSURE LIMITATIONS AND CONDITIONS

1. **Disclosure of personal information.** A regulated insurance entity or insurance support organization may not disclose any personal information about a consumer collected or received in connection with an insurance transaction unless the disclosure is made with due consideration for the safety and reputation of all persons who may be affected by the disclosure, is limited to the minimum amount of personal information necessary to accomplish a lawful purpose and is disclosed:

A. With the written authorization of the individual, only:

(1) If that authorization is submitted directly by the consumer, a person purporting to represent the consumer, another regulated insurance entity or insurance support organization and the authorization meets the requirements of section 2208; or

(2) If the authorization is submitted by a person other than a regulated insurance entity or insurance support organization and the authorization describes with reasonable particularity the nature of the information to be disclosed and the purpose of the disclosure and is:

(a) Dated;

(b) Signed by the consumer, except that another authorized individual may provide authorization or the consumer may authorize disclosure in electronic or telephonic form in accordance with section 2208, subsection 1; and

(c) Obtained one year or less before the date a disclosure is sought pursuant to this subsection; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

B. To a person other than a regulated insurance entity or insurance support organization, only if that disclosure is reasonably necessary:

(1) To enable that person to perform a business, professional or insurance function for the disclosing regulated insurance entity or insurance support organization and that person agrees not to disclose the information further without the consumer's written authorization unless the further disclosure:

(a) Would otherwise be permitted by this section if made by a regulated insurance entity or insurance support organization; or

(b) Is reasonably necessary for that person to perform its function for the disclosing regulated insurance entity or insurance support organization; or

(2) To enable that person to provide information to the disclosing regulated insurance entity or insurance support organization for the purpose of:

(a) Determining a consumer's eligibility for an insurance benefit or payment; or

(b) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

C. To a regulated insurance entity, insurance support organization or self-insurer, only if the information disclosed is limited to that which is reasonably necessary:

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or

(2) For either the disclosing or the receiving regulated insurance entity or insurance support organization to perform its function in connection with an insurance transaction involving the consumer; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

D. To a health care provider for the purpose of:

(1) Verifying insurance coverage or benefits;

(2) Informing a consumer of a medical problem of which the consumer may not be aware; or

(3) Conducting an operations or services audit to verify the consumers of the regulated insurance entity or insurance support organization treated by the health care provider; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

E. To an insurance regulatory authority; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

F. To a law enforcement or other governmental authority to protect the interests of the regulated insurance entity or insurance support organization in preventing or prosecuting the perpetration of fraud upon that entity or organization; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

G. In response to a facially valid administrative or judicial order, including a search warrant or subpoena, or otherwise required by law; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

H. For the purpose of conducting actuarial or research studies, except that:

(1) No insurance consumer may be identified in any actuarial or research report;

(2) Materials allowing the consumer to be identified must be returned or destroyed as soon as they are no longer needed; and

(3) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by a regulated insurance entity or insurance support organization; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

I. To a party or representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the regulated insurance entity or insurance support organization, only if:

(1) Before the consummation of the sale, transfer, merger or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger or consolidation; and

(2) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by a regulated insurance entity or insurance support organization; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

J. To a person whose only use of the information will be in connection with the marketing of a product or service, only if:

(1) No health care information, confidential investigative information or information relating to a consumer's character, personal habits, mode of living or general reputation is disclosed and no classification derived from any such information is disclosed;

(2) The consumer has been given an opportunity to indicate that the consumer does not want personal information disclosed for marketing purposes and has given no indication that the consumer does not want the information disclosed; and

(3) The person receiving the information agrees not to use it except in connection with the marketing of a product or service; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

K. By a consumer reporting agency to a person other than a regulated insurance entity; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

L. To a group policyholder for the purpose of reporting claims experience or conducting an audit of the regulated insurance entity's operations or services, only if the information disclosed is aggregate information and reasonably necessary for the group policyholder to conduct the review or audit; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

M. To a professional peer review organization for the purpose of reviewing the service or conduct of a health care provider; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

N. To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

O. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of a carrier or producer as having a legal or beneficial interest in a policy of insurance, only if:

(1) No health care information is disclosed unless the disclosure would otherwise be permitted by this section; and

(2) The information disclosed is limited to that which is reasonably necessary to permit that person to protect its interests in the policy; [2001, c. 457, §21 (AMD).]

P. To an affiliate whose only use of the information will be in connection with an audit of the regulated insurance entity or the marketing of a product or service of the affiliate, if the information disclosed for marketing purposes does not include health care information and if the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons; [2005, c. 127, §1 (AMD).]

Q. In order to protect the public health and welfare, to state governmental entities only insofar as necessary to enable those entities to perform their duties when reporting is required or authorized by law; or [2005, c. 127, §2 (AMD).]

R. By a regulated insurance entity that is also a covered entity or is a business associate of a covered entity under the standards for privacy of individually identifiable health information, 45 Code of Federal Regulations, Parts 160 and 164 (2004), if the disclosure is made for purposes of treatment, payment or health care operations of the disclosing or receiving entity and is made in full compliance with the requirements of the standards for privacy of individually identifiable health information and any applicable business associate agreement. [2005, c. 127, §3 (NEW).]

[2005, c. 127, §§1-3 (AMD) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF). 2001, c. 457, §§21,22 (AMD). 2005, c. 127, §§1-3 (AMD).

§2216. INSURANCE SUPPORT ORGANIZATIONS

1. **Examination and investigation.** The superintendent may examine and investigate into the affairs of every insurance support organization acting on behalf of a regulated insurance entity that either transacts business in this State or transacts business outside this State that has an effect on a resident of this State in order to determine whether the insurance support organization has been or is engaged in any conduct in violation of this chapter.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Service of process.** An insurance support organization transacting business outside this State that has an effect on a resident of this State is deemed to have appointed the superintendent to accept service of process on its behalf. Service is complete when the superintendent sends a copy of the process by registered mail to the insurance support organization at its last known principal place of business. The return receipt is sufficient proof that notice was properly mailed by the superintendent.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2217. INDIVIDUAL REMEDIES

1. **Appeal to superintendent.** Any insurance consumer aggrieved by a regulated insurance entity's or insurance support organization's response or failure to respond to a request made pursuant to sections 2210, 2211 and 2212 may appeal to the superintendent, who may convene an adjudicatory hearing to determine whether there has been a violation of this chapter and may order the regulated insurance entity or insurance support organization to take such measures as are necessary to comply with this chapter.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

2. **Superior Court action.** An insurance consumer who is injured by a disclosure of information relating to the consumer in violation of section 2215 may bring an action in the Superior Court against the regulated insurance entity or insurance support organization within 2 years after the disclosure is or should have been discovered. The consumer may recover damages, together with costs and disbursements, reasonable attorney's fees and interest on damages at the rate of 1 1/2% per month.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

3. **No private right of action.** Except as specifically provided in this section, this chapter provides no express or implied private right of action.

[1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF) .]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2218. IMMUNITY

No cause of action in the nature of defamation, invasion of privacy or negligence arises against any person for disclosing personal information in accordance with this chapter, nor does such a cause of action arise against any person for furnishing personal information to a regulated insurance entity or insurance

support organization. This section provides no immunity for disclosing or furnishing false information with malice or willful intent to injure any person. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2219. CRIMINAL PENALTIES

A person who knowingly obtains personal information under false pretenses from a regulated insurance entity or insurance support organization is guilty of obtaining personal insurance information under false pretenses. Obtaining personal insurance information under false pretenses is a Class D crime. [1997, c. 677, §3 (NEW); 1997, c. 677, §5 (AFF).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF).

§2220. RULEMAKING

The superintendent may adopt rules to carry out the purposes of this chapter and the privacy protection provisions of the federal Gramm-Leach-Bliley Act, 15 United States Code, Section 6801 et seq. (1999). Rules adopted pursuant to this chapter are routine technical rules as defined by Title 5, chapter 375, subchapter II-A. [2001, c. 262, Pt. C, §3 (AMD).]

SECTION HISTORY
1997, c. 677, §3 (NEW). 1997, c. 677, §5 (AFF). 2001, c. 262, §C3 (AMD).

Chapter 24-A: PROTECTION OF BENEFICIARIES OF STRUCTURED SETTLEMENTS

§2241. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 268, §2 (NEW).]

1. **Annuity issuer.** "Annuity issuer" means an insurer that has issued an insurance contract used to fund periodic payments under a structured settlement.

[1999, c. 268, §2 (NEW) .]

2. **Applicable law.** "Applicable law" means:

A. Federal law; [1999, c. 268, §2 (NEW).]

B. The laws of this State, including principles of equity applied in the courts of this State; and [1999, c. 268, §2 (NEW).]

C. The laws of any other jurisdiction:

(1) That is the domicile of the payee or any other interested party;

(2) Under whose laws a structured settlement agreement was approved by a court or responsible administrative authority; or

(3) In whose courts a settled claim was pending when the parties entered into a structured settlement agreement. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

3. **Dependents.** "Dependents" means a payee's spouse and minor children and all other family members and other persons for whom the payee is legally obligated to provide support, including alimony.

[1999, c. 268, §2 (NEW) .]

4. **Discounted present value.** "Discounted present value" means the fair present value of future payments as determined by discounting such payments to the present using the applicable federal rate for determining the present value of an annuity most recently published by the United States Internal Revenue Service.

[1999, c. 268, §2 (NEW) .]

5. **Favorable tax determination.** "Favorable tax determination," with respect to a proposed transfer of structured settlement payment rights, means any of the following authorities that definitively establishes that the federal income tax treatment of the structured settlement for the parties, other than the payee, to the structured settlement agreement and any qualified assignment agreement will not be affected by that transfer:

A. A provision of the United States Internal Revenue Code or a United States Treasury regulation adopted pursuant to the code; [1999, c. 268, §2 (NEW).]

B. A revenue ruling or revenue procedure issued by the United States Internal Revenue Service; [1999, c. 268, §2 (NEW).]

C. A private letter ruling by the United States Internal Revenue Service with respect to that transfer; or [1999, c. 268, §2 (NEW).]

D. A decision by the United States Supreme Court or a decision of a lower federal court in which the United States Internal Revenue Service has acquiesced. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

6. **Federal hardship standard.** "Federal hardship standard" means a federal standard applicable to transfers of structured settlement payment rights based on findings of a court or responsible administrative authority regarding the payee's needs, as contained in the United States Internal Revenue Code or in a United States Treasury regulation adopted pursuant to the code.

[1999, c. 268, §2 (NEW) .]

7. **Independent professional advice.** "Independent professional advice" means advice of an attorney, certified public accountant, actuary or other licensed professional advisor:

A. Who is engaged by a payee to render advice concerning the legal, tax and financial implications of a transfer of structured settlement payment rights; [1999, c. 268, §2 (NEW).]

B. Who is not in any manner affiliated with or compensated by the transferee of that transfer; and [1999, c. 268, §2 (NEW).]

C. Whose compensation for rendering advice is not affected by whether a transfer occurs or does not occur. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

8. **Interested parties.** "Interested parties" means the payee, any beneficiary designated under the annuity contract to receive payments following the payee's death and any other party that has continuing rights or obligations under the contract. For purposes of this chapter, "interested parties" does not include the structured settlement obligor or the annuity issuer.

[1999, c. 268, §2 (NEW) .]

9. **Payee.** "Payee" means an individual who is receiving tax-free damage payments under a structured settlement and proposes to make a transfer of payment rights under that settlement.

[1999, c. 268, §2 (NEW) .]

10. **Qualified assignment agreement.** "Qualified assignment agreement" means an agreement providing for a qualified assignment within the meaning of Section 130 of the United States Internal Revenue Code, United States Code, Title 26.

[1999, c. 268, §2 (NEW) .]

11. **Responsible administrative authority.** "Responsible administrative authority" means any government authority vested by law with exclusive jurisdiction over the settled claim resolved by a structured settlement.

[1999, c. 268, §2 (NEW) .]

12. **Settled claim.** "Settled claim" means the original tort claim or workers' compensation claim resolved by a structured settlement.

[1999, c. 268, §2 (NEW) .]

13. **Structured settlement.** "Structured settlement" means an arrangement for periodic payment of damages for personal injuries established by settlement or judgment in resolution of a tort claim or for periodic payments in settlement of a workers' compensation claim.

[1999, c. 268, §2 (NEW) .]

14. **Structured settlement agreement.** "Structured settlement agreement" means the agreement, judgment, stipulation or release embodying the terms of a structured settlement, including the rights of the payee to receive periodic payments.

[1999, c. 268, §2 (NEW) .]

15. **Structured settlement obligor.** "Structured settlement obligor" means the party that has the continuing periodic payment obligation to the payee under a structured settlement agreement or a qualified assignment agreement.

[1999, c. 268, §2 (NEW) .]

16. **Structured settlement payment rights.** "Structured settlement payment rights" means rights to receive periodic payments, including lump sum payments, under a structured settlement, whether from the settlement obligor or the annuity issuer, when:

A. The payee, structured settlement obligor, annuity issuer or any other interested party is domiciled in this State; [1999, c. 268, §2 (NEW).]

B. The structured settlement agreement was approved by a court or responsible administrative authority in this State; or [1999, c. 268, §2 (NEW).]

C. The settled claim was pending before the courts of this State when the parties entered into the structured settlement agreement. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

17. **Terms of structured settlement.** "Terms of a structured settlement" means the terms of a structured settlement agreement, an annuity contract, any qualified assignment agreement and any order or approval of any court or responsible administrative authority or other government authority authorizing or approving the structured settlement.

[1999, c. 268, §2 (NEW) .]

18. **Transfer.** "Transfer" means any sale, assignment, pledge, hypothecation or other form of alienation or encumbrance made by a payee for consideration.

[1999, c. 268, §2 (NEW) .]

19. **Transfer agreement.** "Transfer agreement" means the agreement providing for transfer of structured settlement payment rights from a payee to a transferee.

[1999, c. 268, §2 (NEW) .]

20. **Transferee.** "Transferee" means a person that becomes entitled to receive structured settlement payment rights as a result of a transfer agreement.

[1999, c. 268, §2 (NEW) .]

SECTION HISTORY
1999, c. 268, §2 (NEW).

§2242. NOTICE AND REGISTRATION REQUIREMENTS OF TRANSFEREES OF STRUCTURED SETTLEMENTS

1. **Notice.** A transferee of structured settlement payment rights that intends to do business in this State shall, prior to doing business, pay the appropriate fee at the rate established in section 601 and furnish notice to the superintendent to:

A. Identify the state in which the transferee is domiciled; [1999, c. 268, §2 (NEW).]

B. Identify the principal place of business of the group; and [1999, c. 268, §2 (NEW).]

C. Provide such other information as may be required by the superintendent. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

2. **Registration.** The transferee shall register with the superintendent and designate an agent solely for the purpose of receiving service of legal documents or process.

[1999, c. 268, §2 (NEW) .]

3. **Application of law.** Any transferee that was doing business in this State prior to the effective date of this chapter within 30 days after the effective date of this chapter shall furnish notice to the superintendent pursuant to the requirements of subsection 1 and shall comply with the requirements of subsection 2.

[1999, c. 268, §2 (NEW) .]

4. **Notice of change.** A transferee that intends to do business or is doing business in this State shall notify the superintendent within 10 days of any subsequent changes in any information or other items provided pursuant to this section.

[1999, c. 268, §2 (NEW) .]

SECTION HISTORY
1999, c. 268, §2 (NEW).

§2243. TRANSFER OF STRUCTURED SETTLEMENT PAYMENT RIGHTS

1. **Application.** This section applies to any transfer of structured settlement payment rights under a transfer agreement entered into on or after the effective date of this section. This section may not be construed to imply that any transfer under a transfer agreement reached prior to the effective date of this section is effective.

[1999, c. 268, §2 (NEW) .]

2. **Requirements for transfer.** A direct or indirect transfer of structured settlement payment rights is not effective and a structured settlement obligor or annuity issuer is not required to make any payment directly or indirectly to any transferee of structured settlement payment rights unless the transfer has been authorized in advance in a final order of a court of competent jurisdiction or a responsible administrative authority, based on express findings by that court or responsible administrative authority that:

A. The transfer complies with the requirements of this chapter and does not contravene other applicable law; [1999, c. 268, §2 (NEW).]

B. Not less than 10 days prior to the date on which the payee first incurred any obligation with respect to the transfer, the transferee provided to the payee a disclosure statement in bold type, no smaller than 14 points, setting forth:

(1) The amounts and due dates of the structured settlement payments to be transferred;

(2) The aggregate amount of those payments;

(3) The discounted present value of those payments together with the discount rate used in determining that discounted present value;

(4) The gross amount payable to the payee in exchange for the payments;

(5) An itemized listing of all brokers' commissions, service charges, application fees, processing fees, closing costs, filing fees, administrative fees, legal fees, notary fees and other commissions, fees, costs, expenses and charges payable by the payee or deductible from the gross amount otherwise payable to the payee;

(6) The net amount payable to the payee after deduction of all commissions, fees, costs, expenses and charges described in subparagraph (5);

(7) The quotient, expressed as a percentage, obtained by dividing the net payment amount by the discounted present value of the payments; and

(8) The amount of any penalty and the aggregate amount of any liquidated damages, inclusive of penalties, payable by the payee in the event of any breach of the transfer agreement by the payee; [1999, c. 268, §2 (NEW).]

C. The payee has established that the transfer is necessary to enable the payee, the payee's dependents or both to avoid imminent financial hardship, and the transfer is not expected to subject the payee, the payee's dependents or both to undue financial hardship in the future, except that if a federal hardship standard was in effect at the time the payee and the transferee entered into the transfer agreement, in lieu of the foregoing finding the court or responsible administrative authority must make an express finding that the transfer qualifies under that federal hardship standard; [1999, c. 268, §2 (NEW).]

D. The payee has received independent professional advice regarding the legal, tax and financial implications of the transfer; [1999, c. 268, §2 (NEW).]

E. If the transfer would contravene the terms of the structured settlement:

(1) The transfer has been expressly approved in writing by:

(a) Each interested party; and

(b) Any court or government authority, other than the court or responsible administrative authority from which authorization of the transfer is sought under this chapter, that previously approved the structured settlement; and

(2) Signed originals of all approvals required under subparagraph (1) have been filed with the court or responsible administrative authority from which authorization of the transfer is sought under this chapter and originals or copies have been furnished to all interested parties; [1999, c. 268, §2 (NEW).]

F. If the transfer would contravene the terms of the structured settlement, the transfer agreement does not have adverse tax consequences to the structured settlement obligor or annuity issuer. The structured settlement obligor or annuity issuer must demonstrate to the court or responsible administrative authority that the transfer agreement, if approved, will have adverse tax consequences; and [1999, c. 268, §2 (NEW).]

G. The transferee has given written notice of the transferee's name, address and taxpayer identification number to the annuity issuer and the structured settlement obligor and has filed a copy of that notice with the court or responsible administrative authority. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

SECTION HISTORY
1999, c. 268, §2 (NEW).

§2244. JURISDICTION; FILING

1. **Jurisdiction.** The Superior Court has nonexclusive jurisdiction over any application for authorization under this chapter of a transfer of structured settlement payment rights.

[1999, c. 268, §2 (NEW) .]

2. **Filing.** Not less than 30 days prior to the scheduled hearing on any application for authorization of a transfer of structured settlement payment rights under this chapter, the transferee shall file with the court or responsible administrative authority and serve on any other government authority that previously approved the structured settlement, all interested parties, the structured settlement obligor and annuity issuer a notice of the proposed transfer and the application of its authorization, including in that notice:

A. A copy of the transferee's application; [1999, c. 268, §2 (NEW).]

B. A copy of the transfer agreement; [1999, c. 268, §2 (NEW).]

C. A copy of the disclosure statement required under section 2243, subsection 2, paragraph B; [1999, c. 268, §2 (NEW).]

D. Notification that any interested party, structured settlement obligor or annuity issuer is entitled to support, oppose or otherwise respond to the transferee's application, either in person or by counsel, by submitting written comments to the court or responsible administrative authority or by participating in the hearing; and [1999, c. 268, §2 (NEW).]

E. Notification of the time and place of the hearing and notification of the manner in which and the time by which written responses to the application must be filed, which may be not less than 30 days after service of the transferee's notice, in order to be considered by the court or responsible administrative authority. [1999, c. 268, §2 (NEW).]

[1999, c. 268, §2 (NEW) .]

SECTION HISTORY
1999, c. 268, §2 (NEW).

§2245. PROHIBITIONS

1. **Prohibition against waiver.** The provisions of this chapter may not be waived.

[1999, c. 268, §2 (NEW) .]

2. **Prohibition against penalty.** A payee who proposes to make a transfer of structured settlement payment rights may not incur a penalty, forfeit an application fee or other payment or otherwise incur any liability to the proposed transferee based on the failure of that transfer to satisfy the conditions of section 2243.

[1999, c. 268, §2 (NEW) .]

SECTION HISTORY
1999, c. 268, §2 (NEW).

§2246. CONSTRUCTION

Nothing contained in this chapter may be construed to authorize a transfer of structured settlement payment rights in contravention of applicable law or to give effect to a transfer of structured settlement payment rights that is invalid under applicable law. [1999, c. 268, §2 (NEW).]

SECTION HISTORY
1999, c. 268, §2 (NEW).

Chapter 25: RATES AND RATING ORGANIZATIONS

Subchapter 1: GENERAL PROVISIONS

§2301. PURPOSE OF CHAPTER; INTERPRETATION

The purpose of this chapter is to promote the public welfare by regulating insurance rates, in accordance with the intent of Congress as expressed in Public Law 15 -- 79th Congress, to the end that they shall not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate limited cooperative action among insurers in rate-making related activities and in other matters within the scope of this chapter. Nothing in this chapter is intended to prohibit or discourage reasonable competition, or to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in rating systems, rating plans or practices. This chapter shall be liberally interpreted to carry into effect this section. Unless otherwise specified, all hearings held under this chapter shall be in accordance with the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [1989, c. 797, §1 (AMD); 1989, c. 797, §§37, 38 (AFF).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 694, §415 (AMD). 1989, c. 797, §§1,37,38 (AMD).

§2302. SCOPE OF CHAPTER

1. This chapter applies to:

A. Casualty insurance and all forms of motor vehicle insurance on risks or operations in this State; [1969, c. 132, §1 (NEW).]

B. Surety insurance; [1969, c. 132, §1 (NEW).]

C. Property, marine and inland marine insurance on risks located in this State. Inland marine insurance shall be deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the superintendent, or as established by general custom of the business, as inland marine insurance; and [1989, c. 351, §1 (AMD).]

D. Title insurance. [1989, c. 351, §2 (NEW).]

[1989, c. 351, §§1, 2 (AMD) .]

2. This chapter shall not apply to:

A. Reinsurance, except joint reinsurance as provided in section 2322-A; [2007, c. 466, Pt. D, §6 (AMD).]

B. Health insurance; [1969, c. 132, §1 (NEW).]

C. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies; [1969, c. 132, §1 (NEW).]

D. Insurance of hulls of aircraft, including their accessories and equipment, or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance or use of aircraft; [1987, c. 769, Pt. A, §91 (AMD).]

E. Life insurance; or [1989, c. 351, §3 (AMD).]

F. [1989, c. 351, §4 (RP).]

G. Insurance written on an assessment plan by domestic mutual insurers. [1969, c. 132, §1 (NEW).]

[2007, c. 466, Pt. D, §6 (AMD) .]

3. Workers' compensation is primarily subject to chapter 25, subchapter II-B, but any other parts of this subchapter not inconsistent with that subchapter also apply.

[1991, c. 885, Pt. B, §1 (AMD); 1991, c. 885, Pt. B, §13 (AFF) .]

4. Nothing in this chapter shall abridge or restrict the freedom of contract between insurers and agents or brokers with respect to commissions or between insurers and their employees with respect to compensation.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 372, §B2 (AMD). 1987, c. 559, §A1 (AMD). 1987, c. 769, §A91 (AMD). 1989, c. 351, §§1-4 (AMD). 1991, c. 885, §B1 (AMD). 1991, c. 885, §B13 (AFF). 2007, c. 466, Pt. D, §6 (AMD).

§2302-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF).]

1. "Commercial lines" means any line of insurance that is not a personal line.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

2. "Developed losses" means losses, including loss adjustment expenses, adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss and loss adjustment expense payments.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

3. "Expense" means that portion of a rate attributable to acquisition, field supervision and collection expenses; general expenses; and taxes, licenses and fees.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

4. "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

5. "Personal lines" means homeowners, tenants, private passenger nonfleet automobiles, mobile homes and other property and casualty insurance for personal, family or household needs.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

6. "Prospective loss costs" means that portion of a rate that does not include provisions for expenses, other than loss adjustment expenses, or profit, and is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

7. "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variation based on loss or expense considerations, and not including minimum premium.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

8. "Supplementary rating information" means any manual or plan of rates, classification rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan and any other similar information needed to determine the applicable rate in effect or to be in effect.

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

9. "Supporting information" means:

A. The experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer; [1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF).]

B. The interpretation of any other data relied upon by the filer; and [1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF).]

C. Descriptions of methods used in making rates, and any other information required by the superintendent to be filed. [1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF).]

[1989, c. 797, §2 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1989, c. 797, §§2,37,38 (NEW).

§2303. MAKING OF RATES

1. Rates shall be made in accordance with the following provisions.

A. Manual, minimum, class rates, rating schedules or rating plans shall be made and adopted, except in the case of specific inland marine rates on risks specially rated. [1969, c. 132, §1 (NEW).]

B. Rates shall not be excessive, inadequate or unfairly discriminatory. [1969, c. 132, §1 (NEW).]

C. Due consideration must be given:

(1) To past and prospective loss experience within and outside this State;

(2) To the conflagration and catastrophe hazards;

(3) To a reasonable margin for underwriting profit and contingencies;

(4) To dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

(5) To past and prospective expenses both countrywide and those specially applicable to this State;

(6) To all other relevant factors within and outside this State;

(7) In the case of fire insurance rates, to the experience of the fire insurance business during a period of not less than the most recent 5-year period for which such experience is available; and

(8) In the case of title insurance rates, to the reasonableness of commission levels and other acquisition costs both countrywide and those specifically applicable to this State. [1991, c. 885, Pt. B, §2 (AMD); 1991, c. 885, Pt. B, §13 (AFF).]

D. [1989, c. 797, §§37, 38 (AFF); 1989, c. 797, §3 (RP).]

E. [1989, c. 797, §§37, 38 (AFF); 1989, c. 797, §3 (RP).]

F. [1985, c. 372, Pt. B, §4 (RP).]

G. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. These standards may measure any differences among risks that may have a probable effect upon losses or expenses. No risk classification may be based upon race, creed, national origin or the religion of the insured. [1989, c. 797, §4 (NEW); 1989, c. 797, §§37, 38 (AFF).]

H. The expense provisions included in the rates to be used by an insurer must reflect the operating methods of the insurer and its anticipated expenses. [1989, c. 797, §4 (NEW); 1989, c. 797, §§37, 38 (AFF).]

I. Rates may contain a provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit allowance, consideration must be given to investment income. [1989, c. 797, §4 (NEW); 1989, c. 797, §§37, 38 (AFF).]

[1991, c. 885, Pt. B, §2 (AMD); 1991, c. 885, Pt. B, §13 (AFF) .]

2. Nothing in this section shall be taken to prohibit as unreasonable or unfairly discriminatory the establishment of classifications or modifications of classifications or risks based upon size, expense, management, individual experience, purpose of insurance, location or dispersion of hazard, or any other reasonable considerations, provided such classifications and modifications apply to all risks under the same or substantially similar circumstances or conditions.

[1969, c. 132, §1 (NEW) .]

3.

[1989, c. 797, §§37, 38 (AFF); 1989, c. 797, §5 (RP) .]

3-A.

[2007, c. 188, Pt. A, §1 (RP) .]

4. Rates made in accordance with this section may be used subject to this chapter.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 17, (AMD). 1983, c. 551, §1 (AMD). 1985, c. 372, §§B3,4 (AMD). 1987, c. 559, §A2 (AMD). 1989, c. 351, §5 (AMD). 1989, c. 797, §§3-6 (AMD). 1989, c. 797, §§37,38 (AFF). 1991, c. 885, §B2 (AMD). 1991, c. 885, §B13 (AFF). 2007, c. 188, Pt. A, §1 (AMD).

§2303-A. SURCHARGE

An insurer may not surcharge a motor vehicle insurance policy based on a motor vehicle operator's license suspension when that suspension is pursuant to Title 29-A, section 2472, subsection 3, paragraph B, except in accordance with this section. If the person had an alcohol level of at least 0.05 grams or more of alcohol but less than 0.08 grams of alcohol per 100 milliliters of blood or 210 liters of breath, the surcharge is limited to 20%. If the person had an alcohol level of at least 0.02 grams of alcohol but less than 0.05 grams of alcohol per 100 milliliters of blood or 210 liters of breath, the surcharge is limited to 10%. If the policy covers multiple vehicles, the surcharge may be applied only to that portion of the rate attributable to a single vehicle. [2009, c. 447, §22 (AMD).]

SECTION HISTORY
1989, c. 366, §1 (NEW). 1995, c. 65, §A67 (AMD). 1995, c. 65, §§A153,C15 (AFF). 2009, c. 447, §22 (AMD).

§2303-B. CLEAN FUEL VEHICLE INCENTIVE

An insurer may credit or refund any portion of the premium charges for an insurance policy for a clean fuel vehicle in order to encourage its policyholders to use clean fuel vehicles if insurance premiums on other vehicles are not increased to fund these credits or refunds. [1997, c. 500, §7 (NEW).]

For purposes of this section, "clean fuel vehicle" has the same meaning as set out in Title 10, section 963-A, subsection 5-B. [1997, c. 500, §7 (NEW).]

SECTION HISTORY
1997, c. 500, §7 (NEW).

§2304. RATE FILINGS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 113, (AMD). 1973, c. 585, §12 (AMD). 1989, c. 192, §1 (AMD). 1989, c. 797, §§7,37,38 (RP). 1989, c. 843, §1 (AMD). 1991, c. 377, §9 (AMD).

§2304-A. RATE FILINGS

1. Every insurer shall file with the superintendent, except as to inland marine risks, which by general custom of the business are not written according to manual rates or rating plans, every manual rate, minimum premium, class rate, rating schedule or rating plan and every other rating rule, and every modification of any of the foregoing that it proposes to use. The filing must state the effective date of the filing and indicate the character and extent of the coverage contemplated. The filing must be made not less than 30 days in advance of the stated effective date unless that 30-day requirement is waived by the superintendent. The superintendent shall act on a filing no later than 30 days from receipt unless an extension is requested by the filer. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

A. [1991, c. 377, §10 (RP).]

B. [1991, c. 377, §10 (RP).]

C. [1991, c. 377, §10 (RP).]

D. [1991, c. 377, §10 (RP).]

E. [1991, c. 377, §10 (RP).]

F. [1991, c. 377, §10 (RP).]

G. [1991, c. 377, §10 (RP).]

H. [1991, c. 377, §10 (RP).]

[2009, c. 14, §1 (AMD) .]

2. Every insurer must file or incorporate by reference material that has been approved by the superintendent at the time rates are filed, including all supplementary rating, and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include or reference:

A. The experience or judgment of the insurer or information filed by an advisory organization on behalf of the insurer as permitted by sections 2321-D and 2321-E; [1991, c. 377, §10 (RPR).]

B. The insurer's interpretation of any statistical data upon which it relies; [1991, c. 377, §10 (RPR).]

C. The experience of other insurers or advisory organizations; or [1991, c. 377, §10 (RPR).]

D. Any other relevant factors. [1991, c. 377, §10 (RPR).]

[1991, c. 377, §10 (RPR) .]

3. An advisory organization filing of prospective loss costs and supplementary rating information must be filed for approval at least 60 days before it becomes effective. This period may be extended by the superintendent for an additional period not to exceed 60 days if written notice is given to the advisory organization that additional time is needed for the consideration of the filing. Upon written application by the advisory organization, the superintendent may authorize a filing that has been reviewed to become effective before the expiration of the waiting period or any extension of the waiting period. A filing is deemed to meet the requirements of this chapter unless disapproved by the superintendent within the waiting period or any extension of the waiting period.

If the superintendent has requested the advisory organization to furnish the information upon which it supports that filing, the waiting period commences as of the date that information is furnished.

[1991, c. 377, §10 (RPR) .]

4. When a filing is not accompanied by the information upon which the insurer supports that filing, the superintendent may require the insurer to furnish the information upon which it supports the filing.

Any filing may be supported by the experience, or judgment if experience is not available, of the insurer or advisory organization making the filing, the experience of other insurers or advisory organizations or any other factors that the insurer or advisory organization determines relevant. A filing and any other supporting information are open to public inspection after the filing becomes effective.

[1991, c. 377, §10 (RPR) .]

5. Specific inland marine rates on risks specially rated, made by an advisory organization, must be filed with the superintendent, become effective when filed, and are deemed approved and in compliance with the requirements of this chapter until the superintendent rejects the filing.

[1991, c. 377, §10 (RPR) .]

6. Filings of rates to be utilized in connection with one or more mass marketing plans as defined in section 2932 must clearly identify their applicability to those plans.

[1991, c. 377, §10 (RPR) .]

7. Except as provided in section 2304-C, a rate filing and its supporting data are confidential until the filing is approved.

[2005, c. 121, Pt. C, §1 (AMD) .]

8. Nothing in this chapter requires an advisory organization or its members or subscribers immediately to refile final rates or premium charges previously approved or lawfully in effect. Members or subscribers of an advisory organization are authorized to continue to use rates or premium charges approved or lawfully in effect before the effective date of this chapter.

[1991, c. 377, §10 (RPR) .]

SECTION HISTORY
1989, c. 797, §§8,37,38 (NEW). 1989, c. 843, §2 (NEW). 1991, c. 377, §10 (RPR). 2003, c. 671, §A1 (AMD). 2005, c. 121, §C1 (AMD). 2007, c. 188, Pt. B, §1 (AMD). 2009, c. 14, §1 (AMD).

§2304-B. REFERENCE FILINGS

1. An insurer may satisfy its obligations to make rate filings by becoming a participating insurer of a licensed advisory organization that makes reference filings of advisory prospective loss costs and by authorizing the superintendent to accept reference filings on its behalf. The insurer's rates are the prospective loss costs filed by the advisory organization that have been approved in accordance with section 2321-E combined with the modifications and expense and profit factors filed by the insurer.

[1989, c. 797, §8 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

2. An insurer may request that its expense and profit factors and its loss cost modifications remain on file with the superintendent. Upon approval of an advisory organization loss cost reference filing, the insurer's rates are the combination of the approved prospective loss costs and the insurer's expense and profit factors and its loss cost modification filed with the superintendent.

[1989, c. 797, §8 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

3. If an insurer has authorized an advisory organization to file prospective loss cost information on its behalf, the insurer must make a filing with the superintendent pursuant to section 2304-A if it intends to delay, modify or in any way not adopt an approved loss cost filing.

[1989, c. 797, §8 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

4. An insurer's expense and profit factors and loss cost modifications must remain in effect until the insurer withdraws or refiles new factors pursuant to section 2304-A. The superintendent may request that an insurer provide supporting information for the filed expense and profit factors and loss cost modifications at any time.

[1989, c. 797, §8 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1989, c. 797, §§8,37,38 (NEW).

§2304-C. PHYSICIANS AND SURGEONS LIABILITY INSURANCE RATES

Physicians and surgeons liability insurance rate filings are first subject to this section, but any other provisions of this chapter not inconsistent with this section also apply. Notwithstanding this section, filings made by advisory organizations are subject to this section only to the extent permitted by law, and laws prohibiting activities or the filing of certain information by advisory organizations supersede the provisions of this section. [1991, c. 377, §11 (NEW).]

1. **Contents of filing.** Every filing subject to this section must include the data, statistics, schedules or information necessary for the superintendent to determine whether the filing complies with this chapter. The superintendent may waive any noncompliance with this subsection if the superintendent determines that the noncompliance is immaterial. The required information includes, but is not limited to:

A. Rates:

(1) Current rates by rating class at basic limits and larger optional limits of coverage; and

(2) Proposed rates by rating class at basic limits and larger optional limits of coverage; [1991, c. 377, §11 (NEW).]

B. Historical experience:

(1) Maine total limits premium, paid claims, paid allocated loss adjustment expenses, incurred claims, incurred allocated loss adjustment expenses, and incurred loss ratio for not less than the 5 most recent years available;

(2) Maine basic limits written or earned premium or exposure, paid claims, paid allocated loss adjustment expenses, incurred claims, incurred allocated loss adjustment expenses, and incurred loss ratio or pure premium for not less than the 5 most recent years available; and

(3) Any other experience used to support the proposed changes; [1991, c. 377, §11 (NEW).]

C. Adjustment factors:

(1) Premiums or exposure at basic limit adjusted to current rate level or exposure, and a description of the method used to adjust historical earned premium or exposure to current level;

(2) Loss development exhibits showing the change in paid and incurred losses and allocated loss adjustment expenses from period to period, evaluated at least annually, and an explanation of the loss development method used to project the ultimate value of claims and allocated loss adjustment expenses;

(3) Trend factor calculations and application, including the following:

(a) An explanation of the trending procedure and assumptions;

(b) Trend based on experience in this State as well as other actuarially sound sources of trend information; and

(c) Frequency and severity trend factor calculations, shown separately; and

(4) Credibility weighting of alternative sources of data, including a description of the methodology used and the appropriateness of the method to its use in the filing; [1991, c. 377, §11 (NEW).]

D. Classification exposure, premium and loss experience in the State for not less than the 5 most recent years available, and other experience determined to be credible in selecting the proposed classification relativities. Classification experience must be provided in any filing in which the filer has proposed changes to the classification relativities, but not less frequently than every 3 years; [1991, c. 377, §11 (NEW).]

E. Expense provisions used in developing the proposed rates, an explanation of the procedure used to develop these provisions, and the actual historical expenses for each of the 3 most recent years available in the following categories: commissions; other acquisition expenses; general expenses; taxes, licenses and fees; unallocated loss adjustment expenses; and other expenses; [1991, c. 377, §11 (NEW).]

F. An evaluation of any law changes that will become effective during the period in which rates will be in effect or any law changes in effect but not evaluated in a prior filing and not reflected in the reported experience; [1991, c. 377, §11 (NEW).]

G. An estimate of the investment income that will be earned on loss and loss adjustment expense reserves and unearned premium reserves during the period the rates are to be in effect and claims remain unpaid, and evidence that the filing gives full consideration to that estimated income. The filing must include the expected expense and claim payout pattern and an explanation of the derivation of the payout pattern; and [1991, c. 377, §11 (NEW).]

H. Information regarding cost or expense control programs, procedures or practices implemented by the filer to improve efficiency of the company or to control or limit premium charges to insureds. [1991, c. 377, §11 (NEW).]

[1991, c. 377, §11 (NEW) .]

2. **Additional information.** The superintendent may require, at any time, any additional information the superintendent determines necessary.

[1991, c. 377, §11 (NEW) .]

3. **Assertion of confidential status.** Any insurer, rating organization or advisory organization that asserts that any portion of a filing is entitled to confidential status for purposes of subsection 5, shall identify that portion of the filing at the time of filing and shall state the basis for the assertion.

[1991, c. 377, §11 (NEW) .]

4. **Notice of filing.** The superintendent shall maintain a list of all persons who request notice of physicians and surgeons liability insurance rate filings. Within 10 days of receipt of such a rate filing, the superintendent shall notify each person on that list.

[1991, c. 377, §11 (NEW) .]

5. **Interested persons.** Immediately after receiving a filing under this section, the superintendent shall grant access to the entire filing, including confidential information, to any interested person who pays premiums for physicians and surgeons liability coverage to the company that made the filing, and to any person or organization representing a group of such persons. Any person who has access to confidential information under this section shall maintain the confidentiality of that information by means of a confidentiality agreement or pursuant to a protective order of the superintendent.

[1991, c. 377, §11 (NEW) .]

6. **Public hearing.** The superintendent may hold a public hearing on any filing, as provided in sections 229 to 235. At the request of any person described in subsection 5, the superintendent shall, as required by section 229, hold a public hearing on the filing.

[1991, c. 377, §11 (NEW) .]

7. **Procedures; rules.** The superintendent may adopt rules under Title 5, chapter 375, establishing procedures for the administration of this section.

[1991, c. 377, §11 (NEW) .]

SECTION HISTORY
1991, c. 377, §11 (NEW).

§2305. EXEMPTION FROM FILING

Under such rules and regulations as may be adopted, the superintendent may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and advisory organizations affected thereby. The superintendent may make such examination as determined advisable to ascertain whether any rates affected by such order meet the standards set forth in section 2303, subsection 1, paragraph B. [1989, c. 797, §9 (AMD); 1989, c. 797, §§37, 38 (AFF).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§9,37,38 (AMD).

§2306. DISAPPROVAL OF FILING

1. If at any time the superintendent has reason to believe that a filing does not meet the requirements of this chapter, or violates any of the provisions of chapter 23, the superintendent shall, after a hearing held upon not less than 10 days' written notice, specifying the matters to be considered at such hearing, to every insurer and advisory organization which made such filing, issue an order specifying in what respects the superintendent finds that such filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Copies of the order shall be sent to every such insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

[1989, c. 797, §10 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

2. No such order shall be issued by the superintendent with respect to the rate of an insurer, if such rate is one used by any other insurer, unless such order applies equally to all insurers using such rate. Such order may be issued to an insurer without being applicable to all other insurers using the same rate, if the basis for such order is that the insurer affected thereby could not otherwise, with safety to the public and to its policyholders, be permitted to continue to transact business.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 402, §5 (AMD). 1973, c. 585, §12 (AMD). 1989, c. 797, §§10,37,38 (AMD).

§2307. LIMITATION OF DISAPPROVAL POWER

No manual of classifications, rules, rating plans, or any modification of any of the foregoing which establishes standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to section 2304, shall be disapproved if the rates produced meet the requirements of this chapter and chapter 23. [1977, c. 78, §158 (RPR).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §35 (AMD). 1969, c. 402, §6 (AMD). 1977, c. 78, §158 (RPR).

§2308. EXCESS RATES

1. A rate in excess of that provided by a filing otherwise applicable may be used on any specific risk, providing that the following requirements are satisfied.

A. The insurer files a written application with the superintendent signed by the insured or applicant stating the reasons for the request. [1989, c. 797, §11 (AMD); 1989, c. 797, §§37, 38 (AFF).]

B. The superintendent assents to the use of an excess rate for the specific risk. [1987, c. 337, (NEW).]

[1989, c. 797, §11 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

2. To promote the availability of coverage in lines of insurance when coverage is difficult to obtain or unavailable, a form more restrictive than that provided by filings otherwise applicable may be used on any specific risk, provided that the following requirements are satisfied.

A. The restrictive form and applicable rates are filed with the bureau. [1987, c. 337, (NEW).]

B. A disclosure statement detailing the nature of the restriction or restrictions contained in the form and the manner in which the provisions of the restrictive form differ from an otherwise applicable filing is provided to and acknowledged by the applicant for insurance. [1987, c. 337, (NEW).]

C. A copy of the disclosure statement and the written application for insurance submitted by the applicant are submitted to the bureau. [1987, c. 337, (NEW).]

D. The superintendent does not disapprove the use of the restrictive form in the specific case. [1987, c. 337, (NEW).]

[1995, c. 329, §32 (AMD) .]

3. At any subsequent policy renewal in which additional or different restrictive policy forms or excess rates are employed, the provisions of this section must again be satisfied.

[1995, c. 329, §33 (NEW) .]

4. Notification to the superintendent of cancellation or nonrenewal of a policy containing restrictive forms or employing excess rates is required within 30 days following cancellation or nonrenewal of the policy.

[1995, c. 329, §33 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1987, c. 337, (RPR). 1989, c. 797, §§11,37,38 (AMD). 1995, c. 329, §§32,33 (AMD).

§2309. RATING ORGANIZATIONS -- FILINGS FOR MEMBERS AND SUBSCRIBERS AUTHORIZED

(REPEALED)

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §36 (AMD). 1973, c. 585, §12 (AMD). 1989, c. 797, §§12,37,38 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B3 (RP).

§2310. WORKERS' COMPENSATION RATING ORGANIZATIONS -- LICENSING

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 767, §20 (AMD). 1977, c. 694, §§416,417 (AMD). 1989, c. 797, §§13,37,38 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B4 (RP).

§2311. SUBSCRIBERS TO WORKERS' COMPENSATION RATING ORGANIZATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§14,37,38 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B5 (RP).

§2312. NOTICE OF CHANGES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§15,37,38 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B6 (RP).

§2313. RULES NOT TO AFFECT DIVIDENDS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 797, §§16,37,38 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B7 (RP).

§2314. TECHNICAL SERVICES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 797, §§16,37,38 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B7 (RP).

§2315. STAMPING BUREAU

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §17 (AMD). 1989, c. 797, §§37, 38 (AFF). 2011, c. 320, Pt. A, §7 (RP).

§2316. ADHERENCE TO FILINGS

No insurer shall make or issue a contract or policy, except in accordance with the filings which are in effect for the insurer as provided in this chapter or in accordance with sections 2305 (exemption from filing) or 2308 (excess rates). This section shall not apply to contracts or policies for inland marine risks as to which filings are not required. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2317. DEVIATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1983, c. 551, §2 (AMD). 1989, c. 797, §§18,37,38 (RP).

§2318. APPEAL FROM RATING ORGANIZATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 767, §21 (AMD). 1989, c. 797, §§19,37,38 (RP).

§2319. APPEAL BY INSUREDS AS TO FILINGS

1. **Application to the superintendent.** Any insured aggrieved with respect to any filing, rate, expense or premium level that is in effect may make a written application to the superintendent for a hearing. The application must specify the grounds to be relied upon by the applicant in asserting that the filing, rate, expense or premium level is unjust or unreasonable.

A. [1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RP).]

B. [1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RP).]

[1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RPR) .]

2. **Responsive filing and hearing.** If the superintendent finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds were established and that such grounds otherwise justify holding a hearing, the superintendent shall, by written order, require that the insurer, advisory organization or rating organization prepare within 30 days a responsive filing containing information necessary, in the judgment of the superintendent, to review the application. A public hearing may be conducted and, if conducted, must be at least 30 days from the date the responsive filing is determined complete by the superintendent.

A. [1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RP).]

B. [1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RP).]

C. [1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RP).]

[1991, c. 885, Pt. B, §13 (AFF); 1991, c. 885, Pt. B, §8 (RPR) .]

3. If, after such a hearing, the superintendent finds that the filing, rate, expense or premium level does not meet the requirements of this chapter, the superintendent shall issue a final order specifying in what respects the superintendent finds that the filing fails to meet the requirements of this chapter, or is unjust and

unreasonable, and stating when, within a reasonable period thereafter, the filing, rate, expense or premium level shall be changed, replaced or determined no longer effective. Copies of the order shall be sent to the applicant and to every insurer and rating or advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

[1989, c. 467, §1 (AMD); 1989, c. 797, §20 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 467, §1 (AMD). 1989, c. 797, §§20,37,38 (AMD). 1991, c. 885, §B8 (AMD). 1991, c. 885, §B13 (AFF).

§2320. INFORMATION FURNISHED INSUREDS; HEARINGS AND APPEALS OF INSUREDS

1. Every rating organization, advisory organization and insurer shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate, a prospective loss cost or supplementary rating information made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

[1989, c. 797, §21 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

2. Every rating organization, advisory organization and insurer shall provide within this State reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or through an authorized representative, on written request to review the manner in which such rating system has been applied in connection with the insurance afforded that person. If the rating organization, advisory organization or insurer fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if that application had been rejected. Any party affected by the action of such rating organization, advisory organization or such insurer on such request may, within 30 days after written notice of such action, appeal to the superintendent, who, after a hearing held upon not less than 10 days' written notice to the appellant and to such rating organization, advisory organization or insurer, may affirm or reverse such action.

[1989, c. 797, §21 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

3. Upon a request by a person aggrieved by the application of the rating system or an insurer, or either of their authorized representatives, the person aggrieved has the right to a hearing held by the superintendent without the matter first being heard by the rating organization or insurer pursuant to subsection 2. Such hearing must be held within 60 days following receipt by the superintendent of a written request for a hearing. At least 30 days' written notice of the date, time and place of the hearing, together with a reasonably accurate description of the subject matter of the hearing, must be provided by the superintendent to the person aggrieved, the insurer and the rating organization. Upon request by any party, the hearing may be continued to allow a reasonable period for conducting investigation of the matter, discovery and preparation of factual and legal materials for the hearing. Each party to a hearing is entitled to only one continuance. Prior to continuation of a hearing, the superintendent shall, upon not less than 5 days' notice to all parties, conduct an informal prehearing conference at which the parties shall identify the issues to be addressed at the hearing, establish a schedule for all investigation, discovery and hearing preparation reasonably necessary based upon the nature and scope of the hearing and establish a date certain for the hearing.

[1995, c. 317, §1 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§21,37,38 (AMD). 1995, c. 317, §1 (AMD).

§2320-A. COMPETITION AND AVAILABILITY OF INSURANCE

(REPEALED)

SECTION HISTORY
1989, c. 356, §1 (NEW). 1989, c. 878, §A67 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B9 (RP).

§2321. ADVISORY ORGANIZATIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §§37,38 (AMD). 1973, c. 585, §12 (AMD). 1989, c. 797, §§22,37,38 (RP).

§2321-A. LICENSING ADVISORY ORGANIZATIONS

1. No advisory organization may provide any service relating to the rates of any insurance subject to this chapter, and no insurer may utilize the services of that organization for those purposes unless the organization has obtained a license under subsection 3, paragraph C.

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

2. No advisory organization may refuse to supply any services for which it is licensed in this State to any insurer authorized to do business in this State and offering to pay the fair and usual compensation for the services.

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

3. The licensing of advisory organizations is governed by the following.

A. An advisory organization's application for a license must include:

(1) A copy of its constitution, charter, articles of organization, agreement, association or incorporation, and a copy of its bylaws, plan of operation and any other rules or regulations governing the conduct of its business;

(2) A list of its members and subscribers;

(3) The name and address of one or more residents of this State upon whom notices, process affecting it, or orders of the superintendent may be served;

(4) A statement showing its technical qualifications for acting in the capacity for which it seeks a license;

(5) A biography of the ownership and management of the organization; and

(6) Any other relevant information and documents that the superintendent may require. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

B. Every organization which has applied for a license must notify the superintendent of every material change in the facts or in the documents on which its application was based. Any amendment to a document filed under this section must be filed at least 30 days before it becomes effective. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

C. If the superintendent finds that the applicant and the natural persons through whom it acts are competent, trustworthy and technically qualified to provide the services proposed, and that all requirements of the law are met, the superintendent shall issue a license specifying the authorized activity of the applicant. The superintendent may not issue a license if the proposed activity would tend to create a monopoly or to lessen substantially the competition in any market. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

D. The superintendent may at any time, after hearing, revoke or suspend the license of an advisory organization that does not comply with the requirements and standards of this section. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1989, c. 797, §§23,37,38 (NEW).

§2321-B. INSURERS AND ADVISORY ORGANIZATIONS; PROHIBITED ACTIVITY

1. No insurer or advisory organization may:

A. Attempt to monopolize, or combine or conspire with any other person to monopolize an insurance market; or [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

B. Engage in a boycott, on a concerted basis, of an insurance market. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

2. No insurer may agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of any rate, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection or similar material, except as needed to develop statistical plans permitted by section 2323.

A. The fact that 2 or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently the same rates, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

B. Two or more insurers having a common ownership or operating in this State under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this chapter as if they constituted a single insurer. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

3. No insurer or advisory organization may make any arrangement with any other insurer, advisory organization, or other person that has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1989, c. 797, §§23,37,38 (NEW).

§2321-C. ADVISORY ORGANIZATIONS; PROHIBITED ACTIVITY

In addition to the other prohibitions described in section 2321-B, except as specifically permitted under section 2321-D, no advisory organization may compile or distribute recommendations relating to rates that include profit or expenses other than loss adjustment expenses. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

SECTION HISTORY
1989, c. 797, §§23,37,38 (NEW).

§2321-D. ADVISORY ORGANIZATIONS; PERMITTED ACTIVITY

An advisory organization, in addition to other activities not prohibited, is authorized on behalf of its members and subscribers to: [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

1. Develop statistical plans including territorial and class definitions;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

2. Collect statistical data from members, subscribers or any other source;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

3. Prepare and distribute prospective loss costs;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

4. Prepare and distribute factors, calculations or formulas pertaining to classification, territory, increased limits and other variables;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

5. Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expense provisions, profit provisions or minimum premiums;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

6. Distribute information that is required or directed to be filed with the superintendent;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

7. Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

8. Consult with public officials regarding public fire protection as it would affect members, subscribers and others;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

9. Conduct research and collect statistics in order to discover, identify and classify information relating to causes or prevention of losses;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

10. Prepare policy forms and endorsements and consult with members, subscribers and others relative to their use and application;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

11. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

12. Collect, compile and distribute past and current prices of individual insurers, and publish such information;

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

13. File final rates, at the direction of the superintendent, for residual market mechanisms; and

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

14. Furnish any other services, as approved or directed by the superintendent, related to those enumerated in this section.

[1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1989, c. 797, §§23,37,38 (NEW).

§2321-E. FILING OF PROSPECTIVE LOSS COSTS AND SUPPLEMENTAL INFORMATION

Advisory organizations may develop and file with the superintendent for approval prospective loss costs and supplementary rating information. Such filings shall contain the statistical data and supporting information for calculations or assumptions underlying the prospective loss costs. Advisory organization filings are subject to the provisions of sections 2303, 2304-A and 2304-B. [1989, c. 797, §23 (NEW); 1989, c. 797, §§37, 38 (AFF).]

SECTION HISTORY
1989, c. 797, §§23,37,38 (NEW).

§2322. JOINT UNDERWRITERS; JOINT REINSURERS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§24,37,38 (RP).

§2322-A. JOINT UNDERWRITING, JOINT REINSURANCE POOL AND RESIDUAL MARKET ACTIVITIES

1. Notwithstanding section 2321-B, subsection 2 and consistent with sections 2325, 2325-A, 2325-B and 2366, insurers, rating organizations and advisory organizations participating in joint underwriting, joint reinsurance pools or residual market mechanisms may, in connection with such activity, act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections

and investigations, the furnishing of loss and expense statistics or other information, or conducting research. Joint underwriting, joint reinsurance pools and residual market mechanisms are not considered to be advisory organizations.

[2003, c. 671, Pt. B, §1 (AMD) .]

2. Insurers, joint underwriters, joint reinsurance pools and residual market activities are regulated as follows.

A. Except to the extent modified by this section, insurers, joint underwriting, joint insurance pool and residual market mechanism activities are subject to the other provisions of chapters 23 and 25. [1989, c. 797, §25 (NEW); 1989, c. 797, §§37, 38 (AFF).]

B. If, after hearing, the superintendent finds that any activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of this chapter, the superintendent may issue a written order and require the discontinuance of such activity or practice. [1989, c. 797, §25 (NEW); 1989, c. 797, §§37, 38 (AFF).]

[1989, c. 797, §25 (NEW); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1989, c. 797, §§25,37,38 (NEW). 2003, c. 671, §B1 (AMD).

§2323. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE

1. The superintendent, acting pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, may promulgate reasonable rules and statistical plans, reasonably adopted to each of the rating systems on file , which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers be made available at least annually in such form and detail as may be necessary to aid the superintendent in determining whether rating systems comply with the standards set forth in section 2303. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this State and are not susceptible of determination by a prorating of countrywide expense experience. The superintendent may also adopt reasonable rules for companies to use in recording and reporting to the superintendent their rates and other information determined to be necessary or appropriate for the administration of this chapter and the effectuation of its purposes.

[1989, c. 797, §26 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

2. In promulgating such rules and plans, the superintendent shall give due consideration to the rating systems on file with him, and in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it.

[1973, c. 585, §12 (AMD) .]

3. The superintendent may designate one or more rating organizations, advisory organizations or other agencies to assist in gathering such experience and making compilations thereof, and such compilations shall be a public document.

[1989, c. 797, §27 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

4. Each insurer shall report its loss or expense experience to the lawful rating organization, advisory organization or agency of which it is a member or subscriber, but is not required to report its loss or expense experience to any rating organization, advisory organization or agency of which it is not a member or subscriber. Any insurer not reporting such experience to a rating organization, advisory organization or other agency may be required to report such experience to the superintendent. Any report of such experience of any insurer filed with the superintendent is confidential and may not be revealed by the superintendent to any other insurer or other person, but the superintendent may make compilations including such experience.

[2011, c. 320, Pt. A, §8 (AMD) .]

5. **Group self-insurer.** As used in this section, "insurer" shall include:

A. Insurer as defined in section 4; and [1979, c. 658, §2 (NEW).]

B. Group self-insurer as defined in Title 39-A, section 403. [1991, c. 885, Pt. E, §28 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

[1991, c. 885, Pt. E, §28 (AMD); 1991, c. 885, Pt. E, §47 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §418 (AMD). 1979, c. 658, §2 (AMD). 1989, c. 797, §§26,27,37, 38 (AMD). 1991, c. 885, §E28 (AMD). 1991, c. 885, §E47 (AFF). 2011, c. 320, Pt. A, §8 (AMD).

§2324. INTERCHANGE OF RATING PLAN DATA; CONSULTATION; COOPERATIVE ACTION IN RATE-MAKING

1. Acting in accordance with the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may promulgate reasonable rules and plans for the interchange of data necessary for the application of rating plans.

[1977, c. 694, §419 (RPR) .]

2. In order to further uniform administration of rate regulatory laws, the superintendent and every insurer, advisory organization and rating organization may to the extent consistent with this chapter exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to rate making and the application of rating systems.

[1989, c. 797, §28 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

3. Cooperation among rating organizations, advisory organizations and insurers in activities related to rate making or in other matters within the scope of this chapter is authorized, but the filings resulting from such cooperation are subject to all provisions of this chapter which are applicable to filings generally. The superintendent may review such cooperative activities and practices and if, after a hearing, the superintendent finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, the superintendent may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, and requiring the discontinuance of such activity or practice.

[1989, c. 797, §28 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §419 (AMD). 1989, c. 797, §§28,37,38 (AMD).

§2325. ASSIGNED RISKS

1. Agreements may be made among casualty insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the superintendent.

[1973, c. 585, §12 (AMD) .]

2. Every insurer undertaking to transact in this State the business of automobile and motor vehicle bodily injury, property damage liability, physical damage and medical payments insurance and every advisory organization that files rates for that insurance shall cooperate in the preparation and submission of a plan for the equitable apportionment among insurers of applicants for insurance who are in good faith entitled to, but who are unable to procure through ordinary methods, such insurance. Administration of the plan is the responsibility of the plan member insurers subject to regulatory oversight by the bureau. The plan must provide:

A. Reasonable rules governing the equitable distribution of risks by direct insurance, reinsurance or otherwise and their assignment to insurers; [1989, c. 797, §29 (AMD); 1989, c. 797, §§37, 38 (AFF).]

B. Rates and rate modifications applicable to such risks, which may not be excessive, inadequate or unfairly discriminatory; [1991, c. 667, §1 (AMD).]

C. The limits of liability that the insurer is required to assume, except that the maximum amount of physical damage coverage for commercial type vehicles must be determined by the superintendent based on the current cost of new vehicles but not to exceed a maximum amount of $100,000; and [1991, c. 667, §1 (AMD).]

D. A method whereby applicants for insurance, insureds and insurers may have a hearing on grievances and the right of appeal to the superintendent. [1989, c. 797, §29 (AMD); 1989, c. 797, §§37, 38 (AFF).]

[1991, c. 667, §1 (AMD) .]

3. The plan referred to in subsection 2 must be filed in writing with the superintendent. The superintendent shall review the plan as soon as reasonably possible after filing in order to determine whether it meets the requirements set forth in subsection 2, paragraphs A, B, C and D. The plan, unless sooner approved in writing, must be on file for a waiting period of 30 days before it becomes effective. The plan is deemed approved unless disapproved by the superintendent within the waiting period.

Subsequent to the waiting period, the superintendent may disapprove the plan on the grounds that it does not meet the requirements set forth in subsection 2, paragraphs A, B, C and D, but only after a hearing held upon not less than 10 days' written notice to every insurer and advisory organization affected, specifying the matters to be considered at the hearing, and only by an order specifying in what respect the superintendent finds that the plan fails to meet the requirements, and stating when within a reasonable period thereafter the plan is deemed no longer effective. That order does not affect any assignment made or policy issued or made prior to the expiration of the period set forth in the order. Amendments to the plan must be prepared, filed and reviewed in the same manner as provided in this subsection with respect to the original plan.

The superintendent may, as necessary and in accordance with the Maine Administrative Procedure Act, initiate rulemaking with respect to the plan.

[1991, c. 667, §2 (AMD) .]

4. When the plan referred to in subsection 2 or amendments thereto have been approved or promulgated, no insurer shall thereafter issue a policy of automobile and motor vehicle bodily injury, property damage liability, physical damage and medical payments insurance or undertake to transact such business in this State, unless such insurer shall participate in such an approved or promulgated plan.

[1969, c. 132, §1 (NEW) .]

5. If, after hearing, the superintendent finds that any activity or practice of any insurer or advisory organization in connection with the operation of the plan referred to in subsection 2 is unfair or unreasonable or otherwise inconsistent with this section, the superintendent may issue a written order specifying in what respects such activity or practice is unfair or unreasonable or otherwise inconsistent with this section and requiring the discontinuance of such activity or practice.

[1989, c. 797, §30 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

6. The maximum limits of liability insurance offered by the Maine Automobile Insurance Plan for a personal automobile policy may not be less than $250,000 per person for bodily injury liability, $500,000 per occurrence for bodily injury liability and $100,000 for property damage liability. A combined single limit of $500,000 may be offered as an alternative to the mandatory split limits for bodily injury liability and property damage liability.

[1991, c. 667, §3 (NEW) .]

7. When a notice of cancellation for nonpayment of premium is issued by the Maine Automobile Insurance Plan or by an insurer to which the insured has been assigned by the plan, any premium paid by the insured but unearned within the policy term must be returned to the insured within 10 working days from the effective date of cancellation.

[1991, c. 667, §3 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 423, (AMD).
1989, c. 797, §§29,30,37, 38 (AMD). 1991, c. 667, §§1-3 (AMD).

§2325-A. MARKET ASSISTANCE PLANS

1. **Establishment.** Whenever a particular type of insurance is unavailable or unaffordable, the superintendent may establish a market assistance plan.

[1987, c. 627, (NEW) .]

2. **Definition.** For purposes of this section a "market assistance plan" is a voluntary agreement between the Bureau of Insurance and insurers that the insurers will write insurance at an agreed upon rate for those persons or groups that are unable to obtain coverage.

[1987, c. 627, (NEW) .]

3. **Notification.** Whenever the superintendent determines that a market assistance plan is needed, the superintendent shall notify all insurers authorized to write the type of insurance covered by the plan that a market assistance plan is being established and their participation in the plan is requested.

[1987, c. 627, (NEW) .]

4. **Participation.** Each insurer receiving a notice referred to in subsection 3, shall respond within 30 days to the notice. Their response shall indicate the extent to which they are willing to participate and any reasons why they do not wish to participate or only wish to participate on a limited basis.

[1987, c. 627, (NEW) .]

5. **Report.** The superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance by January 30th of each year whether there is, or may be, within the year a lack of availability in any line of insurance.

[1987, c. 627, (NEW) .]

SECTION HISTORY
1987, c. 627, (NEW).

§2325-B. MANDATORY PROPERTY AND CASUALTY INSURANCE MARKET ASSISTANCE PROGRAM

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

A. "Basic property and casualty insurance" means policies that insure against loss or damage to real property that is used for residential purposes, is owner-occupied and consists of not more than 4 apartments, and that may also insure against loss or damage to tangible personal property and the legal liability of a natural person or persons for loss of, damage to or injury to persons or property. "Basic property and casualty insurance" may include standard homeowners package property and liability insurance, functional replacement homeowners package insurance, dwelling fire policies and extended coverage policies. "Basic property and casualty insurance" does not include automobile insurance, workers' compensation insurance or insurance primarily covering risks arising from the conduct of a commercial or industrial enterprise. [2003, c. 671, Pt. B, §2 (NEW).]

B. "Governing committee" means the committee established to operate the program pursuant to subsection 5. [2003, c. 671, Pt. B, §2 (NEW).]

C. "Member insurer" means an authorized insurer who is required to be a member of the program in accordance with subsection 3. [2003, c. 671, Pt. B, §2 (NEW).]

D. "Modified policy form" means any new or amended policy form developed by member insurers for risks written through the program. [2003, c. 671, Pt. B, §2 (NEW).]

E. "Modified rate" means any new or amended rate or rating rule developed by member insurers for risks written through the program. [2003, c. 671, Pt. B, §2 (NEW).]

F. "Modified policy form and rate filing" and "modified filing" mean any modified policy form and modified rate filed with the superintendent under subsection 9. [2003, c. 671, Pt. B, §2 (NEW).]

G. "Net direct premiums" means gross direct written premiums on basic property and casualty insurance in this State less return premiums upon cancelled contracts, irrespective of reinsurance assumed or ceded. [2003, c. 671, Pt. B, §2 (NEW).]

H. "Program" means the mandatory property and casualty insurance market assistance program described in this section. [2003, c. 671, Pt. B, §2 (NEW).]

I. "Underserved areas or risk types," "underserved areas" and "underserved risk types" mean specific geographic areas or property risk types in this State that the superintendent designates by rule as not having reasonable access to basic property and casualty insurance. [2003, c. 671, Pt. B, §2 (NEW).]

[2003, c. 671, Pt. B, §2 (NEW) .]

2. **Authority to establish program.** If the superintendent establishes a voluntary market assistance plan in accordance with section 2325-A to increase the availability of basic property and casualty insurance in this State and the superintendent determines after a public hearing that the number of insurers participating in the voluntary market assistance plan is insufficient or that a sufficient number of risks has not been written through the plan, then the superintendent may establish a mandatory property and casualty insurance market assistance program in accordance with this section. The superintendent shall adopt rules regarding the level of insufficient participation in the voluntary market assistance plan that is necessary for the establishment of a program under this section. The provisions in the rules governing a determination of insufficient participation in the voluntary market assistance plan must take into account the length of time the voluntary market assistance plan is operational.

[2003, c. 671, Pt. B, §2 (NEW) .]

3. **Mandatory insurer participation.** All insurers, except eligible surplus lines insurers, authorized to write and engaged in writing in this State, on a direct basis, basic property and casualty insurance shall cooperate in organizing a program as required by subsection 4. Every such insurer must be a member of the program and remain a member as long as the insurer has net direct premiums on basic property and casualty insurance in this State.

[2003, c. 671, Pt. B, §2 (NEW) .]

4. **Required action by superintendent.** If the superintendent determines that a program under this section should be established in accordance with the requirements of subsection 2, the superintendent shall:

A. Order member insurers to cooperate in the organization of the program; [2003, c. 671, Pt. B, §2 (NEW).]

B. Appoint the members of the governing committee in accordance with subsection 5; [2003, c. 671, Pt. B, §2 (NEW).]

C. Order the governing committee to develop a proposed plan of operation for the program in accordance with subsection 6, including a deadline for the submission of the plan; and [2003, c. 671, Pt. B, §2 (NEW).]

D. Initiate rulemaking in accordance with subsection 8. [2003, c. 671, Pt. B, §2 (NEW).]

[2003, c. 671, Pt. B, §2 (NEW) .]

5. **Governing committee.** The governing committee of the program consists of 8 members as follows:

A. Five members appointed by the superintendent who are full-time employees of member insurers; [2003, c. 671, Pt. B, §2 (NEW).]

B. Two members appointed by the superintendent who are licensed producers with property and casualty authority; and [2003, c. 671, Pt. B, §2 (NEW).]

C. The superintendent or the superintendent's designee, who serves as an ex-officio, nonvoting member. [2003, c. 671, Pt. B, §2 (NEW).]

The terms of members of the governing committee and process for filling vacancies must be established in the plan of operation pursuant to subsection 6.

[2003, c. 671, Pt. B, §2 (NEW) .]

6. **Plan of operation.** The program must be operated by the governing committee established under subsection 5 pursuant to a plan of operation approved by the superintendent. The governing committee shall develop a plan of operation and submit the plan to the superintendent for approval. If the superintendent disapproves the proposed plan of operation, the governing committee must, within 30 days, submit for review an appropriately revised plan of operation and, if the governing committee fails to submit such a plan or if the revised plan is also disapproved by the superintendent, the superintendent must develop a plan of operation consistent with this section. The governing committee may, on its own initiative or at the request of the superintendent, amend the plan of operation with the approval of the superintendent.

The plan of operation must:

A. Adopt a mechanism for the equitable apportionment of risks under the program, including the equitable distribution among member insurers of applications for basic property and casualty insurance to cover underserved areas or risk types from eligible applicants who are in good faith entitled to but who are unable to procure basic property and casualty insurance through ordinary methods in the voluntary admitted market; [2003, c. 671, Pt. B, §2 (NEW).]

B. Establish a methodology for the calculation and the payment of fees or commissions to producers with respect to eligible risks written through the program; [2003, c. 671, Pt. B, §2 (NEW).]

C. Require that member insurers write basic property and casualty insurance for eligible applicants to cover underserved areas or risk types in accordance with each member insurer's underwriting guidelines and rating rules applicable to risks written through the program to the extent not inconsistent with reasonable underwriting and rating rule limitations contained in rules adopted by the superintendent under subsection 8; [2003, c. 671, Pt. B, §2 (NEW).]

D. Permit the use of rate filings and policy forms by member insurers, including:

(1) The ability for member insurers to use existing forms and rates to write basic property and casualty insurance in the program;

(2) The authority for member insurers to file modified policy forms and modified rates in accordance with subsection 9, including permissible surcharges on those policies in accordance with limits established by the superintendent by rule; and

(3) The authority for the program to develop uniform policy forms and rates for use by member insurers subject to approval of the superintendent and the requirements of subsection 9; [2003, c. 671, Pt. B, §2 (NEW).]

E. Establish a procedure for the possible future creation of a risk pooling arrangement or reinsurance program for the distribution of the losses and expenses of basic property and casualty insurance written through the program; [2003, c. 671, Pt. B, §2 (NEW).]

F. Provide that a member insurer is entitled to receive credit for voluntarily writing basic property and casualty insurance in underserved areas or on underserved risk types and that the participation in the program of an insurer who does so must be reduced in accordance with the mechanism of apportionment and distribution established under paragraph A; [2003, c. 671, Pt. B, §2 (NEW).]

G. Establish a grievance process for applicants for insurance, insureds and member insurers with the program and a right to appeal those grievances to the superintendent after an initial decision by the governing committee; [2003, c. 671, Pt. B, §2 (NEW).]

H. Establish procedures for the inspection of properties by or on behalf of member insurers; [2003, c. 671, Pt. B, §2 (NEW).]

I. Establish a uniform process to inform owners of property in underserved areas or of underserved risk types of the specific circumstances and property characteristics that affect the insurability of the property including recommendations for improving the insurability of the property; [2003, c. 671, Pt. B, §2 (NEW).]

J. Require that in order for an applicant to purchase basic property and casualty insurance through the program, the applicant must produce proof of 2 declinations from authorized insurers other than eligible surplus lines insurers, to write insurance on the property. The plan of operation must allow one of the declinations to be in the form of a cancellation or nonrenewal notice unless coverage has been ordered to stay in effect pending the outcome of a hearing before the superintendent, in which case the cancellation or nonrenewal notice may only be used as a declination in the person's application to the program if the decision in the hearing is in favor of the insurer; [2003, c. 671, Pt. B, §2 (NEW).]

K. Establish a finite list of reasons a policy issued through the program may be cancelled, which may include nonpayment of premium, fraud or material misrepresentation; [2003, c. 671, Pt. B, §2 (NEW).]

L. Stipulate that cancellation of policies issued through the program may not be effective less than 20 days after receipt by the insured of the notice of cancellation or, if the cancellation is for nonpayment of premium, may not be effective less than 10 days after receipt by the insured of the notice of cancellation and that a postal certificate of mailing to the named insured at the insured's last known address is conclusive proof of receipt on the 5th calendar day after mailing; [2003, c. 671, Pt. B, §2 (NEW).]

M. Establish eligibility criteria for policies issued through the program, except that any eligibility criteria may not be inconsistent with the purposes for establishing the program; [2003, c. 671, Pt. B, §2 (NEW).]

N. Establish the limits of liability a member insurer is required to assume, except that for any policy issued through the program, the maximum amount of coverage for a dwelling on a residence premises does not exceed $300,000, the maximum limit for any liability coverage does not exceed $300,000 and any limits of liability for additional coverages, including coverage for loss or damage to other structures or tangible personal property or for loss of use, may not count toward the maximum coverage limits applicable to the dwelling or any liability coverage; [2003, c. 671, Pt. B, §2 (NEW).]

O. Establish procedures for the efficient, economical, fair and nondiscriminatory administration of the program; [2003, c. 671, Pt. B, §2 (NEW).]

P. Authorize the governing committee to assess member insurers for reasonable expenses incurred in administering the program; [2003, c. 671, Pt. B, §2 (NEW).]

Q. Establish procedures to govern a member insurer's withdrawal from the program; and [2003, c. 671, Pt. B, §2 (NEW).]

R. Include any other procedures or operational matters considered necessary by the governing committee with the approval of the superintendent. [2003, c. 671, Pt. B, §2 (NEW).]

[2003, c. 671, Pt. B, §2 (NEW) .]

7. **Operation of program contingent upon approval.** The program may not become operational until rules have been adopted as required by this section and the superintendent has approved the plan of operation in accordance with subsection 6.

[2003, c. 671, Pt. B, §2 (NEW) .]

8. **Rulemaking.** In accordance with subsection 4, the superintendent may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules under Title 5, chapter 375, subchapter 2-A. Rules adopted under this section may include:

A. The designation of underserved areas or risk types; [2003, c. 671, Pt. B, §2 (NEW).]

B. Reasonable limitations on underwriting guidelines applicable to all member insurers for the issuance of basic property and casualty insurance through the program; [2003, c. 671, Pt. B, §2 (NEW).]

C. A writing level based on net direct premiums under which an insurer may seek to limit its participation or seek exemption from participation in the program; [2003, c. 671, Pt. B, §2 (NEW).]

D. Maximum allowable caps on rating surcharges and limitations on rating rules for risks written through the program; [2003, c. 671, Pt. B, §2 (NEW).]

E. The process by which the superintendent may suspend or terminate the program; and [2003, c. 671, Pt. B, §2 (NEW).]

F. Any other provisions necessary to implement the requirements of this section. [2003, c. 671, Pt. B, §2 (NEW).]

[2003, c. 671, Pt. B, §2 (NEW) .]

9. **Modified policy form and rate filings.** A modified policy form and modified rate developed by a member insurer must be filed with the superintendent. A modified rate to be used in connection with an existing policy form that consists solely of a permissible surcharge not in excess of the maximum allowable cap contained in rules adopted under subsection 8 may be used by a member insurer immediately upon filing that modified rate with the superintendent. For any other modified filings, a modified policy form and modified rate must be filed with the superintendent not less than 30 days in advance of the stated effective date. A modified rate filing subject to the 30-day advance filing requirement must include any supplementary rating information to be used in conjunction with a rate and, to the extent available, sufficient supporting information to support a rate. A modified rate may not be excessive, inadequate or unfairly discriminatory with respect to risks written through the program. A modified policy form may only be disapproved for the grounds specified in section 2413. All modified policy form and rate filings are confidential until approved in accordance with applicable law.

[2011, c. 320, Pt. A, §9 (AMD) .]

10. **Immunity from liability for inspections.** There is no liability on the part of, and a cause of action does not arise against, member insurers, the program or the governing committee or agents or employees of any of them or the superintendent or the superintendent's authorized representatives with respect to any inspections to be undertaken by this section or for any acts or omissions in connection with those inspections or for any statements made in a report or communication concerning the insurability of the property.

[2003, c. 671, Pt. B, §2 (NEW) .]

11. **Superintendent's authority to suspend.** In the event of impairment or serious financial difficulty of a member insurer, the superintendent may suspend the application of the provisions of this section from applying to the financially distressed member insurer.

[2003, c. 671, Pt. B, §2 (NEW) .]

12. **Expiration of program.** A program established by the superintendent pursuant to this section expires 2 years from the date the program becomes operational unless terminated earlier by the superintendent or unless, after a public hearing, the superintendent determines, based on clear and convincing evidence, that continued operation of the program is necessary to address the unavailability of basic property and casualty insurance for underserved areas or risk types. For purposes of this subsection, the program becomes operational on the effective date of the first policy issued through the program. If the superintendent finds that continued operation of the program is necessary, then any person insured under the program must reapply for coverage as new business under the program at the next renewal date occurring after the date of the

superintendent's order to continue the program. Any policy written through the program that is in force when the program is terminated continues in force until its stated expiration date in accordance with the terms and conditions of the policy and the provisions in the plan of operation.

[2003, c. 671, Pt. B, §2 (NEW) .]

13. **Powers of superintendent.** In addition to any powers conferred upon the superintendent by this or any other law, the superintendent has authority to supervise the program and may:

A. Examine and investigate the operation of the program and member insurers through free access to all the books, records, files, papers and documents relating to their operation and may summon, qualify and examine as witnesses all persons having knowledge of such operations, including the governing committee and its officers, employees and agents; [2003, c. 671, Pt. B, §2 (NEW).]

B. Require reports from the program, the governing committee and member insurers concerning risks insured through the program as the superintendent considers necessary; [2003, c. 671, Pt. B, §2 (NEW).]

C. Approve or disapprove modified policy forms, modified endorsements, modified rates and modified rating and rule manuals for use by member insurers; and [2003, c. 671, Pt. B, §2 (NEW).]

D. Suspend or terminate the program in accordance with subsection 12 and any process established by rule. [2003, c. 671, Pt. B, §2 (NEW).]

[2003, c. 671, Pt. B, §2 (NEW) .]

14. **Penalties for violations.** The superintendent may take any action permitted under section 12-A against a member insurer or any other person required to be licensed under this Title who violates this section or any other applicable law or rule.

[2003, c. 671, Pt. B, §2 (NEW) .]

15. **Annual report.** On or before March 31st of each year, the governing committee shall submit a report detailing the program's operations for the previous calendar year to the superintendent and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters. The annual report is a public record within the meaning of Title 1, chapter 13, subchapter 1.

[2003, c. 671, Pt. B, §2 (NEW) .]

16. **Applicability of provisions.** Insurance provided through the program is subject to all other laws relating to that type of insurance, except policies issued through the program are not subject to section 3007 or to chapter 41, subchapter 5. In the event there is a conflict between any express provision in this section and any other applicable law, then the provisions of this section control. Notwithstanding sections 2162 and 2303, a member insurer may utilize underwriting guidelines, modified policy forms, modified rates and rating rules that differ from its voluntary business with respect to insurance issued through the program, as long as the program underwriting guidelines, modified policy forms, modified rates and rating rules comply with this section, the plan of operation and the rules adopted by the superintendent.

[2003, c. 671, Pt. B, §2 (NEW) .]

SECTION HISTORY
2003, c. 671, §B2 (NEW). 2011, c. 320, Pt. A, §9 (AMD).

§2326. FALSE OR MISLEADING INFORMATION

1. No person or organization shall wilfully withhold information from, or knowingly give false or misleading information to:

A. The superintendent; [1973, c. 585, §12 (AMD).]

B. Any statistical agency designated by the superintendent; or [1973, c. 585, §12 (AMD).]

C. Any rating or advisory organization, or any insurer which will affect the rates or premiums chargeable under this chapter. [1989, c. 797, §31 (AMD); 1989, c. 797, §§37, 38 (AFF).]

[1989, c. 797, §31 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

2. A violation of this section shall subject the one guilty of such violation to the penalties provided in section 2329.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§31,37,38 (AMD).

§2327. FLEET RATES

1. Two or more insurers, who, by virtue of their business associations in the United States, represent themselves to be or are customarily known as a "group" or similar insurance trade designation, may make the same filings or use the same rates for each such insurer, subject to the provisions of section 2303; and nothing contained in this chapter shall be construed to prohibit an agreement to make the same filings or use the same rates and concerted action in connection with such filings or rates by such insurers. This section shall not apply to 2 or more insurers who are not under the same common executive or general management or control and who act in concert in underwriting groups or pools.

[1969, c. 132, §1 (NEW) .]

2. This section shall not be deemed to prohibit or restrict any agreement or action otherwise lawful under section 2322 (joint underwriters; joint reinsurers).

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2328. EXAMINATIONS

The superintendent shall examine the affairs, transactions, accounts and records of each rating organization licensed in this State as provided in section 2310, of each advisory organization licensed in this State as provided in section 2321-A, and of joint underwriters and joint reinsurers as defined in section 2322-A, as often as the superintendent deems advisable, but not less frequently than once every 5 years. The examination must be conducted in the same manner and is subject to the same applicable provisions as apply to examination of insurers in chapter 3. The reasonable costs of any such examination must be paid by the organization or association so examined. In lieu of any such examination, the superintendent may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of such state. [1991, c. 885, Pt. B, §10 (AMD); 1991, c. 885, Pt. B, §13 (AFF).]

If the examination of a rating organization is satisfied by acceptance of another state's report on that rating organization, the superintendent shall submit a report to the joint standing committee of the Legislature having jurisdiction over banking and insurance concerning the superintendent's analysis of that report, any deficiencies noted by the superintendent or in the other state's report and what action has been taken to correct those deficiencies. [1989, c. 356, §2 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 356, §2 (AMD). 1991, c. 885, §B10 (AMD). 1991, c. 885, §B13 (AFF).

§2329. PENALTIES

1.

[1989, c. 797, §§37, 38 (AFF); 1989, c. 797, §32 (RP) .]

2. The superintendent may, after notice and opportunity for hearing, deny, revoke, suspend or limit the permissible activities of any rating or advisory organization or insurer which fails to comply with an order of the superintendent within the time period provided by the order.

[1989, c. 797, §33 (AMD); 1989, c. 797, §§37, 38 (AFF) .]

3.

[1977, c. 694, §421 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §§420,421 (AMD). 1989, c. 797, §§32,33,37, 38 (AMD).

§2330. APPEALS FROM SUPERINTENDENT

Any insurer, advisory organization or rating organization aggrieved by any order or decision of the superintendent may appeal therefrom as provided in section 236. [1989, c. 797, §34 (AMD); 1989, c. 797, §§37, 38 (AFF).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 797, §§34,37,38 (AMD).

Subchapter 2: WORKERS' COMPENSATION COMPETITIVE RATING ACT HEADING: PL 1987, C. 559, PT. A, §3 (RP)

§2331. TITLE

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2332. PURPOSES

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2333. DEFINITIONS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2334. SCOPE OF APPLICATION

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2335. COMPETITIVE MARKET

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2336. RATE STANDARDS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2337. RATING CRITERIA

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2338. FILING OF RATES AND OTHER RATING INFORMATION

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 141, §B23 (AMD). 1987, c. 559, §A3 (RP).

§2339. DISAPPROVAL OF RATES

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2340. MONITORING COMPETITION AND COMPLIANCE

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2341. UNIFORM ADMINISTRATION OF CLASSIFICATIONS; REPORTING OF RATES AND OTHER INFORMATION

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2342. PAYMENT OF DIVIDENDS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2343. UNIFORM EXPERIENCE AND MERIT RATING PLANS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1985, c. 719, §1 (AMD). 1987, c. 559, §A3 (RP).

§2344. SCHEDULE RATING

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2345. COMPLAINTS ON RATES OR FILINGS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2346. LICENSING ADVISORY ORGANIZATIONS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2347. INSURERS AND ADVISORY ORGANIZATIONS; PROHIBITED ACTIVITY

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2348. ADVISORY ORGANIZATIONS; PERMITTED ACTIVITY

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2349. ADVISORY ORGANIZATIONS; FILING REQUIREMENTS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2350. RESIDUAL MARKET MECHANISM

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1985, c. 719, §2 (AMD). 1987, c. 141, §B24 (AMD). 1987, c. 388, §§1,2 (AMD). 1987, c. 559, §A3 (RP).

§2351. SAFETY GROUPS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2352. EXAMINATIONS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2353. PENALTIES

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2354. JUDICIAL REVIEW

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2355. RATE CHANGE LIMITATIONS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2356. COSTS

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1987, c. 559, §A3 (RP).

§2357. NONSEVERABILITY

(REPEALED)

SECTION HISTORY
1985, c. 372, §B5 (NEW). 1985, c. 431, §1 (AMD). 1987, c. 559, §A3 (RP).

Subchapter 2-A: WORKERS' COMPENSATION RATES HEADING: PL 1991, C. 885, PT. B, §11 (RP)

§2361. TITLE

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1987, c. 769, §A93 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2362. WORKERS' COMPENSATION RATES

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2362-A. DISCLOSURE OF PREMIUM INFORMATION

(REPEALED)

SECTION HISTORY
1991, c. 615, §A3 (NEW). 1991, c. 615, §D27 (AFF). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2362-B. WORKPLACE HEALTH AND SAFETY CONSULTATIONS

(REPEALED)

SECTION HISTORY
1991, c. 615, §A4 (NEW). 1991, c. 615, §D27 (AFF). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2363. APPROVAL OF INSURANCE POLICIES AND RATES

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1987, c. 769, §§A94,A95 (AMD). 1989, c. 423, §§1-3 (AMD). 1989, c. 467, §2 (AMD). 1989, c. 502, §B23 (AMD). 1989, c. 673, §1 (AMD). 1989, c. 875, §E43 (AMD). 1991, c. 528, §CC1 (AMD). 1991, c. 528, §RRR (AFF). 1991, c. 591, §CC1 (AMD). 1991, c. 615, §§A5-9 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2364. UNIFORM CLASSIFICATION SYSTEM; EXPERIENCE AND MERIT RATING PLANS

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1987, c. 769, §A96 (AMD). 1991, c. 615, §§A10,C1 (AMD). 1991, c. 615, §D27 (AFF). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2365. OPTIONAL DEDUCTIBLES

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2365-A. MEDICAL EXPENSE DEDUCTIBLES

(REPEALED)

SECTION HISTORY
1991, c. 615, §A11 (NEW). 1991, c. 615, §D27 (AFF). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2366. WORKERS' COMPENSATION INSURANCE RESIDUAL MARKET MECHANISM

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1987, c. 769, §A97 (AMD). 1989, c. 780, §§1,2,9 (AMD). 1989, c. 854, §1 (AMD). 1991, c. 615, §§A12-17,C2 (AMD). 1991, c. 615, §D27 (AFF). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2367. WORKERS' COMPENSATION RATES; ANNUAL SURCHARGES AND CREDITS

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1987, c. 716, §§1,2 (AMD). 1989, c. 673, §§2,3 (AMD). 1989, c. 780, §§3-9 (AMD). 1989, c. 854, §§2,3 (AMD). 1991, c. 377, §§12,13 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2368. SAFETY GROUPS

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2369. EXAMINATIONS

(REPEALED)

SECTION HISTORY

1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2370. REPORT REGARDING REPORT ON UNSAFE WORK SITE

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2371. STATISTICAL RECORDING AND REPORTING

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1987, c. 769, §§A98,A99 (AMD). 1989, c. 434, §§1-6 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2372. PERIODIC PROFITABILITY REPORTS

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1989, c. 434, §7 (AMD). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2373. PENALTY FOR VIOLATIONS

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2374. PUBLIC ADVOCATE

(REPEALED)

SECTION HISTORY
1987, c. 559, §A4 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

§2375. WORKERS' COMPENSATION INSURANCE; REGISTRATION OF EMPLOYEE LEASING COMPANIES

(REPEALED)

SECTION HISTORY
1991, c. 468, §1 (NEW). 1991, c. 885, §B13 (AFF). 1991, c. 885, §B11 (RP).

Subchapter 2-B: WORKERS' COMPENSATION RATING ACT HEADING: PL 1991, C. 885, PT. B, §12 (NEW)

§2381. TITLE

This subchapter may be known and cited as the "Workers' Compensation Rating Act." [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2381-A. PURPOSES

The purposes of this Act are: [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

1. **Prohibition of certain behavior.** To prohibit price-fixing agreements and other anticompetitive behavior by insurers;

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Protection for policyholders and the public.** To protect policyholders and the public from the adverse effects of excessive, inadequate or unfairly discriminatory rates;

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Promotion of price competition.** To promote price competition among insurers so as to provide rates that are responsive to competitive market conditions;

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Provision of regulatory procedures.** To provide regulatory procedures for the maintenance of appropriate data reporting systems;

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Improvement of insurance.** To improve availability, fairness and reliability of insurance;

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

6. **Authorization of action.** To authorize essential cooperative action among insurers in the rate-making process and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly; and

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

7. **Encouragement of practices.** To encourage the most efficient and economical marketing practices.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2381-B. SCOPE OF APPLICATION

This Act applies to workers' compensation insurance and employers' liability insurance written in connection with workers' compensation insurance. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2381-C. DEFINITIONS

As used in this Act, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

1. **Advisory organization.** "Advisory organization" means any entity that either has 2 or more member insurers or is controlled either directly or indirectly by 2 or more insurers and that assists insurers in activities related to workers' compensation rate making. Two or more insurers having a common ownership or operating in this State under common management or control constitute a single insurer for the purpose of this definition. "Advisory organization" does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management or their employees or manager.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Classification system or classification.** "Classification system" or "classification" means the plan, system or arrangement for recognizing differences in exposure to hazards among industries, occupations or operations of insurance policyholders.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Expenses.** "Expenses" means that portion of any rate attributable to acquisition and field supervision; collection expenses and general expenses; and taxes, licenses and fees.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Experience rating.** "Experience rating" means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit or unity modification.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Loss trending.** "Loss trending" means any procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

6. **Market.** "Market" means the interaction between buyers and sellers of workers' compensation and employers liability insurance within this State pursuant to this Act.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

7. **Pure premium rate.** "Pure premium rate" means that portion of the rate that represents the loss cost per unit of exposure including loss adjustment expense.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

8. **Rate.** "Rate" means the cost of insurance per exposure base unit, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

9. **Residual market.** "Residual market" means the instrument to provide coverage to employers not able to obtain coverage in the voluntary market.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

10. **Statistical plan.** "Statistical plan" means the plan, system or arrangement used in collecting data.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

11. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

12. **Supplementary rate information.** "Supplementary rate information" means any manual or plan of rates, classification system, rating schedule, minimum premium, policy fee, rating rule, rating plan and any other similar information needed to determine the applicable premium for an insured.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

13. **Supporting information.** "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required by the superintendent to be filed.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

14. **Voluntary market.** "Voluntary market" means the workers' compensation insurance market in which insurance companies voluntarily offer coverage to applicants who meet the insurers' underwriting standards or guidelines.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2382. RATE STANDARDS

The following standards apply to the making and the use of rates under this Act. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

1. **Rates.** Rates may not be excessive, inadequate, or unfairly discriminatory.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Excessive rates.** Voluntary and residual market rates are subject to the following.

A. Rates in the voluntary market are not excessive. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Rates in the residual market are excessive if they are likely to produce a long-term profit that is unreasonably high for the insurance provided and for surplus requirements or if expenses are unreasonably high in relation to services rendered. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Inadequate rates.** A rate is not inadequate unless insufficient to sustain projected losses and expenses and the use of the rate has had a tendency to create a monopoly or, if continued, will tend to create a monopoly in the market or will cause serious financial harm to the insurer.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Unfair discrimination.** Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Determination of compliance.** Determination of compliance with standards for rate factors, expenses and profits is as follows.

A. In determining whether rates comply with standards under this section, due consideration may be given to:

(1) Past and prospective loss and expense experience within and outside of the State;

(2) Catastrophe hazards and contingencies;

(3) Loadings for leveling premium rates over time;

(4) Dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers; and

(5) Past and prospective expenses, both countrywide and those specifically applicable to the State. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The expense provisions included in the rates to be used by an insurer must reflect the operating methods of the insurer, and, so far as credible, its own actual and anticipated expense experience. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. Rates may contain provision for contingencies and allowance permitting a reasonable profit. In determining the reasonableness of profit, consideration must be given to all investment income attributable to premiums, the reserves associated with those premiums and the amount of capital and surplus allocable to the coverage of risks in the State. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2382-A. PAYMENT OF DIVIDENDS

Nothing in this Act prohibits or regulates the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, but in the payment of such dividends there may be no unfair discrimination between policyholders. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

A plan for the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers is not a rating plan or system. [1991, c. 885, Pt. A, §12 (NEW); 1991, c. 885, Pt. A, §13 (AFF).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2382-B. UNIFORM ADMINISTRATION OF CLASSIFICATIONS; REPORTING OF RATING AND OTHER INFORMATION; MEMBERSHIP IN ADVISORY ORGANIZATION

1. **Uniform classification system; uniform experience rating plan.** Every workers' compensation insurer, including self-insurers, shall adhere to a uniform classification system and uniform experience rating plan filed with the superintendent by an advisory organization designated by the superintendent and subject to the superintendent's disapproval. An insurer may develop subclassifications of the uniform classification system upon which a rate may be made; provided, however, that such subclassifications must be filed with the superintendent 30 days prior to their use. The superintendent shall disapprove a subclassification if:

A. The insurer fails to demonstrate that the data produced can be reported consistently with the uniform statistical plan and classification system; or [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The proposed subclassification:

(1) Is not reasonably related to the exposure to claim;

(2) Is not adequately defined;

(3) Has not been shown to distinguish among insureds based on the potential for or hazard of loss; or

(4) Is or will be unfairly discriminatory. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Designation of advisory organization.** The superintendent shall designate an advisory organization to assist the superintendent in gathering, compiling and reporting relevant statistical information. Every workers' compensation insurer shall record and report its workers' compensation experience to the designated advisory organization as set forth in the uniform statistical plan approved by the superintendent.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Filing of manual rules.** The designated advisory organization shall develop and file manual rules, subject to the approval of the superintendent, reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and the uniform classification system. Every workers' compensation insurer shall adhere to the approved manual rules and experience rating plan

in writing and reporting its business. An insurer may not agree with any other insurer or with an advisory organization to adhere to manual rules that are not reasonably related to the recording and reporting of data pursuant to the uniform classification system or the uniform statistical plan.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Advisory organization membership.** Each workers' compensation insurer shall be a member or subscriber of the workers' compensation advisory organization designated by the superintendent.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2382-C. FILING OF RATES AND OTHER RATING INFORMATION; FILING OF FORMS

1. **Prefiling required.** Every insurer shall file with the superintendent all rates and supplementary rate information to be used in the State, except as filed by an advisory organization as provided in section 2384-A. Such rates and supplementary rate information must be filed at least 30 days prior to the stated effective date. An insurer may adopt by reference, with or without deviation, the rates and supplementary rate information filed by another insurer. Upon application by the filer, the superintendent may authorize an earlier effective date.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Form and manner of filing.** Rates filed pursuant to this section must be filed in a form prescribed by the superintendent. If a filing is not accompanied by the information the superintendent has required under this section, the superintendent shall notify the insurer as soon as possible and the filing is deemed as not made until the information is provided. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 14, §2 (AMD) .]

3. **Public records.** All rates, supplementary rate information and any supporting information for risks filed under this Act are, as soon as filed, public records within the meaning of Title 1, chapter 13.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Additional period.** The period during which the filing may not become effective may be extended by the superintendent for an additional period not to exceed 60 days if the superintendent gives written notice to the insurer or advisory organization that made the filing that the superintendent needs additional time for consideration of the filing.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Advisory organization.** Subject to the provisions of this Act, the designated workers' compensation and advisory organization shall file with the superintendent:

A. Workers' compensation pure premium rates and rating plans; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Workers' compensation policy forms and endorsements to be used by its members; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. The uniform experience rating plans and rules; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. The uniform classification plan and rules; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

E. A uniform statistical plan and rules; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

F. Any other information that the superintendent requests. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

6. **Approved forms.** Every insurance company issuing workers' compensation insurance policies covering the payment of compensation and benefits shall use only policy forms filed and approved pursuant to section 2412. Filings required by that section may be made on behalf of members and subscribers by an approved advisory organization.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 2009, c. 14, §2 (AMD).

§2382-D. UNIFORM EXPERIENCE RATING PLAN; MERIT RATING PLAN

1. **Required contents.** The experience rating plan required under section 2382-C must contain:

A. Reasonable eligibility standards; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Incentives for loss prevention; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. Sufficient premium differentials to encourage safety; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. Provisions for reasonable and equitable limitations on the ability of policyholders to avoid the impact of past adverse claims experience through change of ownership, control, management or operation. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Experience rating.** The uniform experience rating plan must be the exclusive means for providing premium adjustments based on the past claim experience of an insured employer. The experience rating plan must provide that the claims experience for the 3 most recent years for which data is available be considered on the following bases.

A. The claims and exposure for the most recent year for which data is available must be given 40% weight. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The claims and exposure for the 2nd most recent year for which data is available must be given 35% weight. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. The claims and exposure for the 3rd most recent year for which data is available must be given 25% weight. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

If data is available for only 2 years of experience, the weighting must be 60% for the most recent year and 40% for the 2nd most recent year.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Merit rating.** If an insured is not eligible for the experience rating plan, a merit rating plan must be applied using the following guidelines.

A. A plan must provide for the following credits or debits to be applied to the otherwise applicable manual premium, based on the number of lost-time claims of the insured during the most recent 3-year period for which statistics are available:

(1) No claims or a loss ratio of less than 1.0, an 8% credit;

(2) One claim resulting in a loss ratio greater than 1.0, no credit or debit; and

(3) Two or more claims resulting in a loss ratio greater than 1.0, an 8% debit. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The insurer shall notify the insured of the premium adjustment and the reason for the adjustment. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Prior lost-time work-related injury.** The experience rating or merit rating plan may not permit, in the calculation of experience modification factors, consideration of those lost-time claims attributable to work-related injuries that are aggravations of, or combine with, any prior lost-time work-related injury to produce incapacity. The superintendent shall adopt rules to protect employers from the impact of these subsequent injury claims and to equitably compensate insurers that provide coverage to these employers.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Retrospective rating.** Nothing in this section prevents an insurer or an advisory organization from filing rating plans that provide for retrospective premium adjustments based on the insured's experience during the policy period. Except as provided in section 2386, subsection 8, in the voluntary market and the residual market retrospective rating plans must be voluntary and may not be used without the prior consent of the insured.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

6. **Dividend plan.** Nothing in this section prohibits an insurer from developing and operating a dividend plan based on the loss experience of the insured.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2382-E. DISAPPROVAL OF RATES

1. **Timing of disapproval.** A rate that is found not to be in compliance with applicable sections of this Act may be disapproved at any time.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Basis of disapproval.** The superintendent may disapprove a rate if the insurer fails to comply with the filing requirements under section 2382-C.

The superintendent shall disapprove a rate for the voluntary market if there is a finding that the rate is inadequate or unfairly discriminatory using the standards in section 2382.

The superintendent shall disapprove a rate for use in the residual market if there is a finding that the rate is excessive, inadequate or unfairly discriminatory, using the standards in section 2382.

The superintendent may disapprove, pursuant to this subsection, without hearing, rates that have not become effective. An insurer whose rates have been disapproved must be notified of the reason for disapproval and must be given a hearing upon a written request made within 30 days after the disapproval order.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Discontinuance of a rate; interim rates.** Discontinuance of a rate and interim rates are subject to the following.

A. If the superintendent finds that a rate is not in compliance with the standards of section 2382 or is in violation of section 2382-C, the superintendent shall order that its use be discontinued for any policy issued or renewed after the date of the order, and the order may prospectively provide for premium adjustment of any policy then in force. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Whenever an insurer has no legally effective rates as a result of the superintendent's disapproval of rates or other act, the superintendent shall, on request of the insurer, specify interim rates for the insurer that are adequate to protect the interests of all parties and may order that a specified portion of the premiums be placed in a special reserve established by the insurer and approved by the superintendent. When new rates become legally effective, the superintendent shall order the specially reserved funds or any overcharge in the interim rates to be distributed appropriately, except that adjustments that are minimal may not be required. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2382-F. REPORT REQUIRED

In order to comply with Title 26, section 61, subsection 1-A, on or before March 1st of each year, every workers' compensation insurer shall file a report with the superintendent showing the amount of total actual paid workers' compensation losses and the total actual paid workers' compensation medical payments for the previous calendar year. [1997, c. 126, §3 (NEW).]

SECTION HISTORY
1997, c. 126, §3 (NEW).

§2383. INTERCHANGE OF DATA

1. **Exchange of information.** To further uniform administration of rate regulatory laws, the superintendent, insurers and the designated advisory organization may exchange information and experience data with insurance regulatory officials, insurers and advisory organizations in other states and may consult with them with respect to the rating plans permitted by this Act.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Cooperation.** Cooperation among advisory organizations or among advisory organizations and insurers in rating plans and other matters within the scope of this Act is authorized, but any filings resulting from such cooperation are subject to all provisions of this Act. The superintendent may review any such

cooperative activities and practices and if, after hearing, any such activity or practice is found to violate the provisions of this Act, the superintendent may issue an order requiring the discontinuance of the activity or practice and may take any other action as permitted by law.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2383-A. MONITORING COMPETITION

1. **Monitoring.** The superintendent shall monitor the degree of competition in the workers' compensation insurance market. The superintendent shall utilize existing relevant information and analytical techniques and may cause or participate in the development of new relevant information, analytical techniques and other sources.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Consideration of factors.** The superintendent shall consider, in addition to any other relevant factors, the following:

A. The number of insurers actively engaged in providing coverage; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Market shares and changes in market shares; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. Ease of entry and exit by insurers in and out of the workers' compensation insurance market; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. Tests relating to market structure, market performance and market conduct. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Degree of competition.** The superintendent shall consider approved self-insured employers when evaluating the degree of competition in the insurance market. The superintendent shall report by November 1, 1994 and annually thereafter on the status of the market to the Governor and to the joint standing committee of the Legislature having jurisdiction over workers' compensation insurance rate regulation matters.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2384. WORKERS' COMPENSATION ADVISORY ORGANIZATIONS

Sections 2321-A to 2321-D apply to workers' compensation insurers and advisory organizations to the extent not inconsistent with this Act. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2384-A. ADVISORY ORGANIZATION FILING REQUIREMENTS

1. **Filing.** Every advisory organization shall file with the superintendent every pure premium, manual of rating rules, rating schedule and change, amendment or modification of the foregoing proposed for use in the State at least 30 days prior to the proposed effective date.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Effective date.** The superintendent may extend the proposed effective date for an additional period not to exceed 60 days if the superintendent gives written notice to the advisory organization that made the filing that the superintendent needs additional time for consideration of the filing. The superintendent may require any additional information necessary to evaluate the filing.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Disapproval.** The superintendent may disapprove, without hearing, an advisory organization filing that has not become effective if the pure premiums are excessive, inadequate or unfairly discriminatory or if the rating rules or rating procedure would produce premiums that are excessive, inadequate or unfairly discriminatory. If the pure premium rates, rating rules or rating schedule has been disapproved, the advisory organization must be notified of the reason for disapproval and must be given a hearing upon a written request made within 30 days after the disapproval order.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2384-B. STATISTICAL RECORDING AND REPORTING

1. **Collection and reporting system.** The statistical advisory organization designated pursuant to section 2382-B, subsection 2 shall develop and file with the superintendent a plan that includes a comprehensive data collection and reporting system for insurers. The purpose of the system is to permit the superintendent, in a timely manner, to analyze insurance rates and claims practices of insurers.

[2011, c. 83, §1 (AMD) .]

2. **Data collected.** The data collection and reporting system must contain, at a minimum, the following:

A. Basic information on each claim, including:

(1) Name, address and identification information of the employee, employer and insurer or self-insurer;

(2) File identification number or numbers, insurance policy number and occupation and classification codes;

(3) Date of hire, age of employee at injury and employee's prior workers' compensation claim history; and

(4) Attorney, if any, and date of involvement; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Claims history information on each claim, including:

(1) Date of injury or exposure to disease, date of first report, type of injury or exposure disclosure and affected body part;

(2) Preinjury wage history, date of initial payment and date of notice of controversy, if any, together with the reason for denial;

(3) Date of maximum medical improvement;

(4) Identification of cumulative or opened claims; and

(5) Duration of wage loss period or periods; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. Information concerning former Workers' Compensation Commission and Workers' Compensation Board proceedings, including:

(1) For each informal conference, mediation and arbitration, the date, commissioner, hearing officer, mediator or arbitrator for the proceeding, involvement of attorney or other designated representative and the resolution; and

(2) For each hearing, the date, commissioner, hearing officer, involvement of attorney or other designated representative and the decision of the commissioner or the hearing officer. If a disputed claim results in multiple hearing dates, the decision must be reported for the last hearing date; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. Cost of payment information on each claim, identified as open or closed, including:

(1) Aggregate payments to date to any physician, hospital or other medical provider. The superintendent may require information on payments to date to any physician, hospital, medical rehabilitation provider or other medical provider, together with a description of the services, the name of the provider, the amount of payment and the date of service;

(2) Payments made to date for weekly compensation, impairment benefits, death benefits, funeral expenses, employee legal expenses, employer legal expenses, lump sums, witness fees, penalties, employment rehabilitation services with a description of the services and name of the rehabilitation provider, and any other type of payments under former Title 39 or Title 39-A;

(3) With respect to open claims, an estimate of total outstanding liability and separately stated outstanding liability for medical care, indemnity, employment rehabilitation and any other type of payments; and

(4) Identification, both on payments and outstanding liabilities, of benefit offsets for Social Security, unemployment insurance, employer-provided pensions and any other source. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

For medical only claims, the superintendent may establish a claim threshold under which the detailed claim reporting requirements of this subsection do not apply.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Special data calls.** The superintendent may, with prior notice, require the insurer and self-insurer statistical advisory organizations to conduct special data calls to collect information usable to evaluate the costs or operations of the workers' compensation system. Any special data call imposed by the superintendent under this provision must give due consideration to the information collected and maintained by insurers and self-insurers. Requests for information not being collected on the effective date of this subsection must be prospective.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Other data collection systems.** The statistical advisory organization may rely on data collected and reported by other data gathering organizations or agencies, such as the Workers' Compensation Board or the Department of Labor. If the statistical advisory organization is to incorporate data from other sources, it must satisfy itself that the data is sufficiently complete and accurate for the purposes for which it is to be used. The Workers' Compensation Board and the Department of Labor shall assist the statistical advisory

organization in the development and maintenance of a comprehensive data base by recording and making available information within the custody and control of each, respectively, pursuant to the request of the statistical advisory organization.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Noncompliance penalties.** The statistical advisory organization must include as part of its plan a means of monitoring member or subscriber compliance with the reporting requirements and must include a schedule of monetary penalties for failure to comply with reporting requirements.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

6. **Reports.** The superintendent shall prescribe the frequency of and schedule for reports by the statistical advisory organization. Reports must be required on at least an annual basis.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

7. **Rules.** The superintendent shall have the authority to adopt reasonable rules with respect to the recording and reporting of claim information, including the recording and reporting of expense or experience items that are not specifically applicable to the State but require an allocation of experience or expenses to the State.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

8. **Confidentiality.** Any report of information relating to a particular claim is confidential and may not be revealed by the superintendent, except that the superintendent may make compilations including this experience. Any information provided to the superintendent regarding self-insurance is confidential to the extent protected by Title 39-A, section 403.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

9. **Accuracy.** The statistical advisory organization shall take all reasonable steps to ensure the accuracy of the information provided to it and reported by it.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

10. **Claims covered.** This section applies to all claims occurring on or after January 1, 1989 and prior to January 1, 1993 and to all death, permanent total and major permanent partial claims occurring between January 1, 1987 and December 31, 1988; and to a reasonable sample, as approved by the superintendent, of all other indemnity claims occurring between January 1, 1987 and December 31, 1988. The superintendent may suspend the reporting requirements of specific items for periods when information that is to be obtained from the Workers' Compensation Board is temporarily unavailable.

[1995, c. 462, Pt. B, §5 (AMD) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 1993, c. 610, §1 (AMD). 1995, c. 462, §B5 (AMD). 2011, c. 83, §1 (AMD).

§2384-C. DATA COLLECTION

1. **Collection and reporting system.** The superintendent shall adopt rules implementing a data collection system for the purpose of evaluating the costs and operation of the workers' compensation benefit delivery process. The rules must establish reasonable sampling procedures to identify and track a sufficient number of claims to provide reliable information in a cost-effective manner. The superintendent shall, by

rule, establish a cost-effective procedure to designate organizations to collect and compile data for insurers, except that an insurer able to demonstrate its ability to collect, compile and report data on its own claims is permitted to act as its own statistical organization for the purposes of this section. In this section, "statistical organization" includes an insurer acting as its own statistical organization.

[2011, c. 83, §2 (AMD) .]

2. **Data collected.** The data collection and reporting system must contain, at a minimum, the following:

A. Basic information on each surveyed claim, including:

(1) The name and identification information of the employee, employer and insurer or self-insurer; and

(2) The file identification number or numbers, insurance policy number and classification claim history; [1993, c. 610, §2 (NEW).]

B. Claim history information on each claim surveyed, including:

(1) The date of injury or exposures to disease, type of injury or exposure disclosure and affected body part;

(2) The preinjury wage history, date of initial payment and whether claim is controverted; and

(3) Identification of claim status, whether open, closed or reopened; [1993, c. 610, §2 (NEW).]

C. Information concerning Workers' Compensation Board proceedings, including:

(1) For each mediation and arbitration, the date, hearing officer, mediator or arbitrator for the proceeding and the resolution; and

(2) For each hearing, the date, hearing officer and the decision of the hearing officer. If a disputed claim results in multiple hearing dates, the decision must be reported for the last hearing date; and [1993, c. 610, §2 (NEW).]

D. Payment information on each claim, identified as open or closed, including:

(1) Aggregate payments to date to physicians, hospitals or other medical providers;

(2) Payments made to date for weekly compensation, impairment benefits, death benefits and funeral expenses, employee legal expenses, employer legal expenses, lump sums and vocational rehabilitation services;

(3) With respect to all claims, separately stated incurred liability for medical care, indemnity and vocational rehabilitation; and

(4) Identification as to whether there are benefit offsets for social security, unemployment insurance, employer-provided pensions or any other sources. [1993, c. 610, §2 (NEW).]

[1993, c. 610, §2 (NEW) .]

3. **Special data calls.** The superintendent may, with prior notice, require the insurer and self-insurer statistical organizations to conduct special data calls or studies to collect information to evaluate the costs or operations of the workers' compensation system and to evaluate medical injury or disease outcomes of compensable claims. In any special data call imposed by the superintendent under this subsection, consideration must be given to the information collected and maintained by insurers and self-insurers. Requests for information not being collected on the effective date of this subsection must be prospective.

[1993, c. 610, §2 (NEW) .]

4. **Other data collection systems.** The statistical organizations may rely on data collected and reported by other data-gathering organizations or agencies, such as the Workers' Compensation Board or the Department of Labor, and shall coordinate with any other statutorily created medical data collection systems. If a statistical organization is to incorporate data from other sources, it must satisfy itself that the data is sufficiently complete and accurate for the purpose for which it is to be used. The Workers' Compensation Board and the Department of Labor shall assist the statistical organizations in the development and maintenance of a comprehensive data base by recording and making available information within the custody and control of each, respectively, pursuant to the request of the statistical organization. The superintendent may suspend the reporting requirements of specific items for periods when information that is to be obtained from the Workers' Compensation Board is temporarily unavailable or information is found to be unreliable and the unreliability is not a result of the reporting practices of the carriers or self-insurers. The superintendent may accept an established data collection mechanism that is substantially in compliance with the data elements specified in this section and otherwise meets the requirements of this section.

[1993, c. 610, §2 (NEW) .]

5. **Noncompliance penalties.** A statistical organization must include as part of its plan a means of monitoring member or subscriber compliance with the reporting requirements and must include a schedule of monetary penalties for failure to comply with reporting requirements. The statistical agent and companies are responsible for the accuracy of the data maintained and reported to the superintendent in the data base.

[1993, c. 610, §2 (NEW) .]

6. **Reports.** The superintendent shall prescribe the frequency of and schedule for reports by the statistical organization. Reports must be required on at least an annual basis.

[1993, c. 610, §2 (NEW) .]

7. **Confidentiality.** Any report of information relating to a particular claim is confidential and may not be revealed by the superintendent, except that the superintendent may make compilations including this information. Any information provided to the superintendent regarding self-insurance is confidential to the extent protected by Title 39-A, section 403.

[1993, c. 610, §2 (NEW) .]

8. **Accuracy.** The statistical organization shall take all reasonable steps to ensure the accuracy of the information provided to it and reported by it.

[1993, c. 610, §2 (NEW) .]

9. **Retention of records.** Each insurer or self-insurer shall retain its workers' compensation medical claim records for a period not less than 3 years from the date of injury or reported illness. Records may be retained through original source documents or electronic file storage.

[1993, c. 610, §2 (NEW) .]

10. **Application.** This section applies to all claims occurring on or after January 1, 1993.

[1993, c. 610, §2 (NEW) .]

SECTION HISTORY
1993, c. 610, §2 (NEW). 2011, c. 83, §2 (AMD).

§2385. OPTIONAL DEDUCTIBLES

1. **Optional deductible.** Each insurer transacting or offering to transact workers' compensation insurance in the State shall offer optional deductibles to employers that may be used upon election by the insured.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Indemnity.** Deductibles must be available for indemnity benefits in amounts of $1,000 and $5,000 per claim and in other reasonable amounts as may be approved by the superintendent.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Reimbursement.** The deductible form must provide that the claim must be paid by the applicable insurer, which must then be reimbursed by the employer for any deductible amounts paid by the carrier. The employer is liable for reimbursement up to the limit of the deductible.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Deductible not required.** An insurer is not required to offer a deductible to an employer if, as a result of a credit investigation, the insurer determines that the employee is not sufficiently financially stable to be responsible for the payment of deductible amounts.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2385-A. MEDICAL EXPENSE DEDUCTIBLES

Each insurer transacting or offering to transact workers' compensation insurance in the State shall offer deductibles for medical expenses as follows. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

1. **Optional deductible of $250.** To employers who are not experience-rated, insurers shall offer a deductible of $250 per occurrence.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Optional deductible of $250 or $500.** To employers who are experience-rated, insurers shall offer a deductible of $250 or $500 per occurrence.

[1995, c. 551, §1 (AMD) .]

3. **Mandatory deductible of $500.**

[1995, c. 551, §2 (RP) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 1995, c. 551, §§1,2 (AMD).

§2385-B. DISCLOSURE OF PREMIUM INFORMATION

All policies issued to employers for workers' compensation insurance must disclose clearly to the employer as separate figures the base rate and the employer's experience modification factor. [2001, c. 176, §1 (AMD).]

Upon request from an employer, when a policy is issued to an employer for workers' compensation insurance, it must be accompanied by a statement disclosing the percentages of premium expended during the previous year by the insurer for claims paid, loss control and other administrative costs, medical provider expenses, insurer and employee attorney's fees and private investigation costs. [2001, c. 176, §1 (AMD).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 2001, c. 176, §1 (AMD).

§2385-C. WORKPLACE HEALTH AND SAFETY CONSULTATIONS

Workplace health and safety consultation services provided by workers' compensation insurance carriers to employers with an experience rating factor of one or more are subject to the following. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

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

A. "Workplace health and safety consultations" means a service provided to an employer to advise and assist the employer in the identification, evaluation and control of existing and potential accident and occupational health problems. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Standards for workplace health and safety consultations.** The superintendent, in consultation with the Department of Labor, may adopt rules establishing the standards for approval of workplace health and safety consultations provided to employers by insurance carriers, including provision of adequate facilities, qualifications of persons providing the consultations, specialized techniques and professional services to be used and educational services to be offered to employers.

[1997, c. 592, §67 (AMD) .]

3. **Required coverage and premium.** All insurance carriers writing workers' compensation coverage in the State shall offer workplace health and safety consultations to each employer as part of the workers' compensation insurance policy.

[1997, c. 592, §67 (AMD) .]

4. **Optional purchase from another provider.** An employer may elect to purchase workplace health and safety consultation services from a provider other than the insurer.

[1997, c. 592, §67 (AMD) .]

5. **Notification to employer; request for consultation services.** An insurance carrier writing workers' compensation insurance coverage shall notify each employer of the type of workplace health and safety consultation services available and the address or location where these services may be requested. The insurer shall respond within 30 days of receipt of a request for workplace health and safety consultation services.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

6. **Reports to employers.** In any workplace health and safety consultation that includes an on-site visit, the insurer shall submit a report to the employer describing the purpose of the visit, a summary of the findings of the on-site visit and evaluation and the recommendations developed as a result of the evaluation. The insurer shall maintain for a period of 3 years a record of all requests for workplace health and safety consultations and a copy of the insurer's report to the employer.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

7. **Safe workplace responsibility.** Workplace health and safety consultations provided by an insurer do not diminish or replace an employer's responsibility to provide a safe workplace. An insurance carrier or its agents or employees do not incur any liability for illness or injuries that result from any consultation or recommendation.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 1997, c. 592, §67 (AMD).

§2385-D. SAFETY GROUPS

A safety group is an insured plan that provides for an alternative source of insurance for members of an organization or association. An insurer may issue a workers' compensation and employers' liability policy or policies insuring a safety group if the following requirements are met. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

1. **Filings.** The organization or association shall file with the superintendent:

A. A copy of its articles of incorporation and bylaws or its agreement of association and rules governing the conduct of its business, all certified by the custodian of the originals; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. An agreement that only a member of the organization or association is eligible for insurance as a member of the group and that it will notify its insurers within 10 days if any member fails to remain a member in good standing in accordance with the standards and rules of the organization or association; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. A description of the operation and makeup of a safety committee which, by means of education and otherwise, will seek to reduce the incidence and severity of accidents or claims; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. An agreement, if the policy is a group policy, duly executed, guaranteeing that, if the insurer notifies the safety group of the nonpayment of a premium by an insured member within 60 days after the premium was due, the safety group will pay to the insurer the amount of any past due premium that does not exceed the amount of the dividends that are due the safety group or its members from the insurer. The safety group shall promptly notify the insurer of the known insolvency of any member of the group and shall request, upon learning of the insolvency, the removal of the member from the group. A copy of the resolution of the governing superintendent of the group authorizing the execution of the guarantee agreement must be filed with the superintendent and with the insurer issuing the group policy. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Advance premium discounts.** Any advance premium discount for any new or existing safety group must be filed with the superintendent not later than 5 days after the effective date.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Management.** The safety group shall designate a person to act as the manager or authorized representative of the group. The manager or representative may be remunerated by the members for expenses, including all ordinary operating expenses of the group, but the amount charged to members may not exceed 10% of earned premiums.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Dividends.** Dividends or returned premiums paid or credited to a safety group must be paid or credited to the individual members of the group, except that the indebtedness for any unpaid premium must be first deducted from any dividend or premium returned.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Other requirements.** Any safety group formed or operating under this section is subject to the requirements of sections 2931 to 2940, except that the safety group or the insurer may establish reasonable underwriting standards regarding eligibility for acceptance and continued membership of the safety group. These underwriting standards must be filed with the superintendent and may be disapproved by the superintendent if they unreasonably limit membership in the safety group.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2385-E. WORKERS' COMPENSATION INSURANCE; REGISTRATION OF EMPLOYEE LEASING COMPANIES

A corporation, partnership, sole proprietorship or other business entity that provides staff, personnel or employees to be employed in the State to other businesses pursuant to a lease arrangement or agreement must, before becoming eligible to be issued a policy of workers' compensation insurance, register with the superintendent pursuant to Title 32, chapter 125. Employee leasing companies are subject to rules applicable to workers' compensation insurance as adopted by the superintendent and to penalties as defined in Title 32, section 14058. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2385-F. COVERAGE DENIAL

Workers' compensation coverage may not be issued to an employer or continued if it has been issued until the employer pays any undisputed premiums or assessments to a previous workers' compensation insurer, including a domestic mutual insurer established pursuant to section 3703, a group self-insurer approved pursuant to Title 39-A, section 403, subsection 4, or the workers' compensation residual market mechanism. If a premium or assessment is subject to a good faith dispute at the time of termination of a policy or if such a dispute becomes known as a result of a post-termination audit review or other reason after replacement coverage has been issued and if the premium or assessment remains unpaid upon resolution of the dispute by the bureau, this replacement coverage must be cancelled. [1999, c. 121, §1 (AMD).]

SECTION HISTORY
1995, c. 398, §1 (NEW). 1999, c. 121, §1 (AMD).

§2386. WORKERS' COMPENSATION INSURANCE RESIDUAL MARKET MECHANISM

1. **Participation.** All insurers authorized to write workers' compensation and employers' liability insurance in this State shall participate in the workers' compensation insurance residual market mechanism, which is composed of an Accident Prevention Account and a Safety Pool. The residual market mechanism is not a state fund and the State has no proprietary interest in it or in any contributions made to it. This mechanism is exempt from any budgetary control or supervision by state agencies, except to the extent an insurance company is supervised or controlled by state agencies.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Rules.**

[1995, c. 289, §7 (RP) .]

3. **Accident Prevention Account; eligibility.** Eligibility for insurance from the Accident Prevention Account is as follows.

A. The Accident Prevention Account is an insurance plan that provides for the equitable apportionment among insurers of insurance that may be afforded applicants who are entitled to, but unable to, procure that insurance through ordinary methods because of their demonstrated accident frequency problem, measurably adverse loss ratio over a period of years or demonstrated attitude of noncompliance with safety requirements. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. An employer is eligible for insurance from the Accident Prevention Account if:

(1) The employer has at least 2 lost-time claims over $10,000 and a loss ratio greater than 1.0 over the last 3 years for which data is available; and

(2) The employer has attempted to obtain insurance in the voluntary market and has been refused by at least 2 insurers that write that insurance in the State. For the purpose of this section, an employer is considered to have been refused if offered insurance only under a retrospective rating plan or plans. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Safety Pool; eligibility.** Eligibility under the Safety Pool is as follows.

A. The Safety Pool is an insurance plan that provides for an alternative source of insurance for employers with good safety records. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. An employer is eligible for the Safety Pool if that employer:

(1) Has had no more than one lost-time claim in the last 3 years for which data is available, regardless of the resulting loss ratio;

(2) Has a loss ratio that does not exceed 1.0 or has had no more than one lost-time claim over $10,000 over the last 3 years for which data is available; or

(3) Has been in business for less than 3 years, provided that the eligibility terminates if the employer's loss ratio exceeds 1.0 and the employer has at least 2 lost-time claims over $10,000 each at the end of any year. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. A member of the Safety Pool who fails to meet eligibility requirements under paragraph B must be ordered to leave the Safety Pool after notice under former Title 39, section 23, subsection 1. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Plan of operation.** The superintendent shall adopt rules pursuant to Title 5, chapter 375, subchapter II, establishing a plan of operation for the residual market mechanism.

A. The plan must include an experience rating system and merit rating plan providing that the premium of each employer in the account is modified either prospectively or retrospectively. An experience modification may only be applied to the manual rate of the plan. The sensitivity of a rating system may vary by size of the risk involved. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The plan must include a procedure to handle appeals filed pursuant to former Title 39, section 106, subsection 2, paragraph B. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. The plan must provide for premium surcharges for employers in the Accident Prevention Account based on their specific loss experience within a specified period or other factors that are reasonably related to their risk of loss.

(1) No premium surcharge may be applied to a risk whose threshold loss ratio is less than 1.0. The threshold loss ratio is based on the ratio of "L" to "P" where:

(a) "L" is the actual incurred losses of a risk during the previous 3-year experience period as reported, except that the largest single loss during the 3-year period is limited to the amount of premium charged for the year in which the loss occurred; and

(b) "P" is the premium charged to a risk during that 3-year period.

(2) Premium surcharges apply to a premium that is experience or merit rating modified.

(3) Premium surcharges are based on an insured's adverse deviation from expected incurred losses in the State. The surcharge is based on the ratio of "A" to "B" where:

(a) "A" is the actual incurred losses of a risk during the previous 3-year experience period as reported; and

(b) "B" is the expected incurred losses of a risk during that period as calculated under the uniform experience or merit rating plan multiplied by the risk's current experience or merit rating modification factor.

(4) The premium surcharge is as follows:

Ratio of "A" to "B"	Surcharge
Less than 1.20	None
1.20 or greater, but less than 1.30	5%
1.30 or greater, but less than 1.40	10%
1.40 or greater, but less than 1.50	15%
1.50 or greater	20%

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. Commissions under a plan must be established at a level that is neither an incentive nor a disincentive to place an employer in the residual market. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

E. In addition to factors in paragraphs A to C, any servicing contract must be approved on the basis of acceptable price and performance. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

F. If after notice and hearing the superintendent determines that insurers are unwilling to provide services that are reasonably necessary for the operation of the plan, the superintendent may award service contracts within various areas of the State on the basis of acceptable price and performance. If the superintendent chooses to award such contracts, the specifications must give special consideration to loss control, safety engineering and any other factor that affects safety. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

G. Beginning July 1, 1993, the plan must provide for a board of governors, which shall control the affairs and business of the residual market mechanism. The board of governors must be composed of 9 members, 5 of whom represent the business community of the State and 4 of whom represent insurers that are members of the residual market mechanism. The superintendent shall adopt rules to carry out the purposes of this paragraph.

(1) The representatives of insurers on the board of governors are elected by the membership at the annual meeting of the residual market mechanism for staggered terms of 3 years, with the first appointments of one member for one year, one member for 2 years and 2 members for 3 years. An insurer or a group of insurers under common ownership, management or control may not be represented by more than one person on the board of governors. [1995, c. 289, §8 (AMD).]

[1995, c. 289, §8 (AMD) .]

5-A. **Immunity.** A member of the board of governors of the workers' compensation residual market pool created by Maine Insurance Rule Chapter 440 is immune from liability except for willful misconduct by the board member in the performance of the duties of a board member.

[1993, c. 364, §2 (NEW) .]

6. **Rates.** Rate filings for rates in the Accident Prevention Account and the Safety Pool must be made together and are subject to former section 2363.

A. A rate filing for the residual market must include experience and merit rating plans. The experience rating plan is the uniform experience rating plan. The merit plan must provide the maximum credits possible to Safety Pool members on the basis of individual loss experience, including frequency and severity, consistent with this chapter and sound actuarial principles. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The superintendent shall review the rates, rating plans and rules, including rates for individual classifications and subclassifications, in the Accident Prevention Account and the Safety Pool at least once every 2 years and may review rates more frequently if necessary. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. In a residual market rate proceeding, the superintendent may order payment of dividends to insureds in the Safety Pool to the extent that the pool's experience supports them. The superintendent may adopt rules establishing a dividend plan for the Safety Pool to provide an incentive for implementation of safety programs by insureds in the pool. The superintendent may employ outside consultants to assist in the development of these rules, the costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

7. **Mandatory deductible.** A deductible applies to all workers' compensation insurance policies issued to employers in the Accident Prevention Account that meet the following qualifications:

A. A net annual premium of $20,000 or more subject to adjustment pursuant to this section in the State; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. A premium not subject to retrospective rating; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. The employer's threshold loss ratio, as determined under subsection 4, paragraph B, subparagraph (1), is 1.0 or greater. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

The deductible is $1,000 per claim but applies only to wage loss benefits paid on injuries occurring during the policy year. The sum of all deductibles in one policy year may not exceed the lesser of 15% of net annual premium or $25,000. Each loss to which a deductible applies must be paid in full by the insurer. After the policy year has expired, the employer shall reimburse the insurer the amount of the deductibles. This reimbursement must be considered as premium for purposes of cancellation or nonrenewal.

For purposes of calculations required under this section, losses must be evaluated 60 days from the close of the policy year.

Annually, on July 1st, the superintendent shall, by rule, adjust the $20,000 premium level established in this subsection to reflect any change in rates for the Accident Prevention Account and any change in wage levels in the preceding calendar year. Changes in wage levels are determined by reference to changes in the state average weekly wage, as computed by the Department of Labor. Any adjustment is rounded off to the nearest $1,000 increment.

This subsection takes effect on the effective date of the first approved rate filing after the effective date of this Act.

[1995, c. 560, Pt. G, §8 (AMD) .]

8. **Mandatory retrospective rating.** The superintendent may impose retrospective rating plans under the following circumstances:

A. The superintendent shall by rule establish standards governing the application of retrospective rating plans under which the superintendent may order, after hearing, a retrospective rating plan for an employer in the Accident Prevention Account who has sufficient size in terms of premium and number of employees to warrant such rating and:

(1) For the 3 most recent years for which data is available, an experience modification factor and a loss ratio that may indicate a serious problem of workplace safety; or

(2) A demonstrated record of repeated serious violations of workplace health and safety regulations adopted under the Maine Revised Statutes, Title 26, chapter 6, or 29 United States Code, Chapter 15, whichever is applicable. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. The maximum premium, including any applicable surcharge under this section, may not exceed 150% of standard premium. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

9. **Credits for qualifying safety programs.** The superintendent shall adopt rules to establish dividend plans and premium credits between 5% and 15% of net annual premiums for policyholders that establish or maintain qualifying safety programs. The rules must identify the classifications by which policyholders are eligible for the credits and establish criteria for qualifying safety programs and procedures to be followed by servicing carriers in approving and auditing compliance with the safety programs. The superintendent may employ outside consultants to assist in the development of rules under this subsection, the costs of which must be paid by the Safety Education and Training Fund established under Title 26, section 61 to the extent that funds are available.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

10. **Contracts; consultants.**

[1995, c. 289, §9 (RP) .]

11. **Report.**

[1995, c. 289, §9 (RP) .]

12. **Rules.**

[1995, c. 289, §9 (RP) .]

13. **Producer fees.** The servicing carrier in the residual market shall pay a fee to the producer designated by the employer on renewed policies upon payment of premium due. The fee must be 4% of the first $5,000 of renewal premium and 2.5% of renewal premium in excess of $5,000. The fee must be based on the state standard premium.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

14. **Termination of residual market mechanism.** Workers' compensation and employers liability insurance coverage may not be issued through the workers' compensation insurance residual market mechanism on or after January 1, 1993.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

15. **Loan.**

[1995, c. 289, §9 (RP) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 1993, c. 364, §§1,2 (AMD). 1995, c. 289, §§7-9 (AMD). 1995, c. 560, §G8 (AMD). 1995, c. 560, Pt. G, §8 (AMD).

§2386-A. WORKERS' COMPENSATION RATES; ANNUAL SURCHARGES AND CREDITS

(REPEALED)

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). RR 1993, c. 1, §59 (COR). 1993, c. 620, §1 (AMD). 1995, c. 289, §10 (RP).

§2387. PENALTY FOR VIOLATIONS

1. **Civil penalties.** A person or organization in violation of this chapter must be assessed by the superintendent a civil penalty not more than $1,000 for each violation, except that where a violation is willful, a civil penalty of not more than $10,000 must be assessed for each violation. These penalties may be in addition to any other penalty provided by law.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Separate violation.** For purposes of this section, an insurer using a rate for which that insurer has failed to file the rate, supplementary rate information or supporting information as required by this subchapter, has committed a separate violation for each day that failure continues.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **License.** The license of an advisory organization, rating organization or insurer that fails to comply with an order of the superintendent may be suspended or revoked by the District Court.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF); 1999, c. 547, Pt. B, §78 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF).

§2387-A. PUBLIC ADVOCATE

1. **Participation and duties.** The Public Advocate shall represent the interests of insureds and policyholders in matters under this subchapter within the jurisdiction of the superintendent, including, but not limited to:

A. Rate filings under this chapter; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

B. Rulemaking; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

C. Petitions by insurers to terminate license authority, or withdrawal plans submitted pursuant to section 415-A; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

D. Proceedings by the superintendent concerning the reasonableness and adequacy of the service provided by any insurer; [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

E. Proceedings by the superintendent concerning the reasonableness and adequacy of the rates charged by any insurer; and [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

F. Proceedings instituted by the superintendent concerning an insurer's license authority. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

The Public Advocate has the same right to request data as any other party before the superintendent and may petition the superintendent, for good cause shown, to be allowed such other information as may be necessary to carry out the purposes of this section.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

2. **Petition.** The Public Advocate has the right to request that the superintendent investigate the reasonableness of the service provided by, or the rates charged by, insurers.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

3. **Expert witnesses.** The Public Advocate may employ witnesses and pay appropriate compensation and expenses to employ such witnesses. The funds for expert witnesses are available as indicated in section 2386.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

4. **Appeal from superintendent's orders.** The Public Advocate has the same rights of appeal from the superintendent's orders or decisions to which the Public Advocate has been a party as other parties.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

5. **Application.** This section applies to any proceeding under former section 2367 or section 2386-A for policy years 1988 through 1992 and for any other proceeding initiated prior to January 1, 1993 or any continuation or appeal of a proceeding initiated prior to January 1, 1993.

[1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF) .]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

§2387-B. SAVINGS PROVISION

Any experience rating, classification, statistical or other rating plan on file and approved or legally in effect and not required to be revised by this Act or by a decision of the superintendent remains approved for use in the State. These plans need not be refiled on the effective date of this Act. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

Any rates or forms approved for an insurer on file and approved or legally in effect and not required to be revised by this Act or by a decision of the superintendent remain approved for use in the State. These rates and forms need not be refiled on the effective date of this Act. [1991, c. 885, Pt. B, §12 (NEW); 1991, c. 885, Pt. B, §13 (AFF).]

SECTION HISTORY
1991, c. 885, §B12 (NEW). 1991, c. 885, §B13 (AFF).

Chapter 26: THE WORKERS' COMPENSATION RESIDUAL MARKET DEFICIT RESOLUTION AND RECOVERY ACT

§2391. TITLE AND SCOPE OF CHAPTER

1. **Title.** This chapter may be known and cited as "The Workers' Compensation Residual Market Deficit Resolution and Recovery Act."

[1995, c. 289, §11 (NEW) .]

2. **Scope.** This chapter establishes an efficient and effective mechanism for funding the obligations of the residual market mechanism in the State arising from workers' compensation insurance policies with initial effective dates or renewal dates between January 1, 1988 and December 31, 1992.

[1995, c. 289, §11 (NEW) .]

SECTION HISTORY
1995, c. 289, §11 (NEW).

§2392. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1995, c. 289, §11 (NEW).]

1. **Association.** "Association" means the Maine Insurance Guaranty Association.

[1995, c. 289, §11 (NEW) .]

2. **Board.** "Board" means the governing board of the Maine Workers' Compensation Residual Market Pool.

[1995, c. 289, §11 (NEW) .]

3. **Chapter 250.** "Chapter 250" means Bureau of Insurance Rules, Chapter 250, "Requirements for Eligibility to Self-Insurer Workers' Compensation Benefits," as amended and as in existence prior to the effective date of this chapter.

[1995, c. 289, §11 (NEW) .]

4. **Chapter 440.** "Chapter 440" means Bureau of Insurance Rules, Chapter 440, "Plan of Operation for the Workers' Compensation Residual Market Mechanism," as amended, as in existence prior to the effective date of this chapter and as modified in this chapter.

[1995, c. 289, §11 (NEW) .]

5. **Delinquent insurer.** "Delinquent insurer" means an insurer that has not timely paid in full that insurer's allocated share pursuant to section 2393, subsection 1, paragraph A, subparagraphs (1) or (2) or section 2393, subsection 1, paragraph B, subparagraphs (1) to (5), except as provided in section 2393, subsection 1, paragraph A, subparagraph (3), division (d) and section 2393, subsection 1, paragraph B, subparagraph (6), division (d).

[1995, c. 289, §11 (NEW) .]

6. **Employer.** "Employer" means any employer in the State that, at any time relevant under this chapter, is required under the Workers' Compensation Act to secure workers' compensation benefits for its employees.

[1995, c. 289, §11 (NEW) .]

7. **Expense constant.** "Expense constant" means a premium charge approved by the superintendent that applies to every policy, in addition to other premium charges, covering expenses such as those for issuing, recording and auditing that are common to all workers' compensation policies regardless of premium size.

[1995, c. 289, §11 (NEW) .]

8. **Fresh start period.** "Fresh start period" means the period from January 1, 1988 to December 31, 1992.

[1995, c. 289, §11 (NEW) .]

9. **Initial surcharge period.** "Initial surcharge period" means the period from July 1, 1995 to June 30, 2003.

[1995, c. 289, §11 (NEW) .]

10. **Insured employer.** "Insured employer" means an employer in the State that, on or after July 1, 1995, secures or continues to secure workers' compensation benefits under the Workers' Compensation Act for its employees through the purchase of an insurance policy.

[1995, c. 289, §11 (NEW) .]

11. **Insurer.** "Insurer" means every insurer or group of affiliated insurers authorized to provide workers' compensation insurance in the State at any time during the fresh start period. For purposes of this chapter, a group of affiliated companies under common ownership, management or control is treated as one entity.

[1995, c. 289, §11 (NEW) .]

12. **Large deductible policy.** "Large deductible policy" means a workers' compensation policy written with a per occurrence deductible in excess of $5,000 or a medical deductible in excess of $500.

[1995, c. 289, §11 (NEW) .]

13. **Major insurer.** "Major insurer" means any insurer that was designated by the superintendent as a servicing carrier in the workers' compensation residual market in the State as of October 1, 1986.

[1995, c. 289, §11 (NEW) .]

14. **Minor insurer.** "Minor insurer" means any insurer other than a major insurer.

[1995, c. 289, §11 (NEW) .]

15. **Net direct written premium.** "Net direct written premium" means the Maine direct gross premiums charged less all return premiums, except dividends and savings refunded under participating policies, returned to policyholders for all Workers' Compensation and Occupational Disease Insurance written in this State. Excess workers' compensation insurance is not considered "net direct written premium."

[1995, c. 289, §11 (NEW) .]

16. **Net present value.** "Net present value" is the sum of future payments, discounted to a specified valuation date at the discount rate provided.

[1995, c. 289, §11 (NEW) .]

17. **Plan year.** "Plan year" means, for an employer, the period beginning on the self-insured employer's plan approval or renewal date and ending the day before the next plan renewal or anniversary date. The plan renewal date for a member of a group self-insurer is the group's plan renewal date; the plan approval date for a new member joining an established group is the effective date of group membership. The plan year may be less than 12 months as a result of changes in plan accounting periods, midyear entry into a group self-insurance plan or termination of self-insurance authorization.

[1995, c. 289, §11 (NEW) .]

18. **Policy year.** "Policy year" means the following:

A. With respect to a particular calendar year, all policies issued or renewed in that calendar year and all subsequent events occurring in later years relating to those policies, including premium adjustments, audit results and claims experience under those policies; and [1995, c. 289, §11 (NEW).]

B. With respect to a particular employer, the 12-month period beginning upon the date of issuance or renewal of a policy and ending the day before the next renewal date and all subsequent events occurring in later years relating to those policies, including premium adjustments, audit results and claims experience under that policy. [1995, c. 289, §11 (NEW).]

[1995, c. 289, §11 (NEW) .]

19. **Pool.** "Pool" means the Maine Workers' Compensation Residual Market Pool described in and governed by chapter 440.

[1995, c. 289, §11 (NEW) .]

20. **Residual market.** "Residual market" means the instrument to provide coverage to employers not able to obtain coverage in the voluntary market.

[1995, c. 289, §11 (NEW) .]

21. **Self-insured employer.** "Self-insured employer" means an employer that, on or after July 1, 1995, secures or continues to secure workers' compensation through a self-insured program under the Workers' Compensation Act as approved by the superintendent pursuant to the provisions of Title 39-A, section 403, subsection 3.

[1995, c. 289, §11 (NEW) .]

22. **Self-insured group or groups.** "Self-insured group or groups" means a self-insured group approved by the superintendent pursuant to chapter 250, section 3.

[1995, c. 289, §11 (NEW) .]

22-A. **Succession transaction.** "Succession transaction" means an asset sale, merger, consolidation, reorganization or restructuring that creates a successor self-insured employer.

[1995, c. 619, §1 (NEW); 1995, c. 619, §8 (AFF) .]

22-B. **Successor self-insured employer.** "Successor self-insured employer" means any self-insured employer that is a successor entity to another employer or employers doing business in this State. A successor self-insured employer includes any entity that purchases all or a portion of the assets of an employer or the surviving entity in any other merger, consolidation, reorganization or restructuring.

[1995, c. 619, §1 (NEW); 1995, c. 619, §8 (AFF) .]

23. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1995, c. 289, §11 (NEW) .]

24. **Surchargeable premium.** "Surchargeable premium" means:

A. For insured employers, the manual workers' compensation premium applicable to the insured employer, as adjusted by any applicable experience modification factor, premium discount, expense constant and any other debits or credits to a lawfully received premium. In calculating the surchargeable premium for retrospectively rated policies and large deductible policies, "surchargeable premium" means the discounted workers' compensation standard premium, which is the manual premium that would apply to the insured employer absent the retrospectively rated or large deductible nature of the policy, as adjusted by any applicable experience modification factor, premium discount and expense constant. For retrospectively rated and large deductible policies, the insurer shall calculate a discounted standard premium amount utilizing estimated payrolls at policy inception, subject to the final determination upon audit, applying the insurer's manual rates, the insured's experience modification factor, any premium discount, expense constant and other debits or credits to a lawfully received premium. When calculating the discounted standard premium for policies with large deductibles, the maximum credit for the deductible option may not be greater than the amount approved by the superintendent in the most recent advisory loss cost filing for a $5,000 indemnity deductible. [1995, c. 289, §11 (NEW).]

B. For self-insured employers, the manual workers' compensation premium adjusted by the experience modification factor applicable to the self-insured employer, and any applicable premium discount and expense constant. For purposes of this definition, "manual premium" means the workers' compensation premium that would have been applicable to the individual self-insured employer if calculated using the advisory loss costs in effect at the time the surcharge is due multiplied by 1.2, applying the rating rules, excluding any premium discount, and experience rating procedure approved by the superintendent for the designated workers' compensation advisory organization pursuant to section 2382-B, to the exposure and experience of the individual self-insured employer. For a self-insured employer who is a member of a self-insurance group, "surchargeable premium" means the actual amount of workers' compensation premium that is paid to the self-insurance group including experience modification, premium discount and expense constant in accordance with the requirements of chapter 250, but excluding any surplus distributions credited against or applied to reduce premiums. [1995, c. 289, §11 (NEW).]

[1995, c. 289, §11 (NEW) .]

25. **Timely pay; timely paid; timely payment.** "Timely pay," "timely paid" or "timely payment" means payment by the party responsible for the payments on or before the due date specified in this chapter.

[1995, c. 289, §11 (NEW) .]

26. **Voluntary market.** "Voluntary market" means the workers' compensation insurance market in which insurance companies voluntarily offer coverage to applicants who meet the insurers' underwriting standards or guidelines.

[1995, c. 289, §11 (NEW) .]

27. **Workers' Compensation Act.** "Workers' Compensation Act" means and refers to the Maine Workers' Compensation Act of 1992, as amended.

[1995, c. 289, §11 (NEW) .]

28. **Worker's compensation residual market mechanism.** "Worker's compensation residual market mechanism" or "residual market mechanism" means the workers' compensation residual market mechanism described in and governed by Chapter 440.

[1995, c. 289, §11 (NEW) .]

SECTION HISTORY
1995, c. 289, §11 (NEW). 1995, c. 619, §1 (AMD). 1995, c. 619, §8 (AFF).

§2393. INITIAL FUNDING OF POOL

1. **Payments by insurers.** Insurers shall pay to the pool on or before January 1, 1996 the amount of $65,000,000, as follows.

A. Major insurers shall pay to the pool 90% of the $65,000,000 payment, which is $58,500,000. Each major insurer shall pay to the pool that major insurer's allocated share of the payment required by this paragraph as determined in accordance with the following:

(1) If the major insurer's percentage of the total net direct written premium in the voluntary workers' compensation market in the State for the calendar years 1989 and 1990 was less than 3.4% according to data compiled by the National Council on Compensation Insurance, then the major insurer must pay to the pool $4,906,000;

(2) If the major insurer's percentage of the total net direct written premium in the voluntary workers' compensation market in the State for the calendar years 1989 and 1990 was equal to or greater than 3.4%, according to data compiled by the National Council on Compensation Insurance, then the major insurer must pay $4,906,000 less one of the following credits:

(a) If the major insurer's percentage of total net direct written premium in the voluntary market exceeded 25% for each of the calendar years 1989 and 1990, then $1,811,000;

(b) If the major insurer's percentage of total net direct written premium in the voluntary market exceeded 10% for each of the calendar years 1989 and 1990, then $1,772,000;

(c) If the major insurer's percentage of total net direct written premium in the voluntary market exceeded 10% for either calendar year 1989 or 1990, then $807,000;

(d) If the major insurer's percentage of total net direct written premium in the voluntary market exceeded 7.5% for each of the calendar years 1989 and 1990, then $596,000; or

(e) For any other major insurer that qualifies for credit under this subparagraph, $289,000;

(3) One or more major insurers may agree in writing to pay more or less than the amount of their allocated share under subparagraph (1) or (2); except that:

(a) A major insurer may not pay less than the allocated share under subparagraph (1) or (2), unless the written agreement is executed by all major insurers that have timely paid or agreed in writing to timely pay in full at least their allocated share;

(b) The total amount of timely payments to the pool by major insurers is equal to or greater than $58,500,000;

(c) The pool is made a 3rd-party beneficiary to a written agreement among certain major insurers that provides for:

(i) Timely payments to the pool by major insurers that are equal to $58,500,000; and

(ii) An express right of the pool to enforce the payments required by that agreement; and

(d) Timely payment of any share agreed upon in writing pursuant to this subparagraph in an amount less than the allocated share under subparagraph (1) or (2) constitutes timely payment in full of an allocated share for purposes only of subsection 1, paragraph C or section 2396, subsection 1.

(4) If the total amount paid according to the requirements of subparagraphs (1), (2) and (3) exceeds $58,500,000, the pool must disburse within 30 days the excess amount by refunding to each major insurer that has timely paid in full at least its allocated share under subparagraph (1) or (2) in direct proportion to the amount that each major insurer paid to the pool as part of the total major insurers' payment required by this paragraph. [1995, c. 289, §11 (NEW).]

B. Minor insurers shall pay to the pool 10% of the $65,000,000 payment, which is $6,500,000. Each minor insurer shall pay to the pool an allocated share of the payment required by this paragraph as determined in accordance with the following.

(1) Except as provided in subparagraph (2), an allocated share equal to the sum of the amounts described in divisions (a) to (c) must be paid to the pool.

(a) Minor insurers authorized to provide workers' compensation insurance in the State at any time during 1989 pay 59% of the $6,500,000 payment, with each minor insurer paying a per capita share.

(b) Minor insurers authorized to provide workers' compensation insurance in the State at any time during 1990 pay 38% of the $6,500,000 payment, with each minor insurer paying a per capita share.

(c) Minor insurers authorized to provide workers' compensation insurance in the State at any time during 1991 pay 3% of the $6,500,000 payment, with each minor insurer paying a per capita share.

(2) A minor insurer that qualifies for a partial exemption under this subparagraph shall pay to the pool the greater of $10,000 or 2% of the minor insurer's average annual after-tax adjusted earnings for the 3 calendar years immediately prior to enactment of this chapter as reported in the minor insurer's annual statement filed with the superintendent. A minor insurer qualifies for a partial exemption from the per capita share payment required by this paragraph if, for the 3 calendar years immediately prior to enactment of this chapter, as reported in the minor insurer's annual statement filed with the superintendent, the minor insurer's:

(a) Average annual after-tax adjusted earnings were less than $2,000,000; and

(b) Surplus as to policyholders did not exceed $12,500,000.

(3) A minor insurer that has not received a partial exemption under subparagraph (2) is entitled to participation credits determined as follows.

(a) For any policy year beginning on or after January 1, 1989, the share for each minor insurer authorized to write workers' compensation insurance in the year to which the calculation in this division pertains is reduced by .05% for each .10% that its participation ratio for the year to which the assessment relates exceeds its participation ratio for the base period as calculated by dividing the minor insurer's net direct written premium for the base period by the total minor insurer's net direct written premium for the base period. For purposes of this division, "base period" means the calendar years 1983 to 1986. The participation ratio for the year to which the assessment relates is calculated by dividing the minor insurer's net direct written premium in that calendar year by the total net direct written premium of minor insurers that were authorized at any time during that year;

(b) Credits earned by a minor insurer may not result in a minor insurer's participation ratio being adjusted to less than 1/2 of its otherwise allocated share;

(c) For a minor insurer not authorized to write workers' compensation insurance in 1986, its adjusted participation ratio is 1/2 of its participation ratio in the year to which the calculation applies;

(d) Any deficiency must be distributed among all minor insurers in proportion to the adjusted participation ratio, after credit adjustments; and

(e) For purposes of this subparagraph, "adjusted participation ratio" means a minor insurer's participation ratio as calculated in accordance with this subparagraph and after application of any credits. For purposes of this subparagraph, net direct written premium does not include premiums for residual market risks reinsured by the pool or retrospective rating plan adjustments on policies effective prior to January 1, 1988.

(4) The total amount of the differences between the following must be paid by those minor insurers that actually paid their allocated share as of January 1, 1996 by allocating the difference to those minor insurers in the same proportion as each such minor insurer's payment bears to the total aggregate amount actually paid by minor insurers as of January 1, 1996:

(a) The otherwise allocated share payments under subparagraph (1); and

(b) The payments made by minor insurers that qualify for a partial exemption as provided in subparagraph (2) and any participation credits under subparagraph (3).

(5) In the event a minor insurer for any reason fails to pay its allocated share, as described in this paragraph, by January 1, 1996, then the pool may charge the deficiency resulting from those uncollected amounts to all minor insurers that actually pay their allocated share as of January 1, 1996 by allocating that deficiency to those minor insurers in the same proportion as each such minor insurer's payment bears to the total aggregate amount actually paid by minor insurers as of January 1, 1996. Those minor insurers are subrogated to the pool's right to collect such amounts from the delinquent minor insurer.

(6) One or more minor insurers may agree in writing to pay more or less than the amount of their allocated share under subparagraphs (1) to (4), except that:

(a) A minor insurer may not pay less than the allocated shares under subparagraphs (1) to (4) unless the written agreement is executed by all minor insurers that have timely paid or agreed in writing to timely pay in full at least their allocated share;

(b) The total amount of timely payments to the pool by minor insurers is equal to or greater than $6,500,000;

(c) The pool is made a 3rd-party beneficiary to a written agreement among certain minor insurers that provides for:

(i) Timely payments to the pool by minor insurers that are equal to $6,500,000; and

(ii) An express right of the pool to enforce the payments required by that agreement; and

(d) Timely payment of any share agreed upon in writing pursuant to this subparagraph in an amount less than the allocated share under subparagraphs (1) to (4) constitutes timely payment in full of an allocated share for purposes only of subsection 1, paragraph C or section 2396, subsection 1.

(7) If the total amount paid according to the requirements of subparagraphs (1) to (6) exceeds $6,500,000, the pool must disburse within 30 days the excess amount by refunding to each minor insurer that has timely paid in full at least its allocated share under subparagraphs (1) to (4) in direct proportion to the amount that each minor insurer paid to the pool as part of the total minor insurers' payment required by this paragraph. [1995, c. 289, §11 (NEW).]

C. The pool shall bill and collect from each insurer the allocated share established by paragraphs A and B. If an insurer has not timely paid its allocated share in full to the pool on or before January 1, 1996, then the insurer is considered delinquent and the following applies.

(1) The pool has all the rights, powers and authority to take all necessary and appropriate action, as determined in the pool's discretion, against the delinquent insurer to collect any amounts not paid as and when due, and any deficiency is assessed interest at the rate of 10% per annum from January 1, 1996 until full payment from the insurer is received by the pool. The pool is entitled to an award of and reimbursement from any delinquent insurer of the costs of enforcement and collection of any amounts not paid as and when due, including all costs and expenses, reasonable attorney's and paralegal's fees and any other professional fees and expenses associated with the pool's enforcement and collection efforts.

(2) If the pool has received $58,500,000 from major insurers or $6,500,000 from minor insurers, valued as of January 1, 1996, the pool shall provide prompt written notice of this fact to insurers in the same category, either major or minor. Within 90 days following a request, the pool shall assign all such rights, powers and authority, including the entitlement to costs and expenses, to any insurers in the same category of the delinquent insurer that have requested an assignment and timely paid in full at least the allocated share established by paragraphs A and B.

(3) The pool has the right to set off any amounts due under this chapter to the pool from a delinquent insurer against any sums credited by or due from the pool to the delinquent insurer and against any other property of the delinquent insurer in the possession or under the control of the pool.

(4) Regardless of whether any action is taken pursuant to subparagraphs (1) to (3), the superintendent is authorized to exercise all authority as may be provided by and in accordance with law to take appropriate action against any delinquent insurer. In addition to any other authority the superintendent may possess under law, the superintendent upon notice and hearing may suspend a delinquent insurer's authority to transact the business of insurance in the State for so long as the insurer remains delinquent. The authority granted to the superintendent under this paragraph and jurisdiction vested in the bureau are concurrent with other actions by other parties authorized in this paragraph.

(5) Any collection by or on behalf of the pool, or amounts obtained by setoff with respect to a delinquent insurer, are retained by the pool, until the insurers in the same category as the delinquent insurer have paid the total amount required for that category, plus interest pursuant to subparagraph (1) and costs and expenses of the pool for collection in an amount not to exceed the delinquent share, valued as of January 1, 1996, to the pool. Any excess must be distributed within 90 days among the insurers in the same category as the delinquent insurer that have timely paid in full at least the allocated share established by paragraphs A and B in direct proportion to that insurer's payment to the pool as part of the total payments required by paragraph A or B, except that any collection on behalf of the pool as the result of an assignment pursuant to subparagraph (2) must be distributed as agreed among the insurers that receive the assignment from the pool.

(6) No defense or substantive argument that could have been raised or asserted related to an insurer's status as a major insurer or minor insurer or any purported contractual rights under prior or existing law is extinguished or otherwise abridged in any proceeding against a delinquent insurer instituted under subparagraphs (1) to (5). [1995, c. 289, §11 (NEW).]

[1995, c. 289, §11 (NEW) .]

2. Payments by employers. Employers shall pay to the pool the following amounts.

A. Employers shall pay initial surcharges, in the manner described in this subsection, in an aggregate amount equal to $110,000,000, calculated on a net present value basis using January 1, 1995 as the valuation date, a discount rate of 5% and the midpoint of each calendar quarter as the date of actual receipt of surcharge proceeds remitted to the pool for each calendar quarter. Proceeds included in determining when the $110,000,000 initial surcharge is fully paid consist of:

(1) All proceeds from surcharges under this chapter on policies with effective dates on or after July 1, 1995 and surcharges under this chapter on self-insured employers with plan years commencing on or after July 1, 1995; and

(2) All proceeds from surcharges actually received in immediately available funds by the pool after 5:00 p.m., September 30, 1995, whether the proceeds result from a surcharge under this chapter or under laws existing prior to enactment of this chapter. [1995, c. 289, §11 (NEW).]

B. Proceeds from surcharges under existing laws actually received in immediately available funds by the pool on or before 5:00 p.m., September 30, 1995 may not be credited against the initial surcharge requirement. [1995, c. 289, §11 (NEW).]

C. The pool shall maintain records reflecting actual dates of receipt of proceeds from surcharges sufficient to enable the net present value calculation. [1995, c. 289, §11 (NEW).]

D. The initial surcharges must be paid in accordance with the following provisions.

(1) Beginning July 1, 1995 every insurer writing workers' compensation insurance in the State shall collect from workers' compensation insurance policyholders and pay to the pool a surcharge on all surchargeable premiums received by the insurer for those policies. During the initial surcharge period, the surcharge is at a fixed rate of 6.32% of the surchargeable premium. The surcharge may be applied only to policies with an effective date on or after 12:01 a.m., July 1, 1995. All surcharges received by each insurer during the preceding calendar quarter must be remitted to the pool within 15 days following the end of each calendar quarter, except that servicing carriers shall remit on February 15th, May 15th, August 15th and November 15th of each year. Any surcharge proceeds not remitted on a timely basis accrue interest at the rate of 10% per annum from the due date until paid in full. The pool is entitled to reimbursement from any insurer failing to remit surcharge proceeds on a timely basis for the pool's costs of collection of those amounts, including all collection costs and fees, reasonable attorney's and paralegal's fees and any other professional fees and expenses associated with the pool's collection efforts. The surcharges described in this subparagraph do not apply to reinsurance recognized by the superintendent pursuant to Chapter 250, section 2, paragraph G or section 3, paragraph G, procured by an individual self-insured employer or a self-insured employer group.

(2) Self-insured employers that secured their obligation to provide workers' compensation benefits under the Workers' Compensation Act through issuance or renewal at any point during the fresh start period of an insurance policy for any portion of any of the policy years 1988 to 1992 are subject to a surcharge as provided in the following.

(a) During the initial surcharge period the rate of surcharge is 6.32% of the surchargeable premium as adjusted pursuant to this paragraph for the self-insured employer's current plan year utilizing estimated payroll as submitted with the self-insured employer's renewal application for authority to self-insure, in accordance with Chapter 250, section 2, paragraph C, subparagraph 1, division c or Chapter 250, section 3, paragraph C, subparagraph 1, division g as applicable, subject to audit pursuant to division (d), subdivision (iii). If the plan year in which a surcharge is collected or a credit is distributed is shorter than 12 months, due to a change in accounting period or termination of self-insurance authorization, the surcharge or credit for that plan year must be based upon the final audited payroll for the short plan year.

(b) All surcharges must be collected or distributed on a plan year basis. In each plan year, the percentage of the surchargeable premium to be surcharged is the same percentage as is applied to an insured employer whose policy period coincided with the plan year.

(c) Except for a successor self-insured employer, each self-insured employer shall pay surcharges relating to only that portion of the policy years 1988 to 1992 in which the self-insured employer insured its workers' compensation obligations. The surcharge factor, as determined by the board under this chapter, must be adjusted to take into consideration the policy years or portions of policy years 1988 to 1992 in which a self-insured employer was self-insured.

The self-insured employer adjustment is determined as follows. The surcharge factor must be multiplied by the factor attributed to each of the years 1988 to 1992, as set forth in the table below. If a self-insured employer was insured only during a portion of a policy year, then the factor for that year is prorated based on the ratio of the number of days in the policy year during which the self-insured employer was insured to 365 days.

Policy Year	Factor
1988	28.48%
1989	30.70%
1990	23.26%
1991	11.55%
1992	6.01%

(d) The board shall administer the surcharges on self-insured employers as follows.

(i) The board shall issue surcharge billings to self-insured employers, pursue collection of all invoiced surcharges, initiate legal proceedings as necessary to collect surcharges and maintain records adequate to administer the surcharge process. The records of the board and of the bureau form the basis for identifying self-insured employers who are subject to this paragraph.

(ii) Annual surcharges may be paid in a single lump sum within 30 days of the receipt of the pool's invoice or in quarterly installments at the self-insured employer's option. The board shall issue a yearly invoice as soon as practicable after the self-insured employer's plan approval or renewal date and receipt of all necessary supporting information from the superintendent. Each invoice must contain a schedule of dates when quarterly installments are due and clearly state the policy year or years for which the surcharge is imposed, the surcharge percentage multiplied by the factor applicable to each policy year and the amount of the surchargeable premium.

(iii) Each individual self-insured employer shall report final audited payrolls to the pool not later than 60 days after the end of each plan year and each self-insured employer that is a member of a self-insured group or the group's administrator, as the group may select, shall report final audited payrolls to the pool not later than 120 days after the end of each plan year and shall remit with the audit information any additional surcharges resulting from the audit.

(iv) Upon the request of a self-insured employer, including a successor self-insured employer or an administrator of a self-insurance group, the board may determine whether there was a factual inaccuracy in the information underlying a surcharge billing issued by the board for the fresh start period or whether the surcharge calculated by the board is consistent with the provisions of this subparagraph. The request must be filed within 180 days from the date on which the final payment is due and must be in writing, including a statement of the reason for the request and the amount, if known, of the alleged overcharge. If an appeal based upon an alleged overcharge is sustained, the board shall refund the overcharge, together with any investment earnings on those amounts. If a self-insured employer is aggrieved by the final action or decision of the board, or if the board does not act on the written request within 60 days, the self-insured employer may appeal to the superintendent within 60 days of such action or decision of the board. Notwithstanding a pending appeal, a self-insured employer must pay any surcharge billing issued by the board.

(e) Self-insured employers have the following obligations with respect to the surcharge process.

(i) As a condition of continuing authorization to self-insure, each self-insured employer and each group self-insurance administrator shall assist the board and the superintendent in the calculation, billing and collection of any applicable surcharge. The required assistance includes maintaining and providing, upon request of the board or the

superintendent, actual premium history and all payroll and experience information necessary to calculate self-insured employer premiums, as specified in this subparagraph. Information provided by the self-insured employer is subject to audit by the pool and the superintendent at any time and self-insured employers shall provide to the pool, or its designee, and to the superintendent full and complete access to all books and records relating in any way to the audit. Group self-insurance administrators shall give prompt notice to the superintendent of any changes in group membership.

(ii) Information provided by self-insured employers to the board pursuant to this paragraph is confidential. The board shall protect the confidentiality of all self-insured employer information in its possession, whether the information is obtained directly from the self-insured employer or from the superintendent or a group administrator. All information relating to a self-insured employer provided pursuant to this paragraph and in the possession of the board or superintendent continues to be confidential until that information is destroyed.

(iii) A self-insurance group may act as the collection agent for its members. Any group so electing shall notify the board. The board shall bill the group on a consolidated basis. The group shall remit its entire quarterly payment to the board within 30 days after receiving the invoice, whether or not any members remain in default and notify the board and the superintendent of any delinquency.

(iv) Each self-insured employer shall make provisions for possible surcharges in the normal course of operations and pay the full amount of any surcharge installment within 30 days after receiving an invoice from the board or the self-insured employer's self-insurance group. Late payments are subject to interest at the rate of 10% per annum.

(v) The failure of any self-insured employer or self-insurance group to comply with its duties under this paragraph constitutes grounds for suspension, revocation, termination of the option to self-insure, expulsion from a self-insurance group or other appropriate sanctions authorized under section 12-A, in addition to all procedures for the collection of past-due accounts otherwise available by law to the board or the governing body of the self-insurance group.

(f) The superintendent has the following responsibilities with respect to the surcharge process.

(i) The superintendent shall furnish to the board, on a monthly basis, a list of all self-insurance plan approvals, renewals and anniversaries that have occurred since the last report or for any other reason were not included in any previous report, including all approvals, terminations and membership changes for group self-insurers. For each employer listed, the superintendent shall provide all available information necessary for the board's imputed calculations under this paragraph, including: the date the new plan year began; the self-insurance group, if any, to which the self-insured employer belongs; the dates of coverage under each policy issued or renewed in policy years 1988 to 1992; the rating information for the current plan year, including estimated payroll by classification, premium rate for each classification, experience modification and other applicable rating adjustments; information relating to changes of ownership or control, changes of operations, changes of name or organizational structure; and other information necessary to determine successorship.

(ii) The superintendent shall supplement promptly the initial report as necessary, including any revision to the self-insured employer's rating information on audit, any other additions or corrections to incomplete or inaccurate information provided in the initial report and the length of the plan year, if shorter than 12 months.

(g) A successor self-insured employer is subject to surcharge on the same basis as the predecessor employer would be if still actively doing business and self-insured. If a self-insured employer is the successor to more than one employer, then the successor employer's

self-insured employer adjustment is the sum of each predecessor employer's self-insured employer adjustment multiplied by the ratio of the employer's surchargeable premium for the 12-month period immediately preceding the succession transaction to the combined surchargeable premium of all predecessor employers for that 12-month period.

(i) If one or more of the predecessor employers was insured at the time of the succession transaction, its self-insured employer adjustment is calculated pursuant to division (c), (h) or (i) as if it had become self-insured at the time of the succession transaction.

(ii) If business operations that were covered under a single workers' compensation policy or certificate of self-insurance authority are subsequently separately owned by virtue of any succession transaction, dissolution, reincorporation or other transaction or series of transactions, for purposes of this subparagraph each business is treated as a distinct employer, subject to surcharge as either an insured employer or a self-insured employer.

(iii) If substantial changes in operations during the 12-month period immediately preceding the succession transaction make the 12-month surchargeable premium an inappropriate measure of a predecessor employer's workers' compensation exposure prior to the transaction, the board may adopt procedures for calculating an annualized premium in a manner consistent with the intent of this subparagraph.

(h) A self-insured employer that secured its obligation to provide workers' compensation benefits under the Workers' Compensation Act through a self-insurance program approved by the superintendent for the entirety of that self-insured employer's policy years 1988 to 1992, in which the self-insured employer actually had an obligation to secure benefits under the Workers' Compensation Act is not subject to the surcharge.

(i) Except for any successor self-insured employer, self-insured employers that commence operations in the State on or after July 1, 1995 are subject to surcharge under this subparagraph on the same basis as self-insured employers that secured compensation under the Workers' Compensation Act by the purchase of an insurance policy throughout the entire fresh start period.

(3) An employer may, as specified in this subparagraph, prepay all of its surcharges for a period of 10 consecutive policy years or plan years. The 10-year period starts with the employer's first renewal date or plan year following July 1, 1995. Within 30 days after the inception of the first plan year or first policy renewal date following July 1, 1995, if the employer intends to exercise this option, the employer must file with the pool written notice electing to make a lump-sum payment of surcharges and shall include with the notice the employer's full lump-sum payment. If the election is not made within 30 days after the first day of the first plan year or policy year following July 1, 1995, the option expires and is no longer available. The pool shall implement such procedures for administering this option as the board determines necessary. An employer that elects this option shall reimburse the pool for its expenses of administering this option for that employer, including the cost of individually allocating those costs to individual employers, in accordance with billing procedures developed and implemented by the board. This subparagraph does not eliminate or limit the employer's liability to pay adjusted surcharges or supplemental surcharges pursuant to paragraph E or section 2394.

For purposes of this subparagraph, "lump-sum payment" is the surcharge for the first year multiplied by 10 and discounted to net present value using:

(a) A 5% discount rate;

(b) The first day of the first plan year or policy year starting on or after July 1, 1995; and

(c) An assumption that the surcharge for each of the 10 plan years or policy years would have been paid on the first day of each subsequent plan year or policy year. [2011, c. 524, §11 (AMD).]

E. The initial surcharge percentage may be adjusted by the pool in accordance with the following provisions.

(1) Each July 1st beginning in 2003, the board shall establish a surcharge percentage to be imposed on all workers' compensation insurance policies issued or renewed on or after that date until the effective date of any subsequent adjustment in the surcharge percentage established by the board; except that, if supplemental surcharges and assessments have commenced under section 2394, no further adjustments may be made under this subparagraph. The surcharge must be at a level determined by the board to be sufficient to produce cash receipts over the ensuing 24 months that, together with all other funds reasonably anticipated by the board to be available on a cash basis over that period, produce an amount not less than the pool's projected cash requirements to meet its obligations over that period. In making that determination, the board shall employ and rely upon the advice of professional and consulting services, including services available through the pool's internal staff, as the board determines necessary.

(2) If the surcharge percentage established under this subparagraph exceeds 6.32%, then a prepaid employer shall pay surcharges for that future assessment period at the same rate as those employers who paid annually, based upon the employer's surchargeable premium for the policy year or plan year to which the increased surcharge percentage applies. A prepaid employer may take a credit for the surcharges prepaid for that assessment period pursuant to section 2393, subsection 2, paragraph D, subparagraph (3) in an amount equal to the net present value calculated on a basis consistent with paragraph D, subparagraph (2), division (d), subdivision (ii). If the surcharge percentage is less than 6.32% for that future assessment period, then the pool shall refund to a prepaid employer an amount equal to the difference between the value of the lump-sum surcharge paid for the future assessment period calculated on a basis consistent with paragraph D, subparagraph (2), division (d), subdivision (ii) and the amount of surcharge due based upon the adjusted surcharge percentage and applicable surchargeable premium. For purposes of this subparagraph, "prepaid employer" means an employer who has elected to pay surcharges on a lump-sum basis pursuant to paragraph D, subparagraph (3).

(3) The board has authority to make interim adjustments in the surcharge percentage on or after July 1, 2003, to be effective on dates other than July 1st as specified by the board, to the extent considered necessary by the board to produce sufficient cash receipts from surcharges over the ensuing 24 months that, together with all other funds reasonably anticipated by the board to be available on a cash basis to the pool over the ensuing 24 months, will be sufficient to meet the pool's anticipated cash requirements over that period.

(4) In projecting the pool's anticipated cash requirements, the board shall maintain a reserve equal to 25% of the cash expenditures of the pool over the immediately preceding 12-month period. [1995, c. 289, §11 (NEW).]

F. The surcharges required by this subsection are considered premium for cancellation and nonrenewal purposes only and are not subject to premium tax, Maine Insurance Guaranty Association assessments, agents' commissions or other payments required on insurance policy premiums. [1995, c. 289, §11 (NEW).]

G. Employer surcharges required by this chapter are suspended if:

(1) The board determines that the pool's assets are adequate to satisfy all remaining obligations, including any necessary repayment to insurers that satisfy the requirements of subparagraph (2); and

(2) The insurers and employers have been repaid by the pool in amounts necessary to produce a ratio of actual surcharges under this subsection paid by employers calculated on a net present value basis using January 1, 1995 as a valuation date and a discount rate of 5% to actual payments by insurers to the pool under subsection 1, valued as of January 1, 1996, not including employer surcharges remitted to the pool by insurers, that is the same as 11 to 6.5, for employers and insurers respectively. [1995, c. 289, §11 (NEW).]

H. If the board suspends initial surcharges and the pool subsequently requires additional assets to satisfy remaining obligations, the board shall order additional initial surcharges consistent with this subsection. The board shall review the relationship between the pool's assets and liabilities as often as determined necessary by the board, but at least annually. Projections of assets and liabilities contained in any quarterly or annual statements of operation prepared by or at the direction of the board do not constitute a determination under this subsection. [1995, c. 289, §11 (NEW).]

[2011, c. 524, §11 (AMD) .]

3. **Payments by Maine Insurance Guaranty Association.** The association shall pay to the pool $1,538,039 on or before February 15th, May 15th, August 15th, and November 15th of each year for 40 consecutive calendar quarters beginning August 15, 1996.

A. Each payment made by the association to the pool under this subsection is treated as a covered claim pursuant to section 4435, subsection 4, except that any provision or authority for the association to seek reimbursement or recoupment from any source other than by assessments to association member insurers does not apply. This section does not limit or impair a member insurer's right to recoupment under section 4447. [1995, c. 289, §11 (NEW).]

B. The quarterly payments by the association to the pool as required by this subsection must be made regardless of the financial condition or actual or projected cash requirements of the pool. [1995, c. 289, §11 (NEW).]

[1995, c. 289, §11 (NEW) .]

SECTION HISTORY
RR 1995, c. 2, §52 (COR). 1995, c. 289, §11 (NEW). 1995, c. 619, §§2-6 (AMD). 1995, c. 619, §§2-6 (AMD). 1995, c. 619, §8 (AFF). 1995, c. 619, §8 (AFF). 2011, c. 524, §11 (AMD).

§2394. FUNDING SUBSEQUENT CASH DEFICIENCIES

If the insurers have made payments to the pool totalling $65,000,000 valued as of January 1, 1996 pursuant to section 2393, subsection 1 and the employers have paid surcharges totalling $110,000,000 calculated on a net present value basis using January 1, 1995 as a valuation date and a discount rate of 5%, pursuant to section 2393, subsection 2, on each July 1st following the full payment date, or more often if the board considers it necessary: [1995, c. 289, §11 (NEW).]

1. **Determine cash requirements.** The board shall determine the amount of cash receipts that will be required over the ensuing 24 months, in addition to all other funds reasonably anticipated by the board to be available on a cash basis over that period, to produce an amount not less than the pool's projected cash requirements to meet its obligations over that period. In making this determination, the board shall employ and may rely upon professional and consulting services, including such services as may be available through its internal staff, as the board considers necessary. If cash requirements determinations under this subsection commence, any cash requirements determinations and initial surcharge percentage adjustments under section 2393, subsection 2, paragraph E cease. In projecting the pool's anticipated cash requirements, the board shall maintain a reserve equal to 25% of the cash expenditures of the pool over the immediately preceding 12 months; and

[1995, c. 289, §11 (NEW) .]

2. **Establish supplemental surcharges and assessments.** The pool shall establish, bill and collect supplemental surcharges from employers and assessments from insurers in an aggregate amount determined by the board to be sufficient to satisfy the pool's cash requirements, determined under subsection 1, in accordance with the following provisions.

A. Liability for funding cash requirements determined under subsection 1 is allocated 70% to employers and 30% to insurers. [1995, c. 289, §11 (NEW).]

B. The pool shall establish a surcharge on employers, reflected as a percentage of surchargeable premium, that the board reasonably expects will be sufficient to generate cash receipts over the ensuing 24-month period equal to 70% of the pool's cash requirements for such period as determined pursuant to subsection 1. The resulting employer surcharges are billed and collected in the same manner as provided in section 2393, subsection 2, paragraph D. [1995, c. 289, §11 (NEW).]

C. The pool shall establish, bill and collect from insurers assessments equal to the remaining 30% of the pool's cash requirements. Major insurers are responsible for 90% and minor insurers are responsible for 10% of these assessments.

(1) Assessments under this paragraph must be determined and billed quarterly by the pool in an amount equal to 42.9% of the cash receipts actually received by the pool from employer supplemental surcharges during the immediately preceding calendar quarter and must be allocated among existing insurers in the same category in direct proportion to amounts paid by or otherwise collected from those insurers by or on behalf of the pool under section 2393, subsection 1. Assessments billed by the pool must be paid within 30 days of the billing date.

(2) The enforcement provisions established by section 2393, subsection 1, paragraph C apply to assessments on insurers under this paragraph. [1995, c. 289, §11 (NEW).]

D. For purposes of establishing the surcharge upon employers, the pool's cash requirements may not include any amounts necessary to compensate the pool for any failure by insurers to pay the full amount of the assessments charged to insurers under this subsection. [1995, c. 289, §11 (NEW).]

[1995, c. 289, §11 (NEW) .]

For the purposes of this section, "full payment date" means the date on which insurers have paid the entire amount required pursuant to section 2393, subsection 1 and on which employers have paid the entire amount required pursuant to section 2393, subsection 2. [1995, c. 289, §11 (NEW).]

SECTION HISTORY
1995, c. 289, §11 (NEW).

§2395. REVISIONS TO RESIDUAL MARKET MECHANISM PLAN OF OPERATION

1. **Plan manager.** The board shall appoint a plan manager who reports to and serves at the pleasure, direction and control of the board. The board has the exclusive right to retain any individual or organization as plan manager and to terminate the plan manager. The board is exclusively responsible for establishing the terms and conditions, including compensation, under which the plan manager serves.

[1995, c. 289, §11 (NEW) .]

2. **Appointment of employer representatives.** The 5 members of the board of governors serving as representatives of the business community of the State are appointed by the Governor for staggered 3-year terms, with at least one member appointed each year. All members whose terms have not expired on or before July 3, 1995 continue on the board until their terms expire.

[1995, c. 289, §11 (NEW) .]

3. **Staff and consultants.** The board may employ, or otherwise retain, staff and consultants as the board considers necessary or appropriate to effect the purposes of this chapter and chapter 440 and to otherwise administer pool operations. The board or its designee is exclusively responsible for establishing the responsibilities and compensation of all staff employed by the pool and are exclusively responsible for establishing the terms and conditions, including compensation, of all consultants retained by the pool.

[1995, c. 289, §11 (NEW) .]

4. **Transfer of policies.** An insurer may transfer any rights, obligations and liabilities of a workers' compensation insurance policy issued pursuant to the residual market mechanism.

[1995, c. 289, §11 (NEW) .]

5. **Authority to borrow money.** The pool may, when directed by the board, borrow money and enter into financing transactions in the name of and on behalf of the pool and issue evidences of indebtedness in connection with those transactions. To secure the payment of any indebtedness incurred pursuant to this subsection, the pool may pledge and create a lien upon any or all of its receivables or revenues or grant such other security interests in its property as the board determines reasonable and proper for the security of the holders of indebtedness. The terms and conditions of any borrowing, including, but not limited to, dates, maturities, interest and rates, must be established by the board.

[1995, c. 289, §11 (NEW) .]

6. **Report required.** Beginning in 1996, the board shall file an annual report on or before June 1st to the Governor, the superintendent, the President of the Senate and the Speaker of the House of Representatives and the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. The report must identify the following information:

A. The pool's most recent audited financial statements; [1995, c. 400, §1 (NEW).]

B. The total claims payments made by the pool in the preceding 12 months; [1995, c. 400, §1 (NEW).]

C. The most recent actuarial report, including cash flow and deficit projections for the pool; [1995, c. 400, §1 (NEW).]

D. A report of changes to the operations of the pool; [1995, c. 400, §1 (NEW).]

E. A summary of the number of open claims and aggregate reserves for each policy year; and [1995, c. 400, §1 (NEW).]

F. Any information required to be maintained by the pool pursuant to section 2393, subsection 2, paragraph E and section 2394, subsection 1. [1995, c. 400, §1 (NEW).]

[1995, c. 400, §1 (NEW) .]

SECTION HISTORY
1995, c. 289, §11 (NEW). 1995, c. 400, §1 (AMD).

§2396. COORDINATION OF LAW

1. **Causes of action extinguished; exception.** Notwithstanding Title 1, section 302, a cause of action or administrative proceeding that could have been asserted or instituted, whether or not pending, prior to or on the effective date of this Act arising out of or relating to sections 2386 and 2386-A and their predecessor statutes, sections 2366 and 2367 or due to an insurer's performance as a servicing carrier or other participation in the residual market mechanism may not exist or be brought against the pool, the board or an insurer that has timely paid to the pool in full at least the allocated share pursuant to section 2393, subsection 1. This subsection does not apply to: claims by servicing carriers for quarterly reimbursement from the pool;

claims arising from a written agreement among any of the major insurers and the pool relating to payment of the allocated share of a delinquent insurer pursuant to section 2393, subsection 1; claims by an individual policyholder against its insurer; or claims by employees for benefits under residual market policies.

[1995, c. 289, §11 (NEW) .]

2. **Repeal of chapter 720.** The Bureau of Insurance Rules, chapter 720, is repealed effective July 1, 1995. The collection procedures set forth in section 2393, subsection 2, paragraph D, subparagraph (2) apply to surcharges assessed under chapter 720 prior to the effective date of this chapter.

[1995, c. 289, §11 (NEW) .]

3. **Vacation of orders.** All orders of the superintendent relating to surcharges and assessments arising out of section 2386-A are vacated except to the extent that they establish the amount and method of calculation of surcharges paid or to be paid by employers on policies issued or renewed with effective dates on or before June 30, 1995, and self-insurance plan years beginning on or before June 30, 1995. All other decisions, orders and rules issued and adopted by the superintendent relating to workers' compensation insurance are invalid to the extent that they are inconsistent with this chapter.

[1995, c. 289, §11 (NEW) .]

SECTION HISTORY
1995, c. 289, §11 (NEW).

Chapter 27: THE INSURANCE CONTRACT

§2401. SCOPE OF CHAPTER

This chapter applies as to all insurance contracts and annuity contracts, other than: [1969, c. 132, §1 (NEW).]

1. Reinsurance.

[1969, c. 132, §1 (NEW) .]

2. Unless otherwise specifically indicated, policies or contracts not issued for delivery in this State nor delivered in this State; and

[1993, c. 171, Pt. C, §1 (AMD) .]

3. Wet marine and transportation insurance.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 171, §C1 (AMD).

§2402. "POLICY" DEFINED

"Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements and papers which are a part thereof. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2403. "PREMIUM" DEFINED

"Premium" is the consideration for insurance, by whatever name called. Any "assessment", or any "membership", "policy", "survey", "inspection", "service" or similar fee or other charge in consideration for an insurance contract is deemed part of the premium. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2404. INSURABLE INTEREST -- PERSONAL INSURANCE

1. Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. But no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the individual insured or his personal representatives, or to a person having, at the time when such contract was made, an insurable interest in the individual insured.

[1969, c. 132, §1 (NEW) .]

2. If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement, or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

[1969, c. 132, §1 (NEW) .]

3. "Insurable interest" as to such personal insurance means that every individual has an insurable interest in the individual's own life, body, and health, and that a person has an insurable interest in other individuals as follows:

A. In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection; [1969, c. 132, §1 (NEW).]

B. In the case of other persons, a lawful and substantial economic interest in having the life, health or bodily safety of the individual insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the individual insured; [1989, c. 353, §1 (AMD).]

C. A party to a contract or option for the purchase or sale, including a redemption, of an interest in a business proprietorship, partnership or firm, or of shares of stock of a corporation or of an interest in these shares, has an insurable interest in the life, body and health of each individual party to that contract or option, and for the purposes of that contract or option only, in addition to any insurable interest that may otherwise exist as to that individual; [1993, c. 320, §1 (AMD); 1993, c. 320, §4 (AFF).]

D. A corporation has an insurable interest in the lives of its employees, former employees and retirees for the purpose of funding, in the aggregate, all or part of the corporation's cost for preretirement and postretirement medical, death, disability and pension benefits to its employees, former employees, retirees or their beneficiaries, as long as an insurance program used to finance these employee benefits includes former employees, retirees or a broad class of employees selected by objective standards related to age, service, sex or category of employment and that the proceeds created by that insurance program are used for the sole purpose of funding the corporation's preretirement or postretirement benefit programs covering at least a broad class of employees; and [2011, c. 2, §30 (COR).]

E. Any revocable or irrevocable trust has an insurable interest, provided any settlor or any beneficiary of the trust has an insurable interest as provided in paragraph A, B, C or D. A partnership has an insurable interest provided any partner has an insurable interest. [2003, c. 173, §1 (AMD).]

[2011, c. 2, §30 (COR) .]

4. An insurer shall be entitled to rely upon all statements, declarations and representations made by an applicant for insurance relative to the insurable interest of the applicant in the insured; and no insurer shall incur legal liability except as set forth in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 353, §§1,2 (AMD). 1991, c. 548, §§C1-3 (AMD). 1993, c. 320, §§1,2 (AMD). 1993, c. 320, §4 (AFF). 2003, c. 173, §1 (AMD). RR 2011, c. 2, §30 (COR).

§2405. INSURABLE INTEREST -- EXCEPTION WHEN CERTAIN INSTITUTIONS DESIGNATED BENEFICIARY

1. Life insurance contracts may be entered into in which the person, trust or trustee paying the consideration for the insurance has no insurable interest in the life of the individual insured, where charitable, benevolent, educational or religious institutions, or their agencies, are designated irrevocably as the beneficiaries thereof.

[1993, c. 320, §3 (AMD); 1993, c. 320, §5 (AFF) .]

2. In making such contracts, the person paying the premium shall make and sign the application therefor as owner or as settlor of a trust, and shall designate a charitable, benevolent, educational or religious institution, or any agency thereof, irrevocably as the beneficiary or beneficiaries of such contract. The application must be signed also by the individual whose life is to be insured.

[1993, c. 320, §3 (AMD); 1993, c. 320, §5 (AFF) .]

3. Nothing in this section shall be deemed to prohibit any combination of the applicant, premium payer, owner, and beneficiary from being the same person.

[1969, c. 132, §1 (NEW) .]

4. Such a contract shall be valid and binding among the parties thereto, notwithstanding the absence otherwise of an insurable interest in the life of the individual insured.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 320, §3 (AMD). 1993, c. 320, §5 (AFF).

§2406. INSURABLE INTEREST, PROPERTY

1. No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss.

[1969, c. 132, §1 (NEW) .]

2. "Insurable interest" as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2407. POWER TO CONTRACT -- PURCHASE OF INSURANCE AND ANNUITIES BY MINORS

1. Any person of competent legal capacity may contract for insurance.

[1969, c. 132, §1 (NEW) .]

2. Any minor not less than 15 years of age, nearest birthday, may, notwithstanding his minority, contract for or own annuities, or insurance, or affirm by novation or otherwise preexisting contracts for annuities or insurance upon his own life, body, health, property, liabilities or other interests, or on the persons of another in whom the minor has an insurable interest. Such a minor shall, notwithstanding such minority, be deemed competent to exercise all rights and powers with respect to or under any contract for annuity or for insurance upon his own life, body or health, or any contract such minor effected upon his own property, liabilities or other interests, or any contract effected or owned by the minor on the person of another, as might be exercised by a person of full legal age, and may at any time surrender his interest in any such contracts and give valid discharge for any benefit accruing or money payable thereunder. Such a minor shall not, by reason of his minority, be entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated shall not be bound by any unperformed agreement to pay by promissory note or otherwise, any premium on any such annuity or insurance contract.

[1969, c. 132, §1 (NEW) .]

3. Any annuity contract or policy of life or health insurance procured by or for a minor under subsection 2 shall be made payable either to the minor or his estate or to a person having an insurable interest in the life of the minor.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2408. CONSENT OF INSURED FOR HEALTH AND LIFE INSURANCE

1. No life or health insurance contract upon an individual, including contracts which may arise under section 2404, subsection 3, paragraph D, may be made or effectuated, unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies for coverage or has provided written consent, except under the following circumstances.

A. A spouse may effectuate insurance upon the other spouse. [1989, c. 353, §3 (NEW).]

B. Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of the minor. [1989, c. 353, §3 (NEW).]

C. Family policies may be issued insuring 2 or more members of a family on an application signed by either parent, a stepparent or a spouse. [1989, c. 353, §3 (NEW).]

[1989, c. 353, §3 (RPR) .]

2. This section does not apply to:

A. Group life insurance contracts other than group contracts which may arise under section 2404, subsection 3, paragraph D; [1989, c. 353, §3 (NEW).]

B. Group annuity contracts; or [1989, c. 353, §3 (NEW).]

C. Group or blanket health insurance contracts. [1989, c. 353, §3 (NEW).]

[1989, c. 353, §3 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 353, §3 (RPR).

§2409. ALTERATION OF APPLICATION, LIFE AND HEALTH INSURANCE

No alteration of any written application for any life or health insurance policy or annuity contract shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not be ascribed to the applicant. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2410. APPLICATION; STATEMENTS; AS EVIDENCE

1. The insured shall not be bound by any statement made in an application for an individual life or health insurance policy or annuity contract, and the application shall not be admissible in evidence in any action relative to such policy or contract, unless a true copy of the application was attached to or endorsed on the policy or contract when issued as a part thereof. This provision shall not apply to industrial life insurance policies or to group life or group health insurance policies.

[1969, c. 132, §1 (NEW) .]

2. If any policy of life or health insurance delivered in this State is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within 30 days after receipt of such request at its home office, or branch office, deliver or mail to the person making such request a copy of such application reproduced by any legible means. If such copy is not so delivered or mailed after having been so requested, the insurer shall be precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. In the case of such a request from a beneficiary or assignee, the time within which the insurer is required to furnish a copy of such application shall not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's or assignee's vested interest in the policy or contract.

[1969, c. 132, §1 (NEW) .]

3. As to kinds of insurance other than individual life or health insurance, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer has failed, at the expiration of 30 days after receipt by the insurer of written demand therefor by or on behalf of the insured, to furnish to the insured a copy of such application reproduced by any legible means.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2411. REPRESENTATIONS IN APPLICATIONS

All statements and descriptions in any application for insurance or for an annuity contract, by or in behalf of the insured or annuitant, are deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements may not prevent a recovery under the policy or contract unless either: [1999, c. 223, §1 (AMD).]

1. Fraudulent; or

[1969, c. 132, §1 (NEW) .]

2. Material either to the acceptance of the risk, or to the hazard assumed by the insurer, such that the insurer in good faith would either not have issued the insurance or contract, or would not have issued it at the same premium rate, or would not have issued insurance in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

[1999, c. 223, §1 (AMD) .]

3.

[1999, c. 223, §1 (RP) .]

To prevent a recovery under this section for any application for life, credit life, disability, long-term care, accidental injury, specified disease, hospital indemnity or credit or accident insurance, an insurer need only prove one of the acts described in this section, not an act under subsections 1 and 2. [1999, c. 223, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1999, c. 223, §1 (AMD).

§2411-A. PAYMENT OF FEES FOR FILINGS

The superintendent may require insurers to pay filing fees for form and rate approval on a quarterly, biannual or annual basis. [1997, c. 457, §42 (NEW).]

SECTION HISTORY
1997, c. 457, §42 (NEW).

§2412. FILING, APPROVAL OF FORMS

1. An insurance policy or annuity contract form may not be delivered or issued for delivery in this State unless the form has been filed with and approved by the superintendent in accordance with the following.

A. For purposes of this section, "form" includes:

(1) The basic form and any printed rider, endorsement or renewal form;

(2) An application form if a written application is required and is made a part of the policy or contract; and

(3) A certificate of coverage under a group policy or contract that is delivered or issued for delivery in this State. [1997, c. 370, Pt. G, §1 (NEW).]

B. This section does not apply to surety bonds or to specially rated inland marine risks, or to policies, riders, endorsements or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policy holder, contract holder or certificate holder. [1997, c. 370, Pt. G, §1 (NEW).]

C. An advisory organization licensed pursuant to section 2321-A may file forms pursuant to this section on behalf of its members and subscribers. The approval of such a filing does not restrict the right of an insurer authorized to use an advisory organization form to develop and file forms on its behalf in addition to or instead of the advisory organization form. [1997, c. 370, Pt. G, §1 (NEW).]

[1997, c. 370, Pt. G, §1 (RPR) .]

1-A. An insurer may not provide coverage to a resident of this State under a group or blanket policy or contract issued and delivered outside this State unless the following requirements of this subsection are met.

A. For "other group" insurance policies as defined in sections 2612-A and 2808, all forms must be filed with and approved by the superintendent. [1997, c. 370, Pt. G, §2 (NEW).]

B. For trustee group policies as defined in sections 2606-A and 2806 and association group policies as defined in sections 2607-A and 2805-A, certificates of coverage to be delivered or issued for delivery in this State:

(1) Must be filed with the superintendent at least 60 days before any solicitation in this State, with sufficient information concerning the nature of the group, including any trust agreements or association bylaws, to enable the superintendent to determine whether the group satisfies the statutory requirements for a trustee or association group; and

(2) May not have been disapproved. [1997, c. 370, Pt. G, §2 (NEW).]

C. For group or blanket policies other than those specified in paragraphs A and B and in section 2858, the group certificates to be delivered or issued for delivery in this State must be filed with the superintendent at the superintendent's request and may not have been disapproved. [2001, c. 258, Pt. H, §1 (AMD).]

D. The superintendent may disapprove a form filed pursuant to this subsection only if:

(1) The policy or form is not in compliance with the laws of the state in which it was issued or delivered;

(2) The policy or form is not in compliance with the laws of this State that apply when the policy is issued outside this State, such as chapter 36 or section 2843; or

(3) The superintendent determines that the form is deceptive or misleading. [1997, c. 370, Pt. G, §2 (NEW).]

[2001, c. 258, Pt. H, §1 (AMD) .]

2. Every filing must be made not less than 30 days in advance of any delivery. At the expiration of the 30 days, the form so filed is deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the superintendent. Approval of the form by the superintendent constitutes a waiver of any unexpired portion of the waiting period. The superintendent shall act on a filing no later than 30 days from receipt unless an extension is requested by the filer. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. At the expiration of the period so extended, and in the absence of prior affirmative approval or disapproval, any form is deemed approved. The superintendent may at any time, after hearing and for cause shown, withdraw any approval.

[2009, c. 14, §3 (AMD) .]

3. Any order of the superintendent disapproving any such form or withdrawing a previous approval shall state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer thereof. Any such withdrawal of a previously approved form shall be effective at expiration of such period, not less than 30 days after the giving of the order of withdrawal, as the superintendent shall in such order prescribe.

[1973, c. 585, §12 (AMD) .]

4. The superintendent may, by order, exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in such order, to which, in his opinion, this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

[1973, c. 585, §12 (AMD) .]

5. Appeals from orders of the superintendent disapproving any such form or withdrawing a previous approval may be taken as provided in sections 229 to 236.

[1973, c. 585, §12 (AMD) .]

6. **Motor vehicle insurance identification cards.**

[1989, c. 824, §2 (AMD); T. 24-A, §2412, sub-§6 (RP) .]

7. **Motor vehicle insurance identification cards.** Pursuant to this section, the superintendent, with the advice of the Secretary of State, shall adopt rules that prescribe both paper and electronic forms of a motor vehicle insurance identification card for evidence of liability insurance or financial responsibility required under Title 29-A. The superintendent shall require all insurance companies transacting business within this State to provide with each motor vehicle liability insurance policy a form of insurance identification card for each vehicle, describing the vehicle covered. When an insured has 5 or more motor vehicles registered in this State, the insurer may use the designation "all owned vehicles" on each card in lieu of a specific description. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 72, §1 (AMD) .]

8. **Confidentiality of form filings.** Forms filed as required by this section and any supporting information are confidential until the filing is approved.

[2005, c. 121, Pt. C, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1987, c. 341, §§1,7 (AMD). 1987, c. 476, §1 (AMD). 1989, c. 797, §§35,37,38 (AMD). 1989, c. 824, §2 (AMD). 1991, c. 715, §1 (AMD). 1997, c. 126, §4 (AMD). 1997, c. 370, §§G1,2 (AMD). 2001, c. 258, §H1 (AMD). 2003, c. 671, §A2 (AMD). 2005, c. 121, §C2 (AMD). 2009, c. 14, §3 (AMD). 2013, c. 72, §1 (AMD).

§2412-A. LARGE COMMERCIAL CONTRACTS

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

A. "Contract of insurance" means a contract of insurance, as defined in section 3, that provides for property or casualty insurance coverages or a combination of property or casualty insurance, excluding workers' compensation, medical malpractice, life, health and disability insurance. [1999, c. 328, §1 (NEW).]

B. "Large commercial policyholder" means an insurance contract holder that is a corporation, partnership, trust, sole proprietorship or other business or public entity and that has certified that it meets:

(1) At least 2 of the following 3 criteria:

(a) A net worth of $10,000,000 as certified by a certified public accountant or public accountant authorized to do business in this State;

(b) Net revenue or sales of $5,000,000 as certified by a certified public accountant or public accountant authorized to do business in this State; or

(c) A total of more than 25 employees per individual company or more than 50 employees per holding company; and

(2) The following criteria:

(a) The use of an employed or retained risk manager to procure insurance. For purposes of this division, "risk manager" means a chartered property and casualty underwriter, a certified insurance counselor, an associate in risk management, a certified risk manager or a licensed insurance consultant; and

(b) Aggregate property and casualty insurance premiums, excluding workers' compensation, medical malpractice, life, health and disability insurance premiums as follows:

(i) Until December 31, 2000, $90,000;

(ii) From January 1, 2001 until December 31, 2001, $75,000;

(iii) From January 1, 2002 until December 31, 2002, $60,000; and

(iv) After January 1, 2003, $50,000.

"Large commercial policyholder" also includes a nonprofit or public entity with an annual budget or assets of $25,000,000 or more that meets the criteria listed in subparagraph (2) and a municipality with a population of 20,000 or more that meets the premium criteria listed in subparagraph (2), division (b).

A commercial policyholder that meets the premium criteria listed in subparagraph (2), division (b) but that does not meet 3 of the qualifying criteria listed in either subparagraph (1) or subparagraph (2), division (a) may petition the superintendent for a waiver of the remaining criteria. The superintendent may grant a waiver if the superintendent determines that the applicant for a waiver is sufficiently qualified to act as a large commercial policyholder. [2001, c. 3, §1 (AMD).]

[2001, c. 3, §1 (AMD) .]

2. **Regulation of policy; establishing rates.** The provisions of section 2412, subsections 1 to 5 and subsection 8; sections 2413, 2418, 2421 and 2438 to 2445; and chapter 25, subchapter 1, except for section 2303, subsection 1, paragraph B, as the provisions relate to the filing, approval and fixing of or establishing rates, do not apply to any contract of insurance issued to a large commercial policyholder pursuant to this section. Section 2004, subsection 4 also does not apply to any contract of insurance issued pursuant to this section to a large commercial policyholder.

[1999, c. 538, §2 (AMD); 1999, c. 538, §3 (AFF) .]

3. **Underwriting files.** Notwithstanding subsection 2, an insurer issuing contracts of insurance to large commercial policyholders shall maintain underwriting files; premium, loss and expense statistics; claims files and records; written certification from the large commercial policyholder that it meets the criteria for a large commercial policyholder under subsection 1, paragraph B; and financial and other records with regard to such contracts that are subject to examination by the superintendent. A large commercial policyholder shall annually file a certification as a large commercial policyholder with the insurer.

[1999, c. 328, §1 (NEW) .]

4. **Disclaimer required.** Each policy issued to a large commercial policyholder pursuant to this section must include a disclaimer with language similar to the following:

"The contract provisions, rates and rating plans provided for in this policy are exempt from the filing and approval requirements of the Bureau of Insurance."

[1999, c. 328, §1 (NEW) .]

5. **Suspension of program by superintendent.** If the superintendent finds at any time that a sufficient degree of competition does not exist for a particular line, class or type of insurance, then the superintendent may deem the provisions of this section waived for so long as a sufficient degree of competition does not exist. After waiver by the superintendent, upon the request of 5 or more interested parties, the superintendent, within 45 days of the request, shall hold a hearing at which interested parties may present evidence as to whether a sufficient degree of competition exists for the particular line, class or type of insurance.

[1999, c. 328, §1 (NEW) .]

6. **Annual report.** An insurer that issues policies pursuant to this section shall report annually to the superintendent beginning on February 1, 2001 and continuing until February 1, 2005. The report must be made on a form prescribed by the superintendent and must include information relating to the number of policies issued each year sorted by line of insurance; the number of policies renewed each year sorted by line of insurance; and any other pertinent information required by the superintendent.

[1999, c. 328, §1 (NEW) .]

7. **Bureau report.** On or before March 1, 2005, the superintendent shall report to the joint standing committee of the Legislature have jurisdiction over insurance matters on the effects of this section. The report must contain the superintendent's recommendations as to any changes in the criteria established in this section to qualify as a large commercial policyholder.

[1999, c. 328, §1 (NEW) .]

SECTION HISTORY
1999, c. 328, §1 (NEW). 1999, c. 328, §1 (NEW). 1999, c. 538, §§1,2 (AMD). 1999, c. 538, §3 (AFF). 2001, c. 3, §1 (AMD).

§2413. GROUNDS FOR DISAPPROVAL

1. The superintendent shall disapprove any form filed under section 2412, or withdraw any previous approval thereof, only on one or more of the following grounds:

A. If it is in any respect in violation of or does not comply with this Title; [1969, c. 132, §1 (NEW).]

B. If it contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract; [1969, c. 132, §1 (NEW).]

C. If it has any title, heading or other indication of its provisions which is misleading; [1969, c. 132, §1 (NEW).]

D. As to an individual health insurance policy, if the benefits provided therein are unreasonable in relation to the premium charged; or, as to any health insurance contract, if it contains any unjust, unfair or inequitable provision or provisions; [1969, c. 132, §1 (NEW).]

E. As to a life insurance or health insurance policy, if it contains a provision or provisions such as to encourage misrepresentation; [1991, c. 211, §1 (AMD).]

F. As to Medicare supplement policies or contracts, as defined in chapter 67, if the policy cannot be anticipated, as estimated for the entire period for which rates are to be computed to provide coverage, on the basis of incurred claims experience and earned premiums for that period and in accordance with accepted actuarial principles and practices, to return to policyholders in the form of aggregate benefits provided under the policy at least 65% of the aggregate amount of premiums collected in the case of individual policies and at least 75% of the aggregate amount of premiums collected in the case of group policies; or [1991, c. 211, §2 (AMD).]

G. As to an individual health insurance policy, contract or rider, if it insures against a specific disease and does not meet the minimum loss ratio standards specified in subparagraph (2).

(1) As used in this paragraph, unless the context otherwise indicates, the following terms have the following meanings.

(a) "Conditionally renewable" means renewal may be declined by the insurer by class, geographic area or for stated reasons other than health.

(b) "Guaranteed renewable" means renewal may be declined by the insurer only for nonpayment of premium but rates may be revised on a class basis.

(c) "Noncancelable" means renewal may not be declined by the insurer and rates may not be revised.

(d) "Optionally renewable" means renewal is at the option of the insurer.

(2) The loss ratio standards for each type of renewal clause are:

(a) Optionally renewable insurance, 60%;

(b) Conditionally renewable insurance, 55%; and

(c) Guaranteed renewable and noncancelable insurance, 50%. [1991, c. 211, §3 (NEW).]

[1991, c. 211, §§1-3 (AMD) .]

2. The insurer shall not use in this State any such form after disapproval or withdrawal of approval.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 234, §§2,3 (AMD). 1989, c. 27, §1 (AMD). 1991, c. 211, §§1-3 (AMD).

§2414. STANDARD PROVISIONS, IN GENERAL

1. Insurance contracts shall contain such standard or uniform provisions as are required by the applicable provisions of this Title pertaining to contracts of particular kinds of insurance. The superintendent may waive the required use of a particular provision in a particular insurance policy form if:

A. He finds such provision unnecessary for or unrelated to the protection of the insured and inconsistent with the purposes of the policy, and [1969, c. 132, §1 (NEW).]

B. The policy is otherwise approved by him. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

2. No policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used, but the superintendent may approve any substitute provision which is, in his opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

[1973, c. 585, §12 (AMD) .]

3. In lieu of the provisions required by this Title for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the superintendent.

[1973, c. 585, §12 (AMD) .]

4. A policy issued by a domestic insurer for delivery in another jurisdiction may contain or omit any provisions as required or permitted by the laws of such jurisdiction.

[1969, c. 132, §1 (NEW) .]

5. This section does not apply as to the standard fire policy.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2415. CHARTER, BYLAW PROVISIONS

No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer (other than the subscriber's agreement or power of attorney of a reciprocal insurer) a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2416. EXECUTION OF POLICIES

1. Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer.

[1969, c. 132, §1 (NEW) .]

2. A facsimile signature of any such executing individual may be used in lieu of an original signature.

[1969, c. 132, §1 (NEW) .]

3. No insurance contract heretofore or hereafter issued and which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2417. UNDERWRITERS' AND COMBINATION POLICIES

1. Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer.

[1969, c. 132, §1 (NEW) .]

2. Two or more insurers may, with the approval of the superintendent, issue a combination policy which shall contain provisions substantially as follows:

A. That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy, and [1969, c. 132, §1 (NEW).]

B. That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. This section shall not apply to cosurety obligations.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2418. VALIDITY AND CONSTRUCTION OF NONCOMPLYING FORMS

1. A policy hereafter delivered or issued for delivery to any person in this State in violation of this Title but otherwise binding on the insurer, shall be held valid, but shall be construed as provided in this Title.

[1969, c. 132, §1 (NEW) .]

2. Any condition, omission or provision not in compliance with the requirements of this Title and contained in any policy, rider, or endorsement hereafter issued and otherwise valid, shall not thereby be rendered invalid but shall be construed and applied in accordance with such condition, omission or provision as would have applied had the same been in full compliance with this Title.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2419. DELIVERY OF POLICY AS TO MOTOR VEHICLE INSURANCE

In event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the

property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of such duplicate policy or memorandum. This section does not apply to inland marine floater policies. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2420. ASSIGNABILITY; RIGHTS OF INSURER, ASSIGNEE

1. A policy may be assignable or not assignable, as provided or permitted by its terms.

[1969, c. 132, §1 (NEW) .]

2. Subject to its terms relating to assignability, a life or health insurance policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer.

[1969, c. 132, §1 (NEW) .]

3. Any assignment of a policy which is otherwise lawful and of which the insurer has received notice, shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

[1969, c. 132, §1 (NEW) .]

3-A. Upon receiving notice of a revocation of an assignment of a life insurance policy pursuant to this section, an insurer shall notify the assignee of the policy that the insured or owner has revoked the assignment. The insurer shall also notify the assignee if any cash value of the policy has been distributed at the time of revocation. Notice must be sent to the assignee within 30 days. An insurer is deemed to have complied with this subsection if that insurer has mailed notice by first class mail to the last known mailing address of the assignee.

[2003, c. 109, §1 (NEW) .]

4. Any individual insured under a group insurance policy or group annuity contract shall have the right, unless expressly prohibited under the terms of the policy or contract, to assign to any other person his rights and benefits under the policy or contract, including, but not limited to, the right to designate the beneficiary or beneficiaries and the rights as to conversion provided for in sections 2621 to 2625, and, subject to the terms of the policy relating to assignments thereunder, any such assignment, made either before or after January 2, 1970, shall be valid for the purpose of vesting in the assignee all such rights and benefits so assigned. While the assignment is in effect, and whether heretofore or hereafter made, the insurer shall be entitled to deal with the assignee as the owner of such rights and benefits in accordance with the terms of the assignment; but without prejudice to the insurer on account of any lawful action taken or payment made by it prior to receipt by it at its home office of written notice of the assignment or of the termination thereof.

[1973, c. 625, §143 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §39 (AMD). 1973, c. 625, §143 (AMD). 2003, c. 109, §1 (AMD).

§2421. RENEWAL OF POLICY

Any policy terminating by its terms at a specified expiration date and not otherwise renewable, may be renewed or extended at the option of the insurer and upon a currently authorized policy form and at the premium rate then required therefor for a specified additional period or periods by a certificate or other endorsement of the policy, and without requiring issuance of a new policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2422. NOTICE TO, KNOWLEDGE OF AGENT BINDING ON INSURER

1. An agent authorized by an insurer, if the name of such agent is borne on the policy, is the insurer's agent in all matters of insurance. Any notice required to be given by the insured to the insurer or any of its officers may be given in writing to such agent.

[1969, c. 132, §1 (NEW) .]

2. The authorized agent of an insurer shall be regarded as in the place of the insurer in all respects regarding any insurance effected by him. The insurer is bound by his knowledge of the risk and all matters connected therewith. Omissions and misdescriptions known to the agent shall be regarded as known to the insurer and waived by it as if noted in the policy.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2423. FORMS FOR PROOF OF LOSS TO BE FURNISHED

An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2424. CLAIMS ADMINISTRATION NOT WAIVER

Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer may be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder: [2009, c. 2, §67 (COR).]

1. Acknowledgement of the receipt of notice of loss or claim under the policy.

[1969, c. 132, §1 (NEW) .]

2. Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

[1969, c. 132, §1 (NEW) .]

3. Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). RR 2009, c. 2, §67 (COR).

§2425. PAYMENT DISCHARGES INSURER

Whenever the proceeds of or payments under an insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance therewith or in accordance with any written assignment thereof, the person then designated as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2426. ADVANCE PAYMENTS

1. No payment or payments made by any person, or by his insurer by virtue of an insurance policy, on account of bodily injury or death or damage to or loss of property of another, shall constitute an admission of liability or waiver of defense as to such injury, death, loss or damage, or be admissible in evidence in any action brought against the insured person or his insurer for damages, indemnity or benefits arising out of such injury, death, loss or damage unless pleaded as a defense to the action.

[1969, c. 132, §1 (NEW) .]

2. All such payments shall be credited upon any settlement with respect to the same damage, expense, or loss made by, or upon any judgment rendered therefor in such an action against, the payor or his insurer, and in favor of any person to whom or on whose account payment was made.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2427. MINOR MAY GIVE ACQUITTANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 663, §144 (RP).

§2428. EXEMPTION OF PROCEEDS -- LIFE, ENDOWMENT, ANNUITY, ACCIDENT CONTRACTS

1. Certain policies of insurance shall be exempt from claims of creditors, and the rights of beneficiaries and assignees thereof shall be protected, as set forth.

[1969, c. 132, §1 (NEW) .]

2. Except in cases of transfers with intent to defraud creditors, if a contract of life, endowment, annuity or accident insurance, whether heretofore or hereafter issued, is effected by any person on that person's own life or on another life, in favor of a person other than the person effecting that contract, or is assigned or in any way made payable to any other person, the lawful beneficiary or assignee thereof, other than the insured or the person so effecting such contract of insurance or executors or administrators of such insured or of the person so effecting such contract of insurance, is entitled to its proceeds and avails against the creditors and representatives of the insured and of the person effecting the same, whether or not the right to change the beneficiary is reserved or permitted and whether or not the contract of insurance is made payable to the person whose life is insured or to the executor or administrator of such person if the beneficiary or assignee predeceases such person, and such proceeds and avails are exempt from all liability for any debt of the beneficiary existing at the time the proceeds and avails are made available for the beneficiary's use. Subject to the statutes of limitations, the amount of any premiums for such contract of insurance paid with intent to defraud creditors, with interest thereon, inures to the benefit of the creditors from the proceeds of the contract of insurance; but the insurer issuing the contract must be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before such payment the insurer has received written notice, by or in behalf of a creditor with specifications of the amount claimed along with such facts as will assist the insurer to ascertain the particular policy, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, and unless such insurer has been served with trustee process for the cash surrender value of any such contract of insurance as required by law prior to making payment of the proceeds in accordance with the terms of the contract of insurance.

[2013, c. 2, §37 (COR) .]

3. For the purpose of subsection 2, a contract of insurance shall also be deemed to be payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the contract permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by such clause.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). RR 2013, c. 2, §37 (COR).

§2429. EXEMPTION OF PROCEEDS, HEALTH INSURANCE

Except as may otherwise be expressly provided by the policy or contract, the proceeds or avails of all contracts of health insurance and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts heretofore or hereafter effected shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for his use. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2430. EXEMPTION OF PROCEEDS, GROUP INSURANCE

1. A policy of group life insurance or group health insurance or the proceeds thereof payable to the individual insured or to the beneficiary thereunder, shall not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of such insured individual or his beneficiary or of any other person having a right under the policy.

[1969, c. 132, §1 (NEW) .]

2. This section shall not apply to group insurance issued pursuant to this Title to a creditor covering his debtors, to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2431. EXEMPTION OF PROCEEDS, INDIVIDUAL ANNUITY CONTRACTS; ASSIGNABILITY OF RIGHTS

1. The benefits, rights, privileges and options which under any individual annuity contract heretofore or hereafter issued are due or prospectively due the annuitant, shall not be subject to execution nor shall the annuitant be compelled to exercise any such rights, powers, or options, nor shall creditors be allowed to interfere with or terminate the contract, except:

A. As to amounts paid for or as premium on any such annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice received at its home office prior to the making of the payment to the annuitant out of which the creditor seeks to recover. Any such notice shall specify the amount claimed or such facts as will enable the insurer to ascertain such amount, and shall set forth such facts as will enable the insurer to ascertain the annuity contract, the annuitant and the payment sought to be avoided on the ground of fraud. [1969, c. 132, §1 (NEW).]

B. The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity contracts under which he is an annuitant, shall not at any time exceed $450 per month for the length of time represented by such installments, and that such periodic payments in excess of $450 per month shall be subject to garnishee execution to the same extent as are wages and salaries. [1969, c. 132, §1 (NEW).]

C. If the total benefits presently due and payable to any annuitant under all annuity contracts under which he is an annuitant, shall at any time exceed payment at the rate of $450 per month, then the court may order such annuitant to pay to a judgment creditor or apply on the judgment, in installments, such portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court orders. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. If the contract so provides, the benefits, rights, privileges or options accruing under such contract to a beneficiary or assignee shall not be transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained herein for the annuitant, shall apply with respect to such beneficiary or assignee.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2432. EXEMPTION OF EMPLOYEE'S INTEREST -- GROUP ANNUITIES, PENSION TRUSTS

If any group annuity contract or pension trust, whether heretofore or hereafter issued, is effected by an employer for the benefit of his employees, whether or not requiring any contribution toward the cost thereof by such employees, the interest of any employee, beneficiary or joint or contingent annuitant in any policy, certificate or fund in connection therewith and his interest in any payments or proceeds thereof and in any optional or death benefits shall not in any way be subject to execution, levy, attachment, garnishment, trustee process or any other legal or equitable process. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2433. JURISDICTION OF COURTS, LIMITATION OF ACTIONS

No conditions, stipulations or agreements in a contract of insurance shall deprive the courts of this State of jurisdiction of actions against foreign insurers, or limit the time for commencing actions against such insurers to a period of less than 2 years from the time when the cause of action accrues. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2434. SUITS AGAINST FOREIGN INSURERS

Any person having a claim against any foreign insurer may bring a trustee action or any other appropriate action therefor in the courts of this State. Service of process upon such an insurer must be made as provided in section 421. [1997, c. 457, §43 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §43 (AMD).

§2436. INTEREST ON OVERDUE PAYMENTS

1. A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information; except that:

A. The time period applicable to a standard fire policy and to that portion of a policy providing a combination of coverages, as described in section 3003, insuring against the peril of fire must be 60 days, as provided in section 3002; and [2009, c. 244, Pt. H, §1 (NEW).]

B. The time period applicable to individual life insurance must be 2 months as provided in section 2513. [2009, c. 244, Pt. H, §1 (NEW).]

[2009, c. 244, Pt. H, §1 (AMD) .]

1-A. A claimant, including a health care provider, may submit simultaneously a claim for payment with all carriers potentially liable for payment of the claim whether primary or secondary. Payment or denial of a claim by each carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim whether or not another carrier with which it is attempting to coordinate has acted on the claim. Any payment made must be in accordance with rules adopted by the superintendent relative to coordination of benefits.

[2005, c. 58, §1 (NEW) .]

2. An insurer may dispute a claim by furnishing to the insured or beneficiary, or a representative of the insured or beneficiary, a written statement that the claim is disputed with a statement of the grounds upon which it is disputed. The statement must be based upon a reasonable investigation of the claim and must include sufficient detail to permit the insured or beneficiary to understand and respond to the insurer's position. For purposes of this subsection, a claim for payments under a policy or certificate providing health care coverage is disputed if the insurer has denied the claim or has requested further information that is consistent with Bureau of Insurance Rule Chapter 850.

[1999, c. 256, Pt. I, §1 (AMD) .]

2-A. For a claim submitted by a health care provider or health care facility with respect to a health plan as defined in section 4301-A, subsection 7, for purposes of this section, "undisputed claim" means a timely claim for payment of covered health care expenses that is submitted to a carrier in conformity with the following requirements.

A. The claim must be submitted on one of the following claims forms:

(1) For a health care facility claim submitted on paper, the standard claim form, using standards approved by a national uniform billing committee;

(2) For a health care provider claim submitted on paper, the standard claim form, using standards approved by a national uniform claim committee; and

(3) For health care facility and health care provider claims submitted electronically, an electronic form using standards approved by an accredited standards committee of the American National Standards Institute. [2009, c. 613, §9 (NEW).]

[2009, c. 613, §9 (RPR) .]

2-B. If a claim does not conform to the requirements specified in subsection 2-A and payment is denied to a health care provider or health care facility by a carrier, the health care provider or health care facility may not request payment from the insured or beneficiary and shall attempt to rectify the deficiencies with the claim and resubmit the claim to the carrier.

[2009, c. 613, §10 (NEW) .]

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. Notwithstanding this subsection, the superintendent shall adopt rules that establish a minimum

amount of interest payable on an overdue undisputed claim to a health care provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2005, c. 50, §1 (AMD) .]

4. A reasonable attorney's fee for advising and representing a claimant on an overdue claim or action for an overdue claim must be paid by the insurer if overdue benefits are recovered in an action against the insurer or if overdue benefits are paid after receipt of notice of the attorney's representation.

[1999, c. 256, Pt. I, §1 (AMD) .]

5. Nothing in this section prohibits or limits any claim or action for a claim that the claimant has against the insurer.

[1999, c. 256, Pt. I, §1 (AMD) .]

6. This section does not apply to a claim for payment of benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State.

[2013, c. 278, §1 (NEW) .]

SECTION HISTORY
1973, c. 480, (NEW). 1975, c. 157, (AMD). 1975, c. 321, (AMD). 1977, c. 357, (RPR). 1987, c. 344, (RPR). 1999, c. 256, §I1 (AMD). 2001, c. 569, §1 (AMD). 2003, c. 218, §§3, 4 (AMD). 2003, c. 469, Pt. D, §4 (AMD). 2003, c. 469, Pt. D, §9 (AFF). 2005, c. 50, §1 (AMD). 2005, c. 58, §1 (AMD). 2009, c. 244, Pt. H, §1 (AMD). 2009, c. 613, §§9, 10 (AMD). 2013, c. 278, §1 (AMD).

§2436-A. UNFAIR CLAIMS SETTLEMENT PRACTICES

1. **Civil actions.** A person injured by any of the following actions taken by that person's own insurer may bring a civil action and recover damages, together with costs and disbursements, reasonable attorney's fees and interest on damages at the rate of 1 1/2% per month:

A. Knowingly misrepresenting to an insured pertinent facts or policy provisions relating to coverage at issue; [1997, c. 621, §1 (RPR).]

B. Failing to acknowledge and review claims, which may include payment or denial of a claim, within a reasonable time following receipt of written notice by the insurer of a claim by an insured arising under a policy; [1997, c. 621, §1 (RPR).]

C. Threatening to appeal from an arbitration award in favor of an insured for the sole purpose of compelling the insured to accept a settlement less than the arbitration award; [1997, c. 621, §1 (RPR).]

D. Failing to affirm or deny coverage, reserving any appropriate defenses, within a reasonable time after having completed its investigation related to a claim; or [1997, c. 621, §1 (RPR).]

E. Without just cause, failing to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. [1997, c. 621, §1 (NEW).]

[1997, c. 621, §1 (RPR) .]

2. **Without just cause.** For the purposes of this section, an insurer acts without just cause if it refuses to settle claims without a reasonable basis to contest liability, the amount of any damages or the extent of any injuries claimed.

[1997, c. 621, §1 (RPR) .]

3. **No limitation on other cause of action.** Nothing in this section prohibits any other claim or cause of action a person has against an insurer.

[1997, c. 621, §1 (NEW) .]

4. **Application.** This section does not apply to workers' compensation claims.

[1997, c. 621, §1 (NEW) .]

SECTION HISTORY
1987, c. 291, §2 (NEW). 1997, c. 621, §1 (RPR).

§2436-B. DECLARATORY JUDGMENT ACTIONS INVOLVING INSURANCE POLICIES

1. **Definition.** For purposes of this section, "insured" means a natural person and does not include a corporation, trust, partnership, incorporated or unincorporated association or any other legal entity.

[2001, c. 126, §1 (NEW) .]

2. **Costs and attorney's fees.** In an action pursuant to Title 14, chapter 707 to determine an insurer's contractual duty to defend an insured under an insurance policy, if the insured prevails in such action, the insurer shall pay court costs and reasonable attorney's fees.

[2001, c. 126, §1 (NEW) .]

3. **Application.** This section does not apply to workers' compensation, disability, life, health, accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance.

[2001, c. 126, §1 (NEW) .]

4. **Construction.** This section may not be construed to permit any assignment of rights by an insured to any other person or to create or extend any right or cause of action for a 3rd-party claimant under an insurance policy.

[2001, c. 126, §1 (NEW) .]

SECTION HISTORY
2001, c. 126, §1 (NEW).

§2437. PROCEDURES COVERED BY HEALTH INSURANCE POLICIES WHETHER PERFORMED BY PHYSICIAN OR DENTIST

Whenever the terms "physician" or "doctor" are used in any policy of health or accident insurance issued in this State, these terms shall include within their meaning those persons licensed under and in accordance with the laws relating to the practice of dentistry, Title 32, chapter 16, in respect to any care, services,

procedures or benefits covered by that policy of insurance which those persons are licensed to perform, any provisions in any such policy of insurance to the contrary notwithstanding. [1975, c. 345, §2 (NEW).]

SECTION HISTORY
1975, c. 345, §2 (NEW).

§2438. SHORT TITLE

This section and sections 2439 to 2445 shall be known as the "Insurance Policy Language Simplification Act." [1979, c. 267, §2 (NEW).]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2439. DEFINITIONS

As used in sections 2438 to 2445, unless the context otherwise indicates, the following terms shall have the following meanings. [1979, c. 267, §2 (NEW).]

1. **Insurer.** "Insurer" means any life, health, casualty or property insurance company, fraternal benefit society, nonprofit health service corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization and all similar type organizations.

[1979, c. 267, §2 (NEW) .]

2. **Policy or policy form.** "Policy" or "policy form" means any policy, contract, plan or agreement of life or health insurance or casualty or property insurance subject to chapter 39, subchapter II, or chapter 41, subchapter V, including credit life insurance and credit health insurance.

[1979, c. 267, §2 (NEW) .]

3. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1979, c. 267, §2 (NEW) .]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2440. APPLICABILITY

1. **Application.** This Act shall apply to all policies delivered or issued for delivery in this State by an insurer on or after the date the forms must be approved under this Act, but nothing in this Act shall apply to:

A. Any policy which is a security subject to federal jurisdiction; [1979, c. 267, §2 (NEW).]

B. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life or health insurance policy; this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this State; [1979, c. 267, §2 (NEW).]

C. Any group annuity contract which serves as a funding vehicle for pension, profit-sharing or deferred compensation plans; [1979, c. 267, §2 (NEW).]

D. Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates the forms must be approved under this section; [1979, c. 267, §2 (NEW).]

E. The renewal of a policy delivered or issued for delivery prior to the dates the forms must be approved under this Act. [1979, c. 267, §2 (NEW).]

[1979, c. 267, §2 (NEW) .]

2. **Exception.** No other statute of this State setting language simplification standards shall apply to any policy forms.

[1979, c. 267, §2 (NEW) .]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2441. MINIMUM POLICY LANGUAGE SIMPLIFICATION STANDARDS

1. **Delivery.** In addition to any other requirements of law, no policy forms, except as stated in section 2440, shall be delivered or issued for delivery in this State on or after the dates the forms must be approved under this Act unless:

A. The text achieves a minimum score of 50 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection 3; [1979, c. 267, §2 (NEW).]

B. It is printed, except for specification pages, schedules and tables, in not less than 10-point type, one-point leaded; [1979, c. 267, §2 (NEW).]

C. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and [1979, c. 267, §2 (NEW).]

D. It contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words printed on 3 or fewer pages of text, or if the policy has more than 3 pages regardless of the number of words. [1979, c. 267, §2 (NEW).]

[1979, c. 267, §2 (NEW) .]

2. **Test score measured.** For the purposes of this section, a Flesch reading ease test score shall be measured by the following method:

A. For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, the readability of two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines; [1979, c. 267, §2 (NEW).]

B. The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015; [1979, c. 267, §2 (NEW).]

C. The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6; [1979, c. 267, §2 (NEW).]

D. The sum of the figures computed under paragraphs B and C subtracted from 206.835 equals the Flesch reading ease score for the policy form; [1979, c. 267, §2 (NEW).]

E. For purposes of this subsection, paragraphs B, C and D, the following procedures shall be used:

(1) A contraction, hyphenated word or numbers and letters, when separated by space, shall be counted as one word;

(2) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and

(3) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. Where the dictionary shows 2 or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used; and [1979, c. 267, §2 (NEW).]

F. The term "text" as used in this subsection shall include all printed matter except the following:

(1) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules or tables; and

(2) Any policy language which is drafted to conform to the requirements of any federal law, regulation or agency interpretation; any policy language required by any collectively bargained agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation; provided, the insurer identifies the language or terminology excepted by this paragraph and certifies, in writing, that the language or terminology is entitled to be excepted by this subparagraph. [1979, c. 267, §2 (NEW).]

[1979, c. 267, §2 (NEW) .]

3. **Test approval.** Any other reading test may be approved by the superintendent for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

[1979, c. 267, §2 (NEW) .]

4. **Filings.** Filings subject to this Act shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with section 2443. To confirm the accuracy of any certification, the superintendent may require the submission of further information to verify the certification in question.

Notwithstanding any other provision of this Act, rating organizations may act on behalf of their members and subscribers in complying with the requirements of this subsection. A member or subscriber shall be responsible for the actions of a rating organization on behalf of that member or subscriber under this subsection in the same manner as if the member or subscriber had acted on its own behalf.

[1979, c. 267, §2 (NEW) .]

5. **Scoring.** At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

[1979, c. 267, §2 (NEW) .]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2442. CONSTRUCTION

Nothing in this Act shall be construed to negate any law of this State permitting the issuance of any policy form after it has been on file for the time period specified. [1979, c. 267, §2 (NEW).]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2443. POWERS OF THE SUPERINTENDENT

The superintendent may authorize a lower score than the Flesch reading ease score required in section 2441, subsection 1, paragraph A, whenever, in his sole discretion, he finds that a lower score will provide a more accurate reflection of the readability of a policy form, or is warranted by the nature of a particular policy form or type or class of policy forms, or is caused by certain policy language which is drafted to conform to the requirements of any state law, regulation or agency interpretation. [1979, c. 267, §2 (NEW).]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2444. APPROVAL OF FORMS

A policy form meeting the requirements of section 2441, subsection 1 shall be approved notwithstanding the provisions of any other laws which specify the content of policies, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such laws. [1979, c. 267, §2 (NEW).]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2445. EFFECTIVE DATES

1. **Policy form delivered.** No policy form shall be delivered or issued for delivery in this State on or after June 1, 1984, unless approved by the superintendent or permitted to be issued under this Act. Any policy form which has been approved or permitted to be issued prior to June 1, 1984, and which meets the standards set by this Act need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this State upon the filing with the superintendent of a list of forms identified by form number and accompanied by a certificate as to each form in the manner provided in section 2441, subsection 4.

[1979, c. 267, §2 (NEW) .]

2. **Dates extended.** The superintendent may, in his sole discretion, extend the dates in subsection 1.

[1979, c. 267, §2 (NEW) .]

SECTION HISTORY
1979, c. 267, §2 (NEW).

§2450. ELIGIBILITY FOR HEALTH INSURANCE IN CERTAIN CASES

No policy of accident or health insurance, or group or blanket accident or health insurance or renewals thereof, shall be denied or not renewed by the insurer, solely because the mother of the insured has taken or is discovered to have taken diethylstilbestrol, commonly referred to as DES. [1979, c. 415, §3 (NEW).]

SECTION HISTORY
1979, c. 415, §3 (NEW).

§2451. MINIMUM 3-MONTH POLICY FOR MOTOR VEHICLE LIABILITY INSURANCE

(REPEALED)

SECTION HISTORY

1987, c. 341, §§2,7 (NEW). MRSA T. 24-A, §2451 (RP).

§2452. EMPLOYEE BENEFIT EXCESS INSURANCE; NONDISCRIMINATION; PROHIBITED CLAUSES

1. **Discrimination prohibited.** A policy of employee benefit excess insurance may not discriminate unfairly among or against beneficiaries of the underlying benefit plan, or treat conditions related to the Human Immunodeficiency Virus, or HIV, more restrictively than other sicknesses or disabling conditions.

[1991, c. 385, §11 (NEW) .]

2. **Commutation clause.** A policy of employee benefit excess insurance may not contain a commutation clause that extinguishes the excess carrier's gross claims liability to the insured person through the recapture of loss reserves, unless the policy contains a provision giving the insured the option of requiring that the funds transferred in support of such a commutation have been evaluated by a qualified health actuary who is a member of the American Academy of Actuaries and has certified that the aggregate value of reserves to be recaptured are reasonably adequate to discharge the insured's expected liability for future costs of the health benefits covered by the excess policy.

[1991, c. 385, §11 (NEW) .]

3. **Review.** An employee benefit excess insurance form is not exempt from the review provisions otherwise applicable under section 2412 on the ground that the form is designed for insurance on a particular subject.

[1991, c. 385, §11 (NEW) .]

SECTION HISTORY
1991, c. 385, §11 (NEW).

§2453. EFFECTIVE DATE OF CANCELLATION

Life and health insurance policies that do not provide for any refund of premium when a policyholder requests cancellation prior to the end of the period for which premiums have been paid must state that no refund is payable and that the cancellation will take effect at the end of the period for which premiums have been paid unless the policyholder requests an earlier cancellation date. If a policyholder requests cancellation of a contract before the end of the period for which premiums have been paid, then the insurer must inform the policyholder in writing that no refund is payable and give the policyholder an opportunity to amend the cancellation request to take effect at the end of the period for which premiums have been paid. [1997, c. 604, Pt. F, §2 (NEW).]

SECTION HISTORY
1997, c. 604, §F2 (NEW).

Chapter 28: INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

§2471. SHORT TITLE -- ARTICLE 1

This chapter may be known and cited as "the Interstate Insurance Product Regulation Compact." [2003, c. 680, §1 (NEW).]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2472. INTERSTATE INSURANCE PRODUCT REGULATION COMPACT ESTABLISHED; PURPOSES

1. **Compact established.** Pursuant to terms and conditions of this chapter, the State seeks to join with other states and establish the Interstate Insurance Product Regulation Compact, referred to in this chapter as "the compact," and thus become a member of the Interstate Insurance Product Regulation Commission. The superintendent is designated to serve as the representative of this State to the commission.

[2003, c. 680, §1 (NEW) .]

2. **Purposes.** The purposes of this compact are, through means of joint and cooperative action among the compacting states:

A. To promote and protect the interest of consumers of individual and group annuity, life, disability income and long-term care insurance products; [2003, c. 680, §1 (NEW).]

B. To develop uniform standards for insurance products covered under the compact; [2003, c. 680, §1 (NEW).]

C. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states; [2003, c. 680, §1 (NEW).]

D. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard; [2003, c. 680, §1 (NEW).]

E. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact; [2003, c. 680, §1 (NEW).]

F. To create the Interstate Insurance Product Regulation Commission; and [2003, c. 680, §1 (NEW).]

G. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2473. DEFINITIONS -- ARTICLE 2

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2003, c. 680, §1 (NEW).]

1. **Advertisement.** "Advertisement" means any material designed to create public interest in a product or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the rules and operating procedures of the commission.

[2003, c. 680, §1 (NEW) .]

2. **Bylaws.** "Bylaws" means the bylaws established by the commission for its governance or for directing or controlling the commission's actions or conduct.

[2003, c. 680, §1 (NEW) .]

3. **Compacting state.** "Compacting state" means a state that has enacted the compact and that has not withdrawn pursuant to section 2485, subsection 1 or been terminated pursuant to section 2485, subsection 2.

[2003, c. 680, §1 (NEW) .]

4. **Commission.** "Commission" means the Interstate Insurance Product Regulation Commission established by the compact.

[2003, c. 680, §1 (NEW) .]

5. **Commissioner.** "Commissioner" means the chief insurance regulatory official of a compacting state, including, but not limited to, commissioner, superintendent, director or administrator.

[2003, c. 680, §1 (NEW) .]

6. **Domiciliary state.** "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry.

[2003, c. 680, §1 (NEW) .]

7. **Insurer.** "Insurer" means an entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by the compact.

[2003, c. 680, §1 (NEW) .]

8. **Management committee.** "Management committee" means the management committee established under section 2476, subsection 5.

[2003, c. 680, §1 (NEW) .]

9. **Member.** "Member" means the person chosen by a compacting state as its representative to the commission, or the member's designee.

[2003, c. 680, §1 (NEW) .]

10. **Noncompacting state.** "Noncompacting state" means a state that is not a compacting state.

[2003, c. 680, §1 (NEW) .]

11. **Operating procedures.** "Operating procedures" means procedures adopted by the commission implementing a rule, uniform standard or provision of the compact.

[2003, c. 680, §1 (NEW) .]

12. **Product.** "Product" means the form of a policy or contract, including an application, endorsement or related form that is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an insurer is authorized to issue.

[2003, c. 680, §1 (NEW) .]

13. **Rule.** "Rule" means a statement of general or particular applicability and future effect adopted by the commission, including a uniform standard developed pursuant to section 2478, designed to implement, interpret or prescribe law or policy or describing the organization, procedure or practice requirements of the commission, that has the force and effect of law in the compacting states.

[2003, c. 680, §1 (NEW) .]

14. **State.** "State" means any state, district or territory of the United States of America.

[2003, c. 680, §1 (NEW) .]

15. **Third-party filer.** "Third-party filer" means an entity that submits a product filing to the commission on behalf of an insurer.

[2003, c. 680, §1 (NEW) .]

16. **Uniform standard.** "Uniform standard" means a standard adopted by the commission for a product line, pursuant to section 2478, and includes all of the product requirements in aggregate. Each uniform standard must be construed, whether the prohibition is express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public is not unfair, inequitable or against public policy as determined by the commission.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2474. ESTABLISHMENT OF COMMISSION; VENUE -- ARTICLE 3

1. **Commission created.** The compacting states hereby create and establish a joint public agency known as the Interstate Insurance Product Regulation Commission. The commission has the power to develop uniform standards for product lines, receive and provide prompt review of products filed and give approval to those product filings satisfying applicable uniform standards. It is not intended that the commission be the exclusive entity for receipt and review of insurance product filings in the State. This subsection does not prohibit an insurer from filing its product in a state where the insurer is licensed to conduct the business of insurance, and any such filing is subject to the laws of the state where filed.

[2003, c. 680, §1 (NEW) .]

2. **Body corporate.** The commission is a body corporate and politic and an instrumentality of the compacting states.

[2003, c. 680, §1 (NEW) .]

3. **Responsible for liabilities.** The commission is solely responsible for its liabilities except as otherwise specifically provided in the compact.

[2003, c. 680, §1 (NEW) .]

4. **Venue.** Proper and judicial proceedings by or against the commission must be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2475. POWERS OF THE COMMISSION -- ARTICLE 4

The commission has the power: [2003, c. 680, §1 (NEW).]

1. **Promulgate rules.** To promulgate rules, pursuant to section 2478, that have the force of law and are binding in the compacting states to the extent and in the manner provided in the compact;

[2003, c. 680, §1 (NEW) .]

2. **Uniform standards.** To exercise its rule-making authority and establish reasonable uniform standards for products and advertisements, which have the force of law and are binding in the compacting states, but only for those products filed with the commission. A compacting state has the right to opt out of the uniform standard pursuant to section 2478 to the extent and in the manner provided in the compact. A uniform standard established by the commission for long-term care insurance products may provide either the same or greater protections for consumers as, but may not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-term Care Insurance Model Act and Long-term Care Insurance Model Regulation, adopted by the National Association of Insurance Commissioners as of 2001. The commission shall consider whether any subsequent amendments to the National Association of Insurance Commissioners' Long-term Care Insurance Model Act or Long-term Care Insurance Model Regulation adopted as of 2001 by the National Association of Insurance Commissioners require the amendment of the uniform standards established by the commission for long-term care insurance products;

[2003, c. 680, §1 (NEW) .]

3. **Products; receive and review.** To receive and review in an expeditious manner products filed with the commission and rate filings for disability income and long-term care insurance products and to give approval of those products and rate filings that satisfy the applicable uniform standard. Approval by the commission has the force of law and is binding on the compacting states to the extent and in the manner provided in the compact;

[2003, c. 680, §1 (NEW) .]

4. **Advertisements.** To receive and review in an expeditious manner advertisements relating to long-term care insurance products for which uniform standards have been adopted by the commission and give approval to all advertisements that satisfy the applicable uniform standard. For any product covered under the compact, other than long-term care insurance products, the commission has the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could mislead the public. The actions of commission as provided in this section have the force of law and are binding in the compacting states to the extent and in the manner provided in the compact;

[2003, c. 680, §1 (NEW) .]

5. **Self-certification process.** To exercise its rule-making authority and designate products and advertisements that may be subject to a self-certification process without the need for prior approval by the commission;

[2003, c. 680, §1 (NEW) .]

6. **Operating procedures.** To promulgate operating procedures pursuant to section 2478 that are binding in the compacting states to the extent and in the manner provided in the compact;

[2003, c. 680, §1 (NEW) .]

7. **Legal proceedings.** To bring and prosecute legal proceedings or actions in its name as the commission. The standing of a state insurance department to sue or be sued under applicable law is not affected by this subsection;

[2003, c. 680, §1 (NEW) .]

8. **Subpoenas.** To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

[2003, c. 680, §1 (NEW) .]

9. **Establish and maintain offices.** To establish and maintain offices;

[2003, c. 680, §1 (NEW) .]

10. **Insurance; bonds.** To purchase and maintain insurance and bonds;

[2003, c. 680, §1 (NEW) .]

11. **Personnel services.** To borrow, accept or contract for services of personnel, including, but not limited to, employees of a compacting state;

[2003, c. 680, §1 (NEW) .]

12. **Employees; professionals; specialists.** To hire employees, professionals or specialists and elect or appoint officers and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the compact and determine their qualifications. To establish the commission's personnel policies and programs relating to, but not limited to conflicts of interest, rates of compensation and qualifications of personnel;

[2003, c. 680, §1 (NEW) .]

13. **Accept donations.** To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services and to receive, utilize and dispose of the same, striving to avoid any appearance of impropriety;

[2003, c. 680, §1 (NEW) .]

14. **Hold property.** To lease, purchase, accept appropriate gifts or donations of or otherwise to own, hold, improve or use any property, real, personal or mixed, striving at all times to avoid any appearance of impropriety;

[2003, c. 680, §1 (NEW) .]

15. **Sell property.** To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

[2003, c. 680, §1 (NEW) .]

16. **Filing fees.** To remit filing fees to compacting states as may be set forth in the bylaws, rules or operating procedures;

[2003, c. 680, §1 (NEW) .]

17. **Enforce compliance.** To enforce compliance of compacting states with rules, uniform standards, operating procedures and bylaws;

[2003, c. 680, §1 (NEW) .]

18. **Provide for dispute resolution.** To provide for dispute resolution among compacting states;

[2003, c. 680, §1 (NEW) .]

19. **Advice relating to business in noncompacting jurisdictions.** To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of the compact;

[2003, c. 680, §1 (NEW) .]

20. **Advice and training.** To provide advice and training to those personnel in state insurance departments responsible for product review and to be a resource for state insurance departments;

[2003, c. 680, §1 (NEW) .]

21. **Establish budget.** To establish a budget and make expenditures;

[2003, c. 680, §1 (NEW) .]

22. **Borrow money.** To borrow money;

[2003, c. 680, §1 (NEW) .]

23. **Appoint committees.** To appoint committees, including advisory committees of members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives and any other interested persons as may be designated in the bylaws;

[2003, c. 680, §1 (NEW) .]

24. **Cooperation with law enforcement agencies.** To provide information to and receive information from, and to cooperate with, law enforcement agencies;

[2003, c. 680, §1 (NEW) .]

25. **Corporate seal.** To adopt and use a corporate seal; and

[2003, c. 680, §1 (NEW) .]

26. **Perform other functions.** To perform functions other than those set out explicitly in this section as necessary or appropriate to achieve the purposes of the compact consistent with the state regulation of the business of insurance.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2476. ORGANIZATION OF THE COMMISSION -- ARTICLE 5

1. **Membership.** Each compacting state has one member. Each member must be qualified to serve in that capacity pursuant to applicable law of the compacting state. A member may be removed or suspended from office as provided by the law of the state from which the member is appointed. A vacancy occurring in the commission must be filled in accordance with the laws of the compacting state where the vacancy exists. This subsection may not be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

[2003, c. 680, §1 (NEW) .]

2. **One vote.** Each member is entitled to one vote and has an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision of the compact to the contrary, action of the commission with respect to the promulgation of a uniform standard does not take effect unless 2/3 of the members vote in favor of the uniform standard.

[2003, c. 680, §1 (NEW) .]

3. **Bylaws.** The commission shall, by a majority of the members, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including, but not limited to:

A. Establishing the fiscal year of the commission; [2003, c. 680, §1 (NEW).]

B. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee established under subsection 5; [2003, c. 680, §1 (NEW).]

C. Providing reasonable standards and procedures:

(1) For the establishment and meetings of other committees; and

(2) Governing any general or specific delegation of any authority or function of the commission; [2003, c. 2, §86 (COR).]

D. Providing reasonable procedures for calling and conducting meetings of the commission that consist of a majority of commission members, ensuring reasonable advance notice of each meeting and providing for the right of citizens to attend each meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting in whole or in part. As soon as practicable, the commission shall make public a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed and votes taken during the meeting; [2003, c. 680, §1 (NEW).]

E. Establishing the titles, duties, authority and reasonable procedures for the election of the officers of the commission; [2003, c. 680, §1 (NEW).]

F. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or similar laws of any compacting state, the bylaws exclusively govern the personnel policies and programs of the commission; [2003, c. 680, §1 (NEW).]

G. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and [2003, c. 680, §1 (NEW).]

H. Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that might exist after the termination of the compact after the payment or reserving of all of its debts and obligations. [2003, c. 680, §1 (NEW).]

[2003, c. 2, §86 (COR) .]

4. **File bylaws with compacting states.** The commission shall publish its bylaws in a convenient form and file a copy of the bylaws and a copy of any amendment to the bylaws with the appropriate agency or officer in each of the compacting states.

[2003, c. 680, §1 (NEW) .]

5. **Management committee.** The commission shall establish a management committee.

A. The management committee consists of no more than 14 members as follows:

(1) One member from each of the 6 compacting states with the largest premium volume for individual and group annuities and life, disability income and long-term care insurance products, determined from the records of the National Association of Insurance Commissioners for the prior year;

(2) Four members from those compacting states with at least 2% of the market based on the premium volume described in subparagraph (1) other than the 6 compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(3) Four members from those compacting states with less than 2% of the market based on the premium volume described in subparagraph (1) with one selected from each of the 4 zone regions of the National Association of Insurance Commissioners as provided in the bylaws. [2003, c. 680, §1 (NEW).]

B. The management committee has such authority and duties as may be set forth in the bylaws, including, but not limited to:

(1) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(2) Establishing and overseeing an organizational structure within and appropriate procedures for the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing and review of elections made by a compacting state to opt out of a uniform standard. A uniform standard may not be submitted to the compacting states for adoption unless approved by 2/3 of the members of the management committee;

(3) Overseeing the offices of the commission; and

(4) Planning, implementing and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the commission. [2003, c. 680, §1 (NEW).]

C. The commission shall elect annually its officers from the management committee, with each having such authority and duties, as specified in the bylaws. [2003, c. 680, §1 (NEW).]

D. The management committee may, subject to the approval of the commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the commission determines appropriate. The executive director shall serve as secretary to the commission, but may not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

6. **Legislative committee.** A legislative committee of state legislators or their designees is established to monitor the operations of, and make recommendations to, the commission, including the management committee. The manner of selection and term of any legislative committee member is set by the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee.

[2003, c. 680, §1 (NEW) .]

7. **Advisory committees.** The commission shall establish 2 advisory committees, one composed of consumer representatives independent of the insurance industry and the other composed of insurance industry representatives.

[2003, c. 680, §1 (NEW) .]

8. **Additional advisory committees.** The commission may establish advisory committees in addition to those described in subsection 7 as its bylaws may provide for the carrying out of its functions.

[2003, c. 680, §1 (NEW) .]

9. **Corporate records of the commission.** The commission shall maintain its corporate books and records in accordance with the bylaws.

[2003, c. 680, §1 (NEW) .]

10. **Qualified immunity, defense and indemnification.** The members, officers, executive director, employees and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties or responsibilities. Nothing in this subsection may be construed to protect any person from suit or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

[2003, c. 680, §1 (NEW) .]

11. **Defend.** The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, as long as the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct. Nothing in this subsection may be construed to prohibit that person from retaining counsel.

[2003, c. 680, §1 (NEW) .]

12. **Indemnification.** The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, as long as the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
RR 2003, c. 2, §86 (COR). 2003, c. 680, §1 (NEW).

§2477. MEETINGS; ACTS OF COMMISSION -- ARTICLE 6

1. **Meetings.** The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

[2003, c. 680, §1 (NEW) .]

2. **Participate at meetings.** Each member of the commission has the right and power to cast the vote to which the member's compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

[2003, c. 680, §1 (NEW) .]

3. **Annual meeting.** The commission shall meet at least once during each calendar year. Additional meetings are held as set forth in the bylaws.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2478. RULES AND OPERATING PROCEDURES, RULE-MAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS -- ARTICLE 7

1. **Rule-making authority.** The commission shall promulgate reasonable rules, including uniform standards and operating procedures, in order to effectively and efficiently achieve the purposes of this compact. Notwithstanding this subsection, in the event the commission exercises its rule-making authority in a manner that is beyond the scope of the purposes of this chapter or the powers granted under this chapter, then such an action by the commission is invalid and has no effect.

[2003, c. 680, §1 (NEW) .]

2. **Rule-making procedure.** Rules and operating procedures must be made pursuant to a rule-making process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the

commission shall give written notice to the relevant state legislative committee in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

[2003, c. 680, §1 (NEW) .]

3. **Effective date and opting out of uniform standard.** A uniform standard becomes effective 90 days after its promulgation by the commission or such later date as the commission may determine. A compacting state may opt out of a uniform standard as provided in subsection 4. "Opt out" means any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, become effective as of the date specified in each rule, operating procedure or amendment.

[2003, c. 680, §1 (NEW) .]

4. **Procedure for opting out.** A compacting state may opt out of a uniform standard either by legislation or regulation duly promulgated by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, it must give written notice to the commission no later than 10 business days after the uniform standard is promulgated, or at the time the state becomes a compacting state, and must find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh:

A. The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this chapter; and [2003, c. 680, §1 (NEW).]

B. The presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product. [2003, c. 680, §1 (NEW).]

Notwithstanding this subsection, a compacting state may at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such an option in the enacted compact, and opting out may not be treated as a material variance in the offer or acceptance of any state to participate in this compact. Opting out is effective at the time of enactment of this compact by the compacting state and applies to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

[2003, c. 680, §1 (NEW) .]

5. **Effect of opting out.** If a compacting state elects to opt out of a uniform standard, the uniform standard remains applicable in the compacting state electing to opt out until such time as the legislation opting out is enacted into law or the regulation opting out becomes effective.

Once the opting out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard has no further force and effect in that state unless and until the legislation or regulation implementing the opting out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opting out has the same prospective effect as provided under section 2485 for withdrawals.

[2003, c. 680, §1 (NEW) .]

6. **Stay of uniform standard.** If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opting out is pending, the compacting state may petition the commission, at least 15 days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opting out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension may postpone the effective date by up to 90 days, unless the stay is affirmatively extended by the commission. A stay may not be permitted to remain in effect for more than one year unless the compacting state can show extraordinary circumstances that warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge that prevents the compacting state from opting out. A stay may be terminated by the commission upon notice that the rule-making process has been terminated.

[2003, c. 680, §1 (NEW) .]

7. **Petition for judicial review of rule or operating procedure.** Not later than 30 days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure. The filing of such a petition does not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and may not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2479. COMMISSION RECORDS AND ENFORCEMENT -- ARTICLE 8

1. **Public inspection and copying of information and records.** The commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except information and records involving the privacy of individuals and insurers' trade secrets. The commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

[2003, c. 680, §1 (NEW) .]

2. **Laws pertaining to confidentiality or nondisclosure.** Except as to privileged records, data and information, the laws of any compacting state pertaining to confidentiality or nondisclosure do not relieve any compacting state commissioner of the duty to disclose any relevant records, data or information to the commission. Disclosure to the commission may not be considered to waive or otherwise affect any confidentiality requirement. Except as otherwise expressly provided in this chapter, the commission is not subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the commission remains confidential after such information is provided to any commissioner.

[2003, c. 680, §1 (NEW) .]

3. **Compliance.** The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of its noncompliance with commission bylaws, rules or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state is in default as set forth in section 2485.

[2003, c. 680, §1 (NEW) .]

4. **Commissioner's authority to oversee market regulation.** The commissioner of any state in which an insurer is authorized to do business or is conducting the business of insurance shall continue to exercise the commissioner's authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions.

A. With respect to the commissioner's market regulation of a product or advertisement that is approved by or certified to the commission, the content of the product or advertisement does not constitute a violation of the provisions, standards or requirements of the compact except upon a final order of the commission issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission. [2003, c. 680, §1 (NEW).]

B. Before a commissioner may bring an action for violation of any provision, standard or requirement of the compact relating to the content of an advertisement not approved by or certified to the commission, the commission, or an authorized commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the insurer, opportunity for hearing or disclosure of requests for authorization or records of the commission's action on such requests. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2480. DISPUTE RESOLUTION -- ARTICLE 9

The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and that may arise between 2 or more compacting states, or between compacting states and noncompacting states, and the commission shall promulgate an operating procedure providing for resolution of such disputes. [2003, c. 680, §1 (NEW).]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2481. PRODUCT FILING AND APPROVAL -- ARTICLE 10

1. **Filing of product with commission.** Insurers and 3rd-party filers seeking to have a product approved by the commission shall file the product with, and pay applicable filing fees to, the commission. Nothing in this chapter may be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state where the insurer is licensed to conduct the business of insurance, and such filing is subject to the laws of the states where filed.

[2003, c. 680, §1 (NEW) .]

2. **Commission to establish filing and review processes.** The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any other provision of this chapter, the commission shall promulgate rules to establish

conditions and procedures for providing public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets that may be contained in a product filing or supporting information.

[2003, c. 680, §1 (NEW) .]

3. **Product approved by commission may be sold in certain compacting states.** Any product approved by the commission may be sold or otherwise issued in those compacting states in which the insurer is legally authorized to do business.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2482. REVIEW OF COMMISSION DECISIONS REGARDING FILINGS -- ARTICLE 11

1. **Appeal to review panel appointed by commission.** Not later than 30 days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or 3rd-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall promulgate rules to establish procedures for appointing a review panel and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously or in a manner that is an abuse of discretion or otherwise not in accordance with the law is subject to judicial review in accordance with section 2474, subsection 5.

[2003, c. 680, §1 (NEW) .]

2. **Commission may monitor, review and reconsider.** The commission has authority to monitor, review and reconsider products and advertisements subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in subsection 1.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2483. FINANCE -- ARTICLE 12

1. **Commission shall fund its establishment and organization.** The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, compacting states and other sources. Contributions and other forms of funding from other sources must be of such a nature that the independence of the commission concerning the performance of its duties is not compromised.

[2003, c. 680, §1 (NEW) .]

2. **Commission shall collect filing fee.** The commission shall collect a filing fee from each insurer and 3rd-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

[2003, c. 680, §1 (NEW) .]

3. **Notice and comment for budget approval.** The commission's budget for a fiscal year may not be approved until it has been subject to notice and comment as set forth in section 2478.

[2003, c. 680, §1 (NEW) .]

4. **Commission exempt from taxation.** The commission is exempt from all taxation in and by the compacting states.

[2003, c. 680, §1 (NEW) .]

5. **Commission authority to pledge credit of compacting state limited.** The commission may not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

[2003, c. 680, §1 (NEW) .]

6. **Commission to keep complete and accurate accounts.** The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the commission are subject to the accounting procedures established under its bylaws. The financial accounts and reports, including the system of internal controls and procedures of the commission, must be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every 3 years, the review of the independent auditor must include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of each compacting state, which must include a report of the independent audit. The commission's internal accounts are not confidential and such materials may be shared with the commissioner of any compacting state upon request, except that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, must remain confidential.

[2003, c. 680, §1 (NEW) .]

7. **Compacting states do not have ownership of commission property.** A compacting state does not have any claim to or ownership of any property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2484. COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT -- ARTICLE 13

1. **Any state eligible to become compacting state.** Any state is eligible to become a compacting state.

[2003, c. 680, §1 (NEW) .]

2. **Effective dates for compact and commission.** The compact becomes effective and binding upon legislative enactment by 2 compacting states. The commission becomes effective for purposes of adopting uniform standards for, reviewing and giving approval or disapproval of products filed with the commission only after 26 states are compacting states or, alternatively, after states representing more than 40% of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the National Association of Insurance Commissioners for the prior year, are compacting states. Thereafter, it becomes effective and binding as to any other compacting state upon enactment of the compact into law by that state.

[2003, c. 680, §1 (NEW) .]

3. **Amendments to the compact.** Amendments to the compact may be proposed by the commission for enactment by the compacting states. An amendment does not become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2485. WITHDRAWAL, DEFAULT AND TERMINATION -- ARTICLE 14

1. **Withdrawal.** The following provisions govern withdrawal from the compact.

A. Once effective, the compact continues in force and remains binding upon each compacting state. A compacting state may withdraw from the compact by enacting a statute specifically repealing the statute that enacted the compact. [2003, c. 680, §1 (NEW).]

B. The effective date of withdrawal is the effective date of the repealing law. However, the withdrawal does not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in paragraph E. [2003, c. 680, §1 (NEW).]

C. The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state. [2003, c. 680, §1 (NEW).]

D. The commission shall notify the other compacting states of the introduction of such legislation within 10 days after it receives notice under paragraph C. [2003, c. 680, §1 (NEW).]

E. The withdrawing state is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisements prior to the effective date of withdrawal continues to be effective and must be given full force and effect in the withdrawing state unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisements previously approved under state law. [2003, c. 680, §1 (NEW).]

F. Reinstatement following withdrawal of any compacting state occurs upon the effective date of the withdrawing state's reenacting the compact. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

2. **Default.** The following provisions govern default.

A. If the commission determines that a compacting state has defaulted in the performance of any of its obligations or responsibilities under this compact, the bylaws or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges and benefits conferred by this compact on the defaulting state are suspended from the effective date of default as fixed by the commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state must be terminated from the compact and all rights, privileges and benefits conferred by this compact are terminated from the effective date of termination. [2003, c. 680, §1 (NEW).]

B. Product approvals by the commission or product self-certifications, or any advertisement in connection with such a product, that are in force on the effective date of termination remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to subsection 1. [2003, c. 680, §1 (NEW).]

C. Reinstatement following termination of a compacting state requires a reenactment of the compact. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

3. **Dissolution of compact.** The following provisions govern the dissolution of the compact.

A. The compact dissolves upon the date of the withdrawal or default of the compacting state that reduces membership in the compact to one compacting state. [2003, c. 680, §1 (NEW).]

B. Upon the dissolution of this compact, the compact becomes void and is of no further effect, and the business and affairs of the commission must be wound up and any surplus funds must be distributed in accordance with the bylaws. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2486. CONSTRUCTION -- ARTICLE 15

The provisions of this compact must be liberally construed to effectuate its purposes. [2003, c. 680, §1 (NEW).]

SECTION HISTORY
2003, c. 680, §1 (NEW).

§2487. BINDING EFFECT OF COMPACT AND OTHER LAWS -- ARTICLE 16

1. **Laws of compacting state.** Nothing in this chapter prevents the enforcement of any laws of a compacting state other than this compact, except as provided in subsection 2.

[2003, c. 680, §1 (NEW) .]

2. **Exclusive provisions.** For any product approved by or certified to the commission, the rules, uniform standards and any other requirements of the commission constitute the exclusive provisions applicable to the content, approval and certification of that product. For an advertisement that is subject to the commission's authority, any rule, uniform standard or other requirement of the commission that governs the content of

the advertisement constitutes the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding this subsection, an action taken by the commission may not abrogate or restrict:

A. The access of any person to state courts; [2003, c. 680, §1 (NEW).]

B. Remedies available under state law related to breach of contract, tort or other laws not specifically directed to the content of the product; [2003, c. 680, §1 (NEW).]

C. State law relating to the construction of insurance contracts; or [2003, c. 680, §1 (NEW).]

D. The authority of the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

3. **Insurance products subject to laws.** All insurance products filed with individual states are subject to the laws of those states.

[2003, c. 680, §1 (NEW) .]

4. **Binding effect of compact.** The compact is binding as follows.

A. All lawful actions of the commission, including all rules and operating procedures promulgated by the commission, are binding upon the compacting states. [2003, c. 680, §1 (NEW).]

B. All agreements between the commission and the compacting states are binding in accordance with their terms. [2003, c. 680, §1 (NEW).]

C. Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute. [2003, c. 680, §1 (NEW).]

D. In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of a compacting state, the obligation, duty, power or jurisdiction sought to be conferred by that provision upon the commission is ineffective as to that compacting state, and that obligation, duty, power or jurisdiction remains in the compacting state and must be exercised by the agency thereof to which that obligation, duty, power or jurisdiction is delegated by law in effect at the time this compact becomes effective. [2003, c. 680, §1 (NEW).]

[2003, c. 680, §1 (NEW) .]

SECTION HISTORY
2003, c. 680, §1 (NEW).

Chapter 29: LIFE INSURANCE AND ANNUITY CONTRACTS

§2501. SCOPE OF CHAPTER

This chapter applies only to contracts of life insurance and annuities, other than reinsurance, group life insurance and group annuities, except that: [2009, c. 244, Pt. I, §1 (AMD).]

1. Section 2537 also applies as to group life insurance and group annuity contracts; and

[2009, c. 244, Pt. I, §1 (NEW) .]

2. Sections 2541 to 2551 apply to group annuities other than those exempted by section 2542.

[2009, c. 244, Pt. I, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 560, §2 (AMD). 1977, c. 261, §1 (AMD). 1995, c. 375, §C5 (AMD). 2009, c. 244, Pt. I, §1 (AMD).

§2502. INDUSTRIAL LIFE INSURANCE DEFINED

For the purposes of this Title "industrial life insurance" is that form of life insurance written under policies of face amount of $2,500 or less bearing the words "industrial policy," or "weekly premium policy" or words of similar import imprinted on the face thereof as part of the descriptive matter, and under which premiums are payable monthly or more often. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2503. STANDARD PROVISIONS REQUIRED

1. No policy of life insurance other than pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this State unless it contains in substance all of the applicable provisions required by sections 2504 to 2515. This section shall not apply to annuity contracts nor to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

[1969, c. 132, §1 (NEW) .]

2. Any of such provisions or portions thereof not applicable to single premium or nonparticipating or term policies or insurance granted in exchange for lapsed or surrendered policies shall to that extent not be incorporated therein.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2504. PAYMENT OF PREMIUMS

There shall be a provision relating to the time and place of payment of premiums. [1969, c. 132, §1 (NEW).]

SECTION HISTORY

1969, c. 132, §1 (NEW).

§2505. GRACE PERIOD

There shall be a provision that a grace period of 30 days, or, at the option of the insurer, of one month of not less than 30 days, or of 4 weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force. The insurer may impose an interest charge not in excess of 6% per annum for the number of days of grace elapsing before the payment of the premium, and, whether or not such interest charge is imposed, if a claim arises under the policy during such period of grace the amount of any premium due or overdue, together with interest and any deferred installment of the annual premium, may be deducted from the policy proceeds. Grace shall date from the premium due date specified in the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2506. ENTIRE CONTRACT

There shall be a provision that except as otherwise expressly provided by law, the policy and the application therefor, if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties, and that all statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2507. INCONTESTABILITY

There shall be a provision that the policy shall be incontestable after it has been in force during the lifetime of the insured for a period of not more than 2 years after its date of issue, except for nonpayment of premiums and, at the insurer's option, provisions relating to benefits in the event of total and permanent disability and provisions granting additional benefits specifically against death by accident or accidental means. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2508. MISSTATEMENT OF AGE

There shall be a provision that if the age of the insured or of any other person whose age is considered in determining the premium or benefit has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2509. DIVIDENDS

1. There shall be a provision in participating policies that, beginning not later than the end of the 3rd policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy provided the policy is in force and all premiums to that date are paid. Except as hereinafter provided, any dividend becoming payable shall at the option of the party entitled to elect such option be either:

A. Payable in cash, or [1969, c. 132, §1 (NEW).]

B. Applied to any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than 30 days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning of paragraph A even though the policy provides that payment of such dividend is to be deferred for a specified period, provided such period does not exceed 6 years from the date of apportionment and that interest will be added to such dividend at a specified rate. [2011, c. 1, §38 (COR).]

[2011, c. 1, §38 (COR) .]

2. Renewable term policies of 10 years or less may provide that the surplus accrued to such policies shall be determined and apportioned each year after the second policy year, and accumulated during each renewal period, and that at the end of the renewal period, on renewal of the policy by the insured, the insurer shall apply the accumulated surplus as an annuity for the next succeeding renewal term in the reduction of premiums.

[1969, c. 132, §1 (NEW) .]

3. In participating industrial life insurance policies, in lieu of the provision required in subsection 1, there shall be a provision that, beginning not later than the end of the 5th policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

[1969, c. 132, §1 (NEW) .]

4. This section does not apply as to insurance issued in consideration of lapsed or surrendered policies.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). RR 2011, c. 1, §38 (COR).

§2510. POLICY LOAN

1. There shall be a provision that after 3 full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, at a rate of interest as specified in sections 2552 to 2554, an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy. The loan value of the policy shall be at least equal to the cash surrender value at the end of the then current policy year, and the insurer may deduct, either from such loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and interest on the loan to the end of the current policy year. The policy may also provide that if interest on any indebtedness is not paid when due, it shall then be added to the existing indebtedness and shall bear

interest at the same rate, and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void, but not until at least 30 days' notice has been mailed by the insurer to the last address, of record with the insurer, of the insured or other policy owner and of any assignee of record at the insurer's home office. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for 6 months after application therefor. Such provision shall also contain a table showing in figures the loan values each year during the first 20 years of the policy, or during the term of the policy, whichever is shorter. The policy, at the insurer's option, may provide for automatic premium loan.

[1981, c. 698, §108 (AMD) .]

2. This section shall not apply to term policies or to term insurance benefits provided by rider or supplemental policy provisions or to industrial life insurance policies.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 188, §1 (AMD). 1981, c. 698, §108 (AMD).

§2511. TABLE OF INSTALLMENTS

In case the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2512. REINSTATEMENT

There shall be a provision that unless: [1969, c. 132, §1 (NEW).]

1. The policy has been surrendered for its cash surrender value;

[1981, c. 188, §2 (AMD) .]

2. Its cash surrender value has been exhausted; or

[1969, c. 132, §1 (NEW) .]

3. The paid-up term insurance, if any, has expired;

the policy will be reinstated at any time within 3 years, or 2 years in the case of industrial life insurance policies, from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears with interest at a rate not exceeding 6% per annum compounded annually and the payment or reinstatement of any other indebtedness to the insurer upon the policy with interest at the policy loan interest rate.

[1969, c. 132, §1 (NEW); 1981, c. 188, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 188, §2 (AMD).

§2513. PAYMENT OF CLAIMS

There shall be a provision that when the benefits under the policy shall become payable by reason of the death of the insured, settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy and proof of the interest of the claimant. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, such period shall not exceed 2 months from the receipt of such proofs. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2514. BENEFICIARY, INDUSTRIAL POLICIES

An industrial life insurance policy shall have the name of the beneficiary designated thereon or in the application or other form if attached to the policy, with a reservation of the right to designate or change the beneficiary after the issuance of the policy, unless such beneficiary be irrevocably designated. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer, and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2515. TITLE

There shall be a title on the policy, briefly describing the same. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2515-A. RIGHT TO EXAMINE AND RETURN POLICY

1. Every individual life insurance policy delivered or issued for delivery in this State after December 31, 1976, shall contain a provision therein, or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and to have a refund of the premium paid, if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy under an appropriate caption and, if not so printed on the face page of the policy, adequate notice of the provision shall be printed or stamped conspicuously on the face page.

[1975, c. 168, (NEW) .]

2. The policy may be so returned to the insurer at its home or branch office or to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy had not been issued.

[1975, c. 168, (NEW) .]

SECTION HISTORY
1975, c. 168, (NEW).

§2516. EXCLUDED OR RESTRICTED COVERAGE

A clause in any policy of life insurance policy or annuity contract providing that such policy or contract shall be incontestable after a specified period shall preclude only a contest of the validity of the policy or contract, and shall not preclude the assertion at any time of defenses based upon provisions in the policy or contract which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2517. STANDARD PROVISIONS -- ANNUITY AND PURE ENDOWMENT CONTRACTS

1. No annuity or pure endowment contract, other than reversionary annuities, also called survivorship annuities, or group annuities and except as stated herein, shall be delivered or issued for delivery in this State unless it contains in substance each of the provisions specified in sections 2518 to 2523. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

[1969, c. 132, §1 (NEW) .]

2. This section shall not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies, nor to variable annuity contracts.

[1969, c. 132, §1 (NEW) .]

3. The superintendent shall adopt rules regarding the suitability of sales of annuities for the purpose of protecting the consumer and furthering uniformity of laws with other states. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.

[2005, c. 65, Pt. B, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2005, c. 65, §B1 (AMD).

§2518. GRACE PERIOD -- ANNUITIES

In an annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, there shall be a provision that there shall be a period of grace of one month, but not less than 30 days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding 6% per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of

the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2519. INCONTESTABILITY -- ANNUITIES

If any statements, other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to section 2521, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2520. ENTIRE CONTRACT -- ANNUITIES

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2521. MISSTATEMENT OF AGE OR SEX -- ANNUITIES

In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2522. DIVIDENDS -- ANNUITIES

If an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2523. REINSTATEMENT -- ANNUITIES

In an annuity or pure endowment contract, other than a reversionary or group annuity, there shall be a provision that the contract may be reinstated at any time within one year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments shall be paid with interest thereon at a rate to be specified in the contract but not exceeding 6% per annum payable annually and the payment or reinstatement of any other indebtedness to the insurer upon the contract with interest at the policy loan interest rate, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer. [1981, c. 188, §3 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 188, §3 (AMD).

§2524. STANDARD PROVISIONS -- REVERSIONARY ANNUITIES

1. Except as stated herein, no contract for a reversionary annuity shall be delivered or issued for delivery in this State unless it contains in substance each of the following provisions:

A. Any such reversionary annuity contract shall contain the provisions specified in sections 2518 to 2522, except that under section 2518 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract. [1969, c. 132, §1 (NEW).]

B. In such reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within 3 years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding 6% per annum compounded annually. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. This section shall not apply to group annuities, variable annuities, or to annuities included in life insurance policies, and any of such provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2525. LIMITATION OF LIABILITY

1. No policy of life insurance shall be delivered or issued for delivery in this State if it contains any of the following provisions:

A. A provision limiting the time within which an action at law or in equity may be commenced on such a policy to less than 3 years after the cause of action has accrued. [1969, c. 132, §1 (NEW).]

B. A provision that excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances:

(1) Death as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces, or of any act or hazard of such war or action, or of service in the military, naval or air forces or in civilian forces auxiliary thereto, or from any cause while a member of such military, naval or air forces of any country at war, declared or undeclared, or of any country engaged in such military action;

(2) Death as a result of aviation or any air travel or flight;

(3) Death as a result of a specified hazardous occupation or occupations or avocation;

(4) Death while the insured is a resident outside continental United States and Canada;

(5) Death within 2 years from the date of issue of the policy as a result of suicide, while sane or insane; or

(6) Death within 2 years from the date of issue of an increase in policy face amount, as a result of suicide, while sane or insane. [1999, c. 256, Pt. J, §1 (AMD).]

[1999, c. 256, Pt. J, §1 (AMD) .]

2. A policy that contains any exclusion or restriction pursuant to subsection 1, paragraph B, subparagraphs (1) to (5) must also provide that, in the event of death under the circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than the reserve attributable thereto determined according to the commissioners reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits or, if the policy provides for no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy, with adjustment for indebtedness or dividend credit.

[1999, c. 256, Pt. J, §2 (AMD) .]

2-A. A policy that contains any exclusion or restriction pursuant to subsection 1, paragraph B, subparagraph (6) must also provide that, in the event of death under the circumstances to which an exclusion or restriction regarding the increase in policy face amount is applicable, the insurer will pay, with respect to the increase in policy face amount, a return of premiums paid.

[1999, c. 256, Pt. J, §3 (NEW) .]

3. This section shall not apply to group life insurance, health insurance, reinsurance, or annuities, or to any provision in a life insurance policy or contract supplemental thereto relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

[1969, c. 132, §1 (NEW) .]

4. Nothing contained in this section shall prohibit any provision which in the opinion of the superintendent is more favorable to the policyholder than a provision permitted by this section.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1979, c. 541, §A164 (AMD). 1999, c. 256, §§J1-3 (AMD).

§2526. PROHIBITED PROVISIONS

1. No life insurance policy, other than industrial insurance, shall be delivered or issued for delivery in this State, if it contains any of the following provisions:

A. A provision by which the policy purports to be issued or to take effect more than one year before the original application for the insurance was made. [1969, c. 132, §1 (NEW).]

B. A provision for any mode of settlement at maturity of the policy of less value than the amount insured under the policy, plus dividend additions, if any, less any indebtedness to the insurer on or secured by the policy and less any premium that may by the terms of the policy be deducted. [1969, c. 132, §1 (NEW).]

C. A provision to the effect that the agent soliciting the insurance is the agent of the person insured under the policy, or making the acts or representations of such agent binding upon the person so insured under the policy. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. No policy of industrial life insurance shall be delivered or issued for delivery in this State if it contains any of the following provisions:

A. A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer. [1969, c. 132, §1 (NEW).]

B. A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within 2 years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk. [1969, c. 132, §1 (NEW).]

C. A provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right be conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. No insurer shall provide in any policy, certificate, contract or agreement of life insurance for the payment of any insurance, indemnity or benefit in services, goods, wares or merchandise of any kind.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2526-A. ACQUIRED IMMUNE DEFICIENCY SYNDROME

No individual policy of life insurance delivered or issued for delivery in this State may provide more restrictive coverage for death resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases than for death resulting from any other disease or sickness or exclude coverage for death resulting from AIDS, ARC or HIV related diseases. This section shall not apply to death by accident or accidental means. [1989, c. 176, §3 (NEW).]

SECTION HISTORY
1989, c. 176, §3 (NEW).

§2527. PROVISIONS REQUIRED BY LAW OF OTHER JURISDICTION

The policies of a foreign life insurer may contain any provision which the law of the state, territory, district, or country under which the insurer is organized prescribes shall be in such policies when issued in this State, and the policies of a domestic life insurer may, when issued or delivered in any other state, territory, district, or country, contain any provisions required by the laws thereof, anything in this chapter to the contrary notwithstanding. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2528. SHORT TITLE

Sections 2528 to 2534 shall be known as the "Standard Nonforfeiture Law for Life Insurance." [1979, c. 442, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 442, §1 (AMD).

§2529. NONFORFEITURE PROVISIONS

1. In the case of policies issued on or after January 1, 1970, no policy of life insurance, except as stated in section 2534, may be delivered or issued for delivery in this State, unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the superintendent are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and which are essentially in compliance with section 2533-A:

A. Paid-up nonforfeiture benefit. That, in the event of default in any premium payment, the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of that due date, of such amount as may be hereinafter specified. In lieu of the stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits; [1983, c. 346, §10 (AMD).]

B. Cash surrender value. That, upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least 3 full years in the case of ordinary insurance or 5 full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified; [1983, c. 346, §10 (AMD).]

C. Effective date of benefit. That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default; [1983, c. 346, §10 (AMD).]

D. Cash surrender value if policy paid up. That, if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the 3rd policy anniversary in the case of ordinary insurance or the 5th policy anniversary in the case of industrial insurance, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified; [1983, c. 346, §10 (AMD).]

E. Mortality table and interest rate used. In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under

the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter, those values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy; and [1983, c. 346, §10 (AMD).]

F. Method used in computing value and benefit. A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy. [1983, c. 346, §10 (AMD).]

[1983, c. 346, §10 (AMD) .]

2. Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

[1969, c. 132, §1 (NEW) .]

3. The insurer shall reserve the right to defer the payment of any cash surrender value for a period of 6 months after demand therefor with surrender of the policy.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §144 (AMD). 1983, c. 346, §10 (AMD).

§2530. CASH SURRENDER VALUE

1. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by section 2529, shall be an amount not less than the excess, if any, of the present value, on that anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

A. Present value of adjusted premiums. The then present value of the adjusted premiums as defined in sections 2532 and 2532-A, corresponding to premiums which would have fallen due on and after that anniversary; and [1983, c. 346, §11 (NEW).]

B. Amount of indebtedness. The amount of any indebtedness to the insurer on the policy. [1983, c. 346, §11 (NEW).]

[1983, c. 346, §11 (RPR) .]

2. For any policy issued on or after the operative date of section 2532-A as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in

subsection 1 shall be an amount not less than the sum of the cash surrender value as defined in that subsection for an otherwise similar policy issued at the same age without that rider or supplemental policy provision and the cash surrender value as defined in that subsection for a policy which provides only the benefits otherwise provided by that rider or supplemental policy provision.

[1983, c. 346, §11 (RPR) .]

3. For any family policy issued on or after the operative date of section 2532-A as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age 71, the cash surrender value referred to in subsection 1 shall be an amount not less than the sum of the cash surrender value as defined in that subsection for an otherwise similar policy issued at the same age without that term insurance on the life of the spouse and the cash surrender value as defined in that subsection for a policy which provides only the benefits otherwise provided by that term insurance on the life of the spouse.

[1983, c. 346, §11 (NEW) .]

4. Any cash surrender value available within 30 days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by section 2529, shall be an amount not less than the present value, on that anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

[1983, c. 346, §11 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 346, §11 (RPR).

§2531. PAID-UP NONFORFEITURE BENEFITS

Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by sections 2529 to 2534 in the absence of the condition that premiums shall have been paid for at least a specified period. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2532. ADJUSTED PREMIUMS FOR POLICIES ISSUED BEFORE THE OPERATIVE DATE OF SECTION 2532-A

1. This section shall not apply to policies issued on or after the operative date of section 2532-A as defined therein.

[1983, c. 346, §12 (RPR) .]

2. Except as provided in subsection 4, the adjusted premiums for any policy shall be calculated on an annual basis and shall be the uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of cover impairments or special hazards, that the present value, at the date of issue of the policy, of all those adjusted premiums shall be equal to the sum of:

A. The then present value of the future guaranteed benefits provided for by the policy; [1983, c. 346, §12 (NEW).]

B. Two percent of the amount of insurance, if the insurance be uniform in amounts, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; [1983, c. 346, §12 (NEW).]

C. Forty percent of the adjusted premium for the first policy year; and [1983, c. 346, §12 (NEW).]

D. Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. [1983, c. 346, §12 (NEW).]

In applying the percentages specified in paragraphs C and D, no adjusted premium may be deemed to exceed 4% of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

[1983, c. 346, §12 (RPR) .]

3. In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy, provided that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by that policy at age 10.

[1983, c. 346, §12 (RPR) .]

4. The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to:

A. The adjusted premiums for an otherwise similar policy issued at the same age without those term insurance benefits, increased, during the period for which premiums for those term insurance benefits are payable, by [1983, c. 346, §12 (NEW).]

B. The adjusted premiums for that term insurance. [1983, c. 346, §12 (NEW).]

Paragraphs A and B shall be calculated separately and as specified in subsections 2 and 3, except that, for purposes of subsection 2, paragraphs B, C and D, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in paragraph B of this subsection shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in paragraph A.

[1983, c. 346, §12 (RPR) .]

5. Except as provided in subsection 6 and in section 2532-A, all adjusted premiums and present values referred to in sections 2529 to 2534 shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table, provided that, for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than 3 years younger than the actual age of the insured, and those calculations for all policies of industrial insurance shall be made on the basis of the Commissioners 1961 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that that rate of interest shall not exceed 3 1/2% each year, except that a rate of interest not exceeding 4% each year may be used for policies issued on or after December 31, 1975. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit for ordinary insurance, the rates of mortality assumed may not be more than those shown in the Commissioners 1958 Extended Term

Insurance Table and for industrial insurance rates of mortality may not be more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the superintendent.

[1983, c. 346, §12 (RPR) .]

6. In the case of policies issued on or after January 1, 1980, adjusted premiums and present values for any category of ordinary insurance issued on female risks may be calculated according to an age not more than 6 years younger than the actual age of the insured. All calculations for all policies of ordinary and industrial insurance shall be made on the basis of the rate of interest specified on the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that the rate of interest shall not exceed 5 1/2% each year.

[1983, c. 346, §12 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 342, §4 (AMD). 1979, c. 442, §§2,3 (AMD). 1983, c. 346, §12 (RPR).

§2532-A. ADJUSTED PREMIUMS FOR POLICIES ISSUED ON OR AFTER JANUARY 1, 1989, OR ELECTED OPERATIVE DATE OF THIS SECTION

1. This section shall apply to all policies issued on or after the operative date of this section as defined herein. Except as provided in subsection 7, the adjusted premiums for any policy shall be calculated on an annual basis and shall be that uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

A. The then present value of the future guaranteed benefits provided for by the policy; [1983, c. 346, §13 (NEW).]

B. One percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and [1983, c. 346, §13 (NEW).]

C. One hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined. [1983, c. 346, §13 (NEW).]

In applying the percentage specified in paragraph C, no nonforfeiture net level premium may be deemed to exceed 4% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

[1983, c. 346, §13 (NEW) .]

2. The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of the policy on which a premium falls due.

[1983, c. 346, §13 (NEW) .]

3. In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change of that type in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

[1983, c. 346, §13 (NEW) .]

4. Except as otherwise provided in subsection 7, the recalculated future adjusted premiums for any policy of that type shall be that uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums of all those future adjusted premiums shall be equal to the excess of:

A. The sum of the then present value of the then future guaranteed benefits provided for by the policy and the additional expense allowance, if any; over [1983, c. 346, §13 (NEW).]

B. The then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy. [1983, c. 346, §13 (NEW).]

[1983, c. 346, §13 (NEW) .]

5. The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

A. One percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first 10 policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and [1983, c. 346, §13 (NEW).]

B. One hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium. [1983, c. 346, §13 (NEW).]

[1983, c. 346, §13 (NEW) .]

6. The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing paragraph A by paragraph B where:

A. Paragraph A equals the sum of:

(1) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(2) The present value of the increase in future guaranteed benefits provided for by the policy; and [1983, c. 346, §13 (NEW).]

B. Paragraph B equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due. [1983, c. 346, §13 (NEW).]

[1983, c. 346, §13 (NEW) .]

7. Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, that policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for that substandard policy may be calculated as if it were issued to provide those higher uniform amounts of insurance on the standard basis.

[1983, c. 346, §13 (NEW) .]

8. All adjusted premiums and present values referred to in this Standard Nonforfeiture Law for Life Insurance shall, for all policies of ordinary insurance issued after the operative date of this section, be calculated on the basis of the Commissioners 1980 Standard Ordinary Mortality Table or, at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with 10-year select mortality factors; shall, for all policies of industrial insurance, be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall, for all policies issued in a particular calendar year, be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year, provided that:

A. At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year; [1983, c. 346, §13 (NEW).]

B. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by section 2529, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of that paid-up nonforfeiture benefit and paid-up dividend additions, if any; [1983, c. 346, §13 (NEW).]

C. An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values; [1983, c. 346, §13 (NEW).]

D. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance; [1983, c. 346, §13 (NEW).]

E. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the tables mentioned in this section; [1983, c. 346, §13 (NEW).]

F. Any approved commissioners standard ordinary mortality tables, adopted in accordance with paragraph H, may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without 10-year select mortality factors or for the Commissioners 1980 Extended Term Insurance Table; [2013, c. 238, Pt. C, §11 (AMD).]

G. Any approved commissioners standard industrial mortality tables, adopted in accordance with paragraph H, may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table; and [2013, c. 238, Pt. C, §11 (AMD).]

H. For policies issued before the operative date of the valuation manual, as defined in section 951-A, subsection 3, the superintendent may adopt rules approving commissioners standard mortality tables for use in determining the minimum nonforfeiture standard. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. For policies issued on or after the operative date of the valuation manual, the applicable commissioners standard mortality

tables specified in the valuation manual are approved for use in determining the minimum nonforfeiture standard unless superseded by rule adopted by the superintendent. [2013, c. 238, Pt. C, §12 (NEW).]

[2013, c. 238, Pt. C, §§11, 12 (AMD) .]

9. The nonforfeiture interest rate per annum for any policy issued in a particular calendar year must be equal to 125% of the calendar year statutory valuation interest rate for that policy as defined in the Standard Valuation Law, rounded to the nearer 1/4 of 1%, except as otherwise provided in the valuation manual for policies issued on and after the operative date of the valuation manual, as defined in section 951-A, subsection 3.

[2013, c. 238, Pt. C, §13 (AMD) .]

10. Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

[1983, c. 346, §13 (NEW) .]

11. After the effective date of this section, any insurer may file with the superintendent a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which shall be the operative date of this section for that insurer. If an insurer makes no such election, the operative date of this section for that company shall be January 1, 1989.

[1983, c. 346, §13 (NEW) .]

SECTION HISTORY
1983, c. 346, §13 (NEW). 2013, c. 238, Pt. C, §§11-13 (AMD).

§2532-B. SUPERINTENDENT'S AUTHORITY TO APPROVE CERTAIN NEW PLANS

1. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in sections 2529 to 2532-A herein, then:

A. The superintendent must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by sections 2529 to 2532-A herein; [1983, c. 346, §14 (NEW).]

B. The superintendent must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and [1983, c. 346, §14 (NEW).]

C. The cash surrender values and paid-up nonforfeiture benefits provided by that plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by regulations promulgated by the superintendent. [1983, c. 346, §14 (NEW).]

[1983, c. 346, §14 (NEW) .]

SECTION HISTORY
1983, c. 346, §14 (NEW).

§2533. CALCULATION OF CASH SURRENDER VALUE OF CERTAIN POLICIES ON DEFAULT

Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in sections 2530 to 2532-A may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide those additions. Notwithstanding section 2530, additional benefits payable: [1983, c. 346, §15 (AMD).]

1. **Death or accident.** In the event of death or dismemberment by accident or accidental means;

[1969, c. 132, §1 (NEW) .]

2. **Total disability.** In the event of total and permanent disability;

[1969, c. 132, §1 (NEW) .]

3. **Reversionary annuity.** As reversionary annuity or deferred reversionary annuity benefits;

[1969, c. 132, §1 (NEW) .]

4. **Term insurance benefits.** As term insurance benefits provided by a rider or supplemental policy provisions to which, if issued as a separate policy, section 2529 to 2534 would not apply;

[1969, c. 132, §1 (NEW) .]

5. **Child term insurance benefits.** As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child; and

[1969, c. 132, §1 (NEW) .]

6. **Other policy benefits.** As other policy benefits additional to life insurance and endowment benefits; and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by sections 2529 to 2534, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 346, §15 (AMD).

§2533-A. ADDITIONAL PROVISIONS FOR POLICIES ISSUED AFTER JANUARY 1, 1987

1. This section, in addition to all other applicable sections of the Standard Nonforfeiture Law for Life Insurance, applies to all policies issued on or after January 1, 1987. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary must be in an amount that does not differ by more than 2/10ths of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years, from the sum of:

A. The greater of zero and the basic cash value specified in subsection 2; and [1993, c. 1, §60 (COR).]

B. The present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy. [1983, c. 346, §16 (NEW).]

[1993, c. 1, §60 (COR) .]

2. The basic cash value is equal to the present value, on that anniversary, of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as defined in subsection 3, corresponding to premiums that would have fallen due on and after that anniversary, except that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in section 2530 or 2532, whichever is applicable, must be the same as are the effects specified in section 2530 or 2532, whichever is applicable on the cash surrender values defined in that section.

[1993, c. 1, §60 (COR) .]

3. The nonforfeiture factor for each policy year must be an amount equal to a percentage of the adjusted premium for the policy year, as defined in section 2532 or 2532-A, whichever is applicable. Except as is required by subsection 4, that percentage:

A. Must be the same percentage for each policy year between the 2nd policy anniversary and the later of the 5th policy anniversary and the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least 2/10ths of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and [1983, c. 346, §16 (NEW).]

B. Must be such that no percentage after the later of the 2 policy anniversaries, specified in paragraph A, may apply to fewer than 5 consecutive policy years. [1983, c. 346, §16 (NEW).]

[1993, c. 1, §60 (COR) .]

4. No basic cash value may be less than the value that would be obtained if the adjusted premiums for the policy, as defined in section 2532 or 2532-A, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

[1993, c. 1, §60 (COR) .]

5. All adjusted premiums and present values referred to in this section are for a particular policy calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of the Standard Nonforfeiture Law for Life Insurance. The cash surrender values referred to in this section must include any endowment benefits provided for by the policy.

[1993, c. 1, §60 (COR) .]

6. Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment must be determined in manners consistent with the manners specified for determining the analogous minimum amounts in sections 2529 to 2532-A and section 2533. The amounts

of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in section 2533, subsections 1 to 6, must conform with the principles of this section.

[1993, c. 1, §60 (COR) .]

SECTION HISTORY
1983, c. 346, §16 (NEW). RR 1993, c. 1, §60 (COR).

§2534. EXCEPTIONS

Sections 2529 to 2534 do not apply to any of the following: [1993, c. 1, §61 (COR).]

1. Reinsurance;

[1983, c. 346, §17 (NEW) .]

2. Group insurance;

[1983, c. 346, §17 (NEW) .]

3. Pure endowment;

[1983, c. 346, §17 (NEW) .]

4. Annuity or reversionary annuity contract;

[1983, c. 346, §17 (NEW) .]

5. Any term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

[1983, c. 346, §17 (NEW) .]

6. Any term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in sections 2532 and 2532-A, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

[1983, c. 346, §17 (NEW) .]

7. Any policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in sections 2530 to 2532-A, exceeds 2 1/2% of the amount of insurance at the beginning of the same policy year; or

[1983, c. 346, §17 (NEW) .]

8. Any policy that is delivered outside this State through an agent or other representative of the insurer issuing the policy.

[1993, c. 1, §61 (COR) .]

For purposes of the Standard Nonforfeiture Law for Life Insurance, the age at expiry for a joint term life insurance policy is the age at expiry of the oldest life. [1993, c. 1, §61 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 346, §17 (RPR). RR 1993, c. 1, §61 (COR).

§2535. INCONTESTABILITY, LIMITATION OF LIABILITY AFTER REINSTATEMENT

1. A reinstated policy of life insurance or annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

[1969, c. 132, §1 (NEW) .]

2. When any life insurance policy or annuity contract is reinstated, such reinstated policy or contract may exclude or restrict liability to the same extent that such liability could have been or was excluded or restricted when the policy or contract was originally issued, and such exclusion or restriction shall be effective from the date of reinstatement.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2536. PARTICIPATING, NONPARTICIPATING POLICIES -- RIGHT TO ISSUE

A life insurer may issue policies on either the participating basis or the nonparticipating basis, or on both bases, if the right or absence of right of participation is reasonably related to the premium charged and the insurer is otherwise not in violation of sections 2159 (unfair discrimination -- life insurance, annuities, and health insurance) or 2160 (rebates -- life, health and annuity contracts). [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2537. SEPARATE ACCOUNTS

1. Any domestic insurer may establish one or more separate accounts, including that type known as a unit investment trust, as defined by the Investment Company Act of 1940, Stat. 789, 15 U.S.C. § 80a, et seq., as amended, and may allocate to such separate accounts, in accordance with the terms of a written contract or agreement or annuity or pension, profitsharing or retirement plan, whether or not qualified under the applicable provisions of the Internal Revenue Code, 68A Stat. 1, 26 U.S.C. § 1, et seq., as amended, with any individual or any group, any amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, paid or remitted to or held by the insurer which are to be applied to provide for life insurance or annuities and benefits incidental thereto, payable in fixed and guaranteed or variable dollar amounts, or both.

[1973, c. 560, §3 (AMD) .]

2. The amounts allocated to each account of that type and accumulations thereon may be invested and reinvested as provided in section 1159 (special investments: separate accounts). Amounts allocated to a separate account in the exercise of the power granted by this section shall be owned by the insurer, and the insurer shall not be, nor hold itself out to be, a trustee with respect to those amounts.

[1987, c. 399, §15 (AMD) .]

3. The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the separate account, without regard to other income, gains or losses of the insurer. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the insurer may conduct.

[1973, c. 560, §5 (AMD) .]

4. Unless otherwise approved by the superintendent, assets allocated to a separate account shall be valued at their market value on the date of that valuation, or if there is no readily available market, then in accordance with the terms of the contract or the rules or other written agreement applicable to that separate account; except that, unless otherwise approved by the superintendent, the portion of the assets of that separate account at least equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in section 1159, if any, shall be valued in accordance with rules otherwise applicable to the insurer's assets.

[1987, c. 399, §16 (AMD) .]

5. If the contract or agreement provides for payment of benefits in variable amounts, it shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of such variable benefits. Any such contract or agreement, under which the benefits vary to reflect investment experience, including a group agreement and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will so vary and shall contain on its first page a statement that the benefits thereunder are on a variable basis.

[1973, c. 560, §7 (AMD) .]

6. No insurer shall deliver or issue for delivery within this State any contract or agreement providing benefits in variable amounts under this section unless it is duly authorized to conduct a life insurance or annuity business within this State and has satisfied the superintendent that its condition or methods of operation in connection with the issuance of such contracts or agreements will not render its operation hazardous to the public or its policyholders in this State. In determining the qualification of an insurer requesting such authority, the superintendent shall consider, among other things:

A. The history and financial condition of the insurer; [1969, c. 132, §1 (NEW).]

B. The character, responsibility and general fitness of the officers and directors of the insurer; and [1969, c. 132, §1 (NEW).]

C. The law and regulation under which the insurer is authorized in the state of domicile to issue variable contracts. [1973, c. 560, §8 (RPR).]

An insurer which issues variable contracts and which is a subsidiary of, or affiliated through common management or ownership with, another life insurer authorized to transact business in this State may be deemed by the superintendent to have met the provisions of this subsection, if either it or the parent or affiliated insurer meets the requirements hereof.

[1973, c. 585, §12 (AMD) .]

7. Any insurer which establishes one or more separate accounts pursuant to subsection 1, to the extent it deems necessary to comply with the Investment Company Act of 1940, 54 Stat. 789, 15 U.S.C. § 80a, et seq., as amended, may amend its charter to provide, with respect to any separate account or any portion thereof, for the benefit of persons having beneficial interests therein, special voting and other rights and special procedures for the conduct of the business and affairs of such separate account or portion thereof, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and selection of a committee, the members of which need not be otherwise affiliated with the insurer, to manage the business and affairs of such separate account or portion thereof. In addition, the insurer may make such other provisions in respect to the separate account, as the insurer may deem appropriate to facilitate compliance with any requirements of, or pursuant to, any federal or state law, now or hereafter in effect. However, this subsection shall not in any manner affect existing laws pertaining to the voting rights of the policyholders of the insurer.

[1969, c. 132, §1 (NEW) .]

8. No sale, exchange or other transfer of assets may be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account is made,

A. By a transfer of cash, or [1969, c. 132, §1 (NEW).]

B. By a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the superintendent. The superintendent may approve other transfers among such accounts if, in his opinion, such transfers would not be inequitable. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

9. The insurer shall not, in connection with the allocation of investments or expenses, or in any other respect, discriminate unfairly between separate accounts or between separate and other accounts, but this subsection shall not require the insurer to follow uniform investment policies for its accounts.

[1969, c. 132, §1 (NEW) .]

10. A variable annuity contract delivered or issued for delivery in this State may include as an incidental benefit a provision for payment on death during the deferred period of an amount equal to either the value of the contract at the time of death or the sum of the premiums less adjusted withdrawals from the policy, whichever is greater. The beneficiary under the contract may not be paid any other amount. A variable annuity contract that includes such incidental benefit may not be deemed to be life insurance and therefore is not subject to the provisions of this Title governing life insurance contracts. A variable annuity contract with a provision for any other benefit on death during the deferred period is subject to the provisions of this Title governing life insurance contracts. A payment on death pursuant to a variable annuity contract under this subsection must be made in accordance with section 2436. This subsection applies to variable annuity contracts delivered or issued for delivery in this State on or after January 1, 2009.

[2011, c. 163, §1 (AMD) .]

11. Notwithstanding any other provision of law, the superintendent shall have sole authority to regulate the issuance and sale of variable contracts and to promulgate such rules and regulations as may be necessary for the effectuation of this section.

[1973, c. 585, §12 (AMD) .]

12. Except for sections 2505, 2510, 2511, 2512, 2528 to 2534 and 2614, in the case of a variable life insurance policy and except as otherwise provided in this section, all pertinent provisions of this Title shall apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract, delivered or issued for delivery in this State, shall contain grace, reinstatement and nonforfeiture provisions appropriate to such a contract. Any individual variable annuity contract, delivered or issued for delivery in this State, shall contain grace and reinstatement provisions appropriate to such a contract. Any group variable life insurance contract, delivered or issued for delivery in this State, shall contain grace provisions appropriate to such a contract. The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

[1973, c. 560, §11 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §40 (AMD). 1973, c. 560, §§3-11,14 (AMD). 1973, c. 585, §12 (AMD). 1987, c. 399, §§15,16 (AMD). 2007, c. 544, §1 (AMD). 2011, c. 163, §1 (AMD).

§2538. PROHIBITED POLICY PLANS

1. No life insurer shall hereafter deliver or issue for delivery in this State:

A. As part of or in combination with any life insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends, and benefits arising out of any such contract, which provides for the accumulation of profits over a period of years and for payment of all or any part of such accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified or ascertainable period of years. [1969, c. 132, §1 (NEW).]

B. Any "registered" policy; that is, any policy (other than one "registered" as a security under applicable State law) purporting to be "registered" or otherwise specially recorded, with any agency of the State of Maine, or of any other state, or with any bank, trust company, escrow company, or other institution other than the insurer; or purporting that any reserves, assets or deposits are held, or will be so held, for the special benefit or protection of the holder of such policy, by or through any such agency or institution. [1969, c. 132, §1 (NEW).]

C. Any policy or contract under which any part of the premium or of funds or values arising from the policy or contract or from investment of reserves, or from mortality savings, lapses or surrenders, in excess of the normal reserves or amounts required to pay death, endowment, and nonforfeiture benefits in respective amounts as specified in or pursuant to the policy or contract, are on a basis not involving insurance or life contingency features,

(1) To be placed in special funds or segregated accounts or specially designated places or

(2) To be invested in specially designated investments or types thereof, and the funds or earnings thereon to be divided among the holders of such policies or contracts, or their beneficiaries or assignees. This provision does not apply as to any contract authorized under section 2537. [1969, c. 132, §1 (NEW).]

D. Any policy which provides that on the death of anyone not specifically named therein the owner or beneficiary shall receive the payment or granting of anything of value. This provision shall not prohibit family policies insuring unspecified members of a family, nor prohibit payment to unspecified beneficiaries of a class designated by the insured or policy owner. [1969, c. 132, §1 (NEW).]

E. Any policy providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination of the policies of other policyholders, whether by death or otherwise. [1969, c. 132, §1 (NEW).]

F. Any policy, other than as authorized under section 2537 (separate accounts), containing or referring to one or more of the following provisions or statements:

(1) Investment returns or profit-sharing, other than as a participation in the divisible surplus of the insurer under a regular participation provision as provided for in section 2509.

(2) Special treatment in the determination of any dividend that may be paid as to such policy.

(3) Reference to premiums as "deposits".

(4) Relating policyholder interest or returns from such policy or contract to those of stockholders.

(5) That the policyholder as a member of a select group will be entitled to extra benefits or extra dividends not available to policyholders generally. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. This section shall not be deemed to prohibit the provision, payment, allowance or apportionment of regular dividends or "savings" under regular participating forms of policies or contracts.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2539. HOLDING PROCEEDS OF POLICIES IN TRUST

1. Any domestic life insurer shall have power to hold the proceeds of any policy issued by it under a trust or other agreement upon such terms and restrictions as to revocation by the policyholder and control by the beneficiaries and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as shall have been agreed to in writing by the insurer and the policyholder.

[1969, c. 132, §1 (NEW) .]

2. The insurer shall not be required to segregate funds so held but may hold them as a part of its general corporate assets.

[1969, c. 132, §1 (NEW) .]

3. A foreign or alien insurer, when authorized by its charter or the laws of its domicile, may exercise any such powers with respect to policies issued to or held by residents of this State.

[1969, c. 132, §1 (NEW) .]

4. Nothing in this section shall be construed to subject any such insurer to any other laws or requirements of this State which would not be deemed applicable in the absence of this section.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2540. "WHOLESALE LIFE INSURANCE" DEFINED

"Wholesale life insurance" is that plan of life insurance, other than salary savings life insurance or pension trust insurance and annuities, under which individual policies are issued to the employees of any employer and where such policies are issued on the lives of not less than 3 employees at date of issue.

Premiums for such policies shall be paid either wholly from the employer's funds, or funds contributed by him, or partly from such funds and partly from funds contributed by the insured employees. In addition to the wholesale plans referred to in this section, wholesale life insurance may also be issued to any group of persons eligible for franchise health insurance under section 2740, subject to the terms and conditions of that section. [1979, c. 141, (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 204, (AMD). 1979, c. 141, (AMD).

§2541. SHORT TITLE

Sections 2541 to 2551 shall be known as the "Standard Nonforfeiture Law for Individual Deferred Annuities." [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2542. APPLICABILITY

Sections 2541 to 2551 shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under the United States Internal Revenue Code, Section 408, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this State through an agent or other representative of the company issuing the contract. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2543. NONFORFEITURE PROVISIONS

1. In the case of contracts issued on or after January 1, 1980, no contract of annuity, except as stated in section 2542, shall be delivered in this State unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the superintendent are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

A. Upon cessation of payment of considerations under a contract, the insurer will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in sections 2545 to 2548 and section 2550; [1979, c. 442, §4 (NEW).]

B. If a contract provides for a lump sum settlement at maturity, or at any other time, upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in sections 2545 to 2548 and section 2550. The insurer shall reserve the right to defer the payment of the cash surrender benefit for a period of 6 months after demand therefor with surrender of the contract; [1979, c. 442, §4 (NEW).]

C. A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and [1979, c. 442, §4 (NEW).]

D. A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence

of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract or any prior withdrawals from or partial surrenders of the contract. [1979, c. 442, §4 (NEW).]

[1979, c. 442, §4 (NEW) .]

2. Notwithstanding the requirements of sections 2541 to 2551, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of 2 full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to that period would be less than $20 monthly, the insurer may at its option terminate the contract by payment in cash of the then present value of that portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by that payment shall be relieved of any further obligation under that contract.

[1979, c. 442, §4 (NEW) .]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2544. MINIMUM VALUES

The minimum values as specified in sections 2545 to 2548 and section 2550 of any paid-up annuity, cash surrender or death benefits available under an annuity contract must be based upon minimum nonforfeiture amounts as defined in this section. [2003, c. 307, §1 (AMD).]

1. The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments must be equal to an accumulation up to that time at a rate of interest as permitted under subsection 1-A of the net considerations, as hereinafter defined, paid prior to that time, decreased by the sum of:

A. Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest as permitted under subsection 1-A; [2003, c. 307, §1 (AMD).]

B. The amount of any indebtedness to the insurer on the contract, including interest due and accrued; [2003, c. 307, §1 (AMD).]

C. An annual contract charge of $50, accumulated at a rate of interest as permitted under subsection 1-A; and [2003, c. 307, §1 (NEW).]

D. Any premium tax paid by the insurer for the contract, accumulated at a rate of interest as permitted under subsection 1-A. [2003, c. 307, §1 (NEW).]

The net considerations for a given contract year used to define the minimum nonforfeiture amount must be an amount equal to 87 1/2% of the gross considerations credited to the contract during that contract year.

[2003, c. 307, §1 (AMD) .]

1-A. The rate of interest used in determining minimum nonforfeiture amounts must be determined in accordance with the following requirements and specified in any contract providing for recalculation of the rate of interest permitted under this subsection.

A. The rate of interest must be an annual rate of interest determined as the lesser of 3% per annum and the 5-year Constant Maturity Treasury Rate reported by the Federal Reserve rounded to the nearest 1/20th of 1% as of a date, or average over a period, specified in the contract that is no later than 15 months prior to the contract issue date or the redetermination date decreased by 125 basis points as long as the resulting rate of interest is not less than 1%. [2003, c. 307, §1 (NEW).]

B. The rate of interest applies for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, must be stated in the contract. The basis is the date or average over a specified period that produces the value of the 5-year Constant Maturity Treasury Rate to be used at each redetermination date. [2003, c. 307, §1 (NEW).]

C. During the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may increase the reduction described in paragraph A by up to an additional 100 basis points to reflect the value of the equity indexed benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction may not exceed the market value of the benefit. The superintendent may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit and may disallow or limit the reduction if such a demonstration is not accepted. [2003, c. 307, §1 (NEW).]

D. The superintendent may adopt rules to implement this subsection and to provide for further adjustments to the minimum nonforfeiture amounts for contracts providing for substantive participation in an equity indexed benefit and for contracts for which the superintendent determines adjustments are appropriate. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2003, c. 307, §1 (NEW).]

[2003, c. 307, §1 (NEW) .]

2.

[2003, c. 307, §1 (RP) .]

3.

[2003, c. 307, §1 (RP) .]

4.

[2003, c. 307, §1 (NEW); T. 24-A, §2544, sub-§4 (RP) .]

SECTION HISTORY
1979, c. 442, §4 (NEW). 2003, c. 307, §1 (AMD).

§2545. COMPUTATION OF PRESENT VALUE

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2546. CALCULATION OF CASH SURRENDER VALUES

For contracts which provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, the present value being calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the insurer on

the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract. In no event shall any cash surrender benefit be less that the minimum nonforfeiture amount at that time. The death benefit under the contracts shall be at least equal to the cash surrender benefit. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2547. CALCULATION OF PAID-UP ANNUITY BENEFITS

For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, the present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by existing additional amounts credited by the insurer to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2548. MATURITY DATE

For the purpose of determining the benefits calculated under section 2546 and 2547, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2549. DISCLOSURE OF LIMITED DEATH BENEFITS

Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that those benefits are not provided. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2550. INCLUSION OF LAPSE OF TIME CONSIDERATIONS

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2551. PRORATION OF VALUES; ADDITIONAL BENEFITS

For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of sections 2545 to 2548 and section 2550, additional benefits payable, in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all these additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by sections 2541 to 2551. The inclusion of the additional benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits. [1979, c. 442, §4 (NEW).]

SECTION HISTORY
1979, c. 442, §4 (NEW).

§2552. DEFINITIONS

For the purposes of sections 2553 and 2554 the "published monthly average" means: [1981, c. 188, §4 (NEW).]

1. Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Services, Inc. or any successor thereto; or

[1981, c. 188, §4 (NEW) .]

2. In the event that Moody's Corporate Bond Yield Average-Monthly Average Corporates is no longer published, a substantially similar average, established by regulation issued by the superintendent.

[1981, c. 188, §4 (NEW) .]

SECTION HISTORY
1981, c. 188, §4 (NEW).

§2553. MAXIMUM RATE OF INTEREST ON POLICY LOANS

1. Policies issued on or after the effective date of this Act shall provide for policy loan interest rates as follows:

A. A provision permitting a maximum interest rate of not more than 8% each year; or [1981, c. 188, §4 (NEW).]

B. A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as permitted by law. [1981, c. 188, §4 (NEW).]

[1981, c. 188, §4 (NEW) .]

2. The rate of interest charged on a policy loan made under subsection 1, paragraph B, shall not exceed the higher of the following:

A. The published monthly average for the calendar month ending 2 months before the date on which the rate is determined; or [1981, c. 188, §4 (NEW).]

B. The rate used to compute the cash surrender values under the policy during the applicable period plus 1% each year. [1981, c. 188, §4 (NEW).]

[1981, c. 188, §4 (NEW) .]

3. If the maximum rate of interest is determined pursuant to subsection 1, paragraph B, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

[1981, c. 188, §4 (NEW) .]

4. The maximum rate for each policy shall be determined at regular intervals at least once every 12 months, but not more frequently than once in any 3-month period. At the intervals specified in the policy:

A. The rate being charged may be increased whenever such increase, as determined under subsection 2, would increase that rate by 1/2% or more each year; and [1981, c. 188, §4 (NEW).]

B. The rate being charged shall be reduced whenever such reduction, as determined under subsection 2, would decrease that rate by 1/2% or more each year. [1981, c. 188, §4 (NEW).]

[1981, c. 188, §4 (NEW) .]

5. The life insurer shall:

A. Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan; [1981, c. 188, §4 (NEW).]

B. Notify the policyholder, with respect to premium loans, of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in paragraph C; [1981, c. 188, §4 (NEW).]

C. Send to policyholders with loans, reasonable advance notice of any increase in the rate; and [1981, c. 188, §4 (NEW).]

D. Include in the notices required under this subsection the substance of the pertinent provisions of subsections 1 and 3. [1981, c. 188, §4 (NEW).]

[1981, c. 188, §4 (NEW) .]

6. The loan value of the policy shall be determined in accordance with section 2510, but no policy may terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated and if there had been no change during that policy year.

[1981, c. 188, §4 (NEW) .]

7. The substance of the pertinent provisions of subsections 1 and 3 shall be set forth in the policies to which they apply.

[1981, c. 188, §4 (NEW) .]

8. For purposes of this section:

A. The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy; [1981, c. 188, §4 (NEW).]

B. The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due; [1981, c. 188, §4 (NEW).]

C. The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer; and [1981, c. 188, §4 (NEW).]

D. The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans. [1981, c. 188, §4 (NEW).]

[1981, c. 188, §4 (NEW) .]

9. No other provision of law may apply to policy loan interest rates unless made specifically applicable to such rates.

[1981, c. 188, §4 (NEW) .]

SECTION HISTORY
1981, c. 188, §4 (NEW).

§2554. APPLICABILITY TO EXISTING POLICIES

The provisions of sections 2552 and 2553 shall not impair any insurance contract issued before the effective date of this Act. [1981, c. 188, §4 (NEW).]

SECTION HISTORY
1981, c. 188, §4 (NEW).

§2555. INCLUSION OF NURSING HOME BENEFITS IN LIFE INSURANCE POLICIES

1. In order to offer a life insurance policy providing for acceleration of life insurance or annuity benefits in advance of the time the benefits would otherwise be payable because of confinement to a nursing home or long-term care facility, receipt of home health care or hospice care benefits, diagnosis of terminal illness or for substantially similar reasons, the insurer must have a certificate of authority to transact life or life and health insurance in this State.

[1989, c. 26, (NEW) .]

2. The superintendent shall promulgate reasonable rules, in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375, to provide for the full and fair disclosure of information in connection with the sale of the policies referred to in subsection 1, and may include, but are not limited to, definitions, acceptable restrictions on benefit payments, coverage periods and nonforfeiture requirements.

[1989, c. 26, (NEW) .]

SECTION HISTORY

1989, c. 26, (NEW).

§2556. NOTIFICATION PRIOR TO LAPSE OR TERMINATION

1. **Notice to 3rd party.** An individual life insurance policy that has been in force for at least one year may not be terminated for nonpayment of premium unless, at least 21 days prior to the expiration of the grace period, the insurer has mailed a notice of cancellation to the policyholder and any 3rd party designated by the policyholder by name and address in writing. The bureau shall adopt rules to implement the notice requirements under this subsection.

[2007, c. 40, §1 (NEW) .]

2. **Restrictions on lapse or termination; cognitive impairment or functional incapacity.** Notwithstanding any other provision of this chapter, an insurer shall provide restrictions on cancellation, termination or lapse of individual life insurance policies in accordance with this subsection to reduce the danger that a life insurance policyholder will lose life insurance coverage when the policyholder suffers from cognitive impairment or functional incapacity and the loss of coverage is due to that cognitive impairment or functional incapacity. Within 90 days after cancellation, termination or lapse of coverage due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a life insurance policy may request reinstatement on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity. An insurer may request a medical demonstration that the policyholder suffered from cognitive impairment or functional incapacity at the time of cancellation, termination or lapse. The medical demonstration may be at the expense of the policyholder. A policy reinstated pursuant to this subsection must cover any loss or claim occurring from the date of the termination, cancellation or lapse and must be issued without any evidence of insurability. Within 15 days after request from an insurer, a policyholder of a policy reinstated pursuant to this subsection shall pay any unpaid premium from the date of the last premium payment at the rate that would have been in effect had the policy remained in force. If the premium is not paid as required, the policy may not be reinstated and the insurer is not responsible for claims incurred after the initial date of cancellation, termination or lapse of coverage. If an insurer denies a request for reinstatement, the insurer shall notify the policyholder that the policyholder may request a hearing before the superintendent.

[2011, c. 123, §1 (AMD); 2011, c. 123, §5 (AFF) .]

3. **Rulemaking.** The bureau may adopt rules to implement the requirements of this section. The rules adopted pursuant to this subsection apply to all life insurance policies and riders delivered or issued for delivery, continued or renewed in this State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 123, §1 (AMD); 2011, c. 123, §5 (AFF) .]

SECTION HISTORY
2007, c. 40, §1 (NEW). 2011, c. 123, §1 (AMD). 2011, c. 123, §5 (AFF).

Chapter 30: ANNUITY AGREEMENTS WITH THE UNIVERSITY OF MAINE SYSTEM

§2571. ELIGIBILITY

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1985, c. 779, §65 (AMD). 1995, c. 375, §C6 (RP).

§2572. CERTIFICATE OF AUTHORITY

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1981, c. 546, §1 (AMD). 1985, c. 779, §66 (AMD). 1995, c. 375, §C6 (RP).

§2573. RESERVE REQUIREMENTS

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1981, c. 546, §2 (RPR). 1995, c. 375, §C6 (RP).

§2574. FILING COPIES OF ANNUITY AGREEMENTS

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1981, c. 546, §3 (RPR). 1995, c. 375, §C6 (RP).

§2574-A. SURPLUS FUNDS

(REPEALED)

SECTION HISTORY
1981, c. 546, §4 (NEW). 1995, c. 375, §C6 (RP).

§2575. REQUIRED CONTENTS OF ANNUITY AGREEMENT

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1981, c. 546, §§5,6 (AMD). 1995, c. 375, §C6 (RP).

§2576. REINSURANCE

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1981, c. 546, §7 (RPR). 1995, c. 375, §C6 (RP).

§2577. EXAMINATIONS

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1981, c. 546, §8 (RPR). 1995, c. 375, §C6 (RP).

§2578. EXEMPTIONS

(REPEALED)

SECTION HISTORY
1977, c. 261, §2 (NEW). 1995, c. 375, §C6 (RP).

Chapter 31: GROUP LIFE INSURANCE

§2601. SCOPE OF CHAPTER -- SHORT TITLE

1. This chapter applies only to group life insurance.

[1969, c. 132, §1 (NEW) .]

2. This chapter does not apply to any contracts or policies entered into or issued prior to August 6, 1949 nor to any extensions, renewals or modifications thereof or amendments thereto whenever made.

[1969, c. 132, §1 (NEW) .]

3. This chapter may be known and cited as the "Group Life Insurance Law."

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2602. GROUP CONTRACTS MUST MEET GROUP REQUIREMENTS *(REPEALED)*

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §1 (RP).

§2602-A. ELIGIBLE GROUPS

Except as provided in section 2612-A, no policy of group life insurance may be delivered in this State unless it conforms to one of the descriptions in sections 2603 to 2610-A. [1981, c. 150, §2 (NEW).]

SECTION HISTORY
1981, c. 150, §2 (NEW).

§2603. EMPLOYEE GROUPS

The lives of a group of individuals may be insured under a policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustees are considered the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements. [1981, c. 150, §3 (RPR).]

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" includes the employees of one or more subsidiary corporations, and the employees, individual proprietors and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" includes the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" includes retired employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

[1981, c. 150, §3 (RPR) .]

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject that coverage in writing.

[1981, c. 150, §3 (RPR) .]

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §3 (RPR) .]

4.

[1981, c. 150, §3 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §3 (RPR).

§2604. DEBTOR GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §41 (AMD). 1977, c. 672, §1 (AMD). 1979, c. 369, (AMD). 1979, c. 667, §2 (AMD). 1981, c. 150, §4 (RP).

§2604-A. DEBTOR GROUPS

The lives of a group of individuals may be insured under a policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by 2 or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent is considered the policyholder, to insure debtors of the creditor, or creditors, subject to the following requirements. [1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW).]

1. The debtors eligible for insurance under the policy are all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" includes:

A. Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction; [1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW).]

B. The debtors of one or more subsidiary corporations; and [1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW).]

C. The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships or partnerships is under common control. [1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW).]

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

2. The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

3. An insurer may exclude any debtors as to whom evidence of insurability is not satisfactory to the insurer.

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

4. The amount of credit life insurance shall at no time exceed the unpaid amount financed plus earned interest and an allowance for delinquencies as determined by the superintendent or, in the case of open-end credit, the balance upon which a finance charge may be imposed plus earned interest and an allowance for delinquencies as determined by the superintendent. Where the indebtedness is repayable in one sum to the creditor, the insurance on the life of any debtor shall in no instance be in effect for a period in excess of 18 months, except that such insurance may be continued for an additional period not exceeding 6 months in the case of default, extension or recasting of the loan.

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

5. The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment.

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

6. Notwithstanding the provisions of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

7. Notwithstanding subsection 1, in the case of a group policy issued pursuant to this section which provides life insurance on the term plan upon the lives of persons indebted to a creditor, where the indebtedness is secured to the creditor by a mortgage on real estate, where the insurance is afforded on an optional basis and where a separate charge is made to the debtor by the creditor for the insurance, both the debtor and not more than one comaker of the indebtedness are eligible to apply for insurance jointly under the group policy, provided that both of them are individually and jointly liable to repay the indebtedness. This subsection may not be held to restrict the right of an insurer to require satisfactory evidence of insurability of any person requesting the insurance, nor to preclude those exclusions from eligibility for insurance under such a group policy as may be contained therein. Nothing in this subsection may prohibit insurance on the life of one debtor only, if desired by the debtor.

[1981, c. 150, §5 (NEW); 1981, c. 175, §2 (NEW) .]

SECTION HISTORY
1981, c. 150, §5 (NEW). 1981, c. 175, §2 (NEW).

§2605. LABOR UNION GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §6 (RP).

§2605-A. LABOR UNION GROUPS

The lives of a group of individuals may be insured under a policy issued to a labor union, or similar employee organization, which is considered to be the policyholder, to insure members of that union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements. [1981, c. 150, §7 (NEW).]

1. The members eligible for insurance under the policy are all of the members of the union or organization, or all of any class or classes thereof.

[1981, c. 150, §7 (NEW) .]

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject that coverage in writing.

[1981, c. 150, §7 (NEW) .]

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §7 (NEW) .]

SECTION HISTORY
1981, c. 150, §7 (NEW).

§2606. TRUSTEE GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §6 (RP).

§2606-A. TRUSTEE GROUPS

The lives of a group of individuals may be insured under a policy issued to a trust or to the trustee or trustees of a fund established or adopted by 2 or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees are considered the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements. [2011, c. 163, §2 (AMD).]

1. The persons eligible for insurance are all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" includes retired employees, the individual proprietor or partners if an employer is an individual proprietorship or a partnership, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with that trusteeship.

[1981, c. 150, §7 (NEW) .]

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject that coverage in writing.

[1981, c. 150, §7 (NEW) .]

3. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §7 (NEW) .]

SECTION HISTORY
1981, c. 150, §7 (NEW). 2011, c. 163, §2 (AMD).

§2607. TRADE ASSOCIATION GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 655, §1 (AMD). 1977, c. 696, §372 (AMD). 1981, c. 150, §8 (RP).

§2607-A. ASSOCIATION GROUPS

The lives of a group of individuals may be insured under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 50 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least 2 years; and shall have a constitution and bylaws which provides that: The association or associations hold regular meetings not less than annually to further purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements. [1981, c. 150, §9 (NEW).]

1. The policy may insure members of the association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employees' employer.

[1981, c. 150, §9 (NEW) .]

2. The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.

[1981, c. 150, §9 (NEW) .]

3. Except as provided in subsection 4, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject that coverage in writing.

[1981, c. 150, §9 (NEW) .]

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §9 (NEW) .]

SECTION HISTORY
1981, c. 150, §9 (NEW).

§2608. MUNICIPAL EMPLOYEES ASSOCIATION GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §10 (RP).

§2609. PROFESSIONAL ASSOCIATION GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §42 (AMD). 1981, c. 150, §11 (RP).

§2610. CREDIT UNION GROUPS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §12 (RP).

§2610-A. CREDIT UNION GROUPS

The lives of a group of individuals may be insured under a policy issued to a credit union or to a trustee or trustees or agent designated by 2 or more credit unions, which credit union, trustee, trustees or agent is considered the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees or agent or any of their officials, subject to the following requirements. [1981, c. 150, §13 (NEW).]

1. The members eligible for insurance are all of the members of the credit union or credit unions or all of any class or classes thereof.

[1981, c. 150, §13 (NEW) .]

2. The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in subsection 3, must insure all eligible members.

[1981, c. 150, §13 (NEW) .]

3. An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §13 (NEW) .]

SECTION HISTORY
1981, c. 150, §13 (NEW).

§2611. DEPENDENTS' COVERAGE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 433, §62 (AMD). 1971, c. 598, §50 (AMD). 1973, c. 125, (AMD). 1975, c. 203, (AMD). 1979, c. 102, (AMD). 1981, c. 150, §14 (RP).

§2611-A. DEPENDENT'S COVERAGE

Except for a policy issued under section 2604-A, a group life insurance policy may insure the lives of spouses and dependent children of employees or members against loss due to death without also insuring employees or members against loss due to the death of their spouses and dependent children, or any class or classes thereof, subject to the following. [1993, c. 132, §1 (AMD).]

1. The premium for the insurance must be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued or from funds contributed by employees or members, or from both. Except as provided in subsection 2, a policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by employees or members, spouses or dependent children must insure all eligible employees or members with respect to their spouses and dependent children, or all eligible spouses and dependent children, or any class or classes thereof.

[1993, c. 132, §1 (AMD) .]

2. An insurer may exclude or limit the coverage on any spouse or dependent child as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §15 (NEW) .]

3.

[1993, c. 132, §1 (RP) .]

SECTION HISTORY
1981, c. 150, §15 (NEW). 1993, c. 132, §1 (AMD).

§2612. LIMIT AS TO AMOUNT OF INSURANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 202, (AMD). 1977, c. 95, (RP).

§2612-A. OTHER GROUPS

Group life insurance offered to a resident of this State under a group life insurance policy issued to a group other than one described in sections 2602-A to 2610-A is subject to the following requirements. [1981, c. 150, §16 (NEW).]

1. No group life insurance policy may be delivered in this State, pursuant to this section, unless the superintendent finds that:

A. The policyholder is a bona fide group formed for purposes other than the procurement of insurance; [1987, c. 476, §2 (AMD).]

B. The issuance of the group policy would be actuarially sound; [1981, c. 150, §16 (NEW).]

C. The issuance of the group policy would result in economies of acquisition or administration; and [1987, c. 476, §2 (AMD).]

D. The benefits are reasonable in relation to the premiums charged. [1981, c. 150, §16 (NEW).]

[1987, c. 476, §2 (AMD) .]

2. No group life insurance coverage may be offered in this State, pursuant to this section, by an insurer under a policy issued in another state, unless the superintendent has made a determination that the requirements of subsection 1, paragraphs A, B, C and D have been met.

[1987, c. 476, §3 (RPR) .]

2-A. Notwithstanding subsections 1 and 2, an employee leasing company registered pursuant to Title 32, chapter 125 qualifies as an eligible group for purposes of the purchase of group life insurance as provided in this section.

[1995, c. 618, §2 (NEW) .]

3. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

[1981, c. 150, §16 (NEW) .]

4. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1981, c. 150, §16 (NEW) .]

SECTION HISTORY
1981, c. 150, §16 (NEW). 1987, c. 476, §§2,3 (AMD). 1995, c. 618, §2 (AMD).

§2613. PROVISIONS REQUIRED IN GROUP CONTRACTS

No policy of group life insurance may be delivered in this State unless it contains in substance the provisions set forth in this section and sections 2614 to 2628, or provisions which in the opinion of the superintendent are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder, provided: [1981, c. 150, §17 (RPR).]

1. That sections 2619 to 2623 and section 2628 do not apply to policies insuring the lives of debtors;

[1981, c. 150, §17 (RPR) .]

2. That the standard provisions required for individual life insurance policies do not apply to group life insurance policies; and

[1981, c. 150, §17 (RPR) .]

3. That if the group life insurance policy is on a plan of insurance other than the term plan, it contains a nonforfeiture provision or provisions which in the opinion of the superintendent is or are equitable to the insured persons and to the policyholder, but nothing herein may be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

[1981, c. 150, §17 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §43 (AMD). 1973, c. 585, §12 (AMD). 1981, c. 150, §17 (RPR).

§2614. GRACE PERIOD

The group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2615. INCONTESTABILITY

1. The group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premium, after it has been in force for 2 years from its date of issue; and that no statement made by any person insured under the policy relating to his insurability may be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime nor unless it is contained in a written instrument signed by him; provided, that no such provision may preclude the assertion at any time of defenses based upon provisions in the policy which relate to eligibility for coverage.

[1981, c. 150, §18 (AMD) .]

2.

[1981, c. 150, §19 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §§18,19 (AMD).

§2616. APPLICATION; STATEMENTS DEEMED REPRESENTATIONS

The group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest, unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of death or incapacity of the insured person, to his beneficiary or personal representative. [1981, c. 150, §20 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §20 (AMD).

§2617. INSURABILITY

The group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his coverage. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2618. MISSTATEMENT OF AGE

The group life insurance policy shall contain a provision specifying an equitable adjustment of premiums or of benefits or both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2619. PAYMENT OF BENEFITS

The group life insurance policy shall contain a provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that where the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy, in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding $2,000 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured. [1981, c. 150, §21 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §21 (AMD).

§2620. INFORMATION AS TO INSURANCE

The group life insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured printed information as to the insurance protection to which he is entitled and the rights and conditions set forth in section 2621, 2622, 2623 and 2628. The insurer shall also provide for distribution by the policyholder to each member of the insured group a statement setting forth to whom the benefits under such policy are payable. [1981, c. 150, §22 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 183, §1 (AMD). 1981, c. 150, §22 (AMD).

§2621. CONVERSION ON TERMINATION OF ELIGIBILITY

There shall be a provision that if the insurance, or any portion of it, on a person covered under the policy or on the dependent of a person covered, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within 31 days after such termination, and provided further that: [1981, c. 150, §23 (AMD).]

1. The individual policy shall, at the option of such person, be on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance;

[1981, c. 150, §24 (AMD) .]

2. The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination less the amount of any life insurance for which such person is or becomes eligible under the same or any other group policy within 31 days after such termination; provided, that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

[1969, c. 132, §1 (NEW) .]

3. The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his age attained on the effective date of the individual policy.

[1969, c. 132, §1 (NEW) .]

Subject to the same conditions set forth in this section, the conversion privilege shall be available: To a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of the death; and to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy. [1981, c. 150, §25 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §§23-25 (AMD).

§2622. CONVERSION ON TERMINATION OF POLICY

The group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least 5 years prior to such termination date shall be entitled to have issued to him by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by section 2621, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of: [1981, c. 150, §26 (AMD).]

1. The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under a group policy issued or reinstated by the same or another insurer within 31 days after such termination, and

[1981, c. 150, §26 (AMD) .]

2. $10,000.

[1981, c. 150, §26 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §26 (AMD).

§2623. DEATH PENDING CONVERSION

The group life insurance policy shall contain a provision that if a person insured under the policy, or the insured dependent of a covered person, dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with sections 2621 or 2622 and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made. [1981, c. 150, §27 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §27 (AMD).

§2624. INFORMATION TO DEBTOR

In the case of a policy insuring the lives of debtors, a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the death benefit shall first be applied to reduce or extinguish the indebtedness. [1981, c. 150, §28 (RPR).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 150, §28 (RPR).

§2625. NOTICE AS TO CONVERSION RIGHT

If any individual insured under a group life insurance policy hereafter delivered in this State becomes entitled under the terms of such policy to have an individual policy of life insurance issued to him without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least 15 days prior to the expiration date of such period, then, in such event the individual shall have an additional period within which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire 15 days next after the individual is given such notice but in no event shall such additional period extend beyond 60 days next after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2626. RATE OF PREMIUMS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §44 (AMD). 1973, c. 585, §12 (AMD). 1975, c. 196, (RP).

§2627. APPLICATION OF DIVIDENDS, RATE REDUCTIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §45 (AMD). 1991, c. 200, §D1 (RP).

§2627-A. DIVIDENDS AND EXPERIENCE REFUNDS

The following requirements apply to all group life insurance with the exception of insurance in which the policyholder is subject to the fiduciary standards of the federal Employee Retirement Income Security Act of 1974, ERISA, 29 United States Code, Section 1001-1381 (1975). [1991, c. 200, Pt. D, §2 (NEW).]

1. **Refunds.** The amount by which any dividend, experience refund or rate reduction exceeds the amount of premium contributed by the group policyholder for the same period must be refunded to the employees, members or debtors in proportion to their premium contributions for that period, except as provided in subsection 2.

[1991, c. 200, Pt. D, §2 (NEW) .]

2. **Refund amounts less than $25 per employee, member or debtor.** If the refunds required by subsection 1 would average less than $25 per employee, member or debtor, then the group policyholder may request approval from the superintendent to apply those amounts in a different manner. The superintendent shall approve the request if, in the superintendent's opinion, the manner of application proposed would be for the sole benefit of insured employees, members or debtors.

[1991, c. 200, Pt. D, §2 (NEW) .]

SECTION HISTORY
1991, c. 200, §D2 (NEW).

§2628. TOTAL DISABILITY

Where active employment is a condition of insurance, the group life insurance policy shall contain a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium paying basis for a period of 6 months from the date on which the total disability started, but not beyond the earlier of: [1981, c. 150, §29 (NEW).]

1. Approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain; or

[1981, c. 150, §29 (NEW) .]

2. The discontinuance of the group insurance policy.

[1981, c. 150, §29 (NEW) .]

SECTION HISTORY
1981, c. 150, §29 (NEW).

§2629. ACQUIRED IMMUNE DEFICIENCY SYNDROME

No group life insurance policy delivered or issued for delivery in this State may provide more restrictive coverage for death resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases than the death resulting from any other disease or sickness or exclude coverage for death resulting from AIDS, ARC or HIV related diseases except through an exclusion under

which deaths resulting from all sicknesses and diseases are treated the same or as provided by section 2159, subsection 4. This section shall not apply to death by accident or accidental means. [1989, c. 176, §4 (NEW).]

SECTION HISTORY
1989, c. 176, §4 (NEW).

§2630. SUICIDE

A group life insurance policy delivered or issued for delivery in this State may not contain a more restrictive exclusion from liability for death resulting from suicide than death by suicide, while sane or insane, within 2 years from the date coverage commences or within 2 years of an increase in coverage. [2001, c. 89, §3 (NEW).]

SECTION HISTORY
2001, c. 89, §3 (NEW).

Chapter 32: PREFERRED PROVIDER ARRANGEMENT ACT

§2670. SHORT TITLE

This chapter may be cited as the "Preferred Provider Arrangement Act." [1999, c. 609, §4 (AMD).]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §4 (AMD).

§2671. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [1985, c. 704, §4 (NEW).]

1. "Administrator" means any person, other than a carrier, that administers a preferred provider arrangement. An administrator does not include a health maintenance organization licensed pursuant to chapter 56 or a nonprofit health care plan regulated by the superintendent pursuant to Title 24. An employer exempt from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered an administrator.

[1999, c. 609, §5 (AMD) .]

1-A. "Capitation" has the same meaning as defined in section 4331, subsection 2.

[1999, c. 609, §5 (NEW) .]

2.

[1999, c. 609, §5 (RP) .]

2-A. "Carrier" means an insurance company licensed in accordance with this Title, a fraternal benefit society authorized pursuant to chapter 55 or a nonprofit hospital or medical service organization licensed pursuant to Title 24. An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

[1999, c. 609, §5 (NEW) .]

2-B. "Enrollee" means an individual entitled to reimbursement for expenses of health care services under a health plan.

[1999, c. 609, §5 (NEW) .]

3. "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's legal authorization.

[1985, c. 704, §4 (NEW) .]

3-A. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan.

[1999, c. 609, §5 (NEW) .]

4.

[1999, c. 609, §5 (RP) .]

5.

[1999, c. 609, §5 (RP) .]

6. "Preferred provider" means a provider who enters into a preferred provider arrangement with an administrator or carrier.

[1999, c. 609, §5 (AMD) .]

7. "Preferred provider arrangement" means a contract, agreement or arrangement between a carrier or administrator and a provider in which the provider agrees to provide services to a health plan enrollee whose plan benefits include incentives for the enrollee to use the services of that provider.

[1999, c. 609, §5 (AMD) .]

8. "Provider" means an individual or entity duly licensed or otherwise legally authorized to provide health care services, including, but not limited to, the treatment of physical health and mental health and provision for medical supplies and pharmaceutical supplies.

[1999, c. 609, §5 (AMD) .]

9. "Superintendent" means the Superintendent of Insurance.

[1999, c. 609, §5 (AMD) .]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1995, c. 332, §P1 (AMD). 1999, c. 609, §5 (AMD).

§2672. SELECTIVE CONTRACTING AUTHORIZED

Carriers or administrators may enter into preferred provider arrangements with providers of their choice. In selecting preferred providers, carriers or administrators may consider, among other factors, price differences between or among providers, geographic accessibility, specialization and projected utilization by enrollees. Selective contracting does not constitute unreasonable discrimination against or among providers. [1999, c. 609, §6 (AMD).]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §6 (AMD).

§2673. POLICIES, AGREEMENTS OR ARRANGEMENTS WITH INCENTIVES OR LIMITS ON REIMBURSEMENT AUTHORIZED

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1989, c. 588, §A49 (RPR). 1999, c. 609, §7 (RP).

§2673-A. PREFERRED PROVIDER ARRANGEMENTS

1. **Filing with superintendent; disapproval.** A carrier or administrator who proposes to offer a preferred provider arrangement shall file with the superintendent proposed agreements, rates, geographic service areas, provider networks and other materials relevant to the proposed arrangement. The superintendent shall disapprove any preferred provider arrangement if the arrangement contains any unjust, unfair or inequitable provisions; unreasonably restricts access and availability of health care services; or fails to comply with other requirements of this chapter, chapter 56-A or rules adopted by the superintendent.

[1999, c. 609, §8 (NEW) .]

2. **Considered separate preferred provider arrangements.** If health plans offered by the same carrier have different geographic service areas, or if there are preferred providers in one health plan who are nonpreferred providers in another health plan offered by the same carrier or administered by the same administrator or who are in a different preference tier if the plan is a multitier plan, then the plans represent different preferred provider arrangements and must be separately filed and approved.

[1999, c. 609, §8 (NEW) .]

3. **Rules.** Preferred provider arrangements offered by carriers that are subject to chapter 56-A must be in compliance with applicable provisions of that chapter and any rules adopted under that chapter. Employer-sponsored plans that are exempt from this chapter pursuant to federal law and administrators offering preferred provider arrangements to employer-sponsored plans are not subject to the provisions of chapter 56-A or rules adopted under that chapter, provided either the administrator or any other participating entity, other than the self-insured employer, does not undertake insurance risk. The superintendent may adopt rules establishing procedures for filing and approval of preferred provider arrangements, including the time period within which the superintendent must act on a completed application; specific criteria for determining when a term or condition is unjust, unfair or inequitable or has the effect of unreasonably restricting access and availability to health care services; and standards consistent with this chapter and chapter 56-A for the ongoing operation and oversight of approved provider arrangements. The rules may prohibit the carrier from applying a benefit level differential to enrollees who must travel an unreasonable distance to obtain the service. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

[1999, c. 609, §8 (NEW) .]

SECTION HISTORY
1999, c. 609, §8 (NEW).

§2674. REQUIREMENTS APPLICABLE TO ADMINISTRATORS

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §9 (RP).

§2674-A. REQUIREMENTS FOR ADMINISTRATORS AND CARRIERS

1. **Registration fee.** All administrators of a preferred provider arrangement shall register with the superintendent and pay an annual registration fee pursuant to section 601, subsection 20. The superintendent shall by rule establish criteria for the registration, including minimum solvency requirements. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

[1999, c. 609, §10 (NEW) .]

2. **Compilation of current listing.** The bureau shall compile and maintain a current listing of administrators and carriers offering preferred provider arrangements authorized under this chapter.

[1999, c. 609, §10 (NEW) .]

3. **Prohibition against insurance risk.** Except as specifically authorized in section 2676, an administrator may provide administrative services only and may not accept insurance risk.

[1999, c. 609, §10 (NEW) .]

4. **Approval required before marketing or making available.** A carrier may not issue a health plan incorporating a preferred provider arrangement and an administrator may not market or otherwise make available a preferred provider arrangement until the superintendent pursuant to section 2673-A has approved the arrangement.

[1999, c. 609, §10 (NEW) .]

5. **Registration as insurance administrator.** In addition to meeting the requirements of the preferred provider arrangement, each preferred provider administrator who directly or indirectly transfers funds, manages funds, adjusts claims or asserts control over the transfer of funds for the purpose of payment of provider services shall register with the superintendent as an insurance administrator pursuant to chapter 18.

[1999, c. 609, §10 (NEW) .]

6. **Provision of document to beneficiary.** Each preferred provider administrator shall inform all carriers that the carriers must provide to each enrollee of any health plan subject to this chapter a plan description that complies with the requirements of and rules adopted under chapter 56-A, subchapter I.

[1999, c. 609, §10 (NEW) .]

SECTION HISTORY
1999, c. 609, §10 (NEW).

§2675. REQUIREMENTS APPLICABLE TO INSURERS

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1989, c. 588, §§A50-52 (AMD). 1999, c. 609, §11 (RP).

§2676. RISK TRANSFER

Preferred provider arrangements may include capitated payments that are limited to the health services provided by the provider. [1999, c. 609, §12 (AMD).]

Preferred provider arrangements may embody risk transfer between carriers and providers in accordance with the provisions of chapter 56-A, subchapter III. Any other acceptance of insurance risk by a person that does not hold a valid certificate of authority or license and is not exempt by law from licensure constitutes the unauthorized transaction of insurance within the meaning of section 404 and chapter 21. [1999, c. 609, §12 (NEW).]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1989, c. 588, §A53 (RPR). 1999, c. 609, §12 (AMD).

§2677. ALTERNATIVE HEALTH CARE BENEFITS

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1987, c. 34, §2 (AMD). 1989, c. 588, §A54 (RPR). 1993, c. 600, §B19 (AMD). 1999, c. 609, §13 (RP).

§2677-A. PAYMENT FOR NONPREFERRED PROVIDERS

1. **Nonpreferred providers.** A carrier incorporating a preferred provider arrangement into a health plan shall provide for payment of covered health care services rendered by providers that are not preferred providers.

[1999, c. 609, §14 (NEW) .]

2. **Benefit level.** The benefit level differential between services rendered by preferred providers and nonpreferred providers may not exceed 20% of the allowable charge for the service rendered, except that the superintendent may waive this requirement for a given benefit plan. Compliance with this requirement for a given benefit plan may be demonstrated on an aggregate basis. This demonstration of compliance must be based on a reasonably anticipated mix of claims certified by a qualified actuary who is a member of the American Academy of Actuaries or a successor organization. As used in this subsection, "allowable charge" means the amount that would be payable for services under the preferred provider arrangement including deductible and coinsurance amounts.

[2001, c. 369, §3 (AMD) .]

SECTION HISTORY
1999, c. 609, §14 (NEW). 2001, c. 369, §3 (AMD).

§2678. ANNUAL EXPERIENCE REPORT

On or before April 1st of each year, an administrator or carrier who issues or administers a program, policy or contract in this State that includes incentives for the enrollee to use the services of a provider who has entered into an agreement with the carrier or administrator shall file a report of its activities for the preceding year with the superintendent. The report must be in the form prescribed by the superintendent and at a minimum must contain the following: [1999, c. 609, §15 (AMD).]

1. A provider directory that includes the name, address and scope of license of each preferred provider; and

[1999, c. 609, §15 (AMD) .]

2.

[1999, c. 609, §15 (RP) .]

3. Annual information specified in chapter 56-A or rules adopted under that chapter. Annual information reported to the superintendent pursuant to chapter 56-A under another license must be referenced in the report and not reported in a duplicate manner.

[1999, c. 609, §15 (NEW) .]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §15 (AMD).

§2678-A. ANNUAL REPORT

(REPEALED)

SECTION HISTORY
1989, c. 588, §A55 (NEW). 1999, c. 609, §16 (RP).

§2679. UTILIZATION REVIEW DATA

(REPEALED)

SECTION HISTORY
1987, c. 168, §3 (NEW). 1999, c. 609, §17 (RP).

§2680. STANDARDIZED CLAIM FORM

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner or licensed hospital shall accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An administrator 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. [2003, c. 469, Pt. D, §5 (AMD); 2003, c. 469, Pt. D, §9 (AFF).]

SECTION HISTORY
1993, c. 477, §D9 (NEW). 1993, c. 477, §F1 (AFF). 1999, c. 609, §18 (RPR). 2003, c. 218, §5 (AMD). 2003, c. 469, §D5 (AMD). 2003, c. 469, §D9 (AFF).

Chapter 32-A: TYPES OF HEALTH INSURANCE

§2691. SCOPE

1. **Health insurance policies.** This chapter applies to individual health insurance policies subject to chapter 33 and to group health insurance policies and certificates subject to chapter 35.

[2001, c. 410, Pt. C, §1 (NEW) .]

2. **Dental plans and vision care plans.** This chapter applies to dental plans and vision care plans only as specified.

[2001, c. 410, Pt. C, §1 (NEW) .]

3. **Policies not subject to this chapter.** This chapter does not apply to:

A. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when that group or individual policy or contract includes provisions that are inconsistent with the requirements of this chapter; [2001, c. 410, Pt. C, §1 (NEW).]

B. Policies issued to employees or members as additions to franchise plans in existence on the effective date of this chapter; [2001, c. 410, Pt. C, §1 (NEW).]

C. Medicare supplement policies subject to chapter 67; [2001, c. 410, Pt. C, §1 (NEW).]

D. Long-term care insurance policies subject to chapters 68 and 68-A; [2003, c. 428, Pt. G, §2 (AMD).]

E. Group disability income protection coverage; or [2001, c. 410, Pt. C, §1 (NEW).]

F. Insurance policies supplemental to the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55 (2000). [2001, c. 410, Pt. C, §1 (NEW).]

[2003, c. 428, Pt. G, §2 (AMD) .]

SECTION HISTORY
2001, c. 410, §C1 (NEW). 2003, c. 428, §G2 (AMD).

§2692. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2001, c. 410, Pt. C, §1 (NEW).]

1. **Certificate.** "Certificate" means a statement of the coverage and provisions of a policy of group health insurance that has been delivered or issued for delivery in this State. "Certificate" includes riders, endorsements and enrollment forms, if attached.

[2001, c. 410, Pt. C, §1 (NEW) .]

2. **Dental plan.** "Dental plan" means insurance written to provide coverage for dental treatment.

[2001, c. 410, Pt. C, §1 (NEW) .]

3. **Direct response advertising.** "Direct response advertising" means a solicitation through a sponsoring or endorsing entity or individually through mail, telephone, the Internet or other mass communication media.

[2001, c. 410, Pt. C, §1 (NEW) .]

4. **Form.** "Form" means a policy, contract, rider, endorsement or application as provided in section 2412.

[2001, c. 410, Pt. C, §1 (NEW) .]

5. **Policy.** "Policy" means an entire contract between the insurer and the insured, including riders, endorsements and the application, if attached.

[2001, c. 410, Pt. C, §1 (NEW) .]

6. **Vision care plan.** "Vision care plan" means insurance written to provide coverage for eye care.

[2001, c. 410, Pt. C, §1 (NEW) .]

SECTION HISTORY
2001, c. 410, §C1 (NEW).

§2693. STANDARDS FOR POLICY PROVISIONS

1. **Rules regarding manner, content and required disclosure.** The superintendent may adopt rules to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content and required disclosure for the sale of individual and group health insurance. The superintendent may adopt additional rules to establish specific standards for the sale of dental plans and vision care plans.

[2001, c. 410, Pt. C, §1 (NEW) .]

2. **Rules regarding prohibited policies or provisions.** The superintendent may adopt rules that specify prohibited policies or policy provisions not otherwise specifically authorized by statute that, in the opinion of the superintendent, are unjust, unfair or unfairly discriminatory to the policyholder or a person insured under the policy or to a beneficiary of the policy.

[2001, c. 410, Pt. C, §1 (NEW) .]

SECTION HISTORY
2001, c. 410, §C1 (NEW).

§2694. MINIMUM STANDARDS FOR BENEFITS

The superintendent shall adopt rules to establish minimum standards for benefits under individual and group health insurance. These rules must clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A. The rules must also set minimum standards for benefits for each of the following categories of coverage: [2001, c. 410, Pt. C, §1 (NEW).]

1. **Basic hospital expense coverage.** Basic hospital expense coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

2. **Basic medical-surgical expense coverage.** Basic medical-surgical expense coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

3. **Basic hospital and medical-surgical expense coverage.** Basic hospital and medical-surgical expense coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

4. **Hospital confinement indemnity coverage.** Hospital confinement indemnity coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

5. **Individual major medical expense coverage.** Individual major medical expense coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

6. **Individual basic medical expense coverage.** Individual basic medical expense coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

7. **Individual disability income protection coverage.** Individual disability income protection coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

8. **Accident only coverage.** Accident only coverage;

[2001, c. 410, Pt. C, §1 (NEW) .]

9. **Specified disease coverage.** Specified disease coverage; and

[2001, c. 410, Pt. C, §1 (NEW) .]

10. **Specified accident coverage.** Specified accident coverage.

[2001, c. 410, Pt. C, §1 (NEW) .]

This section does not preclude the issuance of a policy or contract that combines 2 or more of the categories of coverage in subsections 1 to 10. [2001, c. 410, Pt. C, §1 (NEW).]

SECTION HISTORY
2001, c. 410, §C1 (NEW).

§2694-A. PHYSICIAN PERFORMANCE MEASUREMENT, REPORTING AND TIERING PROGRAMS

1. **Performance measurement, reporting and tiering programs.** An insurer delivering or issuing for delivery within the State any individual health insurance policy or group health insurance policy or certificate shall annually file with the superintendent on or before October 1, 2010 and annually by October 1st in subsequent years a full and true statement of its criteria, standards, practices, procedures and programs that measure or tier health care provider performance with respect to quality, cost or cost-efficiency. The statement must be on a form prepared by the superintendent and may be supplemented by additional information required by the superintendent. The statement must be verified by the oath of the insurer's president or vice-president, and secretary or chief medical officer. A filing and supporting information are public records notwithstanding Title 1, section 402, subsection 3, paragraph B.

[2013, c. 383, §2 (AMD) .]

2. **Duties.** The superintendent shall review the statements, if any, assemble the statements in one table using a side-by-side comparison format and provide an analysis identifying the commonalities and differences of the statements. Notwithstanding any provision of law to the contrary, the superintendent shall adopt by rule a program and performance measures designed to:

A. Ensure transparency and fairness and promote the continued strengthening of measurement programs to meet patients' needs; [2009, c. 350, Pt. B, §1 (NEW).]

B. Promote the consistency, efficiency and fairness of physician performance measurement; and [2009, c. 350, Pt. B, §1 (NEW).]

C. Promote an appropriate balance between innovation and standardization. [2009, c. 350, Pt. B, §1 (NEW).]

[2009, c. 350, Pt. B, §1 (NEW) .]

3. **Advisory panel.**

[2011, c. 90, Pt. J, §20 (RP) .]

4. **Rulemaking.** The superintendent may adopt rules to implement this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 350, Pt. B, §1 (NEW) .]

SECTION HISTORY
2009, c. 350, Pt. B, §1 (NEW). 2011, c. 90, Pt. J, §20 (AMD). 2013, c. 383, §2 (AMD).

§2695. DISCLOSURE REQUIREMENTS

1. **Outline of coverage.** Except as provided in subsections 7 and 8, an insurer shall deliver an outline of coverage to an applicant or enrollee in connection with the sale of individual health insurance, group health insurance, dental plans and vision care plans delivered or issued for delivery in this State.

[2001, c. 410, Pt. C, §1 (NEW) .]

2. **Sale through producer.** If the sale of a policy described in subsection 1 occurs through a producer, the outline of coverage must be delivered to the applicant at the time of application or to the certificate holder at the time of enrollment.

[2001, c. 410, Pt. C, §1 (NEW) .]

3. **Sale through direct-response advertising.** If the sale of a policy described in subsection 1 occurs through direct-response advertising, the outline of coverage must be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate.

[2001, c. 410, Pt. C, §1 (NEW) .]

4. **Outline of coverage not delivered at time of application or enrollment.** If the outline of coverage required in subsections 1 and 8 and in any rules adopted by the superintendent pursuant to this chapter is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee must contain all the information required in subsection 8 and in any rules adopted by the superintendent pursuant to this chapter.

[2001, c. 410, Pt. C, §1 (NEW) .]

5. **Outline of coverage delivered at time of application or enrollment.** If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the insurer must collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the insurer must maintain evidence of the delivery.

[2001, c. 410, Pt. C, §1 (NEW) .]

6. **Coverage issued on basis other than as applied for.** If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued must be delivered with the policy or certificate to the applicant or enrollee.

[2001, c. 410, Pt. C, §1 (NEW) .]

7. **Outline of coverage not required.** An outline of coverage for group health insurance, a group dental plan or a group vision care plan is not required to be delivered to certificate holders if the certificate contains a brief description of:

A. Benefits; [2001, c. 410, Pt. C, §1 (NEW).]

B. Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits; [2001, c. 410, Pt. C, §1 (NEW).]

C. Renewability provisions; and [2001, c. 410, Pt. C, §1 (NEW).]

D. Notice requirements as provided in rules adopted pursuant to this chapter. [2001, c. 410, Pt. C, §1 (NEW).]

[2001, c. 410, Pt. C, §1 (NEW) .]

8. **Superintendent shall prescribe format and content of outline of coverage.** The superintendent shall prescribe the format and content of the outline of coverage required by subsection 1. As used in this subsection, "format" means style, arrangement and overall appearance, including items such as the size, color and prominence of type and the arrangement of text and captions. The rules may exempt certain group policies from the requirement to deliver an outline of coverage to an applicant or enrollee. The outline of coverage must include:

A. A statement identifying the applicable category or categories of coverage as prescribed in section 2694; [2001, c. 410, Pt. C, §1 (NEW).]

B. A description of the principal benefits and coverage provided; [2001, c. 410, Pt. C, §1 (NEW).]

C. A statement of exceptions, reductions and limitations; [2001, c. 410, Pt. C, §1 (NEW).]

D. A statement of renewal provisions, including any reservation by the insurer of a right to change premiums; and [2001, c. 410, Pt. C, §1 (NEW).]

E. A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing policy provisions. [2001, c. 410, Pt. C, §1 (NEW).]

[2001, c. 410, Pt. C, §1 (NEW) .]

9. **Notice must be delivered to all applicants eligible for Medicare.** An insurer shall deliver the notice required under rules applicable to Medicare supplement insurance to all applicants eligible for Medicare.

[2001, c. 410, Pt. C, §1 (NEW) .]

SECTION HISTORY

2001, c. 410, §C1 (NEW).

§2696. PREEXISTING CONDITIONS

1. **Exclusion based on preexisting condition limited after 12 months.** Notwithstanding the provisions of section 2706, subsection 2, division (b), if an insurer elects to use a simplified application or enrollment form, with or without a question as to the prospective insured's health at the time of application or enrollment but without any questions concerning the prospective insured's health history or medical treatment history, the policy must cover any loss occurring after the policy has been in force for 12 months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except for such specific exclusions, the policy or certificate may not include wording that would permit a defense based upon preexisting conditions, other than rescission for affirmative misrepresentations, after it has been in force for 12 months.

[2001, c. 410, Pt. C, §1 (NEW) .]

2. **Exclusion based on preexisting condition limited after 6 months.** Notwithstanding the provisions of subsection 1 and section 2706, subsection 2, division (b), an insurer that issues a specified disease policy or certificate may not deny a claim for any covered loss that begins after the policy or certificate has been in force for at least 6 months, unless that loss results from a preexisting condition that was diagnosed by a physician before the date of application for coverage or that first manifested itself within the 6 months immediately preceding the application date. Other defenses based upon preexisting conditions are not permitted except for rescission for misrepresentation. This subsection applies regardless of whether the policy or certificate is issued on the basis of a detailed application form, a simplified application form or an enrollment form.

[2007, c. 199, Pt. G, §1 (AMD) .]

SECTION HISTORY
2001, c. 410, §C1 (NEW). 2007, c. 199, Pt. G, §1 (AMD).

§2697. RULEMAKING

The superintendent may adopt rules to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined by Title 5, chapter 375, subchapter II-A. [2001, c. 410, Pt. C, §1 (NEW).]

SECTION HISTORY
2001, c. 410, §C1 (NEW).

Chapter 33: HEALTH INSURANCE CONTRACTS

§2701. SCOPE OF CHAPTER

Nothing in this chapter shall apply to or affect: [1969, c. 132, §1 (NEW).]

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein;

[1989, c. 502, Pt. A, §94 (AMD) .]

2. Any group or blanket policy, except that:

A. Sections 2736, 2736-A and 2736-B apply to group Medicare supplement policies as defined in chapter 67, group nursing home care and long-term care insurance policies as defined in chapter 68 or 68-A; [2003, c. 428, Pt. G, §3 (AMD).]

B. Section 2752 applies with respect to mandated benefits for group or blanket health policies; and [1995, c. 332, Pt. J, §1 (AMD).]

C. Sections 2736, 2736-A, 2736-B and 2736-C apply to:

(1) Association groups as defined by section 2805-A, except as to any employer subgroups of the association group when the employer is a member of the group and provides coverage through the group as a bona fide employee benefit;

(1-A) Credit union groups as defined by section 2807-A; and

(2) Other groups as defined by section 2808, except:

(a) Employee leasing companies registered pursuant to Title 32, chapter 125; and

(b) As to any employer subgroups of the other group when the employer provides coverage to its employees through the group as a bona fide employee benefit. [2009, c. 244, Pt. F, §1 (AMD).]

[2009, c. 244, Pt. F, §1 (AMD) .]

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as:

A. Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means, or as [1969, c. 132, §1 (NEW).]

B. Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; [1983, c. 801, §8 (AMD).]

[1983, c. 801, §8 (AMD) .]

4. Reinsurance; and

[1983, c. 801, §8 (AMD) .]

5. Legal services insurance.

[1983, c. 801, §9 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1983, c. 801, §§8,9 (AMD). 1985, c. 648, §9 (AMD). 1989, c. 502, §A94 (AMD). 1989, c. 556, §A4 (AMD). 1991, c. 701, §5 (AMD). 1995, c. 332, §J1 (AMD). 2001, c. 258, §E1 (AMD). 2003, c. 428, §G3 (AMD). 2005, c. 121, §B1 (AMD). 2009, c. 244, Pt. F, §1 (AMD).

§2702. SHORT TITLE

This chapter may be cited as the "Uniform Health Policy Provision Law". [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2703. SCOPE, FORMAT OF POLICY

No policy of health insurance shall be delivered or issued for delivery to any person in this State unless it otherwise complies with this Title, and complies with the following: [1969, c. 132, §1 (NEW).]

1. The entire money and other considerations therefore shall be expressed therein;

[1969, c. 132, §1 (NEW) .]

2. The time when the insurance takes effect and terminates shall be expressed therein;

[1969, c. 132, §1 (NEW) .]

3. It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 23 years and any other person dependent upon the policyholder;

[1969, c. 132, §1 (NEW) .]

4. The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than one hundred and twenty-point; the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

[1969, c. 132, §1 (NEW) .]

5. The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in sections 2705 to 2729, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions", or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

[1969, c. 132, §1 (NEW) .]

6. Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

[1969, c. 132, §1 (NEW) .]

7. The policy shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2704. REQUIRED PROVISIONS; CAPTIONS -- OMISSIONS -- SUBSTITUTIONS

1. Except as provided in subsection 2, each such policy delivered or issued for delivery to any person in this State shall contain the provisions specified in sections 2705 to 2716, in the words in which the same appear; except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the superintendent which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent may approve.

[1973, c. 585, §12 (AMD) .]

2. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the superintendent, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2705. ENTIRE CONTRACT -- CHANGES

There shall be a provision as follows: [1969, c. 132, §1 (NEW).]

Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2706. TIME LIMIT ON CERTAIN DEFENSES

There shall be a provision as follows: [1969, c. 132, §1 (NEW).]

Time limit on certain defenses: [1969, c. 132, §1 (NEW).]

(a). After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such 3-year period.

[1969, c. 132, §1 (NEW) .]

1. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 3-year period, nor to limit the application of sections 2717 through 2723 in the event of misstatement with respect to age or occupation or other insurance.

[1969, c. 132, §1 (NEW) .]

2. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium 1 until at least age 50 or, 2 in the case of a policy issued after age 44, for at least 5 years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause in parentheses may be omitted at the insurer's option, under the caption "Incontestable:"

[1969, c. 132, §1 (NEW) .]

After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application. [1969, c. 132, §1 (NEW).]

(b). No claim for loss incurred or disability, as defined in the policy, commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2707. GRACE PERIOD

There shall be a provision as follows: [1969, c. 132, §1 (NEW).]

A grace period of . . . . ., insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies, days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. [1969, c. 132, §1 (NEW).]

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: [1969, c. 132, §1 (NEW).]

Unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the company written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2707-A. NOTIFICATION PRIOR TO CANCELLATION; RESTRICTIONS ON LAPSE OR TERMINATION DUE TO COGNITIVE IMPAIRMENT OR FUNCTIONAL INCAPACITY

An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium. [2011, c. 123, §2 (AMD); 2011, c. 123, §5 (AFF).]

Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was the result of the policyholder's cognitive impairment or functional incapacity. An insurer may require a medical demonstration that the policyholder suffered from cognitive impairment or functional incapacity at the time of cancellation. If the medical demonstration is waived or substantiates the existence of a cognitive impairment or functional incapacity at the time of policy cancellation to the satisfaction of the insurer, the policy must be reinstated. The medical demonstration may be at the expense of the policyholder. [2011, c. 123, §2 (NEW); 2011, c. 123, §5 (AFF).]

A policy reinstated pursuant to this section must cover any loss or claim occurring from the date of the cancellation. Within 15 days after request from an insurer, a policyholder of a policy reinstated pursuant to this section shall pay any unpaid premium from the date of the last premium payment at the rate that would have been in effect had the policy remained in force. If the premium is not paid as required, the policy may not be reinstated and the insurer is not responsible for claims incurred after the initial date of cancellation. If an insurer denies a request for reinstatement, the insurer shall notify the policyholder that the policyholder may request a hearing before the superintendent. [2011, c. 123, §2 (NEW); 2011, c. 123, §5 (AFF).]

The superintendent may adopt rules to implement the requirements of this section. The rules may include, but are not limited to, definitions, minimum disclosure requirements, notice provisions and the right of reinstatement. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 123, §2 (AMD); 2011, c. 123, §5 (AFF).]

SECTION HISTORY
1989, c. 835, §2 (NEW). 2011, c. 123, §2 (AMD). 2011, c. 123, §5 (AFF).

§2708. REINSTATEMENT

1. There shall be a provision as follows:

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed herein or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

[1969, c. 132, §1 (NEW) .]

2. The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums

A. Until at least age 50, or [1969, c. 132, §1 (NEW).]

B. In the case of a policy issued after age 44, for at least 5 years from its date of issue. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2709. NOTICE OF CLAIM

1. There shall be a provision as follows:

Notice of claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

[1969, c. 132, §1 (NEW) .]

2. In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may at its option insert the following between the first and 2nd sentence of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, he shall, at least once in every 6 months after having given notice of the claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2710. CLAIM FORMS

There shall be a provision as follows:

Claim forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2711. PROOFS OF LOSS

There shall be a provision as follows:

Proofs of loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2712. TIME OF PAYMENT OF CLAIMS

There shall be a provision as follows:

Time of payment of claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2713. PAYMENT OF CLAIMS

1. There shall be a provision as follows:

Payment of claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the company, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

[1969, c. 132, §1 (NEW) .]

2. The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

A. "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. [1969, c. 132, §1 (NEW).]

B. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of

filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person. Nothing in this provision prohibits an insurer from providing an incentive for insureds to use the services of a particular provider. [1985, c. 704, §5 (AMD).]

[1985, c. 704, §5 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1985, c. 704, §5 (AMD).

§2713-A. EXPLANATION AND NOTICE TO PARENT

If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: [2009, c. 244, Pt. B, §1 (AMD).]

1. **Payment or denial of claim.** An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

[2009, c. 244, Pt. B, §1 (AMD) .]

2. **Change in terms and conditions.** An explanation of any proposed change in the terms and conditions of the policy; or

[1989, c. 556, Pt. D, §2 (NEW) .]

3. **Notice of lapse.** Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

[1989, c. 556, Pt. D, §2 (NEW) .]

In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy. [2009, c. 244, Pt. B, §1 (AMD).]

SECTION HISTORY
1989, c. 556, §D2 (NEW). 2009, c. 244, Pt. B, §1 (AMD).

§2714. PHYSICAL EXAMINATION, AUTOPSY

There shall be a provision as follows:

> Physical examination and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2715. LEGAL ACTIONS

There shall be a provision as follows:

Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2716. CHANGE OF BENEFICIARY

1. There shall be a provision as follows:

Change of beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

[1969, c. 132, §1 (NEW) .]

2. The first clause of the above provision relating to the irrevocable designation of beneficiary may be omitted at the insurer's option.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2717. RIGHT TO EXAMINE AND RETURN POLICY

1. Except as to nonrenewable accident policies and individual credit health insurance policies, every individual health insurance policy shall contain a provision therein or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. The provision shall be set forth in the policy under an appropriate caption, and if not so printed on the face page of the policy adequate notice of the provision shall be printed or stamped conspicuously on the face page.

[1969, c. 132, §1 (NEW) .]

2. The policy may be so returned to the insurer at its home or branch office to the agent through whom it was applied for, and thereupon shall be void as from the beginning and as if the policy had not been issued.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2717-A. DISABILITY BENEFIT OFFSETS

1. **Disclosure to applicants.** At or before the time of application for any policy subject to this chapter that provides disability income benefits, the insurer shall provide the applicant with a clear and conspicuous written notice, on the application form or in a separate document, that accurately explains to the applicant all types of other sources of income that may result in a reduction of the benefits payable under the policy.

[2005, c. 42, §1 (NEW) .]

2. **Recovery of disability benefit overpayments.** For claims filed after January 1, 2006, an insurer that is entitled to reduce disability income benefit payments when the insured receives income from other sources and that is entitled to recover overpayments through offsets against current payments to the insured may not recover such overpayments at a rate greater than 20% of the net benefit per benefit payment period unless:

A. For policies applied for after September 13, 2003, the insurer has complied with the requirements of subsection 1; [2005, c. 42, §1 (NEW).]

B. The insurer effects the offset of benefits within 60 days of notice to the insurer, or such later date as the insurer begins paying benefits to the insured, that the insured is receiving or is entitled to receive income that may result in a reduction of benefits payable under the policy; [2005, c. 42, §1 (NEW).]

C. The overpayment did not result from the insurer's miscalculation of benefit reductions or the insurer's miscalculation of benefits payable under the policy; and [2005, c. 42, §1 (NEW).]

D. The insurer provided the insured with clear and conspicuous written notice that accurately explains to the insured all types of other sources of income that may result in a reduction of the benefits payable under the policy within 30 days of the date a claim for disability benefits was filed. [2005, c. 42, §1 (NEW).]

[2005, c. 42, §1 (NEW) .]

SECTION HISTORY
2003, c. 321, §1 (NEW). 2005, c. 42, §1 (RPR).

§2718. OPTIONAL POLICY PROVISIONS

Except as provided in section 2704, subsection 2, no such policy delivered or issued for delivery to any person in this State shall contain provisions respecting the matters set forth in sections 2719 to 2728, unless such provisions are in the words in which the same appear in the applicable section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the superintendent which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the superintendent may approve. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §46 (AMD). 1973, c. 585, §12 (AMD).

§2719. CHANGE OF OCCUPATION

There may be a provision as follows:

Change of occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the company as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2720. MISSTATEMENT OF AGE

There may be a provision as follows:

Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2721. OVERINSURANCE -- SAME INSURER

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 247, (RP).

§2721-A. OVERINSURANCE IN ACCIDENT POLICIES -- SAME INSURER

Whenever accident policies are effective immediately upon purchase, including but not limited to those policies purchased through coin-operated machines, there may be a provision included in the policy as follows:

"If an accident policy or policies previously issued by the insurer to the insured be in force concurrently herewith making the aggregate indemnity for (insert type of coverage or coverages) in excess of $ (insert maximum limit of indemnity or indemnities) the excess shall be void and all premiums for such excess shall be returned to the insured or to his estate."

[1975, c. 121, §1 (NEW).]

SECTION HISTORY
1975, c. 121, (NEW).

§2721-B. FLIGHT INSURANCE LIMITATION

(REPEALED)

SECTION HISTORY
1975, c. 121, (NEW). 1999, c. 256, §K1 (RP).

§2722. INSURANCE WITH OTHER INSURERS, PROVISION OF SERVICE OR EXPENSE INCURRED BASIS

1. There may be a provision as follows:

Insurance with other insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

[1969, c. 132, §1 (NEW) .]

2. If the foregoing policy provision is included in a policy which also contains the policy provision set out in section 2723 there shall be added to the caption of the foregoing provision the phrase "-- expense incurred benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organization or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

[1989, c. 502, Pt. A, §95 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 502, §A95 (AMD).

§2723. INSURANCE WITH OTHER INSURERS -- OTHER BENEFITS

1. There may be a provision as follows:

Insurance with other insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

[1969, c. 132, §1 (NEW) .]

2. If the foregoing policy provision is included in a policy which also contains the policy provision set out in section 2722, there shall be added to the caption of the foregoing provision the phrase "other benefits." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the superintendent, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the superintendent. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage."

[1989, c. 502, Pt. A, §96 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 502, §A96 (AMD).

§2723-A. COORDINATION OF BENEFITS

1. **Authorization.** There may be a provision for coordination of benefits payable under the policy and under other plans of insurance or health care coverage, in conformance with rules adopted by the superintendent to establish uniformity in the permissive use of coordination of benefits provisions in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital or medical service organization plans and nonprofit health care organization plans. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 256, Pt. N, §1 (NEW) .]

2. **Coordination with Medicare.** Coordination of benefits with Medicare is governed by the following provisions.

A. The policy may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the policy states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage. [1999, c. 256, Pt. N, §1 (NEW).]

B. The policy may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the policy was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the policy will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B. [1999, c. 790, Pt. D, §7 (AMD).]

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B. [1999, c. 256, Pt. N, §1 (NEW).]

[1999, c. 790, Pt. D, §7 (AMD) .]

3. **Credit toward deductible.** When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

[2005, c. 121, Pt. D, §2 (NEW) .]

SECTION HISTORY
1999, c. 256, §N1 (NEW). 1999, c. 790, §D7 (AMD). 2005, c. 121, §D2 (AMD).

§2724. RELATION OF EARNINGS TO INSURANCE

There may be a provision as follows:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (A.) until at least age 50 or, (B.) in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the superintendent, which definition shall be limited in subject

matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the superintendent or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

[1989, c. 502, Pt. A, §97 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 502, §A97 (AMD).

§2725. UNPAID PREMIUMS

There may be a provision as follows:

Unpaid premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2726. CONFORMITY WITH STATE STATUTES

There may be a provision as follows:

Conformity with state statutes: Any provision of this policy which, on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2727. ILLEGAL OCCUPATION

There may be a provision as follows:

Illegal occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation

[1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2728. INTOXICANTS AND NARCOTICS

1. **Intoxicants; narcotics.** A policy under this chapter may not include the following provision:

"Intoxicants and narcotics. The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic or of any hallucinogenic drug, unless administered on the advice of a physician."

[2007, c. 216, §1 (NEW) .]

2. **Exemption.** This section does not apply to the following types of insurance or any combination of the following types of insurance: accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

[2007, c. 216, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2007, c. 216, §1 (RPR).

§2729. RENEWABILITY

Health insurance policies, other than accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide in substance in a provision thereof or in an endorsement thereon or rider attached thereto that subject to the right to terminate the policy upon nonpayment of premium when due, such right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement), and that any refusal of renewal shall be without prejudice to any claim originating while the policy is in force. The parenthetic reference to lapse and reinstatement may be omitted at the insurer's option. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2729-A. LIMITS ON PRIORITY LIENS

No policy for health insurance shall provide for priority over the insured of payment for any hospital, nursing, medical or surgical services or of any expenses paid or reimbursed under the policy, in the event the insured is entitled to receive payment reimbursement from any other person as a result of legal action or claim, except as provided herein. [1975, c. 471, §1 (NEW).]

A policy may contain a provision that allows such payments, if that provision is approved by the superintendent, and if that provision requires the prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. A just and equitable basis shall mean that any factors that diminish the potential value of the insured's claim shall likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors shall include, but are not limited to: [1975, c. 471, §1 (NEW).]

1. **Legal defenses.** Questions of liability and comparative negligence or other legal defenses;

[1975, c. 471, §1 (NEW) .]

2. **Exigencies of trial.** Exigencies of trial that reduce a settlement or award in order to resolve the claim; and

[1975, c. 471, §1 (NEW) .]

3. **Limits of coverage.** Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured.

[1975, c. 471, §1 (NEW) .]

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, the dispute shall be determined if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute. [1975, c. 471, §1 (NEW).]

SECTION HISTORY
1975, c. 471, §1 (NEW).

§2730. ORDER OF CERTAIN PROVISIONS

The provisions which are the subject of sections 2704 to 2716, and 2718 to 2728, or any corresponding provisions which are used in lieu thereof in accordance with such sections shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided that the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse or likely to mislead a person to whom the policy is offered, delivered or issued. [1969, c. 177, §47 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §47 (AMD).

§2731. THIRD PARTY OWNERSHIP

The word "insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2731-A. "MEDICALLY NECESSARY MASTECTOMY SURGERY" DEFINED *(REPEALED)*

SECTION HISTORY
1991, c. 333, §1 (NEW). 1995, c. 295, §2 (RP).

§2732. REQUIREMENTS OF OTHER JURISDICTIONS

1. Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this State, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

[1969, c. 132, §1 (NEW) .]

2. Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2733. POLICIES ISSUED FOR DELIVERY IN ANOTHER STATE

If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance superintendent or corresponding public official of such other state has informed the superintendent that any such policy is not subject to approval or disapproval by such official, the superintendent may by ruling require that the policy meet the standards set forth in sections 2703 to 2732. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2734. CONFORMING TO STATUTE

1. No policy provision which is not subject to this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

[1969, c. 132, §1 (NEW) .]

2. A policy delivered or issued for delivery to any person in this State in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2735. AGE LIMIT

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force, subject to any right of termination, until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2735-A. NOTICE OF RATE FILING AND RATE INCREASE

1. **Notice of rate filing or rate increase on existing policies.** An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least 60 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any formula or classification of risks. Except as otherwise provided in section 2736-C, subsection 2-B, the notice must also inform policyholders of their right to request a hearing pursuant to section 229. The notice must show the proposed rate and, unless otherwise provided in section 2736-C, subsection 2-B, state that the rate is subject to regulatory approval. Except as otherwise provided in section 2736-C, subsection 2-B, the superintendent may not take final action on a rate filing until 40 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until 60 days after the notice is provided or until the effective date under section 2736, whichever is later.

[2011, c. 364, §1 (AMD) .]

1-A. **Notice of rate filings or rate increase on existing policies renewed in calendar year 2006.**

[2005, c. 400, Pt. A, §1 (NEW); T. 24-A, §2735-A, sub-§1-A (RP) .]

2. **Notice of rate increase on new business.** When an insurer offering individual health plans as defined in section 2736-C quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following 90 days. If the quote is in writing, the disclosure must also be in writing. If the increase is pending approval at the time of notice, the disclosure must include the proposed rate and state that it is subject to regulatory approval. If disclosure required by this subsection is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided or the effective date under section 2736, whichever is later.

[2001, c. 432, §4 (NEW) .]

3. **Notice of rate increase on new business for calendar year 2006.**

[2005, c. 400, Pt. A, §1 (NEW); T. 24-A, §2735-A, sub-§3 (RP) .]

SECTION HISTORY
2001, c. 432, §4 (NEW). 2005, c. 400, §A1 (AMD). 2009, c. 244, Pt. C, §4 (AMD). 2011, c. 364, §1 (AMD). MRSA T. 24-A, §2735-A, sub-§3 (AMD). MRSA T. 24-A, §2735-A, sub-§1A (AMD).

§2736. RATE FILINGS ON INDIVIDUAL HEALTH INSURANCE POLICIES

1. **Filing of rate information.** Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. If the filing applies to individual health plans as defined in section 2736-C, the insurer shall simultaneously file a copy with the Attorney General. Every such filing must state the effective date of the filing. Every such filing 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. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 439, Pt. C, §1 (RPR) .]

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 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 all supporting information, except for protected health information required to be kept confidential by state or federal statute and descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to section 2736-A.

[2009, c. 439, Pt. C, §2 (AMD) .]

3. **Criteria for special rate hearings.**

[2009, c. 244, Pt. C, §5 (RP) .]

4. **Special rate hearing.**

[2009, c. 244, Pt. C, §6 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 493, §3 (RPR). 1979, c. 558, §§6,7 (AMD). 1985, c. 648, §10 (AMD). 1997, c. 344, §8 (AMD). 2001, c. 432, §§5,6 (AMD). 2003, c. 428, §F2 (AMD). 2003, c. 469, §§E9,10 (AMD). 2007, c. 629, Pt. M, §§1, 2 (AMD). 2009, c. 14, §4 (AMD). 2009, c. 244, Pt. C, §§5, 6 (AMD). 2009, c. 244, Pt. G, §1 (AMD). 2009, c. 439, Pt. C, §§1, 2 (AMD).

§2736-A. HEARING

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory. [2011, c. 364, §2 (AMD).]

Hearings held under this section must conform to the procedural requirements set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4. [2003, c. 469, Pt. E, §11 (AMD).]

SECTION HISTORY
1977, c. 493, §4 (NEW). 1977, c. 694, §422 (AMD). 1979, c. 330, §2 (AMD). 1979, c. 558, §8 (RPR). 2003, c. 469, §E11 (AMD). 2007, c. 629, Pt. M, §3 (AMD). 2009, c. 439, Pt. C, §3 (AMD). 2011, c. 364, §2 (AMD).

§2736-B. ORDER

The superintendent shall issue an order or decision within 30 days after the close of the hearing, or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish

the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision. [1989, c. 269, §14 (AMD).]

SECTION HISTORY
1979, c. 558, §9 (NEW). 1989, c. 269, §14 (AMD).

§2736-C. INDIVIDUAL HEALTH PLANS

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

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue individual health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all individual health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

B. "Community rate" means the rate charged to all eligible individuals for individual health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. It includes both individual contracts and certificates issued under group contracts specified in section 2701, subsection 2, paragraph C. "Individual health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment;

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance; or

(12) Short-term policies, as described in section 2849-B, subsection 1. [2011, c. 238, Pt. D, §1 (AMD).]

C-1. "Legally domiciled" means a person who lives in this State and who satisfies the criteria contained in 2 of the following subparagraphs.

(1) The person has a motor vehicle operator's license or nondriver identification card from this State.

(2) The person has a valid passport or visa and is lawfully admitted to the United States.

(3) The person is registered to vote in this State.

(4) The person has a permanent dwelling place in this State.

(5) The person submits a written sworn affidavit declaring that person's intent to reside in this State.

(6) The person files an income tax return for this State that declares the person is a Maine resident.

A person may establish that that person is legally domiciled in this State by providing evidence of other relevant criteria associated with residency. A child is legally domiciled in this State if at least one of the child's parents or the child's legal guardian is legally domiciled in this State. A person with a developmental or other disability that prevents that person from obtaining a motor vehicle operator's license, registering to vote or filing an income tax return is legally domiciled in this State by living in this State. [2005, c. 493, §1 (RPR).]

C-2. "Resident" means a person who is legally domiciled in this State and has been for at least the last 60 days. [1997, c. 445, §8 (NEW); 1997, c. 445, §32 (AFF).]

D. "Premium rate" means the rate charged to an individual for an individual health plan. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended. [1997, c. 370, Pt. E, §2 (NEW).]

[2011, c. 238, Pt. D, §1 (AMD) .]

2. Rating practices. The following requirements apply to the rating practices of carriers providing individual health plans.

A. A carrier issuing an individual health plan after December 1, 1993 must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent prior to issuance of any individual health plan. [1993, c. 547, §3 (AMD).]

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual. [2007, c. 629, Pt. A, §3 (AMD).]

C. A carrier may vary the premium rate due to family membership to the extent permitted by the federal Affordable Care Act. [2011, c. 364, §3 (AMD).]

C-1. A carrier may vary the premium rate due to geographic area in accordance with the limitation set out in this paragraph. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the rating factor used by a carrier for geographic area may not exceed 1.5. [2011, c. 90, Pt. A, §2 (NEW).]

D. A carrier may vary the premium rate due to age and tobacco use in accordance with the limitations set out in this paragraph.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and June 30, 2012, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015, the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1. [2011, c. 364, §4 (AMD).]

E. A separate community rate may be established for individuals eligible for Medicare Part A without paying a premium; however, this rate may not be applied if both the Medicare eligibility date and the issue date are prior to July 1, 2000. [1999, c. 44, §1 (AMD); 1999, c. 44, §2 (AFF).]

F. A carrier that adjusts its rate shall account for the savings offset payment or any recovery in that offset payment in its experience consistent with this section and former section 6913. [2007, c. 629, Pt. M, §4 (AMD).]

G. [2011, c. 90, Pt. B, §10 (AFF); 2011, c. 90, Pt. B, §4 (RP).]

H. [2011, c. 90, Pt. A, §4 (RP).]

I. A carrier that offered individual health plans prior to July 1, 2012 may close its individual book of business sold prior to July 1, 2012 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after July 1, 2012. If a carrier closes its individual book of business as permitted under this paragraph, the carrier may vary the premium rate for individuals in that closed book of business only as permitted in this paragraph and paragraphs C and C-1.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2013 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1.

The superintendent shall direct the Consumer Health Care Division, established in section 4321, to work with carriers and health advocacy organizations to provide information about comparable alternative insurance options to individuals in a carrier's closed book of business . [2011, c. 364, §5 (AMD).]

J. Except for enrollees in grandfathered health plans under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all individual health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act. [2011, c. 364, §6 (NEW).]

[2011, c. 90, Pt. A, §§2, 4 (AMD); 2011, c. 90, Pt. B, §4 (AMD); 2011, c. 90, Pt. B, §10 (AFF); 2011, c. 364, §§3-6 (AMD) .]

2-A. **Reinsurance requirement.**

[2011, c. 90, Pt. B, §10 (AFF); 2011, c. 90, Pt. B, §5 (RP) .]

2-B. **Optional guaranteed loss ratio.** Notwithstanding section 2736, subsection 1 and section 2736-A, at the carrier's option, rate filings for a carrier's credible block of individual health plans may be filed in accordance with this subsection. Rates filed in accordance with this subsection are filed for informational purposes unless rate review is required pursuant to the federal Affordable Care Act.

A. A carrier's individual health plans are considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to section 2736, subsection 1 and section 2736-A. [2011, c. 364, §7 (AMD).]

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing the calculation of rebates as required pursuant to the federal Affordable Care Act, except that the calculation must be based on a minimum medical loss ratio of 80% if the applicable federal minimum for the individual market in this State is lower. If the calculation indicates that rebates must be paid, the carrier must pay the rebates in the same manner as is required for rebates pursuant to the federal Affordable Care Act. [2011, c. 364, §7 (AMD).]

[2011, c. 364, §7 (AMD) .]

3. **Guaranteed issuance and guaranteed renewal.** Carriers providing individual health plans must meet the following requirements on issuance and renewal.

A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A. Coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

(1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and

(2) Deny coverage to individuals if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this subparagraph may not enroll individuals residing within the area subject to denial of coverage or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage. [2011, c. 621, §1 (AMD).]

B. Renewal is guaranteed, pursuant to section 2850-B. [1997, c. 445, §32 (AFF); 1997, c. 445, §10 (RPR).]

C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.

(1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;

(2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and

(3) The carrier complies with the rating practices requirements of subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage. [1999, c. 256, Pt. D, §1 (NEW).]

E. As part of the application process for individual health coverage, a carrier shall require an individual to complete the health statement developed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association pursuant to section 3955, subsection 1, paragraph E . A carrier may not deny coverage or refuse to renew or cancel an individual health plan on the basis of an individual's complete or incomplete health statement, claims history or risk scores or on the basis of any omission of material information from a health statement or misrepresentation of an individual's health status. The rejection of an application for individual health coverage by a carrier because an individual has not submitted a completed health statement is not a denial of coverage for the purposes of this paragraph. [2011, c. 621, §1 (AMD).]

[2011, c. 621, §1 (AMD) .]

4. **Cessation of business.** Carriers that provide individual health plans after the effective date of this section that plan to cease doing business in the individual health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau 3 months prior to the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal. [2001, c. 258, Pt. B, §1 (AMD).]

B. Carriers that cease to write new business in the individual health plan market continue to be governed by this section. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

C. Carriers that cease to write new business in the individual health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent unless the superintendent waives this requirement for good cause shown. [2001, c. 258, Pt. B, §2 (AMD).]

[2001, c. 258, Pt. B, §§1, 2 (AMD) .]

5. **Loss ratios.** Except as provided in subsection 2-B, for all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims.

[2011, c. 90, Pt. D, §3 (AMD) .]

6. **Fair marketing standards.** Carriers providing individual health plans must meet the following standards of fair marketing.

A. Each carrier must actively market individual health plan coverage, including any standardized plans defined pursuant to subsection 8, to individuals in this State. [1995, c. 332, Pt. K, §1 (AMD).]

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; or

(2) Encouraging or directing individuals to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of an individual health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

E. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

F. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of individual health plans in this State. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

G. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of individual health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [1993, c. 477, Pt. C, §1 (NEW); 1993, c. 477, Pt. F, §1 (AFF).]

[1995, c. 332, Pt. K, §1 (AMD) .]

7. **Applicability.** This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1993 with the exception of short-term contracts, as defined in section 2849-B. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

[1997, c. 445, §11 (AMD); 1997, c. 445, §32 (AFF) .]

8. **Authority of the superintendent.**

[2011, c. 90, Pt. F, §1 (RP) .]

9. **Exemption for certain associations.** The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the requirements of subsection 3, paragraph A; subsection 6, paragraph A; and subsection 8 if:

A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents; [1995, c. 570, §7 (NEW).]

B. Rates for the association comply with the premium rate requirements of subsection 2 or are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any; [1995, c. 570, §7 (NEW).]

C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%; [1995, c. 570, §7 (NEW).]

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect; [1995, c. 570, §7 (NEW).]

E. The association's group health plan is not marketed to the general public; [1995, c. 570, §7 (NEW).]

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A; [1995, c. 570, §7 (NEW).]

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and [1995, c. 570, §7 (NEW).]

H. Granting an exemption to the association does not conflict with the purposes of this section. [1995, c. 570, §7 (NEW).]

Except for individuals with grandfathered health plans under the federal Affordable Care Act, this subsection does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014.

[2011, c. 364, §8 (AMD) .]

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

A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements. [2007, c. 629, Pt. I, §1 (NEW).]

B. Notwithstanding any requirements in this Title for specific health services, specific diseases and certain providers of health care services, the superintendent may adopt minimum benefit requirements that exclude certain benefits if determined by the superintendent to provide affordable and attractive individual health plans for persons under 30 years of age. [2007, c. 629, Pt. I, §1 (NEW).]

C. A pilot project approved by the superintendent pursuant to this subsection qualifies as creditable coverage under this Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under a pilot project approved under this subsection is not subject to any preexisting conditions exclusion provisions. Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates. [2007, c. 629, Pt. I, §1 (NEW).]

D. Beginning in 2010, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any pilot project approved by the superintendent pursuant to this subsection. The report must include an analysis of the effectiveness of the pilot project in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the pilot project on the broader insurance market, including any impact on premiums and availability of coverage. [2007, c. 629, Pt. I, §1 (NEW).]

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection. [2007, c. 629, Pt. I, §1 (NEW).]

[2007, c. 629, Pt. I, §1 (NEW) .]

11. **Open enrollment.** Notwithstanding subsection 3, on or after January 1, 2014, a carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods consistent with requirements of the federal Affordable Care Act.

[2013, c. 271, §1 (NEW) .]

SECTION HISTORY

1993, c. 477, Pt. C, §1 (NEW). 1993, c. 477, Pt. F, §1 (AFF). 1993, c. 546, §1 (AMD). 1993, c. 547, §3 (AMD). 1993, c. 645, §§A3, B2 (AMD). 1995, c. 177, §1 (AMD). 1995, c. 332, §§J2, K1 (AMD). 1995, c. 342, §§4, 5 (AMD). 1995, c. 570, §7 (AMD). 1997, c. 370, Pt. E, §§2-4 (AMD). 1997, c. 445, §§8-11 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 44, §1 (AMD). 1999, c. 44, §2 (AFF). 1999, c. 256, §§C1, D1, 2 (AMD). RR 2001, c. 1, §30 (COR). 2001, c. 258, §§B1, 2, E2 (AMD). 2001, c. 410, Pt. A, §§1, 2 (AMD). 2001, c. 410, Pt. A, §10 (AFF). 2003, c. 428, Pt. H, §3 (AMD). 2003, c. 469, Pt. E, §§12, 13 (AMD). 2005, c. 493, §1 (AMD). 2007, c. 629, Pt. A, §§3-7 (AMD). 2007, c. 629, Pt. I, §1 (AMD). 2007, c. 629, Pt. M, §§4, 5 (AMD). 2011, c. 90, Pt. A, §§1-5 (AMD). 2011, c. 90, Pt. B, §§4-6 (AMD). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. D, §§2, 3 (AMD). 2011, c. 90, Pt. F, §1 (AMD). 2011, c. 238, Pt. D, §1 (AMD). 2011, c. 364, §§3-8 (AMD). 2011, c. 621, §1 (AMD). 2013, c. 271, §1 (AMD).

§2737. NONCANCELLABLE DISABILITY INSURANCE DEFINED

"Noncancellable disability insurance" means insurance against disability resulting from sickness, ailment or bodily injury, but not including insurance solely against accidental injury, under any contract which does not give the insurer the option to cancel or otherwise terminate the contract at or after one year from its effective date or renewal date. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2738. NOTICE AS TO RENEWABILITY

The superintendent shall have the right to make the following requirements: [1973, c. 585, §12 (AMD).]

1. When a policy has neither a brief description nor a separate statement printed on the first page and on the filing back, referring to the renewal conditions of the policy, a separately captioned provision, setting forth the conditions under which the policy may be renewed, must appear on the first page of the policy. The caption shall be clear and definite and shall be approved by the superintendent; but any one of the following captions is acceptable:

"RENEWAL SUBJECT TO CONSENT OF COMPANY.

RENEWAL SUBJECT TO COMPANY CONSENT.

RENEWABLE AT OPTION OF COMPANY."

[1973, c. 585, §12 (AMD) .]

2. If the policy is not renewable, a separate, appropriately captioned provision on the first page of the policy shall so state.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2739. LAPSE OF POLICY, ADVANCE NOTICE; LIMITATION OF ACTION

No individual policy of health insurance issued or delivered in this State, except a policy which by its terms is renewable or continuable with the insurer's consent, or except a policy the premiums for which are payable monthly or at shorter intervals, shall terminate or lapse for nonpayment of any premium until the expiration of 3 months from the due date of such premium, unless the insurer, within not less than 10 nor more than 45 days prior to said due date, shall have mailed, postage prepaid, duly addressed to the insured at his last address shown by the insurer's records, a notice showing the amount of such premium and its due date. If such a notice is not so sent, the insured may pay the premium in default at any time within such period of 3 months. The affidavit of any officer, clerk or agent of the insurer, or of any other person authorized to mail such notice, that the notice required by this section has been duly mailed by the insurer in the manner required shall be prima facie evidence that such notice was duly given. No action shall be maintained on any policy to which this section applies and which has lapsed for nonpayment of any premium unless such action is commenced within 2 years from the due date of such premium. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2740. FRANCHISE HEALTH INSURANCE LAW

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 205, (AMD). 1995, c. 332, §C1 (RP).

§2741. MATERNITY BENEFITS FOR UNMARRIED WOMEN POLICYHOLDERS AND THE MINOR DEPENDENTS OF POLICYHOLDERS WITH DEPENDENT OR FAMILY COVERAGE REQUIRED

All health insurance policies and plans shall provide, at appropriate rates, the same maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage under the same terms and conditions as such maternity coverage is provided to married policyholders or the wives of policyholders with maternity coverage. This requirement shall apply to all insurance policies and plans issued or renewed after the effective date of this Act. [1975, c. 276, §2 (NEW).]

SECTION HISTORY
1975, c. 276, §2 (NEW). 1975, c. 428, §2 (NEW). 1975, c. 561, (NEW).
1975, c. 770, §§102,103 (RP).

§2741-A. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS

1. **Definition.** As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a policyholder who:

A. Is a mentally competent adult as is the policyholder; [2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the policyholder for at least 12 months; [2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the policyholder and expects to remain so; and [2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the policyholder for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.
[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF).]

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

2. **Mandated offer of domestic partner benefits.** All individual health insurance policies or contracts issued by any insurer operating pursuant to this chapter must make available to policyholders the option for additional benefits for the domestic partner of a policyholder, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married policyholders.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

3. **Financial dependency.** Financial dependency of a domestic partner on the policyholder may not be required as a condition for eligibility for coverage.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

4. **Evidence of domestic partnership.** As a condition of eligibility for coverage, an insurer may require a policyholder and the policyholder's domestic partner to sign an affidavit attesting that the policyholder and the policyholder's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

5. **Preexisting conditions.** A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a policyholder.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

6. **Termination of domestic partner benefits.** An insurer may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a policyholder upon notification by the policyholder that the domestic partner relationship has terminated. A policyholder may not enroll another individual as a domestic partner under an individual contract until 12 months after the termination of coverage for a prior domestic partner.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

7. **Construction.** This section does not prohibit an insurer from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

8. **Exemption.** This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies.

[2001, c. 347, §2 (NEW); 2001, c. 347, §5 (AFF) .]

SECTION HISTORY
2001, c. 347, §2 (NEW). 2001, c. 347, §5 (AFF).

§2742. CHILD COVERAGE

1. **Definitions.** For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with the policyholder, member or spouse of the policyholder or member. [1993, c. 666, Pt. A, §3 (NEW).]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [1993, c. 666, Pt. A, §3 (NEW).]

[1993, c. 666, Pt. A, §3 (RPR) .]

2. **Coverage.** All insurance policies or plans issued in accordance with the requirements of section 2741 must provide unmarried women policyholders with the coverage or option of coverage for dependent children, under the same terms and conditions and at appropriate rates as are extended to married policyholders with dependents.

[1991, c. 200, Pt. B, §3 (NEW) .]

3. **Financial dependency.** Financial dependency of dependent children on the policyholder or the spouse of the policyholder may not be required as a condition for eligibility coverage.

[1991, c. 200, Pt. B, §3 (NEW) .]

4. **Adopted children.** All individual policies issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the policyholder or spouse of the policyholder under the same terms and conditions as apply to natural dependent children or stepchildren of the policyholder or spouse of the policyholder, irrespective of whether the adoption has become final.

[1993, c. 666, Pt. A, §4 (NEW) .]

5. **Compliance.** An insurer issuing policies under this chapter must comply with 42 United States Code, Section 1396g-1. If a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, the insurer shall permit either of the child's parents or the Department of Health and Human Services to enroll the child under the family coverage without regard to any enrollment season restrictions if the child is otherwise eligible for the coverage. An insurer must provide policy information to the custodial parent of any dependent child so that the custodial parent can obtain benefits for the child directly from the insurer. An insurer must permit the custodial parent of any dependent child to submit claims for covered services without the approval of the noncustodial parent. If the custodial parent approves, an insurer must permit the provider to submit claims for covered services without the approval of the noncustodial parent. An insurer shall make payment on claims submitted under this section directly to the custodial parent or, if the custodial parent approves, to the provider.

[1997, c. 795, §8 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

6. **Nondiscrimination.** An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance and who is covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered. If a child is otherwise eligible for health coverage, an insurer may not refuse to provide the coverage for the child because the child is eligible for medical assistance under Title 22.

[1997, c. 795, §9 (NEW) .]

SECTION HISTORY
1975, c. 276, §2 (NEW). 1991, c. 200, §B3 (RPR). 1993, c. 666, §§A3,4 (AMD). 1995, c. 418, §C2 (AMD). 1997, c. 795, §§8,9 (AMD). 2003, c. 689, §B6 (REV).

§2742-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN

Notwithstanding section 2703, subsection 3, an individual health insurance policy that provides coverage for a dependent child at certain ages only if the child is a student must continue that coverage if the child is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury. This coverage may be terminated at the age at which coverage for students terminates under the terms of the policy. An insurer may require, as a condition of eligibility for continued coverage in accordance with this section, that the student provide written documentation from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury. [2005, c. 532, §1 (NEW).]

SECTION HISTORY
2005, c. 532, §1 (NEW).

§2742-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE

1. **Dependent child; definition.** As used in this section, "dependent child" means the child of a person covered under an individual health insurance policy when that child:

A. Is unmarried; [2007, c. 115, §1 (NEW); 2007, c. 115, §5 (AFF).]

B. Has no dependent of the child's own; and [2007, c. 514, §1 (AMD).]

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education. [2007, c. 514, §2 (AMD).]

D. [2007, c. 514, §3 (RP).]

[2007, c. 514, §§1-3 (AMD) .]

2. **Offer of coverage.** Notwithstanding section 2703, subsection 3, an individual health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child is 25 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

[2007, c. 514, §4 (AMD) .]

3. **Notice.**

[2007, c. 514, §5 (NEW); T. 24-A, §2742-B, sub-§3 (RP) .]

SECTION HISTORY
2007, c. 115, §1 (NEW). 2007, c. 115, §5 (AFF). 2007, c. 514, §§1-5 (AMD). MRSA T. 24-A, §2742-B, sub-§3 (AMD).

§2743. NEWBORN CHILDREN COVERAGE

All individual health insurance policies providing coverage on an expense-incurred basis must provide that health insurance benefits are payable with respect to a newly born child of the insured or subscriber from the moment of birth. [1997, c. 604, Pt. C, §2 (AMD).]

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [1997, c. 604, Pt. C, §2 (AMD).]

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2743-A must be paid regardless of whether coverage under this section is elected. [1997, c. 604, Pt. C, §2 (AMD).]

The requirements of this section apply to all policies delivered or issued for delivery in this State more than 120 days after the effective date of this Act. [1997, c. 604, Pt. C, §2 (AMD).]

SECTION HISTORY
1975, c. 770, §104 (NEW). 1995, c. 332, §N2 (AMD). 1997, c. 604, §C2 (AMD).

§2743-A. MATERNITY AND ROUTINE NEWBORN CARE

An insurer that issues individual contracts providing maternity benefits, including benefits for childbirth, shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. [2001, c. 258, Pt. A, §2 (AMD).]

SECTION HISTORY
1995, c. 615, §2 (NEW). 2001, c. 258, §A2 (AMD).

§2744. MENTAL HEALTH SERVICES

1. Notwithstanding any provision of a health insurance policy subject to this chapter, whenever the policy provides for payment or reimbursement for services that are within the lawful scope of practice of a professional listed in subsection 2-A, any person covered by the policy is entitled to reimbursement for these services if the services are performed by a physician or a professional listed in subsection 2-A. Payment or reimbursement for services rendered by a professional listed in subsection 2-A, paragraph B, C, D, E or

F may not be conditioned upon prior diagnosis or referral by a physician or other health care professional, except when diagnosis of the condition for which the services are rendered is beyond the scope of their licensure.

[2005, c. 683, Pt. A, §39 (RPR) .]

2. Nothing in subsection 1 may be construed to require a health insurance policy subject to this chapter to provide for reimbursement of services that are within the lawful scope of practice of a professional listed in subsection 2-A.

[2005, c. 683, Pt. A, §39 (RPR) .]

2-A. Subsections 1 and 2 apply with respect to the following types of professionals:

A. A psychologist licensed to practice in this State; [2005, c. 683, Pt. A, §39 (RPR).]

B. A certified social worker licensed for the independent practice of social work in this State; [2005, c. 683, Pt. A, §39 (RPR).]

C. A licensed clinical professional counselor licensed for the independent practice of counseling in this State; [2005, c. 683, Pt. A, §39 (RPR).]

D. A licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing; [2005, c. 683, Pt. A, §39 (RPR).]

E. A marriage and family therapist licensed as a marriage and family therapist in this State; and [2005, c. 683, Pt. A, §39 (NEW).]

F. A licensed pastoral counselor licensed as a pastoral counselor in this State. [2005, c. 683, Pt. A, §39 (NEW).]

[2005, c. 683, Pt. A, §39 (RPR) .]

3. **Mental health services provided by counseling professionals.** Except as provided in subsection 1 with regard to reimbursement of clinical professional counselors, pastoral counselors and marriage and family therapists licensed in this State, an insurer that issues individual health care contracts providing coverage for mental health services shall offer coverage for those services when performed by a counseling professional who is licensed by the State pursuant to Title 32, chapter 119 to assess and treat interpersonal and intrapersonal problems, has at least a master's degree in counseling or a related field from an accredited educational institution and has been employed as a counselor for at least 2 years. Any contract providing coverage for the services of counseling professionals pursuant to this section may be subject to any reasonable limitations, maximum benefits, coinsurance, deductibles or exclusion provisions applicable to overall benefits under the contract. This subsection applies to all contracts executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1997. For purposes of this subsection, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

[2005, c. 683, Pt. A, §39 (RPR) .]

SECTION HISTORY
1975, c. 770, §104 (NEW). 1983, c. 546, §2 (AMD). 1983, c. 805, §2 (AMD). 1987, c. 80, §2 (AMD). 1995, c. 561, §2 (AMD). 2003, c. 65, §1 (AMD). 2003, c. 65, §5 (AFF). 2005, c. 121, §§I1,2 (AMD). 2005, c. 213, §1 (AMD). 2005, c. 213, §3 (AFF). 2005, c. 214, §1 (AMD). 2005, c. 214, §3 (AFF). 2005, c. 683, §A39 (RPR).

§2745. HOME HEALTH CARE COVERAGE

Every insurer which issues or issues for delivery in this State individual health policies, which provide coverage on an expense incurred basis for inpatient hospital care, shall make available such coverage for home health care services by a home health care provider. [1977, c. 470, §2 (NEW).]

The policy providing coverage for home health care services may contain reasonable limitation on the number of home care visits and other services provided, but the number of such visits shall not be less than 90 in any continuous period of 12 months for each person covered under the policy. Each visit by an individual member of a home health care provider shall be considered as one home care visit. [1977, c. 470, §2 (NEW).]

1. **Definition of home health care services.** "Home health care services" means those health care services rendered in his place of residence on a parttime basis to a covered person only if:

A. Hospitalization or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., would otherwise have been required if home health care was not provided; and [1977, c. 470, §2 (NEW).]

B. The plan covering the home health services is established as prescribed in writing by a physician. [1977, c. 470, §2 (NEW).]

There shall be no requirement that hospitalization be an antecedent to coverage under the policy.

[1977, c. 470, §2 (NEW) .]

2. **Home health care services included.** Home health care services shall include:

A. Visits by a registered nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated; [1977, c. 470, §2 (NEW).]

B. A physician's home or office visits or both; [1977, c. 470, §2 (NEW).]

C. Visits by a registered physical, speech, occupational, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending physician, or both; [1977, c. 470, §2 (NEW).]

D. Any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a physician, but only to the extent that such charges would have been covered under the contract if the covered person had remained in the hospital; and [1977, c. 470, §2 (NEW).]

E. Visits by persons who have completed a home health aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services. [1977, c. 470, §2 (NEW).]

[1977, c. 470, §2 (NEW) .]

3. **Home health care provider.** "Home health care provider" means a home health care agency which is certified under Title XVIII of the Social Security Act of 1965, as amended, which:

A. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services; [1977, c. 470, §2 (NEW).]

B. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse; [1977, c. 470, §2 (NEW).]

C. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day; [1977, c. 470, §2 (NEW).]

D. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician; [1977, c. 470, §2 (NEW).]

E. Has under contract the services of a physician-advisor licensed by the State or a physician; [1977, c. 470, §2 (NEW).]

F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and [1977, c. 470, §2 (NEW).]

G. Maintains a complete medical record on each patient. [1977, c. 470, §2 (NEW).]

[1977, c. 470, §2 (NEW) .]

4. **Exclusions.**

A. No policy shall require home health care coverage to persons eligible for medicare; and [1977, c. 470, §2 (NEW).]

B. No payment shall be made for services provided by a person who resides in the covered person's residence or who is a member of the covered person's family. [1977, c. 470, §2 (NEW).]

[1977, c. 470, §2 (NEW) .]

SECTION HISTORY
1977, c. 470, §2 (NEW).

§2745-A. SCREENING MAMMOGRAMS

1. **Definition.** For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

[2007, c. 153, §1 (AMD); 2007, c. 153, §5 (AFF) .]

2. **Required coverage.** All individual insurance policies that cover radiologic procedures, except those designed to cover only specific diseases, accidental injury or dental procedures, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

A. [1997, c. 408, §8 (AFF); 1997, c. 408, §3 (RP).]

B. [1997, c. 408, §8 (AFF); 1997, c. 408, §3 (RP).]

[1997, c. 408, §8 (AFF); 1997, c. 408, §3 (RPR); 2003, c. 689, Pt. B, §6 (REV) .]

3. **Application.** This section applies to all policies, contracts and certificates that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, executed, delivered, issued for delivery, continued or renewed in this State on or after March 1, 1991. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.

[1991, c. 156, §1 (AMD) .]

4. **Reports.** Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year beginning with 1991 not later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

[1991, c. 701, §6 (AMD) .]

SECTION HISTORY
1989, c. 875, §I3 (NEW). 1991, c. 156, §1 (AMD). 1991, c. 701, §6 (AMD). 1997, c. 408, §3 (AMD). 1997, c. 408, §8 (AFF). 2003, c. 689, §B6 (REV). 2007, c. 153, §1 (AMD). 2007, c. 153, §5 (AFF).

§2745-B. ACUPUNCTURE SERVICES

All individual insurance policies providing coverage for acupuncture must provide coverage for those services when performed by an acupuncturist licensed pursuant to Title 32, chapter 113-B, subchapter II, under the same conditions that apply to the services of a licensed physician. [1995, c. 671, §9 (AMD).]

SECTION HISTORY
1991, c. 647, §2 (NEW). 1995, c. 671, §9 (AMD).

§2745-C. COVERAGE FOR BREAST CANCER TREATMENT

1. **Inpatient care.** All individual health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

[1997, c. 408, §4 (NEW); 1997, c. 408, §8 (AFF) .]

2. **Reconstruction.** All individual health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

[1997, c. 408, §4 (NEW); 1997, c. 408, §8 (AFF) .]

SECTION HISTORY

RR 1995, c. 1, §15 (COR). 1995, c. 295, §3 (NEW). 1995, c. 369, §2 (NEW). 1997, c. 408, §8 (AFF). 1997, c. 408, §4 (RPR).

§2745-D. MEDICAL FOOD COVERAGE FOR INBORN ERROR OF METABOLISM

1. **Inborn error of metabolism; special modified low-protein food product.** As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

[1995, c. 369, §2 (NEW) .]

2. **Required coverage.** All individual insurance policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must provide coverage for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. The policies and contracts must reimburse:

A. For metabolic formula; and [1995, c. 369, §2 (NEW).]

B. Up to $3,000 per year for special modified low-protein food products. [1995, c. 369, §2 (NEW).]

[1995, c. 369, §2 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1995, c. 369, §2 (NEW) .]

SECTION HISTORY
RR 1995, c. 1, §15 (RNU). 1995, c. 369, §2 (NEW).

§2745-E. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER

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

A. "Medically accepted indication" includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is supported by one or more citations in the standard reference compendia or if the insurer involved, based upon guidance provided by the federal Department of Health and Human Services Medicare program pursuant to 42 United States Code, Section 1395x(t), determines that that use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. [1997, c. 701, §2 (NEW).]

B. "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §2 (NEW).]

C. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §2 (NEW).]

D. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §2 (NEW).]

[1997, c. 701, §2 (NEW) .]

2. **Required coverage for off-label use.** All individual insurance policies and contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Individual insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage for any such drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as use of that drug is a medically accepted indication for the treatment of cancer. [1997, c. 701, §2 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §2 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §2 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §2 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §2 (NEW).]

[1997, c. 701, §2 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

§2745-E. Coverage for prostate cancer screening

(As enacted by PL 1997, c. 754, §2 is REALLOCATED TO TITLE 24-A, SECTION 2745-G)

[1997, c. 701, §2 (NEW) .]

SECTION HISTORY
RR 1997, c. 2, §51 (RAL). 1997, c. 701, §2 (NEW). 1997, c. 754, §2 (NEW).

§2745-F. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR HIV OR AIDS

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

A. "Off-label use" means the prescription and use of drugs for indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §2 (NEW).]

B. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §2 (NEW).]

C. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §2 (NEW).]

[1997, c. 701, §2 (NEW) .]

2. **Required coverage for off-label use.** All individual insurance policies and contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Individual insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage for any such drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature. [1997, c. 701, §2 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §2 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §2 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §2 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §2 (NEW).]

[1997, c. 701, §2 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 701, §2 (NEW) .]

SECTION HISTORY
1997, c. 701, §2 (NEW).

§2745-G. COVERAGE FOR PROSTATE CANCER SCREENING

(REALLOCATED FROM TITLE 24-A, SECTION 2745-E)

1. **Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:

A. A digital rectal examination; and [1997, c. 2, §51 (RAL).]

B. A prostate-specific antigen test. [1997, c. 2, §51 (RAL).]

[1997, c. 2, §51 (RAL) .]

2. **Required coverage for prostate cancer screening.** All individual insurance policies and contracts except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.

[1997, c. 2, §51 (RAL) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 2, §51 (RAL) .]

SECTION HISTORY
RR 1997, c. 2, §51 (RAL).

§2746. OPTIONAL COVERAGE FOR CHIROPRACTIC SERVICES

(REALLOCATED TO TITLE 24-A, SECTION 2840)

SECTION HISTORY
1979, c. 335, §2 (NEW). 1979, c. 663, §145 (RAL).

§2747. REVIEW AND ARBITRATION

1. Any insurer denying medical expense reimbursement benefits on any of the grounds specified in subsection 2 for a claim filed pursuant to a policy issued under this chapter, other than a policy that is subject to section 4312, shall provide the policy or certificate holder with an opportunity to have the denial reviewed by the insurer and to arbitrate the denial if not satisfied after review. The right to review and arbitrate must be prominently set forth in any written notice sent to the policy or certificate holder denying the claim. The arbitration is nonbinding and must be carried out in accordance with procedures established by the insurer.

[2003, c. 428, Pt. H, §4 (AMD) .]

2. The procedure specified in subsection 1 shall apply to the denial of any medical expense reimbursement benefits based upon:

A. A health condition existing prior to the effective coverage of the policy or certificate; or [1981, c. 205, §2 (NEW).]

B. The lack of medical necessity. [1981, c. 205, §2 (NEW).]

[1981, c. 205, §2 (NEW) .]

SECTION HISTORY
1981, c. 205, §2 (NEW). 2003, c. 428, §H4 (AMD).

§2748. COVERAGE FOR CHIROPRACTIC SERVICES

1. **Therapeutic, adjustive and manipulative services.** Notwithstanding any other provisions of this chapter, every insurer which issues health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall provide coverage to any subscriber or other person covered under those contracts for those services when performed by a chiropractor, to the extent that the services are within the lawful scope of practice of a chiropractor licensed to practice in this State. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

[1985, c. 516, §3 (NEW) .]

2. **Limits; coinsurance; deductibles.** Any contract which provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section or the limitations, coinsurance, deductibles or exclusions imposed on other providers.

[1985, c. 516, §3 (NEW) .]

3. **Reports to the Superintendent of Insurance.** Every insurer subject to this section shall report its experience for each calendar year to the Superintendent of Insurance not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for health care contracts. The report must include complaints concerning access to services under this section and the results of those complaints. The superintendent shall compile this data for all insurers in an annual report.

[1993, c. 669, §2 (AMD) .]

4. **Application; expiration.**

[1989, c. 141, §4 (RP) .]

SECTION HISTORY
1985, c. 516, §3 (NEW). 1989, c. 141, §§3,4 (AMD). 1993, c. 669, §2 (AMD).

§2749. UTILIZATION REVIEW DATA

1. **Report required.** On or before April 1st of each year, any insurer which issues a program or contract in this State providing coverage for hospital care that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed.

(1) For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: Presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service; [1987, c. 168, §4 (NEW).]

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the insurer; [1987, c. 168, §4 (NEW).]

C. The number and result of any appeals by patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [1987, c. 168, §4 (NEW).]

D. Any complaints filed in a court of competent jurisdiction and served upon an insurer filing under this section stating a cause of action against that insurer on the basis of damages to patients alleged to have been proximately caused by a delay, reduction or denial of medical benefits by the insurer, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint. [1987, c. 168, §4 (NEW).]

[1987, c. 168, §4 (NEW) .]

2. **Maine residents.** This section is applicable to evaluations, appeals and complaints relating to Maine residents only.

[1987, c. 168, §4 (NEW) .]

3. **Confidentiality.** Any information provided pursuant to this section shall not identify the names of patients.

[1987, c. 168, §4 (NEW) .]

SECTION HISTORY
1987, c. 168, §4 (NEW).

§2749-A. PENALTY FOR FAILURE TO NOTIFY OF HOSPITALIZATION

An insurance policy may not include a provision permitting the insurer to impose a penalty for the failure of any person to notify the insurer of an insured person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22, section 1829. [1989, c. 767, §3 (NEW).]

This section applies to policies and certificates executed, delivered, issued for delivery, continued or renewed in this State after the effective date of this section. For purposes of this section, all policies are deemed to be renewed no later than the next yearly anniversary of the contract date. [1989, c. 767, §3 (NEW).]

SECTION HISTORY
1989, c. 767, §3 (NEW).

§2749-B. PENALTY FOR NONCOMPLIANCE WITH UTILIZATION REVIEW PROGRAMS

A health insurance policy issued or renewed in this State after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary. [1995, c. 332, Pt. M, §4 (AMD).]

SECTION HISTORY
1993, c. 645, §B3 (NEW). 1995, c. 332, §M4 (AMD).

§2749-C. MANDATED OFFER OF COVERAGE FOR CERTAIN MENTAL ILLNESSES

1. **Coverage for treatment for certain mental illnesses.** Coverage for medical treatment for mental illnesses listed in paragraph A by all individual policies is subject to this section.

A. All individual policies must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder. [2003, c. 20, Pt. VV, §8 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State must make available coverage providing benefits that meet the requirements of this paragraph.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy. [2003, c. 20, Pt. VV, §8 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §8 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

2. **Contracts; providers.** An insurer incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

[2003, c. 20, Pt. VV, §9 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

3. **Limits; coinsurance; deductibles.** A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1995, c. 407, §5 (NEW) .]

4. **Reports to the superintendent.** Every insurer subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services

required by this section and the total amount of claims paid in this State for individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[1995, c. 407, §5 (NEW) .]

5. **Application.** Except as otherwise provided, the requirements of this section apply to all policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996. For purposes of this section, all policies are deemed renewed no later than the next yearly anniversary of the contract date. Nothing in this section applies to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

[1995, c. 407, §5 (NEW) .]

SECTION HISTORY
1995, c. 407, §5 (NEW). 1995, c. 637, §3 (AMD). 2003, c. 20, §§VV8,9 (AMD). 2003, c. 20, §VV25 (AFF).

§2750. ACQUIRED IMMUNE DEFICIENCY SYNDROME

No individual or family health insurance policy delivered or issued for delivery in this State may provide more restrictive benefits for sickness or disablement or the related expenses resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases than for any other sickness or disabling condition or exclude benefits for AIDS, ARC or HIV related diseases except through an exclusion under which all sickness and diseases are treated the same. This section shall not apply to a policy providing benefits for specific diseases or accidental injury only. [1989, c. 176, §5 (NEW).]

SECTION HISTORY
1989, c. 176, §5 (NEW).

§2751. ASSESSMENT OF MANDATED BENEFITS PROPOSALS; STUDIES OF MANDATED BENEFITS ISSUES

(REPEALED)

SECTION HISTORY
1989, c. 556, §A5 (NEW). 1989, c. 875, §§I4,5 (AMD). 1991, c. 333, §2 (AMD). 1991, c. 701, §7 (RP).

§2752. MANDATED HEALTH LEGISLATION PROCEDURES

1. **Mandated health benefits proposals.** For purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of individual or group health insurance policies. A mandated option is not a mandated benefit for purposes of this section.

[1991, c. 701, §8 (NEW) .]

2. **Procedures before legislative committees.** Whenever a legislative measure containing a mandated health benefit is proposed, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the Bureau of Insurance for review and evaluation

pursuant to subsection 3. Once a review and evaluation has been completed, the committee shall review the findings of the bureau. A proposed mandate may not be enacted into law unless review and evaluation pursuant to subsection 3 has been completed.

[1997, c. 616, §4 (AMD) .]

3. **Review and evaluation.** Upon referral of a mandated health benefit proposal from the joint standing committee of the Legislature having jurisdiction over the proposal, the Bureau of Insurance shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

A. The social impact of mandating the benefit, including:

(1) The extent to which the treatment or service is utilized by a significant portion of the population;

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

(4) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(5) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered;

(15) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(16) The impact of making the benefit applicable to the state employee health insurance program; [2011, c. 90, Pt. J, §21 (AMD).]

B. The financial impact of mandating the benefit, including:

(1) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(2) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(3) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;

(4) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(5) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years;

(6) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(7) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(8) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;

(9) The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and

(10) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this State.

In order to enable the committee to assess the financial impact of the benefit, the report must include a comparison of the rate of increase in the Consumer Price Index for medical care services to the rate of increase in the Consumer Price Index for the previous year and the current year as reported by the United States Department of Labor, Bureau of Labor Statistics; [2005, c. 125, §1 (AMD).]

C. The medical efficacy of mandating the benefit, including:

(1) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(2) If the legislation seeks to mandate coverage of an additional class of practitioners:

(a) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(b) The methods of the appropriate professional organization that assure clinical proficiency; and [1991, c. 701, §8 (NEW).]

D. The effects of balancing the social, economic and medical efficacy considerations, including:

(1) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

(2) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

(3) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage. [1997, c. 616, §5 (AMD).]

[2011, c. 90, Pt. J, §21 (AMD) .]

SECTION HISTORY
1991, c. 701, §8 (NEW). 1997, c. 616, §§4,5 (AMD). 2001, c. 258, §I1 (AMD). 2005, c. 125, §1 (AMD). 2011, c. 90, Pt. J, §21 (AMD).

§2753. STANDARDIZED CLAIM FORMS

All 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 health care practitioner must accept the current standardized claim form for professional services approved by the Federal

Government and submitted electronically. All 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. [2005, c. 97, §2 (AMD).]

SECTION HISTORY
1993, c. 477, §D10 (NEW). 1993, c. 477, §F1 (AFF). 2003, c. 218, §6 (AMD). 2003, c. 469, §D6 (AMD). 2003, c. 469, §D9 (AFF). 2005, c. 97, §2 (AMD).

§2754. COVERAGE FOR DIABETES SUPPLIES

All individual health policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must provide coverage for the medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: [1995, c. 592, §2 (NEW).]

1. **Certification of medical necessity.** The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and

[1995, c. 592, §2 (NEW) .]

2. **Provision of medical services.** The diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

[1995, c. 592, §2 (NEW) .]

SECTION HISTORY
1995, c. 592, §2 (NEW).

§2755. ASSIGNMENT OF BENEFITS

All policies providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy. [1999, c. 21, §2 (AMD).]

SECTION HISTORY
1997, c. 604, §E2 (NEW). 1999, c. 21, §2 (AMD).

§2756. COVERAGE FOR CONTRACEPTIVES

1. **Coverage requirements.** All individual health policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies and contracts, that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services. For purposes of this section, the term "outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy.

[1999, c. 341, §2 (NEW); 1999, c. 341, §5 (AFF) .]

§2756. Coverage for services of certified nurse practitioners; certified nurse midwives

2. **Exclusion for religious employer.** A religious employer may request and an insurer shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective insureds and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing an insurer to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121 (w) (3) (A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c) (3).

(As enacted by PL 1999, c. 396, §2 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 2757)

§2756. Coverage for services provided by registered nurse first assistants

(As enacted by PL 1999, c. 412, §2 is REALLOCATED TO TITLE 24-A, SECTION 2758)

[1999, c. 341, §2 (NEW); 1999, c. 341, §5 (AFF) .]

SECTION HISTORY
RR 1999, c. 1, §§32,33 (RAL). 1999, c. 341, §2 (NEW). 1999, c. 341, §5 (AFF). 1999, c. 396, §2 (NEW). 1999, c. 396, §7 (AFF). 1999, c. 412, §2 (NEW).

§2757. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES

(REALLOCATED FROM TITLE 24-A, SECTION 2756)

1. **Required coverage for services upon referral of primary care provider.** An insurer that issues individual health insurance policies and contracts shall provide coverage under those contracts for services performed by a certified nurse practitioner or certified nurse midwife to a patient who is referred to the certified nurse practitioner or certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse practitioner or certified nurse midwife.

[1999, c. 1, §32 (RAL) .]

2. **Required coverage for self-referred services.** With respect to individual health insurance policies and contracts that do not require the selection of a primary care provider, an insurer shall provide coverage under those contracts for services performed by a certified nurse practitioner or certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the certified nurse practitioner or certified nurse midwife.

[1999, c. 1, §32 (RAL) .]

3. **Limits; coinsurance; deductibles.** Any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 1, §32 (RAL) .]

SECTION HISTORY
RR 1999, c. 1, §32 (RAL).

§2758. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS

(REALLOCATED FROM TITLE 24-A, SECTION 2756)

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

A. "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and postoperative nursing care to surgical patients. [1999, c. 1, §33 (RAL).]

B. "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistants as established by the Association of Operating Room Nurses or its successor organization. [1999, c. 1, §33 (RAL).]

C. "Registered nurse first assistant," or "RNFA," means a person who:

(1) Is licensed as a registered nurse under Title 32, chapter 31;

(2) Is experienced in perioperative nursing; and

(3) Has successfully completed a recognized program. [1999, c. 1, §33 (RAL).]

[1999, c. 1, §33 (RAL) .]

2. **Institutional powers.** Each health care institution, as defined in Title 22, chapter 405, may establish specific procedures for the appointment and reappointment of registered nurse first assistants and for granting, renewing and revising their clinical privileges.

[1999, c. 1, §33 (RAL) .]

3. **Required coverage for services.** Notwithstanding any other provisions of this chapter, an insurer that issues individual health insurance policies and contracts that provide coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed those services is used as a substitute. This section does not apply to policies or contracts that cover only specified diseases.

[1999, c. 1, §33 (RAL) .]

4. **Limits; coinsurance; deductibles.** Any contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 1, §33 (RAL) .]

SECTION HISTORY
RR 1999, c. 1, §33 (RAL).

§2759. COVERAGE FOR HOSPICE CARE SERVICES

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

A. "Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to a person who is terminally ill and that person's family. "Hospice care services" includes, but is not limited to, physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services. [2001, c. 358, Pt. LL, §2 (NEW); 2001, c. 358, Pt. LL, §5 (AFF).]

B. "Person who is terminally ill" means a person that has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course. [2001, c. 358, Pt. LL, §2 (NEW); 2001, c. 358, Pt. LL, §5 (AFF).]

[2001, c. 358, Pt. LL, §2 (NEW); 2001, c. 358, Pt. LL, §5 (AFF) .]

2. **Coverage for hospice care services.** All individual health policies must provide coverage for hospice care services to a person who is terminally ill. Hospice care services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Coverage for hospice care services must be provided whether the services are provided in a home setting or an inpatient setting.

§2759. Coverage for general anesthesia for dentistry

(As enacted by PL 2001, c. 423, §2 and affected by § 5 is REALLOCATED TO TITLE 24-A, SECTION 2760)

[2001, c. 358, Pt. LL, §2 (NEW); 2001, c. 358, Pt. LL, §5 (AFF) .]

SECTION HISTORY
RR 2001, c. 1, §31 (RAL). 2001, c. 358, §LL2 (NEW). 2001, c. 358, §LL5 (AFF). 2001, c. 423, §2 (NEW). 2001, c. 423, §5 (AFF).

§2760. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY

(REALLOCATED FROM TITLE 24-A, SECTION 2759)

1. **Enrollee defined.** For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual health insurance contract provided by an insurer.

[2001, c. 1, §31 (RAL) .]

2. **General anesthesia and associated facility charges.** An insurer that issues individual health insurance contracts shall provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee

requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

[2001, c. 1, §31 (RAL) .]

3. **Limitations on coverage.** This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; [2001, c. 1, §31 (RAL).]

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [2001, c. 1, §31 (RAL).]

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and [2001, c. 1, §31 (RAL).]

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [2001, c. 1, §31 (RAL).]

[2001, c. 1, §31 (RAL) .]

4. **Dental procedures and dentist's fee not covered.** This section does not require an insurer that issues individual contracts to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual contract that apply generally to other benefits.

[2001, c. 1, §31 (RAL) .]

5. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the insurer providing individual health insurance is the secondary payer.

[2001, c. 1, §31 (RAL) .]

SECTION HISTORY
RR 2001, c. 1, §31 (RAL).

§2761. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY

All individual health insurance policies, contracts and certificates must make available coverage for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary health care as defined in section 4301-A, subsection 10-A. [2005, c. 128, §2 (NEW); 2005, c. 128, §5 (AFF).]

SECTION HISTORY
2005, c. 128, §2 (NEW). 2005, c. 128, §5 (AFF).

§2762. COVERAGE FOR HEARING AIDS

1. **Hearing aid; definition.** For purposes of this section, "hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

[2007, c. 452, §2 (NEW) .]

2. **Required coverage.** In accordance with the application of coverage set forth in subsection 3, all individual health policies and contracts must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy or contract in accordance with the following requirements.

A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77. [2007, c. 452, §2 (NEW).]

B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A. [2007, c. 452, §2 (NEW).]

C. The policy or contract may limit coverage to $1,400 per hearing aid for each hearing-impaired ear every 36 months. [2007, c. 452, §2 (NEW).]

[2007, c. 452, §2 (NEW) .]

3. **Application of coverage.** The requirements of subsection 2 apply to an individual:

A. From birth to 5 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2008; [2007, c. 452, §2 (NEW).]

B. From 6 to 13 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2009; and [2007, c. 452, §2 (NEW).]

C. From 14 to 18 years of age, who is covered under a policy or contract that is issued or renewed on or after January 1, 2010. [2007, c. 452, §2 (NEW).]

[2007, c. 452, §2 (NEW) .]

4. **Limits; coinsurance; deductibles.** Except as otherwise provided in this section, any policy or contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2007, c. 452, §2 (NEW) .]

SECTION HISTORY
2007, c. 452, §2 (NEW).

§2763. COVERAGE FOR COLORECTAL CANCER SCREENING

1. **Colorectal cancer screening.** For the purposes of this section, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

[2007, c. 516, §2 (NEW); 2007, c. 516, §5 (AFF) .]

2. **Required coverage.** All individual health insurance policies and contracts must provide coverage for colorectal cancer screening for asymptomatic individuals who are:

A. Fifty years of age or older; or [2007, c. 516, §2 (NEW); 2007, c. 516, §5 (AFF).]

B. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. [2007, c. 516, §2 (NEW); 2007, c. 516, §5 (AFF).]

[2007, c. 516, §2 (NEW); 2007, c. 516, §5 (AFF) .]

3. **Billing.** If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure.

§2763. Coverage for medically necessary infant formula

(As enacted by PL 2007, c. 595, §2 is REALLOCATED TO TITLE 24-A, SECTION 2764)

[2007, c. 516, §2 (NEW); 2007, c. 516, §5 (AFF) .]

SECTION HISTORY
RR 2007, c. 2, §11 (RAL). 2007, c. 516, §2 (NEW). 2007, c. 516, §5 (AFF). 2007, c. 595, §2 (NEW). 2007, c. 595, §5 (AFF).

§2764. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA

(REALLOCATED FROM TITLE 24-A, SECTION 2763)

All individual health insurance policies, contracts and certificates must provide coverage for amino acid-based elemental infant formula for children 2 years of age and under in accordance with this section. [2007, c. 2, §11 (RAL).]

1. **Determination of medical necessity.** Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A, subsection 10-A, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing medical necessity at least annually.

[2007, c. 2, §11 (RAL) .]

2. **Method of delivery.** Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

[2007, c. 2, §11 (RAL) .]

3. **Required diagnosis.** Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis; [2007, c. 2, §11 (RAL).]

B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; [2007, c. 2, §11 (RAL).]

C. A history of anaphylaxis; [2007, c. 2, §11 (RAL).]

D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; [2007, c. 2, §11 (RAL).]

E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; [2007, c. 2, §11 (RAL).]

F. Cystic fibrosis; or [2007, c. 2, §11 (RAL).]

G. Malabsorption of cow milk-based or soy milk-based infant formula. [2007, c. 2, §11 (RAL).]

[2007, c. 2, §11 (RAL) .]

4. **Health savings accounts.** Coverage for amino acid-based elemental infant formula under a health insurance policy, contract or certificate issued in connection with a health savings account as authorized under Title XII of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate.

[2007, c. 2, §11 (RAL) .]

SECTION HISTORY
RR 2007, c. 2, §11 (RAL).

§2765. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST

1. **Services provided by independent practice dental hygienist.** An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by an independent practice dental hygienist licensed under Title 32, chapter 16, subchapter 3-B when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.

[2009, c. 307, §2 (NEW); 2009, c. 307, §6 (AFF) .]

2. **Limits; coinsurance; deductibles.** A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2009, c. 307, §2 (NEW); 2009, c. 307, §6 (AFF) .]

3. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.

[2009, c. 307, §2 (NEW); 2009, c. 307, §6 (AFF) .]

4. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2009, c. 307, §2 (NEW); 2009, c. 307, §6 (AFF) .]

SECTION HISTORY
2009, c. 307, §2 (NEW). 2009, c. 307, §6 (AFF).

§2765-A. COVERAGE FOR SERVICES PROVIDED BY DENTAL HYGIENE THERAPIST

1. **Services provided by dental hygiene therapist.** An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental hygiene therapist licensed under Title 32, chapter 16, subchapter 3-C when those services are covered services under the contract and when they are within the lawful scope of practice of the dental hygiene therapist.

[2013, c. 575, §5 (NEW); 2013, c. 575, §10 (AFF) .]

2. **Limits; coinsurance; deductibles.** A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2013, c. 575, §5 (NEW); 2013, c. 575, §10 (AFF) .]

3. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.

[2013, c. 575, §5 (NEW); 2013, c. 575, §10 (AFF) .]

4. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2013, c. 575, §5 (NEW); 2013, c. 575, §10 (AFF) .]

SECTION HISTORY
2013, c. 575, §5 (NEW). 2013, c. 575, §10 (AFF).

§2766. ENROLLMENT OF DEPENDENT CHILDREN IN DENTAL COVERAGE

1. **Offer of dependent coverage; enrollment period.** All individual dental insurance policies and contracts that offer dependent coverage must offer the opportunity to enroll a dependent child in the dental insurance coverage at appropriate rates during the following periods:

A. From birth to 30 days of age; and [2009, c. 578, §2 (NEW); 2009, c. 578, §4 (AFF).]

B. Any open or annual enrollment period. [2009, c. 578, §2 (NEW); 2009, c. 578, §4 (AFF).]

§2766. Coverage for children's early intervention services

(As enacted by PL 2009, c. 634, §2; §5 is REALLOCATED TO TITLE 24-A, SECTION 2767)

§2766. Coverage for the diagnosis and treatment of autism spectrum disorders

(As enacted by PL 2009, c. 635, §2; §6 is REALLOCATED TO TITLE 24-A, SECTION 2768)

[2009, c. 578, §2 (NEW); 2009, c. 578, §4 (AFF) .]

SECTION HISTORY

2009, c. 578, §2 (NEW). 2009, c. 578, §4 (AFF). 2009, c. 634, §2 (NEW). 2009, c. 634, §5 (AFF). 2009, c. 635, §2 (NEW). 2009, c. 635, §6 (AFF). 2011, c. 420, Pt. A, §23 (RAL). 2011, c. 420, Pt. A, §24 (RAL).

§2767. COVERAGE FOR CHILDREN'S EARLY INTERVENTION SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 2766)

1. **Definition.** For purposes of this section, "children's early intervention services" means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq.

[2011, c. 420, Pt. A, §23 (RAL) .]

2. **Required coverage.** All individual health insurance policies, contracts and certificates must provide coverage for children's early intervention services in accordance with this subsection.

A. A referral from the child's primary care provider is required. [2011, c. 420, Pt. A, §23 (RAL).]

B. The policy, contract or certificate may limit coverage to $3,200 per year for each child not to exceed $9,600 by the child's 3rd birthday. [2011, c. 420, Pt. A, §23 (RAL).]

C. The policy, contract or certificate may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section. [2011, c. 420, Pt. A, §23 (RAL).]

[2011, c. 420, Pt. A, §23 (RAL) .]

SECTION HISTORY
2011, c. 420, Pt. A, §23 (RAL).

§2768. COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS

(REALLOCATED FROM TITLE 24-A, SECTION 2766)

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

A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. [2011, c. 420, Pt. A, §24 (RAL).]

B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. [2011, c. 420, Pt. A, §24 (RAL).]

C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

(3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. [2011, c. 420, Pt. A, §24 (RAL).]

[2011, c. 420, Pt. A, §24 (RAL) .]

2. **Required coverage.** All individual health insurance policies and contracts must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is 10 years of age or under in accordance with the following.

A. The policy or contract must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. [2011, c. 420, Pt. A, §24 (RAL).]

B. The policy or contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually. [2011, c. 420, Pt. A, §24 (RAL).]

C. The policy or contract may not include any limits on the number of visits. [2011, c. 420, Pt. A, §24 (RAL).]

D. The policy or contract may limit coverage for applied behavior analysis to $36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. [2011, c. 420, Pt. A, §24 (RAL).]

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract. [2011, c. 420, Pt. A, §24 (RAL).]

[2013, c. 597, §1 (AMD); 2013, c. 597, §4 (AFF) .]

3. **Limits; coinsurance; deductibles.** Except as otherwise provided in this section, any policy or contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2011, c. 420, Pt. A, §24 (RAL) .]

4. **Individualized education plan.** This section may not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized education plan or an individualized family service plan.

[2011, c. 420, Pt. A, §24 (RAL) .]

SECTION HISTORY

2011, c. 420, Pt. A, §24 (RAL). 2013, c. 597, §1 (AMD). 2013, c. 597, §4 (AFF).

Chapter 34: LICENSURE OF MEDICAL UTILIZATION REVIEW ENTITIES

§2771. REVIEW ENTITIES

1. **Licensure.** A person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than $400 and an annual license fee of not more than $100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

[1995, c. 332, Pt. M, §5 (AMD) .]

2. **Listing.** The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section.

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Information required.** Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:

A. The process by which the entity carries out its utilization review services. The information provided to the bureau must include the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State. The information provided to the bureau also must include copies of any licensure agreements the utilization review entity has in effect with any entity that sells or furnishes the utilization review entity with medical utilization review criteria and the expiration date of any such agreements. If the utilization review entity develops its own medical utilization review criteria, the utilization review entity shall include copies of any policies and procedures or both for the use of the criteria; [1995, c. 332, Pt. M, §6 (AMD).]

B. The process used by the entity for addressing beneficiary or provider complaints; [1989, c. 556, Pt. C, §2 (NEW).]

C. The types of utilization review programs offered by the entity, such as:

(1) Second opinion programs;

(2) Prehospital admission certification;

(3) Preinpatient service eligibility determination; or

(4) Concurrent hospital review to determine appropriate length of stay; and [1989, c. 556, Pt. C, §2 (NEW).]

D. The process chosen by the entity to preserve beneficiary confidentiality of medical information. [1989, c. 556, Pt. C, §2 (NEW).]

As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.

[1995, c. 332, Pt. M, §6 (AMD) .]

4. **Transition for existing entities.** Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services.

[1989, c. 556, Pt. C, §2 (NEW) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW). 1989, c. 878, §B22 (AMD). 1991, c. 200, §A2 (AMD). 1993, c. 171, §B1 (AMD). 1993, c. 602, §4 (AMD). 1995, c. 332, §§M5,6 (AMD).

§2772. MINIMUM STANDARDS

A utilization review program of the applicant must meet the following minimum standards. [1989, c. 556, Pt. C, §2 (NEW).]

1. **Notification of adverse decisions.** Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking and must include the name of the utilization review agent who made the decision.

[1993, c. 602, §5 (AMD) .]

2. **Reconsideration of determinations.** All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Accessibility of representatives.** A representative of the licensee must be accessible by telephone to insureds, patients or providers and the superintendent may adopt standards of accessability by rule.

[1989, c. 556, Pt. C, §2 (NEW) .]

3-A. **Medical utilization review criteria.** The licensee must have written medical utilization review criteria to be employed in the review process. The criteria must be available for review as a part of any review conducted pursuant to section 2774, subsection 1 and a copy of the criteria must be provided to the bureau upon request.

[1995, c. 332, Pt. M, §7 (NEW) .]

4. **Information materials; confidentiality.** A copy of the materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed must be filed with the bureau.

[1989, c. 556, Pt. C, §2 (NEW) .]

5. **Penalty for noncompliance with utilization review programs.** A medical utilization review program may not recommend or implement a penalty of more than $500 for failure to provide notification. This subsection does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

[1995, c. 332, Pt. M, §8 (AMD) .]

6. **Prohibited activities.** A medical utilization review entity shall ensure that an employee does not perform medical utilization review services involving a health care provider or facility in which that employee has a financial interest.

[1993, c. 2, §15 (RNU) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW). RR 1993, c. 2, §15 (COR). 1993, c. 602, §§5,6 (AMD). 1993, c. 645, §B4 (AMD). 1995, c. 332, §§M7,8 (AMD).

§2773. UTILIZATION REVIEW SERVICES

As used in this chapter, unless the context indicates otherwise, "utilization review services" or "medical utilization review services" means a program or process by which a person, partnership or corporation, on behalf of an insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer that is a payor for or that arranges for payment of medical services, seeks to review the utilization, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer. The terms include these programs or processes whether they apply prospectively or retrospectively to medical services. Utilization review services include, but are not limited to, the following: [1993, c. 602, §7 (AMD).]

1. **Second opinion programs.** Second opinion programs;

[1989, c. 556, Pt. C, §2 (NEW) .]

2. **Prehospital admission certification.** Prehospital admission certification;

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Preinpatient service eligibility certification.** Preinpatient service eligibility certification; and

[1989, c. 556, Pt. C, §2 (NEW) .]

4. **Concurrent hospital review.** Concurrent hospital review to determine appropriate length of stay.

[1989, c. 556, Pt. C, §2 (NEW) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW). 1993, c. 602, §7 (AMD).

§2774. ENFORCEMENT

The following provisions govern enforcement of this chapter. [1989, c. 556, Pt. C, §2 (NEW).]

1. **Periodic reviews.** The superintendent may conduct periodic reviews of the operations of the entities licensed pursuant to this chapter to ensure that they continue to meet the minimum standards set forth in section 2772 and any applicable rules adopted by the superintendent. The superintendent may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required by section 2772.

[1989, c. 556, Pt. C, §2 (NEW) .]

2. **Action against licensee.** The superintendent is authorized to take appropriate action against a licensee which fails to meet the standards of this chapter or any rules adopted by the superintendent, or who fails to respond in a timely manner to corrective actions ordered by the superintendent. The superintendent may impose a civil penalty not to exceed $1,000 for each violation, as permitted by section 12-A, or may deny, suspend or revoke the license.

[1989, c. 556, Pt. C, §2 (NEW) .]

3. **Opportunity to provide information and request hearing.** Before taking the actions authorized by this section to deny, suspend or revoke the license, the superintendent shall provide the licensee with reasonable time to supply additional information demonstrating compliance with the requirements of this chapter and the opportunity to request a hearing to be held consistent with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375.

[1989, c. 556, Pt. C, §2 (NEW) .]

4. **Authority to adopt rules.** The superintendent may adopt rules necessary to implement the provisions of this chapter.

[1989, c. 556, Pt. C, §2 (NEW) .]

5. **Rulings on appropriateness of medical judgments not authorized.** Nothing in this chapter requires or authorizes the superintendent to rule on the appropriateness of medical decisions or judgments rendered by review entities and their agents.

[1989, c. 556, Pt. C, §2 (NEW) .]

SECTION HISTORY
1989, c. 556, §C2 (NEW).

Chapter 35: GROUP AND BLANKET HEALTH INSURANCE

§2801. SCOPE OF CHAPTER -- SHORT TITLE

1. This chapter applies only to group health insurance contracts and to blanket health insurance contracts as herein provided. Nothing in this chapter pertains to legal services insurance as described in chapter 38, except to the extent expressly permitted in that chapter.

[1983, c. 801, §10 (AMD) .]

2. This chapter may be cited as the "Group or Blanket Health Insurance Law."

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1983, c. 801, §10 (AMD).

§2802. GROUP INSURANCE DEFINED

1. Any policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person, except blanket accident policies as defined in section 2813 and family accident and sickness policies conforming to section 2703, shall be deemed a group accident insurance policy.

[1969, c. 177, §48 (AMD) .]

2. Any policy or contract which insures against disablement, disease or sickness of the insured, excluding disablement which results from accident or from accidental means, and which covers more than one person, except blanket sickness insurance policies as defined in section 2813 and family accident and sickness policies conforming to section 2703, shall be deemed a group sickness insurance policy or contract.

[1969, c. 132, §1 (NEW) .]

3. Any policy or contract of insurance which combines the coverage of group accident insurance and of group sickness insurance shall be deemed a group accident and sickness insurance policy.

[1969, c. 132, §1 (NEW) .]

4. Any reference hereinafter to group health insurance shall mean group accident, group sickness and group accident and sickness insurance as herein defined.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §48 (AMD).

§2803. REQUIREMENTS

A policy of group health insurance may not be delivered in this State, nor may any certificate of group health insurance that derives from a policy issued in another state be delivered in this State unless the group policyholder conforms to one of the descriptions set forth in sections 2804 to 2808. [2011, c. 238, Pt. G, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 147, §1 (RPR). 1993, c. 171, §C2 (AMD). 2011, c. 238, Pt. G, §1 (AMD).

§2803-A. LOSS INFORMATION

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section. [1995, c. 71, §2 (NEW).]

B. "Loss information" means the aggregate claims experience of the group insurance policy or contract. "Loss information" includes the amount of premium received, the amount of claims paid and the loss ratio. "Loss information" does not include any information or data pertaining to the medical diagnosis, treatment or health status that identifies an individual covered under the group contract or policy. [1995, c. 71, §2 (NEW).]

C. "Loss ratio" means the ratio between the amount of premium received and the amount of claims paid by the insurer under the group insurance contract or policy. [1995, c. 71, §2 (NEW).]

[1995, c. 71, §2 (NEW) .]

2. **Disclosure of basic loss information.** Upon written request, every insurer shall provide loss information concerning a group policy or contract to its policyholder, to a former policyholder or to a school administrative unit pursuant to Title 20-A, section 1001, subsection 14, paragraph E within 21 business days of the date of the request. This subsection does not apply to a former policyholder whose coverage terminated more than 18 months prior to the date of a request.

[2011, c. 1, §39 (COR) .]

3. **Transmittal of request.** An insurance producer or other authorized representative who receives a request for loss information in accordance with this section shall transmit the request for loss information to the insurer within 4 business days.

[2001, c. 410, Pt. B, §1 (AMD) .]

4. **Exception.** An insurer is not required to provide the loss information described in this section for a group that is eligible for small group coverage pursuant to section 2808-B.

[2001, c. 410, Pt. B, §2 (AMD) .]

SECTION HISTORY
1995, c. 71, §2 (NEW). 1997, c. 370, §E5 (AMD). 2001, c. 410, §§B1,2 (AMD). 2003, c. 428, §D1 (AMD). RR 2011, c. 1, §39 (COR). 2011, c. 395, §4 (AMD).

§2804. EMPLOYEE GROUPS

A group of individuals may be insured under a policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements. [1981, c. 147, §2 (RPR).]

1. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" includes the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" includes the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" includes retired employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

[1981, c. 147, §2 (RPR) .]

2. The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing.

[1981, c. 147, §2 (RPR) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §1 (AMD) .]

4.

[1981, c. 147, §2 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §49 (AMD). 1981, c. 147, §2 (RPR). 1989, c. 867, §§2,10 (AMD). 1999, c. 256, §G1 (AMD).

§2804-A. PRIVATE PURCHASING ALLIANCES

A group of individuals may be insured under a policy issued to a private purchasing alliance meeting the requirements of chapter 18-A. [1995, c. 673, Pt. A, §4 (NEW).]

SECTION HISTORY
1995, c. 673, §A4 (NEW).

§2805. LABOR UNION GROUPS

A group of individuals may be insured under a policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of that union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements. [1981, c. 147, §3 (RPR).]

1. The members eligible for insurance under the policy shall be all of the members of the union or organization or all of any class or classes thereof.

[1981, c. 147, §3 (RPR) .]

2. The premium for the policy shall be paid either from funds of the union or organization, or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing.

[1981, c. 147, §3 (RPR) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §2 (AMD) .]

4.

[1981, c. 147, §3 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 147, §3 (RPR). 1989, c. 867, §§3,10 (AMD). 1999, c. 256, §G2 (AMD).

§2805-A. ASSOCIATION GROUPS

A group of individuals may be insured under a policy issued to an association or to a trust or to the trustees of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 50 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least 2 years; and shall have a constitution and bylaws which provides that: The association or associations hold regular meetings not less than annually to further purposes of the members; except for credit unions, the association or associations collect dues or solicit contributions from members; and the members have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements. [1981, c. 147, §4 (NEW).]

1. The policy may insure members of the association or associations, employees thereof or employees of members or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employees' employer.

[1981, c. 147, §4 (NEW) .]

2. The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations or employer members.

[1981, c. 147, §4 (NEW) .]

3. Except as provided in subsection 4, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject that coverage in writing.

[1981, c. 147, §4 (NEW) .]

4. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §3 (AMD) .]

SECTION HISTORY
1981, c. 147, §4 (NEW). 1989, c. 867, §§4,10 (AMD). 1999, c. 256, §G3 (AMD).

§2806. TRUSTEE GROUPS

A group of individuals may be insured under a policy issued to a trust or to the trustee or trustees of a fund established by 2 or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements. [1981, c. 147, §5 (RPR).]

1. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" includes retired employees, the individual proprietor or partners if an employer is an individual proprietorship or a partnership and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with that trusteeship.

[1981, c. 147, §5 (RPR) .]

2. The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing.

[1981, c. 147, §5 (RPR) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §4 (AMD) .]

4.

[1981, c. 147, §5 (RP) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1969, c. 177, §§50,51 (AMD). 1977, c. 655, §2 (AMD). 1981, c. 147, §5 (RPR). 1989, c. 867, §§5,10 (AMD). 1999, c. 256, §G4 (AMD).

§2807. DEBTOR GROUPS

A group of individuals may be insured under a policy issued to a creditor, or its parent holding company or to a trustee or trustees or agent designated by 2 or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors, as the case may be, all as defined and set forth under section 2604-A, provided that the amount of indemnity payable with respect to any person insured thereunder shall not at any time exceed the aggregate of the periodic scheduled unpaid installments, including, with respect to mortgage indebtedness, such real estate taxes and insurance costs incident to the mortgaged property as may become due during the scheduled period and provided that nothing in this paragraph may be construed or deemed to apply to or affect disability benefit provisions in group credit life insurance policies as authorized under section 2604-A. [1981, c. 698, §109 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1979, c. 127, §§156-A (AMD). 1981, c. 147, §6 (AMD). 1981, c. 698, §109 (AMD).

§2807-A. CREDIT UNION GROUPS

A group of individuals may be insured under a policy issued to a credit union or to a trustee or trustees or agent designated by 2 or more credit unions, which credit union, trustee, trustees or agent is considered the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees or agent or any of their officials, subject to the following requirements. [1981, c. 147, §7 (NEW).]

1. The members eligible for insurance are all of the members of the credit union or credit unions or all of any class or classes thereof.

[1981, c. 147, §7 (NEW) .]

2. The premium for the policy shall be paid either from funds of the credit union or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in subsection 3, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

[1981, c. 147, §7 (NEW) .]

3. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §5 (AMD) .]

SECTION HISTORY
1981, c. 147, §7 (NEW). 1989, c. 867, §§6,10 (AMD). 1999, c. 256, §G5 (AMD).

§2808. OTHER GROUPS

Group health insurance offered to a resident of this State under a group health insurance policy issued to a group other than one described in sections 2804 to 2807-A is subject to the following requirements. [1981, c. 147, §8 (RPR).]

1. No group health insurance policy may be delivered in this State, pursuant to this section, unless the superintendent finds that:

A. The policyholder is a bona fide group formed for purposes other than procurement of insurance; [1987, c. 476, §4 (AMD).]

B. The issuance of the group policy would be actuarially sound; [1981, c. 147, §8 (NEW).]

C. The issuance of the group policy would result in economies of acquisition or administration; and [1987, c. 476, §4 (AMD).]

D. The benefits are reasonable in relation to the premiums charged. [1981, c. 147, §8 (NEW).]

[1987, c. 476, §4 (AMD) .]

2. No group health insurance coverage may be offered in this State, pursuant to this section, by an insurer under a policy issued in another state, unless the superintendent has made a determination that the requirements of subsection 1, paragraphs A, B, C and D have been met.

[1987, c. 476, §5 (RPR) .]

2-A. Notwithstanding subsections 1 and 2, an employee leasing company registered pursuant to Title 32, chapter 125 qualifies as an eligible group for purposes of the purchase of group health insurance as provided in this section.

[1997, c. 393, Pt. A, §26 (AMD) .]

3. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

[1981, c. 147, §8 (NEW) .]

4. Except as provided in section 2736-C, section 2808-B and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

[1999, c. 256, Pt. G, §6 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 147, §8 (RPR). 1987, c. 476, §§4,5 (AMD). 1989, c. 867, §§7,10 (AMD). 1995, c. 618, §3 (AMD). 1997, c. 393, §A26 (AMD). 1999, c. 256, §G6 (AMD).

§2808-A. RATING PRACTICES IN GROUP HEALTH INSURANCE

(REPEALED)

SECTION HISTORY
1989, c. 422, §2 (NEW). 1991, c. 353, (AMD). 1991, c. 696, (AMD). 1991, c. 828, §24 (AMD). 1995, c. 332, §B1 (RP).

§2808-B. SMALL GROUP HEALTH PLANS

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

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue small group health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all small group health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations. [1991, c. 861, §2 (NEW).]

B. "Community rate" means the rate to be charged to all eligible groups for small group health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [1991, c. 861, §2 (NEW).]

C. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees employees who retire from the employer's employment. [1999, c. 256, Pt. P, §1 (AMD).]

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 50 or fewer eligible employees during the preceding calendar year.

(1) If an employer was not in existence throughout the preceding calendar year, the determination must be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(2) In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(3) A group is not an eligible group if there is any one other state where there are more eligible employees than are employed within this State and the group had coverage in that state or is eligible for guaranteed issuance of coverage in that state.

(4) An employer qualifies as an eligible group for 2-person coverage if the employer provides a carrier with the following information demonstrating that the employer's business and employees meet the minimum qualifications for group coverage in paragraph C:

(a) A copy of the most recent quarterly combined filing for income tax withholding and unemployment contributions, Form 941/C1-ME;

(b) For an employee claimed to be an employee eligible for group coverage whose name is not listed on Form 941/C1-ME, a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding;

(c) If an employer is exempt from filing Form 941/C1-ME for group coverage, documentation of that exemption and a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding; or

(d) If the name of the business owner or employee does not appear on Form 941/C1-ME, a copy of one of the following:

(i) Federal income tax Form Schedule C or Schedule F;

(ii) Federal income tax Form 1120S, Schedule K-1;

(iii) Federal income tax Form 1065, Schedule K-1;

(iv) A workers' compensation insurance audit or evidence of a waiver of benefits under Title 39-A;

(v) A description of operations in a commercial general liability insurance policy or equivalent insurance policy providing coverage for the business; or

(vi) A signature card from a financial institution or credit union authorizing the employee to sign checks on a business checking or share draft account that is at least 6 months old; a notarized affidavit from the employer describing the duties of the employee and the average number of hours worked by the employee and attesting that the employer is not defrauding the carrier and is aware of the consequences of committing fraud or making a material misrepresentation to the carrier, including a loss of coverage and benefits; and, if the group coverage is purchased through a producer, a notarized affidavit from the producer affirming the producer's belief that the employer qualifies as an eligible group for coverage.

In determining if a new business or a business that adds an owner or a new employee to payroll during the course of a year qualifies as an eligible group for 2-person coverage under this subparagraph, the employer must submit an affidavit stating that all employees meet the criteria in this subparagraph and that the documentation and forms required under this subparagraph will be provided to the carrier when payroll records become available, when ownership distribution forms become available or the first renewal date of the coverage, whichever date is earlier. A false affidavit or misrepresentation on an affidavit submitted by an employer may result in the loss of group coverage and repayment of claims paid. This subparagraph may not be construed to prohibit a carrier from recognizing an employer as an eligible group if the employer has not produced the documentation required in this subparagraph.

This subparagraph applies only to an employer applying for group health insurance coverage as a 2-person group from October 1, 2001 to December 31, 2013. [2011, c. 364, §9 (AMD).]

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A, B, C-1 or D. [1997, c. 777, Pt. B, §2 (AMD).]

F. "Premium rate" means the rate charged to an eligible group or eligible individual for a small group health plan. [1991, c. 861, §2 (NEW).]

G. "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an eligible group. "Small group health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance. [1991, c. 861, §2 (NEW).]

H. "Subgroup" means an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract. For group policies issued to an employee leasing company as defined in Title 32, chapter 125, each client having 50 or fewer employees is considered a separate subgroup. [2009, c. 244, Pt. F, §2 (AMD).]

[2011, c. 364, §9 (AMD) .]

2. **Rating practices.** The following requirements apply to the rating practices of carriers providing small group health plans. This subsection does not apply to policies issued before January 1, 1998 to eligible groups that employed, on average, 25 to 50 eligible employees until their first renewal date on or after January 1, 1998.

A. [2003, c. 469, Pt. E, §14 (RP).]

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group. [1993, c. 477, Pt. B, §1 (AMD); 1993, c. 477, Pt. F, §1 (AFF).]

C. A carrier may vary the premium rate due to occupation and industry, family membership and participation in wellness programs to the extent permitted by the federal Affordable Care Act. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for participation in wellness programs and rating for occupation and industry pursuant to this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 638, §1 (AMD).]

C-1. A carrier may vary the premium rate due to geographic area in accordance with the limitation set out in this paragraph. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the rating factor used by a carrier for geographic area may not exceed 1.5. [2011, c. 90, Pt. A, §7 (NEW).]

D. A carrier may vary the premium rate due to age, group size and tobacco use only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and September 30, 2011, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1. [2011, c. 638, §2 (AMD).]

D-1. [2011, c. 90, Pt. A, §9 (RP).]

D-2. Notwithstanding the requirements of paragraph D, rates with respect to employees whose work site is not in this State may be based on area adjustment factors appropriate to that location. [1997, c. 1, §22 (RAL).]

E. The superintendent may authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806, as long as association group membership or eligibility for participation in the trustee group is not conditional on health status, claims experience or other risk selection criteria and all small group health plans offered by the carrier through that association or trustee group:

(1) Are otherwise in compliance with the premium rate requirements of this subsection; and

(2) Are offered on a guaranteed issue basis to all eligible employers that are members of the association or are eligible to participate in the trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:

(a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;

(b) Has been actively in existence for 5 years;

(c) Has a constitution and bylaws or other analogous governing documents;

(d) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

(g) Has at least 1,000 members if it is a national association; 200 members if it is a state or local association;

(h) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and

(i) Is governed by a board of directors and sponsors annual meetings of its members.

Producers may only market association memberships, accept applications for membership or sign up members in the professional association where the individuals are actively engaged in or directly related to the profession represented by the professional association.

Except for employers with plans that have grandfathered status under the federal Affordable Care Act, this paragraph does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014. [2011, c. 1, §40 (COR).]

F. Premium rates charged to a private purchasing alliance, as defined by chapter 18-A, may be reduced in accordance with rules adopted pursuant to that chapter. [1995, c. 673, Pt. A, §6 (NEW).]

G. [2003, c. 469, Pt. E, §15 (RP).]

H. A carrier that offered small group health plans prior to October 1, 2011 may close its small group book of business sold prior to October 1, 2011 and may establish a separate community rate for eligible groups applying for coverage under a small group health plan on or after October 1, 2011. If a carrier closes its small group book of business as permitted under this paragraph, the carrier may vary the premium rate for that closed book of business only as permitted in this paragraph and paragraphs C and C-1.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1. [2011, c. 638, §3 (AMD).]

I. Except for plans that have grandfathered status under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all small group health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act. [2011, c. 364, §14 (NEW).]

[2011, c. 638, §§1-3 (AMD) .]

2-A. **Rate filings.** A carrier offering small group health plans shall file with the superintendent the community rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

A. Every filing must state the effective date of the filing. Every filing 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. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. [2009, c. 244, Pt. C, §7 (AMD).]

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, paragraph B or F. [2009, c. 439, Pt. D, §1 (AMD).]

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004, except that the filing of rates for small group health plans are not required to account for any payment or any recovery of that payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005. [2007, c. 629, Pt. M, §6 (AMD).]

[2009, c. 244, Pt. C, §7 (AMD); 2009, c. 439, Pt. D, §1 (AMD) .]

2-B. **Rate review and hearings.** Except as provided in subsection 2-C, rate filings are subject to this subsection.

A. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims. [2009, c. 244, Pt. G, §2 (AMD).]

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall

establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision. [2003, c. 469, Pt. E, §16 (NEW).]

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing. [2011, c. 364, §15 (AMD).]

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and former section 6913. [2007, c. 629, Pt. M, §8 (AMD).]

E. [2009, c. 244, Pt. C, §8 (RP).]

F. [2009, c. 244, Pt. C, §9 (RP).]

[2011, c. 364, §15 (AMD) .]

2-C. **Guaranteed loss ratio.** Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to subsection 2-B. [2011, c. 364, §16 (AMD).]

A-1. [2011, c. 364, §16 (RP).]

B. [2011, c. 364, §16 (RP).]

C. [2011, c. 364, §16 (RP).]

D. [2011, c. 364, §16 (RP).]

E. [2011, c. 364, §16 (RP).]

[2011, c. 90, Pt. D, §4 (AMD); 2011, c. 364, §16 (AMD) .]

3. **Coverage for late enrollees.** In providing coverage to late enrollees, small group health plan carriers are allowed to exclude or limit coverage for a late enrollee subject to the limitations set forth in section 2849-B, subsection 3.

[1999, c. 256, Pt. L, §1 (AMD) .]

4. **Guaranteed issuance and guaranteed renewal.** Carriers providing small group health plans must meet the following requirements on issuance and renewal.

A. Any small group health plan offered to any eligible group or subgroup must be offered to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. In determining compliance with minimum participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan. A carrier may deny coverage under a managed care plan, as defined by section 4301-A:

(1) To employers who have no employees who live, reside or work within the approved service area of the plan; and

(2) To employers if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this subparagraph may not enroll individuals residing within the area subject to denial of coverage, or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage. [2001, c. 1, §32 (COR).]

B. Renewal is guaranteed under section 2850-B. [1997, c. 445, §32 (AFF); 1997, c. 445, §17 (RPR).]

[2001, c. 1, §32 (COR) .]

5. **Cessation of business.**

[1997, c. 445, §32 (AFF); 1997, c. 445, §18 (RP) .]

6. **Fair marketing standards.** Carriers providing small group health plans must meet the following standards of fair marketing.

A. Each carrier must actively market small group health plan coverage, including any standardized plans required to be offered pursuant to subsection 8-A, to eligible groups in this State. [2009, c. 439, Pt. D, §2 (AMD).]

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing eligible groups to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; and

(2) Encouraging or directing eligible groups to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [1991, c. 861, §2 (NEW).]

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of a small group health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2. [1991, c. 861, §2 (NEW).]

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2. [1991, c. 861, §2 (NEW).]

E. A carrier or representative of the carrier may not induce or otherwise encourage an eligible group to separate or otherwise exclude an employee from small group health plan coverage or benefits. [1991, c. 861, §2 (NEW).]

F. Denial by a carrier of an application for coverage from an eligible group must be in writing and must state the reason or reasons for the denial. [1991, c. 861, §2 (NEW).]

G. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of small group health plans in this State. [1991, c. 861, §2 (NEW).]

H. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of small group health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [1991, c. 861, §2 (NEW).]

I. Notwithstanding any other provision of this section, prior to January 1, 2014, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage. [2011, c. 364, §17 (AMD).]

[2011, c. 364, §17 (AMD) .]

7. **Applicability.** This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary date of the policy, plan, contract or certificate.

[1995, c. 332, Pt. D, §4 (AMD) .]

8. **Standardized plans.**

[2001, c. 410, Pt. A, §7 (RP) .]

8-A. **Authority of the superintendent.** The superintendent may by rule define one or more standardized small group health plans that must be offered by all carriers offering small group health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 439, Pt. D, §3 (NEW) .]

9. **Reinsurance mechanism.** Small group carriers, except nonprofit hospital and medical service organizations, may form a reinsurance pool for the purpose of reinsuring small group risks. This pool may not become operative until the superintendent has approved a plan of operation. The superintendent may approve a plan only after the superintendent determines that the plan is in the public interest and is consistent with this section. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool. That guarantee constitutes a permanent financial obligation of each participant on a pro rata basis.

[1993, c. 325, §1 (NEW) .]

SECTION HISTORY
1991, c. 861, §2 (NEW). 1993, c. 325, §1 (AMD). 1993, c. 477, §§B1-3 (AMD). 1993, c. 477, §F1 (AFF). 1993, c. 546, §2 (AMD). 1993, c. 588, §§1,2 (AMD). 1993, c. 645, §A4 (AMD). 1995, c. 177, §2 (AMD). 1995, c. 332, §§D1-4,K2 (AMD). 1995, c. 673, §§A5,6 (AMD). RR 1997, c. 1, §22 (COR). 1997, c. 370, §E6 (AMD). 1997, c. 445, §§12-18 (AMD). 1997, c. 445, §32 (AFF). 1997, c. 777, §B2 (AMD). 1999, c. 256, §§E1,2,L1,P1 (AMD). RR 2001, c. 1, §32 (COR). 2001, c. 258, §§D1,E3,4 (AMD). 2001, c. 400, §1 (AMD). 2001, c. 400, §2 (AFF). 2001, c. 410, §§A3-7 (AMD). 2001, c. 410, §A10 (AFF). 2003, c. 313, §§1,2 (AMD). 2003, c. 428, §H5 (AMD). 2003, c. 469, §§E14-16 (AMD). 2005, c. 121, §§E1,2 (AMD). 2007,

c. 629, Pt. M, §§6-10 (AMD). 2009, c. 244, Pt. C, §§7-9 (AMD). 2009, c. 244, Pt. F, §2 (AMD). 2009, c. 244, Pt. G, §2 (AMD). 2009, c. 439, Pt. D, §§1-3 (AMD). RR 2011, c. 1, §40 (COR). 2011, c. 90, Pt. A, §§6-10 (AMD). 2011, c. 90, Pt. D, §4 (AMD). 2011, c. 364, §§9-17 (AMD). 2011, c. 638, §§1-3 (AMD).

§2809. COVERAGE OF FAMILY, DEPENDENTS; CONTINUATION OF COVERAGE

1. Any policy of group health insurance issued pursuant to sections 2804 (employee groups), 2805 (labor union groups), 2805-A (association groups), 2806 (trustee groups), 2807-A (credit union groups) or 2808 (other groups) may include coverage for members of the family or dependents of individuals otherwise insured in such groups.

[1981, c. 147, §9 (AMD) .]

1-A. Any such policy of group health insurance that provides coverage for family members or dependents of individuals in the insured group may not define the terms "family" or "dependent" to exclude from coverage those minor children of any covered individual who do not reside with that individual. Insurers must comply with 42 United States Code, Section 1396g-1.

[1995, c. 418, Pt. C, §3 (AMD) .]

2. Any group health insurance policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical or surgical services for members of the family or dependents of an individual in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of such individual.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 147, §9 (AMD). 1985, c. 652, §51 (AMD). 1995, c. 418, §C3 (AMD).

§2809-A. CONVERSION ON TERMINATION OF POLICY OR ELIGIBILITY

1. A group policy issued prior to January 1, 1996, that provides hospital, surgical or major medical expense insurance or any combination thereof, other than a policy that provides benefits for specific diseases or accidental injuries only, must contain a provision that if the insurance on an employee or member ceases because of termination of employment or termination of the policy or any portion of a policy, and the person has been continuously insured for a period of at least 3 months under the group policy or under the group policy and any prior group policy or contract providing similar benefits that it replaces, that person is entitled to have issued to that person by the insurer, without evidence of insurability, an individual policy or, at the insurer's option, a group certificate of health insurance, provided that application is made and the first premium paid to the insurer within 90 days after that termination. At the option of the employee or member, the converted policy may cover the employee or member, the employee or member and the employee or member's dependents or the dependents of the employee or member if, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependent persons were not eligible for coverage until after the beginning of the 3-month period. The insurer has the option to provide the required coverage upon conversion through either a group or individual policy, and may issue a separate converted policy to cover any dependent. An insurer is not required to provide a conversion privilege

if termination of insurance under the group policy occurred because the employee or member failed to pay any required contribution or if any discontinued group coverage is replaced by continuous and substantially similar group coverage within 31 days.

[1995, c. 332, Pt. A, §8 (AMD) .]

1-A. **Notification of cancellation.** An insurer may not cancel or refuse to renew any policy for hospital, surgical, dental or major medical expense insurance until the insurer has provided by first class mail at least 10 days' prior notification according to this section. The notice must include the date of cancellation of coverage and, if applicable, the time period for exercising policy conversion rights. The notice also must include an explanation of any applicable grace period. Notification is not required when the insurer has received written notice from the group policyholder that replacement coverage has been obtained.

A. Notice must be mailed to the group policyholder or subgroup sponsor. [1995, c. 625, Pt. A, §25 (RPR).]

B. [2003, c. 156, §2 (RP).]

B-1. At the time of notification under paragraph A, notice must be mailed to the certificate holder at the last address provided to the insurer by the subgroup sponsor, the group policyholder or the certificate holder. If the insurer does not have an address on file for the certificate holder, the notice must be mailed to the office of the subgroup sponsor, if any, or the group policy holder. The notice must also include information to the certificate holder about the availability of individual coverage as described in subsection 1-B. [2003, c. 428, Pt. B, §2 (AMD).]

B-2. All notices of cancellation sent to certificate holders pursuant to paragraph B-1 must include a toll-free telephone number that certificate holders can call to determine if the policy has been cancelled for nonpayment of premium or if the policy has been reinstated because the premium has been paid. [2009, c. 439, Pt. A, §1 (NEW).]

C. [2003, c. 428, Pt. B, §2 (RP).]

[2009, c. 439, Pt. A, §1 (AMD) .]

1-B. **Notification of availability of individual coverage.** An insurer shall provide forms to group policyholders, and certificate holders when required by subsection 1-A, for the purpose of informing terminating group members of their right to purchase any individual health plan available in this State. An adequate supply of forms must be provided to each group policyholder when the policy is issued and at least annually after the policy is issued. The superintendent may prescribe the content of the form by routine technical rule pursuant to Title 5, chapter 375, subchapter 2-A. The form must include at least the following:

A. A statement that all state residents not eligible for Medicare have a right to purchase any individual health plan available in this State; [1997, c. 604, Pt. B, §3 (NEW).]

B. A statement that in order to avoid a gap in coverage, the individual should apply for individual coverage prior to termination of group coverage; [1997, c. 604, Pt. B, §3 (NEW).]

C. A statement that if more than 90 days pass between the time the group coverage ends and the time individual coverage begins, the individual coverage may exclude preexisting conditions for one year; and [1997, c. 604, Pt. B, §3 (NEW).]

D. A statement that information concerning individual coverage is available from the Bureau of Insurance. The bureau's toll-free telephone number must also be provided. [1997, c. 604, Pt. B, §3 (NEW).]

[2007, c. 199, Pt. F, §1 (AMD) .]

2. If a conversion privilege is applicable pursuant to subsection 1, it must also be available:

A. Upon the death of an employee or member, to the surviving spouse with respect to the spouse and the children whose coverage terminates by reason of that death, or if there is no surviving spouse to each surviving child whose coverage so terminates. If the group policy provides for continuation of dependents' coverage upon the death of the employee or member, the conversion privilege must be made available at the end of that continuation; [1995, c. 332, Pt. A, §10 (AMD).]

B. To the spouse of a member or employee upon termination of coverage by reason of ceasing to be a qualified family member under the group policy whether by divorce or otherwise, whether or not the employee or member remains insured, with respect to the spouse and the children whose coverage terminates at the same time; [1981, c. 606, §2 (NEW).]

C. To a child upon termination of coverage by reason of ceasing to be a qualified family member under the group policy if a conversion privilege is not otherwise provided with respect to that child in this subsection; or [1995, c. 332, Pt. A, §10 (AMD).]

D. To an employee or member whose coverage would otherwise continue under the group policy upon retirement prior to eligibility for coverage under Medicare,"United States Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, at the option of that employee or member in lieu of continued coverage under the group policy. [1981, c. 606, §2 (NEW).]

[1995, c. 332, Pt. A, §10 (AMD) .]

3. The insurer shall not be required to issue a converted policy covering an otherwise eligible person:

A. If:

(1) That person is eligible for Medicare; or

(2) That person:

(a) Is covered for similar benefits by any other plan or program;

(b) Is eligible for similar benefits under any group coverage arrangement whether on an insured or uninsured basis; or

(c) Has similar benefits provided for or available to him pursuant to requirements of any state or federal law; and [1981, c. 606, §2 (NEW).]

B. The benefits as described in paragraph A, subparagraph 2, division (a) (b) or (c) provided for or available to the person together with the benefits provided by the converted policy would result in overinsurance according to standards which have been filed by the insurer prior to denial of coverage and approved by the superintendent. [1981, c. 606, §2 (NEW).]

[1981, c. 606, §2 (NEW) .]

3-A. **Policies issued or renewed on or after January 1, 1996.** An insurer that offers individual health plans pursuant to section 2736-C is permitted, but not required, to include a conversion privilege in group policies issued or renewed on or after January 1, 1996. If the insurer does include a conversion privilege in those policies, individuals exercising these rights must be offered a choice of any individual health plan offered by the insurer. An insurer that does not offer individual health plans pursuant to section 2736-C may not include a conversion privilege in group policies issued or renewed on or after January 1, 1996.

[1995, c. 332, Pt. A, §11 (NEW) .]

4. The premium on the converted policy must be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered and the type and amount of insurance provided. Experience under converted policies is not an acceptable basis for establishing rates for converted policies, except to the extent permitted by rules adopted by the superintendent.

The superintendent may establish maximum rates by rule for standard benefit options.

Maximum rates do not apply if all of the following conditions are met:

A. Conversion is provided through a form that is also issued to members of the general public applying for an individual health plan pursuant to section 2736-C; [1995, c. 332, Pt. A, §12 (AMD).]

B. The rates for that form comply with section 2736-C; and [1995, c. 332, Pt. A, §12 (AMD).]

C. The rates have been filed pursuant to section 2736. [1991, c. 668, §2 (NEW).]

[1995, c. 332, Pt. A, §12 (AMD) .]

5. The effective date of the converted policy shall be the date of termination of the individual's insurance under the group policy.

[1981, c. 606, §2 (NEW) .]

6. A converted policy issued under this section must conform to rules adopted by the superintendent. These rules must ensure that continuity of coverage with similar benefits as determined by the superintendent is offered. The rules must also specify plans with more limited benefits that must be offered, but may not require an insurer to provide benefits in excess of those provided under the group policy from which conversion is made.

[1991, c. 668, §2 (AMD) .]

7. **Notice.** Notice of the conversion privilege, if one is applicable, must be included in each certificate of coverage.

[1995, c. 332, Pt. A, §13 (AMD) .]

8. A converted policy issued pursuant to this section which is delivered outside this State may be on such form as the insurer may then be offering for that conversion in the jurisdiction where the delivery is to be made.

[1981, c. 606, §2 (NEW) .]

9. **Refusal to renew.** A policy issued pursuant to the conversion privilege provided by this section may provide that the insurer may refuse to renew the policy or coverage of any person insured only as permitted by section 2736-C.

A. [1995, c. 332, Pt. A, §13 (RP).]

B. [1995, c. 332, Pt. A, §13 (RP).]

[1995, c. 332, Pt. A, §13 (AMD) .]

10. **Additional conversion period for injured workers.**

[1995, c. 332, Pt. A, §14 (RP) .]

11. **Continued group coverage; certain circumstances.** Notwithstanding this section, if the termination of an individual's group insurance coverage is for one of the reasons listed in paragraph A-1, the insurer shall allow the member or employee to elect, within the time period prescribed by paragraph B, to continue coverage under the group policy at no higher level than the level of benefits or coverage received

by the employee immediately before termination and at the member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section.

A. For the purposes of this subsection, the term "member or employee" includes only those persons who have been a member or employee for at least 6 months. [1985, c. 684, §2 (NEW).]

A-1. A member or employee is eligible for continued coverage under this section only if the member or employee's group insurance coverage terminated for one of the following reasons:

(1) The member or employee was temporarily laid off;

(2) The member or employee was permanently laid off on or after the effective date of this paragraph and is eligible for premium assistance pursuant to federal law providing premium assistance for laid-off employees who continue coverage under their former employer's group health plan as determined by the superintendent; or

(3) The member or employee lost employment because of an injury or disease that the employee claims to be compensable under former Title 39 or Title 39-A. [2009, c. 574, §1 (NEW).]

B. [1989, c. 447, §2 (RP).]

B-1. The member or employee has 31 days from the termination of coverage in which to elect and make the initial payment under this subsection. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

C. An insurer is not required to continue coverage under a group policy if the member or employee meets the conditions set out in subsection 3, paragraph A. [1985, c. 684, §2 (NEW).]

D. The payment amount for continued group coverage under this subsection may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any. [1987, c. 25, §3 (AMD).]

E. At the option of the member or employee, the continued group coverage may cover the member or employee, the member or employee and any dependents or only the dependents of the member or employee; provided that, in the latter 2 cases, the dependents have been covered for a period of at least 3 months under the group policy, unless the dependents were not eligible for coverage until after the beginning of the 3-month period. [1989, c. 447, §2 (AMD).]

F. Except as provided in paragraph G, coverage provided under this section continues and may not be terminated until one year from the last day of work. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

G. Coverage provided under this section may be terminated sooner than provided under paragraph F if:

(1) The member or employee fails to make timely payment of a required premium amount;

(2) The member or employee becomes eligible for coverage under another group policy; or

(3) The Workers' Compensation Board determines that the injury or disease that entitles the employee to continue coverage under this section is not compensable under Title 39-A. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

H. At the expiration of any continued group coverage obtained under this subsection, the member or employee has the same conversion privileges as otherwise granted under this section. [1985, c. 684, §2 (NEW).]

I. This subsection may not be construed to:

(1) Prevent members or employees from negotiating for or receiving greater continued coverage of group insurance than is provided in this subsection;

(2) Require coverage beyond the time limit set in paragraph F; or

(3) Permit an employee to increase the level of benefits or coverage that the employee received immediately before the termination of the employee's coverage. [1991, c. 885, Pt. E, §30 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

J. This subsection does not apply to any group policy subject to the United States Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003. [1987, c. 25, §4 (NEW).]

[2009, c. 574, §1 (AMD) .]

12. This section applies to all policies issued in other states to the extent they cover employees whose primary workplace is in this State.

[1991, c. 668, §3 (NEW) .]

SECTION HISTORY
1981, c. 606, §2 (NEW). 1983, c. 91, §2 (AMD). 1985, c. 684, §2 (AMD). 1987, c. 25, §§3,4 (AMD). 1989, c. 447, §2 (AMD). 1991, c. 668, §§2,3 (AMD). 1991, c. 822, §§3,4 (AMD). 1991, c. 822, §6 (AFF). 1991, c. 885, §§E29,30 (AMD). 1991, c. 885, §E47 (AFF). 1995, c. 189, §2 (AMD). 1995, c. 189, §4 (AFF). 1995, c. 332, §§A8-14 (AMD). 1995, c. 625, §A25 (AMD). 1997, c. 604, §B3 (AMD). 2003, c. 156, §§2-4 (AMD). 2003, c. 428, §B2 (AMD). 2007, c. 199, Pt. F, §1 (AMD). 2009, c. 439, Pt. A, §1 (AMD). 2009, c. 574, §1 (AMD).

§2810. GROUP HEALTH INSURANCE PAYMENTS; BENEFICIARIES

The benefits payable under any policy or contract of group health insurance shall be payable to the employee or other insured member of the group or to some beneficiary or beneficiaries designated by him, other than the employer or the association or any officer thereof as such; but if there is no designated beneficiary as to all or any part of the insurance at the death of the employee or member, then the amount of insurance payable for which there is no designated beneficiary shall be payable to the estate of the employee or member, except that the insurer may in such case, at its option, pay such insurance to any one or more of the following surviving relatives of the employee or member: Wife, husband, mother, father, child or children, brothers or sisters; and except that payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in section 2811, may be made by the insurer to the hospital or other person or persons furnishing such aid. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2811. PAYMENT OF EXPENSES

Any policy or contract of group health insurance may include provisions for the payment by the insurer of benefits for expenses incurred, by the employee or other member of the insured group, on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other persons chiefly dependent upon him for support and maintenance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2812. READJUSTMENT OF PREMIUM RATE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §52 (AMD). 1991, c. 200, §D3 (RP).

§2812-A. DIVIDENDS AND EXPERIENCE REFUNDS

The following requirements apply to all group health insurance with the exception of insurance in which the policyholder is subject to the fiduciary standards of the federal Employee Retirement Income Security Act of 1974, ERISA, 29 United States Code, Section 1001-1381 (1975). [1991, c. 200, Pt. D, §4 (NEW).]

1. **Refunds.** The amount by which any dividend, experience refund or rate reduction exceeds the amount of premium contributed by the group policyholder for the same period must be refunded to the employees, members or debtors in proportion to their premium contributions for that period, except as provided in subsection 2.

[1991, c. 200, Pt. D, §4 (NEW) .]

2. **Refund amounts less than $25 per employee, member or debtor.** If the refunds required by subsection 1 would average less than $25 per employee, member or debtor, then the group policyholder may request approval from the superintendent to apply those amounts in a different manner. The superintendent shall approve the request if, in the superintendent's opinion, the manner of application proposed would be for the sole benefit of insured employees, members or debtors.

[1991, c. 200, Pt. D, §4 (NEW) .]

SECTION HISTORY
1991, c. 200, §D4 (NEW).

§2813. "BLANKET HEALTH INSURANCE" DEFINED

Blanket health insurance is hereby declared to be that form of health insurance covering groups of persons as enumerated in one of the following paragraphs: [1969, c. 132, §1 (NEW).]

1. Under a policy or contract issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation.

[1969, c. 132, §1 (NEW) .]

2. Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

[1969, c. 132, §1 (NEW) .]

3. Under a policy or contract issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers, or employees.

[1969, c. 132, §1 (NEW) .]

4. Under a policy or contract issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

[1969, c. 132, §1 (NEW) .]

5. Under a policy or contract issued to a sports team, camp or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials or supervisors.

[1969, c. 132, §1 (NEW) .]

6. Under a policy or contract issued to any volunteer fire department or first aid, emergency management or other such volunteer organization, which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by the policyholder.

[2013, c. 462, §3 (AMD) .]

7. Under a policy or contract issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

[1969, c. 132, §1 (NEW) .]

8. Under a policy or contract issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

[1969, c. 132, §1 (NEW) .]

9. Under a policy or contract issued to cover any other risk or class of risks which, in the discretion of the superintendent, may be properly eligible for blanket health insurance. The discretion of the superintendent may be exercised on an individual risk basis or class of risks, or both.

[1973, c. 585, §12 (AMD) .]

Policies that otherwise meet the description of group policies pursuant to section 2804, 2805, 2805-A, 2806, 2807, 2807-A or 2808-B are not blanket policies. [2011, c. 238, Pt. B, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2011, c. 238, Pt. B, §1 (AMD). 2013, c. 462, §3 (AMD).

§2814. BLANKET HEALTH INSURANCE -- PAYMENTS; BENEFICIARIES

All benefits under any blanket health insurance policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, as shall be specified in the policy, except that if the person insured be a minor, such benefits may be made payable to his parent, guardian or other person actually supporting him, or to a person or persons chiefly dependent upon him for support and maintenance. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2815. LEGAL LIABILITY OF POLICYHOLDERS

Nothing contained in this chapter shall be deemed to affect the legal liability of policyholders for the death of or injury to any member of any such group. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2816. REQUIREMENTS

No policy of group or blanket health insurance shall, except as provided in section 2829, be delivered or issued for delivery in this State, unless the policy contains in substance each and all of the provisions set forth in sections 2817 to 2828, or provisions which in the opinion of the superintendent are more favorable to the holders of such certificates or not less favorable to the holders of such certificates and more favorable to policyholders. Insurers offering policies under this chapter shall offer to certificate holders the right of review and arbitration set forth in section 2747, subsection 1, with respect to denials of medical expense reimbursement benefits based upon the grounds set forth in section 2747, subsection 2, except that the requirement of section 2747, subsection 1 shall not apply to certificate holders in groups subject to the United States Employee Retirement Income Security Act of 1974, Public Law 93-406, as amended, or to any policy or certificate holder to whom the insurer voluntarily extends a review similar to that which it provides to persons insured under group policies subject to that Act. [1981, c. 698, §110 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §53 (AMD). 1981, c. 205, §3 (AMD). 1981, c. 698, §110 (AMD).

§2817. APPLICANT'S STATEMENTS; WAIVERS, AMENDMENTS

There shall be a provision that no statement made by the applicant for insurance shall avoid the insurance or reduce benefits thereunder unless contained in the written application signed by the applicant; and a provision that no agent has authority to change the policy or to waive any of its provisions; and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by indorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2818. STATEMENTS IN APPLICATION

There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2819. NEW EMPLOYEES, MEMBERS

There shall be a provision that all new employees or new members, as the case may be, in the groups or classes eligible for such insurance must be added to such groups or classes for which they are respectively eligible. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2820. RENEWAL OF POLICY

There shall be a provision stating the conditions under which the insurer may decline to renew the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2821. INDIVIDUAL CERTIFICATES

Except in the case of blanket health insurance, a provision that the insurer shall issue to the policyholder, for delivery to each member of the insured group, an individual certificate or printed information setting forth in summary form a statement of the essential features of the insurance coverage of such employee or such member and in substance the provisions of sections 2821 to 2828. The insurer shall also provide for distribution by the policyholder to each member of the insured group a statement, where applicable, setting forth to whom the benefits under such policy are payable. If dependents are included in the coverage, only one certificate or printed summary need be issued for each family unit. [1975, c. 183, §2 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §54 (AMD). 1975, c. 183, §2 (AMD).

§2822. AGE LIMITS

There shall be a provision specifying the ages, if any there be, to which the insurance provided therein shall be limited; and the ages, if any there be, for which additional restrictions are placed on benefits and the additional restrictions placed on the benefits at such ages. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2823. NOTICE OF CLAIM

There shall be a provision that written notice of sickness or of injury must be given to the insurer within 30 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2823-A. EXPLANATION AND NOTICE TO PARENT

If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: [2009, c. 244, Pt. B, §2 (AMD).]

1. **Payment or denial of claim.** An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

[2009, c. 244, Pt. B, §2 (AMD) .]

2. **Change in terms and conditions.** An explanation of any proposed change in the terms and conditions of the policy; or

[1989, c. 556, Pt. D, §3 (NEW) .]

3. **Notice of lapse.** Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified.

[1989, c. 556, Pt. D, §3 (NEW) .]

In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy. [2009, c. 244, Pt. B, §2 (AMD).]

SECTION HISTORY
1989, c. 556, §D3 (NEW). 2009, c. 244, Pt. B, §2 (AMD).

§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. [2005, c. 97, §3 (AMD).]

SECTION HISTORY
1993, c. 477, §D11 (NEW). 1993, c. 477, §F1 (AFF). 2003, c. 218, §7 (AMD). 2003, c. 469, §D7 (AMD). 2003, c. 469, §D9 (AFF). 2005, c. 97, §3 (AMD).

§2824. PROOF OF LOSS

There shall be a provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 30 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2825. FORMS FOR PROOF OF LOSS

There shall be a provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer received notice of any claim under the policy, the person making such claim shall be deemed to

have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2826. EXAMINATION, AUTOPSY

There shall be a provision that the insurer shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2827. TIME FOR PAYMENT OF BENEFITS

There shall be a provision that all benefits payable under the policy, other than benefits for loss of time, will be payable not more than 60 days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2827-A. ASSIGNMENT OF BENEFITS

All policies and certificates providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy or certificate. [1999, c. 21, §3 (AMD).]

SECTION HISTORY
1997, c. 604, §E3 (NEW). 1999, c. 21, §3 (AMD).

§2828. TIME FOR SUITS

There shall be a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all, unless brought within 2 years from the expiration of the time within which proof of loss is required by the policy. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2829. EXCEPTIONS

1. Any portion of any such policy, delivered or issued for delivery in this State, which purports, by reason of the circumstances under which a loss is incurred, to reduce any benefits promised thereunder to an amount less than that provided for the same loss occurring under ordinary circumstances, shall be printed in

such policy and in each certificate issued thereunder, in bold face type and with greater prominence than any other portion of the rest of such policy or certificate, respectively; and all other exceptions of the policy shall be printed in the policy and certificate with the same prominence as the benefits to which they apply.

[1969, c. 132, §1 (NEW) .]

2. If any such policy contains any provision which affects the liability of the insurer because of any violation of law by the insured during the term of the policy, it shall be in the following form: The insurer shall not be liable for death, injury incurred or disease contracted, to which a contributing cause was the insured's commission of or attempt to commit a felony, or which occurs while the insured is engaged in an illegal occupation.

[1969, c. 132, §1 (NEW) .]

3. If any such policy contains any provision which affects the liability of the insurer because of the insured's use of intoxicating liquor or narcotics or hallucinogenic drugs during the term of the policy, it shall be in the following form: The insurer shall not be liable for death, injury incurred or disease contracted while the insured is intoxicated or under the influence of narcotics or hallucinogenic drugs unless administered on the advice of a physician.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2829-A. DISABILITY BENEFIT OFFSETS

1. **Disclosure to persons eligible for coverage.** For any policy or contract subject to this chapter that provides disability income benefits, if the benefits under that policy or contract are subject to reduction due to other sources of income, then the insurer shall include in any written enrollment material and certificate of coverage developed by the insurer that is intended to be distributed to persons eligible for coverage under the policy or contract a clear and conspicuous notice that accurately explains all types of other sources of income that may result in a reduction of the benefits payable under the policy or contract. The notice requirement under this section does not apply to an advertisement intended for the general public.

[2005, c. 42, §2 (NEW) .]

2. **Recovery of disability benefit overpayments.** For claims filed after January 1, 2006, an insurer that is entitled to reduce disability income benefit payments when the insured receives income from other sources and that is entitled to recover overpayments through offsets against current payments to the insured may not recover such overpayments at a rate greater than 20% of the net benefit per benefit payment period unless:

A. For policies applied for after September 13, 2003, the insurer has complied with the requirements of subsection 1; [2005, c. 42, §2 (NEW).]

B. The insurer effects the offset of benefits within 60 days of notice to the insurer, or such later date as the insurer begins paying benefits to the insured, that the insured is receiving or is entitled to receive income that may result in a reduction of benefits payable under the policy; [2005, c. 42, §2 (NEW).]

C. The overpayment did not result from the insurer's miscalculation of benefit reductions or the insurer's miscalculation of benefits payable under the policy; and [2005, c. 42, §2 (NEW).]

D. The insurer provided the insured with clear and conspicuous written notice that accurately explains to the insured all types of other sources of income that may result in a reduction of the benefits payable under the policy within 30 days of the date a claim for disability benefits was filed. [2005, c. 42, §2 (NEW).]

[2005, c. 42, §2 (NEW) .]

SECTION HISTORY
2003, c. 321, §2 (NEW). 2005, c. 42, §2 (RPR).

§2830. OMISSIONS, MODIFICATIONS: SUPERINTENDENT MAY APPROVE

The superintendent may approve any form of group or blanket health insurance policy, or any form of certificate or printed information to be issued under such policy, which omits or modifies any of the provisions hereinbefore required, if he deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§2831. HOSPITAL, MEDICAL BENEFITS -- DIRECT PAYMENT

Any such group or blanket policy may include benefits payable on account of hospital or medical or surgical aid for an employee or other member of the group insured by such policy, his or her spouse, child or children or other dependents, and may provide that, at the insured's option, any such benefits be paid by the insurer directly to the hospital, physician, surgeon doctor, nurse or other person furnishing services covered by such provisions of the policy. [1987, c. 219, (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 219, (AMD).

§2832. MATERNITY BENEFITS FOR UNMARRIED WOMEN CERTIFICATE HOLDERS AND THE MINOR DEPENDENTS OF CERTIFICATE HOLDERS WITH DEPENDENT OR FAMILY COVERAGE REQUIRED

All group or blanket health insurance policies, contracts and certificates shall provide the same maternity benefits for unmarried women certificate holders, and the minor dependents of certificate holders with dependent or family coverage, as is provided married certificate holders with maternity coverage and the wives of certificate holders with maternity coverage. This requirement applies to all group or blanket insurance written or renewed after the effective date of this Act, and includes, but is not limited to, all types and forms of group insurance issued by individual companies or corporations. [2003, c. 517, Pt. B, §11 (AMD).]

SECTION HISTORY
1975, c. 276, §3 (NEW). 1975, c. 428, §3 (NEW). 1975, c. 471, §2 (NEW). 1975, c. 562, (NEW). 1975, c. 770, §§105-107 (RP). 1979, c. 663, §146 (AMD). 2003, c. 517, §B11 (AMD).

§2832-A. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS

1. **Definition.** As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of a certificate holder who:

A. Is a mentally competent adult as is the certificate holder; [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the certificate holder for at least 12 months; [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the certificate holder and expects to remain so; and [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the certificate holder for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property. [2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF).]

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

2. **Mandated offer of domestic partner benefits.** All group or blanket health insurance policies or contracts issued by any insurer operating pursuant to this chapter must make available to group policyholders the option for additional benefits for the domestic partner of a certificate holder, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married certificate holders covered under a group policy.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

3. **Financial dependency.** Financial dependency of a domestic partner on the certificate holder may not be required as a condition for eligibility for coverage.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

4. **Evidence of domestic partnership.** As a condition of eligibility for coverage, an insurer or group policyholder may require a certificate holder and the certificate holder's domestic partner to sign an affidavit attesting that the certificate holder and the certificate holder's domestic partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

5. **Preexisting conditions.** A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of a certificate holder.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

6. **Termination of domestic partner benefits.** An insurer may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of a certificate holder upon notification by the certificate holder that the domestic partner relationship has terminated. A certificate holder may not enroll another individual as a domestic partner under a group contract until 12 months after the termination of coverage for a prior domestic partner.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

7. **Construction.** This section does not prohibit an insurer from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

8. **Exemption.** This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies.

[2001, c. 347, §3 (NEW); 2001, c. 347, §5 (AFF) .]

SECTION HISTORY
2001, c. 347, §3 (NEW). 2001, c. 347, §5 (AFF).

§2833. CHILD COVERAGE

1. **Definitions.** For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the certificate holder, member or spouse of the certificate holder or member. [1993, c. 666, Pt. A, §5 (NEW).]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [1993, c. 666, Pt. A, §5 (NEW).]

[1993, c. 666, Pt. A, §5 (RPR) .]

2. **Coverage.** All group or blanket health insurance plans issued in accordance with the requirements of section 2832 must provide unmarried women certificate holders with the option of coverage of their children from the date of birth. A certificate holder who, pursuant to the laws of this State or any other state, has been adjudicated or has acknowledged himself to be the father of an illegitimate child must be given the option of coverage for that child from the date of his adjudication or acknowledgement of paternity. This optional coverage must be the same as that provided the children of a married certificate holder with family or dependent coverage.

[1991, c. 200, Pt. B, §4 (NEW) .]

3. **Financial dependency.** Financial dependency of dependent children on the certificate holder or the spouse of the certificate holder may not be required as a condition for eligibility for coverage.

[1991, c. 200, Pt. B, §4 (NEW) .]

4. **Adopted children.** All group or blanket health insurance policies and certificates issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the certificate holder or spouse of the certificate holder under the same terms and conditions as apply to natural dependent children or stepchildren of the certificate holder, irrespective of whether the adoption has become final.

[1993, c. 666, Pt. A, §6 (NEW) .]

SECTION HISTORY
1975, c. 276, §3 (NEW). 1979, c. 663, §147 (AMD). 1985, c. 652, §52 (AMD). 1991, c. 200, §B4 (RPR). 1993, c. 666, §§A5,6 (AMD).

§2833-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN

Notwithstanding section 2822, a group health insurance policy that provides coverage for a dependent child at certain ages only if the child is a student must continue that coverage if the child is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury. This

coverage may be terminated at the age at which coverage for students terminates under the terms of the policy. An insurer may require, as a condition of eligibility for continued coverage in accordance with this section, that the student provide written documentation from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury. [2005, c. 532, §2 (NEW).]

SECTION HISTORY
2005, c. 532, §2 (NEW).

§2833-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE

1. **Dependent child; definition.** As used in this section, "dependent child" means the child of a person covered under a group health insurance policy when that child:

A. Is unmarried; [2007, c. 115, §2 (NEW); 2007, c. 115, §5 (AFF).]

B. Has no dependent of the child's own; and [2007, c. 514, §6 (AMD).]

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education. [2007, c. 514, §7 (AMD).]

D. [2007, c. 514, §8 (RP).]

[2007, c. 514, §§6-8 (AMD) .]

2. **Offer of coverage.** Notwithstanding section 2822, a group health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child is 25 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

[2007, c. 514, §9 (AMD) .]

3. **Notice.**

[2007, c. 514, §10 (NEW); T. 24-A, §2833-B, sub-§3 (RP) .]

SECTION HISTORY
2007, c. 115, §2 (NEW). 2007, c. 115, §5 (AFF). 2007, c. 514, §§6-10 (AMD).

§2834. NEWBORN CHILDREN COVERAGE

All group and blanket health insurance policies and certificates providing coverage on an expense-incurred basis must provide that health insurance benefits are payable for a newly born child of the insured or subscriber from the moment of birth. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. Preexisting conditions of an adopted child may not be excluded from coverage. [2003, c. 517, Pt. A, §5 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

The coverage for newly born children must consist of coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [1997, c. 604, Pt. C, §3 (AMD).]

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 2834-A must be paid regardless of whether coverage under this section is elected. [1997, c. 604, Pt. C, §3 (AMD).]

The requirements of this section apply to all policies and certificates delivered or issued for delivery in this State. [2003, c. 517, Pt. A, §6 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY
1975, c. 770, §108 (NEW). 1993, c. 686, §12 (AMD). 1993, c. 686, §13 (AFF). 1995, c. 332, §N3 (AMD). 1997, c. 604, §C3 (AMD). 2003, c. 517, §§A5,6 (AMD). 2003, c. 517, §A13 (AFF).

§2834-A. MATERNITY AND ROUTINE NEWBORN CARE

An insurer that issues group contracts and certificates providing maternity benefits, including benefits for childbirth, shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. [2003, c. 517, Pt. B, §12 (AMD).]

SECTION HISTORY
1995, c. 615, §3 (NEW). 2001, c. 258, §A3 (AMD). 2003, c. 517, §B12 (AMD).

§2834-B. DEPENDENT SPECIAL ENROLLMENT PERIOD

1. **Application.** This section applies to all group and blanket medical insurance policies issued by nonprofit hospital or medical service organizations, insurers or health maintenance organizations except hospital indemnity, specified accident, specified disease and long-term care policies.

[1997, c. 445, §19 (NEW); 1997, c. 445, §32 (AFF) .]

2. **Definition.** For purposes of this section, an "eligible individual" is a person who is a certificate holder under the policy or who has met any waiting period applicable to becoming a certificate holder and is eligible to be enrolled under the policy but for a failure to enroll during a previous enrollment period.

[1997, c. 445, §19 (NEW); 1997, c. 445, §32 (AFF) .]

3. **Requirement.** If a policy makes coverage available with respect to dependents of certificate holders, the policy must provide for a dependent special enrollment period when a person becomes a dependent of an eligible individual through marriage, birth or adoption or placement for adoption, if a court order is issued changing custody of a child or if a dependent who has other coverage loses eligibility under that coverage. During this period, the dependent may be enrolled under the plan as a dependent of the eligible individual

and, in the case of the birth or adoption of a child, the spouse of the eligible individual may be enrolled as a dependent if otherwise eligible for coverage. If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

[2007, c. 199, Pt. A, §1 (AMD) .]

4. **Length of period.** A dependent special enrollment period under this section must be a period of not less than 30 days and must begin on the latest of:

A. The date dependent coverage is made available; [2007, c. 199, Pt. A, §2 (AMD).]

B. The date of the marriage, birth or adoption or placement for adoption or the date of the court order; and [2007, c. 199, Pt. A, §2 (AMD).]

C. The date a dependent loses other coverage. [2007, c. 199, Pt. A, §2 (NEW).]

[2007, c. 199, Pt. A, §2 (AMD) .]

5. **No waiting period.** If an individual seeks to enroll a dependent during the first 30 days of a dependent special enrollment period, the coverage of the dependent becomes effective:

A. In the case of marriage, no later than the first day of the first month beginning after the date the completed request for enrollment is received; [1997, c. 445, §19 (NEW); 1997, c. 445, §32 (AFF).]

B. In the case of a dependent's birth, as of the date of the birth; [1999, c. 256, Pt. B, §3 (AMD).]

C. In the case of a dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption; [2007, c. 199, Pt. A, §3 (AMD).]

D. In the case of a court order changing custody of a child, as of the date of the order; or [2007, c. 199, Pt. A, §3 (AMD).]

E. In the case of a dependent who loses other coverage, as of the date of application for enrollment. [2007, c. 199, Pt. A, §3 (NEW).]

[2007, c. 199, Pt. A, §3 (AMD) .]

SECTION HISTORY
1997, c. 445, §19 (NEW). 1997, c. 445, §32 (AFF). 1999, c. 256, §§B1-4 (AMD). 2007, c. 199, Pt. A, §§1-3 (AMD).

§2834-C. COMPLIANCE WITH FEDERAL LAW

1. **Application.** This section applies to all group and blanket medical insurance policies issued by nonprofit hospital or medical service organizations, insurers or health maintenance organizations except hospital indemnity, accidental injury, specified disease and long-term care policies.

[2009, c. 244, Pt. E, §1 (NEW) .]

2. **Requirement.** Policies subject to this section must comply with the federal Children's Health Insurance Program Reauthorization Act of 2009, Section 311 concerning special enrollment periods in case of termination of coverage under a Medicaid plan or a state child health plan or eligibility for assistance in the purchase of employment-based coverage.

[2009, c. 244, Pt. E, §1 (NEW) .]

SECTION HISTORY

2009, c. 244, Pt. E, §1 (NEW).

§2835. MENTAL HEALTH SERVICES

1. Notwithstanding any provision of a health insurance policy or certificate issued under a group policy subject to this chapter, whenever the policy provides for payment or reimbursement for services that are within the lawful scope of practice of a professional listed in subsection 2-A, any person covered by the policy is entitled to reimbursement for these services if the services are performed by a physician or a professional listed in subsection 2-A. Payment or reimbursement for services rendered by a professional listed in subsection 2-A, paragraph B, C, D, E or F may not be conditioned upon prior diagnosis or referral by a physician or other health care professional, except when diagnosis of the condition for which the services are rendered is beyond the scope of their licensure.

[2005, c. 683, Pt. A, §40 (RPR) .]

2. Nothing in subsection 1 may be construed to require a health insurance policy subject to this chapter to provide for reimbursement of services that are within the lawful scope of practice of a professional listed in subsection 2-A.

[2005, c. 683, Pt. A, §40 (RPR) .]

2-A. Subsections 1 and 2 apply with respect to the following types of professionals:

A. A psychologist licensed to practice in this State; [2005, c. 683, Pt. A, §40 (RPR).]

B. A certified social worker licensed for the independent practice of social work in this State; [2005, c. 683, Pt. A, §40 (RPR).]

C. A licensed clinical professional counselor licensed for the independent practice of counseling in this State; [2005, c. 683, Pt. A, §40 (RPR).]

D. A licensed nurse who is certified by the American Nurses' Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing; [2005, c. 683, Pt. A, §40 (RPR).]

E. A marriage and family therapist licensed as a marriage and family therapist in this State; and [2005, c. 683, Pt. A, §40 (NEW).]

F. A licensed pastoral counselor licensed as a pastoral counselor in this State. [2005, c. 683, Pt. A, §40 (NEW).]

[2005, c. 683, Pt. A, §40 (RPR) .]

3. **Mental health services provided by counseling professionals.** Except as provided in subsection 1 with regard to reimbursement of clinical professional counselors, pastoral counselors and marriage and family therapists licensed in this State, an insurer that issues group health care contracts providing coverage for mental health services shall make available coverage for those services when performed by a counseling professional who is licensed by the State pursuant to Title 32, chapter 119 to assess and treat interpersonal and intrapersonal problems, has at least a master's degree in counseling or a related field from an accredited educational institution and has been employed as a counselor for at least 2 years. Any contract providing coverage for the services of counseling professionals pursuant to this section may be subject to any reasonable limitations, maximum benefits, coinsurance, deductibles or exclusion provisions applicable to overall benefits

under the contract. This subsection applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this subsection, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

[2005, c. 683, Pt. A, §40 (RPR) .]

SECTION HISTORY
1975, c. 770, §108 (NEW). 1979, c. 541, §A165 (AMD). 1983, c. 546, §3 (AMD). 1983, c. 805, §3 (AMD). 1987, c. 80, §3 (AMD). 1995, c. 561, §3 (AMD). 2003, c. 65, §2 (AMD). 2003, c. 65, §5 (AFF). 2003, c. 517, §B13 (AMD). 2005, c. 121, §§I3-5 (AMD). 2005, c. 213, §2 (AMD). 2005, c. 213, §3 (AFF). 2005, c. 214, §2 (AMD). 2005, c. 214, §3 (AFF). 2005, c. 683, §A40 (RPR).

§2836. LIMITS ON PRIORITY LIENS

No group or blanket policy shall provide for priority over the insured member of payment for any hospital, nursing, medical or surgical services, or of any expenses paid or reimbursed under the policy, in the event the insured member is entitled to receive payment reimbursement from any other person as a result of legal action or claim, except as provided in this section. [1975, c. 770, §108 (NEW).]

A policy may contain a provision that allows such payments, if that provision is approved by the superintendent, and if that provision requires the prior written approval of the insured member and allows such payments only on a just and equitable basis, and not on the basis of a priority lien. A just and equitable basis shall mean that any factors that diminish the potential value of the insured member's claim shall likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors shall include, but are not limited to: [1975, c. 770, §108 (NEW).]

1. **Legal defenses.** Questions of liability and comparative negligence or other legal defenses;

[1975, c. 770, §108 (NEW) .]

2. **Exigencies of trial.** Exigencies of trial that reduce a settlement or award in order to resolve the claim; and

[1975, c. 770, §108 (NEW) .]

3. **Limits of coverage.** Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured member.

[1975, c. 770, §108 (NEW) .]

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, the dispute shall be determined if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute. [1975, c. 770, §108 (NEW).]

SECTION HISTORY
1975, c. 770, §108 (NEW).

§2837. HOME HEALTH CARE COVERAGE

Every insurer which issues or issues for delivery in this State group or blanket health insurance policies or plans, which provide coverage on an expense incurred basis for inpatient hospital care, shall make available that coverage for home health care services by a home health care provider. [1977, c. 696, §202 (RPR).]

The policy providing coverage for home health care services may contain reasonable limitation on the number of home care visits and other services provided, but the number of such visits shall not be less than 90 in any continuous period of 12 months for each person covered under the policy. Each visit by an individual member of a home health care provider shall be considered as one home care visit. [1977, c. 470, §3 (NEW).]

1. **Home health care services.** "Home health care services" means those health care services rendered in his place of residence on a part-time basis to a covered person only if:

A. Hospitalization or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, 42 U.S.C. § 1395, et seq., would otherwise have been required if home health care was not provided; and [1977, c. 470, §3 (NEW).]

B. The plan covering the home health services is established as prescribed in writing by a physician. [1977, c. 470, §3 (NEW).]

There shall be no requirement that hospitalization be an antecedent to coverage under the policy.

[1977, c. 470, §3 (NEW) .]

2. **Home health care included.** "Home health care services" shall include:

A. Visits by a registered nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated; [1977, c. 470, §3 (NEW).]

B. A physician's home or office visits or both; [1977, c. 470, §3 (NEW).]

C. Visits by a registered physical, speech, occupational, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending physician, or both; [1977, c. 470, §3 (NEW).]

D. Any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a physician, but only to the extent that such charges would have been covered under the contract if the covered person had remained in the hospital; and [1977, c. 470, §3 (NEW).]

E. Visits by persons who have completed a home health aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services. [1977, c. 470, §3 (NEW).]

[1977, c. 470, §3 (NEW) .]

3. **Home health care provider.** "Home health care provider" means a home health care agency which is certified under Title XVIII of the Social Security Act of 1965, as amended, which:

A. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services; [1977, c. 470, §3 (NEW).]

B. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse; [1977, c. 470, §3 (NEW).]

C. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day; [1977, c. 470, §3 (NEW).]

D. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician; [1977, c. 470, §3 (NEW).]

E. Has under contract the services of a physician-advisor licensed by the State or a physician; [1977, c. 470, §3 (NEW).]

F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and [1977, c. 470, §3 (NEW).]

G. Maintains a complete medical record on each patient. [1977, c. 470, §3 (NEW).]

[1977, c. 470, §3 (NEW) .]

4. **Exclusions.**

A. No policy shall require home health care coverage to persons eligible for medicare; and [1977, c. 470, §3 (NEW).]

B. No payment shall be made for services provided by a person who resides in the covered person's residence or who is a member of the covered person's family. [1977, c. 470, §3 (NEW).]

[1977, c. 470, §3 (NEW) .]

SECTION HISTORY
1977, c. 470, §3 (NEW). 1977, c. 696, §202 (AMD).

§2837-A. SCREENING MAMMOGRAMS

1. **Definition.** For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

[2007, c. 153, §2 (AMD); 2007, c. 153, §5 (AFF) .]

2. **Required coverage.** All group insurance policies that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

A. [1997, c. 408, §8 (AFF); 1997, c. 408, §5 (RP).]

B. [1997, c. 408, §8 (AFF); 1997, c. 408, §5 (RP).]

[1997, c. 408, §8 (AFF); 1997, c. 408, §5 (RPR); 2003, c. 689, Pt. B, §6 (REV) .]

3. **Application.** This section applies to all policies, contracts and certificates that cover radiologic procedures, except those policies that cover only dental procedures, accidental injury or specific diseases, executed, delivered, issued for delivery, continued or renewed in this State on or after March 1, 1991. For purposes of this section, all policies and contracts are deemed to be renewed no later than the next yearly anniversary of the policy or contract date.

[1991, c. 156, §2 (AMD) .]

4. **Reports.** Each insurer that issues policies subject to this section shall report to the superintendent its experience for each calendar year beginning with 1991 not later than April 30th of the following calendar year. The report must include the information required and be presented in the form prescribed by the

superintendent. The report must include the amount of claims paid in this State for services required by this section. The superintendent shall compile this data in an annual report and submit the report to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters.

[1991, c. 701, §9 (AMD) .]

SECTION HISTORY
1989, c. 875, §I6 (NEW). 1991, c. 156, §2 (AMD). 1991, c. 701, §9 (AMD). 1997, c. 408, §5 (AMD). 1997, c. 408, §8 (AFF). 2003, c. 689, §B6 (REV). 2007, c. 153, §2 (AMD). 2007, c. 153, §5 (AFF).

§2837-B. ACUPUNCTURE SERVICES

All group insurance policies and certificates providing coverage for acupuncture must provide coverage for those services when performed by an acupuncturist licensed pursuant to Title 32, chapter 113-B, subchapter 2, under the same conditions that apply to the services of a licensed physician. [2003, c. 517, Pt. B, §14 (AMD).]

SECTION HISTORY
1991, c. 647, §3 (NEW). 1995, c. 671, §10 (AMD). 2003, c. 517, §B14 (AMD).

§2837-C. COVERAGE FOR BREAST CANCER TREATMENT

1. **Inpatient care.** All group health policies providing coverage for medical and surgical benefits, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, a group health policy may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All group health policies must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

[1997, c. 408, §6 (NEW); 1997, c. 408, §8 (AFF) .]

2. **Reconstruction.** All group health policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

[1997, c. 408, §6 (NEW); 1997, c. 408, §8 (AFF) .]

3. **Application.** The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §15 (NEW) .]

SECTION HISTORY
RR 1995, c. 1, §17 (COR). 1995, c. 295, §4 (NEW). 1995, c. 369, §3 (NEW). 1997, c. 408, §8 (AFF). 1997, c. 408, §6 (RPR). 2003, c. 517, §B15 (AMD).

§2837-D. MEDICAL FOOD COVERAGE FOR INBORN ERROR OF METABOLISM

1. **Inborn error of metabolism; special modified low-protein food product.** As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

[1995, c. 369, §3 (NEW) .]

2. **Required coverage.** All group insurance policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts, must provide coverage for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. The policies and contracts must reimburse:

A. For metabolic formula; and [1995, c. 369, §3 (NEW).]

B. Up to $3,000 per year for special modified low-protein food products. [1995, c. 369, §3 (NEW).]

[1995, c. 369, §3 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1995, c. 369, §3 (NEW) .]

SECTION HISTORY
RR 1995, c. 1, §17 (RNU). 1995, c. 369, §3 (NEW).

§2837-E. COVERAGE FOR PAP TESTS

All group health insurance policies, contracts and certificates must provide coverage for screening Pap tests recommended by a physician. [2003, c. 517, Pt. A, §7 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY
1995, c. 617, §3 (NEW). 1995, c. 617, §6 (AFF). 2003, c. 517, §A7 (AMD). 2003, c. 517, §A13 (AFF).

§2837-F. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER

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

A. "Medically accepted indication" includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is supported by one or more citations in the standard reference compendia or if the insurer involved, based upon guidance provided by the federal Department of Health and Human Services Medicare program pursuant to 42 United States Code, Section 1395x(t), determines that that use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. [1997, c. 701, §3 (NEW).]

B. "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §3 (NEW).]

C. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §3 (NEW).]

D. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (NEW) .]

2. **Required coverage for off-label use.** All group insurance policies and contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Group insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage of any such drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that use of that drug is a medically accepted indication for the treatment of cancer. [1997, c. 701, §3 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §3 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §3 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §3 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

§2837-F. Coverage for prostate cancer screening

(As enacted by PL 1997, c. 754, §3 is REALLOCATED TO TITLE 24-A, SECTION 2837-H)

[1997, c. 701, §3 (NEW) .]

SECTION HISTORY
RR 1997, c. 2, §52 (RAL). 1997, c. 701, §3 (NEW). 1997, c. 754, §3 (NEW).

§2837-G. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR HIV OR AIDS

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

A. "Off-label use" means the prescription and use of drugs for indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §3 (NEW).]

B. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §3 (NEW).]

C. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (NEW) .]

2. **Required coverage for off-label use.** All group insurance policies and contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Group insurance policies and contracts that provide coverage for prescription drugs may not exclude coverage of any such drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature. [1997, c. 701, §3 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §3 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §3 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §3 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §3 (NEW).]

[1997, c. 701, §3 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 701, §3 (NEW) .]

SECTION HISTORY
1997, c. 701, §3 (NEW).

§2837-H. COVERAGE FOR PROSTATE CANCER SCREENING

(REALLOCATED FROM TITLE 24-A, SECTION 2837-F)

1. **Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:

A. A digital rectal examination; and [1997, c. 2, §52 (RAL).]

B. A prostate-specific antigen test. [1997, c. 2, §52 (RAL).]

[1997, c. 2, §52 (RAL) .]

2. **Required coverage for prostate cancer screening.** All group insurance policies and contracts except accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care and other limited benefit health insurance policies and contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.

[1997, c. 2, §52 (RAL) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 2, §52 (RAL) .]

SECTION HISTORY
RR 1997, c. 2, §52 (RAL).

§2838. COMMUNITY HEALTH SERVICE COVERAGE

(REPEALED)

SECTION HISTORY
1979, c. 419, §2 (NEW). 1979, c. 558, §10 (NEW). 1979, c. 663, §148 (AMD). 1979, c. 663, §149 (RAL). 1983, c. 515, §5 (RP).

§2839. RATES FILED

A policy of group or blanket health insurance may not be delivered in this State until a copy of the rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care insurance contracts and for certain association groups and other groups specified in section 2701, subsection 2, paragraph C must be filed in accordance with section 2736. Rates for small group health insurance subject to section 2808-B are subject to the additional filing requirements specified in that section. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 238, Pt. C, §1 (AMD).]

SECTION HISTORY
1979, c. 558, §10 (NEW). 1979, c. 663, §149 (RAL). 1985, c. 648, §11 (AMD). 2003, c. 428, §E2 (AMD). 2009, c. 14, §5 (AMD). 2011, c. 238, Pt. C, §1 (AMD).

§2839-A. NOTICE OF RATE INCREASE

1. **Notice of rate increase on existing policies.** An insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by mail or electronically of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 60 days before the effective date of any increase in premium rates. An increase in premium rates may not be implemented until 60 days after the notice is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

[2011, c. 90, Pt. F, §2 (AMD) .]

1-A. **Notice of rate increase on existing policies renewed in calendar year 2006.**

[2005, c. 400, Pt. A, §2 (NEW); T. 24-A, §2839-A, sub-§1-A (RP) .]

2. **Notice of rate increase on new business.** When an insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, quotes a rate for new business, it must disclose any rate increase that the insurer anticipates implementing within the following 90 days. If the quote is in writing, the disclosure must also be in writing. If such disclosure is not provided, an increase may not be implemented until at least 90 days after the date the quote is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

[2005, c. 121, Pt. F, §1 (AMD) .]

3. **Notice of rate increase on new business for calendar year 2006.**

[2005, c. 400, Pt. A, §2 (NEW); T. 24-A, §2839-A, sub-§3 (RP) .]

SECTION HISTORY
2001, c. 432, §7 (NEW). 2005, c. 121, §F1 (AMD). 2005, c. 400, §A2 (AMD). 2011, c. 90, Pt. F, §2 (AMD).

§2839-B. LARGE GROUP RATES

1. **Application.** This section applies to group health insurance offered in the large group market as defined in section 2850-B, except insurance covering only accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

[2003, c. 469, Pt. E, §17 (NEW) .]

2. **Annual filing.** Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. The filing must also certify that the carrier has included in its experience any savings offset payments or recovery of those savings offset payments consistent with former section 6913. The filing also must state the number of policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

[2007, c. 629, Pt. M, §11 (AMD) .]

3. **Documentation.** Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrates that its rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board.

[2003, c. 469, Pt. E, §17 (NEW) .]

SECTION HISTORY
2003, c. 469, §E17 (NEW). 2007, c. 629, Pt. M, §11 (AMD).

§2840. OPTIONAL COVERAGE FOR CHIROPRACTIC SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 2746)
(REPEALED)

SECTION HISTORY
1979, c. 663, §145 (RAL). 1981, c. 282, §2 (AMD). 1985, c. 516, §4 (RP).

§2840-A. COVERAGE FOR CHIROPRACTIC SERVICES

1. **Therapeutic, adjustive and manipulative services.** Notwithstanding any other provisions of this chapter, every insurer which issues group or blanket health care contracts providing coverage for the services of a "physician" or "doctor" to residents of this State shall provide coverage to any subscriber or other person covered under those contracts for those services when performed by a chiropractor, to the extent that the services are within the lawful scope of practice of a chiropractor licensed to practice in this State. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

[1985, c. 516, §5 (NEW) .]

2. **Limits; coinsurance; deductibles.** Any contract which provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1985, c. 516, §5 (NEW) .]

3. **Reports to the Superintendent of Insurance.** Every insurer subject to this section shall report its experience for each calendar year to the Superintendent of Insurance not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for health care contracts. The report must include complaints concerning access to services under this section and the results of those complaints. The superintendent shall compile this data for all insurers in an annual report.

[1993, c. 669, §3 (AMD) .]

4. **Application; expiration.**

[1989, c. 141, §6 (RP) .]

SECTION HISTORY
1985, c. 516, §5 (NEW). 1989, c. 141, §§5,6 (AMD). 1993, c. 669, §3 (AMD).

§2841. OPTIONAL COVERAGE FOR OPTOMETRIC SERVICES

1. **Coverage required to be made available.** Every insurer which issues for delivery in this State group health policies which provide coverage on an expense-incurred basis for the services of a "physician" or "doctor" to residents of this State shall make available to all groups coverage for such services when performed by an optometrist, to the extent the services are within the scope of the practice of an optometrist licensed to practice in this State.

[1981, c. 254, §2 (NEW) .]

2. **Policy.** The group or blanket policy making available coverage for the services referred to in this section shall contain provisions for maximum benefits and coinsurance, and reasonable limitations, deductibles and exclusions.

[1981, c. 254, §2 (NEW) .]

SECTION HISTORY
1981, c. 254, §§2,3 (NEW).

§2842. EQUITABLE HEALTH CARE FOR ALCOHOLISM AND DRUG DEPENDENCY TREATMENT

1. **Purpose.** The Legislature recognizes that alcoholism and drug dependency constitute major health problems in the State and in the Nation. The Legislature further recognizes that alcoholism is a disease and that alcoholism and drug dependency can be effectively treated. As such, alcoholism and drug dependency warrant the same attention from the health care industry as other serious diseases and illnesses. The Legislature further recognizes that health insurance contracts, at times, fail to provide adequate benefits for the treatment of alcoholism and drug dependency, which results in more costly health care for treatment of complications caused by the lack of early intervention and other treatment services for persons suffering from these illnesses. This situation causes a higher health care, social, law enforcement and economic cost

to the citizens of this State than is necessary, including the need for the State to provide treatment to some insureds at public expense. To assist the many citizens of this State who suffer from these illnesses in a more cost effective way, the Legislature declares that certain health insurance coverage providing benefits for the treatment of the illness of alcoholism and drug dependency shall be included in all group health insurance contracts.

[1983, c. 527, §2 (RPR) .]

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

A. "Outpatient care" means care rendered by a state-licensed, approved or certified detoxification, residential treatment or outpatient program, or partial hospitalization program on a periodic basis, including, but not limited to, patient diagnosis, assessment and treatment, individual, family and group counseling and educational and support services. [1983, c. 527, §2 (NEW).]

B. "Residential treatment" means services at a facility that provides care 24 hours daily to one or more patients, including, but not limited to, the following services: Room and board; medical, nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services, including a designated unit of a licensed health care facility providing any and all other services specified in this paragraph to patients with the illnesses of alcoholism and drug dependency. [1983, c. 527, §2 (NEW).]

C. "Treatment plan" means a written plan initiated at the time of admission, approved by a Doctor of Medicine, Doctor of Osteopathy or a Registered Substance Abuse Counselor employed by a certified or licensed substance abuse program, including, but not limited to, the patient's medical, drug and alcoholism history; record of physical examination; diagnosis; assessment of physical capabilities; mental capacity; orders for medication, diet and special needs for the patient's health or safety and treatment, including medical, psychiatric, psychological, social services, individual, family and group counseling; and educational, support and referral services. [1983, c. 527, §2 (NEW).]

[1983, c. 527, §2 (RPR) .]

3. **Requirement.** Every insurer which issues group health care contracts providing coverage for hospital care to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for the treatment of alcoholism and other drug dependency pursuant to a treatment plan.

[1983, c. 527, §2 (NEW) .]

4. **Services; providers.** Each group contract shall provide, at a minimum, for the following coverage, pursuant to a treatment plan:

A. Residential treatment at a hospital or free-standing residential treatment center which is licensed, certified or approved by the State; and [1983, c. 527, §2 (NEW).]

B. Outpatient care rendered by state licensed, certified or approved providers. [1983, c. 527, §2 (NEW).]

Treatment or confinement at any facility shall not preclude further or additional treatment at any other eligible facility, provided that the benefit days used do not exceed the total number of benefit days provided for under the contract.

[1983, c. 527, §2 (NEW) .]

5. **Exceptions.** This section shall not apply to employee group insurance policies issued to employers with 20 or fewer employees insured under the group policy or to group policies designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as described in Title 10 of the United States Code, Title 10, Section 1072, subsection 4.

[1989, c. 490, §3 (AMD) .]

6. **Limits; coinsurance; deductibles.** Any policy or contract which provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance, and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1983, c. 527, §2 (NEW) .]

7. **Notice.** At the time of delivery or renewal, the group health insurer shall provide written notification to all individuals eligible for benefits under group policies or contracts of these alcoholism and drug dependency benefits.

[1983, c. 527, §2 (NEW) .]

8. **Confidentiality.** Alcoholism and drug treatment patient records are confidential.

[2011, c. 320, Pt. A, §10 (AMD) .]

9. **Reports to the Superintendent of Insurance.** Every insurer subject to this section shall report its experience for each calendar year beginning with 1984 to the superintendent not later than April 30th of the following year. The report shall be in a form prescribed by the superintendent and shall include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[1983, c. 527, §2 (NEW) .]

10. **Application; expiration.** The requirements of this section shall apply to all policies and any certificates or contracts executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1984. For purposes of this section, all contracts shall be deemed to be renewed no later than the next yearly anniversary of the contract date.

[1987, c. 480, §5 (RPR) .]

SECTION HISTORY
1981, c. 319, §§2,3 (NEW). 1983, c. 527, §2 (RPR). 1987, c. 480, §5 (AMD). 1989, c. 490, §3 (AMD). 2011, c. 320, Pt. A, §10 (AMD).

§2843. MENTAL HEALTH SERVICES COVERAGE

1. **Findings.** The Legislature finds that:

A. Mental illness affects nearly 170,000 Maine people each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families; [1983, c. 515, §6 (NEW).]

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by Maine businesses in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs; [1983, c. 515, §6 (NEW).]

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and [1983, c. 515, §6 (NEW).]

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment. [1983, c. 515, §6 (NEW).]

[1983, c. 515, §6 (NEW) .]

2. **Policy and purpose.** The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness, including mental and emotional disorders, which are of significant consequence to the health of Maine people and which can be treated in a cost effective manner; [1983, c. 515, §6 (NEW).]

B. Assure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in least restrictive settings; [1983, c. 515, §6 (NEW).]

C. Assure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and [1983, c. 515, §6 (NEW).]

D. Assure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits shall be provided. [1983, c. 515, §6 (NEW).]

[1983, c. 515, §6 (NEW) .]

3. **Definitions.** For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours per day. [1983, c. 515, §6 (NEW).]

A-1. "Diagnostic and statistical manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association. [2003, c. 20, Pt. VV, §10 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;

(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and

(3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §10 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Health and Human Services or accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting. [1983, c. 515, §6 (NEW); 2003, c. 689, Pt. B, §6 (REV).]

B-1. "Medically necessary health care" has the same meaning as in section 4301-A, subsection 10-A. [2003, c. 20, Pt. VV, §11 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups. [1983, c. 515, §6 (NEW).]

D. "Person suffering from a mental illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the areas of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion or physical well-being. [2003, c. 20, Pt. VV, §12 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

E. "Provider" means individuals included in section 2835, and a licensed physician with 3 years approved residency in psychiatry, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Health and Human Services. All agency or institutional providers named in this paragraph shall assure that services are supervised by a psychiatrist or licensed psychologist. [1995, c. 560, Pt. K, §82 (AMD); 1995, c. 560, Pt. K, §83 (AFF); 2001, c. 354, §3 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 20, Pt. VV, §§10-12 (AMD); 2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

4. **Requirement.** Every insurer that issues group health care contracts providing coverage to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

[2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5. **Services.** Each group contract must provide for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness:

A. Inpatient care; [1983, c. 515, §6 (NEW).]

B. Day treatment services; [2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

C. Outpatient services; and [2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

D. Home health care services. [2003, c. 20, Pt. VV, §13 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §13 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5-A. **Exceptions.** This section shall not apply to employee group insurance policies issued to employers with 20 or fewer employees insured under the group policy or to group policies designed primarily to supplement the Civilian Health and Medical Program of the Uniformed Services, as described in the United States Code, Title 10, Section 1072, subsection 4.

[1989, c. 490, §4 (AMD) .]

5-B. **Coverage for certain mental illness treatment.**

[1991, c. 881, §3 (NEW); 1991, c. 881, §7 (AFF); 1991, c. 881, §8 (RP).]

5-C. **Coverage for treatment for certain mental illness.** Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A. [2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 20, Pt. VV, §14 (RP).]

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;

(2) Dissociative disorders;

(3) Mood disorders;

(4) Anxiety disorders;

(5) Personality disorders;

(6) Paraphilias;

(7) Attention deficit and disruptive behavior disorders;

(8) Pervasive developmental disorders;

(9) Tic disorders;

(10) Eating disorders, including bulimia and anorexia; and

(11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §14 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must provide benefits that meet the requirements of this paragraph.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage provided for treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits. [2003, c. 20, Pt. VV, §14 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

[2003, c. 20, Pt. VV, §14 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5-D. **Mandated offer of coverage for certain mental illnesses.** Except as otherwise provided in subsection 5-C, coverage for medical treatment for mental illnesses listed in paragraph A by all group contracts is subject to this subsection.

A. All group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder. [2003, c. 20, Pt. VV, §15 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must make available coverage providing benefits that meet the requirements of this paragraph.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract. [2003, c. 20, Pt. VV, §15 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §15 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

6. **Limits; coinsurance; deductibles.** Any policy or contract which provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1983, c. 515, §6 (NEW) .]

7. **Reports to the Superintendent of Insurance.** Every insurer subject to this section shall report its experience for each calendar year to the superintendent not later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

[1995, c. 407, §8 (AMD) .]

8. **Application.** This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies. Except as otherwise provided in this section, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §16 (AMD) .]

SECTION HISTORY
1983, c. 515, §6 (NEW). 1983, c. 816, §B7 (AMD). 1987, c. 480, §6 (AMD). 1989, c. 490, §4 (AMD). 1991, c. 881, §§3,4 (AMD). 1991, c. 881, §§7,8 (AFF). 1993, c. 441, §§3,4 (AMD). 1993, c. 586, §§3,4 (AMD). 1995, c. 19, §2 (AMD). 1995, c. 332, §G2 (AMD). 1995, c. 407, §§6-9 (AMD). 1995, c. 560, §K82 (AMD). 1995, c. 560, §K83 (AFF). 1995, c. 625, §B8 (AMD). 1995, c. 625, §B9 (AFF). 1995, c. 637, §§4,5 (AMD). 2001, c. 354, §3 (AMD). 2003, c. 20, §§VV10-15 (AMD). 2003, c. 20, §VV25 (AFF). 2003, c. 517, §B16 (AMD). 2003, c. 689, §B6 (REV).

§2844. COORDINATION OF BENEFITS

1. **Authorization.** Provisions contained in group and blanket health insurance contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to rules adopted by the superintendent. These rules may establish uniformity in the permissive use of coordination of benefits provisions in order to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital, medical service and health care plans.

[1995, c. 332, Pt. H, §1 (AMD) .]

1-A. **Coordination with Medicare.** Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

(1) The insured is enrolled in Medicare Part A;

(2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or

(4) The insured is eligible for Medicare Part A without paying a premium and the certificate states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage. [1997, c. 604, Pt. G, §2 (NEW).]

B. The contract may not coordinate benefits with Medicare Part B unless:

(1) The insured is enrolled in Medicare Part B;

(2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;

(3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or

(4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the certificate was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B. [1997, c. 604, Pt. G, §2 (NEW).]

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B. [1997, c. 604, Pt. G, §2 (NEW).]

[1997, c. 604, Pt. G, §2 (NEW) .]

2. **Medicaid and Cub Care programs.** Insurers may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3174-T, referred to as the "Cub Care program," when considering coverage eligibility or benefit calculations for insureds and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program or the Cub Care program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the insured or family member to payment by the insurer for those health care items or services. Upon presentation of proof that the Medicaid program or the Cub Care program has paid for covered items or services, the insurer shall make payment to the Medicaid program or the Cub Care program according to the coverage provided in the contract or certificate. [1997, c. 777, Pt. B, §3 (AMD).]

B. An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Cub Care coverage and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual. [1997, c. 777, Pt. B, §3 (AMD).]

[2005, c. 683, Pt. A, §41 (AMD) .]

3. **Credit toward deductible.** When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

[2005, c. 121, Pt. D, §3 (NEW) .]

SECTION HISTORY
1985, c. 526, §2 (NEW). RR 1993, c. 2, §47 (COR). 1993, c. 666, §B2 (RPR). 1995, c. 332, §H1 (AMD). 1997, c. 604, §G2 (AMD). 1997, c. 777, §B3 (AMD). 2005, c. 121, §D3 (AMD). 2005, c. 683, §A41 (AMD).

§2845. CARDIAC REHABILITATION COVERAGE

1. **Requirement.** Every insurer which issues group health care contracts providing coverage for hospital care to residents of this State shall make available to groups of 20 or more persons, at the option of the policyholder, benefits as required by this section to any certificate holder or other person covered under those contracts for the expense of cardiac rehabilitation.

[1987, c. 293, §2 (NEW) .]

2. **Cardiac rehabilitation.** "Cardiac rehabilitation" means multidisciplinary, medically necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a hospital or other setting. That treatment shall include outpatient treatment which is initiated within 26 weeks after the diagnosis of that disease and physician-recommended continuance of Phase II rehabilitation services for up to 36 sessions in a hospital or community-based setting and up to 36 Phase III sessions in a community-based setting.

[1987, c. 293, §2 (NEW) .]

3. **Limitations.** Benefits required to be made available pursuant to this section may be made subject to any reasonable limitation, maximum benefit, coinsurance, deductible or exclusion provisions applicable to overall benefits under the policy or certificate.

[1987, c. 293, §2 (NEW) .]

4. **Application.** The requirements of this section shall apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1988. For purposes of this section only, all group policies shall be deemed to be renewed no later than the next yearly anniversary of the contract date.

[1987, c. 293, §2 (NEW) .]

SECTION HISTORY
1987, c. 293, §2 (NEW).

§2846. ACQUIRED IMMUNE DEFICIENCY SYNDROME

A group health insurance policy or certificate delivered or issued for delivery in this State may not provide more restrictive benefits for sickness or disablement or the related expenses resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases than for any other sickness or disabling condition or exclude benefits for AIDS, ARC or HIV related diseases except through an exclusion under which all sicknesses and diseases are treated the same. This section does not apply to a policy providing benefits for specific diseases or accidental injury only. [2003, c. 517, Pt. B, §17 (AMD).]

SECTION HISTORY
1989, c. 176, §6 (NEW). 2003, c. 517, §B17 (AMD).

§2847. UTILIZATION REVIEW DATA

1. **Report required.** On or before April 1st of each year, any insurer or 3rd-party administrator which issues or administers a program or contract in this State providing coverage for hospital care that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening eligibility program or any similar preutilization review or screening procedure prior to

the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed. For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service; [1989, c. 556, Pt. C, §3 (NEW).]

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the insurer; [1989, c. 556, Pt. C, §3 (NEW).]

C. The number and result of any appeals by the patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [1989, c. 556, Pt. C, §3 (NEW).]

D. Any complaints filed in a court of competent jurisdiction and served upon an insurer filing under this section stating a cause of action against that insurer on the basis of damages to patients alleged to have been approximately caused by a delay, reduction or denial of medical benefits by the insurer, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint. [1989, c. 556, Pt. C, §3 (NEW).]

[1989, c. 556, Pt. C, §3 (NEW) .]

2. **Residents.** This section is applicable to evaluations, appeals and complaints relating to residents of this State only.

[1989, c. 556, Pt. C, §3 (NEW) .]

3. **Confidentiality.** Any information provided pursuant to this section shall not identify the patients.

[1989, c. 556, Pt. C, §3 (NEW) .]

SECTION HISTORY
1989, c. 556, §C3 (NEW).

§2847-A. PENALTY FOR FAILURE TO NOTIFY OF HOSPITALIZATION

An insurance policy may not include a provision permitting the insurer to impose a penalty for the failure of any person to notify the insurer of an insured person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22, section 1829. [1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW).]

This section applies to policies and certificates executed, delivered, issued for delivery, continued or renewed in this State after the effective date of this section. For purposes of this section, all policies are deemed to be renewed no later than the next yearly anniversary of the contract date. [1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW).]

SECTION HISTORY
1991, c. 695, §5 (NEW). 1991, c. 824, §A51 (NEW).

§2847-B. JURY SERVICE

1. **Prohibition.** An insurer that issues group or blanket health care contracts providing coverage for medical care to residents of this State may not terminate coverage for any person covered under those contracts because the person has been summonsed for or is engaged in jury service under Title 14, chapter 305, subchapter I-A.

[1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW) .]

2. **Application.** This section applies to all policies and any certificate executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1991. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW) .]

SECTION HISTORY
1991, c. 695, §5 (NEW). 1991, c. 824, §A51 (NEW).

§2847-C. NOTIFICATION PRIOR TO CANCELLATION; RESTRICTIONS ON CANCELLATION, TERMINATION OR LAPSE DUE TO COGNITIVE IMPAIRMENT OR FUNCTIONAL INCAPACITY

An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance certificate for nonpayment of premium. [2011, c. 123, §3 (AMD); 2011, c. 123, §5 (AFF).]

Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity. An insurer may require a medical demonstration that the policyholder suffered from cognitive impairment or functional incapacity at the time of cancellation. If the medical demonstration is waived or substantiates the existence of a cognitive impairment or functional incapacity at the time of policy cancellation to the satisfaction of the insurer, the policy must be reinstated. The medical demonstration may be at the expense of the policyholder. [2011, c. 123, §3 (NEW); 2011, c. 123, §5 (AFF).]

A policy reinstated pursuant to this section must cover any loss or claim occurring from the date of the cancellation. Within 15 days after request from an insurer, a policyholder of a policy reinstated pursuant to this section shall pay any unpaid premium from the date of the last premium payment at the rate that would have been in effect had the policy remained in force. If the premium is not paid as required, the policy may not be reinstated and the insurer is not responsible for claims incurred after the initial date of cancellation. If an insurer denies a request for reinstatement, the insurer shall notify the policyholder that the policyholder may request a hearing before the superintendent. [2011, c. 123, §3 (NEW); 2011, c. 123, §5 (AFF).]

The superintendent may adopt rules to implement the requirements of this section. The rules may include, but are not limited to, definitions, minimum disclosure requirements, notice provisions and the right of reinstatement. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 123, §3 (AMD); 2011, c. 123, §5 (AFF).]

The requirements of this section apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State. [1991, c. 695, §5 (NEW); 1991, c. 824, Pt. A, §51 (NEW).]

SECTION HISTORY

1991, c. 695, §5 (NEW). 1991, c. 824, §A51 (NEW). 2011, c. 123, §3 (AMD). 2011, c. 123, §5 (AFF).

§2847-D. PENALTY FOR NONCOMPLIANCE WITH UTILIZATION REVIEW PROGRAMS

A policy or certificate issued or renewed after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary. [1995, c. 332, Pt. M, §9 (AMD).]

SECTION HISTORY
1993, c. 645, §B5 (NEW). 1995, c. 332, §M9 (AMD).

§2847-E. COVERAGE FOR DIABETES SUPPLIES

All group insurance policies, contracts and certificates must provide coverage for the medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: [2003, c. 517, Pt. A, §8 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

1. **Certification of medical necessity.** The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and

[1995, c. 592, §3 (NEW) .]

2. **Provision of medical services.** The diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

[1995, c. 592, §3 (NEW) .]

The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. [2003, c. 517, Pt. A, §8 (NEW); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY
1995, c. 592, §3 (NEW). 2003, c. 517, §A8 (AMD). 2003, c. 517, §A13 (AFF).

§2847-F. GYNECOLOGICAL AND OBSTETRICAL SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 2850-A)

1. **Coverage in managed care plans.** With respect to managed care plans that require group members to select primary care physicians, an insurer that issues group health insurance policies, contracts and certificates must meet the following requirements.

A. The insurer must permit a physician who specializes in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the insurer's credentialling policy. [1997, c. 370, Pt. H, §1 (RAL).]

B. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. [1997, c. 370, Pt. H, §1 (RAL).]

C. If the examination specified in paragraph B reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner or certified nurse midwife to secure from the patient's primary care physician a referral to the participating physician, certified nurse practitioner or certified nurse midwife from whom such care may be obtained. [1997, c. 370, Pt. H, §1 (RAL).]

[2003, c. 517, Pt. A, §9 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

2. **Application.** This section applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. A, §9 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

This section does not prohibit a carrier from requiring a physician, certified nurse practitioner or certified nurse midwife participating in the plan to inform a woman's primary care physician prior to each treatment pursuant to this section. [1997, c. 370, Pt. H, §1 (RAL).]

SECTION HISTORY
1997, c. 370, §H1 (RAL). 2003, c. 517, §A9 (AMD). 2003, c. 517, §A13 (AFF).

§2847-G. COVERAGE FOR CONTRACEPTIVES

1. **Coverage requirements.** All group insurance policies and contracts, except accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care and other limited benefit health insurance policies and contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services. For purposes of this section, the term "outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy.

[1999, c. 341, §3 (NEW); 1999, c. 341, §5 (AFF) .]

2. **Exclusion for religious employer.** A religious employer may request and an insurer shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective insureds and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing an insurer to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association

of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121 (w) (3) (A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c) (3).

[1999, c. 341, §3 (NEW); 1999, c. 341, §5 (AFF) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

§2847-G. Coverage for services of certified nurse practitioners; certified nurse midwives

(As enacted by PL 1999, c. 396, §3 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 2847-H)

§2847-G. Coverage for services provided by registered nurse first assistants

(As enacted by PL 1999, c. 412, §3 is REALLOCATED TO TITLE 24-A, SECTION 2847-I)

[2003, c. 517, Pt. B, §18 (NEW) .]

SECTION HISTORY
RR 1999, c. 1, §§34,35 (RAL). 1999, c. 341, §3 (NEW). 1999, c. 341, §5 (AFF). 1999, c. 396, §3 (NEW). 1999, c. 396, §7 (AFF). 1999, c. 412, §3 (NEW). 2003, c. 517, §B18 (AMD).

§2847-H. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES

(REALLOCATED FROM TITLE 24-A, SECTION 2847-G)

1. **Required coverage for services upon referral of primary care provider.** An insurer that issues group health insurance policies and contracts shall provide coverage under those contracts for services performed by a certified nurse practitioner or certified nurse midwife to a patient who is referred to the certified nurse practitioner or certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the certified nurse practitioner or certified nurse midwife.

[1999, c. 1, §34 (RAL) .]

2. **Required coverage for self-referred services.** With respect to group health insurance policies and contracts that do not require the selection of a primary care provider, an insurer shall provide coverage under those contracts for services performed by a certified nurse practitioner or certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the certified nurse practitioner or certified nurse midwife.

[1999, c. 1, §34 (RAL) .]

3. **Limits; coinsurance; deductibles.** Any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 1, §34 (RAL) .]

4. **Application.** The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §19 (NEW) .]

SECTION HISTORY
RR 1999, c. 1, §34 (RAL). 2003, c. 517, §B19 (AMD).

§2847-I. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS

(REALLOCATED FROM TITLE 24-A, SECTION 2847-G)

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

A. "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and postoperative nursing care to surgical patients. [1999, c. 1, §35 (RAL).]

B. "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistants as established by the Association of Operating Room Nurses or its successor organization. [1999, c. 1, §35 (RAL).]

C. "Registered nurse first assistant," or "RNFA," means a person who:

(1) Is licensed as a registered nurse under Title 32, chapter 31;

(2) Is experienced in perioperative nursing; and

(3) Has successfully completed a recognized program. [1999, c. 1, §35 (RAL).]

[1999, c. 1, §35 (RAL) .]

2. **Institutional powers.** Each health care institution, as defined in Title 22, chapter 405, may establish specific procedures for the appointment and reappointment of registered nurse first assistants and for granting, renewing and revising their clinical privileges.

[1999, c. 1, §35 (RAL) .]

3. **Required coverage for services.** Notwithstanding any other provisions of this chapter, an insurer that issues group health insurance policies and contracts that provide coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed those services is used as a substitute. This section does not apply to policies or contracts that cover only specified diseases.

[1999, c. 1, §35 (RAL) .]

4. **Limits; coinsurance; deductibles.** Any contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 1, §35 (RAL) .]

5. **Application.** The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §20 (NEW) .]

SECTION HISTORY
RR 1999, c. 1, §35 (RAL). 2003, c. 517, §B20 (AMD).

§2847-J. COVERAGE FOR HOSPICE CARE SERVICES

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

A. "Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to a person who is terminally ill and that person's family. "Hospice care services" includes, but is not limited to, physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services. [2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF).]

B. "Person who is terminally ill" means a person that has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course. [2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF).]

[2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF) .]

2. **Coverage for hospice care services.** All group insurance policies and contracts must provide coverage for hospice care services to a person who is terminally ill. Hospice care services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Coverage for hospice care services must be provided whether the services are provided in a home setting or an inpatient setting.

[2001, c. 358, Pt. LL, §3 (NEW); 2001, c. 358, Pt. LL, §5 (AFF) .]

3. **Application.** The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

§2847-J. Coverage for general anesthesia for dentistry

(As enacted by PL 2001, c. 423, §3 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 2847-K)

[2003, c. 517, Pt. B, §21 (NEW) .]

SECTION HISTORY
RR 2001, c. 1, §33 (RAL). 2001, c. 358, §LL3 (NEW). 2001, c. 358, §LL5 (AFF). 2001, c. 423, §3 (NEW). 2001, c. 423, §5 (AFF). 2003, c. 517, §B21 (AMD).

§2847-K. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY

(REALLOCATED FROM TITLE 24-A, SECTION 2847-J)

1. **Enrollee defined.** For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under a group health insurance contract provided by an insurer.

[2001, c. 1, §33 (RAL) .]

2. **General anesthesia and associated facility charges.** An insurer that issues group health insurance contracts shall provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

[2001, c. 1, §33 (RAL) .]

3. **Limitations on coverage.** This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; [2001, c. 1, §33 (RAL).]

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [2001, c. 1, §33 (RAL).]

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and [2001, c. 1, §33 (RAL).]

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [2001, c. 1, §33 (RAL).]

[2001, c. 1, §33 (RAL) .]

4. **Dental procedures and dentist's fee not covered.** This section does not require an insurer that issues group contracts to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the group contract that apply generally to other benefits.

[2001, c. 1, §33 (RAL) .]

5. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the insurer providing group health insurance is the secondary payer.

[2001, c. 1, §33 (RAL) .]

6. **Application.** The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §22 (NEW) .]

SECTION HISTORY

RR 2001, c. 1, §33 (RAL). 2003, c. 517, §B22 (AMD).

§2847-L. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY

All group health insurance policies, contracts and certificates must make available coverage for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary health care as defined in section 4301-A, subsection 10-A. [2005, c. 128, §3 (NEW); 2005, c. 128, §5 (AFF).]

SECTION HISTORY
2005, c. 128, §3 (NEW). 2005, c. 128, §5 (AFF).

§2847-M. ENROLLMENT FOR INDIVIDUALS OR FAMILIES ESTABLISHING ELIGIBILITY FOR MAINECARE

When an individual or family is eligible for MaineCare and is also eligible for health insurance coverage provided by an employer, the insurer must permit the individual or family to enroll in the health insurance coverage without regard to any enrollment season restrictions. [2007, c. 448, §11 (NEW).]

§2847-M. Coverage for hearing aids

(As enacted by PL 2007, c. 452, §3 is REALLOCATED TO TITLE 24-A, SECTION 2847-O)

SECTION HISTORY
2007, c. 448, §11 (NEW). 2007, c. 452, §3 (NEW). 2007, c. 695, Pt. A, §29 (RAL).

§2847-N. COVERAGE FOR COLORECTAL CANCER SCREENING

1. **Colorectal cancer screening.** For the purposes of this section, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

[2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

2. **Required coverage.** All group health insurance policies, contracts and certificates must provide coverage for colorectal cancer screening for asymptomatic individuals who are:

A. Fifty years of age or older; or [2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF).]

B. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. [2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF).]

[2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

3. **Billing.** If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure.

§2847-N. Coverage for medically necessary infant formula

(As enacted by PL 2007, c. 595, §3 is REALLOCATED TO TITLE 24-A, SECTION 2847-P)

[2007, c. 516, §3 (NEW); 2007, c. 516, §5 (AFF) .]

SECTION HISTORY
2007, c. 516, §3 (NEW). 2007, c. 516, §5 (AFF). 2007, c. 595, §3 (NEW). 2007, c. 595, §5 (AFF). 2007, c. 595, (RAL). 2007, c. 695, Pt. C, §15 (RAL).

§2847-O. COVERAGE FOR HEARING AIDS

(REALLOCATED FROM TITLE 24-A, SECTION 2847-M)

1. **Hearing aid; definition.** For purposes of this section, "hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

[2007, c. 695, Pt. A, §29 (RAL) .]

2. **Required coverage.** In accordance with the application of coverage set forth in subsection 3, all group health insurance policies, contracts and certificates must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate who is 18 years of age or under in accordance with the following requirements.

A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77. [2007, c. 695, Pt. A, §29 (RAL).]

B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A. [2007, c. 695, Pt. A, §29 (RAL).]

C. The policy, contract or certificate may limit coverage to $1,400 per hearing aid for each hearing-impaired ear every 36 months. [2007, c. 695, Pt. A, §29 (RAL).]

[2007, c. 695, Pt. A, §29 (RAL) .]

3. **Application of coverage.** The requirements of subsection 2 apply to an individual:

A. From birth to 5 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2008; [2007, c. 695, Pt. A, §29 (RAL).]

B. From 6 to 13 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2009; and [2007, c. 695, Pt. A, §29 (RAL).]

C. From 14 to 18 years of age, who is covered under a policy, contract or certificate that is issued or renewed on or after January 1, 2010. [2007, c. 695, Pt. A, §29 (RAL).]

[2007, c. 695, Pt. A, §29 (RAL) .]

4. **Limits; coinsurance; deductibles.** Except as otherwise provided in this section, any policy, contract or certificate that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2007, c. 695, Pt. A, §29 (RAL) .]

SECTION HISTORY
2007, c. 695, Pt. A, §29 (RAL).

§2847-P. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA

(REALLOCATED FROM TITLE 24-A, SECTION 2847-N)

All group health insurance policies, contracts and certificates must provide coverage for amino acid-based elemental infant formula for children 2 years of age and under in accordance with this section. [2007, c. 695, Pt. C, §15 (RAL).]

1. **Determination of medical necessity.** Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A, subsection 10-A, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing medical necessity at least annually.

[2007, c. 695, Pt. C, §15 (RAL) .]

2. **Method of delivery.** Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

[2007, c. 695, Pt. C, §15 (RAL) .]

3. **Required diagnosis.** Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis; [2007, c. 695, Pt. C, §15 (RAL).]

B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; [2007, c. 695, Pt. C, §15 (RAL).]

C. A history of anaphylaxis; [2007, c. 695, Pt. C, §15 (RAL).]

D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; [2007, c. 695, Pt. C, §15 (RAL).]

E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; [2007, c. 695, Pt. C, §15 (RAL).]

F. Cystic fibrosis; or [2007, c. 695, Pt. C, §15 (RAL).]

G. Malabsorption of cow milk-based or soy milk-based infant formula. [2007, c. 695, Pt. C, §15 (RAL).]

[2007, c. 695, Pt. C, §15 (RAL) .]

SECTION HISTORY
2007, c. 695, Pt. C, §15 (RAL).

§2847-Q. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST

1. **Services provided by independent practice dental hygienist.** An insurer that issues group dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by an independent practice dental hygienist licensed under Title 32, chapter 16, subchapter 3-B when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.

[2009, c. 307, §3 (NEW); 2009, c. 307, §6 (AFF) .]

2. **Limits; coinsurance; deductibles.** A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2009, c. 307, §3 (NEW); 2009, c. 307, §6 (AFF) .]

3. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing group health insurance is the secondary payer.

[2009, c. 307, §3 (NEW); 2009, c. 307, §6 (AFF) .]

4. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2009, c. 307, §3 (NEW); 2009, c. 307, §6 (AFF) .]

SECTION HISTORY
2009, c. 307, §3 (NEW). 2009, c. 307, §6 (AFF).

§2847-R. ENROLLMENT OF DEPENDENT CHILDREN IN DENTAL COVERAGE

1. **Offer of dependent coverage; enrollment period.** All group dental insurance policies, contracts and certificates that offer dependent coverage must offer the opportunity to enroll a dependent child in the dental insurance coverage at appropriate rates during the following periods:

A. From birth to 30 days of age; and [2009, c. 578, §3 (NEW); 2009, c. 578, §4 (AFF).]

B. Any open or annual enrollment period. [2009, c. 578, §3 (NEW); 2009, c. 578, §4 (AFF).]

§2847-R. Coverage for children's early intervention services

(As enacted by PL 2009, c. 634, §3; §5 is REALLOCATED TO TITLE 24-A, SECTION 2847-S)

§2847-R. Coverage for the diagnosis and treatment of autism spectrum disorders

(As enacted by PL 2009, c. 635, §3; §6 is REALLOCATED TO TITLE 24-A, §2847-T)

[2009, c. 578, §3 (NEW); 2009, c. 578, §4 (AFF) .]

SECTION HISTORY

2009, c. 578, §3 (NEW). 2009, c. 578, §4 (AFF). 2009, c. 634, §3 (NEW). 2009, c. 634, §5 (AFF). 2009, c. 635, §3 (NEW). 2009, c. 635, §6 (AFF). 2011, c. 420, Pt. A, §25 (RAL). 2011, c. 420, Pt. A, §26 (RAL).

§2847-S. COVERAGE FOR CHILDREN'S EARLY INTERVENTION SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 2847-R)

1. **Definition.** For purposes of this section, "children's early intervention services" means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq.

[2011, c. 420, Pt. A, §25 (RAL) .]

2. **Required coverage.** All group health insurance policies, contracts and certificates must provide coverage for children's early intervention services in accordance with this subsection.

A. A referral from the child's primary care provider is required. [2011, c. 420, Pt. A, §25 (RAL).]

B. The policy, contract or certificate may limit coverage to $3,200 per year for each child not to exceed $9,600 by the child's 3rd birthday. [2011, c. 420, Pt. A, §25 (RAL).]

C. The policy, contract or certificate may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section. [2011, c. 420, Pt. A, §25 (RAL).]

[2011, c. 420, Pt. A, §25 (RAL) .]

SECTION HISTORY
2011, c. 420, Pt. A, §25 (RAL).

§2847-T. COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS

(REALLOCATED FROM TITLE 24-A, SECTION 2847-R)

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

A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. [2011, c. 420, Pt. A, §26 (RAL).]

B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. [2011, c. 420, Pt. A, §26 (RAL).]

C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

(3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. [2011, c. 420, Pt. A, §26 (RAL).]

[2011, c. 420, Pt. A, §26 (RAL) .]

2. **Required coverage.** All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate who is 10 years of age or under in accordance with the following.

A. The policy, contract or certificate must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. [2011, c. 420, Pt. A, §26 (RAL).]

B. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually. [2011, c. 420, Pt. A, §26 (RAL).]

C. The policy, contract or certificate may not include any limits on the number of visits. [2011, c. 420, Pt. A, §26 (RAL).]

D. Notwithstanding section 2843 and to the extent allowed by federal law, the policy, contract or certificate may limit coverage for applied behavior analysis to $36,000 per year. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. [2011, c. 420, Pt. A, §26 (RAL).]

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy, contract or certificate. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy, contract or certificate. [2011, c. 420, Pt. A, §26 (RAL).]

[2013, c. 597, §2 (AMD); 2013, c. 597, §4 (AFF) .]

3. **Limits; coinsurance; deductibles.** Except as otherwise provided in this section, any policy, contract or certificate that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2011, c. 420, Pt. A, §26 (RAL) .]

4. **Individualized education plan.** This section may not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized education plan or an individualized family service plan.

[2011, c. 420, Pt. A, §26 (RAL) .]

SECTION HISTORY

2011, c. 420, Pt. A, §26 (RAL). 2013, c. 597, §2 (AMD). 2013, c. 597, §4 (AFF).

§2847-U. COVERAGE FOR SERVICES PROVIDED BY DENTAL HYGIENE THERAPIST

1. **Services provided by dental hygiene therapist.** An insurer that issues group dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental hygiene therapist licensed under Title 32, chapter 16, subchapter 3-C when those services are covered services under the contract and when they are within the lawful scope of practice of the dental hygiene therapist.

[2013, c. 575, §6 (NEW); 2013, c. 575, §10 (AFF) .]

2. **Limits; coinsurance; deductibles.** A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2013, c. 575, §6 (NEW); 2013, c. 575, §10 (AFF) .]

3. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing group health insurance is the secondary payer.

[2013, c. 575, §6 (NEW); 2013, c. 575, §10 (AFF) .]

SECTION HISTORY
2013, c. 575, §6 (NEW). 2013, c. 575, §10 (AFF).

Chapter 36: CONTINUITY OF HEALTH INSURANCE COVERAGE

§2848. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1993, c. 349, §52 (RPR).]

1. **Evidence of individual insurability.** "Evidence of individual insurability" means medical information or other information that indicates health status, such as whether the individual is actively at work, used to determine whether coverage of an individual within the group is to be limited or excluded.

[1993, c. 349, §52 (RPR) .]

1-A. **COBRA continuation provision.** "COBRA continuation provision" means any of the following:

A. Section 4980B of the Internal Revenue Code of 1986, other than Subsection (f)(1) as it relates to pediatric vaccines; [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

B. Part 6 of Subtitle B of Title I of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1161, other than Section 609; or [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

C. Title XXII of the federal Public Health Service Act, 42 United States Code, Section 201. [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

[1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF) .]

1-B. **Federally creditable coverage.** "Federally creditable coverage" is defined as follows.

A. "Federally creditable coverage" means health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier;

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act;

(4-A) A state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 et seq. or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e). [2013, c. 588, Pt. A, §27 (AMD).]

B. "Federally creditable coverage" does not include coverage consisting solely of one or more of the following:

(1) Coverage for accident or disability income insurance or any combination of those coverages;

(2) Liability insurance, including general liability insurance and automobile liability insurance;

(3) Coverage issued as a supplement to liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit insurance;

(7) Coverage for on-site medical clinics; or

(8) Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits. [1999, c. 256, Pt. L, §2 (AMD).]

C. "Federally creditable coverage" does not include the following benefits if those benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination of those benefits; and

(3) Other similar, limited benefits as specified in federal regulations issued pursuant to Public Law 104-191. [1999, c. 256, Pt. L, §2 (AMD).]

D. "Federally creditable coverage" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, and if no coordination exists between the provision of the benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and those benefits are paid for an event without regard to whether benefits are provided for that event under a group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance. [1999, c. 256, Pt. L, §2 (AMD).]

E. "Federally creditable coverage" does not include the following if it is offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance under the Social Security Act, Section 1882(g)(1);

(2) Coverage supplemental to the coverage provided under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55; and

(3) Similar supplemental coverage under a group health plan. [1999, c. 256, Pt. L, §2 (AMD).]

For purposes of this subsection, a "period of continuing federally creditable coverage" means a period in which an individual has maintained federally creditable coverage through one or more plans or programs, with no break in coverage exceeding 63 days. In calculating the aggregate length of a period of continuing federally creditable coverage that includes one or more breaks in coverage, only the time actually covered is counted. A waiting period is not counted as a break in coverage, but is not counted as a period of actual

coverage unless the individual has other federally creditable coverage during this period. For purposes of this subsection and subsection 1-C, "group health plan" has the same meaning as specified in the federal Public Health Service Act, Title XXVII, Section 2791(a).

[2013, c. 588, Pt. A, §27 (AMD) .]

1-C. **Federally eligible individual.** "Federally eligible individual" means an individual:

A. Who has had a period of continuing federally creditable coverage, as defined in subsection 1-B, ending not more than 63 days before applying for an individual health plan, with an aggregate length of federally creditable coverage, as defined in subsection 1-B, of at least 18 months; [1999, c. 256, Pt. L, §3 (AMD).]

B. Whose most recent prior federally creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan; [1999, c. 256, Pt. L, §3 (AMD).]

C. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, Medicare, or a state plan under Title XIX, Medicaid or any successor program and who does not have other health insurance coverage; [1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF).]

D. Whose most recent federally creditable coverage was not terminated based on nonpayment of premiums, fraud or intentional misrepresentation of material fact; and [1999, c. 256, Pt. L, §3 (AMD).]

E. Who, if offered the option of continuation of coverage under a COBRA continuation provision, as defined by subsection 1-A, or under a similar state program, elected continuation of coverage and has exhausted that coverage. For purposes of this paragraph, an individual is considered to have exhausted COBRA continuation coverage when the individual no longer resides, lives or works in a service area of a managed care plan and there is no other COBRA continuation coverage available to the individual. [2001, c. 258, Pt. D, §2 (AMD).]

[2001, c. 258, Pt. D, §2 (AMD) .]

1-D. **Governmental plan.** "Governmental plan" has the meaning given under Section 3(32) of the federal Employee Retirement Income Security Act of 1974 or any federal governmental employee plan.

[1997, c. 445, §20 (NEW); 1997, c. 445, §32 (AFF) .]

2. **Group.** "Group" means any of the types of groups under sections 2804 to 2808.

[1993, c. 349, §52 (RPR) .]

2-A. **Medical care.** Medical care includes the amounts paid for:

A. The diagnosis, care, mitigation, treatment or prevention of disease, or the amounts paid for the purpose of affecting a structure or function of the body; [1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF).]

B. Transportation primarily for, and essential to, medical care under paragraph A; and [1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF).]

C. Insurance coverage for medical care under paragraphs A and B. [1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF).]

[1997, c. 445, §21 (NEW); 1997, c. 445, §32 (AFF) .]

3. **Preexisting condition exclusion.**

[1997, c. 445, §32 (AFF); 1997, c. 445, §22 (RP) .]

4. **Subgroup.** "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

[1993, c. 349, §52 (RPR) .]

5. **Waiting period.** "Waiting period" means a period of time after the date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.

[1999, c. 256, Pt. L, §4 (AMD) .]

SECTION HISTORY
1989, c. 767, §4 (NEW). 1989, c. 801, §3 (NEW). 1989, c. 867, §§8,10 (NEW). 1991, c. 695, §6 (RPR). 1991, c. 824, §A52 (RPR). 1993, c. 349, §52 (RPR). 1997, c. 445, §§20-22 (AMD). 1997, c. 445, §32 (AFF). 1997, c. 683, §A13 (AMD). 1997, c. 777, §B4 (AMD). 1999, c. 256, §§L2-4 (AMD). 2001, c. 258, §§D2,E5 (AMD). 2005, c. 121, §H1 (AMD). 2011, c. 238, Pt. E, §1 (AMD). 2013, c. 588, Pt. A, §27 (AMD).

§2848-A. APPLICABILITY TO CERTAIN SELF-INSURED EMPLOYERS

For purposes of this chapter, an uninsured employee health plan that covers employees working in this State, including the uninsured portion of a partially insured employee health plan, is considered a group medical insurance policy and the employer maintaining the plan is considered an insurer, if the plan is subject to state regulation by virtue of the governmental plan or nonelecting church plan exception to the federal definition of "employee benefit plan" in the federal Employee Retirement Income Security Act, 29 United States Code, Section 1003(b). [1997, c. 445, §23 (NEW); 1997, c. 445, §32 (AFF).]

SECTION HISTORY
1997, c. 445, §23 (NEW). 1997, c. 445, §32 (AFF).

§2849. CONTINUITY ON REPLACEMENT OF GROUP POLICY

1. **Policies subject to this section.** Notwithstanding any other provision of law, this section applies to all group and blanket medical insurance policies issued by insurers or health maintenance organizations to policyholders who are obtaining coverage for a group or subgroup to replace coverage under a different contract or policy issued by a nonprofit hospital or medical service organization, insurer or health maintenance organization, or to replace coverage under an uninsured employee benefit plan that provides payment for health services received by employees or their dependents if the policyholder has applied for coverage under the replacement policy within 90 days after termination of coverage under the contract or policy being replaced. For purposes of this section, the group or blanket policy issued to replace the prior contract or policy is the "replacement policy." The group or blanket contract or policy or uninsured employee benefit plan, or a number of individual contracts or policies if the premiums were paid by the employer or by payroll deduction, being replaced is the "replaced contract or policy."

[2007, c. 199, Pt. D, §1 (AMD) .]

2. **Persons provided continuity of coverage under this section.** This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.

[1993, c. 349, §53 (RPR) .]

3. **Prohibition against discontinuity.** In a replacement policy subject to this section, an insurer or health maintenance organization may not, for any person described in subsection 2:

A. Request that the person provide or otherwise seek to obtain evidence of individual insurability. This in no way limits the insurer's right to require information concerning the health of the individuals in the group to determine whether the group as a whole is insurable or to determine rates for the group as a whole; [1993, c. 349, §53 (RPR).]

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; [1997, c. 370, Pt. B, §2 (AMD).]

C. Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section; or [2009, c. 244, Pt. E, §2 (AMD).]

D. Direct or propose to the employer or the person that the person purchase an individual plan in lieu of providing coverage under the replacement policy. The superintendent shall initiate enforcement proceedings when investigation of the circumstances surrounding procurement of an individual policy at the time of replacement of the group policy produces evidence that such procurement was undertaken in violation of this section and section 2155-A. [1997, c. 370, Pt. B, §3 (NEW).]

[2009, c. 244, Pt. E, §2 (AMD) .]

3-A. **Persons subject to a preexisting condition exclusion.** Notwithstanding subsection 3, paragraph C, an insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the replaced contract or policy. The preexisting condition exclusion period under the replacement policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the replaced contract or policy.

[2009, c. 244, Pt. E, §3 (NEW) .]

4. **Persons covered for fewer than 90 continuous days.**

[2001, c. 258, Pt. E, §6 (RP) .]

5. **Liability after discontinuance.** The nonprofit hospital or medical service organization, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.

[1993, c. 349, §53 (RPR) .]

6. **Rules.** The superintendent may adopt rules that substitute for the requirement of subsection 3, paragraph C a requirement that prohibits application of a preexisting condition exclusion or waiting period with respect to classes or categories of benefits that are covered under the replaced contract or policy. The rules must define those classes or categories consistent with any federal regulations adopted pursuant to the federal Public Health Service Act, Title XXVII, Section 2701(c)(3)(B).

[1997, c. 445, §24 (NEW); 1997, c. 445, §32 (AFF) .]

SECTION HISTORY
1989, c. 835, §3 (NEW). 1989, c. 867, §§8,10 (NEW). 1991, c. 695, §7 (RPR). 1991, c. 824, §A53 (RPR). 1993, c. 349, §53 (RPR). 1993, c. 666, §D3 (AMD). 1995, c. 332, §F3 (AMD). 1997, c. 370, §§B2,3 (AMD). 1997, c. 445, §24 (AMD). 1997, c. 445, §32 (AFF). 2001, c. 258, §E6 (AMD). 2007, c. 199, Pt. D, §1 (AMD). 2009, c. 244, Pt. E, §§2, 3 (AMD).

§2849-A. EXTENSION OF BENEFITS FOR DISABLED PERSONS

1. **Policies subject to this section.** This section applies to group and blanket policies that provide hospital or medical expense coverage or specific indemnity during hospital confinement. This section does not apply to group policies providing coverage only for dental expense or to group long-term care policies as defined in section 5051 or group short-term and long-term disability policies.

[1999, c. 256, Pt. L, §5 (AMD) .]

2. **Requirement.** Every group or blanket policy subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group or blanket policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A premium may not be charged during the period of extension. For a policy providing hospital or medical expense coverage, an extension of benefits provision is reasonable if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement.

[2007, c. 199, Pt. D, §2 (AMD) .]

3. **Description of benefit extension.** The extension of benefits provision must be described in all policies and group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the policy.

[1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

4. **Liability after discontinuance.** After discontinuance of a policy, the insurer or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits.

[1997, c. 604, Pt. H, §1 (AMD) .]

4-A. **Coordination of benefits.** If replacement coverage is secured by the group or blanket policyholder from an insurer, nonprofit hospital or medical service organization or health maintenance organization and a totally disabled person is covered under the replacement coverage, the replacement coverage must pay as primary coverage and the replaced coverage must pay as secondary coverage for the covered expenses directly relating to the condition causing total disability during the extension of benefits required under this section.

[2007, c. 199, Pt. D, §3 (AMD) .]

5. **Rules.** The superintendent shall adopt rules to define the term "total disability" for purposes of this section. The definition must identify persons who are unable, as a result of disability, to obtain comparable alternative coverage through comparable employment or otherwise.

[1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

SECTION HISTORY
1989, c. 867, §§8,10 (NEW). 1991, c. 695, §8 (AMD). 1997, c. 604, §§H1,2 (AMD). 1999, c. 256, §§L5,6 (AMD). 2007, c. 199, Pt. D, §§2, 3 (AMD).

§2849-B. CONTINUITY FOR INDIVIDUAL WHO CHANGES GROUPS

1. **Policies subject to this section.** This section applies to all individual, group and blanket medical insurance policies except hospital indemnity, specified accident, specified disease, long-term care and short-term policies issued by insurers or health maintenance organizations. For purposes of this section, a short-term policy is an individual, nonrenewable policy issued for a term that is less than 12 months. This section does not apply to Medicare supplement policies as defined in section 5001, subsection 4.

[2011, c. 90, Pt. G, §1 (AMD) .]

2. **Persons provided continuity of coverage.** Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under an individual, group or blanket insurance policy or health maintenance organization policy if:

A. That person was covered under an individual, group or blanket contract or policy issued by a nonprofit hospital or medical service organization, insurer, health maintenance organization or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program, including, but not limited to, those listed in section 2848, subsection 1-B, paragraph A, subparagraphs (3) to (10). For purposes of this section, the individual, group or blanket policy under which the person is seeking coverage is the "succeeding policy." The group, blanket or individual contract or policy, uninsured employee benefit plan or governmental program that previously covered the person is the "prior contract or policy"; and [2007, c. 199, Pt. D, §4 (AMD).]

B. Coverage under the prior contract or policy terminated:

(1) Within 180 days before the date the person enrolls or is eligible to enroll in the succeeding contract if:

(a) Coverage was terminated due to unemployment, as defined in Title 26, section 1043;

(b) The person was eligible for and received unemployment compensation benefits for the period of unemployment, as provided under Title 26, chapter 13; and

(c) The person is employed at the time replacement coverage is sought under this provision; or

(2) Within 90 days before the date the person enrolls or is eligible to enroll in the succeeding contract.

A period of ineligibility for a health plan imposed by terms of employment may not be considered in determining whether the coverage ended within a time period specified under this section. [2007, c. 199, Pt. D, §4 (AMD).]

C. [1997, c. 445, §32 (AFF); 1997, c. 445, §25 (RP).]

D. [1999, c. 36, §3 (RP).]

This section does not apply to replacements of group or blanket coverage within the scope of section 2849 or if the succeeding policy is an individual policy and the prior contract or policy was a short-term policy.

[2007, c. 199, Pt. D, §4 (AMD) .]

3. **Exception for late enrollees.** Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee except as provided in this subsection. A late enrollee may be excluded from coverage for a waiting period of not more than 12 months based on medical underwriting or preexisting conditions. If a shorter waiting period or no waiting period is imposed, coverage for the late enrollee may exclude preexisting conditions for the lesser of 18 months, reduced by any federally creditable coverage, or 12 months. The exclusion is subject to the limitations set forth in section 2850. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding contract or policy or terminated coverage under the succeeding contract because that individual was covered under a prior contract or policy and:

(1) Coverage under that contract or policy ceased because the individual became ineligible for reasons other than fraud or material misrepresentation, including, but not limited to, termination of employment, termination of the group policy or group contract under which the individual was covered, death of a spouse or divorce; or

(2) Employer contributions toward that coverage were terminated; [1997, c. 445, §32 (AFF); 1997, c. 445, §26 (RPR).]

A-1. That person incurs a claim under a prior contract or policy that would meet or exceed that contract or policy's lifetime limit on all benefits, and a request for enrollment is made not later than 30 days after a claim is denied in whole or in part due to the operation of a lifetime limit on all benefits. [2007, c. 199, Pt. A, §4 (NEW).]

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order; [1995, c. 332, Pt. F, §5 (AMD).]

C. [1997, c. 777, Pt. B, §5 (RP).]

C-1. That person was covered by the Cub Care program under Title 22, section 3174-T, and the request for replacement coverage is made while coverage is in effect or within 30 days from the termination of coverage; or [2005, c. 683, Pt. A, §42 (AMD).]

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible. [1995, c. 332, Pt. F, §5 (NEW).]

[2007, c. 199, Pt. A, §4 (AMD) .]

3-A. **Prohibition against discontinuity in group policies.** Except as provided in this section, in a group policy subject to this section, the insurer or health maintenance organization shall, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

[2009, c. 244, Pt. E, §4 (NEW) .]

3-B. **Persons subject to a preexisting condition exclusion.** Notwithstanding subsection 3-A, an insurer or health maintenance organization may impose a preexisting condition exclusion period on a person who was subject to a preexisting condition exclusion under the prior contract or policy. The preexisting condition exclusion period under the succeeding policy or contract must end no later than the date the preexisting condition exclusion period would have ended under the prior contract or policy.

[2009, c. 244, Pt. E, §5 (NEW) .]

4. **Prohibition against discontinuity in individual and blanket policies.** Except as provided in this section, in an individual or blanket policy subject to this section, the insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect or to the extent that benefits would have been payable under the prior contract or policy if not for the operation of a lifetime limit on all benefits. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

[2009, c. 244, Pt. E, §6 (AMD) .]

4-A. **Alternative method.** The superintendent may adopt rules that substitute for the requirement of subsection 3-A a requirement that prohibits application of a medical underwriting or preexisting condition exclusion with respect to classes or categories of benefits that are covered under the replaced contract or policy. The rules must define those classes or categories consistent with any federal regulations adopted pursuant to the federal Public Health Service Act, Title XXVII, Section 2701(c)(3)(B).

[2009, c. 511, Pt. D, §1 (AMD) .]

5. **Determination of benefits.** When a determination of benefit under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.

[1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

6. **Limit on premium increase.** For rating purposes, an insurer or health maintenance organization may not charge claims for preexisting conditions of any person subject to this section, during the first 12 months of employment of that person, directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. The insurer or health maintenance organization may pool any additional claims among all such groups and subgroups covered by that insurer or health maintenance organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

[1989, c. 867, §8 (NEW); 1989, c. 867, §10 (AFF) .]

7. **Reinsurance, excess insurance or administrative services.** An insurer may only offer, issue or renew reinsurance or excess insurance coverage or offer administrative services to an uninsured employee benefit plan that provides payment for health services received by employees and their dependents when that plan for the payment of health services and reinsurance and excess insurance coverage meets the requirements of continuity of coverage in this chapter.

[1993, Pt. A, §14 (NEW); 1993, Pt. F, §1 (NEW) .]

8. **Short-term insurance.** A person eligible for continuity of coverage under subsection 2 may be allowed to purchase coverage under an individual, nonrenewable short-term policy. The issuance of a short-term policy is subject to the following conditions.

A. Upon offering an individual short-term policy for purchase, an insurer or the insurer's agent or broker must provide written disclosure of the terms and benefits of the policy. Specific disclosure that the short-term policy is not subject to any limitation on preexisting condition exclusions or the provisions of guaranteed renewal and continuity of coverage is required. [1995, c. 342, §8 (NEW).]

B. An insurer or the insurer's agent or broker may not issue a short-term policy that replaces a prior short-term policy if the combined term of the new policy and all prior successive policies exceed 24 months. All individuals making an application for coverage under a short-term policy must disclose any prior coverage under a short-term policy and the policy duration. [2011, c. 90, Pt. G, §2 (AMD).]

[2011, c. 90, Pt. G, §2 (AMD) .]

SECTION HISTORY

1989, c. 867, §§8,10 (NEW). 1991, c. 695, §§9,10 (AMD). 1993, c. 477, §§A8-14 (AMD). 1993, c. 477, §F1 (AFF). 1993, c. 666, §D4 (AMD). 1995, c. 77, §2 (AMD). 1995, c. 332, §§F4,5 (AMD). 1995, c. 342, §§6-8 (AMD). 1995, c. 625, §B10 (AMD). 1995, c. 673, §B3 (AMD). 1997, c. 370, §C4 (AMD). 1997, c. 445, §§25-27 (AMD). 1997, c. 445, §32 (AFF). 1997, c. 777, §§B5,6 (AMD). 1999, c. 36, §§1-3 (AMD). 1999, c. 256, §L7 (AMD). 2001, c. 258, §§E7,8 (AMD). 2005, c. 683, §A42 (AMD). 2007, c. 199, Pt. A, §§4, 5 (AMD). 2007, c. 199, Pt. D, §4 (AMD). 2009, c. 244, Pt. E, §§4-6 (AMD). 2009, c. 511, Pt. D, §1 (AMD). 2011, c. 90, Pt. G, §§1, 2 (AMD).

§2849-C. CERTIFICATIONS OF COVERAGE

1. **Application.** This section applies to:

A. Individual health plans subject to section 2736-C; and [2001, c. 258, Pt. C, §1 (NEW).]

B. Group and blanket health insurance contracts subject to chapter 35, except:

(1) Medicare supplement policies subject to chapter 67; and

(2) Contracts designed to cover specific diseases, hospital indemnity or accidental injury only. [2001, c. 258, Pt. C, §1 (NEW).]

[2001, c. 258, Pt. C, §1 (NEW) .]

2. **Requirement for certification of period of creditable coverage.** The requirement for a certification of the period of creditable coverage is as follows.

A. A carrier, as defined in section 4301-A, subsection 3, must provide the certification described in paragraph B with respect to health plans subject to this section:

(1) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(2) In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(3) On the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in subparagraph (1) or (2), whichever is later. The certification under subparagraph (1) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision. [2001, c. 258, Pt. C, §1 (NEW).]

B. The certification described in this paragraph is a written certification of:

(1) The period of federally creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision;

(2) The waiting period, if any, imposed with respect to the individual for any coverage under the plan; and

(3) An educational statement regarding the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, consistent with federal law. [2007, c. 199, Pt. A, §6 (AMD).]

[2007, c. 199, Pt. A, §6 (AMD) .]

3. **Alternative evidence of prior coverage.** A carrier may not deny continuity rights as required by section 2849-B solely because the individual does not provide a certification described in subsection 2. The carrier must accept alternative evidence of prior coverage provided by the individual. If the individual asserts the existence of prior coverage but is unable to provide evidence, the carrier must make reasonable efforts to verify the existence of the prior coverage. The carrier may deny continuity rights if the individual refuses to cooperate in the carrier's efforts to verify prior coverage, such as if the individual refuses to provide needed authorization for the release of information to the carrier when requested by the carrier.

[2001, c. 258, Pt. C, §1 (NEW) .]

4. **Notice.** A carrier may not impose a preexisting condition exclusion before providing the individual with notice consistent with federal law of the individual's continuity rights and giving the individual an opportunity to provide a certification as described in subsection 2 or alternative evidence of prior coverage as described in subsection 3.

[2007, c. 199, Pt. A, §7 (AMD) .]

5. **Rules.** The superintendent may issue rules specifying the contents of certifications or other requirements consistent with this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 258, Pt. C, §1 (NEW) .]

SECTION HISTORY
2001, c. 258, §C1 (NEW). 2007, c. 199, Pt. A, §§6, 7 (AMD).

§2850. LIMITATIONS ON EXCLUSION AND WAITING PERIODS

1. **Application.** This section applies to individual, group and blanket medical insurance contracts subject to chapters 33 and 35, except Medicare supplement contracts, converted contracts issued under section 2809-A and contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

[1999, c. 256, Pt. L, §8 (AMD) .]

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

A. "Date of enrollment" means the effective date of coverage or, if earlier, the first day of the waiting period for such coverage. [2001, c. 258, Pt. E, §9 (NEW).]

B. "Preexisting condition exclusion," with respect to coverage, means a limitation or exclusion of benefits relating to a condition based on the fact or perception that the condition was present, or that the person was at particularized risk of developing the condition, before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. [2001, c. 258, Pt. E, §9 (NEW).]

[2001, c. 258, Pt. E, §9 (RPR) .]

2. **Limitation.** An individual, group or blanket contract issued by an insurer may not impose a preexisting condition exclusion except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months from the date of enrollment, including the waiting period, if any. For purposes of this subsection, "waiting period" includes any period between the time a substantially complete application for an individual or small group health plan is filed and the time the coverage takes effect. A preexisting condition exclusion may not be more restrictive than as follows.

A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period ending on the earlier of the date of enrollment in the contract and the date of enrollment in a prior contract covering the same group if there has not been a gap in coverage of greater than 90 days between contracts. An exclusion may not be imposed relating to pregnancy as a preexisting condition. [2009, c. 244, Pt. E, §7 (AMD).]

B. In an individual contract not subject to paragraph C, or in a blanket policy, a preexisting condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the date of application or to a pregnancy existing on the effective date of coverage. [1999, c. 256, Pt. L, §9 (AMD).]

C. An individual policy issued on or after January 1, 1998 to a federally eligible individual as defined in section 2848 may not contain a preexisting condition exclusion. [1997, c. 445, §29 (NEW); 1997, c. 445, §32 (AFF).]

D. A routine preventive screening or test yielding only negative results may not be considered to be diagnosis, care or treatment for the purposes of this subsection. [1999, c. 256, Pt. L, §9 (AMD).]

E. Genetic information may not be used as the basis for imposing a preexisting condition exclusion in the absence of a diagnosis of the condition relating to that information. For the purposes of this paragraph, "genetic information" has the same meaning as set forth in the Code of Federal Regulations. [1997, c. 445, §29 (NEW); 1997, c. 445, §32 (AFF).]

F. Except for individual health plans in effect on March 23, 2010 that have grandfathered status under the federal Affordable Care Act, a carrier as defined in section 4301-A, subsection 3 offering a health plan as defined in section 4301-A, subsection 7 may not apply a preexisting condition exclusion to any enrollee under 19 years of age. A preexisting condition exclusion may not be imposed on any enrollee after January 1, 2014 to the extent prohibited by the federal Affordable Care Act. [2011, c. 364, §18 (NEW).]

[2011, c. 364, §18 (AMD) .]

SECTION HISTORY
1989, c. 867, §§8,10 (NEW). 1991, c. 695, §11 (AMD). 1993, c. 477, §A15 (AMD). 1993, c. 477, §F1 (AFF). 1993, c. 547, §4 (AMD). 1997, c. 370, §C5 (AMD). 1997, c. 445, §§28,29 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 256, §§L8,9 (AMD). 2001, c. 258, §§D3,E9 (AMD). 2007, c. 199, Pt. A, §8 (AMD). 2009, c. 244, Pt. E, §7 (AMD). 2011, c. 364, §18 (AMD).

§2850-A. GYNECOLOGICAL AND OBSTETRICAL SERVICES

(REALLOCATED TO TITLE 24-A, SECTION 2847-F)

SECTION HISTORY
1995, c. 617, §4 (NEW). 1995, c. 617, §6 (AFF). 1997, c. 370, §H1 (RAL).

§2850-B. GUARANTEED RENEWAL; CESSATION OF BUSINESS

1. **Application.** This section applies to:

A. Individual health plans subject to section 2736-C; and [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

B. Group and blanket medical insurance contracts subject to chapter 35 except:

(1) Medicare supplement policies subject to chapter 67; and

(2) Contracts designed to cover specific diseases, hospital indemnity or accidental injury only. [1999, c. 256, Pt. L, §10 (AMD).]

[1999, c. 256, Pt. L, §10 (AMD) .]

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

A. "Carrier" means an insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue group health plans in this State. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

B. "Individual market" means individual or group policies or contracts subject to section 2736-C. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

C. "Large group market" means groups not subject to section 2736-C or 2808-B. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

D. "Small group market" means groups subject to section 2808-B. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

[1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

3. **Renewal.** Coverage may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

A. When the policyholder or contract holder fails to pay premiums or contributions in accordance with the terms of the contract or the carrier has not received timely premium payments; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

B. For fraud or intentional misrepresentation of material fact by the policyholder or contract holder; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

C. With respect to coverage of individuals under a group policy or contract, for fraud or intentional misrepresentation of material fact on the part of the individual or the individual's representative; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

D. In the large or small group market, for noncompliance with the carrier's minimum participation requirements, which may not exceed the participation requirement when the policy was issued; [2007, c. 199, Pt. C, §1 (AMD).]

E. With respect to a managed care plan, as defined in section 4301-A, if there is no longer an insured who lives, resides or works in the service area; [2001, c. 1, §34 (COR).]

F. When the carrier ceases offering large or small group health plans in compliance with subsection 4 and does not renew any existing policies in that market; [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

F-1. When the carrier ceases offering individual health plans in compliance with section 2736-C, subsection 4 and does not renew any existing policies in that market; [2007, c. 199, Pt. C, §2 (NEW).]

G. When the carrier ceases offering a product and meets the following requirements:

(1) In the large group market:

(a) The carrier provides notice to the policyholder and to the certificate holders at least 90 days before termination;

(b) The carrier offers to each policyholder the option to purchase any other product currently being offered in the large group market; and

(c) In exercising the option to discontinue the product and in offering the option of coverage under division (b), the carrier acts uniformly without regard to the claims experience of the policyholders or the health status of the certificate holders or their dependents or prospective certificate holders or their dependents;

(2) In the small group market:

(a) The carrier replaces the product with a product that complies with the requirements of this section, including renewability, and with section 2808-B;

(b) The superintendent finds that the replacement is in the best interests of the policyholders; and

(c) The carrier provides notice of the replacement to the policyholder and to the certificate holders at least 90 days before replacement, including notice of the policyholder's right to purchase any other product currently being offered by that carrier in the small group market pursuant to section 2808-B, subsection 4; or

(3) In the individual market:

(a) The carrier replaces the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent finds that the replacement is in the best interests of the policyholders; and

(c) The carrier provides notice of the replacement to the policyholder and, if a group policy subject to section 2736-C, to a certificate holder at least 90 days before replacement, including notice of the policyholder's or certificate holder's right to purchase any other product currently being offered by that carrier in the individual market pursuant to section 2736-C, subsection 3; [2011, c. 238, Pt. F, §1 (AMD).]

H. In renewing a large group policy in accordance with this section, a carrier may modify the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications are applied uniformly to all policyholders of the same product; or [2003, c. 428, Pt. A, §1 (AMD).]

I. In renewing an individual or small group policy in accordance with this section, a carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Modifications not meeting the requirements in this paragraph are considered a discontinuance of the product pursuant to paragraph G.

(1) A modification pursuant to this paragraph must be approved by the superintendent. The superintendent shall approve the modification if it meets the requirements of this section.

(2) A change in a requirement for eligibility is not a minor modification pursuant to this paragraph if the change results in the exclusion of a class or category of enrollees currently covered.

(3) Benefit modifications required by law are deemed minor modifications for purposes of this paragraph.

(4) Benefit modifications other than modifications required by law are minor modifications only if they meet the requirements of this subparagraph. For purposes of this subparagraph, changes in administrative conditions or requirements specified in the policy, such as preauthorization requirements, are not considered benefit modifications.

(a) The total of any increases in benefits may not increase the actuarial value of the total benefit package by more than 5%.

(b) The total of any decreases in benefits may not decrease the actuarial value of the total benefit package by more than 5%.

(c) For purposes of the calculations in divisions (a) and (b), increases and decreases must be considered separately and may not offset one another.

(5) A carrier must give 60 days' notice of any modification pursuant to this paragraph to all affected policyholders and certificate holders. [2011, c. 90, Pt. F, §3 (AMD).]

[2011, c. 90, Pt. F, §3 (AMD); 2011, c. 238, Pt. F, §1 (AMD) .]

4. **Cessation of business.** Carriers that provide health plans in the large group or small group markets after the effective date of this section that plan to cease offering coverage in one or both of those markets must comply with the following requirements.

A. Notice of the decision to cease business in that market must be provided to the bureau 3 months before the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the bureau and to the policyholder or contract holder 6 months before nonrenewal. [2001, c. 258, Pt. B, §3 (AMD).]

B. Carriers that cease to write new small group business continue to be governed by section 2808-B with respect to small group contracts in force and their renewal or replacement contracts. [2001, c. 258, Pt. E, §11 (AMD).]

C. Carriers that cease to write new business in that market are prohibited from writing new business in that market for a period of 5 years after the date of termination of the last policy unless the superintendent waives this requirement for good cause shown. [2001, c. 258, Pt. B, §3 (AMD).]

[2001, c. 258, Pt. B, §3 (AMD); 2001, c. 258, Pt. E, §11 (AMD) .]

5. **Association plans.** The requirements of this subsection apply to group contracts that are subject to this section and that are issued to association groups pursuant to section 2805-A. Carriers shall renew coverage for association members if coverage through an association is terminated because the association ceases to exist, changes its membership eligibility criteria, fails to pay premiums, commits fraud or misrepresentation or voluntarily terminates the group policy.

A. If coverage to an employer through an association is terminated, the carrier shall renew the coverage with the employer becoming the policyholder. [2005, c. 121, Pt. G, §1 (NEW).]

B. If coverage to an individual member of an association is terminated, the carrier shall renew the coverage with the individual becoming the policyholder. A carrier that has been granted an exemption pursuant to section 2736-C, subsection 9 does not lose that exemption simply by virtue of renewing coverage to individuals under this paragraph. [2005, c. 121, Pt. G, §1 (NEW).]

The requirements of this subsection do not apply if the employer or individual fails to pay premiums, commits fraud or misrepresentation, voluntarily terminates membership in the association or ceases to qualify for membership for reasons other than a change in the association's membership eligibility criteria.

[2005, c. 121, Pt. G, §1 (NEW) .]

SECTION HISTORY
1997, c. 445, §30 (NEW). 1997, c. 445, §32 (AFF). 1999, c. 256, §L10 (AMD). RR 2001, c. 1, §34 (COR). 2001, c. 258, §B3 (AMD). 2001, c. 258, §§E10,11 (AMD). 2003, c. 428, §§A1,2 (AMD). 2005, c. 121, §G1 (AMD). 2007, c. 199, Pt. C, §§1, 2 (AMD). 2011, c. 90, Pt. F, §3 (AMD). 2011, c. 238, Pt. F, §1 (AMD).

§2850-C. NONDISCRIMINATION

1. **Application.** This section applies to group medical insurance contracts subject to chapter 35 other than contracts designed to cover specific diseases, hospital indemnity or accidental injury only.

[1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

2. **Eligibility and premium contributions.** A carrier may not establish rules for eligibility of an individual to enroll, or require an individual to pay a premium or contribution that is greater than that for a similarly situated individual, based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability in relation to the individual or a dependent of the individual. Nothing in this section requires a group health plan to provide particular benefits other than those provided under the terms of the plan or restricts the amount an employer may be charged for coverage. Nothing in this section prohibits establishing limitations or restrictions on the amount, level, extent or nature of the benefits for similarly situated individuals enrolled in the plan. Nothing in this section prohibits a carrier from establishing premium discounts or refunds or modifying applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

[1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF) .]

SECTION HISTORY
1997, c. 445, §30 (NEW). 1997, c. 445, §32 (AFF).

§2850-D. RULES

Rules adopted pursuant to this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 445, §30 (NEW); 1997, c. 445, §32 (AFF).]

SECTION HISTORY
1997, c. 445, §30 (NEW). 1997, c. 445, §32 (AFF).

Chapter 37: CONSUMER CREDIT INSURANCE

§2851. SCOPE OF PROVISIONS

All life insurance and all health insurance in connection with loans or other credit transactions, credit property insurance, credit involuntary unemployment insurance and other consumer credit insurance specifically authorized by the superintendent in rules adopted pursuant to section 2865 are subject to this chapter, except the following: [2001, c. 471, Pt. D, §25 (AMD).]

1. **Long-term loan.** Insurance in connection with a loan or other credit transaction of more than 15 years' duration;

[1999, c. 256, Pt. H, §1 (NEW) .]

2. **Isolated transactions.** Insurance issued in an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor;

[2001, c. 138, §4 (AMD) .]

3. **Real estate loan.** Insurance in connection with real estate loans when the charge, if any, to the debtor is periodic and not financed;

[2001, c. 138, §4 (AMD) .]

4. **Casualty insurance.** Insurance issued pursuant to section 707, subsection 1, paragraph I against loss or damage resulting from failure of debtors to pay their obligations to the insured; or

[2001, c. 138, §4 (NEW) .]

5. **Debt cancellation agreements.** Debt cancellation agreements entered into between financial institutions or credit unions and their debtors.

[2001, c. 138, §4 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 288, §4 (AMD). 1981, c. 175, §3 (RPR). 1999, c. 256, §H1 (RPR). 2001, c. 138, §4 (AMD). 2001, c. 471, §D25 (AMD).

§2851-A. SHORT TITLE

This chapter may be known and cited as the "Consumer Credit Insurance Act." [2001, c. 138, §5 (NEW).]

SECTION HISTORY
2001, c. 138, §5 (NEW).

§2852. PURPOSE; CONSTRUCTION

The purpose of this chapter is to promote the public welfare by regulating consumer credit insurance. Nothing in this chapter is intended to prohibit or discourage reasonable competition. This chapter must be liberally construed. [2001, c. 138, §6 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 2001, c. 138, §6 (AMD).

§2853. DEFINITIONS

For the purpose of this chapter: [1969, c. 132, §1 (NEW).]

1. "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

[1969, c. 132, §1 (NEW) .]

2. "Credit health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

[1969, c. 132, §1 (NEW) .]

2-A. "Credit involuntary unemployment insurance" means involuntary unemployment insurance insuring a debtor pursuant to or in connection with a specific loan or other credit transaction.

[2001, c. 138, §7 (NEW) .]

2-B. "Credit property insurance" means property insurance on property that is purchased on credit or pledged as collateral on a loan when the insurance is purchased by or issued to the debtor in connection with that loan or credit transaction.

[2001, c. 138, §7 (NEW) .]

2-C. "Consumer credit insurance" means insurance subject to this chapter under section 2851.

[2001, c. 138, §7 (NEW) .]

3. "Creditor" means the lender of money or vendor or lessor of goods, services or property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them, or any director, officer or employee of any of them, or any other person in any way associated with any of them.

[1969, c. 132, §1 (NEW) .]

4. "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

[1969, c. 132, §1 (NEW) .]

5. "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 138, §7 (AMD).

§2854. FORMS AVAILABLE

Consumer credit insurance may be issued only in the following forms: [2001, c. 138, §8 (AMD).]

1. **Individual life.** Individual policies of life insurance issued to debtors on the term plan;

[1969, c. 132, §1 (NEW) .]

2. **Individual accident and health.** Individual policies of health insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance;

[1969, c. 132, §1 (NEW) .]

3. **Group life.** Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

[1969, c. 132, §1 (NEW) .]

4. **Group accident and health.** Group policies of health insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide such coverage;

[1969, c. 132, §1 (NEW) .]

4-A. **Individual credit property insurance.** Individual policies of property insurance on property that is purchased on credit or pledged as collateral on a loan when the insurance is purchased by or issued to the debtor in connection with that loan or credit transaction;

[2001, c. 138, §8 (NEW) .]

4-B. **Group credit property insurance.** Group policies of property insurance on property that is purchased on credit or pledged as collateral on a loan when the insurance is purchased by or issued to the debtor in connection with that loan or credit transaction;

[2001, c. 138, §8 (NEW) .]

4-C. **Individual credit involuntary unemployment insurance.** Individual involuntary unemployment policies insuring a debtor pursuant to or in connection with a specific loan or other credit transaction but not including disability insurance policies;

[2001, c. 138, §8 (NEW) .]

4-D. **Group credit involuntary unemployment insurance.** Group involuntary unemployment policies insuring a debtor pursuant to or in connection with a specific loan or other credit transaction but not including disability insurance policies; or

[2001, c. 138, §8 (NEW) .]

5. **Combination.** A combination under subsections 1 and 2, or under 3 and 4.

[1969, c. 132, §1 (NEW) .]

The superintendent may by rules adopted pursuant to section 2865 or chapter 40-A designate other permissible types of consumer credit insurance. [2001, c. 138, §8 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 138, §8 (AMD).

§2855. AMOUNTS OF INSURANCE

1. **Credit life insurance.**

A. The amount of credit life insurance shall at no time exceed the unpaid amount financed plus earned interest and an allowance for delinquencies as determined by the superintendent or, in the case of open-end credit, the balance upon which a finance charge may be imposed, plus earned interest and an allowance for delinquencies as determined by the superintendent. [1977, c. 672, §2 (RPR).]

[1977, c. 672, §2 (RPR) .]

2. **Agricultural credit commitments.** Notwithstanding subsection 1, paragraph A, insurance on agricultural credit transaction commitments not exceeding 2 years in duration may be written up to the amount of the loan commitment, on a nondecreasing or level term plan.

[1969, c. 132, §1 (NEW) .]

3. **Educational credit commitments.** Notwithstanding subsection 1, paragraph A, insurance on educational credit transaction commitments may be written for the amount of the portion of such commitment that has not been advanced by the creditor.

[1969, c. 132, §1 (NEW) .]

4. **Credit health insurance.**

A. Coverage limited. The total amount of indemnity payable by credit health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §55 (AMD). 1977, c. 672, §2 (AMD).

§2856. TERM OF INSURANCE

1. The term of credit life insurance or credit health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor; except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy.

[1969, c. 132, §1 (NEW) .]

2. Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance.

[1969, c. 132, §1 (NEW) .]

3. The term of such insurance shall not extend more than 15 days beyond the original or revised scheduled maturity date of the indebtedness, except when extended without additional cost to the debtor.

[1969, c. 132, §1 (NEW) .]

4. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 2859.

[1969, c. 132, §1 (NEW) .]

5. For credit involuntary unemployment insurance, benefits must start after a waiting period of not longer than 30 days but need not be retroactive to the first day of unemployment and must have a maximum benefit period of at least 6 months.

[2001, c. 138, §9 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 138, §9 (AMD).

§2857. POLICY PROVISIONS; DELIVERY OR DISCLOSURE TO DEBTORS

1. **Policy or certificate delivered.** All consumer credit insurance must be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance must be delivered to the debtor.

[2001, c. 138, §10 (AMD) .]

2. **Content of policy or certificate.** Each individual policy or group certificate of consumer credit insurance must, in addition to other requirements of law, set forth the name and home office address of the insurer, the name or names of the debtor, or, in the case of a certificate under a group policy, the identity by name or otherwise of the debtor; the premium or amount of payment, if a separate identifiable charge is paid by the debtor separately for consumer credit insurance; a description of the coverage, including the amount and term of the coverage, and any exceptions, limitations and restrictions, including conditions under which the policy may be terminated, which must be highlighted in bold print; and must state that the benefit is paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any excess is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate. During the 30 days immediately following the commencement date, the debtor may cancel the insurance and request in writing a full refund of premium for any reason.

[2001, c. 138, §10 (AMD) .]

3. **When delivered.** The individual policy or group certificate of insurance must be delivered to the insured debtor at the time the indebtedness is incurred, except as otherwise provided.

[2001, c. 138, §10 (AMD) .]

4. **Notice of proposed insurance.** If the individual policy or group certificate of insurance is not delivered to the debtor at the time indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor, if a separate identifiable charge is made separately for consumer credit insurance, the amount, term and a brief description of the coverage provided, must be delivered to the debtor at the time such indebtedness is incurred. Failure

to comply with the foregoing requirement precludes the use of such application as evidence in any action brought against the insured. The copy of the application for, or notice of proposed insurance, must refer exclusively to insurance coverage, and must be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance must state that upon acceptance by the insurer the insurance becomes effective as provided in section 2856.

[2001, c. 138, §10 (AMD) .]

5. **Risk not accepted.** If the named insurer does not accept the risk, the debtor must receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance, an appropriate refund must be made.

[2001, c. 138, §10 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1995, c. 238, §1 (AMD). 2001, c. 138, §10 (AMD).

§2858. FILING, APPROVAL AND WITHDRAWAL OF FORMS, RATES; APPEALS

1. **Forms filed.** All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this State and the schedules of premium rates pertaining thereto shall be filed with the superintendent.

[1973, c. 585, §12 (AMD) .]

2. **Approval of forms and rates.** The superintendent shall, within 30 days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, disapprove any such form, if the benefits provided therein are not reasonable in relation to the premium charge or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any provision of the insurance laws or of any regulation promulgated thereunder. In determining whether to disapprove any such form or premium rates, the superintendent shall give due consideration to past and prospective loss experience and mortality or morbidity rates, based on an appropriate mortality or morbidity table, and claim adjustment expenses, general administrative expenses, including handling cost for return premiums, commissions to agents, cost and compensation to the creditor, branch and field expenses and other acquisition costs, federal, state and local taxes, profit to the insurer, reasonable underwriting judgment, and any and all other factors and trends demonstrated to be relevant. The insurer may support these factors by statistical information, experience, actuarial computations and estimates certified by an executive officer of the insurer, and the superintendent shall give due consideration to such supporting data.

[1973, c. 585, §12 (AMD) .]

3. **Notice of disapproval; waiting period.** If the superintendent notifies the insurer that the form or rates are disapproved, it is unlawful thereafter for such insurer to issue or use such form or rates. In such notice, the superintendent shall specify the reason for his disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer. No such policy, certificate of insurance, notice

of proposed insurance, or any application, endorsement or rider or rate shall be issued or used until the expiration of 30 days after it has been so filed, unless the superintendent shall give his prior written approval thereto.

[1973, c. 585, §12 (AMD) .]

4. **Approval withdrawn.** The superintendent may, at any time after a hearing held not less than 20 days after written notice to the insurer, withdraw his approval of any such form or rate on any ground set forth in subsection 2. The written notice of such hearing shall state the reason for the proposed withdrawal. The insurer shall not use a form or rate after withdrawal of approval thereof.

[1973, c. 585, §12 (AMD) .]

5. **Group certificate filing.** If a group policy of consumer credit insurance has been delivered in this State before September 16, 1961, or has been or is delivered in another state before or after such date, the insurer shall file only the group certificate and notice of proposed insurance delivered or issued for delivery in this State as specified in section 2857, subsections 2 and 4, and such forms must be approved by the superintendent, if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the superintendent.

[2001, c. 138, §11 (AMD) .]

All hearings held under this section shall be conducted in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [1977, c. 694, §423 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §423 (AMD). 2001, c. 138, §11 (AMD).

§2859. PREMIUM RATES; REFUNDS; ACCOUNTS CREDITED WHEN INSURANCE NOT ISSUED

1. **Rates filed; life and health.** Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the superintendent; however, no upward revision in insurance charges to debtors may be made in connection with closed-end credit that would apply to debtors whose credit insurance is already in force. In the case of open-end credit, the debtor must be given a 31-day notice prior to an upward revision unless a waiver of that notice is obtained from the superintendent, in which case the notice of the upward revision must be given at the next regular billing cycle. An insurer may not issue any credit life insurance policy or credit health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the superintendent.

[2001, c. 138, §12 (AMD) .]

1-A. **Rates filed; property and casualty.** All rates charged in connection with credit property insurance or credit involuntary unemployment insurance must be filed in accordance with section 2304-A. An insurer may not issue any credit property insurance or credit involuntary unemployment insurance policy for which the premium rate exceeds those rates then on file with the superintendent.

[2001, c. 138, §12 (NEW) .]

1-B. **Rating standards.** The superintendent may by rules adopted pursuant to section 2865 or chapter 40-A establish specific rating standards for particular types of consumer credit insurance.

[2001, c. 138, §12 (NEW) .]

2. **Refund.** Each individual policy or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance must be paid or credited promptly to the debtor. The superintendent shall prescribe a minimum refund and no refund that would be less than such minimum need be made. The formula to be used in computing such refund must be filed with and approved by the superintendent.

[2001, c. 138, §12 (AMD) .]

3. **Accounts credited where insurance not issued.** If a creditor requires a debtor to make any payment for consumer credit insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

[2001, c. 138, §12 (AMD) .]

4. **Termination.** Any policy for consumer credit insurance issued subsequent to the enactment of this section must contain a provision that the insurance provided for may be terminated under only the following conditions:

A. The date the indebtedness is discharged, renewed or refinanced; [1977, c. 672, §4 (NEW).]

B. Upon written request of a debtor; [1977, c. 672, §4 (NEW).]

C. When a debtor is insured under an individual or group policy, nonpayment by such a debtor of any required premium over 31 days past due, provided that at least 10 days prior to termination the debtor has been given a notice of the right to cure in substantially the same form required by Title 9-A, section 5-110, subsection 3; [1993, c. 149, §1 (AMD).]

D. In the case where debtors are insured under group policies, the group policy may be terminated after 31 days prior notice to the debtor from the creditor:

(1) In a noncontributory policy, at the option of the creditor;

(2) At the time the insurance risk is transferred to a succeeding insurance carrier; or

(3) If the group policyholder fails to pay the premium; [2001, c. 138, §12 (AMD).]

E. In the case where credit is extended on open-ended basis:

(1) At attainment by the debtor of an age determined in advance by the contract of insurance; or

(2) If the creditor elects to terminate all insurance on credit extended on an open-ended basis; [2001, c. 138, §12 (AMD).]

F. If credit is extended on a closed-end basis, coverage for an individual insured under the policy may be terminated upon expiration of the term of the loan or term for which a charge was paid; or [1993, c. 149, §2 (AMD).]

G. When consumer credit insurance is paid for by the debtor in a single premium at the inception of the debt, if the debt is placed in charged-off status by the creditor because the debt is uncollectible, the insurance coverage may be terminated by the creditor and any refund of premium must be applied against any outstanding indebtedness. The creditor shall give notice of the termination of insurance coverage to the debtor at the debtor's last known address. [2001, c. 138, §12 (AMD).]

[2001, c. 138, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 672, §§3,4 (AMD). 1979, c. 127, §§156B-156D (AMD). 1993, c. 149, §§1-3 (AMD). 2001, c. 138, §12 (AMD).

§2860. AUTHORIZED INSURER, AGENT REQUIRED

All policies of consumer credit insurance may be delivered or issued for delivery in this State only by an insurer authorized to transact such insurance therein, and may be issued only through holders of licenses or authorizations issued by the superintendent. [2001, c. 138, §13 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2001, c. 138, §13 (AMD).

§2860-A. COMMISSIONS

A commission not exceeding 5% of credit life and health insurance premiums, as set forth by rules adopted by the superintendent, may be paid to any creditor who is a licensed credit insurance agent. This section does not prohibit fees paid to a lender for handling or processing credit life or health insurance not exceeding 10% of prima facie premiums as set forth by rules adopted by the superintendent. [1993, c. 645, Pt. B, §6 (AMD).]

SECTION HISTORY
1993, c. 208, §3 (NEW). 1993, c. 645, §B6 (AMD).

§2861. PREMIUM NOT DEEMED INTEREST; AMOUNT, COLLECTION

1. Except as provided in Title 9-A, section 4-104, the premium of cost of such insurance when issued through any creditor shall not be deemed interest, or charges, or consideration, or an amount in excess of permitted charges in connection with the loan or other credit transaction, and any benefit or return or other gain or advantage to the creditor arising out of the sale or provision of such insurance shall not be deemed a violation of any other law, general or special, of the State of Maine.

[1973, c. 762, §11 (AMD) .]

2. The amount charged to a debtor for any consumer credit insurance may not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

[2001, c. 138, §14 (AMD) .]

3. The insurance premium or other identifiable charge for such insurance may be collected from the insured or included in the finance charge or principal of any loan or other credit transaction at the time such transaction is completed.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 762, §11 (AMD). 2001, c. 138, §14 (AMD).

§2862. CLAIMS

1. **Claims reported.** All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

[1969, c. 132, §1 (NEW) .]

2. **Claims paid.** All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

[1969, c. 132, §1 (NEW) .]

3. **Creditor may not adjust claims.** No plan or arrangement shall be used whereby any person other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; except that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2863. EXISTING INSURANCE; CHOICE OF INSURER

When credit life insurance or credit health insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact such insurance within this State. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2864. ENFORCEMENT

Whenever the superintendent finds that there has been a violation of this chapter or any regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the superintendent, such hearing to conform to the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV, he shall set forth the details of his findings

together with an order for compliance by a specified date. Such order shall be binding on the insurer and other person authorized or licensed by the superintendent on the date specified unless sooner withdrawn by the superintendent. [1977, c. 694, §424 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §424 (AMD).

§2865. RULEMAKING

The superintendent may adopt rules establishing specific requirements and procedures for consumer credit insurance policies, certificates of coverage and rates, consistent with the purposes of this chapter. These rules may specify additional types of consumer credit insurance that may be issued on an individual basis or, pursuant to chapter 40-A, on a group basis. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter II-A. [2001, c. 138, §15 (NEW).]

SECTION HISTORY
2001, c. 138, §15 (NEW).

Chapter 38: GROUP LEGAL SERVICES INSURANCE

§2881. EXEMPTION FROM CHAPTER

Legal services insurance, as defined in this chapter, does not include the payment by a voluntary association, other than a voluntary association which is an insurer, on behalf of one of its members of fees, costs or expenses related to or arising out of legal services performed for the member by an attorney who either is an employee of the paying association or who provides the legal services to the association's member, pursuant to an agreement with that association. [1983, c. 801, §11 (NEW).]

SECTION HISTORY
1983, c. 801, §11 (NEW).

§2882. INSURERS AUTHORIZED TO SELL LEGAL SERVICES INSURANCE

Upon application to an approval by the superintendent, an insurer incorporated by or under the laws of this State or any foreign or alien insurance company duly licensed to transact insurance in its state of domicile may make application for a certificate of authority to transact the business of legal services insurance, including reinsurance, in this State, if that company is authorized or qualified to be authorized to transact a health insurance business in this State. [1983, c. 801, §11 (NEW).]

SECTION HISTORY
1983, c. 801, §11 (NEW).

§2883. LEGAL SERVICES INSURANCE DEFINED

"Legal services insurance" is insurance which involves the assumption of a contractual obligation to reimburse the beneficiary against or pay on behalf of the beneficiary all or a portion of the beneficiary's fees, costs or expenses related to or arising out of services performed by or under the supervision of an attorney who is not an employee of or under the control of the insurer directly or indirectly and who is licensed to practice in the jurisdiction in which the services are performed. Legal services insurance may also include provisions for basic legal advice only rendered to the beneficiary, by telephone or mail, by one or more attorneys licensed to practice in the jurisdiction in which the advice is given; none of whom are employees of or under the control of the insurer, directly or indirectly. Legal services insurance does not include the provision of or reimbursement for legal services incidental to other insurance coverages. [2009, c. 2, §68 (COR).]

SECTION HISTORY
1983, c. 801, §11 (NEW). RR 2009, c. 2, §68 (COR).

§2884. LEGAL SERVICES INSURANCE AUTHORIZED TO BE SOLD ON A GROUP BASIS

An insurance company authorized to write legal services insurance in this State, which for the purposes of this chapter only is considered a form of health insurance, has the power to issue group legal services insurance policies or may, by providing for the mental and emotional welfare of individuals and members of an individual's family by defraying the costs of legal services, include legal services insurance in and as a part of a group health insurance policy. Group legal services insurance is that form of voluntary legal services insurance covering employees or members, with or without their eligible dependents, written under a master policy issued to any governmental corporation, unit, agency or department or to any employer, association of employers or employee leasing company registered pursuant to Title 32, chapter 125, including the trustee or trustees of a fund established by that employer, association of employers or registered employee leasing company, a labor union or other employee organization, including the trustees of a fund established by that

labor union or employee organization. The terms "employee" and "employees" have the same meaning as are given to those terms for the purposes of writing group life insurance in this State. Legal services insurance may only be issued in this State on a group policy basis. [1995, c. 618, §4 (AMD).]

SECTION HISTORY
1983, c. 801, §11 (NEW). 1995, c. 618, §4 (AMD).

§2885. FILING OF GROUP MANUAL RATES FOR INFORMATIONAL PURPOSES

No policy of group legal services insurance may be delivered in this State until a copy of the group manual rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. [1983, c. 801, §11 (NEW).]

SECTION HISTORY
1983, c. 801, §11 (NEW).

§2886. FREEDOM OF SELECTION OF ATTORNEY

Beneficiaries of legal services insurance shall not be required to select an attorney other than one of the beneficiary's own choosing to provide covered legal services, except for basic legal advice rendered by telephone or mail, as described in this chapter. [1983, c. 801, §11 (NEW).]

SECTION HISTORY
1983, c. 801, §11 (NEW).

§2887. LEGAL SERVICES INSURANCE POLICY RESERVES

For all legal services insurance policies, the insurer shall establish and maintain thereon a reserve which shall place a sound value on its liabilities under those policies and be not less than the reserve according to appropriate standards set forth in rules issued by the superintendent and, in no event, less in the aggregate than the pro rata gross unearned premiums for those policies. [1983, c. 801, §11 (NEW).]

SECTION HISTORY
1983, c. 801, §11 (NEW).

§2888. AUTHORITY OF SUPERINTENDENT TO ADOPT ADDITIONAL RULES

The superintendent may also issue rules regarding the content of legal services insurance policies and marketing arrangements, including delivery of legal services by licensed professionals. [1983, c. 801, §11 (NEW).]

Nothing in this chapter may be construed to authorize the practice of law by any person in violation of Title 4, section 807, or to authorize the superintendent to infringe upon the authority of the Supreme Judicial Court to regulate the practice of law. [1983, c. 801, §11 (NEW).]

SECTION HISTORY
1983, c. 801, §11 (NEW).

Chapter 39: CASUALTY INSURANCE CONTRACTS

Subchapter 1: GENERAL PROVISIONS

§2901. CONTRACTS SUBJECT TO GENERAL PROVISIONS

All contracts of casualty insurance delivered or issued for delivery in this State and covering subjects resident, located, or to be performed in this State are also subject to the applicable provisions of chapter 27 (the insurance contract) and to other applicable provisions of this Title. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2902. UNINSURED VEHICLE COVERAGE; INSOLVENCY OF INSURER

1. A policy insuring against liability arising out of the ownership, maintenance or use of any motor vehicle may not be delivered or issued for delivery in this State with respect to any such vehicle registered or principally garaged in this State, unless coverage is provided in the policy or supplemental to the policy for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured, underinsured or hit-and-run motor vehicles, for bodily injury, sickness or disease, including death, sustained by an insured person resulting from the ownership, maintenance or use of such uninsured, underinsured or hit-and-run motor vehicle. The coverage required by this section may be referred to as "uninsured vehicle coverage." For the purposes of this section, "underinsured motor vehicle" means a motor vehicle for which coverage is provided, but in amounts less than the minimum limits for bodily injury liability insurance provided for under the motorist's financial responsibility laws of this State or less than the limits of the injured party's uninsured vehicle coverage.

[2005, c. 591, §1 (AMD) .]

2. With respect to motor vehicle insurance policies subject to the Maine Automobile Insurance Cancellation Control Act and policies in the assigned risk plan established pursuant to section 2325 securing private passenger auto insurance coverage, the amount of coverage to be so provided may not be less than the amount of coverage for liability for bodily injury or death in the policy offered or sold to a purchaser unless the purchaser expressly rejects such an amount, but in any event may not be less than the minimum limits for bodily injury liability insurance provided for under Title 29-A, section 1605, subsection 1.

A rejection of equal coverage by the purchaser under this subsection must be in writing on a form provided by the insurer. The rejection must be signed by the purchaser, dated and include the following language: "I understand that Maine law requires uninsured motor vehicle coverage limits to equal the limits I have selected for liability coverage for bodily injury or death in this policy unless I expressly reject such an amount of coverage. Pursuant to the Maine Revised Statutes, Title 24-A, section 2902, subsection 2, I have elected to purchase uninsured motor vehicle coverage with lesser limits."

For coverage purchased on or after October 1, 2000, the form must be provided to the purchaser prior to the effective date of coverage. For renewal policies in force as of September 30, 2000, the form must be provided upon the first offer of renewal to each purchaser who has current coverage limits less than those required under this subsection. To be effective, a form must be signed by any one named insured under the policy. If a signed form rejecting higher coverage is not received by the insurer prior to the effective date of the policy to which it applies, then the higher coverage must be provided consistent with this subsection from the policy issuance date for coverage purchased on or after October 1, 2000 and from the effective date of the first renewal on or after October 1, 2000 for policies in force as of September 30, 2000.

This subsection may not be construed to prohibit an insured from prospectively changing coverage to alternative limits of uninsured motor vehicle coverage so long as a signed form, if necessary, is submitted to the insurer prior to the effective date of the change. If an insured has maintained the same uninsured vehicle

coverage limits for 2 consecutive years with the same insurer, then the insured will be conclusively presumed to have accepted that amount of uninsured coverage in all future policies, until such time as the insured notifies the insurer in writing of an election to change the amount of uninsured coverage.

Reinstatement or renewal of coverage by the insured with the same insurer within 30 days of expiration of a policy must be considered, for purposes of this section, as continuous coverage and does not require a new rejection to be executed by the insured.

With respect to motor vehicle insurance policies not subject to the Maine Automobile Insurance Cancellation Control Act, the amount of coverage so provided may not be less than the minimum limits for bodily injury liability insurance provided for under Title 29-A, section 1605, subsection 1.

[1999, c. 663, §1 (AMD); 1999, c. 663, §4 (AFF) .]

3. For the purposes of this section, the term "uninsured motor vehicle" shall be deemed also to include, subject to the terms and conditions of such coverage, an insured other motor vehicle where:

A. The liability insurer of such other motor vehicle is unable because of its insolvency to make payment with respect to the legal liability of its insured within the limits specified in its policy; [1969, c. 132, §1 (NEW).]

B. The occurrence out of which such legal liability arose took place while the uninsured vehicle coverage required under subsection 1, was in effect; and [1969, c. 132, §1 (NEW).]

C. Written notice of such occurrence shall have been given to the insurer within 2 years thereof. [1969, c. 132, §1 (NEW).]

Nothing contained in this subsection shall be deemed to prevent any insurer from providing insolvency protection to its insureds under more favorable terms.

[1969, c. 132, §1 (NEW) .]

4. In the event of payment to any person under uninsured vehicle coverage, and subject to the terms of such coverage, to the extent of such payment the insurer shall be entitled to the proceeds of any settlement or recovery from any person legally responsible for the bodily injury as to which such payment was made, and to amounts recoverable from the assets of the insolvent insurer of the other motor vehicle.

[1969, c. 132, §1 (NEW) .]

5. An insurer or licensed producer holding an appointment from the insurer shall disclose to the purchaser of a motor vehicle liability insurance policy the requirements for uninsured motor vehicle coverage under subsection 2.

[1999, c. 271, §2 (NEW) .]

6. When 2 or more persons are legally entitled to recover damages from a particular owner or operator of an underinsured motor vehicle, the amount of underinsured vehicle coverage applicable to each injured person is determined as provided in this subsection.

A. If the underinsured motor vehicle policy applicable to 2 or more persons who are legally entitled to recover damages contains both a per person and a per accident limit, the amount of underinsured vehicle coverage applicable to each injured person is determined by subtracting any payments actually made to that person from any bodily injury liability insurance coverage applicable to the particular owner or operator of the underinsured motor vehicle from that person's, operator's or owner's underinsured vehicle coverage policy limits if applicable to that person. [2013, c. 284, §1 (NEW).]

B. If the underinsured motor vehicle policy applicable to 2 or more persons who are legally entitled to recover damages contains only a single per accident limit, the amount of underinsured vehicle coverage available to each injured person is determined by subtracting any payment received by that person from

the owner or operator of the underinsured motor vehicle from that single per accident limit. In no event may the maximum amount payable by the insurer to all injured persons exceed the single per accident limit. [2013, c. 284, §1 (NEW).]

C. The amount of underinsured vehicle coverage determined under paragraph A or B must be further reduced by the amount by which the bodily injury liability insurance coverage applicable to the particular owner or operator of the underinsured motor vehicle exceeds all payments from that coverage to all persons legally entitled to recover damages from that particular owner or operator of the underinsured motor vehicle. [2013, c. 284, §1 (NEW).]

D. This subsection does not prohibit an insurer from providing greater amounts of underinsured vehicle coverage than are required under this section. [2013, c. 284, §1 (NEW).]

[2013, c. 284, §1 (RPR) .]

7. Notwithstanding the requirements of subsection 2 relating to the amount of uninsured motor vehicle coverage required to be maintained under motor vehicle insurance policies subject to the Maine Automobile Insurance Cancellation Control Act and policies in the assigned risk plan established pursuant to section 2325 securing private passenger auto insurance coverage, a policy providing uninsured motor vehicle coverage underwritten on a commercial policy form approved for use in this State must provide coverage in an amount not less than the minimum limits for bodily injury liability insurance provided for under Title 29-A, section 1605, subsection 1. Coverage provided to an insured pursuant to this subsection does not obligate the insured to affirmatively reject an offer of higher limits of uninsured motor vehicle coverage. This subsection may not be construed to limit or compel an insured's election of higher limits of uninsured motor vehicle coverage.

[2001, c. 109, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 437, §§1, 2 (AMD). 1975, c. 676, (AMD). 1995, c. 65, §§A153, C15 (AFF). 1995, c. 65, Pt. A, §68 (AMD). 1999, c. 271, §§1, 2 (AMD). 1999, c. 271, §3 (AFF). 1999, c. 663, §§1, 2 (AMD). 1999, c. 663, §§3, 4 (AFF). 2001, c. 109, §1 (AMD). 2005, c. 591, §1 (AMD). 2013, c. 284, §1 (AMD).

§2902-A. HOUSEHOLD EXCLUSION

(REPEALED)

SECTION HISTORY
1985, c. 136, (NEW). 1989, c. 390, §§1,2 (AMD). 1991, c. 126, §§1-3 (AMD). 1993, c. 69, §1 (RP).

§2902-B. MOTORCYCLE PASSENGER EXCLUSION

No insurer may sell or renew, on or after January 1, 1986, a liability insurance policy covering a motorcycle, as defined in Title 29-A, section 101, subsection 38, that excludes coverage for injuries sustained by passengers on the insured's motorcycle unless the insurer notifies the bureau in writing of its utilization of the exclusion, the insurer notifies each of its licensed agents within the State of its utilization of the exclusion and the exclusion is provided by a separate endorsement to the insured's policy. An exclusion that does not meet the requirements of this section is invalid and of no effect. [1995, c. 65, Pt. A, §69 (AMD); 1995, c. 65, Pt. A, §153 (AFF); 1995, c. 65, Pt. C, §15 (AFF).]

SECTION HISTORY
1985, c. 737, §A60 (RAL). 1995, c. 65, §A69 (AMD). 1995, c. 65, §§A153,C15 (AFF).

§2902-C. REFUSAL TO ISSUE INSURANCE PROHIBITED

No insurer may refuse to issue motor vehicle liability insurance to an applicant solely because the applicant is 65 years of age or older. [1991, c. 106, (NEW).]

SECTION HISTORY
1991, c. 106, (NEW).

§2902-D. FAMILY EXCLUSIONS PROHIBITED

An insurer may not sell or renew a motor vehicle liability insurance policy on or after January 1, 1994 with a provision that excludes coverage for injury to the insured or any family member of the insured. [1993, c. 69, §2 (NEW).]

SECTION HISTORY
RR 1993, c. 1, §62 (COR). 1993, c. 69, §2 (NEW). 1993, c. 93, §1 (NEW).

§2902-E. LIMITATION ON SURCHARGE

An insurer may not impose a surcharge or otherwise increase the rate for a motor vehicle insurance policy solely on the basis that the named insured, a member of the insured's household or a person who customarily operates the insured's vehicle has had an operator's license suspended pursuant to Title 28-A, sections 2052 and 2053. [1993, c. 93, §1 (NEW).]

SECTION HISTORY
RR 1993, c. 1, §62 (RNU). 1993, c. 93, §1 (NEW).

§2902-F. VOLUNTEER DRIVERS

An insurer may not refuse to issue motor vehicle liability insurance to an applicant solely because the applicant is a volunteer driver. An insurer may not impose a surcharge or otherwise increase the rate for a motor vehicle policy solely on the basis that the named insured, a member of the insured's household or a person who customarily operates the insured's vehicle is a volunteer driver. For purposes of this section, "volunteer driver" means a person who provides services, including transporting individuals or goods, without compensation above expenses to a nonprofit agency or charitable organization as defined in Title 14, section 158-A. This section does not prohibit an insurer from refusing to renew, imposing a surcharge or otherwise raising the rate for a motor vehicle liability insurance policy based upon factors other than the volunteer status of the insured driver. [1995, c. 132, §1 (NEW).]

SECTION HISTORY
1995, c. 132, §1 (NEW).

§2902-G. DISCOUNTED PREMIUMS FOR OLDER DRIVERS

1. **Discount; accident prevention course required.** Any rates, rating schedules or rating manuals for the liability, personal injury protection and collision coverages of a motor vehicle insurance policy submitted to or filed with the bureau must provide for an appropriate discount in premium charges for such coverages for a 3-year period when the principal operator of the covered vehicle is an insured 55 years of age or older who successfully completes a motor vehicle accident prevention course approved by the Department of Public Safety, Bureau of Highway Safety.

[2001, c. 130, §1 (NEW) .]

2. **Condition.** The premium reduction required by subsection 1 is effective for a 3-year period after an insured 55 years of age or older successfully completes an approved motor vehicle accident prevention course, except that the insurer may require, as a condition of providing and maintaining the discount, that for a 3-year period after the course is completed:

A. The insured or a member of the insured's household insured under the policy not be involved in an accident for which the insured is at fault; [2001, c. 130, §1 (NEW).]

B. The insured or a member of the insured's household insured under the policy not have committed a moving violation as defined in Title 29-A, section 101, subsection 44; or [2001, c. 130, §1 (NEW).]

C. The insured or a member of the insured's household insured under the policy not be subject to a driver's license suspension. [2001, c. 130, §1 (NEW).]

[2001, c. 130, §1 (NEW) .]

3. **Qualification; certificate.** An organization offering an approved motor vehicle accident prevention course used to qualify for the premium discount required by subsection 1 shall issue a certificate to a person who successfully completes the course.

[2001, c. 130, §1 (NEW) .]

4. **Application.** An insured is not eligible for the premium discount under subsection 1 when the insured is required by a court or other government entity to complete the approved motor vehicle accident prevention course because the insured has committed a moving violation as defined in Title 29-A, section 101, subsection 44.

[2001, c. 130, §1 (NEW) .]

5. **Eligibility.** An insured must pass an approved motor vehicle accident prevention course every 3 years to continue to be eligible for the premium discount.

[2001, c. 130, §1 (NEW) .]

SECTION HISTORY
2001, c. 130, §1 (NEW).

§2903. LIABILITY ABSOLUTE WHEN LOSS OCCURS

The liability of every insurer which insures any person against accidental loss or damage on account of personal injury or death or on account of accidental damage to property shall become absolute whenever such loss or damage, for which the insured is responsible, occurs. The rendition of a final judgment against the insured for such loss or damage shall not be a condition precedent to the right or obligation of the insurer to make payment on account of such loss or damage. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§2904. JUDGMENT CREDITOR MAY HAVE INSURANCE; EXCEPTIONS

Whenever any person, administrator, executor, guardian, recovers a final judgment against any other person for any loss or damage specified in section 2903, the judgment creditor shall be entitled to have the insurance money applied to the satisfaction of the judgment by bringing a civil action, in his own name, against the insurer to reach and apply the insurance money, if when the right of action accrued, the judgment debtor was insured against such liability and if before the recovery of the judgment the insurer had had notice

of such accident, injury or damage. The insurer shall have the right to invoke the defenses described in this section in the proceedings. None of the provisions of this paragraph and section 2903 shall apply: [1969, c. 132, §1 (NEW).]

1. **Motor vehicle operated illegally or by one under age.** When the insured automobile, motor vehicle or truck is being operated by any person contrary to law as to age or by any person under the age of 16 years where no statute restricts the age; or

[1969, c. 132, §1 (NEW) .]

2. **Motor vehicle used in race contest.** When such automobile, motor vehicle or trust is being used in any race or speed contest; or

[1969, c. 132, §1 (NEW) .]

3. **Motor vehicle used for towing a trailer.** When such automobile, motor vehicle or truck is being used for towing or propelling a trailer unless such privilege is indorsed on the policy or such trailer is also insured by the insurer; or

[1969, c. 132, §1 (NEW) .]

4. **Liability assumed.** In the case of any liability assumed by the insured for others; or

[1969, c. 132, §1 (NEW) .]

5. **Liability under workers' compensation.** In the case of any liability under any workers' compensation agreement, plan or law; or

[1989, c. 502, Pt. A, §98 (AMD) .]

6. **Fraud or collusion.** When there is fraud or collusion between the judgment creditor and the insured.

[1969, c. 132, §1 (NEW) .]

No civil action shall be brought against an insurer to reach and apply such insurance money until 20 days shall have elapsed from the time of the rendition of the final judgment against the judgment debtors. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1989, c. 502, §A98 (AMD).

§2905. CANCELLATION, RELEASE OF INTEREST INSURED UNDER, AUTOMOBILE PHYSICAL DAMAGE INSURANCE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 339, §2 (RP).

§2906. AUTOMOBILE INSURANCE, CANCELLATION, NONRENEWAL AND CERTAIN CHANGES BECAUSE OF AGE, PROHIBITED

(REPEALED)

SECTION HISTORY
1971, c. 160, (NEW). 1971, c. 622, §79 (AMD). 1973, c. 339, §2 (RP).

§2907. COVERAGE FOR SALES TAX CREDIT

All contracts of motor vehicle casualty insurance delivered or issued for delivery in this State covering motor vehicles registered in this State shall provide coverage for the value of the sales tax credit that would have been available upon trade thereof at the highest book value at the time of loss or destruction of the insured vehicle. [1973, c. 219, (NEW).]

SECTION HISTORY
1973, c. 219, (NEW).

§2908. CANCELLATION AND NONRENEWAL

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

A. "Cancellation" means termination of a policy at a date other than its expiration date. [1985, c. 671, §1 (NEW).]

B. "Expiration date" means the date upon which coverage under a policy ends. It also means, for a policy written for a term longer than one year or with no fixed expiration date, each annual anniversary date of the policy. [1985, c. 671, §1 (NEW).]

C. "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premium on a policy of insurance subject to this section, whether the payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. [1985, c. 671, §1 (NEW).]

D. "Nonrenewal" means termination of a policy at its expiration date. [1985, c. 671, §1 (NEW).]

E. "Renewal" or "to renew" means the issuance of, or the offer to issue by an insurer, a policy succeeding a policy previously issued and delivered by the same insurer or an affiliate of the insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date. For the purposes of this section, the transfer of a policy from an insurer to an affiliate is considered a policy renewal. [2007, c. 188, Pt. C, §1 (AMD).]

[2007, c. 188, Pt. C, §1 (AMD) .]

2. Except as provided in subsection 8, no contract of casualty insurance may be cancelled by an insurer prior to the expiration of the policy, except for one or more of the following grounds:

A. Nonpayment of premium; [1985, c. 671, §1 (NEW).]

B. Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim under the policy; [1985, c. 671, §1 (NEW).]

C. Substantial change in the risk which increases the risk of loss after insurance coverage has been issued or renewed, including, but not limited to, an increase in exposure due to rules, legislation or court decision; [1985, c. 671, §1 (NEW).]

D. Failure to comply with reasonable loss control recommendations; [1985, c. 671, §1 (NEW).]

E. Substantial breach of contractual duties, conditions or warranties; or [1985, c. 671, §1 (NEW).]

F. Determination by the superintendent that the continuation of a class or block of business to which the policy belongs will jeopardize a company's solvency or will place the insurer in violation of the insurance laws of this State or any other state. [1985, c. 671, §1 (NEW).]

The grounds listed in paragraphs A to E shall be contained in all policies issued, issued for delivery or renewed on or after the effective date of this section. Insurers shall have 30 days from the effective date of this section to notify insureds of these grounds for cancellation on policies issued or issued for delivery before the effective date of this section.

[1985, c. 671, §1 (NEW) .]

3. If a policy has been issued for a term longer than one year and, for additional premium consideration, a premium has been guaranteed, the insurer may not refuse to renew the policy or increase the policy premium for the term of that policy.

[1985, c. 671, §1 (NEW) .]

4. If an insurer offers or purports to renew a contract, but on less favorable terms to the insured or at higher rates or a higher rating plan, the new terms or rates and rating plan may take effect on the renewal date, if the insurer has provided the insured 30 days notice. If the insurer has not so notified the contract holder, the contract holder may elect to cancel the renewal policy within the 30-day period after receipt of the notice or delivery. Earned premium for the period of coverage for such time as the renewal contract may have been in force, shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective immediately following the prior policy's expiration or anniversary date. This section does not apply if the change is a rate, form or plan filed with the superintendent and applicable to the entire class of business to which the policy belongs or to a premium increase based on the altered nature or extent of the risk insured against.

[1985, c. 671, §1 (NEW) .]

5. Cancellation or nonrenewal is not effective until notice is received by the insured as follows.

A. Except for workers' compensation insurance, cancellation may not be effective prior to 10 days after receipt by the insured of a notice of cancellation. Notice of cancellation of workers' compensation insurance is subject to Title 39-A, section 403, subsection 1. The notice must state the effective date of and the reason or reasons for cancellation. [1991, c. 885, Pt. E, §31 (AMD); 1991, c. 885, Pt. E, §47 (AFF).]

B. Nonrenewal subject to this section shall not be effective prior to 30 days after receipt of written notice by the insured. If an insurer provides a notice of nonrenewal as described in this subsection and thereafter extends the policy 90 days or less, an additional notice of nonrenewal is not required with respect to this extension. [1985, c. 671, §1 (NEW).]

C. A post-office certificate of mailing to the named insured at his last known address is conclusive proof of receipt of notice on the 3rd calendar day after mailing. [1985, c. 671, §1 (NEW).]

D. For policies providing automobile physical damage coverage, like notice of cancellation or nonrenewal must also be given to any party named in a loss payable clause. [2007, c. 188, Pt. C, §2 (NEW).]

[2007, c. 188, Pt. C, §2 (AMD) .]

6. Any insured who has received a notice of an insurer's intent to cancel a policy may, within 45 days of the receipt of the notice, request a hearing before the superintendent. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence given by the insurer in its notice of cancellation. The burden of proof of the reason for cancellation shall be upon the insurer. The superintendent shall have the authority to order that a policy remain in effect both pending and, if the superintendent finds in

favor of the insured, subsequent to a hearing. If the superintendent finds in favor of the insurer at a hearing, the superintendent may order the policy to remain in force for 14 days to allow the insured to obtain other coverage.

[1989, c. 172, §3 (AMD) .]

7. Except as provided in Title 10, chapter 209-B, no insurer or licensed agent or employee of the insurer may be held liable in any civil action for statements made in a notice of cancellation or nonrenewal or at a hearing held under this section if the statements were made in good faith and, in the case of cancellation, are reasonably related to the grounds for cancellation.

[2013, c. 588, Pt. C, §12 (AMD) .]

8. Except for the definitions in subsection 1 and cancellation notice requirements set forth in subsection 5, this section does not apply to any insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time notice of cancellation is mailed or otherwise delivered. This section does not apply to any policy subject to the Maine Automobile Insurance Cancellation Control Act, subchapter II. This section does not apply to any assigned risk program. The superintendent may suspend, in whole or in part, the applicability of this section to any insurer if, in the superintendent's discretion, its application will endanger the ability of the insurer to fulfill its contractual obligations.

[1997, c. 126, §5 (AMD) .]

9. This section applies to all contracts of casualty insurance, except surplus lines contracts, delivered or issued for delivery in this State, both before and after the effective date of this section. Provisions in this section relating to nonrenewal of policies shall take effect 30 days after the effective date of this section.

[1989, c. 172, §3 (AMD) .]

SECTION HISTORY
1985, c. 671, §1 (NEW). 1987, c. 559, §A5 (AMD). 1989, c. 172, §§2,3 (AMD). 1991, c. 25, §1 (AMD). 1991, c. 885, §E31 (AMD). 1991, c. 885, §E47 (AFF). 1997, c. 126, §5 (AMD). 2007, c. 188, Pt. C, §§1, 2 (AMD). 2013, c. 588, Pt. C, §12 (AMD).

§2909. INSURANCE FOR DEALERS AND TRANSPORTERS

1. As used in this section, "owner" means the owner of a motor vehicle, the owner's agent, employee or independent contractor.

[1989, c. 261, §1 (NEW) .]

2. The superintendent may not approve any policy required pursuant to Title 29-A, section 1612, unless coverage is provided for both the owner and operator of the motor vehicle.

[1995, c. 65, Pt. A, §70 (AMD); 1995, c. 65, Pt. A, §153 (AFF); 1995, c. 65, Pt. C, §15 (AFF) .]

3. The owner's policy must provide primary coverage up to the limits specified in Title 29-A, section 1612. Any other valid and collectible insurance policy available to an operator who is not the owner must provide excess coverage.

[1995, c. 65, Pt. A, §70 (AMD); 1995, c. 65, Pt. A, §153 (AFF); 1995, c. 65, Pt. C, §15 (AFF) .]

SECTION HISTORY
1989, c. 261, §1 (NEW). 1995, c. 65, §A70 (AMD). 1995, c. 65, §§A153,C15 (AFF).

§2910. LOSS INFORMATION TO BE SUPPLIED

1. **Request for information.** Every insurer shall provide loss information concerning an insurance policy to its insured within 30 calendar days of the receipt of a written request from the insured or an insurance agent or other authorized representative of the insured. An insurer may not cancel or refuse to renew an insurance policy for the nonpayment of premium during any period within which the insurer fails to provide the loss information requested under this section, unless the insured requests that information fewer than 45 calendar days prior to the expiration date of the insurance policy.

[1989, c. 696, §1 (NEW) .]

2. **Transmittal of request.** If an insured requests loss information from an insurance agent or an authorized representative of the insured, the representative or agent shall transmit the request for loss information to the insurer within 4 working days.

[1989, c. 696, §1 (NEW) .]

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section. [1989, c. 696, §1 (NEW).]

B. "Loss information," except with respect to workers' compensation insurance, means the following items: the name of the insured, the date of the loss, the date that the claim was received by the insurer, a description of the loss, any amount paid by the insurer on account of the loss, any amount reserved for the loss and whether the claim is open or closed. [1989, c. 696, §1 (NEW).]

C. "Loss information," with respect to workers' compensation insurance, means the following items: the name of the claimant, the date of the injury, a description of the injury, any amount paid for medical expense, any amount paid for indemnity expense, any medical reserve, the total incurred losses and whether the claim is open or closed. [1989, c. 696, §1 (NEW).]

[1989, c. 696, §1 (NEW) .]

SECTION HISTORY
1989, c. 696, §1 (NEW).

§2910-A. SUBROGATION; MEDICAL PAYMENTS COVERAGE

1. **Policy requirements.** A casualty insurance policy subject to this chapter may not provide for subrogation or priority over the insured of payment for any hospital, nursing, medical or surgical services or of any expenses paid or reimbursed under the medical payments coverage in the policy in the event the insured is entitled to receive payment or reimbursement from any other person as a result of legal action or claim, except as provided in this section.

The coverage may contain a provision that allows the payments if:

A. [2011, c. 509, §1 (RP).]

B. The provision requires the written approval of the insured; [2009, c. 222, §1 (NEW).]

C. The provision provides that the insurer's subrogation right is subject to subtraction to account for the pro rata share of the insured's attorney's fees incurred in obtaining the recovery from another source; and [2009, c. 222, §1 (NEW).]

D. The provision is approved by the superintendent. [2009, c. 222, §1 (NEW).]

[2011, c. 509, §1 (AMD) .]

2. **Dispute resolution.** In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, that dispute must be determined, if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute.

[1997, c. 369, §2 (NEW) .]

3. **Exception.** Nothing in this section prevents an insurer from exercising its subrogation rights directly against any person legally responsible for the insured's injury. In the event that the insurer pursues its subrogation rights directly against such a person, the insurer's subrogation right is not subject to any subtraction to account for attorney's fees and the insurer is entitled to full recovery.

[1997, c. 369, §2 (NEW) .]

SECTION HISTORY
1997, c. 369, §2 (NEW). 2009, c. 222, §1 (AMD). 2011, c. 509, §1 (AMD).

Subchapter 2: AUTOMOBILE INSURANCE CANCELLATION CONTROL ACT

§2911. TITLE

This subchapter shall be known as the "Maine Automobile Insurance Cancellation Control Act." Unless otherwise specified, all hearings held under this subchapter shall conform to the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [1977, c. 694, §425 (AMD).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP).
1977, c. 694, §425 (AMD).

§2912. DEFINITIONS

As used in this subchapter, unless otherwise required by the context, the following words shall have the following meanings. [1973, c. 339, §1 (NEW).]

1. **Policy.** "Policy" means an automobile insurance policy providing bodily injury liability, property damage liability, medical payments, uninsured motorist coverage, physical damage coverage, or any combination thereof, delivered or issued for delivery in this State, insuring a single individual or one or more related individuals resident in the same household, as named insured and insuring vehicles of the following types only:

A. Motor vehicles of the private passenger or station wagon type that are not used as public conveyances nor rented to others; and [2007, c. 188, Pt. C, §3 (AMD).]

B. Any other 4-wheel motor vehicles with a load capacity of 1,500 pounds or less that are not used in the business or professions of the insured. [2007, c. 188, Pt. C, §3 (AMD).]

[2007, c. 188, Pt. C, §3 (AMD) .]

2. **Renewal or renew.** "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy replacing at the end of the previous policy term a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the coverage of the policy beyond its original term. For purposes of this subchapter, the transfer of a policy from an insurer to an affiliate is considered a policy renewal.

Any policy written for a term longer than one year or with no fixed expiration date is considered written for successive policy terms of one year for the purposes of this subchapter.

[2007, c. 188, Pt. C, §4 (AMD) .]

3. **Nonpayment of premium.** "Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premium on the policy, or any installment of a premium, whether the premium is payble directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

[1973, c. 339, §1 (NEW) .]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP). 1977, c. 403, §1 (AMD). 2005, c. 114, §1 (AMD). 2007, c. 188, Pt. C, §§3, 4 (AMD).

§2913. WHEN NOT APPLICABLE

This subchapter shall not apply to any policy: [1973, c. 339, §1 (NEW).]

1. Insured under an automobile assigned risk plan;

[1973, c. 339, §1 (NEW) .]

2. Covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards;

[1973, c. 339, §1 (NEW) .]

3. Insuring more than 4 automobiles;

[1973, c. 339, §1 (NEW) .]

4. Issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance or use of a motor vehicle on the premises of such insured or on the ways immediately adjoining the premises.

[1973, c. 339, §1 (NEW) .]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP).

§2914. NOTICE OF CANCELLATION -- REASONS

No policy may be cancelled except by notice to the insured and any other person mentioned in the loss payable clause of an automobile physical damage policy, as provided in this subchapter. [1973, c. 339, §1 (NEW).]

No notice of cancellation of a policy shall be effective unless it is based on one or more of the following reasons: [1973, c. 339, §1 (NEW).]

1. **Nonpayment of premium.** No notice of cancellation for nonpayment of premium shall be effective unless deemed received under section 2915 after the premium due date;

[1979, c. 347, §1 (AMD) .]

2. Fraud or material misrepresentation affecting the policy or the presentation of a claim;

[1973, c. 339, §1 (NEW) .]

3. Violation of terms or conditions of the policy;

[1973, c. 339, §1 (NEW) .]

4. The named insured or any operator who either resides in the same household or customarily operates an automobile insured under the policy has a driver's license suspended, other than a first or 2nd suspension under Title 29-A, section 2471, subsection 2 or section 2472, subsection 2 or a suspension under Title 28-A, section 2052, or revoked during the policy term or, if the policy is a renewal, during its term or the 180 days immediately preceding its effective date.

[1995, c. 65, Pt. A, §71 (AMD); 1995, c. 65, Pt. A, §153 (AFF); 1995, c. 65, Pt. C, §15 (AFF) .]

During the policy period, an automobile insurance policy may not be modified except by agreement between the insured and the insurer. Modification agreed upon between the insured and the insurer shall not be deemed a cancellation of the coverage or of the policy. [1977, c. 403, §2 (RPR).]

This section shall not apply to any policy or coverage which has been in effect less than 60 days at the time notice of cancellation is received by the named insured nor shall section 2920 apply to any policy or coverage that has been in effect less than 60 days. [1979, c. 347, §2 (AMD).]

This section shall not apply to nonrenewal of an automobile insurance policy. [1977, c. 403, §2 (NEW).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP). 1977, c. 403, §2 (AMD). 1979, c. 347, §§1,2 (AMD). 1987, c. 138, (AMD). 1993, c. 93, §2 (AMD). 1995, c. 65, §A71 (AMD). 1995, c. 65, §§A153,C15 (AFF).

§2915. DELIVERY OF NOTICE

A notice of cancellation of a policy is not effective unless received by the named insured at least 20 days prior to the effective date of cancellation, or, when the cancellation is for nonpayment of premium, at least 10 days prior to the effective date of cancellation. In the event the policy provides automobile physical damage coverage, like notice of cancellation must also be given to any party mentioned in the loss payable clause.
A postal service certificate of mailing to the named insured at the insured's last known address is conclusive proof of receipt on the 5th calendar day after mailing. [2007, c. 188, Pt. C, §5 (AMD).]

Except for a policy that has been in effect for less than 60 days at the time notice of cancellation is received by the named insured, the reason for cancellation must accompany the notice, together with a notice of the right to apply for a hearing before the superintendent within 30 days, as provided in section 2920. [2007, c. 188, Pt. C, §5 (AMD).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §145 (RP). 1977, c. 403, §3 (AMD). 1979, c. 347, §§3,4 (AMD). 1989, c. 172, §4 (AMD). 2005, c. 114, §2 (AMD). 2007, c. 188, Pt. C, §5 (AMD).

§2916. AUTOMOBILE INSURANCE, CANCELLATION, NONRENEWAL AND CERTAIN CHANGES BECAUSE OF AGE, PROHIBITED

No insurance company authorized to transact business in this State shall cancel, reduce liability limits, refuse to renew or increase the premium of any automobile insurance policy of any kind whatsoever for the sole reason that the person to whom such policy has been issued has reached a certain age. [1973, c. 339, §1 (NEW).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP).

§2916-A. NONRENEWAL -- REASONS

A notice of nonrenewal may not be issued unless it is based upon a reason for which the policy could have been cancelled or unless it is based upon one or more of the following grounds that occurred during the 36-month period preceding the yearly anniversary date of the policy. A nonrenewal is effective only on the policy's yearly anniversary date. [2007, c. 188, Pt. C, §6 (AMD).]

1. **Convictions.** When a named insured or any operator who either resides in the same household or customarily operates an automobile insured under the policy is convicted of any of the following:

A. Operating a motor vehicle while intoxicated or impaired by the consumption of alcohol or drugs; [1979, c. 336, §1 (NEW).]

B. Homicide or assault arising out of the use of the operation of a motor vehicle, criminal negligence in the use or operation of a motor vehicle resulting in the injury or death of another person or use or operation of a motor vehicle directly or indirectly in the commission of a felony; [1979, c. 336, §1 (NEW).]

C. Operating a motor vehicle in excess of the speed limit or in a reckless manner where injury or death results therefrom; [1979, c. 336, §1 (NEW).]

D. Operating a motor vehicle in excess of the speed limit or reckless driving or any combination thereof on 3 or more occasions; [1979, c. 336, §1 (NEW).]

E. Operating a motor vehicle insured under the policy without a valid license or registration in effect, except when the person convicted had possessed a valid license or registration which had expired and was subsequently renewed, or during a period of revocation or suspension thereof or in violation of the limitations set forth on the operator's license; [1979, c. 336, §1 (NEW).]

F. Operating a motor vehicle while attempting to avoid apprehension or arrest by a law enforcement officer; [1979, c. 336, §1 (NEW).]

G. Filing or attempting to file a false or fraudulent automobile insurance claim or knowingly aiding or abetting in the filing or attempted filing of any such claim; [1979, c. 336, §1 (NEW).]

H. Leaving the scene of an accident without reporting; [1979, c. 336, §1 (NEW).]

I. Filing a false document with the Secretary of State or the Bureau of Motor Vehicles or using a license or registration obtained by filing a false document with the Secretary of State or the Bureau of Motor Vehicles; [1991, c. 837, Pt. A, §50 (AMD).]

J. Operating a motor vehicle in a race or speed test; or [1979, c. 336, §1 (NEW).]

K. Knowingly permitting or authorizing an unlicensed driver to operate a motor vehicle insured under the policy. [1979, c. 336, §1 (NEW).]

[1991, c. 837, Pt. A, §50 (AMD) .]

2. **Accidents.** When a named insured or any other person who operates a motor vehicle insured under the policy is individually or are aggregately involved in 2 or more vehicle accidents while operating a motor vehicle insured under the policy or under another policy issued by the same insurer for a motor vehicle in the same household, resulting in either personal injury or property damage in excess of the amount defined as a reportable accident under Title 29-A, section 2251, subsection 1. For the purpose of this subsection any of the following occurrences involving a motor vehicle operated by a named insured or such other person is not considered an accident when:

A. The motor vehicle was struck from the rear; [1979, c. 336, §1 (NEW).]

B. The motor vehicle was struck while parked; [1979, c. 336, §1 (NEW).]

C. Only the operator of another motor vehicle involved in the accident was convicted of a crime, offense or violation contributing to the accident; or [1979, c. 336, §1 (NEW).]

D. The named insured or other operator of the motor vehicle insured under the policy or the insurer of the policy, was reimbursed by or on behalf of, a person responsible for the accident or has a judgment against that person. [1999, c. 617, §2 (AMD).]

When more than one motor vehicle in a household is insured by the same insurer, the aggregate number of accidents that would permit nonrenewal of the policy or policies insuring those vehicles must be increased by one for each additional motor vehicle insured.

[2003, c. 26, §1 (AMD) .]

3. **Insurability.** When there is a material change in the type of motor vehicle insured which so substantially increases the hazard insured against as to render the motor vehicle uninsurable in accordance with the insurer's underwriting standards in effect at the time the policy was issued or last renewed; provided that if the insured motor vehicle is uninsurable for physical damage coverages only, the insurer shall offer to renew the policy without the physical damage coverages.

[1979, c. 336, §1 (NEW) .]

SECTION HISTORY
1979, c. 336, §1 (NEW). 1987, c. 261, (AMD). 1991, c. 837, §A50 (AMD). 1999, c. 617, §2 (AMD). 2003, c. 26, §1 (AMD). 2007, c. 188, Pt. C, §6 (AMD).

§2916-B. EXCLUSION OF COVERED PERSONS UNDER PERSONAL AUTOMOBILE POLICY

In order to avoid cancellation or nonrenewal of an automobile insurance policy, and to allow an insurer to provide or to continue to provide coverage without an unreasonable risk, an insurer and the named insured may agree, by an endorsement to the policy signed by the interested parties, to exclude from coverage as operators of the insured vehicle or vehicles any covered person or persons who commit an act or acts for

which the policy could be cancelled under section 2914, subsection 4, or for which the insurer could refuse to renew under section 2916-A subsections 1 and 2. Every endorsement under this section shall contain the following notice in conspicuous print:

> "NOTICE TO POLICYHOLDER IF THE PERSON EXCLUDED FROM COVERAGE BY THIS ENDORSEMENT IS UNDER THE AGE OF 18 YEARS, YOU CAN BE HELD LIABLE UNDER STATE LAW FOR HIS OR HER NEGLIGENCE WHEN HE OR SHE OPERATES YOUR VEHICLE WITH YOUR PERMISSION. YOUR POLICY DOES NOT INSURE YOU AGAINST THIS LIABILITY."

[1981, c. 69, (NEW).]

SECTION HISTORY
1981, c. 69, (NEW).

§2916-C. DISCONTINUANCE OF A LINE OF BUSINESS

If an insurer files a plan with the superintendent to discontinue business in a line of insurance subject to this subchapter, the superintendent may authorize the nonrenewal of policies in that line of business if the plan filed by the insurer demonstrates the availability of substantially similar coverage in the admitted market. The nonrenewal of a policyholder pursuant to this section may not be considered by an insurer in future coverage determinations. An insurer may resume transacting business in a line of insurance discontinued pursuant to this section upon written notification to the superintendent. [2005, c. 49, §1 (AMD).]

SECTION HISTORY
1995, c. 544, §9 (NEW). 2005, c. 49, §1 (AMD).

§2917. NOTICE OF INTENT

An insurer may not fail to renew a policy except by notice to the insured as provided in this subchapter. A notice of intention not to renew is not effective unless received by the named insured at least 30 days prior to the expiration date of the policy. In the event the policy provides automobile physical damage coverage, like notice of intention not to renew must be given to any party named in the loss payable clause. A post office department certificate of mailing to the named insured at the insured's last known address is conclusive proof of receipt on the 3rd calendar day after mailing. [2007, c. 188, Pt. C, §7 (AMD).]

The reason or reasons for the intended nonrenewal action must accompany the notice of intent not to renew and the reason or reasons must be explicit. Explanations such as "underwriting reasons," "underwriting experience," "loss record," "driving experience," "credit report" and similar insurance terms are not by themselves acceptable explanations of an insurer's intended nonrenewal of an automobile insurance policy. A notice of a right to apply for a hearing before the superintendent within 30 days as provided in this section must accompany the notice of intent not to renew. [2007, c. 188, Pt. C, §7 (AMD).]

This section does not apply: [2007, c. 188, Pt. C, §7 (AMD).]

1. If the insurer has manifested its willingness to renew;

[1973, c. 339, §1 (NEW) .]

2. If the insured fails to pay any premium due or any advance premium required by the insurer for renewal; or

[2007, c. 188, Pt. C, §7 (AMD) .]

3. If the insurer has transferred a policy to an affiliate. Prior to the date of renewal of a policy that has been transferred by an insurer to an affiliate, the insured must receive notice of any changes to the terms of the policy that are less favorable to the insured.

[2007, c. 188, Pt. C, §7 (NEW) .]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §145 (RP). 1977, c. 403, §4 (AMD). 1977, c. 597, (AMD). 1979, c. 347, §§5,6 (AMD). 2007, c. 188, Pt. C, §7 (AMD).

§2918. DUPLICATE COVERAGE

If an insured obtains a 2nd policy which provides equal or more extensive coverage for any vehicle designated in both policies, the first policy's coverage of such vehicle may be terminated by failure to renew as of the effective time and date of the 2nd policy, whether or not the first policy insurer complies with all provisions of section 2917. [1973, c. 339, §1 (NEW).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP).

§2919. RENEWAL NOT A WAIVER OR ESTOPPEL

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of renewal. [1973, c. 339, §1 (NEW).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 625, §145 (RP).

§2920. HEARING BEFORE SUPERINTENDENT

Any named insured who has received a statement of reason for cancellation, or of reason for an insurer's intent not to renew a policy, may, within 30 days of the receipt of a statement of reason, request a hearing before the Superintendent of Insurance. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence given by the insurer in its reason for cancellation or intent not to renew. The burden of proof of the reason for cancellation or intent not to renew shall be upon the insurer. The superintendent shall have the authority to order that a policy continue in effect both pending and, if the superintendent finds in favor of the insured, subsequent to a hearing. If the superintendent finds in favor of the insurer at a hearing, the superintendent may order the policy to remain in force for 14 days to allow the insured to obtain other coverage. Acting in conformity with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may adopt rules for carrying out this section. [1989, c. 172, §5 (AMD).]

SECTION HISTORY
1973, c. 339, §1 (NEW). 1973, c. 439, (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §145 (RP). 1977, c. 403, §5 (AMD). 1977, c. 694, §426 (AMD). 1979, c. 336, §2 (AMD). 1979, c. 347, §7 (AMD). 1989, c. 172, §5 (AMD).

§2921. INSURED TOLD OF ALTERNATE COVERAGE

When automobile bodily injury and property damage liability coverage is cancelled or not renewed, other than for nonpayment of premium, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through the Maine Automobile Insurance Plan. Such notice shall accompany the notice of cancellation or intent not to renew. [1973, c. 339, §1 (NEW).]

SECTION HISTORY
1973, c. 339, §1 (NEW).

§2922. SUPERINTENDENT'S AUTHORITY TO SUSPEND

In the event of impairment or serious financial difficulty of an insurer, the superintendent shall have the authority to suspend the provisions of this Act from applying to the policies of the financially distressed insurer. [1977, c. 403, §6 (NEW).]

SECTION HISTORY
1977, c. 403, §6 (NEW).

§2923. NONLIABILITY FOR CERTAIN STATEMENTS

1. **Notices.** Except as provided in Title 10, chapter 209-B, no insurer or licensed agent or employee of the insurer may be held liable in any civil action for statements made in a notice of cancellation or intent not to renew under this chapter if:

A. The statements were made in good faith; [1979, c. 112, §1 (NEW).]

B. The statements are reasonably related to the reason for cancellation or intent not to renew; and [1979, c. 112, §1 (NEW).]

C. In the case of a notice of cancellation, the reason for cancellation is a reason permitted under section 2914. [1979, c. 112, §1 (NEW).]

[2013, c. 588, Pt. C, §13 (AMD) .]

2. **Hearings.** Except as provided in Title 10, chapter 209-B, no person may be held liable in any civil action for statements made or information given at a hearing held under this chapter if:

A. The statements were made or the information was given in good faith; [1979, c. 112, §1 (NEW).]

B. The statements or the information are reasonably related to the reason for cancellation or intent not to renew; and [1979, c. 112, §1 (NEW).]

C. In the case of a hearing held on a notice of cancellation, the reason for cancellation is a reason permitted under section 2914. [1979, c. 112, §1 (NEW).]

[2013, c. 588, Pt. C, §13 (AMD) .]

SECTION HISTORY
1979, c. 112, §1 (NEW). 2013, c. 588, Pt. C, §13 (AMD).

§2924. ASSIGNED RISK INSURANCE PLAN

If no payment for renewal of a policy has been received by the insurer 15 days prior to the expiration date of the policy, the insurer shall notify the insured in accordance with this section. Written notice shall be mailed or delivered to the named insured no less than 10 days prior to the expiration date. The notice shall state that the policy will terminate on the expiration date if the insurer does not receive payment by that date. A post-office department certificate of mailing is proof of mailing. [1989, c. 354, (NEW).]

SECTION HISTORY
1989, c. 354, (NEW).

Subchapter 3: PERSONAL AUTOMOBILE INSURANCE AND RENTAL VEHICLE COVERAGE HEADING: PL 1991, C. 335 (NEW)

§2927. PERSONAL AUTOMOBILE INSURANCE; RENTAL VEHICLE COVERAGE

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

A. "Authorized driver" means:

(1) The renter;

(2) The renter's spouse, if that person is a licensed driver meeting the rental company's minimum age requirement;

(3) The renter's employer or coworker, if that person is engaged in business activity with the renter and is a licensed driver meeting the rental company's minimum age requirement;

(4) A person who operates the vehicle during an emergency or while parking the vehicle in the course of that person's employment at a commercial establishment; or

(5) A person listed by the rental company on the rental agreement as an authorized driver. [1991, c. 335, (NEW).]

B. "Covered rental agreement" means a written agreement with a term of 45 continuous days or fewer setting forth the terms and conditions governing the use of a covered rental vehicle provided by a rental company. [1991, c. 335, (NEW).]

C. "Covered rental vehicle" means a private passenger motor vehicle rented pursuant to a covered rental agreement, regardless of where that rental vehicle is registered, rented or operated. [1991, c. 335, (NEW).]

D. "Private passenger motor vehicle" means a motor vehicle of the private passenger, sedan, station wagon or private passenger minivan type. [1991, c. 335, (NEW).]

E. "Rental company" means any person or organization, including franchisees, in the business of providing private passenger motor vehicles to the public. [1991, c. 335, (NEW).]

[1991, c. 335, (NEW) .]

2. **Rental vehicle coverage required.** A personal automobile insurance policy that provides liability and collision, liability and comprehensive or liability, comprehensive and collision coverage must provide coverage for the obligation of the insured for actual damage to a covered rental vehicle, including charges for verifiable and actual loss of use not to exceed 30 days, rented by an insured in the United States, its territories

or possessions, or Canada under a covered rental agreement. The deductible applicable to the covered rental vehicle may not exceed the highest of the deductibles for the collision coverage in the event of a collision loss or for the comprehensive coverage in the event of a comprehensive loss, applicable to the insured vehicle.

[1991, c. 335, (NEW) .]

3. **Notice to insureds.** Every policy to which this section applies, either upon policy issuance or upon the first renewal after January 1, 1992, must be accompanied or supplemented by a notice, in a form prescribed or approved by the superintendent, advising the insured of the rental vehicle coverage provided pursuant to this section.

[1991, c. 335, (NEW) .]

4. **Application.** This subchapter applies to all personal automobile policies issued for delivery in this State or renewed on or after January 1, 1992.

[1991, c. 335, (NEW) .]

SECTION HISTORY
1991, c. 335, (NEW).

Chapter 40: MASS MARKETING OF CASUALTY AND PROPERTY INSURANCE

§2931. PURPOSE

The purpose of this chapter is to prevent abuses in connection with sale of casualty and property insurance in this State pursuant to mass marketing plans, while preserving for consumers the potential benefits of this form of marketing. [1973, c. 625, §146 (NEW).]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2932. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following words shall have the following meanings. [1973, c. 625, §146 (NEW).]

1. **Casualty insurance.** "Casualty insurance" means all contracts of insurance covered by section 707.

[1973, c. 625, §146 (NEW) .]

2. **Mass marketing plan.** "Mass marketing plan" means a method of selling property and casualty insurance wherein such insurance is offered to employees of particular employers or to members of particular associations or organizations or to persons grouped in other ways and the employer, association or organization has agreed to or otherwise affiliated itself with, or facilitated, the sale of such insurance to its employees or members and employees and includes without limitation such plans whether described as "mass merchandising," "group merchandising," "franchise merchandising" or "collective merchandising."

[1973, c. 625, §146 (NEW) .]

3. **Property insurance.** "Property insurance" means all contracts of insurance covered by section 705.

[1973, c. 625, §146 (NEW) .]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2933. PREMIUM RATES

Premium rates under a mass marketing plan shall comply with all standards set forth in the Maine Insurance Code, including without limitation the requirement that rates shall not be excessive, inadequate or unfairly discriminatory. Rates shall not be deemed to be unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the difference with reasonable accuracy. Rates shall not be deemed to be unfairly discriminatory if they are averaged broadly among persons insured under a mass marketing plan. [1973, c. 625, §146 (NEW).]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2934. STATISTICS

An insurer selling insurance pursuant to mass marketing plans shall maintain separate statistics as to loss and expense experience pertinent thereto. [1973, c. 625, §146 (NEW).]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2935. COMPULSORY PARTICIPATION PROHIBITED

No insurer shall sell insurance pursuant to a mass marketing plan, if it is a condition of employment or of membership in an association, organization or other group that any employee or member purchase insurance pursuant to such plan, or if any employee or member shall be subject to any penalty by reason of his nonparticipation. [1973, c. 625, §146 (NEW).]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2936. TIE-IN SALES PROHIBITED

1. No insurer shall sell insurance pursuant to a mass marketing plan if:

A. Purchase of insurance available under such plan is contingent upon the purchase of any other insurance product or insurance service, or [1973, c. 625, §146 (NEW).]

B. The purchase of any other insurance product or insurance service is contingent upon the purchase of insurance available under such plan. [1973, c. 625, §146 (NEW).]

[1973, c. 625, §146 (NEW) .]

2. This section shall not be deemed to prohibit the reasonable requirement of safety devices, such as heat detectors, lightning rods, theft prevention equipment and the like.

[1973, c. 625, §146 (NEW) .]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2937. DISCLOSURE REQUIRED

Every insurer, agent or broker selling insurance pursuant to a mass marketing plan shall, prior to sale, make full and fair disclosure to prospective insureds of all features of such plan, whether favorable or unfavorable, including, but not limited to, the stability of the premium rates, benefits, duration of coverage, policyholder services, conversion privileges available, and the financial and interlocking interests in the plan, if any, of the sponsoring employer, association, organization or group. [1973, c. 625, §146 (NEW).]

SECTION HISTORY
1973, c. 625, §146 (NEW).

§2937-A. DISCLOSURE OF UNDERWRITING

A person is deemed to be engaged in deceptive advertising if the person makes, publishes or circulates or causes to be made, published or circulated any written statement relating to an underwritten Maine mass marketing plan, if that written statement does not include a conspicuous notice that some members of the

group to which the plan is marketed will not be eligible for insurance. A person making the statement is subject to a desist order issued under section 2165 and to any applicable penalty provided by law. [1989, c. 192, §2 (NEW).]

SECTION HISTORY
1989, c. 192, §2 (NEW).

§2938. AVAILABILITY

(REPEALED)

SECTION HISTORY
1973, c. 625, §146 (NEW). 1989, c. 192, §3 (RP).

§2938-A. AVAILABILITY

The insurer shall file with the superintendent its underwriting rules pertaining to eligibility for the mass marketing plan. No insurer may use underwriting standards for individual risk selection in a mass marketing plan that are, on the whole, more restrictive than the standards used by that insurer for individual risk selection in the sale of the same kind of insurance in this State other than pursuant to mass marketing plans. If an insurer does not sell that kind of insurance in this State other than pursuant to mass marketing plans, its underwriting standards for individual risk selection in those plans, on the whole, may be no more restrictive than the standards used by its principal affiliate, if any, for individual risk selection in the sale of that kind of insurance in this State other than pursuant to mass marketing plans. With respect to motor vehicle insurance, all policies issued under the mass marketing plans must provide at least the financial responsibility limits of coverage stated in Title 29-A, section 1605, subsection 1. [1995, c. 65, Pt. A, §72 (AMD); 1995, c. 65, Pt. A, §153 (AFF); 1995, c. 65, Pt. C, §15 (AFF).]

If an insurer rejects an applicant for coverage pursuant to a mass marketing plan, the insurer shall provide a notice of rejection to the applicant. Explanations such as "underwriting reasons," "loss record," "location of risk" and similar insurance terms are not by themselves acceptable explanations of an insurer's rejection. [1989, c. 192, §4 (NEW).]

The insurance shall be offered without discrimination against any eligible member of the plan as to rates, forms or coverages. Nothing in this section shall preclude the establishment of different classes of risk. [1989, c. 192, §4 (NEW).]

Insurers may not cancel, fail to renew or change the rating classification of insureds who have coverage in force under existing plans as of the effective date of this section for the sole reason that the insured fails to meet underwriting standards which are applicable to persons enrolling in the plans after the effective date of this section. [1989, c. 192, §4 (NEW).]

SECTION HISTORY
1989, c. 192, §4 (NEW). 1995, c. 65, §A72 (AMD). 1995, c. 65, §§A153,C15 (AFF).

§2939. CANCELLATION AND NONRENEWAL

1. Cancellation and nonrenewal shall be subject to the applicable provisions set forth elsewhere in this Title.

[1973, c. 625, §146 (NEW) .]

2. The failure of an employer, association, organization or other group to remit premiums when due for any reason, including, but not limited to, interruption or termination of employment or membership, shall not be regarded as nonpayment of premium by any insured under any such plan providing for remittance of

premium by such employer, association, organization or other group, unless such insured shall have been given written notice of such failure to remit and shall not himself have paid such premium by the later of 20 days after such notice, or the due date of such premium remittance under the mass marketing plan or pursuant to regulations set forth by the superintendent.

[1973, c. 625, §146 (NEW) .]

3. Upon the termination of employment or membership or upon the discontinuance of the mass marketing plan, such insured member or employee may maintain his policy in force, in the same amount, upon payment of the premium applicable to the class of risk to which he belongs, on an individual basis.

[1973, c. 625, §146 (NEW) .]

4. Any notice of cancellation or nonrenewal of any policy of any employee or member insured under a mass marketing plan shall be accompanied by a notice to the employee or member that, at his request, the insurer will afford the employer, association, organization or other group a reasonable opportunity to consult with the insured and to present facts in opposition to cancellation or nonrenewal.

[1973, c. 625, §146 (NEW) .]

SECTION HISTORY
1973, c. 585, §12 (AMD). 1973, c. 625, §146 (NEW).

§2940. APPLICABILITY

This chapter shall be applicable only to insurance policies issued or renewed in this State after November 1, 1973 and is in addition to, and not in substitution for, other applicable requirements of the Maine Insurance Code and bureau regulations. [1973, c. 585, §12 (AMD); 1973, c. 625, §146 (NEW).]

SECTION HISTORY
1973, c. 585, §12 (AMD). 1973, c. 625, §146 (NEW).

Chapter 40-A: GROUP PROPERTY AND CASUALTY INSURANCE

§2951. GROUP PROPERTY AND CASUALTY INSURANCE

1. **Group coverage permitted.** The following lines of property and casualty insurance may be written on a group basis, subject to the requirements of this section and other applicable law:

A. Liability insurance issued to a risk purchasing group in compliance with chapter 72-A; [2001, c. 138, §16 (NEW).]

B. Credit involuntary unemployment insurance issued to a debtor group in compliance with chapter 37; and [2001, c. 138, §16 (NEW).]

C. Other lines of insurance designated by the superintendent in compliance with rules adopted pursuant to section 2953. [2001, c. 138, §16 (NEW).]

[2001, c. 138, §16 (NEW) .]

2. **Terms of coverage.** A policy must provide insured group members with terms of coverage that are no less favorable to the insured than would be required for comparable nongroup policies, at rates consistent with the requirements of this Title.

[2001, c. 138, §16 (NEW) .]

3. **Certificate of coverage.** An insured group member must be issued a certificate of coverage adequately describing that insured's rights and responsibilities under the group policy in a manner satisfactory to the superintendent, delivered in the same time and manner as is required for the delivery of comparable nongroup policies.

[2001, c. 138, §16 (NEW) .]

SECTION HISTORY
2001, c. 138, §16 (NEW).

§2952. TERMINATION OF COVERAGE

Cancellation and nonrenewal of group policies and of coverage of group members under group policies are governed by this section. [2001, c. 138, §16 (NEW).]

1. **Involuntary termination.** Involuntary termination of the group policy is governed by section 2908. Individual insureds do not have standing to contest cancellation or nonrenewal of the group policy unless they have the right to represent the group policyholder.

[2001, c. 138, §16 (NEW) .]

2. **Prior notice of involuntary termination of coverage.** Except as otherwise provided in this section, individual insureds have the same rights to prior notice before involuntary termination of coverage and opportunity for hearing before the superintendent to contest the termination as would be available under the cancellation control laws applicable to comparable nongroup policies.

[2001, c. 138, §16 (NEW) .]

3. **Termination of group policy.** Termination of the group policy, whether voluntary or involuntary, is a valid ground for termination of coverage for all group members, if adequate notice to group members has been given in accordance with subsection 2.

[2001, c. 138, §16 (NEW) .]

4. **Termination of group membership.** Termination of group membership is a valid ground for termination of the member's coverage under a group policy, if the certificate of coverage so provides. If the certificate of coverage gives adequate notice that coverage ceases immediately upon voluntary withdrawal from the group, no further advance notice is required as a condition precedent to the termination of coverage.

[2001, c. 138, §16 (NEW) .]

5. **Continued coverage.** An insurer's obligation to issue or offer continued coverage to a group member under this chapter may be satisfied by the issuance or offer of a comparable nongroup policy.

[2001, c. 138, §16 (NEW) .]

SECTION HISTORY
2001, c. 138, §16 (NEW).

§2953. RULEMAKING

The superintendent may adopt rules, which are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A, establishing specific requirements and procedures for group property and casualty policies, certificates of coverage and rates, consistent with the purposes of this chapter. These rules may specify additional types of insurance that may be issued on a group basis and the types of groups that may be policyholders, if the superintendent determines that the issuance of multiple individual policies to group members in accordance with chapter 40 does not adequately address the needs of the market. [2001, c. 138, §16 (NEW).]

SECTION HISTORY
2001, c. 138, §16 (NEW).

Chapter 41: PROPERTY INSURANCE CONTRACTS

Subchapter 1: STANDARD FIRE POLICY

§3001. CONTRACTS SUBJECT TO GENERAL PROVISIONS

All contracts of property insurance covering subjects located in this State are subject to this chapter, to the applicable provisions of chapter 27 (the insurance contract) and to other applicable provisions of this Title. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3002. STANDARD FIRE POLICY REQUIRED; EXCEPTIONS

1. No insurer may issue fire insurance policies on property in this State other than those of the Maine standard fire insurance policy which shall contain the following consideration and insuring clause, assignment clause and the general conditions and stipulations set forth after these consideration, insuring and assignment clauses:

Consideration and Insuring Clause

In Consideration of the Provisions and Stipulations herein or added hereto and of the premium above specified, this Company, for the term of ..... from ..... at 12:01 a.m. (Standard Time) to ..... at 12:01 a.m. (Standard Time) at location of property involved, to an amount not exceeding the amount(s) above specified, does insure ..... and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all DIRECT LOSS BY FIRE, LIGHTNING AND BY REMOVAL FROM PREMISES ENDANGERED BY THE PERILS INSURED AGAINST IN THIS POLICY, EXCEPT AS HEREINAFTER PROVIDED, to the property described herein while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

Assignment Clause

Assignment of this policy shall not be valid except with the written consent of this Company.

This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which are hereby made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

General Conditions and Stipulations

Concealment, fraud. This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

Uninsurable and excepted property. This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically, named hereon in writing, bullion or manuscripts.

Perils not included. This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly by: (a) enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this Company be liable for loss by theft.

Other insurance. Other insurance may be prohibited or the amount of insurance may be limited by endorsement attached hereto.

Conditions suspending or restricting insurance. Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring (a) while the hazard is increased by any means within the control or knowledge of the insured; or

(b) while a described building, whether intended for occupancy by owner or tenant, is vacant or unoccupied beyond a period of sixty consecutive days; or (c) as a result of explosion or riot, unless fire ensues, and in that event for loss by fire only.

Other perils or subjects. Any other peril to be insured against or subject of insurance to be covered in this policy shall be by endorsement in writing hereon or added hereto.

Added provisions. The extent of the application of insurance under this policy and of the contribution to be made by this Company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change.

Waiver provisions. No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this Company relating to appraisal or to any examination provided for herein.

Cancellation of policy. This policy shall be cancelled at any time at the request of the insured, in which case this Company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time. This policy may be cancelled at any time by this Company by giving to the insured a ten days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand. Notice of cancellation shall state that said excess premium (if not tendered) will be refunded on demand.

Mortgagee interests and obligations. If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be cancelled by giving to such mortgagee a ten days' written notice of cancellation.

If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within sixty (60) days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this Company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing.

Pro rata liability. This Company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Requirements in case loss occurs. The insured shall give immediate written notice to this Company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within sixty days after the loss, unless such time is extended in writing by this Company, the insured shall render to this Company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: The time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this Company all that remains of any property herein described, and submit to examinations under oath by any person named by this Company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this Company or its representative, and shall permit extracts and copies thereof to be made.

Appraisal. In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting that appraiser and the expenses of appraisal and umpire shall be paid by the parties equally.

Company's options. It shall be optional with this Company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within thirty days after the receipt of the proof of loss herein required.

Abandonment. There can be no abandonment to this Company of any property.

When loss payable. The amount of loss for which this Company may be liable shall be payable sixty days after proof of loss, as herein provided, is received by this Company and ascertainment of the loss is made either by agreement between the insured and this Company expressed in writing or by the filing with this Company of an award as herein provided.

Suit. No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within two years next after inception of the loss.

Subrogation. This Company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this Company.

[1989, c. 316, §1 (AMD) .]

2. The insurer may use an endorsement or rider attached to its printed policy forms used in other states in order, where necessary, to bring the terms of such form into compliance with the above provisions.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §56 (AMD). 1989, c. 316, §1 (AMD).

§3003. COMBINATION COVERAGES

Any policy or contract otherwise subject to section 3002 (standard fire policy required; exceptions), which includes either on an unspecified basis as to the coverage or for a single premium coverage against the peril of fire and substantial coverage against other perils need not comply with such provisions, provided: [1969, c. 132, §1 (NEW).]

1. Such policy or contract shall afford coverage, with respect to the peril of fire, not less than the coverage afforded by such Maine standard fire policy;

[1969, c. 132, §1 (NEW) .]

2. That such coverage as to the peril of fire shall be made subject without change to the same general provisions and stipulations as those of such standard fire policy;

[1969, c. 132, §1 (NEW) .]

3. The provisions in relation to mortgagee interests and obligations in such standard fire policy shall be incorporated therein without change;

[1969, c. 132, §1 (NEW) .]

4. Such policy or contract is complete as to all of its terms without reference to the standard form of fire insurance policy or any other policy;

[1969, c. 132, §1 (NEW) .]

5. The superintendent is satisfied that such policy or contract complies with the provisions hereof.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3004. LINES NUMBERED CONSECUTIVELY

The lines of the conditions of the standard fire insurance policy shall be numbered consecutively at the option of the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3004-A. ACTUAL CASH VALUE

1. **Actual cash value.** "Actual cash value", as used in section 3002, means the replacement cost of an insured item of property at the time of loss, less the value of physical depreciation as to the item damaged. "Physical depreciation" means a value as determined according to standard business practices.

[1989, c. 316, §2 (NEW) .]

SECTION HISTORY
1989, c. 316, §2 (NEW).

§3005. CANCELLATION OF STANDARD FIRE POLICY FOR NONPAYMENT OF PREMIUM

An insurer issuing fire insurance policies on property in this State, under the standard form required by section 3002, may cancel any such policy in the manner provided by law without tendering to the assured a ratable proportion of the premium, if the premium has not been paid to the insurer or its agent, or to a duly licensed insurance broker through whom the contract of insurance was negotiated. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3006. WILLFUL VIOLATIONS

Any insurer or agent who shall make, issue or deliver a policy of fire insurance in willful violation of sections 3002 or 3003 shall forfeit for each offense not less than $50 nor more than $200, but the policy shall nevertheless be binding upon the insurer issuing the same. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3007. CANCELLATION AND NONRENEWAL

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

A. "Cancellation" means termination of a policy at a date other than its expiration date. [1985, c. 671, §2 (NEW).]

B. "Expiration date" means the date upon which coverage under a policy ends. It also means, for a policy written for a term longer than one year or with no fixed expiration date, each annual anniversary date of the policy. [1985, c. 671, §2 (NEW).]

C. "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premium on a policy of insurance subject to this section, whether the payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. [1985, c. 671, §2 (NEW).]

D. "Nonrenewal" means termination of a policy at its expiration date. [1985, c. 671, §2 (NEW).]

E. "Renewal" or "to renew" means the issuance of, or the offer to issue by an insurer or an affiliate of an insurer, a policy succeeding a policy previously issued and delivered by the same insurer or an affiliated insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date. For purposes of this section, the transfer of a policy from an insurer to an affiliate is considered a policy renewal. [2005, c. 114, §3 (AMD).]

[2005, c. 114, §3 (AMD) .]

2. Except as provided by subsection 8, no contract of property insurance may be cancelled by an insurer prior to the expiration of the policy, except for one or more of the following grounds:

A. Nonpayment of premium; [1985, c. 671, §2 (NEW).]

B. Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim under the policy; [1985, c. 671, §2 (NEW).]

C. Substantial change in the risk which increases the risk of loss after insurance coverage has been issued or renewed, including, but not limited to, an increase in exposure due to regulation, legislation or court decision; [1985, c. 671, §2 (NEW).]

D. Failure to comply with reasonable loss control recommendations; [1985, c. 671, §2 (NEW).]

E. Substantial breach of contractual duties, conditions or warranties; or [1985, c. 671, §2 (NEW).]

F. Determination by the superintendent that the continuation of a class or block of business to which the policy belongs will jeopardize a company's solvency or will place the insurer in violation of the insurance laws of this State or any other state. [1985, c. 671, §2 (NEW).]

The grounds listed in paragraphs A to E shall be contained in all policies issued, issued for delivery or renewed on or after the effective date of this section. Insurers shall have 30 days from the effective date of this section to notify insureds of these grounds for cancellation on policies issued or issued for delivery before the effective date of this section.

[1985, c. 671, §2 (NEW) .]

3. If a policy has been issued for a term longer than one year and, for additional premium consideration, a premium has been guaranteed, the insurer may not refuse to renew or increase the policy premium for the term of that policy.

[1985, c. 671, §2 (NEW) .]

4. If an insurer offers or purports to renew a contract, but on less favorable terms to the insured or at higher rates, and a higher rating plan, the new terms or rates and rating plan may take effect on the renewal date if the insurer has provided the insured notice as required by this section. If the insurer has not so notified the contract holder, the contract holder may elect to cancel the renewal policy within the 30-day period after receipt of the notice or delivery. Earned premium for the period of coverage for such time as the renewal contract may have been in force shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective immediately following the prior policy's expiration or anniversary date. This section does not apply if the change is a rate, form or plan filed with the superintendent and applicable to the entire class of business to which the policy belongs or to a premium increase based on the altered nature or extent of the risk insured against.

[1985, c. 671, §2 (NEW) .]

5. Cancellation or nonrenewal is not effective until notice is received by the insured as follows.

A. To the extent that section 3002 is applicable, the notice of cancellation shall be given as provided for in that section. If section 3002, is not applicable, cancellation shall not be effective prior to 10 days after receipt by the insured of a notice of cancellation. The notice shall state the effective date of and the reason or reasons for cancellation. [1985, c. 671, §2 (NEW).]

B. Nonrenewal subject to this section is not effective prior to 30 days after receipt of written notice by the insured. Prior to the date of renewal of a policy that has been transferred by an insurer to an affiliate, the insured must receive notice of any changes to the terms of the policy that are less favorable to the insured. [2009, c. 415, Pt. A, §13 (AMD).]

C. A post-office certificate of mailing to the named insured at his last known address shall be conclusive proof of receipt of notice on the 3rd calendar day after mailing. [1985, c. 671, §2 (NEW).]

[2009, c. 415, Pt. A, §13 (AMD) .]

6. Any insured who has received a notice of an insurer's intent to cancel a policy may, within 45 days of the receipt of the notice, request a hearing before the superintendent. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence given by the insurer in its notice of cancellation. The burden of proof of the reason for cancellation shall be upon the insurer. The superintendent shall have the authority to order that a policy remain in force both pending and, if the superintendent finds in favor of the insured, subsequent to a hearing. If the superintendent finds in favor of the insurer at a hearing, the superintendent may order the policy to remain in force for 14 days to allow the insured to obtain other coverage.

[1989, c. 172, §6 (AMD) .]

7. Except as provided in Title 10, chapter 209-B, no insurer or licensed agent or employee of the insurer may be held liable in any civil action for statements made in a notice of cancellation or nonrenewal or at a hearing held under this section if the statements were made in good faith and, in the case of cancellation, are reasonably related to the grounds for cancellation.

[2013, c. 588, Pt. C, §14 (AMD) .]

8. This section does not apply to any insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time notice of cancellation is mailed or otherwise delivered, except as provided in subsection 1, paragraph A and subsection 5, paragraphs A and C. This section does not apply to any policy subject to subchapter 5. This section does not apply to any policy issued pursuant to any assigned risk plan. The superintendent may suspend, in whole or in part, the applicability of this section to any insurer if, in the superintendent's discretion, its application will endanger the ability of the insurer to fulfill its contractual obligation.

[2007, c. 188, Pt. C, §8 (AMD) .]

9. This section applies to all contracts of property insurance, except surplus lines contracts, delivered or issued for delivery in this State, both before and after the effective date of this section. Provisions in this section relating to nonrenewal of policies shall take effect 30 days after the effective date of this section.

[1989, c. 172, §6 (AMD) .]

SECTION HISTORY
1985, c. 671, §2 (NEW). 1989, c. 172, §6 (AMD). 1991, c. 25, §2 (AMD). 2005, c. 114, §§3,4 (AMD). 2007, c. 188, Pt. C, §8 (AMD). 2009, c. 415, Pt. A, §13 (AMD). 2013, c. 588, Pt. C, §14 (AMD).

Subchapter 2: DEPOSIT NOTES

§3020. POLICY AND DEPOSIT NOTE ONE CONTRACT; INSOLVENCY; LIABILITY OF INSURED; NOTE SURRENDERED

1. A policy of insurance issued by a fire or marine insurer, domestic or foreign, and a deposit note given therefor are one contract. A loss under such policy or other equitable claims may be proved in defense to the note, though it was indorsed or assigned before it was due.

[1969, c. 132, §1 (NEW) .]

2. When an insurer becomes insolvent, the maker of the note is only liable for the equitable proportion thereof which accrued during the solvency. If the insolvency occurs within 60 days of the date of the note, it is void except for the amount of the maker's claim, if any, on the insurer. No insured shall be held to contribute to any losses or expenses beyond the amount of his deposit note. At the expiration of his term of insurance, his note, on payment of all assessments for which it is liable, shall be relinquished to him, except as provided in section 3021.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3021. LIEN ON INSURED REAL ESTATE

Any fire insurer shall have a lien against the insured, on the buildings insured and the land appurtenant thereto, for the amount at any time due on the note referred to in section 3020, to commence from the time of the recording of the same, and to continue 60 days after the expiration of the policy on which such note is given, if the insurer causes a certificate of its claim to such lien, signed by the secretary, to be recorded by the register of deeds for the county or district. During the pendency of such lien, an attachment of such property, in a civil action on the note in favor of the insurer, has priority of all other attachments or claims. Execution, when recovered, may be levied on it accordingly. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3022. LIEN CONTINUES ON DECEASED'S PROPERTY; POLICY DESCENDS TO ESTATE

Upon the death of a member, the lien of the insurer remains good on the property insured to the amount due on the deposit note, and the policy descends to the executor or administrator of the deceased for the benefit of the estate during its continuance, unless voluntarily surrendered or forfeited by the charter of the insurer. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

Subchapter 3: LIEN OF MORTGAGEES ON POLICIES

§3030. LIEN ESTABLISHED; APPLICATION OF PAYMENTS

The mortgagee of any real estate or the mortgagee of any personal property shall have a lien upon any policy of insurance against loss by fire procured thereon by the mortgagor, to take effect from the time he files with the insurer, at its home office, a written notice, briefly describing his mortgage, the estate conveyed thereby and the sum remaining unpaid thereon. If the mortgagor, by a writing by him signed and filed with the

secretary, consents that the whole of the sum secured by the policy, or so much as is required to discharge the amount due on the mortgage at the time when a loss occurs, shall be applied to the payment of the mortgage, it shall be so paid by the insurer and the mortgagee's receipt therefor shall be a sufficient discharge of the insurer. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3031. ENFORCEMENT OF LIEN

If the mortgagor does not consent as provided for in section 3030, the mortgagee of any real estate may, at any time within 60 days after a loss, and the mortgagee of any personal property may at any time within 30 days after a loss, enforce his lien by a civil action against the mortgagor, and the insurer as his trustee, in which judgment may be rendered for what is found due from the insurer upon the policy, notwithstanding the time of payment of the whole sum secured by the mortgage has not arrived, and which action shall be commenced and service made on the trustee within such 60 or 30 days. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3032. APPLICATION OF AMOUNT RECOVERED

The amount recovered under section 3031 shall be applied first to the payment of the costs of the civil action and officer's fees on the execution and next to the payment of the amount due on the mortgage. The balance, if any, shall be retained by the insurer and paid to the mortgagor. If the insurer assumes the defense, it shall be liable to the plaintiff for costs in the same manner as the principal defendant, defending the action, would be. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3033. PRIORITY OF MORTGAGEES

When 2 or more mortgagees claim the benefit of sections 3030 to 3032, their rights shall be determined according to the priority of their claims and mortgages by the principles of law. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3034. MORTGAGEE'S POLICY VOID, UNLESS CONSENTED TO

When any mortgagee claims the benefit of sections 3030 to 3033, any policy of insurance which he had procured or subsequently procures on his interest in the same property by virtue of his mortgage is void, unless consented to by the insurer insuring the mortgagor's interest. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

Subchapter 4: GENERAL PROVISIONS

§3040. INSURANCE ON FURNITURE, OWNED JOINTLY BY HUSBAND AND WIFE

Insurance effected by a husband or wife on a dwelling house owned by the insured and on the furniture therein is valid for all the furniture, although part is owned by the husband and part by the wife. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3041. TIME LIMIT FOR ADJUSTING, PAYING FIRE LOSS; PENALTY

1. In case of physical loss by fire to property insured by any insurer, the insurer or its representative shall begin adjustment of such loss within 20 days after the receipt of the notice of loss provided for by the policy.

[1969, c. 132, §1 (NEW) .]

2. In any statute relating to fire insurance or in any policy of fire insurance, reference to the date of loss or the time when a loss occurs shall mean the day of the fire against which the policy insures.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3042. LOSS INFORMATION TO BE SUPPLIED

1. **Request for information.** Every insurer shall provide loss information concerning an insurance policy to its insured within 30 calendar days of the receipt of a written request from the insured or an insurance agent or other authorized representative of the insured. An insurer may not cancel or refuse to renew an insurance policy for the nonpayment of premium during any period within which the insurer fails to provide the loss information requested under this section, unless the insured requests that information fewer than 45 calendar days prior to the expiration date of the insurance policy.

[1989, c. 696, §2 (NEW) .]

2. **Transmittal of request.** If an insured requests loss information from an insurance agent or an authorized representative of the insured, the representative or agent shall transmit the request for loss information to the insurer within 4 working days.

[1989, c. 696, §2 (NEW) .]

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

A. "Insurance policy" means the insurance policy relating to the loss information requested pursuant to this section. [1989, c. 696, §2 (NEW).]

B. "Loss information" means the following items: the name of the insured, the date of the loss, the date the claim was received by the insurer, a description of the loss, any amount paid by the insurer on account of the loss, any amount reserved for the loss and whether the claim is open or closed. [1989, c. 696, §2 (NEW).]

[1989, c. 696, §2 (NEW) .]

SECTION HISTORY
1989, c. 696, §2 (NEW).

Subchapter 5: MAINE PROPERTY INSURANCE CANCELLATION CONTROL ACT

§3048. SCOPE OF SUBCHAPTER

This subchapter shall apply to policies of insurance, other than automobile insurance and workers' compensation insurance, on risks located or resident in this State which are issued and take effect or which are renewed after the effective date of this subchapter and insuring against any of the following: [1989, c. 502, Pt. A, §99 (AMD).]

1. Loss of or damage to real property which is used solely for residential purposes and which consists of not more than 4 apartments and which is owner-occupied;

[1973, c. 239, (NEW) .]

2. Loss of or damage to personal property in which natural persons resident in specifically described real property of the kind described in subsection 1 have an insurable interest, except personal property used in the conduct of a commercial or industrial enterprise;

[1973, c. 239, (NEW) .]

3. Legal liability of a natural person or persons for loss of, damage to or injury to persons or property, but not including policies primarily insuring risks arising from the conduct of a commercial or industrial enterprise.

[1973, c. 239, (NEW) .]

Any policy written for a term longer than one year or with no fixed expiration date shall be considered, for purposes of this subchapter, written for successive policy terms of one year. [1979, c. 411, §1 (NEW).]

SECTION HISTORY
1973, c. 239, (NEW). 1979, c. 411, §1 (AMD). 1989, c. 502, §A99 (AMD).

§3048-A. HEARINGS

Unless otherwise specified, all hearings held under this subchapter shall conform to the procedures set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV. [1977, c. 694, §427 (NEW).]

SECTION HISTORY
1977, c. 694, §427 (NEW).

§3049. NOTICE OF CANCELLATION; REASONS

No policy may be cancelled except by notice to the insured as provided in this subchapter. No notice of cancellation of a policy shall be effective unless it is based on one or more of the following reasons: [1973, c. 239, (NEW).]

1. Nonpayment of premium, including nonpayment of any additional premiums, calculated in accordance with the current rating manual of the insurer, justified by a physical change in the insured property or a change in its occupancy or use. A notice of cancellation for nonpayment of premium is not effective unless deemed received under section 3050 after the premium due date;

[2007, c. 188, Pt. C, §9 (AMD) .]

2. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against;

[1973, c. 239, (NEW) .]

3. Discovery of fraud or material misrepresentation by any one of the following:

A. The insured or the insured's representative in obtaining the insurance; or [2003, c. 671, Pt. A, §3 (AMD).]

B. The named insured in pursuing a claim under the policy; [1973, c. 239, (NEW).]

[2003, c. 671, Pt. A, §3 (AMD) .]

4. Discovery of either:

A. Negligent acts or omissions by the insured substantially increasing any of the hazards insured against; or [2003, c. 671, Pt. A, §4 (NEW).]

B. A failure to disclose a material fact in relation to the application for insurance that would, if coverage is effectuated without knowledge by the insurer, substantially alter the terms of the policy; [2003, c. 671, Pt. A, §4 (NEW).]

[2003, c. 671, Pt. A, §4 (RPR) .]

5. Physical changes in the insured property that result in the property becoming uninsurable;

[2003, c. 671, Pt. A, §5 (AMD) .]

6. The insured property is vacant and custodial care is not maintained on the property;

[2003, c. 671, Pt. A, §6 (NEW) .]

7. The presence of a trampoline on the premises if the insured is notified that the policy will be cancelled if the trampoline is not removed and the trampoline, after notice, remains on the property 30 or more days after the date of notice;

[2003, c. 671, Pt. A, §6 (NEW) .]

8. The presence of a swimming pool upon the insured property that is not fenced in, in accordance with the standards established in Title 22, section 1631, if the pool remains in noncompliance with those standards for 30 days after notice by the insurer of the defective condition and intent to cancel the policy;

[2003, c. 671, Pt. A, §6 (NEW) .]

9. A loss occasioned by a dog bite, unless, after notice of cancellation or nonrenewal is received, the insured removes the dog; or

[2003, c. 671, Pt. A, §6 (NEW) .]

10. Failure to comply with reasonable loss control recommendations within 90 days after notice from the insurer.

[2003, c. 671, Pt. A, §6 (NEW) .]

This section does not apply to any policy or coverage that has been in effect less than 90 days at the time notice of cancellation is received by the named insured, or 120 days in the case of residential property that is expected to be continuously unoccupied for 3 months in any 12-month period and that is other than the insured's primary residence, unless it is a renewal policy. An insured does not have the right to a hearing before the Superintendent of Insurance for the purpose of contesting cancellation of a new policy that has been in force less than 90 days or 120 days in the case of residential property other than the insured's primary residence that is expected to be continuously unoccupied for 3 months in any 12-month period. [2003, c. 671, Pt. A, §7 (AMD).]

This section shall not apply to the nonrenewal of a policy. [1977, c. 414, §1 (NEW).]

"Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premium on the policy, or any installment of a premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit. [1979, c. 35, (NEW).]

SECTION HISTORY
1973, c. 239, (NEW). 1977, c. 414, §1 (AMD). 1979, c. 35, (AMD). 1979, c. 347, §§8,9 (AMD). 1979, c. 411, §2 (AMD). 1979, c. 663, §§150,151 (AMD). 2003, c. 671, §§A3-7 (AMD). 2007, c. 188, Pt. C, §9 (AMD).

§3050. DELIVERY OF NOTICE

A notice of cancellation of a policy is not effective unless received by the named insured at least 20 days prior to the effective date of cancellation, or, when the cancellation is for nonpayment of premium, at least 10 days prior to the effective date of cancellation. Like notice must also be given to any party named as mortgagee on the policy. A postal service certificate of mailing to the named insured at the insured's last known address is conclusive proof of receipt on the 5th calendar day after mailing. [2007, c. 188, Pt. C, §10 (AMD).]

Except for a policy that has been in effect for less than 90 days at the time notice of cancellation is received by the named insured, the reason for cancellation must accompany the notice, together with a notice of the right to apply for a hearing before the superintendent within 30 days, as provided in section 3054. [2007, c. 188, Pt. C, §10 (AMD).]

SECTION HISTORY
1973, c. 239, (NEW). 1973, c. 585, §12 (AMD). 1977, c. 414, §§2,3 (AMD). 1979, c. 347, §§10,11 (AMD). 1989, c. 172, §7 (AMD). 2005, c. 114, §5 (AMD). 2007, c. 188, Pt. C, §10 (AMD).

§3051. NOTICE OF INTENT

An insurer may not fail to renew a policy except by notice to the insured as provided in this subchapter. A notice of intention not to renew is not effective unless received by the named insured at least 30 days prior to the expiration date of the policy. Like notice must also be given to any party named as mortgagee on the policy. A post office certificate of mailing to the named insured at the insured's last known address

is conclusive proof of receipt on the 3rd calendar day after mailing. The reason must accompany the notice of intent not to renew, together with notification of the right to apply for a hearing before the superintendent within 30 days as provided. [2007, c. 188, Pt. C, §11 (AMD).]

The reason or reasons for the intended nonrenewal action must accompany the notice of intent not to renew and the reason or reasons must be explicit. Explanations such as "underwriting reasons," "underwriting experience," "loss record," "location of risk," "credit report" and similar insurance terms are not by themselves acceptable explanations of an insurer's intended nonrenewal of a policy insuring property of the kind defined in section 3048. The reason for nonrenewal must be a good faith reason and related to the insurability of the property or a ground for cancellation pursuant to section 3049. [2003, c. 671, Pt. A, §8 (AMD).]

This section does not apply: [2003, c. 671, Pt. A, §8 (AMD).]

1. If the insurer has manifested its willingness to renew;

[2005, c. 114, §6 (AMD) .]

2. If the insured fails to pay any premium due or any advance premium required by the insurer for renewal; or

[2005, c. 114, §7 (AMD) .]

3. If the insurer has transferred a policy to an affiliate.

[2007, c. 188, Pt. C, §11 (AMD) .]

Prior to the date of renewal of a policy that has been transferred by an insurer to an affiliate, the insured must receive notice of any changes to the terms of the policy that are less favorable to the insured. [2007, c. 188, Pt. C, §11 (NEW).]

SECTION HISTORY
1973, c. 239, (NEW). 1973, c. 585, §12 (AMD). 1977, c. 414, §§4,5 (AMD). 1979, c. 144, (AMD). 1979, c. 347, §12 (AMD). 2003, c. 671, §A8 (AMD). 2005, c. 114, §§6-8 (AMD). 2007, c. 188, Pt. C, §11 (AMD).

§3052. DUPLICATE COVERAGE

If an insured obtains a replacement policy which provides equal or more extensive coverage for any property designated in both policies, the first insurer's coverage of such property may be terminated by failure to renew as of the effective time and date of the replacement policy, whether or not the first insurer complies with all provisions of section 3051. [1973, c. 239, (NEW).]

SECTION HISTORY
1973, c. 239, (NEW).

§3053. RENEWAL NOT A WAIVER OR ESTOPPEL

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of renewal. [1973, c. 239, (NEW).]

SECTION HISTORY
1973, c. 239, (NEW).

§3054. HEARING BEFORE SUPERINTENDENT OF INSURANCE

A named insured who has received a statement of reason for cancellation, or of reason for an insurer's intent not to renew a policy, may, within 30 days of the receipt of a statement of reason, request a hearing before the Superintendent of Insurance. The purpose of this hearing is limited to establishing the existence of the proof or evidence used by the insurer in its reason for cancellation or intent not to renew. The burden of proof of the reason for cancellation or intent not to renew is on the insurer. If an insurer's reason for nonrenewal is not based on a ground for cancellation permitted under section 3049, the insurer must provide proof or evidence that the reason for nonrenewal is a good faith reason and related to the insurability of the property. A statement from the insurer that the risk does not meet the insurer's underwriting guidelines alone is not considered sufficient proof or evidence. The superintendent shall adopt rules for carrying out this section. The superintendent may order the policy to continue in effect both pending and, if the superintendent finds in favor of the insured, subsequent to a hearing. If the superintendent finds in favor of the insurer at a hearing, the superintendent may order the policy to remain in force for 14 days to allow the insured to obtain other coverage. [2003, c. 671, Pt. A, §9 (AMD).]

SECTION HISTORY
1973, c. 239, (NEW). 1973, c. 585, §12 (AMD). 1979, c. 347, §13 (AMD). 1989, c. 172, §8 (AMD). 2003, c. 671, §A9 (AMD).

§3055. SUPERINTENDENT'S AUTHORITY TO SUSPEND

In the event of impairment or serious financial difficulty of an insurer or insurers, the superintendent shall have the authority to suspend the provisions of the Maine Property Insurance Cancellation Control Act from applying to the policies of the financially distressed insurer or insurers. [1977, c. 414, §6 (NEW).]

SECTION HISTORY
1977, c. 414, §6 (NEW).

§3055-A. DISCONTINUANCE OF A LINE OF BUSINESS

If an insurer files a plan with the superintendent to discontinue business in a line of insurance subject to this subchapter, the superintendent may authorize the nonrenewal of policies in that line of business if the plan filed by the insurer demonstrates the availability of substantially similar coverage in the admitted market. The nonrenewal of a policyholder pursuant to this section may not be considered by an insurer in future coverage determinations. An insurer may resume transacting business in a line of insurance discontinued pursuant to this section upon written notification to the superintendent. [2005, c. 49, §2 (AMD).]

SECTION HISTORY
1995, c. 544, §10 (NEW). 2005, c. 49, §2 (AMD).

§3056. NONLIABILITY FOR CERTAIN STATEMENTS

1. **Notices.** Except as provided in Title 10, chapter 209-B, no insurer or licensed agent or employee of the insurer may be held liable in any civil action for statements made in a notice of cancellation or intent not to renew under this chapter if:

A. The statements were made in good faith; [1979, c. 112, §2 (NEW).]

B. The statements are reasonably related to the reason for cancellation or intent not to renew; and [1979, c. 112, §2 (NEW).]

C. In the case of a notice of cancellation, the reason for cancellation is a reason permitted under section 3049. [1979, c. 112, §2 (NEW).]

[2013, c. 588, Pt. C, §15 (AMD) .]

2. **Hearings.** Except as provided in Title 10, chapter 209-B, no person may be held liable in any civil action for statements made or information given at a hearing held under this chapter if:

A. The statements were made or the information was given in good faith; [1979, c. 112, §2 (NEW).]

B. The statements or the information are reasonably related to the reason for cancellation or intent not to renew; and [1979, c. 112, §2 (NEW).]

C. In the case of a hearing held on a notice of cancellation, the reason for cancellation is a reason permitted under section 3049. [1979, c. 112, §2 (NEW).]

[2013, c. 588, Pt. C, §15 (AMD) .]

SECTION HISTORY
1979, c. 112, §2 (NEW). 2013, c. 588, Pt. C, §15 (AMD).

§3057. ACTIONS RELATED TO AGE OF DWELLING PROHIBITED

An insurance company authorized to transact business in this State may not cancel or refuse to issue or renew a property insurance policy subject to this subchapter solely on the basis of the age of the dwelling and without consideration of the current condition of the property. [2003, c. 671, Pt. A, §10 (NEW).]

SECTION HISTORY
2003, c. 671, §A10 (NEW).

§3058. REFUSAL BASED ON PREVIOUS OWNER'S LOSSES

An insurance company authorized to transact business in this State may not refuse to issue a property insurance policy subject to this subchapter for the sole reason that a previous owner of the property submitted claims for losses to the property. [2003, c. 671, Pt. A, §10 (NEW).]

SECTION HISTORY
2003, c. 671, §A10 (NEW).

§3059. INSURER VALUATION OF PROPERTY; INCREASE IN PREMIUM; NOTICE

1. **Increase in valuation.** If an insurer determines that the stated insured value of a property covered by a policy subject to this subchapter should be increased to depict more accurately its current value and the increase in valuation will result in an increase in premium for the policy, then the increase in the stated insured value and the corresponding increase in premium may be implemented only at the time of renewal.

[2003, c. 671, Pt. A, §10 (NEW) .]

2. **Notice.** If an insurer increases the stated insured value in accordance with subsection 1, then the insurer must provide notice to the named insured on the policy at least 30 days prior to the effective date of the renewal policy stating the reason for the increase in premium and the amount of premium increase

associated with the increase in valuation. The notice also must state that upon written request by the named insured the insurer will disclose the specific reasons and specific property characteristics that contributed to the resulting increase in stated value.

[2003, c. 671, Pt. A, §10 (NEW) .]

3. **Exemptions.** This section does not apply to routinely scheduled increases in valuation under the policy based on inflation or to increases in the stated insured value of a property agreed to by the insured.

[2003, c. 671, Pt. A, §10 (NEW) .]

SECTION HISTORY
2003, c. 671, §A10 (NEW).

§3060. INSURANCE COVERAGE FOR FAMILY CHILD CARE PROVIDERS

1. **Evidence of business liability insurance.** An insurer may not refuse to issue or renew a policy covering the primary residence of a family child care provider certified under Title 22, section 8301-A, subsection 3 or cancel such policy within the first 90 days of coverage unless the denial of coverage or cancellation is based solely on underwriting factors other than the presence of a family child care business on the premises if the family child care provider has demonstrated satisfactory evidence that the child care business is covered by separate insurance coverage for business liability, including medical payments coverage equivalent to coverage in the policy. For purposes of cancellation or nonrenewal under section 3049 or 3051, an insurer may not treat the presence of the family child care business activity as a factor related to the insurability of the primary residence of a family child care provider certified under Title 22, section 8301-A, subsection 3 if the family child care provider has demonstrated satisfactory evidence that the child care business is covered by separate insurance coverage for business liability in accordance with this subsection.

[2009, c. 185, §1 (NEW) .]

2. **No liability under property insurance policy.** An insurer has no duty to defend or indemnify a family child care provider certified under Title 22, section 8301-A, subsection 3 under a policy covering the primary residence of a family child care provider issued by the insurer if:

A. The loss or damage for which the family child care provider is liable or alleged to be liable arises in whole or in part from the family child care business activity; [2009, c. 185, §1 (NEW).]

B. The policy issued by the insurer expressly excludes that loss or damage arising from the family child care business activity; [2009, c. 185, §1 (NEW).]

C. The family child care provider has demonstrated satisfactory evidence of separate insurance coverage for child care business liability in accordance with subsection 1; and [2009, c. 185, §1 (NEW).]

D. The insurer issuing the policy covering the primary residence has disclosed to the family child care provider that failure to maintain separate insurance coverage for child care business liability might result in cancellation or nonrenewal of the policy covering the primary residence and that the child care business activity is excluded under the policy. [2009, c. 185, §1 (NEW).]

[2009, c. 185, §1 (NEW) .]

3. **Effect of cancellation or nonrenewal of business liability policy.** If a family child care provider has demonstrated satisfactory evidence of separate insurance coverage for child care business liability to the insurer as provided in subsection 2, paragraph C, the insurer issuing the policy covering the primary residence continues to have no duty to defend if the insurance policy for child care business liability is cancelled or nonrenewed during the term of the policy covering the primary residence.

[2009, c. 185, §1 (NEW) .]

SECTION HISTORY
2009, c. 185, §1 (NEW).

§3061. UNIFORM POLICY STANDARDS CONCERNING HURRICANE DEDUCTIBLE PROGRAMS

The superintendent shall adopt rules establishing procedures and standards for an insurer that uses a hurricane deductible program or programs regarding the applicability of hurricane deductibles. Procedures and standards must include without limitation uniform policy standards and the form of notice that the insurer must provide to the named insured under a policy subject to this subchapter issued by the insurer. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A. [2013, c. 38, §1 (NEW).]

SECTION HISTORY
2013, c. 38, §1 (NEW).

Chapter 43: SURETY INSURANCE CONTRACTS

§3101. CONTRACTS SUBJECT TO GENERAL PROVISIONS

All contracts of surety insurance delivered or issued for delivery in this State and covering subjects resident, located, or to be performed in this State are also subject to the applicable provisions of chapter 27 (the insurance contract) and to other applicable provisions of this Title. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3102. ACCEPTANCE AS SURETY ON BONDS

Any insurer duly authorized to transact surety insurance in this State may be accepted as surety upon the bond of any person required by the laws of the State to execute a bond. If such insurer shall furnish satisfactory evidence of its ability to provide all the security required by law, no additional surety may be exacted, but other surety or sureties may, in the discretion of the official authorized to approve such bond, be required. Such insurer may be released from its liability on the same terms and conditions as are by law prescribed for the release of individuals. It is the true intent and meaning of this section to enable corporations created for that purpose to become surety on bonds required by law, subject to all the rights and liabilities of private individuals. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3102-A. INDEMNIFICATION; SURETY ON BONDS

(REPEALED)

SECTION HISTORY
1995, c. 296, §1 (NEW). 2011, c. 38, §1 (RP).

§3103. PREMIUMS ON BONDS

Any court or officer whose duty it is to pass upon the account of any person required by law to give a bond may, whenever such person has given any such surety insurer as surety upon the bond, allow in the settlement of such account a reasonable sum for the expense of procuring such surety. The premiums on account of all official bonds required by law to be given by county officials shall be paid from the treasuries of their several counties. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3104. NOTICE OF AUTHORIZATION TO REGISTERS OF PROBATE

Whenever any surety insurer is authorized to transact business in this State, the superintendent shall maintain the name of such insurer and the names of all agents of such insurer who have been licensed by the superintendent, their places of residence and the dates when their licenses will expire. [1993, c. 637, §34 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 330, (RPR). 1993, c. 637, §34 (AMD).

§3105. ESTOPPEL TO DENY CORPORATE POWER

An insurer must attach a power of attorney to every bond it executes through an attorney-in-fact in this State; except that bonds executed by an officer of this insurer are exempt from this requirement. The power of attorney must identify the name and address of its attorney-in-fact who is authorized to act for the insurer within this State together with the scope of authority of the attorney-in-fact. Any insurer which shall execute any bond as surety under section 3102 shall be estopped in any proceedings to enforce the liability which it shall have assumed to incur, to deny its corporate power or the authority of its attorney in fact within the scope of the power of attorney filed in accordance with this section, to execute such instrument or assume such liability or the authority of any licensed agent to countersign such instrument. [1993, c. 637, §35 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1993, c. 637, §35 (AMD).

Chapter 45: TITLE INSURANCE CONTRACTS

§3201. CONTRACTS SUBJECT TO GENERAL PROVISIONS

All contracts of title insurance delivered or issued for delivery in this State and covering subjects located in this State are subject to the applicable provisions of chapter 27 (the insurance contract) and to other applicable provisions of this Title. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3202. CLOSING PROTECTION LETTERS

1. **Title insurer may issue closing or settlement protection.** A title insurer may issue closing or settlement protection on a form of closing protection letter approved by the superintendent pursuant to section 2412. Only a buyer, borrower or lender that is a party to a transaction in which a title insurance policy will be issued by or on behalf of the title insurer issuing the closing or settlement protection is eligible to receive the benefit of closing or settlement protection. Closing or settlement protection issued pursuant to this subsection must benefit each buyer, borrower and lender that is a party to the transaction for which that closing or settlement protection is issued.

[2013, c. 233, §1 (NEW) .]

2. **Indemnity.** The closing or settlement protection issued pursuant to subsection 1 may indemnify a buyer, borrower or lender against loss because of one of the following acts of a policy-issuing title insurance agent or other settlement service provider under the terms and conditions of the closing protection letter as issued by the title insurer:

A. Theft or misappropriation of settlement funds in connection with a transaction, but only to the extent that the theft relates to the status of the title to an insured interest in land or to the validity, enforceability and priority of the lien of the mortgage on an insured interest in land; and [2013, c. 233, §1 (NEW).]

B. Failure to comply with the written closing instructions when agreed to by the settlement agent or title agent, but only to the extent that the failure to comply with the instructions relates to the status of the title to an insured interest in land or the validity, enforceability and priority of the lien of the mortgage on an insured interest in land. [2013, c. 233, §1 (NEW).]

[2013, c. 233, §1 (NEW) .]

3. **Fee.** The fee charged by a title insurer for closing or settlement protection coverage must be filed with the superintendent pursuant to section 2304-A. The fee may not be subject to any agreement requiring a division of fees or premiums collected on behalf of the title insurer. A title insurer may charge only one fee for a closing or settlement protection letter for the protection of all parties receiving the benefit of closing or settlement protection in connection with the real property transaction giving rise to the issuance of the closing or settlement protection letter.

[2013, c. 233, §1 (NEW) .]

4. **Provision of other protection prohibited.** Except as provided in this section, a title insurer may not provide any protection that purports to indemnify against improper acts or omissions of a person with regard to settlement or closing services.

[2013, c. 233, §1 (NEW) .]

SECTION HISTORY
2013, c. 233, §1 (NEW).

Chapter 47: ORGANIZATION, CORPORATE POWERS, PROCEDURES OF DOMESTIC LEGAL RESERVE STOCK AND MUTUAL INSURERS

Subchapter 1: ORGANIZATION AND GENERAL POWERS

§3301. SCOPE OF CHAPTER

This chapter applies only as to domestic stock and mutual insurers transacting insurance on the cash premium or legal reserve plan. [1973, c. 788, §107 (AMD).]

1.

[1973, c. 788, §107 (RP) .]

2.

[1973, c. 788, §107 (RP) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 788, §107 (AMD).

§3302. INSURERS TO BE ORGANIZED UNDER THIS TITLE

All domestic stock and mutual legal reserve insurers hereafter organized shall be organized under the provisions of this Title, and not otherwise. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3303. RESERVATION OF POWER

The Legislature shall have power to amend, repeal or modify this Title at pleasure. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3304. APPLICABILITY OF GENERAL CORPORATION STATUTES

Domestic stock and mutual insurers shall be governed by the applicable provisions of the general statutes of this State relating to private corporations organized for profit, as such statutes are now or hereafter may be constituted, except where such general statutes are in conflict with the express provisions of this Title and the reasonable implications thereof, and in which case the provisions of this Title shall govern. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3305. "STOCK," "MUTUAL" INSURERS DEFINED

1. A "stock" insurer is as defined in section 400.

[1969, c. 132, §1 (NEW) .]

2. A "mutual" insurer is as defined in section 401.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3306. INCORPORATION OF DOMESTIC STOCK, MUTUAL INSURERS

1. **This section applies to stock and mutual insurers hereafter incorporated in this State.** Such an insurer may be formed for the purpose of transacting any kind or kinds of insurance, as well as annuity business.

[1969, c. 132, §1 (NEW) .]

2. **Incorporators.** Three or more individuals, none of whom is less than 18 years of age, may incorporate a stock insurer; 10 or more such individuals may incorporate a mutual insurer. At least a majority of the incorporators must be citizens of the United States of America.

[1973, c. 625, §148 (AMD) .]

3. **Articles of incorporation.** The incorporators shall execute articles of incorporation in triplicate, and at least a majority of the incorporators shall acknowledge their execution of the articles of incorporation under oath. The articles of incorporation must state and show:

A. The name of the corporation, which must be generally indicative of the business to be transacted and be subject to section 408 (name of insurer); if a mutual, the word "mutual" must be a part of the name. An alternative name or names may be specified for use in foreign countries, or in jurisdictions where conflict of name with that of another insurer or organization might otherwise prevent the corporation from being authorized to transact insurance in the foreign country; [2013, c. 299, §2 (AMD).]

B. The duration of its existence, which may be perpetual; [2013, c. 299, §2 (AMD).]

C. The kinds of insurance, as defined in this Title, that the corporation is formed to transact; [2013, c. 299, §2 (AMD).]

D. If a stock corporation, its authorized capital and the number of shares of stock into which divided. The capital stock must consist entirely of common stock of one uniform class, par value not less than $1.00 per share, each outstanding share of which having equal rights in every respect with every other such share, except that treasury stock may not have dividend or voting rights. Shares without par value may not be authorized; [2013, c. 299, §2 (AMD).]

E. If a stock corporation, the extent, if any, to which shares of its stock are subject to assessment; [2013, c. 299, §2 (AMD).]

F. If a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred. Such liability must be as stated in the articles of incorporation, but may not be less than one or more than 6 times the premium for the member's policy at the annual premium rate for a term of one year; [2013, c. 299, §2 (AMD).]

G. If a mutual corporation, the amount, if any, of its guaranty capital shares, the number and par value of shares into which divided, the voting and other rights of such shares, and the conditions under which such shares must or may be retired by the corporation, all consistent with section 3358 (guaranty capital shares); [2013, c. 299, §2 (AMD).]

H. The number of directors who constitute the board of directors and conduct the affairs of the corporation; and the names, addresses and terms of the members of the initial board of directors, who shall conduct the corporation's affairs for the term specified in the articles, but for not more than one year after date of incorporation; [2013, c. 299, §2 (AMD).]

I. The city or town and county in this State in which the corporation's principal place of business is to be located; [2013, c. 299, §2 (AMD).]

J. The name, residence address and national citizenship of each incorporator; and [2013, c. 299, §2 (AMD).]

K. Other provisions, not inconsistent with law, determined appropriate by the incorporators, and including, in the case of life insurers, the power to act as trustee with respect to proceeds of maturity or death benefits payable under life insurance or annuity contracts issued or assumed by it. [2013, c. 299, §2 (AMD).]

[2013, c. 299, §2 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 625, §148 (AMD). 2013, c. 299, §2 (AMD).

§3307. ARTICLES OF INCORPORATION, APPROVAL AND FILING

1. The incorporators of a proposed insurer shall deliver the triplicate originals of the articles of incorporation to the superintendent. The superintendent shall deliver one set of such originals to the Attorney General of this State, and the Attorney General shall examine the same. If the Attorney General finds that the articles of incorporation comply with law, the Attorney General shall so certify in writing and return the original of the articles of incorporation, so certified, to the superintendent.

[2013, c. 299, §3 (AMD) .]

2. When the articles of incorporation have been approved and returned by the Attorney General pursuant to subsection 1, the superintendent shall also endorse the superintendent's approval upon each set of the articles of incorporation and return the triplicate originals of the articles of incorporation to the incorporators. The incorporators shall then file one of the sets with the Secretary of State and one set with the superintendent bearing the certification of the Secretary of State and shall retain the remaining set in the corporate records.

[2013, c. 299, §3 (AMD) .]

3. For filing the articles of incorporation of a mutual insurer, the Secretary of State shall charge and collect a filing fee of $25; except that if it is a mutual insurance corporation with provision for guaranty capital shares, the Secretary of State shall charge and collect for the filing of the articles of incorporation the same amount as would be payable by a stock insurance corporation having a like amount of authorized capital stock.

[2013, c. 299, §3 (AMD) .]

4. If the Attorney General finds that the proposed articles of incorporation do not comply with law, the Attorney General shall refuse to approve the same and shall return the set of the articles of incorporation to the superintendent, together with a written statement of the respects in which the Attorney General finds that the articles do not comply. The superintendent shall return all sets of the proposed articles of incorporation to the proposed incorporators together with the Attorney General's written statement.

[2013, c. 299, §3 (AMD) .]

5. The Secretary of State may not permit the filing in the Secretary of State's office of any articles of incorporation unless the articles bear the superintendent's approval as provided in this section.

[2013, c. 299, §3 (AMD) .]

6. The approval of the Attorney General or superintendent, as provided for in this section, is considered to relate only to the form and contents of the articles, and does not constitute approval or commitment as to any other aspect or operation of the proposed insurer or relative to its entitlement, if any, to a certificate of authority.

[2013, c. 299, §3 (AMD) .]

7. The superintendent and Attorney General shall perform all duties required of them under this section within a reasonable time after the articles of incorporation have been submitted to the superintendent as provided in subsection 1.

[2013, c. 299, §3 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §3 (AMD).

§3308. CERTIFICATE OF SECRETARY OF STATE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2009, c. 56, §17 (RP).

§3308-A. FILING BY THE SECRETARY OF STATE

1. **Duty to file.** If a document delivered to the office of the Secretary of State for filing pursuant to this chapter satisfies the requirements of Title 13-C and this chapter, the Secretary of State shall file the document.

[2013, c. 299, §4 (AMD) .]

2. **Recording as filed; acknowledgment.** The Secretary of State files a document pursuant to subsection 1 by recording it as filed on the date of receipt. After filing a document, the Secretary of State shall deliver to the corporation or its representative a copy of the document with an acknowledgment of the date of filing.

[2009, c. 56, §18 (NEW) .]

3. **Evidentiary effect of copy of filed document.** A certificate from the Secretary of State delivered with a copy of a document filed by the Secretary of State is conclusive evidence that the original document is on file with the Secretary of State.

[2009, c. 56, §18 (NEW) .]

SECTION HISTORY
2009, c. 56, §18 (NEW). 2013, c. 299, §4 (AMD).

§3309. COMPLETION OF INCORPORATION; GENERAL POWERS, DUTIES

The incorporation of an insurer is effective as of the date of filing of the appropriate document by the Secretary of State as provided for in section 3308-A, and thereupon the corporation is vested with all the powers, rights and privileges and is subject to all the duties, liabilities and restrictions applicable to insurer corporations subject to qualification and application for, and issuance to the corporation of, a certificate of authority as an insurer by the superintendent under this Title. [2009, c. 56, §19 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2009, c. 56, §19 (AMD).

§3310. AMENDMENT OF ARTICLES OF INCORPORATION; CHANGE OF PRINCIPAL PLACE OF BUSINESS

1. A stock insurer may amend its articles of incorporation for any lawful purpose by authorization or vote of stockholders as provided for business corporations in general under the laws of this State applicable to such business corporations.

[2013, c. 299, §5 (AMD) .]

2. A mutual insurer may amend its articles of incorporation for any lawful purpose by affirmative vote of a majority of those of its members entitled to vote and present or represented by proxy at a lawful meeting of its members of which the notice given members included due notice of the proposal to amend and the substance of such proposal, and by affirmative vote of the holders of at least 2/3 of the insurer's outstanding guaranty capital shares, if any.

[2013, c. 299, §5 (AMD) .]

3. Upon adoption of an amendment under subsection 2, the insurer shall make in triplicate a certificate, sometimes referred to as a "certificate of amendment", setting forth the amendment and the date and manner of the adoption of the amendment. The certificate must be executed by the insurer's president or vice-president and secretary or assistant secretary and duly sworn to by one of them. The insurer shall deliver to the superintendent the triplicate originals of the certificate for review, certification and approval or disapproval by the Attorney General and the superintendent, and filing and recording, all as provided for original articles of incorporation under section 3307. The Secretary of State shall charge and collect for the use of the State a fee of $20 for filing and recording the certificate of amendment of a mutual insurer. The amendment is effective when duly approved and filed with the Secretary of State.

[2013, c. 299, §5 (AMD) .]

4. An insurer may change its principal place of business without amendment of its articles of incorporation, by resolution of its board of directors. A copy of the resolution, duly certified under oath by the corporate secretary, must be executed in triplicate and filed with the superintendent, with the Secretary of State and in the corporate records.

[2013, c. 299, §5 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §5 (AMD).

§3311. INSURANCE BUSINESS EXCLUSIVE; EXCEPTIONS

1. No domestic insurer heretofore or hereafter formed shall engage in any business other than the insurance business and in business activities reasonably and necessarily incidental to such insurance business.

[1969, c. 132, §1 (NEW) .]

2. Except that:

A. A title insurer may also engage in business as an escrow agent; [1969, c. 132, §1 (NEW).]

B. Any insurer may also engage in business activities reasonably related to the management, supervision, servicing of, and protection of its interests as to its lawful investments; [1969, c. 132, §1 (NEW).]

C. An insurer may own subsidiaries or subsidiaries owning other subsidiaries which may engage in such businesses all as provided for in section 1115 (stocks of subsidiaries) or in section 1157 (investment in subsidiaries); [1987, c. 399, §17 (AMD).]

D. An insurer may utilize its facilities to perform administrative services for any governmental body, unit or agency; and [1987, c. 399, §17 (AMD).]

E. An insurer transacting business of a type described in section 702, life insurance; section 703, annuity; or section 704, health insurance; or any combination of those types of business, may engage in any other business in which it is otherwise qualified to engage to the extent and in the manner approved by the superintendent. [1987, c. 399, §18 (NEW).]

[1987, c. 399, §§17, 18 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1987, c. 399, §§17,18 (AMD).

Subchapter 2: PROVISIONS APPLYING ONLY TO MUTUAL INSURERS

§3352. MUTUAL INSURERS, INITIAL QUALIFICATIONS

1. When hereafter newly organized, a mutual insurer may be authorized to transact any one of the kinds of insurance listed in the schedule contained in subsection 2 or any combination of such kinds as provided in subsection 3.

[1969, c. 132, §1 (NEW) .]

2. When applying for an original certificate of authority, the insurer must be otherwise qualified therefor under this Title, and must have received and accepted bona fide applications as to substantial insurable subjects for insurance coverage of a substantial character of the kind of insurance proposed to be transacted, must have collected in cash the full premium therefor at a rate not less than that usually charged by other insurers for comparable coverages, must have surplus funds on hand and deposited as of the date such insurance coverages are to become effective, or, in lieu of such applications, premiums and surplus, may deposit and thereafter maintain surplus, all in accordance with that part of the following schedule which applies to each kind of insurance the insurer proposes to transact:

(A) Kind of Ins.	(B) Min. No. of Apps. Accepted	(C) Min. No. Subjects Covered	(D) Minimum Premium Collected	(E) Minimum Amount Ins. Ea. Subject	(F) Maxi- mum Amount Ins. Ea. Subject (5)	(G) Deposit Minimum Surplus Fund (6)	(H) Deposit Surplus in Lieu (7)
Life (1)	500	500	Annual	$2,500	$50,000	1,000,000	$1,250,000
Health (2)	500	500	Quarterly	100 (wkly. indem.)	300 (wkly. indem.)	500,000	750,000

Property (3)	100	250	Annual	10,000	100,000	500,000
Casualty (4)	250	500	Annual	25,000	100,000	750,000

The following provisions are respectively applicable to the foregoing schedule and provisions as indicated by like numerals appearing in such schedule.

(1) No group insurance or term policies for terms of less than 10 years may be included.

(2) No group, blanket or family plans of insurance may be included. In lieu of weekly indemnity, a like premium value in medical, surgical and hospital benefits may be provided. Any accidental death or dismemberment benefit provided shall not exceed $15,000.

(3) Only insurance of the owner's interest in real property may be included.

(4) Such insurance must include coverage of legal liability for bodily injury and property damage, to which the maximum and minimum insured amounts apply.

(5) The maximums provided for in column (F) are net of applicable reinsurance.

(6) The deposit of surplus in the amount specified in columns (G) and (H) must thereafter be maintained unimpaired. The deposit is subject to chapter 15 (administration of deposits).

(7) Deposit surplus, when utilized, in lieu of the alternative procedure of accepting deposit application funds shall be in those amounts enumerated for each identified kind of insurance.

Expendable surplus: In addition to surplus deposited and thereafter to be maintained as shown in columns (G) or (H), the insurer when first authorized must have on hand surplus funds, which it can thereafter expend in the conduct of its business, in amount not less than 50% of the applicable deposited and maintained surplus required of it under the schedule set up in this subsection.

Notwithstanding the requirements for expendable surplus otherwise required by this section for newly organized insurance companies seeking a certificate of authority in this State, any such insurer may transact legal services insurance, to the extent provided for in chapter 38, without additional expendable funds, if the corporation is otherwise qualified for a certificate of authority to transact the business of health, life and health or multiple lines insurance, and possesses and thereafter maintains, in addition to the amounts enumerated in the table in this subsection, an additional amount of unimpaired basic surplus of not less than $500,000.

[1983, c. 801, §12 (AMD) .]

3. An insurer may initially qualify for authority to transact both life and health insurances by fulfilling the foregoing requirements as to each such kind of insurance; and may in like manner initially qualify for authority to transact both property and casualty insurance. An insurer shall not, however, so qualify to transact any other combination of such insurances, except as provided in section 3357.

[1969, c. 132, §1 (NEW) .]

4. Domestic mutual insurers, possessing a certificate of authority to conduct business solely on an assessment plan upon the effective date of this subsection, and newly organized assessment plan mutual insurers authorized after the effective date of this subsection shall be governed as to surplus funds requirements by the provisions of chapter 51.

[1983, c. 709, §3 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §57 (AMD). 1983, c. 709, §§2,3 (AMD). 1983, c. 801, §12 (AMD).

§3353. QUALIFYING APPLICATIONS FOR INSURANCE; BOND OR DEPOSIT

1. Before soliciting any applications for insurance required under section 3352 as qualification for the original certificate of authority, the incorporators of the proposed insurer shall file with the superintendent a corporate surety bond in the penalty of $15,000, in favor of the State and for the use and benefit of the State and of applicant members and creditors of the corporation. The bond must be conditioned in the event the corporation fails to complete its organization and secure a certificate of authority within one year after the date of its articles of incorporation:

A. For the prompt return to applicant members of all premiums collected in advance; [1969, c. 132, §1 (NEW).]

B. For payment of all indebtedness of the corporation; and [1969, c. 132, §1 (NEW).]

C. For payment of costs incurred by the State in the event of any legal proceedings for liquidation or dissolution of the corporation. [2013, c. 299, §6 (AMD).]

[2013, c. 299, §6 (AMD) .]

2. In lieu of such bond, the incorporators may deposit with the commissioner $15,000 in cash or United States government bonds, negotiable and payable to the bearer, with a market value at all times of not less than $15,000 and to be held in trust upon the same conditions as required for the bond.

[1969, c. 132, §1 (NEW) .]

3. The superintendent shall release and discharge any such bond filed or deposit or remaining portion thereof held under this section upon settlement and termination of all liabilities against it.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §6 (AMD).

§3354. QUALIFYING APPLICATIONS FOR INSURANCE; SOLICITATION

1. Upon receipt of the superintendent's approval of the bond or deposit as provided in section 3353, the directors and officers of the proposed domestic mutual insurer may commence solicitation of such requisite applications for insurance policies as they may accept, and may receive deposits of premiums thereon.

[1973, c. 585, §12 (AMD) .]

2. All such applications shall be in writing signed by the applicant, covering subjects of insurance resident, located or to be performed in this State.

[1969, c. 132, §1 (NEW) .]

3. All applications must provide that:

A. Issuance of the policy is contingent upon the insurer qualifying for and receiving a certificate of authority; [1969, c. 132, §1 (NEW).]

B. Insurance is not in effect until the certificate of authority has been issued; and [2013, c. 299, §7 (AMD).]

C. The prepaid premium or deposit, and membership or policy fee, if any, must be refunded in full to the applicant if organization is not completed and the certificate of authority is not issued and received by the insurer before a specified reasonable date, which date may not be later than one year after the date of the articles of incorporation. [2013, c. 299, §7 (AMD).]

[2013, c. 299, §7 (AMD) .]

4. All qualifying premiums collected shall be in cash.

[1969, c. 132, §1 (NEW) .]

5. Solicitation for such qualifying applications for insurance must be by licensed producers of the corporation, and the superintendent shall, upon the corporation's application therefor, issue temporary producer's licenses expiring on the date specified pursuant to subsection 3, paragraph C to individuals qualified as for a resident producer's license except as to the taking or passing of an examination. The superintendent may suspend or revoke any such license for any of the causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of producers in general under chapter 16.

[1997, c. 457, §44 (AMD); 1997, c. 457, §55 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §44 (AMD). 1997, c. 457, §55 (AFF). 2013, c. 299, §7 (AMD).

§3355. DEPOSIT OF QUALIFYING PREMIUMS; EFFECTIVE DATE OF INSURANCE

1. All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance therein shall be deposited in trust in a bank or trust company in this State under a written trust agreement consistent with this section and with section 3354, subsection 3, paragraph C. The corporation shall file an executed copy of such trust agreement with the superintendent.

[1973, c. 585, §12 (AMD) .]

2. Upon issuance to the corporation of a certificate of authority as an insurer for the kind or kinds of insurance for which such applications were solicited, all funds so held in trust shall become the funds of the insurer, and the insurer shall thereafter in due course issue and deliver its policies for which premiums had been paid and accepted. The insurance provided by such policies shall be effective as of the date of the certificate of authority or thereafter as provided by the respective policies.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3356. FAILURE TO COMPLETE AND QUALIFY

If the proposed domestic mutual insurer fails to complete its organization and to secure its original certificate of authority within one year after the date its articles of incorporation were filed with the Secretary of State, its corporate powers cease, and the superintendent shall return or cause to be returned to the persons entitled to them all advance deposits or payments of premium held in trust under section 3355. [2013, c. 299, §8 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §8 (AMD).

§3357. AUTHORITY TO TRANSACT ADDITIONAL KINDS OF INSURANCE

After being authorized to transact one kind or combination of kinds of insurance as provided in section 3352, a mutual insurer may be authorized by the superintendent to transact such additional kinds of insurance as are permitted under section 409 (combinations of insuring powers), while otherwise in compliance with this Title and while maintaining unimpaired surplus and guaranty capital funds in an amount not less than the amount of paid-in capital stock required to be maintained by a like domestic stock insurer transacting the same kinds of insurance. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3358. GUARANTY CAPITAL SHARES

1. A mutual insurer formed to transact or transacting any kind of insurance has the right to provide for guaranty capital shares in its articles of incorporation. Outstanding guaranty capital shares at the par value take the place of a like amount of basic surplus otherwise required for authority to transact insurance.

[2013, c. 299, §9 (AMD) .]

2. Shares of guaranty capital stock shall have a par value of $100 each, and shall be paid for in cash. Nothing in this Title shall be deemed to prohibit the sale of such shares at a price above such par value in order to provide the insurer with capital surplus.

[1969, c. 132, §1 (NEW) .]

3. Only one class of such guaranty capital shares shall be provided for, and each such share outstanding shall have equal voting, dividend, retirement and other rights with every other such share. Each such share shall have one vote on matters coming to a vote at meetings of the insurer's shareholders and members. Policyholders of the insurer shall have the same voting rights as would exist in the absence of such guaranty capital.

[1969, c. 132, §1 (NEW) .]

4. Noncumulative dividends, not exceeding in any one year 12% or lesser reasonable amount as determined by prevailing rates for loans of similar risk characteristics at the time the shares are issued, may be declared and paid by the insurer on outstanding guaranty capital shares out of that portion of the insurer's expendable surplus representing net realized earnings from its operations; and may be so paid even though the amount of the insurer's expendable surplus is then less in amount than any prior total of expendable contributed, borrowed or paid-in surplus. Such a dividend may be paid in cash or in guaranty capital shares, or part in each. An amount equal to the par value of shares so distributed as dividend shall be transferred from the insurer's earned surplus account to its guaranty capital shares account.

[1981, c. 501, §44 (AMD) .]

5. If the guaranty capital becomes impaired, the impairment shall be cured as provided in section 3423 (impairment of capital funds).

[1969, c. 132, §1 (NEW) .]

6. The insurer shall retire and cancel the guaranty capital shares, in part and in whole as soon as is reasonably possible, out of expendable surplus resulting from net realized earnings from its operations, or out of surplus created through issuance of agreements authorized by section 3415. The insurer shall retire and cancel the guaranty capital shares in their entirety when such retirement would, in the superintendent's opinion, leave the insurer with surplus as to policyholders reasonably adequate to enable it to continue to transact the kinds and volume of insurance business transacted.

[1973, c. 585, §12 (AMD) .]

7. In any liquidation of the insurer, outstanding guaranty capital shares shall have the same rights and priority as to the insurer's assets as are possessed by the stockholders of a like stock insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 501, §44 (AMD). 2013, c. 299, §9 (AMD).

§3359. BYLAWS

1. A domestic mutual insurer shall have bylaws for the government of its affairs. The insurer's initial board of directors shall adopt original bylaws, subject to the approval of the insurer's members at the next meeting of members.

[1969, c. 132, §1 (NEW) .]

2. The bylaws shall contain provisions, consistent with this Title, relating to:

A. The voting rights of members; [1969, c. 132, §1 (NEW).]

B. Election of directors, and the number, qualifications, terms of office and powers of directors; [1969, c. 132, §1 (NEW).]

C. Annual and special meetings of members; [1969, c. 132, §1 (NEW).]

D. The number, designation, election, terms and powers and duties of the respective corporate officers; [1969, c. 132, §1 (NEW).]

E. Deposit, custody, disbursement and accounting for corporate funds; [1969, c. 132, §1 (NEW).]

F. Fidelity bonds covering such officers and employees of the insurer as handle its funds, to be issued by a corporate surety and to be in such amount as may be reasonable; and [1969, c. 132, §1 (NEW).]

G. Such other matters as may be customary, necessary or convenient for the management or regulation of corporate affairs. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. The insurer shall promptly file with the superintendent a copy, certified by the insurer's secretary, of its bylaws and of every modification thereof or addition thereto. The superintendent shall disapprove any bylaw provision deemed by him, after a hearing held thereon, to be unlawful, unreasonable, inadequate, unfair

or detrimental to the proper interests or protection of the insurer's members or any class thereof. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision so disapproved.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3360. MEMBERS ARE POLICYHOLDERS

1. Each policyholder of a domestic mutual insurer, other than of a reinsurance contract, is a member of the insurer with all rights and obligations of such membership, as the charter and as the policy shall so specify.

[1969, c. 132, §1 (NEW) .]

2. Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee or fiduciary may be a member of a domestic, foreign or alien mutual insurer. Any officer, stockholder, trustee or legal representative of any such corporation, board, association or estate may be recognized as acting for or on its behalf for the purpose of such membership, and shall not be personally liable upon any contract of insurance for acting in such representative capacity.

[1969, c. 132, §1 (NEW) .]

3. Any domestic corporation may participate as a member of a mutual insurer as an incidental purpose for which such corporation is organized, and as much granted as the rights and powers expressly conferred.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3361. MEETINGS OF MEMBERS, IN GENERAL

1. Meetings of members of a domestic mutual insurer shall be held in the city or town of its principal office in this State, except as may otherwise be provided in the insurer's bylaws with the superintendent's approval.

[1973, c. 585, §12 (AMD) .]

2. Each such insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its members to fill vacancies existing or occurring in the board of directors, receive and consider reports of the insurer's officers as to its affairs and transact such other business as may properly be brought before it.

[1969, c. 132, §1 (NEW) .]

3. Written notice of the time and place of the annual meeting of members shall be given members not less than 30 days prior to the meeting. Notice may be given by imprinting the notice plainly on the policies issued by the insurer or in any other appropriate manner. Any change of the date or place of the annual meeting shall be made only by an annual meeting of members. Notice of such change, among other appropriate methods, may be given:

A. By imprinting such new date or place on all policies which will be in effect as of the date of such changed meeting; or [1969, c. 132, §1 (NEW).]

B. Unless the superintendent otherwise orders, notice of the new date or place need be given only through policies issued after the date of the annual meeting at which such change was made and in premium notices and renewal certificates issued during the 24 months immediately following such meeting. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

4. If more than 6 months are allowed to elapse after an annual meeting of members is due to be held and without such annual meeting being held, the superintendent shall, upon written request of any officer, director or member of the insurer, cause written notice of such meeting to be given to the insurer's members, and the meeting shall be held as soon as reasonably possible thereafter.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3362. SPECIAL MEETINGS OF MEMBERS

1. **A special meeting of the members of a mutual insurer may be held for any lawful purpose.** The meeting shall be called by the corporate secretary pursuant to request of the insurer's president or of its board of directors, or upon request in writing signed by not less than 1/10 of the insurer's members. The meeting shall be held at such time as the secretary may fix, but not less than 10 nor more than 30 days after receipt of the request. If the secretary fails to issue such call, the president, directors or members making the request may do so.

[1969, c. 132, §1 (NEW) .]

2. **Not less than 10 days' written notice of the meeting shall be given.** Notice addressed to the insurer's members at their respective post-office addresses last of record with the insurer and deposited, postage prepaid, in a letter depository of the United State post office, shall be deemed to have been given when so mailed. In lieu of mailed notice, the insurer may publish the notice in such publication or publications as shall afford a majority of its members a reasonable opportunity to have actual advance notice of the meeting. The notice shall state the purposes of the meeting, and no business shall be transacted at the meeting of which notice was not so given.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3363. VOTING RIGHTS OF MEMBERS

1. Each member of a mutual insurer is entitled to one vote upon each matter coming to a vote at a meeting of members, or to such other vote as may be provided for on a reasonable basis in the insurer's bylaws with the superintendent's approval.

[1973, c. 585, §12 (AMD) .]

2. A member shall have the right to vote in person or by his written proxy filed with the corporate secretary not less than 20 days prior to the meeting. No such proxy shall be made irrevocable, nor be valid beyond the earlier of the following dates:

A. The date of expiration set forth in the proxy; or [1969, c. 132, §1 (NEW).]

B. The date of termination of membership; or [1969, c. 132, §1 (NEW).]

C. 5 years from the date of execution of the proxy. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. No member's vote upon any proposal to divest the insurer of its business or assets, or the major part thereof, shall be registered or taken, except in person or by proxy newly executed and specific as to the matter to be voted upon.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3364. CONTINGENT LIABILITY OF MEMBERS

1. Except as provided otherwise in section 3367 with respect to nonassessable policies, each member of a domestic mutual insurer has a contingent liability, pro rata and not one for another, for the discharge of its obligations, which contingent liability may not be greater than 6 times the annual premium for the member's policy at the annual premium rate, as is specified in the insurer's articles of incorporation or bylaws.

[2013, c. 299, §10 (AMD) .]

2. Every policy issued by the insurer shall contain a plain and legible statement of the contingent liability upon either the face or back thereof.

[1969, c. 132, §1 (NEW) .]

3. Termination of the policy of any such member shall not relieve the member of contingent liability for his proportion of the obligations of the insurer which accrued while the policy was in force.

[1969, c. 132, §1 (NEW) .]

4. Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 501, §45 (AMD). 2013, c. 299, §10 (AMD).

§3365. LEVY OF CONTINGENT LIABILITY

1. If at any time the assets of a domestic mutual insurer are less than its liabilities, exclusive of guaranty capital shares, if any, at par value, and the minimum amount of surplus required to be maintained by it under this Title for authority to transact the kinds of insurance being transacted, and the deficiency is not cured from other sources, its directors may, if the same is approved by the superintendent as being reasonable and in the best interests of the insurer and its members, levy an assessment only on its members who held the

policies providing for contingent liability at any time within the 12 months next preceding the date the levy was authorized by the board of directors, and such members shall be liable to the insurer for the amount so assessed.

[1973, c. 585, §12 (AMD) .]

2. The levy of assessment shall be for such an amount as is required to cure such deficiency and to provide a reasonable amount of working funds above such minimum amount of surplus, but such working funds so provided shall not exceed 5% of the sum of the insurer's liabilities and such minimum required surplus as of the date of the levy.

[1969, c. 132, §1 (NEW) .]

3. As to the respective policies subject to the levy, the assessment shall be computed upon the basis of premium earned during the period covered by the levy.

[1969, c. 132, §1 (NEW) .]

4. No member shall have an offset or counterclaim against any assessment for which he is liable, on account of any claim for unearned premium or loss payable.

[1969, c. 132, §1 (NEW) .]

5. As to life insurance, any part of such an assessment upon a member which remains unpaid following notice of assessment, demand for payment, and lapse of a reasonable waiting period as specified in such notice, may, if approved by the superintendent as being in the best interests of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held or to be held by the insurer to the credit of the member's policy.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3366. ENFORCEMENT OF CONTINGENT LIABILITY

1. The insurer shall notify each member of the amount of assessment to be paid, and the date -- not less than 20 days after mailing date -- by which payment is to be made, by written notice mailed to the member at his address last of record with the insurer. Failure of the member to receive the notice so mailed, within the time specified therein for the payment of the assessment or at all, shall be no defense in any action to collect the assessment.

[1969, c. 132, §1 (NEW) .]

2. If a member fails to pay the assessment within the period specified in the notice, the insurer may institute suit to collect the same.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3367. NONASSESSABLE POLICIES; LIMITS OF ASSESSABILITY; USE OF FUNDS; COMBINATION OPERATION

1. A domestic mutual insurer may extinguish the contingent liability to assessment of its members as to cash premium plan policies in force and may omit provisions imposing contingent liability in such policies currently issued while it has and maintains surplus, as determined by its financial statement filed with the superintendent as of the year end next preceding, of not less than $100,000 as to an insurer formed prior to January 1, 1968, and of not less than $200,000 as to an insurer formed after January 1, 1968.

[1973, c. 585, §12 (AMD) .]

2. If the insurer after qualifying to issue such a nonassessable policy fails to maintain the applicable above requirement, it shall cease to issue nonassessable policies until it has again met and maintained the requirement for a period of one year.

[1969, c. 132, §1 (NEW) .]

3. Any assessment levied under the contingent liability provisions of the policy shall be for the exclusive benefit of the holders of policies subject to contingent liability, and such policyholders shall not be liable to assessment in an amount greater in proportion to the total deficiency than the ratio that the deficiency attributable to the contingently liable business bears to the total deficiency. An assessment shall apply only to the holders of the type of policy or plan under which the deficiency occurred, and funds received from the assessment shall be for the exclusive benefit of such holders.

[1969, c. 132, §1 (NEW) .]

4. Nothing in this chapter shall be deemed to prohibit a domestic mutual insurer formed prior to January 1, 1968 from at any one time transacting, in respective departments or divisions of its operations, insurance business on any two or all of the following bases:

A. Cash premium plan, without contingent liability to assessment, and issuance of nonassessable policies if qualified therefor as above provided in this section; [1969, c. 132, §1 (NEW).]

B. Cash premium plan, with contingent liability to assessment; and [1969, c. 132, §1 (NEW).]

C. Assessment plan. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

Subchapter 3: PROVISIONS APPLYING TO STOCK AND MUTUAL INSURERS

§3408. HOME OFFICE, RECORDS, ASSETS TO BE IN STATE; EXCEPTIONS

1. Every domestic insurer shall have and maintain its principal place of business and home office in this State, and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer.

[1969, c. 132, §1 (NEW) .]

2. Every domestic insurer shall have and maintain its assets in this State, except as to:

A. Real property and personnal property appurtenant thereto lawfully owned by the insurer and located outside this State; [1981, c. 501, §46 (AMD).]

B. Such property of the insurer as may be customary, necessary and convenient to enable and facilitate the operation of its branch offices located outside this State as referred to in subsection 4; and [1981, c. 501, §46 (AMD).]

C. United States public obligations and other corporate securities for which definitive certificates have not been issued, but are issued through the book-entry systems of federal reserve banks or depository trust companies. Insurers investing in securities in book-entry form shall make available at the time of examination the following:

(1) A copy of the custodial or safekeeping agreement entered into by the insurer and the custodian, a state-chartered bank, a member bank of the federal reserve system or a depository trust company if the deposit was made directly to the entity, which sets forth the provisions for the use of the book-entry securities on behalf of the insurer by the custodian. The agreement shall provide for a standard of responsibility on the part of the custodian which shall be the responsibility of a bailee for hire under the law of the jurisdiction of the custodian's state of domicile. The agreement shall provide that the securities held by the custodian are subject to the instructions of the insurer and may be withdrawn immediately upon demand of the insurer; and

(2) Affidavits evidencing ownership of the book-entry securities signed by a responsible official of the custodian and stating that the custodian is holding the securities for the insurer pursuant to the terms of the custodial agreement. These book-entry securities shall be treated as "admitted assets" of the insurer on production of the affidavit.

The required custodial agreement and affidavit shall conform to such standards as may be prescribed from time to time by the Superintendent of Insurance. [1981, c. 501, §47 (NEW).]

[1981, c. 501, §§46, 47 (AMD) .]

3. No person shall remove all or a material part of the records or assets of a domestic insurer from this State, except pursuant to a plan of merger, consolidation or bulk reinsurance approved by the superintendent under this Title, or for such reasonable purposes and periods of time as may be approved by the superintendent in writing in advance of such removal, or conceal such records or assets or such material part thereof from the superintendent. Any person who removes or attempts to remove such records of assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this State with the intent to remove the same from this State, or who conceals or attempts to conceal the same from the superintendent, in violation of this section, shall upon conviction thereof be guilty of a felony, punishable by a fine of not more than $10,000 or by imprisonment for not more than 5 years, or by both in the discretion of the court. Upon any removal or attempted removal of such records of assets, or upon retention of such records or assets or material part thereof outside this State, beyond the period therefor specified in the superintendent's consent under which the records were so removed thereat, or upon concealment of or attempt to conceal records or assets in violation of this section, the superintendent may institute delinquency proceedings against the insurer pursuant to chapter 57.

[1973, c. 585, §12 (AMD) .]

4. This section shall not be deemed to prohibit or prevent an insurer from:

A. Establishing and maintaining regional home offices or branch offices in other states or countries where necessary or convenient to the transaction of its business, and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the superintendent at his request; [1973, c. 585, §12 (AMD).]

B. Having, depositing or transmitting funds and assets of the insurer in or to jurisdictions outside of this State required by the law of such jurisdiction or as reasonably and customarily required or convenient in the regular course of its business. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 501, §§46,47 (AMD).

§3409. VOUCHERS FOR EXPENDITURES

1. No insurer shall make any disbursement of $50 or more, unless such disbursement is evidenced by a voucher or other document correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf of the person receiving the money, or made through an electronic or wire funds transfer system supported by accurate records identifying the payor, payee, date of electronic or wire transfer payment, and the nature of the disbursement so made.

[1981, c. 501, §47-A (AMD) .]

2. If the disbursement is for services and reimbursement, the voucher or other document, or some other writing referred to therein, shall describe the services and itemize the expenditures.

[1969, c. 132, §1 (NEW) .]

3. If in a particular instance a required voucher cannot be obtained, the expenditure must be supported by an affidavit executed by an officer of the insurer stating the reasons for such inability and the particulars of such expenditure as otherwise required in this section.

[1981, c. 501, §47-A (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1981, c. 501, §§47-A (AMD).

§3410. DESTRUCTION OF RECORDS

1. An insurer may destroy its obsolete records after expiration of such reasonable period after completion of the transactions to which they relate as the insurer may deem proper. The insurer may so destroy its closed files relating to losses and claims arising under its policies after the first to occur of the following events:

A. Completion of a regular examination of the insurer by the superintendent and to which the closed file was subject; or [1973, c. 585, §12 (AMD).]

B. Expiration of 6 years after the file was duly closed. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

2. Records preserved on microfilm or other similar process and freely retrievable shall not be deemed to have been destroyed.

[1969, c. 132, §1 (NEW) .]

3. This section shall not relieve the insurer of any responsibility or liability otherwise arising under law with respect to the existence and availability of any record.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3411. DIRECTORS

1. The affairs of every domestic insurer must be managed by a board of directors consisting of not less than 7 directors or more than 21 directors, except that a domestic insurer may be managed by an initial board of not less than 3 directors during its first year of existence if so provided for by its articles of incorporation.

[2013, c. 299, §11 (AMD) .]

2. Directors, other than initial directors named in the insurer's articles of incororation, must be elected by the members or stockholders of a domestic insurer at the annual meeting of stockholders or members. Directors may be elected for terms of not more than 3 years each and until their successors are elected and have qualified; and, if the directors are to be elected for terms of more than one year, the insurer's bylaws may provide for a staggered term system under which the terms of a proportionate part of the members of the board of directors expire on the date of each annual meeting of stockholders or members. A directorship becoming vacant before expiration of the term may be filled by the board of directors for the remainder of the term.

[2013, c. 299, §11 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2013, c. 299, §11 (AMD).

§3412. OFFICERS; NOTICE OF CHANGE

1. An insurer's board of directors shall elect one of their number as president, and shall elect a corporate secretary and such other officers as may be provided for in the bylaws or otherwise required by law. Any such officer shall serve for such term as may be fixed in the bylaws or by the board of directors, but shall be subject to removal as an officer by the board of directors at any time.

[1969, c. 132, §1 (NEW) .]

2. Each officer shall have such powers and duties as may be prescribed by or pursuant to the insurer's charter or bylaws.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3413. PROHIBITED PECUNIARY INTEREST OF OFFICIALS AND OTHERS; USE OF CONFIDENTIAL INFORMATION PROHIBITED

1. Any officer or director, or any member of any committee or any employee of a domestic insurer, having the duty or power of investing or handling the insurer's funds, shall not deposit or invest such funds except in the insurer's name; shall not borrow the funds of the insurer; or be pecuniarily interested in any

loan, pledge, deposit, security, investment, sale, purchase, exchange, reinsurance or other similar transaction or property of the insurer except as a stockholder, member, employee or director, unless the transaction is authorized or approved by the insurer's board of directors, with knowledge and recording of such pecuniary interest, by affirmative vote of not less than 2/3 of the directors; and shall not take or receive to his own use any fee, brokerage, commission, gift or other similar consideration for or on account of any such transaction made by or on behalf of the insurer.

[1969, c. 132, §1 (NEW) .]

2. No director, officer or employee of a domestic insurer shall directly or indirectly use for his own private pecuniary advantage confidential information concerning the insurer or its past, existing or proposed affairs or transactions acquired by him in the course of his services as such director, officer or employee. The amount of any financial gain realized directly or indirectly by any such individual and accompanied by violation of this subsection shall belong to the insurer, and shall be recoverable by the insurer by civil suit. This subsection shall not apply as to transactions in shares of a stock insurer which are subject to section 16 of the Securities Exchange Act of 1934, as amended.

[1969, c. 132, §1 (NEW) .]

3. No insurer shall guarantee the financial obligation of any of its officers or directors.

[1969, c. 132, §1 (NEW) .]

4. This section shall not prohibit such a director, officer, member of a committee, or employee from becoming a policyholder of the insurer and enjoying the usual rights of a policyholder or from participating as beneficiary in any pension trust, deferred compensation plan, profit sharing plan, stock option plan or similar plan authorized by the insurer and to which he may be eligible; or prohibit any director or member of a committee from receiving a reasonable fee for lawful services actually rendered to the insurer.

[1969, c. 132, §1 (NEW) .]

5. The superintendent may, by regulation from time to time, define and permit additional exceptions to the prohibition contained in subsection 1 solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer, or to a corporation or firm in which a director is interested, for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of such director, corporation or firm.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3414. MANAGEMENT, COMMISSION, EXCLUSIVE AGENCY CONTRACTS

1. No domestic insurer shall hereafter make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the material exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, or, if an officer, director or otherwise part of the insurer's management, is to receive any commission, bonus or compensation based upon the volume of the insurer's business or transactions, unless the contract is filed with and not disapproved by the superintendent. The contract shall become effective in accordance with its terms unless

disapproved by the superintendent within 20 days after date of filing, subject to such reasonable extension of time as the superintendent may require by notice given within such 20 days. Any disapproval shall be delivered to the insurer in writing stating the grounds therefor.

[1973, c. 585, §12 (AMD) .]

2. Any such contract shall provide that any such manager, producer of its business or contract holder shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during such calendar year, with specification of the emoluments received therefrom by the respective directors, officers and other principal management personnel of the manager or producer, and with such classification of items and further detail as the insurer's board of directors may reasonably require.

[1969, c. 132, §1 (NEW) .]

3. The superintendent shall disapprove any such contract if he finds that it:

A. Subjects the insurer to excessive charges; or [1969, c. 132, §1 (NEW).]

B. Is to extend for an unreasonable length of time; or [1969, c. 132, §1 (NEW).]

C. Does not contain fair and adequate standards of performance; or [1969, c. 132, §1 (NEW).]

D. Contains other inequitable provision or provisions which impair the proper interests of stockholders or members of the insurer. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

4. The superintendent may, after a hearing held thereon, disapprove any such contract theretofore permitted to become effective, if he finds that the contract should be disapproved on any of the grounds referred to in subsection 3.

[1973, c. 585, §12 (AMD) .]

5. This section does not apply as to contracts entered into prior to January 1, 1970, or to amendment of such contracts other than extensions thereof.

[1973, c. 625, §149 (AMD) .]

6. This section shall not be deemed to prohibit receipt of commissions on insurance written personally by a director or officer who is duly licensed and regularly engaged in business as an insurance agent or broker; or to prohibit receipt of vested commissions by a director or officer based upon insurance business theretofore written by him.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §149 (AMD).

§3415. BORROWED CAPITAL FUNDS

1. A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding, per annum, a rate of 5 percentage points in excess of the

then current discount rate of the Federal Reserve Bank, Boston, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus as stipulated in the agreement. No commission or promotion expense may be paid in connection with any such loan, except that if sale is made of the loan securities through established securities brokers or by public offering, the insurer may pay the reasonable costs thereof approved by the superintendent.

[1983, c. 709, §4 (RPR) .]

2. Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement, or be the basis of any set-off or counterclaim; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

[1969, c. 132, §1 (NEW) .]

3. Any such loan shall be subject to the superintendent's approval. The insurer shall, in advance of the loan, file with the superintendent a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after date of such filing the insurer is notified of the superintendent's disapproval and the reasons therefor. The superintendent shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

[1973, c. 585, §12 (AMD) .]

4. Any such loan to an insurer or substantial portion thereof may be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such a loan, whether heretofore or hereafter outstanding shall be made, other than as provided in the loan agreement, unless approved in advance by the superintendent.

[1973, c. 585, §12 (AMD) .]

5. This section shall not apply to other kinds of loans obtained by the insurer in ordinary course of business, or to loans secured by pledge or mortgage of assets.

[1969, c. 132, §1 (NEW) .]

6. Loans authorized under this section may be made by domestic insurers as well as by other persons; but such a loan shall not constitute an asset in any determination of the financial condition of the lending insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §58 (AMD). 1973, c. 585, §12 (AMD). 1983, c. 709, §4 (AMD).

§3416. DIVIDENDS TO STOCKHOLDERS

1. A domestic stock insurer shall not pay any cash dividend to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains.

[1969, c. 132, §1 (NEW) .]

2. A cash dividend otherwise lawful may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed or paid-in surplus.

[1969, c. 132, §1 (NEW) .]

3. A stock dividend may be paid out of any available surplus funds, other than "surplus" resulting from borrowed capital funds such as provided for under section 3415.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3417. PARTICIPATING POLICIES

1. If provided for in its articles of incorporation, certificate of organization or charter, a stock insurer or mutual insurer may issue any or all of its policies or contracts with or without participation in profits, savings, unabsorbed portions of premiums or surplus; may classify policies issued and perils insured on a participating and nonparticipating basis; and may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination must be reasonable, and may not unfairly discriminate as between policies so classified.

[2013, c. 299, §12 (AMD) .]

2. A life insurer may issue both participating and nonparticipating policies or contracts if the right or absence of right to participate is reasonably related to the premium charged.

[1969, c. 132, §1 (NEW) .]

3. After the first policy year, no dividend, otherwise earned under a life or health insurance policy or annuity contract, shall be made contingent upon the payment of renewal premium on any such policy or contract; except that a participating life or health insurance policy providing for participation at the end of the first or second policy year may provide that the dividend or dividends will be paid subject to payment of premium for the next ensuing year.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2013, c. 299, §12 (AMD).

§3418. DIVIDENDS TO POLICYHOLDERS

1. The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its accumulated surplus funds which represents net realized savings, net realized earnings and net realized capital gains, all in excess of the surplus required by law to be maintained by the insurer.

[1969, c. 132, §1 (NEW) .]

2. A dividend otherwise proper may be payable out of such savings, earnings and gains even though the insurer's total surplus is then less than the aggregate of contributed surplus remaining unpaid by the insurer.

[1969, c. 132, §1 (NEW) .]

3. A domestic stock insurer may pay dividends to holders of its participating policies out of any available surplus funds.

[1969, c. 132, §1 (NEW) .]

4. No dividend shall be paid which is inequitable, or which unfairly discriminates as between classifications of policies or policies within the same classifications.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3419. PENSION AND OTHER PLANS FOR EMPLOYEES AND OTHERS

1. Pursuant to the terms of a pension plan or plans or any modification thereof, heretofore or hereafter adopted by the insurer's board of directors and approved by the superintendent, any domestic stock or mutual insurer may pay the whole or any part of the cost of retirement or disability pensions for such of its officers, employees or full-time insurance agents as are specified in such plan or plans or modifications thereof. If so specified in the plan or plans, in lieu of such pensions actuarially equivalent benefits may be paid to such officers, employees or full-time agents or to their designated beneficiaries.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall approve any such plan unless he finds the same not to be within the reasonable financial resources of the insurer or not fair and equitable as between the respective classifications of participants therein.

[1973, c. 585, §12 (AMD) .]

3. Nothing contained in this section or in section 3420 shall be deemed to prohibit profit-sharing, stock option or similar plans for an insurer's officers, employees or agents.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3420. INSURANCE BENEFITS FOR EMPLOYEES AND OTHERS

Pursuant to vote of its board of directors heretofore or hereafter made, any domestic stock or mutual insurer may provide for its officers, employees or full-time insurance agents a plan or plans of insurance, to be issued under group or individual policies. The insurer may pay the cost, in whole or in part, of such insurance; or, if duly authorized by its charter and bylaws, may itself provide such benefits directly as the insurer thereof, without requirement of placement through a licensed insurance agent, and in such case may adjust the premium rate for the insurance to reflect such savings in expense as the insurer may deem applicable. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3421. SOLICITATION, INSURING IN OTHER STATES

1. No domestic insurer shall knowingly solicit insurance business in any reciprocating state in which not then licensed as an authorized insurer. This subsection shall not prohibit advertising through publications and radio, television and other media originating outside such reciprocating state, if the insurer is licensed in the state in which the advertising originates and the advertising is not specifically directed to residents of such reciprocating state. This subsection shall not apply as to surplus lines insurance, or reinsurance, or prohibit insurance covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed, or insurance otherwise effectuated in accordance with the laws of the reciprocating state. A "reciprocating" state, as used herein, is one under the laws of which a similar prohibition is imposed upon and enforced against insurers domiciled in that state.

[1969, c. 132, §1 (NEW) .]

2. A domestic insurer duly authorized to transact insurance in another jurisdiction may frame and issue policies for delivery in such jurisdiction pursuant to applications for insurance solicited and obtained therein, in accordance with the laws thereof, subject only to such restrictions, if any, as may be contained in the insurer's articles of incorporation or bylaws; and subject, in the case of health insurers, to the provisions of section 2733 (policies issued for delivery in another state).

[2013, c. 299, §13 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §59 (AMD). 2013, c. 299, §13 (AMD).

§3422. PURCHASE OF OWN SHARES BY STOCK INSURER

A domestic stock insurer shall have the right to purchase or acquire shares of its own stock only as follows: [1969, c. 132, §1 (NEW).]

1. For elimination of fractional shares.

[1969, c. 132, §1 (NEW) .]

2. Incidental to the enforcement of rights of the insurer with respect to lawful transactions previously entered into in good faith for purposes other than the acquisition of such shares.

[1969, c. 132, §1 (NEW) .]

3. For the purposes of a general savings and investment plan for employees or agents of the insurer.

[1969, c. 132, §1 (NEW) .]

4. For mutualization of the insurer, as provided in section 3472.

[1969, c. 132, §1 (NEW) .]

5. For retirement or otherwise of the shares under a plan submitted to and approved in writing by the superintendent. The superintendent shall not approve a plan unless found by him to be reasonable, fair and equitable as to remaining stockholders of the insurer, and not materially adverse to the protection of the insurer's policyholders.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3423. IMPAIRMENT OF CAPITAL FUNDS

1. If a domestic stock insurer's paid-in capital stock, as represented by the aggregate par value of its outstanding capital stock, becomes impaired, or the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of basic surplus required to be maintained by it under this Title for authority to transact the kinds of insurance being transacted, the superintendent shall at once determine the amount of deficiency and serve notice upon the insurer to cure the deficiency and file proof thereof with him within the period specified in the notice, which period shall be not less than 30 nor more than 90 days from the date of the notice. Such notice may be so served by delivery to the insurer, or by mailing to the insurer addressed to its registered office in this State.

[1973, c. 585, §12 (AMD) .]

2. The deficiency may be made good in cash or in assets eligible under chapter 13 (investments) for the investment of the insurer's funds or by amendment of the insurer's certificate of authority to cover only such kind or kinds of insurance thereafter for which the insurer has sufficient paid-in capital stock, if a stock insurer, or surplus, if a mutual insurer, under this Title; or, if a stock insurer, by reduction of the number of shares of the insurer's authorized capital stock or the par value of the capital stock through amendment of its certificate of organization or articles of incorporation, to an amount of authorized and unimpaired paid-in capital stock not below the minimum required for the kinds of insurance thereafter to be transacted.

[2013, c. 299, §14 (AMD) .]

3. If the deficiency is not made good and proof thereof filed with the superintendent within the period required by the notice as specified in subsection 1, the insurer shall be deemed insolvent and the superintendent shall institute delinquency proceedings against it under chapter 57.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §14 (AMD).

§3424. RESTRICTIONS DURING IMPAIRMENT; PENALTY

1. During the existence of impairment of the capital stock or surplus of an insurer, as referred to in section 3423, the superintendent shall require such restriction of, or arrangements as to, operations of the insurer while the impairment exists as he deems advisable for protection of policyholders, the insurer or the public.

[1973, c. 585, §12 (AMD) .]

2. Any officer, director, representative or employee of the insurer who knowingly violates or fails to comply with any such restriction or requirement shall upon conviction thereof be subject to fine of not less than $500 or more than $5,000, or imprisonment for less than one year or to both such fine and imprisonment.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

Subchapter 4: CONVERSION, AMALGAMATION, DISSOLUTION

§3471. SCOPE OF SUBCHAPTER

This subchapter applies as to domestic stock and mutual insurers whether heretofore or hereafter formed, including insurers chartered under special legislative Acts, notwithstanding any inconsistent provisions in the charters of the insurers. [1985, c. 399, §2 (RPR).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1985, c. 399, §2 (RPR).

§3472. MUTUALIZATION OF STOCK INSURER

1. A stock insurer other than a title insurer may become a mutual insurer, or a combination stock and mutual insurer, under such plan and procedure as may be approved by the superintendent after a hearing thereon.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall not approve any such plan, procedure or mutualization unless:

A. It is equitable to stockholders and policyholders; [1969, c. 132, §1 (NEW).]

B. It is subject to approval by the holders of not less than 2/3 of the insurer's outstanding capital stock having voting rights, and by not less than 2/3 of the insurer's policyholders who vote on such plan in person, by proxy or by mail pursuant to such notice and procedure as may be approved by the superintendent; [1973, c. 585, §12 (AMD).]

C. If a life insurer, the right to vote thereon is limited to holders of policies other than term or group policies, and whose policies have been in force for more than one year; [1969, c. 132, §1 (NEW).]

D. Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraisers; [1969, c. 132, §1 (NEW).]

E. The plan provides for the purchase of the shares of any nonconsenting stockholder in the same manner and subject to the same applicable conditions as provided by the general corporation law of the State as to rights of nonconsenting stockholders, with respect to consolidation or merger of private corporations; [1969, c. 132, §1 (NEW).]

F. The plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and [1969, c. 132, §1 (NEW).]

G. The mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance, and for the kinds of insurance included in its certificates of authority in such states. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. Any such combination stock and mutual insurer referred to in subsection 1 above must have and maintain separate paid-in capital stock and basic surplus in respective amounts as would be required under this Title of separate domestic stock and mutual insurers transacting the same kind or kinds of insurance.

[1969, c. 132, §1 (NEW) .]

4. No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their customary salaries or other regular compensation, for in any manner aiding, promoting or assisting in the mutualization, except as set forth in the plan of mutualization as approved by the superintendent.

[1973, c. 585, §12 (AMD) .]

5. This section shall not apply to mutualization under order of court pursuant to rehabilitation or reorganization of an insurer under chapter 57.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3473. CONVERSION OF STOCK INSURER TO ORDINARY BUSINESS CORPORATION

1. A domestic stock insurer may convert to a Maine ordinary business corporation through the following procedures:

A. The insurer must give the superintendent written notice of its intent to convert to an ordinary business corporation; [1973, c. 585, §12 (AMD).]

B. The insurer must bulk reinsure all of its insurance, if any, in force, with another authorized insurer under a bulk reinsurance agreement approved by the superintendent as provided in section 3483. The agreement of bulk reinsurance may be made contingent upon approval of stockholders as provided in paragraph D; [1973, c. 585, §12 (AMD).]

C. The insurer must set aside funds in a special reserve in such amount and subject to such administration as may be found by the superintendent to be reasonable and adequate for the purpose, for payment of all obligations, if any, of the insurer incurred by it and remaining unpaid under its insurance contracts prior to the effective date of such bulk reinsurance, or make other reasonable disposition satisfactory to the superintendent for such payment; [1973, c. 585, §12 (AMD).]

D. The proposed conversion must be approved by affirmative vote of not less than 2/3 of each class of outstanding securities of the insurer having voting rights, at a special meeting of holders of such securities called for the purpose; and at such meeting and by a like vote the certificate of organization or articles of incorporation of the corporation must be amended to remove from the certificate of organization or articles of incorporation the power to transact an insurance business as an insurer, to provide for such new powers and purposes authorized by the general corporation laws of this State as may be consistent with the purposes for which the corporation is thereafter to exist, and to make such further alterations in the certificate of organization or articles of incorportation as may be required under such general corporation laws of an ordinary business corporation; [2013, c. 299, §15 (AMD).]

E. Security holders of the corporation who dissent from such proposed conversion shall have the same applicable rights as exist under such general corporation laws with respect to dissent from a proposed merger of the corporation; and [1969, c. 132, §1 (NEW).]

F. Upon compliance with paragraphs A to D, and upon filing of the amendment of the certificate of organization or articles of incorporation with the superintendent and otherwise as required by laws applicable to ordinary business corporations, the conversion becomes effective. [2013, c. 299, §16 (AMD).]

[2013, c. 299, §§15, 16 (AMD) .]

2. An insurer which has once converted to an ordinary business corporation shall not have power thereafter to convert to an insurer; and no ordinary business corporation shall have power to convert to an insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §§15, 16 (AMD).

§3474. MERGER, CONSOLIDATION OF STOCK INSURERS

1. Subject to the provisions of this section, a domestic stock insurer, whether or not authorized to transact insurance in this State, may merge or consolidate with one or more domestic or foreign stock corporations by complying with the applicable provisions of the laws of this State governing the merger or consolidation of stock corporations formed for profit.

A. A corporation merging or consolidating with a domestic stock insurer must be incorporated as an insurer in the manner provided by its state of incorporation, but the corporation need not be authorized or licensed to transact insurance by any state prior to the merger or consolidation. [1989, c. 611, §2 (NEW); 1989, c. 611, §4 (AFF).]

B. A foreign or alien insurer may merge or consolidate pursuant to this section with a domestic insurer only if, at the time of the merger or consolidation:

(1) The domestic insurer is authorized to transact insurance in this State; or

(2) The foreign or alien insurer meets all requirements applicable to a domestic insurer set forth in this Title for initial authorization to transact in this State the kinds of insurance, as defined in chapter 9, then transacted by that insurer in any jurisdiction. [1989, c. 611, §2 (NEW); 1989, c. 611, §4 (AFF).]

C. A domestic insurer may not participate in a merger or consolidation that will result in the surviving or new corporation being domiciled in a jurisdiction other than this State unless the surviving or new insurer in the merger or consolidation obtains a certificate of authority in the jurisdiction in which it will be domiciled and in this State to transact the kinds of insurance for which any participating insurers were authorized at the time of the merger or consolidation and agrees to maintain that certificate of authority in this State until and unless the superintendent approves a plan of withdrawal filed pursuant to section 415-A. [1991, c. 2, §92 (COR).]

D. The following provisions apply to the authority of the surviving or new corporation to transact insurance in this State following the merger or consolidation.

(1) If the surviving or new corporation is a domestic insurer and no participating corporation in the merger or consolidation was authorized or licensed to transact insurance in this State, the surviving or new domestic insurer shall meet all applicable requirements of this Title for initial authorization to transact all kinds of insurance, as defined in chapter 9, formerly transacted by any participating insurer or insurers in any jurisdiction.

(2) If the surviving or new corporation is a domestic insurer and seeks authority to transact kinds of insurance other than those for which the domestic insurer or insurers participating in the merger or consolidation were authorized at the time of the merger or consolidation, that corporation must meet the requirements set forth in this Title for initial authorization to transact those kinds of insurance.

(3) If the surviving or new corporation is a foreign or alien insurer that seeks to transact insurance in this State, that corporation shall meet all applicable requirements of this Title for initial authorization to transact all kinds of insurance, as defined in chapter 9, formerly transacted by any participating insurer or insurers as well as for any additional kinds of insurance for which authority is sought. [1989, c. 611, §2 (NEW); 1989, c. 611, §4 (AFF).]

[1991, c. 2, §92 (COR) .]

2. No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the superintendent and approved in writing by the superintendent after a hearing thereon after notice to the stockholders of each insurer involved. The superintendent shall give such approval within a reasonable time after such filing unless the superintendent finds that the plan or agreement:

A. Is contrary to law; [1989, c. 611, §3 (AMD); 1989, c. 611, §4 (AFF).]

B. Is unfair or inequitable to the policyholders of any insurer involved; [1989, c. 611, §3 (AMD); 1989, c. 611, §4 (AFF).]

C. Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this State or elsewhere; [1989, c. 611, §3 (AMD); 1989, c. 611, §4 (AFF).]

D. Would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or [1969, c. 132, §1 (NEW).]

E. Is subject to other material and reasonable objections. [1969, c. 132, §1 (NEW).]

In making any determination required by paragraph C, the superintendent may consider, among other factors, whether the surplus of the surviving or new corporation satisfies the requirements of section 410.

[1989, c. 611, §3 (AMD); 1989, c. 611, §4 (AFF) .]

3. No director, officer, agent or employee of any insurer party to the merger or consolidation shall receive any fee, commission, compensation or other valuable consideration whatsoever for in any manner aiding, promoting or assisting therein except as set forth in the plan or agreement.

[1969, c. 132, §1 (NEW) .]

4. If the superintendent does not approve the plan or agreement, he shall so notify the insurer in writing specifying his reasons therefor.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 611, §§2-4 (AMD). RR 1991, c. 2, §92 (COR).

§3475. EXCHANGE OF SECURITIES BETWEEN INSURERS

1. Upon application of any domestic insurer, the superintendent is authorized to approve the fairness of the terms and conditions of the issuance by the insurer of any shares of its capital stock or of guaranty capital or bonds or its other securities or obligations in exchange for one or more bona fide outstanding securities, claims or property interest of any other insurer or corporation, domestic or foreign, or partly in such exchange and partly for cash; but only after a hearing has been held by the superintendent upon the fairness of such terms and conditions at which all persons to whom it is proposed to issue securities in such exchange shall have the right to appear and be heard.

[1973, c. 585, §12 (AMD) .]

2. Notice of such hearing and conduct thereof shall be as provided in chapter 3 (the insurance superintendent).

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3476. ACQUISITION OF CONTROLLING STOCK

1. Any person proposing to acquire the controlling capital stock or guaranty capital shares of any domestic stock insurer and thereby to change the control of the insurer, other than through merger or consolidation or affiliation as provided for in this chapter, shall first apply to the superintendent in writing for approval of such proposed change of control. The application shall state the names and addresses of the proposed new owners of the controlling stock or shares and contain such additional information as the superintendent may reasonably require.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall not approve the proposed change of control if he finds:

A. That the proposed new owners are not qualified by character, experience and financial responsibility to control and operate the insurer, or cause the insurer to be operated, in a lawful and proper manner; or [1969, c. 132, §1 (NEW).]

B. That as a result of the proposed change of control the insurer may not be qualified for a certificate of authority under section 407 (ownership, management); or [1969, c. 132, §1 (NEW).]

C. That the interests of the insurer or other stockholders of the insurer or policyholder would be impaired through the proposed change of control; or [1969, c. 132, §1 (NEW).]

D. That the proposed change of control would tend materially to lessen competition, or to create any monopoly, in a business of insurance in this State or elsewhere. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. If the superintendent does not by affirmative action approve or disapprove the proposed change of control within 30 days after the date such application was so filed with the superintendent, the proposed change may be made without such approval. Except that if the superintendent gives notice to the parties of a hearing to be held by the superintendent with respect to the proposed change of control, and the hearing is held within such 30 days or on a date mutually acceptable to the superintendent and the parties,

the superintendent shall have 30 days after the conclusion of the hearing within which to so approve or disapprove the proposed change; and if not so approved or disapproved, the change may thereafter be made without the superintendent's approval.

[1989, c. 269, §15 (AMD) .]

4. If the superintendent disapproves the proposed change he shall give written notice thereof to the parties, setting forth in detail the reasons for disapproval.

[1973, c. 585, §12 (AMD) .]

5. The superintendent shall file a complaint with the District Court seeking to suspend or revoke the certificate of authority held by any insurer, the control of which has been changed in violation of this section.

[1977, c. 694, §428 (RPR); 1999, c. 547, Pt. B, §78 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §428 (AMD). 1989, c. 269, §15 (AMD). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF).

§3477. CONVERSION OF MUTUAL TO STOCK INSURER

1. A mutual insurer may amend its charter pursuant to this section to become a stock insurer, or a combination stock and mutual insurer, under such reasonable plan and procedure as may be approved by the superintendent after a hearing thereon of which notice was given to the insurer, its directors or trustees, its officers, employees and its policyholders, all of whom shall have the right to appear and be heard at the hearing.

[1985, c. 399, §3 (AMD) .]

2. The superintendent shall not approve any such plan or procedure unless:

A. Its terms and conditions are fair and equitable; [1969, c. 132, §1 (NEW).]

B. It is subject to approval by vote of not less than 2/3 of the insurer's policyholders voting thereon in person, by proxy, or by mail at a meeting of policyholders called for the purpose pursuant to such reasonable notice and procedure as may be approved by the superintendent and each such policyholder shall be entitled to one vote, provided that only persons who were policyholders both at least one year prior to the submission of the insurer's plan to the superintendent and on a subsequent date, found reasonable by the superintendent, prior to the vote shall be entitled to vote; provided that as to life insurers chartered by special Act prior to January 1, 1970, the persons entitled to vote shall be further limited to owners of life insurance policies and contracts, and those persons shall be entitled to one vote and to an additional vote for each $1,000 of insurance above 1,000, except that in the case of any policy or contract of group life insurance or any group annuity contract providing life insurance, the employer or other person, firm, corporation or association, to whom or in whose name the master policy or contract shall have been issued or held, shall be deemed to be the owner within the meaning of this paragraph and shall be entitled to one vote for each such policy or contract of group life insurance or each such group annuity contract irrespective of the number of lives insured under that policy or contract; [1985, c. 399, §4 (RPR).]

C. The equity of each member in the insurer is determinable under a fair and reasonable formula approved by the superintendent, which such equity shall be based upon the insurer's entire surplus as shown by the insurer's financial statement filed with the superintendent, including all voluntary reserves

but excluding contingently repayable funds and outstanding guaranty capital shares at the redemption value thereof, and without taking into account the value of nonadmitted assets or of insurance business in force; [1973, c. 585, §12 (AMD).]

D. The plan gives to each member of the insurer as specified in paragraph E, a preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer, or all of the stock of a proposed parent corporation of the insurer, within a designated reasonable period, as such part is determinable under the plan of conversion, and to apply upon the purchase thereof the amount of his equity in the insurer as determined under paragraph C, except that the plan may provide, subject to the approval of the superintendent, that such preemptive right will not apply to members who reside in jurisdictions in which the issuance of stock is impossible, would involve unreasonable delay or would require the insurer to bear unreasonable costs, provided that any such member shall receive 100% of his equity share in the insurer in the form of a cash payment; [1985, c. 399, §5 (AMD).]

E. The members entitled to participate in the purchase of stock or distribution of assets shall include not less than all policyholders of the insurer as of the date the plan was submitted to the superintendent and each existing person who had been a policyholder of the insurer within 3 years prior to such date; [1985, c. 399, §6 (AMD).]

F. Shares are to be offered to members at a price not greater than to be thereafter offered under the plan to others; [1969, c. 132, §1 (NEW).]

G. The plan provides for payment to each member of his entire equity share in the insurer, with that payment to be made in cash or to be applied for or upon the purchase of stock to which the member is preemptively entitled, or both, provided that with respect to each member who is not given the option of receiving his entire equity share in cash, the plan shall provide that that member shall have the option to receive a reasonable portion of his equity share, as provided in the plan, but not in excess of 50% of his entire equity, in the form of a cash payment, which payment together with the amount applied to the purchase of stock shall constitute full payment and discharge of the member's equity or property interest in that mutual insurer; provided further that the superintendent may permit an insurer to forego the option of making a cash payment to members if he determines that it would be reasonable not to provide for the cash election, after taking into account all the facts and circumstances, including whether there is expected to be an active market for the stock to be received in the conversion; [1985, c. 399, §7 (RPR).]

H. The plan, when completed, would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital stock required of a new domestic stock insurer upon initial authorization to transact like kinds of insurance, together with expendable surplus funds in amount not less than 1/2 of such required capital stock; and [1969, c. 132, §1 (NEW).]

I. The superintendent finds that the insurer'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 insurer's members to be entitled to participate in such plan, or to secure for the individuals comprising management any unfair advantage through such plan. [1973, c. 585, §12 (AMD).]

[1985, c. 399, §§4-7 (AMD) .]

3. Any such combination stock and mutual insurer referred to in subsection 1 must have and maintain separate paid-in capital stock and basic surplus in respective amounts as would be required under this Title of separate domestic stock and mutual insurers transacting the same kind or kinds of insurance.

[1969, c. 132, §1 (NEW) .]

4. Subsection 2 shall not be deemed to prohibit the inclusion in the conversion plan of provisions under which the individuals comprising the insurer's management and employee group shall be entitled to purchase for cash at the same price as offered to the insurer's members, shares of stock not taken by members on the preemptive offering to members, in accordance with such reasonable classification of such individuals as may be included in the plan and approved by the superintendent.

[1973, c. 585, §12 (AMD) .]

5. No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their usual regular salaries and compensation, for in any manner aiding, promoting or assisting in such conversion except as set forth in the plan approved by the superintendent. This provision shall not be deemed to 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 insurer.

[1973, c. 585, §12 (AMD) .]

6. Costs. For the purpose of determining whether a conversion plan meets the requirements of this section and any other relevant provisions of this Title, the superintendent may employ staff personnel and outside consultants. All reasonable costs related to the review of a plan of conversion, including those costs attributable to the use of staff personnel, shall be borne by the insurer or insurers making the filing.

[1985, c. 399, §8 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1985, c. 399, §§3-8 (AMD).

§3478. MERGER, CONSOLIDATION OF MUTUAL INSURERS AUTHORIZED

1. Any one or more mutual insurers existing under any of the laws of this State, may absorb by merger or consolidation, or be merged into or consolidate with, any one or more domestic or foreign mutual insurers either authorized to transact insurance in this State or qualified for such authority. The procedure for effectuation of such merger or consolidation shall be as set forth in sections 3479 to 3482.

[1969, c. 132, §1 (NEW) .]

2. Nothing in this section shall authorize the merger or consolidation of a mutual insurer with a stock insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3479. -- PLAN, AGREEMENT OF MERGER, CONSOLIDATION; APPROVAL BY CORPORATIONS

1. The plan and agreement for a merger or consolidation referred to in section 3478 shall be in writing signed by the duly authorized officers and under the corporate seals of the respective insurers; and shall be acknowledged to be the act, deed and agreement of the insurer by one of the executing officers of the respective insurers before an officer authorized by law to take acknowledgments of deeds. The plan and

agreement shall be approved and authorized by vote of the majority of the directors of the respective insurers, and approved by vote of at least 2/3 of such policyholders of the respective insurers who are entitled to vote and do vote thereon in person or by proxy at a special meeting of such members call for the purpose.

[1969, c. 132, §1 (NEW) .]

2. Notice of such special meeting of members shall be given by publishing the same once weekly for 3 consecutive weeks in a newspaper circulated in each county of this State, the last such publication to be at least 7 days prior to such meeting. Notice to its members by a foreign insurer shall be in accordance with the laws of its domiciliary jurisdiction.

[1969, c. 132, §1 (NEW) .]

3. All of the members of the insurer shall be bound by the vote of policyholders as above provided for, and shall not have thereafter any right as to dissent or appraisal.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3480. -- APPROVAL BY SUPERINTENDENT

1. The plan and agreement referred to in section 3479 shall not be effectuated until filed with and approved by the superintendent in writing. The insurers shall furnish the superintendent such additional information in relation to the proposed merger or consolidation as the superintendent may reasonably require.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall approve the plan and agreement unless he finds that it:

A. Is contrary to law; or [1969, c. 132, §1 (NEW).]

B. Is inequitable to the policyholders of any domestic insurer involved; or [1969, c. 132, §1 (NEW).]

C. Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer; or [1969, c. 132, §1 (NEW).]

D. Would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or [1969, c. 132, §1 (NEW).]

E. Is subject to other material and reasonable objections. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. If the superintendent does not approve the plan and agreement he shall so notify the insurers parties thereto in writing, specifying his reasons therefor.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3481. -- REVIEW BY ATTORNEY GENERAL; FILING WITH SECRETARY OF STATE

1. Upon approval by the superintendent as provided in section 3480, the plan and agreement of merger or consolidation shall be submitted to the Attorney General and be examined by him. If the Attorney General finds the plan and agreement to be properly drawn and signed and otherwise in conformity with the Constitution and laws of this State, he shall so certify thereon in writing.

[1973, c. 585, §12 (AMD) .]

2. Within 60 days from date of approval by the superintendent, both an original and a copy of the plan and agreement showing thereon the certificate of the Attorney General, shall be delivered to the office of the Secretary of State. The Secretary of State shall file such copy and enter the date of filing on both the copy and the original, shall record the copy and return the original to the surviving merged or consolidated corporation.

[1973, c. 585, §12 (AMD) .]

3. From time of filing the copy of the plan and agreement in the office of the Secretary of State, the agreement shall be deemed to be the agreement and act of merger or consolidation of the insurers, and the original of such agreement or a certified copy thereof shall be evidence of the existence of such merged or consolidated corporation and of the performance of all acts and conditions necessary for the effectuation of such merger or consolidation.

[1969, c. 132, §1 (NEW) .]

4. If a domestic insurer is merged into or consolidated with a foreign insurer, the foreign insurer shall not transact insurance in this State until it has procured a certificate of authority from the superintendent therefor under this Title.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3482. -- EFFECTIVE DATE OF MERGER, CONSOLIDATION; EFFECT AS TO ASSETS, LIABILITIES, RIGHTS AND POWER

1. When the plan and agreement for merger or consolidation has been so signed, acknowledged, approved, authorized, certified, filed and recorded as provided in sections 3478 to 3481, then the separate existence of all of the constituent corporations other than the surviving corporation into which the other corporation or corporations parties have merged or consolidated shall cease.

[1969, c. 132, §1 (NEW) .]

2. The surviving corporation shall be the merged or consolidated corporation by the name provided for in the agreement; and shall thereby possess all the rights, privileges, powers, franchises and immunities as well of a public as of a private nature, and shall thereby be subject to all the liabilities, restrictions and duties, of each of the merged or consolidated corporations, and have all and singular the rights, privileges, powers, franchises and immunities of each of such corporations, together with all property, real, personal and mixed, wheresoever located, and all debts due to any of such constituent corporations on whatever account; and all other things in action of each of such corporations, are by virtue of such merger or consolidation automatically vested in such surviving corporation.

[1969, c. 132, §1 (NEW) .]

3. All such property, rights, privileges, powers, franchises and immunities and all and every other such interest shall be thereafter as effectually the property of the surviving corporation as they were of the respective constituent corporations; and title to any real estate, whether by deed or otherwise, under the laws of this State, vested in any of such constituent corporations shall not revert or be in any way impaired by reason of such merger or consolidation. All rights of creditors and all liens upon the property of any of such constituent corporations shall be preserved unimpaired, limited to the property affected by such liens at the time of the merger or consolidation; and all debts, liabilities and duties of the respective constituent corporations shall thenceforth attach to the surviving corporation and may be enforced against it to the same extent as if such debts, liabilities and duties had been incurred or contracted by it.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3483. BULK REINSURANCE

1. A domestic insurer may reinsure, and thereby transfer its direct liability as the insurer with respect to, all or substantially all of its business in force, or all or substantially all of a major class thereof, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. No such agreement shall become effective unless filed with the superintendent, or if disapproved by him.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall disapprove such agreement within a reasonable time after filing if he finds:

A. That the plan and agreement are unfair and inequitable to any insurer or to policyholders involved; or [1969, c. 132, §1 (NEW).]

B. That the reinsurance, if effectuated, would substantially reduce the protection or service to the policyholders of any domestic insurer involved; or [1969, c. 132, §1 (NEW).]

C. That the agreement does not embody adequate provisions by which the reinsuring insurer becomes liable to the original insureds for any loss or damage occurring under the policies reinsured in accordance with the original terms of such policies; or [1969, c. 132, §1 (NEW).]

D. That the assuming reinsurer is not authorized to transact such insurance in this State, or is not qualified as for such authorization or will not appoint the superintendent and his successors as its irrevocable attorney for service of process, so long as any policy so reinsured or claim thereunder remains in force or outstanding; or [1973, c. 585, §12 (AMD).]

E. That such reinsurance would materially tend to lessen competition in the insurance business in this State or elsewhere as to the kinds of insurance involved, or would materially tend to create a monopoly as to such business; or [1969, c. 132, §1 (NEW).]

F. That the proposed bulk reinsurance is not free of other reasonable objections. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

3. If the superintendent disapproves the agreement, he shall forthwith notify in writing each insurer involved, specifying his reasons therefor.

[1973, c. 585, §12 (AMD) .]

4. If for reinsurance of all or substantially all of the business in force of an insurer at a time when the insurer's capital, if a stock insurer, or surplus, if a mutual insurer, is not impaired, the plan and agreement of such reinsurance must be approved by a vote of not less than 2/3 of the insurer's outstanding stock

having voting rights, if a stock insurer, or of members, if a mutual insurer, voting thereon, at a meeting of stockholders or members called for the purpose pursuant to such reasonable notice and procedure as is provided for in the agreement. If a mutual life insurer, right to vote may be limited to members otherwise entitled to vote and whose policies are other than term policies for terms of less than 20 years, or group policies, and have been in effect for more than one year.

[1969, c. 132, §1 (NEW) .]

5. No director, officer, agent or employee of any insurer party to such reinsurance, or any other person, shall receive any special compensation for arranging or with respect to, any such reinsurance except as is set forth in the reinsurance agreement filed with the superintendent.

[1973, c. 585, §12 (AMD) .]

6. The superintendent may adopt rules, subject to Title 5, chapter 375, to effectuate this section.

[1989, c. 846, Pt. E, §3 (NEW); 1989, c. 846, Pt. E, §4 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1989, c. 846, §§E3,4 (AMD).

§3484. VOLUNTARY DISSOLUTION

1. A solvent domestic stock or mutual insurer, which then is not the subject of a delinquency proceeding under chapter 57, may voluntarily dissolve under a plan therefor in writing authorized by its board of directors, approved or adopted by stockholders or members as hereinafter provided, and filed with and approved by the superintendent. The plan shall provide for the disposition, by bulk reinsurance or other lawful procedure, of all insurance in force in the insurer, for full discharge of all obligations of the insurer, and designate or provide for trustees to conduct and administer the settlement of the insurer's affairs.

[1973, c. 585, §12 (AMD) .]

2. The superintendent shall approve the plan unless found by him to be unlawful or unfair or inequitable or prejudicial to the interests of any stockholder, policyholder or creditor.

[1973, c. 585, §12 (AMD) .]

3. If a mutual insurer, the plan must have been approved by vote of not less than 2/3 of the policyholders voting thereon at a special meeting of such policyholders called and held for the purpose pursuant to such reasonable notice and information as the superintendent may have approved.

[1973, c. 585, §12 (AMD) .]

4. If a stock insurer, the plan must have been adopted by vote of not less than 2/3 of all outstanding voting securities of the insurer at a special meeting of such security holders called and held for the purpose.

[1969, c. 132, §1 (NEW) .]

5. Following approval of the dissolution and plan for dissolution by members or adoption by stockholders as provided in this section, and approval by the superintendent, the trustees designated or provided for in the plan shall proceed to execute the plan. When all liabilities of the corporation have been discharged or otherwise adequately provided for, and all assets of the corporation have been liquidated and distributed in accordance with the plan, the trustees shall so certify in triplicate under oath in writing. The trustees shall deliver the original and the 2 copies of such certificate to the superintendent, together with the

fee for filing the certificate of the trustees with the Secretary of State. The superintendent shall make such examination of the affairs of the corporation, and of the liquidation and distribution of its assets and discharge of or provision for its liabilities as the superintendent determines advisable. If upon such examination the superintendent finds that the facts set forth in the certificate of the trustees are true, the superintendent shall inscribe the superintendent's approval on the certificate, file the original of the certificate so inscribed in the office of the Secretary of State, file a copy of the certificate in the bureau and return the remaining copy to the trustees for the corporate files.

[2013, c. 299, §17 (AMD) .]

6. Upon receipt of the filing of the certificate of the trustees as provided in subsection 5, the Secretary of State shall issue to the trustees the Secretary of State's acknowledgment of the date of filing. The effective date of dissolution is the effective date of that filing with the Secretary of State. The Secretary of State shall charge and collect a fee of $25 for the filing of the trustee's certificate, and shall deposit the same with the Treasurer of State for credit to the General Fund.

[2013, c. 299, §18 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 299, §§17, 18 (AMD).

§3485. MUTUAL MEMBER'S SHARE OF ASSETS ON LIQUIDATION

1. Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, retirement of guaranty fund capital shares and payment of expenses of administration and of the dissolution and liquidation procedure, shall be distributed to currently existing persons who had been members of the insurer for at least a year and who were its members at any time within 36 months next preceding the date such liquidation was authorized or ordered, or date of last termination of the insurer's certificate of authority, whichever date is the earlier; except, that if the superintendent has reason to believe that those in charge of the insurer's management have caused or encouraged the reduction of the number of members of the insurer, or changed the identity thereof, in anticipation of liquidation and for the purpose of reducing or controlling thereby the number or identity of persons who may be entitled to share in distribution of the insurer's assets, he may enlarge the qualification period in such manner as he deems to be reasonable.

[1973, c. 585, §12 (AMD) .]

2. The insurer shall make a reasonable classification of its policies so held by such members, and a formula based upon such classification for determination of the equitable distributive share of each such member. Such classification and formula shall be subject to the approval of the superintendent, who shall approve the same except for reasonable cause.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3486. PLANS FOR ACQUISITION OF MINORITY INTERESTS IN DOMESTIC STOCK INSURANCE COMPANIES AND APPRAISAL OF STOCK OF DISSENTING SHAREHOLDERS

1. Any parent corporation directly or indirectly owning at least 95% of the aggregate issued and outstanding shares of all classes of voting stock of a domestic stock insurance company or any such domestic stock insurance company whose voting stock is so owned may, pursuant to a plan for acquisition of minority interests in such subsidiary, acquire all of its remaining issued and outstanding shares of voting stock, by exchange of stock, other securities, cash, other consideration or any combination thereof.

[1977, c. 377, (NEW) .]

2. The board of directors, trustees or other governing body of the parent corporation or the domestic stock insurance company may adopt a plan for the acquisition of minority interests in such subsidiary insurer. Every plan shall set forth:

A. The name of the company whose shares are to be acquired; [1977, c. 377, (NEW).]

B. The total number of issued and outstanding shares of each class of voting stock of the company, the number of its shares owned by the parent corporation and, if either of the foregoing is subject to change prior to the effective date of acquisition, the manner in which any change may occur; [1977, c. 377, (NEW).]

C. The terms and conditions of the plan, including the manner and basis of exchanging the shares to be acquired for shares or other securities of the parent corporation, for cash, other consideration, or any combination of the foregoing, the proposed effective date of acquisition and a statement clearly describing the rights of dissenting shareholders to demand appraisal; [1977, c. 377, (NEW).]

D. If the parent corporation has adopted the plan and is neither a domestic corporation nor an authorized insurer, its agreement to be bound by this section with respect to the plan, its consent to the enforcement against it in this State of the rights of shareholders pursuant to the plan, and a designation of the superintendent as the agent upon whom process may be served against the parent corporation in the manner set forth in section 421 in any action or proceeding to enforce any such rights; and [1977, c. 377, (NEW).]

E. Such other provisions with respect to the plan as the board of directors, trustees or other governing body deems necessary or desirable, or which the superintendent may prescribe. [1977, c. 377, (NEW).]

[1977, c. 377, (NEW) .]

3. Upon adoption of the plan, it shall be duly executed by the president and attested by the secretary, or the executive officers corresponding thereto, under the corporate seal of the parent corporation or the domestic stock insurance company which has adopted the plan, as the case may be. Thereupon, a certified copy of the plan, together with a certificate of its adoption subscribed by such officers and affirmed by them as true under the penalties of perjury and under the seal of the parent corporation or the domestic stock insurance company, as the case may be, shall be submitted to the superintendent for his approval. The superintendent shall thereupon consider the plan and, if satisfied that it complies with this section, is fair and equitable and not inconsistent with law, he shall approve the plan. If the superintendent disapproves the plan, notification of his disapproval, assigning the reasons therefor, shall be given in writing by him to the parent corporation or domestic stock insurance company that submitted the plan. No plan shall take effect unless the approval of the superintendent has been obtained.

[1977, c. 377, (NEW) .]

4. If the superintendent approves the plan, the parent corporation or the domestic stock insurance company which has adopted the plan shall deliver to each person who, as of the date of delivery, is a holder of record of stock to be acquired pursuant to the plan, a copy of the plan, or a summary thereof approved by the superintendent, in person or by depositing the same in the post office, postage prepaid, addressed to the stockholder at his address of record. On or before the date of acquisition proposed in the plan, the parent corporation or the domestic stock insurance company which has adopted the plan shall file with the superintendent a certificate, executed by its president and attested by its secretary, or the executive officers corresponding thereto, and subscribed by such officers and affirmed by them as true under the penalties of perjury, and under the seal of the parent corporation or the domestic stock insurance company, as the case may be, attesting to compliance with this subsection.

[1977, c. 377, (NEW) .]

5. Upon compliance with this section, ownership of the shares to be acquired pursuant to the plan shall vest in the parent corporation or the domestic stock insurance company which has adopted the plan on the date of acquisition proposed in the plan whether or not the certificates for such shares have been surrendered for exchange. If the plan was adopted by the parent corporation it shall be entitled to have new certificates registered in its name. If the plan was adopted by the domestic stock insurance company the shares shall be retired and the capital of the domestic company reduced by the par value of the retired shares. Shareholders whose shares have been so acquired shall thereafter retain only the right either to receive the consideration to be paid in exchange for their shares pursuant to the plan or to dissent to the plan and demand appraisal and receive payment of the fair value of their shares as hereinafter provided. The fair value of shares shall be determined as of the day prior to the date on which the plan was adopted, excluding any appreciation or depreciation of shares in anticipation of such corporate action. A shareholder may not dissent as to less than all of the shares registered in his name.

[1977, c. 377, (NEW) .]

6. A dissenting shareholder shall file, within 20 days after the delivery to that shareholder of either a copy of the plan or a summary of the plan pursuant to subsection 4, a written notice of the shareholder's election to dissent from the plan and a demand for payment of the fair value of the shareholder's shares. The notice and demand must be filed with the company that adopted the plan by personally delivering it, or by mailing it via certified or registered mail, to the company at its registered office within this State or to its principal place of business as shown on its most recent annual report or, in the case of a foreign corporation that has not yet delivered an annual report, in its application for a certificate of authority pursuant to Title 13-C, section 130.

[2003, c. 344, Pt. D, §13 (AMD) .]

7. At the time of filing his notice and demand for the payment of the fair value of his shares, or within 20 days thereafter, a dissenting shareholder shall surrender the certificate or certificates representing his shares to the company which adopted the plan.

[1977, c. 377, (NEW) .]

8. Within 10 days after the expiration of the period provided in subsection 6 for the shareholder to file his notice and demand, the company which adopted the plan shall make a written offer to each dissenting shareholder to pay for such shares at a specified price deemed by such company to be the fair value thereof. Such offer shall be made at the same price per share to all dissenting shareholders of the same class. The notice and offer shall be accompanied by a balance sheet of the corporation, the shares of which the dissenting shareholder holds, as of the latest available date and not more than 12 months prior to the making of such offer and a profit and loss statement of such corporation, for the 12-months' period ended on the date of such balance sheet.

[1977, c. 377, (NEW) .]

9. If, within 20 days after the date by which the company is required by the terms of subsection 8 to make a written offer to each dissenting shareholder to pay for his shares, the fair value of such shares is agreed upon between any dissenting shareholder and the company, payment therefor shall be made within 90 days after the date of delivery of the plan or a summary thereof as provided in subsection 4. Upon payment of the agreed value, the dissenting shareholder shall cease to have any interest in such shares.

[1977, c. 377, (NEW) .]

10. If, within the additional 20-day period prescribed by subsection 9, one or more dissenting shareholders and the company have failed to agree as to the fair value of the shares, then Title 13-C, chapter 13, subchapter 3 applies, except that:

A. The term "the corporation" as used in that subchapter is deemed to refer to the company that adopted a plan pursuant to subsection 2; [2003, c. 344, Pt. D, §14 (AMD).]

B. [2003, c. 344, Pt. D, §14 (RP).]

C. The references in Title 13-C, chapter 13, subchapter 3 to a shareholder's "demand for payment under section 1327" is deemed to refer to a shareholder's notice and demand filed pursuant to subsection 6; [2003, c. 344, Pt. D, §14 (AMD).]

D. [2003, c. 344, Pt. D, §14 (RP).]

E. The reference in Title 13-C, section 1331, subsection 2 to the county in the State where the principal office or the registered office of the domestic corporation merged with the foreign corporation is located is deemed, where the parent corporation that has adopted the plan is neither a domestic corporation nor an authorized insurer, to include the county where the registered office of the subsidiary domestic stock insurance company whose stock is being acquired is located; [2003, c. 344, Pt. D, §14 (AMD).]

F. [2003, c. 344, Pt. D, §14 (RP).]

G. [2003, c. 344, Pt. D, §14 (RP).]

H. Title 13-C, section 1331, subsection 5, paragraph B does not apply; and [2003, c. 344, Pt. D, §14 (NEW).]

I. The reference in Title 13-C, section 1332, subsection 2, paragraph A to the corporation's failure to substantially comply with the requirements of section 1321, 1323, 1325 or 1326 is deemed to refer to the corporation's failure to comply with this section, and the reference in Title 13-C, section 1332, subsection 4 to the failure of the corporation to make required payments pursuant to section 1325, 1326 or 1327 is deemed to refer to the failure of the corporation to make required payments under this section. [2003, c. 344, Pt. D, §14 (NEW).]

[2003, c. 344, Pt. D, §14 (AMD) .]

11.

[2003, c. 344, Pt. D, §15 (RP) .]

12. If the court determines pursuant to Title 13-C, chapter 113, subchapter 3 that a shareholder is not entitled to receive payment of the fair value of the shareholder's shares because of the shareholder's failure to satisfy the requirements of Title 13-C, chapter 113, subchapter 3 and of this section, then the shareholder shall receive the consideration that was specified as payment in exchange for the shareholder's shares pursuant to the plan. Such payment may not include the allowance for interest specified in Title 13-C, section 1331, subsection 5.

[2003, c. 344, Pt. D, §16 (AMD) .]

13. Neither the right granted by this section nor the exercise thereof by a parent corporation or domestic stock insurance company shall preclude the exercise by it of any other rights it may have under this section.

[1977, c. 377, (NEW) .]

14. The provisions of Title 33, chapter 41 apply to any unclaimed payment to which a shareholder may be entitled under this section.

[2003, c. 344, Pt. D, §16 (AMD) .]

15. All laws and parts of laws of this State inconsistent with this section are superseded with respect to matters covered by this section.

[1977, c. 377, (NEW) .]

SECTION HISTORY
1977, c. 377, (NEW). 2003, c. 344, §§D13-16 (AMD). 2003, c. 344, §D14 (AMD). 2003, c. 344, §D15 (AMD). 2003, c. 344, §D16 (AMD).

§3487. REDOMESTICATION OF INSURERS

1. **Redomestication of foreign insurers to Maine.** Any stock or mutual insurer that is organized under the laws of any other state and has a valid certificate of authority to do business in this State may become a domestic insurer with approval of the superintendent by amending its articles of incorporation or equivalent corporate charter and by designating a location in this State as its principal place of business. The redomestication must be approved if the chief insurance regulatory official of the other state certifies to the superintendent that the redomestication is in compliance with all requirements established by the laws of that state, and the superintendent determines that the insurer's operations and corporate organization will comply with the requirements of this chapter and that the redomestication is not contrary to the interests of policyholders or the public. The amendments to the insurer's articles of incorporation may provide that the corporation is a continuation of the corporate identity of the original foreign corporation and that the original date of incorporation in its original domiciliary state is the date of incorporation of the domestic insurer. The insurer's certificate of authority must be amended as of the effective date of the superintendent's approval to reflect the insurer's status as a domestic insurer and its new home office, and the insurer is thereafter subject to all provisions of this Title applicable to domestic insurers.

[2013, c. 299, §19 (AMD) .]

2. **Redomestication of domestic insurers.** Any domestic insurer may, upon the approval of the superintendent, transfer its domicile to any other state in which it is authorized to transact the business of insurance in accordance with the procedures established by the laws of that state. The proposed redomestication must be approved if the superintendent determines that the articles of incorporation have been amended in conformance with section 3310 and that the redomestication is not contrary to the interests of policyholders or the public. The insurer ceases to be a domestic insurer as of the date the redomestication is recognized by its new state of domicile. Unless the superintendent determines that the insurer no longer qualifies for a certificate of authority, the insurer's certificate of authority must be amended as of the effective date of the redomestication to reflect the insurer's status as a domestic insurer and its new home office in its new state of domicile, and the insurer is thereafter subject to all provisions of this Title applicable to foreign insurers.

[2013, c. 299, §19 (AMD) .]

3. **Effect of redomestication.** The certificate of authority, producers' appointments and licenses, rate approvals and all other actions and permissions by the superintendent that are in effect at the time any insurer authorized to transact the business of insurance in this State transfers its corporate domicile to this State or any other state pursuant to this section or by merger, consolidation or any other lawful method continue in full force and effect upon the redomestication if the insurer remains duly qualified to transact the business of insurance in this State. All outstanding policies and other legal or contractual obligations of any redomesticating insurer remain in full force and need not be endorsed as to the new name of the company or its new location unless ordered by the superintendent. The insurer shall file new policy forms with the superintendent on or before the effective date of the redomestication but may use existing policy forms with appropriate endorsements if allowed by and under such conditions as approved by the superintendent. Each redomesticating insurer shall notify the superintendent of the details of the proposed redomestication and shall file promptly any resulting amendments to corporate documents filed or required to be filed with the superintendent.

[1999, c. 113, §23 (NEW) .]

4. **Filing with Secretary of State.** Each insurer that transfers its domicile to this State shall file with the Secretary of State a long-form certificate of good standing or its equivalent, duly certified by the proper official of the previous state of domicile and an application for redomestication to become a Maine insurer in a form prescribed by the Secretary of State and approved by the superintendent. Each foreign insurer qualified to do business in this State that transfers its domicile to a state other than Maine shall file with the Secretary of State a notification by a foreign insurer of redomestication in a form prescribed by the Secretary of State and approved by the superintendent. Each domestic insurer that transfers its domicile to another state shall file with the Secretary of State a notification of redomestication in a form prescribed by the Secretary of State and approved by the superintendent.

[1999, c. 1, §36 (COR) .]

SECTION HISTORY
RR 1999, c. 1, §36 (COR). 1999, c. 113, §23 (NEW). 2013, c. 299, §19 (AMD).

§3488. REORGANIZATION OF MUTUAL INSURER THROUGH FORMATION OF MUTUAL HOLDING COMPANY

1. **Procedure for reorganization as stock insurer.** A mutual insurer may be reorganized as a stock insurer within a mutual holding company as provided in this section. The mutual insurer shall submit to the superintendent a reasonable reorganization plan, referred to in this section as the "plan," and the procedure for putting the plan into effect. A hearing must be held on the plan. Notice of the hearing must be provided pursuant to section 230 to the insurer, its directors or trustees, its officers, employees and its policyholders, all of whom have the right to appear and be heard at the hearing. The plan may not take effect unless approved by the superintendent.

[1999, c. 656, §5 (NEW) .]

2. **Plan requirements.** The plan must contain provisions for:

A. The reorganizing insurer to become a stock insurer; [1999, c. 656, §5 (NEW).]

B. The formation of a mutual holding company; [1999, c. 656, §5 (NEW).]

C. The members of the reorganizing insurer to become members of the mutual holding company with membership interests therein and the membership interests in the reorganizing insurer to be extinguished; and [1999, c. 656, §5 (NEW).]

D. At least 51% of the voting stock issued and outstanding by the reorganized insurer to be acquired and held, directly or through one or more stock holding companies, by the mutual holding company. [1999, c. 656, §5 (NEW).]

[1999, c. 656, §5 (NEW) .]

3. **Number of stock holding companies.** The plan may provide for the formation of one or more intermediate stock holding companies.

[1999, c. 656, §5 (NEW) .]

4. **Approval of plan.** The superintendent may not approve a plan unless:

A. The terms and conditions of the plan are fair and equitable; [1999, c. 656, §5 (NEW).]

B. The plan is subject to approval by vote of not less than 2/3 of the insurer's policyholders voting on the plan in person, by proxy or by mail at a meeting of policyholders called by the insurer for that purpose pursuant to reasonable notice of the meeting and procedures as approved by the superintendent. The plan must specify that only persons who were policyholders both at least one year before the submission of the plan to the superintendent and on a subsequent date before the vote found reasonable by the superintendent are entitled to vote. Each eligible policyholder is entitled to one vote; [1999, c. 656, §5 (NEW).]

C. The plan, when completed, would provide paid-in capital stock for the reorganized insurer in an amount not less than the minimum paid-in capital stock required of a new domestic stock insurer upon initial authorization to transact like kinds of insurance, together with expendable surplus funds in an amount not less than 1/2 of such required capital stock; and [1999, c. 656, §5 (NEW).]

D. The superintendent finds that the insurer's management has not, through reduction in volume of new business written or cancellation or any other means, sought to reduce, limit or affect the number or identity of the reorganizing insurer's members to be entitled to participate in the plan or to secure for the individuals comprising management any unfair advantage through the plan. [1999, c. 656, §5 (NEW).]

[1999, c. 656, §5 (NEW) .]

5. **Compensation.** A director, officer, agent or employee of the reorganizing insurer or any other person may not receive any fee, commission or other valuable consideration whatsoever, other than that person's usual regular salary and compensation, for in any manner aiding, promoting or assisting in the reorganization except as set forth in the plan approved by the superintendent. This provision does not prohibit the payment of reasonable fees and compensation to attorneys, accountants or actuaries for services performed in the independent practice of their professions, even though they also may be directors of the insurer.

[1999, c. 656, §5 (NEW) .]

6. **Effective date of plan.** The plan becomes effective, after approval by the superintendent and by the policyholders, upon the filing with the superintendent and the Secretary of State of amended and restated articles of incorporation of the reorganized insurer pursuant to section 3310 and articles of incorporation of the mutual holding company and any related stock holding company.

[1999, c. 656, §5 (NEW) .]

7. **Consequence of effective plan.** The following are the consequences of a plan that becomes effective pursuant to subsection 6.

A. The reorganizing insurer immediately becomes a domestic stock insurer. [1999, c. 656, §5 (NEW).]

B. The members of the reorganizing insurer on the effective date immediately become members of the mutual holding company with membership interests in that holding company. All membership interests in the reorganizing insurer are extinguished. [1999, c. 656, §5 (NEW).]

C. A person becoming a policyholder of the reorganized insurer after the effective date of the plan becomes a member of the mutual holding company immediately upon issuance of the policy or contract. [1999, c. 656, §5 (NEW).]

D. One hundred percent of the voting stock issued by the reorganized insurer in the reorganization is owned, directly or through one or more stock holding companies, by the mutual holding company. All stock issued by the reorganized insurer in the reorganization is considered duly and validly issued, fully paid and nonassessable. [1999, c. 656, §5 (NEW).]

E. The reorganized insurer is a continuation of the reorganizing insurer. The reorganization may not annul, modify or change any of the insurer's existing suits, rights, contracts or liabilities except as provided in the plan. [1999, c. 656, §5 (NEW).]

[1999, c. 656, §5 (NEW) .]

8. **Assistance in determining approval of plan.** For the purpose of determining whether a plan meets the requirements of this section and any other relevant provisions of this Title, the superintendent may employ staff personnel and outside consultants. All reasonable costs related to the review of a plan, including those attributable to the use of staff personnel, must be borne by the insurer or insurers making the filing.

[1999, c. 656, §5 (NEW) .]

9. **Injunctive relief and damages.** If the reorganizing insurer complies substantially and in good faith with the requirements of subsection 4, paragraph B with respect to the giving of any required notice to policyholders, the insurer's failure to give notice to a person entitled to notice does not impair the validity of the actions and proceedings taken under this section or entitle that person to any injunctive or other equitable relief with respect to those actions and proceedings. This subsection does not impair any claim for damages that person would otherwise have due to failure to give notice.

[1999, c. 656, §5 (NEW) .]

10. **Exclusion of certain insurers.** This section does not apply to an insurer authorized to transact life insurance or annuities or an insurer formed pursuant to chapter 52.

[1999, c. 656, §5 (NEW) .]

SECTION HISTORY
1999, c. 656, §5 (NEW).

§3489. REQUIREMENTS APPLICABLE TO A MUTUAL HOLDING COMPANY

1. **Definitions.** As used in section 3488, this section and section 3490, unless the context otherwise indicates, the following terms have the following meanings.

A. "Mutual holding company" means a mutual holding company formed pursuant to section 3488. [1999, c. 656, §5 (NEW).]

B. "Outside director" means a person who is not an officer, employee or consultant of the mutual holding company, a related stock holding company, the reorganized insurer or other subsidiary of the mutual holding company or a related stock holding company. [1999, c. 656, §5 (NEW).]

C. "Public offering" means an offer that includes an offer to individuals that is made by means of public advertising or general solicitation. "Public offering" does not include:

(1) Issuance of stock to the mutual holding company or any related stock holding company; or

(2) An offer or sale that is exempt from registration by virtue of Title 32, section 16202, subsections 13, 15, 16, 19 or 26. [2005, c. 65, Pt. C, §11 (AMD).]

D. "Reorganized insurer" means a mutual insurer reorganized as a stock insurer pursuant to section 3488. [1999, c. 656, §5 (NEW).]

E. "Stock holding company" and "related stock holding company" mean an incorporated entity that holds, directly or indirectly, at least 51% of the voting stock of a reorganized insurer. [1999, c. 656, §5 (NEW).]

F. "Voting stock" means common stock with general voting rights in the election of directors. [1999, c. 656, §5 (NEW).]

[2005, c. 65, Pt. C, §11 (AMD) .]

2. **Mutual holding company formed through reorganization.** The following provisions apply to a mutual holding company.

A. The provisions of Title 13-C that are applicable to a mutual insurer apply to a mutual holding company as though it were a mutual insurer. [2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §44 (COR).]

B. A mutual holding company may not dissolve, liquidate or wind up except through proceedings under this Title for the liquidation or dissolution of the reorganized insurer or as the superintendent may otherwise approve. In the event proceedings are instituted for the complete liquidation of the reorganized insurer:

(1) The mutual holding company automatically becomes a party to the proceedings;

(2) All of the mutual holding company's assets, including its holdings of shares in the reorganized insurer or any stock holding company, are deemed assets of the estate of the reorganized domestic stock insurer to the extent necessary to satisfy claims of persons who have class 1, class 2, class 3 or class 4 claims under section 4379; and

(3) Members of the mutual holding company are deemed to hold class 8 claims with respect to the mutual holding company under section 4379. [1999, c. 656, §5 (NEW).]

C. The name of a mutual holding company must contain the word "mutual" and may not contain the words "insurance," "assurance" or "annuity." The mutual holding company's powers may not include doing insurance business. The articles of incorporation of a mutual holding company must contain provisions stating that:

(1) It is "a mutual holding company organized under the Maine Revised Statutes, Title 24-A, section 3488";

(2) A purpose of the mutual holding company is to hold, directly or through one or more stock holding companies, not less than 51% of the voting stock of a reorganized insurer;

(3) It is not authorized to issue voting stock;

(4) It is not authorized to conduct any business other than that of a holding company, except for the acquisition, ownership, management and disposition of its assets and all reasonably related actions; and

(5) Its members have the rights specified in, and are subject to, sections 3360, 3361, 3362, 3363, 3488, this section, the mutual holding company's articles of incorporation and its bylaws. [1999, c. 656, §5 (NEW).]

D. At least a majority of the directors of the mutual holding company and any related stock holding company and any committee of the board of directors of the mutual holding company and of any related stock holding company must be outside directors. [1999, c. 656, §5 (NEW).]

E. Each time voting stock of the reorganized insurer or any related stock holding company is offered in a public offering for a price payable in cash, each policyholder of the reorganized insurer must receive, without payment, nontransferable subscription rights to purchase that voting stock at the same price and in accordance with procedures approved by the superintendent as fair and equitable. [1999, c. 656, §5 (NEW).]

F. At least 30 days before the issuance of any voting stock or securities convertible into voting stock of the reorganized insurer or any related stock holding company, other than in an underwritten public offering or a bona fide sale to an unrelated 3rd party, the reorganized insurer or related stock holding company shall provide to the superintendent written notice of the proposed price of those securities or the procedure whereby the price will be determined and the terms and conditions of the offering. The superintendent may disapprove the issuance of the stock or securities if the superintendent finds that the price is unfair. The superintendent's failure to make a finding on a transaction subject to this paragraph within 30 days after it has been filed with the superintendent has the effect of an approval unless the superintendent has requested supplemental information or issued a notice of hearing. [1999, c. 656, §5 (NEW).]

G. The stock holding company or the reorganized insurer may not award any stock options or stock grants to officers or directors of the mutual holding company, the stock holding company or the reorganized insurer until 6 months after the completion of either a public offering or private placement of voting stock or securities convertible into voting stock of the reorganized insurer or a related stock holding company to any person other than the mutual holding company or the stock holding company. [1999, c. 656, §5 (NEW).]

H. The aggregate percentage of voting stock of the reorganized insurer or any related stock holding company directly or indirectly owned or controlled by outside directors may not exceed 18%, unless the reorganized insurer or the related stock holding company has provided at least 30 days' prior written notice to the superintendent and the superintendent has not objected to a higher percentage. [1999, c. 656, §5 (NEW).]

I. The aggregate percentage of voting stock of the reorganized insurer or any related stock holding company directly or indirectly owned or controlled by directors and officers of the mutual holding company, a related stock holding company or the reorganized insurer who are also employed by any of the foregoing may not exceed 18% of the voting stock of the reorganized insurer or any related stock holding company, unless the reorganized insurer or the related stock holding company has provided 30 days' prior written notice to the superintendent and the superintendent has not objected to a higher percentage. [1999, c. 656, §5 (NEW).]

J. A trust established in connection with an employee stock ownership plan or other employee benefit plan established for the benefit of employees of the reorganized insurer, a related stock holding company or the mutual holding company may not directly or indirectly own or control, in the aggregate, more than 10% of the voting stock of the stock holding company or the reorganized insurer, unless the reorganized insurer or the related stock holding company has provided 30 days' prior written notice to the superintendent and the superintendent has not objected to a higher percentage. The holdings of any such employee stock ownership plan or other employee benefit plan that are allocated to directors and officers who are employees must be included in determining compliance with paragraph I. [1999, c. 656, §5 (NEW).]

K. A person may not own or control, directly or indirectly, more than 15% of any class of voting stock of the reorganized insurer or any related stock holding company without the prior approval of the superintendent. [1999, c. 656, §5 (NEW).]

L. All voting stock of the reorganized insurer or any related stock holding company acquired by any person in excess of the maximum amount permitted to be acquired by that person pursuant to this subsection is deemed to be nonvoting stock for so long as it is held by any person in excess of those limitations. In addition to any other enforcement powers of the superintendent under this Title, a violation of the limitations of ownership may be enforced or enjoined, as the case may be, by appropriate proceedings commenced by the reorganized insurer or any related stock holding company,

the superintendent, the attorney general, any member of the mutual holding company or any stockholder of the reorganized insurer or of any related stock holding company. The action must be commenced in the Kennebec County Superior Court or the superior court in the jurisdiction of which the reorganized insurer has its home office, and the court may issue any order, injunctive or otherwise, that it finds necessary to cure the violation or to prevent the action. [1999, c. 656, §5 (NEW).]

M. A mutual holding company and a related stock holding company are each deemed to be a holding company of the reorganized insurer within the meaning of section 222, and all provisions of that section apply to transactions occurring between the mutual holding company, the stock holding company and the reorganized insurer. Approval of the plan of reorganization by the superintendent pursuant to section 3488 is considered approval of the acquisition of control by a mutual holding company and any related stock holding company under sections 222 and 3476. [1999, c. 656, §5 (NEW).]

N. For purposes of the limitations on ownership or control of voting stock contained in this subsection, any issued and outstanding securities that represent the right to acquire or that are convertible into voting stock, including warrants, options and rights to purchase voting stock, are deemed to represent the number of shares of voting stock issuable upon conversion or exercise of such securities or rights for the purposes of both the number of shares owned or controlled by a person and the total number of shares of voting stock outstanding.

For purposes of determining ownership or control of voting stock, the indirect ownership of stock in the reorganized insurer by virtue of having an ownership interest in the mutual holding company may not be considered. [1999, c. 656, §5 (NEW).]

[2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §44 (COR) .]

3. **Merger or consolidation by mutual holding company or stock holding company.** With the written approval of the superintendent, a mutual holding company or stock holding company may:

A. Merge or consolidate with or acquire the assets of a mutual holding company organized pursuant to this chapter or pursuant to the mutual holding company laws of another state; [1999, c. 656, §5 (NEW).]

B. Either alone or together with one or more of the reorganized insurers or stock holding companies or subsidiaries of any of them, merge or consolidate with or acquire the assets of a mutual insurer; or [1999, c. 656, §5 (NEW).]

C. Merge or consolidate with any other person. [1999, c. 656, §5 (NEW).]

[1999, c. 656, §5 (NEW) .]

4. **Merger with another mutual holding company.** If a mutual holding company merges with a mutual holding company organized under the laws of another state or acquires the membership interests in a foreign mutual insurer, that merger or acquisition must comply with the requirements of Maine law and rules and of any other state's law, rule or regulation that is applicable to the foreign mutual holding company or mutual insurer. In the event of a conflict of state laws, rules or regulations, Maine laws and rules apply. A foreign mutual insurer that is merged or acquired pursuant to this section may at the same time redomesticate to this State by complying with the applicable requirements of this State and of the foreign mutual insurer's state of domicile.

[1999, c. 656, §5 (NEW) .]

5. **Acquisition of stock or assets of other persons.** A mutual holding company may acquire the capital stock or assets of other persons.

[1999, c. 656, §5 (NEW) .]

6. **Membership interest.** A membership interest in a mutual holding company does not constitute a security under Title 32, section 16102, subsection 28 or any other law of this State and is not transferable.

[2005, c. 65, Pt. C, §12 (AMD) .]

7. **Election of directors.** Directors of the mutual holding company must be elected by plurality vote of all members voting in that election in person or by proxy. If the mutual holding company takes any action, other than election of its directors, that would require a vote of policyholders if the mutual holding company were a mutual insurer, then that action requires a vote of members of the mutual holding company.

[1999, c. 656, §5 (NEW) .]

SECTION HISTORY
1999, c. 656, §5 (NEW). RR 2001, c. 2, §B58 (AFF). RR 2001, c. 2, §B44 (COR). 2005, c. 65, §§C11,12 (AMD).

§3490. CONVERSION OF MUTUAL HOLDING COMPANY

1. **Approval of reorganization plan.** A mutual holding company may be reorganized in accordance with a plan of reorganization:

A. Approved by the superintendent, if the superintendent finds the plan to be fair and equitable, after a hearing of which notice has been given to the company's members pursuant to section 230; and [1999, c. 656, §5 (NEW).]

B. Approved by vote of not less than 2/3 of the company's members voting on the plan in person, by proxy or by mail at a meeting of members called by the company for that purpose. The mutual holding company shall provide reasonable notice to its members and determine the procedure for the meeting, subject to approval by the superintendent. The plan must specify that only persons who were members both at least one year before the submission of the plan and on a subsequent date before the vote found reasonable by the superintendent are entitled to vote. Each member is entitled to one vote. [1999, c. 656, §5 (NEW).]

[1999, c. 656, §5 (NEW) .]

2. **Membership interests disposition.** A plan of reorganization pursuant to subsection 1 must provide for extinguishment of the membership interests in the mutual holding company and may provide for either:

A. The conversion of the mutual holding company into a stock corporation, in which event the consideration, if any, distributed to members of the mutual holding company must be equal to that required under section 3477; or [1999, c. 656, §5 (NEW).]

B. The distribution to eligible members of the mutual holding company of consideration consisting of all assets of the mutual holding company, including all stock of the reorganized insurer or any stock holding company owned by the mutual holding company, or other consideration having equivalent aggregate value. The form of the other consideration may be cash, securities, additional insurance or annuity benefits or policy credits, increased dividends or other consideration. All such consideration must be allocated among eligible members of the mutual holding company in a manner that is fair and equitable to the company's members. [1999, c. 656, §5 (NEW).]

[1999, c. 656, §5 (NEW) .]

SECTION HISTORY
1999, c. 656, §5 (NEW).

Chapter 49: CONTINUITY OF MANAGEMENT

§3551. PURPOSE

Enemy attack could seriously disrupt the management functions of an insurance organization. Prompt resumption of insurance operations following attack is in the public interest and requires provisions for the continuity of management. It is essential that advance corporate action be taken to provide for the reconstitution of the board of directors or substitute governing body, for the succession of key personnel and for the designation of alternate headquarters. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3552. DEFINITIONS; INTERPRETATION OF CHAPTER

When used in this chapter, the following terms mean and include the following. [2009, c. 2, §69 (COR).]

1. **Acting director.** Acting director means an acting director elected or appointed in accordance with this chapter.

[1969, c. 132, §1 (NEW) .]

2. **Acting officer.** Acting officer means an acting officer appointed in accordance with this chapter.

[1969, c. 132, §1 (NEW) .]

3. **Acute emergency.** Acute emergency means a period, as formally declared and proclaimed by the Governor of this State, in which, by reason of loss of life, epidemic disease, destruction or damage of property, contamination of property by radiological, chemical or bacteriological means, or disruption of the means of transportation or communication, resulting from an attack, it is impossible or impractical for the business of insurance in this State to be conducted in strict accord with the provision of law or charters applicable thereto.

[1969, c. 132, §1 (NEW) .]

4. **Attack.** Attack means any attack, actual or imminent, or series of attacks by an enemy of a foreign nation upon the United States causing, or which may cause, substantial damage or injury to civilian property or persons in the United States in any manner by sabotage or by the use of bombs, shell fire, or atomic, radiological, chemical, bacteriological or biological means or other weapons or processes.

[1969, c. 132, §1 (NEW) .]

5. **Board.** Board means the board of directors, board of trustees, committee or similar body having control of the affairs of an insurance organization.

[1969, c. 132, §1 (NEW) .]

6. **Charter.** Charter means the certificate of organization or incorporation or special law incorporating a corporation together with its bylaws, or the agreement establishing a fund or association together with its constitution and bylaws.

[1969, c. 132, §1 (NEW) .]

7. **Superintendent.** Superintendent means the State Insurance Superintendent or person duly designated to exercise the powers of that office during an attack or acute emergency.

[1973, c. 585, §12 (AMD) .]

8. **Director.** Director means the director, trustee or member of the board.

[1969, c. 132, §1 (NEW) .]

9. **Domestic organization.** Domestic organization means any insurance organization which is domiciled in this State.

[1969, c. 132, §1 (NEW) .]

10. **Insurance organization.** Insurance organization means any insurer, rating organization, service or advisory organization, joint underwriting association, welfare or pension fund, which is subject, in whole or in part, to the insurance laws of this State.

[1969, c. 132, §1 (NEW) .]

11. **Officer.** Officer means an officer of a domestic insurance organization.

[1969, c. 132, §1 (NEW) .]

12. **Quorum.** Quorum means the minimum number of directors required by charter and bylaw, exclusive of the provisions of this chapter, to be present for valid action to be taken at a meeting of a board with respect to each particular item of business which may come before such meeting.

[1969, c. 132, §1 (NEW) .]

This chapter does not and shall not be construed to limit the powers of, or permit or require, any insurance organization which is not domiciled in this State or of any branch office, or agents of such insurance organization, or the directors, officers, members, policyholders or stockholders of any such organization to act, or fail to act, in such fashion as would violate the laws of the jurisdiction wherein such organization has its domicile. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). RR 2009, c. 2, §69 (COR).

§3553. EMERGENCY BYLAWS

1. With the approval of the superintendent, any domestic organization may, at any time, adopt, in the same manner as in the case of ordinary bylaws, emergency bylaws to become operative during a period of acute emergency. Emergency bylaws may contain provisions with respect to the number of directors capable of acting which shall constitute its board, the number of such directors which shall constitute a quorum at a meeting of the board, the number of votes necessary for action by such board, the manner in which vacancies on the board shall be filled, the line of succession of its officers, and the interim management of the affairs of the insurance organization; such provisions, if approved by the superintendent, need not comply with the requirement of the charter of such domestic organization or of the insurance or incorporation laws of this State.

[1973, c. 585, §12 (AMD) .]

2. Section 3554 and section 3555, subsections 2 to 6 shall not be applicable during a period of acute emergency to any domestic organization operating in accordance with and under emergency bylaws theretofore approved by the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3554. CHANGE OF LOCATION; EMERGENCY BOARDS OF DIRECTORS

Notwithstanding any provision of its charter, any domestic insurance organization, without complying with any provision of law requiring approval, or application for approval, of a change of location of its principal office may, from time to time, change the location thereof during an acute emergency to a suitable location within the United States, and may carry on its business at such new location during such acute emergency, and for a reasonable time thereafter. Any insurance organization which changes the location of its principal office during an acute emergency shall notify the superintendent thereof in writing as soon as practical, stating the address of the new location, the address of the former location, and the dates when business is ceasing at the former location and commencing at the latter location. [1973, c. 585, §12 (AMD).]

Notwithstanding any contrary provision of law or with its charter, if at any time during an acute emergency affecting any domestic insurance organization, no person otherwise empowered to call meetings of the board is capable of acting, a meeting thereof may be called by any director or acting director or if no director or acting director is capable of acting, by any officer or acting officer. If it shall be impracticable or impossible to give notice of a meeting of the board in the manner prescribed by charter and law, other than this chapter, the person calling such a meeting may give notice thereof by making such reasonable efforts as circumstances may permit to notify each director and acting director of the time and place of the meeting, but need not specify the purposes thereof. Failure of any director or acting director to receive actual notice of a meeting of directors and acting directors shall not affect the power of the directors and acting directors present at such meeting to exercise the powers of an emergency board of directors as prescribed in this section. Nothing in this chapter shall be construed as requiring a meeting of the board of such an organization to be convened in any manner different from that prescribed by its charter and by the provisions of law other than this chapter. [1969, c. 132, §1 (NEW).]

If 3 or more directors and acting directors of any domestic insurance organization are present at any meeting of its board duly convened during an acute emergency affecting such domestic insurance organization, they shall constitute its emergency board of directors which, notwithstanding any contrary provision of law or of its charter, shall have the power, subject to the limitations prescribed by this chapter, by a majority of those present, to take any and every action which may be necessary to enable such domestic insurance organization to meet the exigencies of the acute emergency and conduct its business during such period, but no other powers. The powers of an emergency board of directors shall include, but shall not be limited to, the following powers: [1969, c. 132, §1 (NEW).]

1. **Fill vacancies and absentees.** At any meeting, to elect such acting directors as it may deem necessary, without regard to the number of directors which would otherwise be required, to serve in any positions on such board which are vacant or in place of any directors or acting directors who are absent from such meeting, but not to elect any director on a permanent basis;

[1969, c. 132, §1 (NEW) .]

2. **Acting officers and duties.** To elect such acting officers as it may deem necessary, without regard to the number of officers which would otherwise be required, to serve in any offices which are vacant or in place of any officers or acting officers who fail to appear and assume their duties, to fix the compensation and

determine the powers and duties of acting officers and to remove acting officers but not to remove any officer or to fill any vacancy on a permanent basis or to cause the insurance organization to enter into any contract of employment for a term in excess of one year;

[1969, c. 132, §1 (NEW) .]

3. **Change of location.** To cause the insurance organization to change the location of its principal office, pursuant to this section, or any of its places of business, and to authorize such action as it may deem appropriate to acquire space and facilities at new locations, but not to acquire for use as its principal office property in fee or for a term in excess of one year;

[1969, c. 132, §1 (NEW) .]

4. **Postpone meetings.** To postpone any meeting of the stockholders, policyholders or members or directors of such organization if, in the judgment of majority of the members of such emergency board of directors, it would be impracticable to hold such meeting at the time it would otherwise have been held or conducted;

[1969, c. 132, §1 (NEW) .]

5. **Call meetings.** If it shall appear to an emergency board of directors that a quorum of the board cannot be assembled within a reasonable time, to call a meeting of the stockholders, policyholders or members of the insurance organization to be held as soon as the circumstances may reasonably permit, at a place to be designated by the emergency board of directors within this State or a contiguous state, for the purpose of electing directors to fill vacancies on the board, but for no other purpose, and to propose nominees for such election. Any such meetings of stockholders, policyholders or members shall be held upon notice given in accordance with the charter of the organization and applicable law other than this section.

[1969, c. 132, §1 (NEW) .]

As soon as practicable after each meeting of an emergency board of directors, the person who presided thereat shall notify the superintendent in writing of the time and place of such meeting, of the manner in which notice thereof was given, of the persons present and of all actions taken at such meeting. [1973, c. 585, §12 (AMD).]

No person prohibited by law or by the charter of a domestic insurance organization from serving as a member of its board shall be eligible to serve as an acting director, except that no person shall be disqualified to serve as an acting director by reason of his not being a stockholder, policyholder or member of such insurance organization, by reason of his not being a resident of this State or of a contiguous state, or by reason of the number of directors or acting directors who are officers, acting officers or employees of the insurance organization. Any person may serve as an acting director of a fund who is a director, acting director, officer or acting officer of an organization which is a party to the agreement creating the fund. No oath of acting directors shall be required. [1969, c. 132, §1 (NEW).]

Acting directors elected under this section or appointed under section 3555 shall be entitled to vote at all meetings of emergency board of directors equally with directors. Acting directors shall not be entitled to take part in the deliberations or to vote at any meeting of the board which is duly convened in accordance with the applicable provisions of its charter and of law other than this chapter and at which a quorum is present. Each acting director shall serve until the director or acting director in whose place he was elected or appointed shall attend the meeting of the board or until the director is duly elected to fill the vacancy in which such acting director has been serving, whichever event occurs earlier. An acting director shall be entitled to the compensation, if any, payable to a director. [1969, c. 132, §1 (NEW).]

Acting officers elected pursuant to this section shall have powers and duties and receive such compensation as may from time to time be determined by the emergency board of directors. Each acting officer shall serve until the officer in whose place he was elected shall appear and assume his duties or until his successor officer or acting officer shall be elected, whichever event occurs earlier. [1969, c. 132, §1 (NEW).]

This section shall not be deemed applicable during a period of acute emergency to any domestic organization operating in accordance with and under emergency bylaws theretofore approved by the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3555. POWERS OF THE SUPERINTENDENT

1. **Designate additional acting directors.** If at any time during an acute emergency, the number of directors or acting directors of a domestic insurance organization who are capable of acting shall be less than 3, as determined by the superintendent after a reasonable investigation, the superintendent shall have the power to designate additional acting directors in such number as will bring to 3 the number of directors and acting directors who are capable of acting.

[1973, c. 585, §12 (AMD) .]

2. **Resolve controversies.** To resolve controversy as to the power of any group of persons purporting to act as an emergency board of directors so to act, the superintendent shall, upon a determination that such action will tend to promote the safe and sound and orderly conduct of the business of any domestic insurance organization, have power to issue orders declaring that any such group shall or shall not have the powers of an emergency board of directors, or confirming, modifying or vacating in whole or in part any action taken or purportedly taken by any such group or by removing any acting director.

[1973, c. 585, §12 (AMD) .]

3. **Declare provisions of law operative or inoperative.** At any time after an attack, upon his determination that such action will tend to promote certainty as to the powers of insurance organizations or individuals pursuant to this chapter or that such action is desirable to enable insurance organizations to take preparatory precautions prior to the occurrence of an acute emergency, the superintendent shall have power to declare that any provision of this chapter which he may specify shall be operative with respect to any domestic insurance organization or to the Maine business of any other insurance organization which he may designate. Upon such declaration such organization and its directors, officers, acting directors and acting officers shall have all powers conferred by this chapter. The failure of the superintendent so to declare shall not be deemed to limit the powers of any organization or its directors, officers, acting directors or acting officers where an acute emergency exists in fact.

At any time after the commencement of an acute emergency or after the superintendent shall have declared any provision of this chapter operative under this subsection upon his determination that an insurance organization is able, in whole or in part, to carry on its business in compliance with its charter and the laws, other than this chapter, the superintendent shall have power to declare that any provision of this chapter which he may specify shall be inoperative with respect to any domestic insurance organization or in the Maine business of any other insurance organization which he may designate. Upon such declaration, such organization shall be governed by its charter and the provisions of law other than this chapter, except insofar as they remain inoperative.

[1973, c. 585, §12 (AMD) .]

4. **Possession of business and property.** Upon the determination that, as a result of an acute emergency, the business and affairs of an insurance organization cannot otherwise be conducted in a safe and sound manner, the superintendent may forthwith take possession of the business and property of the insurance organization within this State or, if a domestic insurance organization, its business and property wherever situated. This chapter shall be applicable in any case in which the superintendent takes possession of an insurance organization under this subsection as though the insurance organization were an insurer of which the superintendent had taken possession under this chapter, except that no such provision shall be applicable which the superintendent shall have declared inapplicable under this subsection. The superintendent shall have power to declare inapplicable any such provision upon his determination that the same is inappropriate or unnecessary to protect the interest of the public or the stockholders or creditors of the insurance organization, in view of the acute emergency and the nature of the organization.

[1973, c. 585, §12 (AMD) .]

5. **When powers exercised.** The powers given the superintendent by subsections 2 and 4 shall be exercised by him only in the event that there is no court of competent jurisdiction available to which an application can be made for an order permitting him to exercise such powers with respect to a particular insurance organization. The powers conferred by subsection 4 shall not be exercised in a case of an insurance organization which is not insolvent within the meaning of this chapter, unless the superintendent finds that such insurance organization lacks personnel able to manage its business in the interest of the public stockholders and policyholders.

[1973, c. 585, §12 (AMD) .]

6. **Regulations.** The superintendent shall have power to issue general and specific regulations, directives and orders consistent with and in furtherance of the purposes of this chapter.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3556. GENERAL PROVISIONS

1. **Presumption.** In any action or proceeding it shall be presumed that an acute emergency existing within any city or county within this State constitutes an acute emergency affecting every insurance organization doing business within such city or county.

[1969, c. 132, §1 (NEW) .]

2. **Powers of board.** During an acute emergency the board of a domestic insurance organization which has adopted emergency bylaws approved by the superintendent shall have all of the powers conferred by such bylaws, and no other or different powers with respect to the subject matter of this chapter, and the board of a domestic insurance organization which has not adopted emergency bylaws approved by the superintendent shall have all of the powers of an emergency board of directors as the same are provided for under this chapter.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3557. GOVERNOR'S AUTHORITY; EFFECT OF OTHER LAWS

The Governor of this State, or his successor in office, alone shall have the power to proclaim and declare the fact that a period of "acute emergency" exists at any time or times or has terminated, as such term is defined in this chapter. Nothing in this chapter shall be deemed or construed to affect sections 471 to 479, to the extent that the latter sections may be inconsistent herewith. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

Chapter 51: DOMESTIC MUTUAL ASSESSMENT INSURERS

§3601. SCOPE OF CHAPTER

1. This chapter applies only as to domestic mutual insurers heretofore or hereafter authorized to transact and transacting property insurances in this State on the assessment plan, as defined in section 3603, and to the assessment department of insurers also transacting insurance on the cash premium plan.

[1969, c. 177, §60 (AMD) .]

2. Insurers to the extent to which subject to this chapter may in this chapter be referred to as "mutual assessment insurers."

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §60 (AMD).

§3602. CHAPTER EXCLUSIVE

Nothing in this Title shall either directly or indirectly apply to such mutual assessment insurers except as contained or referred to in this chapter. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3603. MUTUAL ASSESSMENT PLANS; DEFINITIONS

1. For the purposes of this Title a mutual assessment insurer is a mutual insurer which is doing business on:

A. A post-loss assessment plan; or [1969, c. 132, §1 (NEW).]

B. On an advance assessment or contingent liability plan. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. A post-loss assessment plan insurer is one which depends in whole or substantial part on regular or special assessments levied upon its members after a loss or series of losses for payment of losses and expenses. A post-loss assessment plan insurer may collect from each member such initial amount as it may deem proper prior to or at the time of the effectuation of the member's insurance. Future regular or special assessments may be secured by use of a premium note signed by the policyholder.

[1969, c. 132, §1 (NEW) .]

3. An advance assessment plan insurer shall by its bylaws and policies fix the contingent mutual liability of its members for the payment of losses and expenses not provided for by its cash funds; but such contingent liability of a member shall not be less than one or more than 6 times the advance assessment for the member's policy at the annual advance assessment rate for a term of one year. Such an advance assessment plan insurer may issue both assessable and nonassessable advance cash premium policies. Any assessment, special or regular, levied under the contingent liability provisions of this chapter shall be for the

exclusive benefit of the holders of policies subject to assessment, and such policyholders shall not be liable to an assessment in an amount greater in proportion to the total deficiency than the ratio that the deficiency attributable to the assessable business bears to the total deficiency.

[1969, c. 132, §1 (NEW) .]

4. Nothing in this chapter shall be deemed to prohibit the acquisition, accumulation and maintenance of surplus and unallocated funds.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3604. INSURING POWERS; REINSURANCE

1. An assessment plan insurer shall have authority to transact, and shall transact only such insurance as is permitted by its charter and by its certificate of authority.

[1969, c. 132, §1 (NEW) .]

2. Any such insurer shall have power to cede reinsurance of any risk or part thereof which it is authorized to insure direct; and shall have power to accept reinsurance from other domestic assessment plan insurers of any risk which it has authority to insure direct.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3605. FORMATION OF NEW ASSESSMENT PLAN INSURERS

Assessment plan insurers must be formed under the applicable provisions of sections 3306 (incorporation of domestic stock, mutual insurers) to 3309 (completion of incorporation; general powers, duties), except that the articles of incorporation of the corporation must stipulate that the corporation is formed to transact insurance on the assessment plan and other provisions contained in the certificate must be consistent with the applicable provisions of this chapter. [2013, c. 299, §20 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2013, c. 299, §20 (AMD).

§3606. CERTIFICATE OF AUTHORITY REQUIRED

No such insurer shall transact insurance in this State except as authorized by a subsisting certificate of authority issued to the insurer by the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3607. CAPITAL FUNDS REQUIRED; EXISTING INSURERS

1. A mutual assessment insurer heretofore organized to transact and transacting only fire, marine and glass insurance shall not have a net retention of liability on any one risk in excess of $200 until its gross assets exceed $2,000, after which its net retention of liability shall be as provided in section 3623.

[1969, c. 132, §1 (NEW) .]

2. Mutual insurers organized prior to January 1968 to transact and transacting kinds of insurance other than fire, marine and glass shall have a guaranty capital fund in amount not less than as required under laws in force immediately prior to January 1, 1970, and if organized on or after January 1, 1968, shall have guaranty capital funds of not less than $500,000. Such an insurer shall not be authorized to transact insurance until at least 1/4 of its guaranty capital funds have been paid in, in cash, and invested in such manner as is provided in chapter 13.

[1973, c. 625, §150 (AMD) .]

3. If an insurer operating under this section fails to comply with the superintendent's request to increase its paid-in guaranty capital funds within the amount otherwise required by law, it shall cease to write any class or kind of insurance other than fire, marine or glass until such time as the superintendent's request has been complied with.

[1973, c. 585, §12 (AMD) .]

4. Except as hereinabove provided, all such insurers holding subsisting certificates of authority immediately prior to January 1, 1970 may continue to be so authorized as long as qualified for such authority as under laws in force immediately prior to such effective date.

[1973, c. 625, §150 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §150 (AMD).

§3608. CAPITAL FUNDS REQUIRED; NEW MUTUAL ASSESSMENT INSURERS

A mutual insurer hereafter organized to transact property insurance on the assessment plan shall not be authorized to transact insurance unless it: [1969, c. 132, §1 (NEW).]

1. Establishes and maintains guaranty capital funds of at least $50,000, all of which shall have been paid in, in cash, and

[1969, c. 132, §1 (NEW) .]

2. Receives not less than 25 bona fide written applications from not less than 25 persons for insurance of the kind proposed to be transacted, of not less than $100,000 in amount at risk as to principal hazards to be insured, and

[1969, c. 132, §1 (NEW) .]

3. Receives or collects the initial payment on the premium for the insurance applied for, together with such premium notes as it is contemplated to use in connection with applications for insurance in general, and

[1969, c. 132, §1 (NEW) .]

4. Is otherwise qualified for such authority under this chapter.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3609. NEW ASSESSMENT PLAN INSURERS; CONVERSION

Mutual insurers organized to transact insurance on the assessment plan are not authorized to transact any kind of insurance other than property insurance or to transact insurance of any kind on the cash premium plan, unless the insurer qualifies for such authority in accordance with the requirements of domestic mutual insurers organized under chapter 47 (organization, corporate powers, procedures of domestic legal reserve stock and mutual insurers), and by appropriate amendment to its articles of incorporation converts to such a legal reserve insurer. [2013, c. 299, §21 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2013, c. 299, §21 (AMD).

§3610. GUARANTY CAPITAL SHARES; DIVIDENDS, INVESTMENT, DEPOSIT, VOTING RIGHTS

1. Where the insurer is permitted or required to have guaranty capital shares, such capital shall be divided into shares of $100 each and certificates shall be issued therefor.

[1969, c. 132, §1 (NEW) .]

2. The holders of guaranty capital shares may receive dividends not exceeding 7% of the amount received by the insurer for issuance of such shares in any one calendar year from the net earnings of the insurer after providing for all expenses, losses, reserves and liabilities then incurred.

[1969, c. 132, §1 (NEW) .]

3. Guaranty capital resulting from shares shall be invested in such manner as is provided in chapter 13.

[1969, c. 132, §1 (NEW) .]

4. Guaranty capital shareholders and members of the insurer shall be subject to the same provisions of law relative to their right to vote as apply respectively to stockholders in stock insurers and policyholders in purely mutual insurers.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3611. GUARANTY CAPITAL SHARES; INCREASE OF PAID-IN CAPITAL

If an insurer heretofore or hereafter has been authorized to transact insurance upon the basis of guaranty capital shares not 100% paid-in, the unpaid portion of such guaranty or so much thereof as the superintendent deems necessary, shall be paid in at such times as in the opinion of the superintendent is necessary for the adequate protection of the policyholders. [1973, c. 585, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3612. GUARANTY CAPITAL SHARES; DEFICIENCY AND ASSESSMENT

When the cash and other available assets of an insurer with guaranty capital shares are exhausted, such part of the guaranty capital fund as may be required shall, with the approval of the superintendent, be drawn and used to pay losses then due. When such fund is so drawn upon, the directors of the insurer shall make good the amount so drawn by assessments upon the contingent funds or notes of the insurer or by borrowed funds as provided for under section 3415; and unless such fund is restored within 6 months from the date of withdrawal, the holders of guaranty fund shares shall be assessed in proportion to the amount of such shares owned by them for the purpose of restoring such capital. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3613. GUARANTY CAPITAL SHARES; RETIREMENT

Guaranty capital shares may be retired by vote of the policyholders of the insurer when the insurer's surplus, over and above all liabilities including guaranty capital, equals or exceeds the amount of the guaranty capital shares. The guaranty capital shares may be retired in part when the insurer's remaining net surplus and guaranty fund will not thereby be reduced below the amount of original guaranty capital. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3614. NOTICE OF CONTINGENT LIABILITY; REDUCTION

Where contingent liability of policyholders is provided for, notice of the existence of such liability shall be plainly and legibly given in each policy. Whenever any reduction is made in the contingent liability of members, the reduction shall apply proportionally to all policies in force. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3615. DELIVERY, ACCEPTANCE OF POLICY

The delivery of the policy to the insured and payment by the insured of the initial charge shall be deemed an acceptance of the contract. [1969, c. 177, §61 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 177, §61 (AMD).

§3616. ASSESSMENT; REMEDY IF NOT PAID

If any lawful assessment is not paid within 30 days after written demand by the insurer or its agent, the directors may declare the policy suspended until the assessment is paid or may at their option sue for and collect the amount due on such assessment. Mailing such demand addressed to the insured at his address last of record with the insurer, or delivering it to him in hand by an authorized agent or officer of the insurer, shall be deemed conclusive proof that demand has been duly made. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3617. ASSESSMENT -- COURT REVIEW; ADJUSTMENT OF CLAIMS WHERE NO ASSESSMENT MADE

1. Whenever the directors of a mutual assessment insurer make an assessment or call on its members for money, or by vote determine that there exists a necessity for such assessment or call, they, or any person interested in the insurer as an officer, policyholder or creditor, may file in the Superior Court in any county, a complaint praying the court to examine the assessment or call or to determine the necessity therefor and all matters connected therewith, and to ratify, amend or annul the assessment or call or to order that the same be made as law and justice may require.

[1969, c. 132, §1 (NEW) .]

2. The decision on such complaint, when filed by any party except the insurer, or a receiver, or the superintendent, shall rest in the discretion of the court.

[1973, c. 585, §12 (AMD) .]

3. Whenever the directors unreasonably neglect to make an assessment or call to satisfy an admitted or ascertained claim upon the insurer, any judgment creditor, or any person holding such admitted or ascertained claim, or the superintendent may make the application. Upon such application, if made by the directors, or upon order of court if made by application of any other party, the directors shall set forth the claims against the insurer, its assets and all other facts and particulars appertaining to the matter.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3618. -- ORDER OF NOTICE TO PARTIES INTERESTED, AND PROCEEDINGS

The court before which the complaint described in section 3617 is filed shall order notice to all parties interested, by publication or otherwise. Upon the return thereof, the court shall proceed to examine the assessment or call, the necessity therefor and all matters connected therewith. Any parties interested may appear and be heard thereon, and all questions that may arise shall be heard and determined as in other civil actions in which equitable relief is sought. The court may refer the apportionment or calculation to any competent person, and upon the examination may ratify, amend or annul the assessment or call, or order one to be made. In case the assessment or call is altered or amended, or one is ordered, the directors shall forthwith proceed to vote the same in legal form and the record of such vote shall be set forth in a supplemental answer. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3619. -- PROCEEDINGS BEFORE MASTER OR AUDITOR

Whenever the court appoints a master or auditor to make the apportionment or calculation for an assessment, such master or auditor shall appoint a time and place to hear all parties interested in the assessment or call, and shall give personal notice thereof, in writing, to the superintendent, and through the post office or in such other manner as the court directs, so far as he is able, to all persons liable upon the assessment or call. The auditor or master shall hear the parties and make report to the court of all his doings

respecting such assessment or call and all matters connected therewith, and all parties interested in such report or assessment have a right to be heard by the court respecting the same, in the same manner as is provided. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3620. -- WHEN ASSESSMENT FINAL; COSTS; CONTROL OF FUNDS AND PAYMENT OF ASSESSMENTS

1. When an assessment or call has been ratified, ascertained or established as provided for in sections 3617 to 3619, a decree shall be entered which shall be final and conclusive upon the insurer and all parties liable to the assessment or call as to the necessity of the same, the authority of the insurer to make or collect it, the amount thereof and all formalities connected therewith. Where an assessment or call is altered or amended by vote of directors and decree of the court thereon, such amended or altered assessment or call is binding upon all parties who would have been liable under it as originally made, and in all legal proceedings shall be held to be such original assessment or call.

[1969, c. 132, §1 (NEW) .]

2. All proceedings shall be at the cost of the insurer, unless the court for cause otherwise orders.

[1969, c. 132, §1 (NEW) .]

3. In all cases the court may control the disposal of the funds collected under these proceedings, and may issue all necessary processes to enforce the payment of such assessments against all persons liable therefor.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3621. -- ASSESSMENT NOT SUFFICIENT; COLLECTION STAYED BY COURT

Whenever it shall appear to the court before which the complaint provided for in section 3617 is pending, that the net proceeds of any assessment or call will not be sufficient to furnish substantial relief to those having claims against the insurer, it may decree that no assessment shall be collected. When, on application of the superintendent or any person interested, the court is of opinion that further attempts to collect an assessment then partially collected will not benefit those having claims against the insurer, it may stay its further collection. [1973, c. 585, §12 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3622. NONASSESSABLE POLICIES; ASSESSABLE, NONASSESSABLE LIABILITY

1. A mutual insurer heretofore formed and transacting insurance under this chapter may issue nonassessable advance cash premium policies in this State upon compliance with either of the following requirements:

A. Surplus. The insurer shall have and maintain a surplus to policyholders, as determined by its last annual statement filed with the superintendent, of not less than $100,000, or [1973, c. 585, §12 (AMD).]

B. Surplus and unearned premium reserve. The insurer shall have and maintain a surplus to policyholders, as determined by its latest annual statement filed with the superintendent, of not less than $75,000, provided its unearned premium reserve is at all times less than its surplus to policyholders. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

2. If such an insurer, after qualifying to issue a nonassessable cash premium policy, fails to maintain one of the above requirements it shall cease to issue a nonassessable policy until it has again met and maintained the requirements for a period of one year.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3623. LIMIT OF RISK

1. Except as provided in section 3607, subsection 1, an insurer shall not retain liability as to any one risk in an amount exceeding 10% of its surplus and in addition 8% of the amount at any time due on its premium notes.

[1975, c. 124, (AMD) .]

2. Valid reinsurance ceded by the insurer and then in force shall be deducted from the gross risk assumed in determining net risk retained.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1975, c. 124, (AMD).

§3624. UNEARNED PREMIUM RESERVE

An insurer which collects a cash premium or advance assessment shall maintain an unearned premium reserve equal to 50% of the cash premium or advance assessment on its policies in force. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3625. DIRECTORS' RESIDENCE, COMPENSATION

1. A majority of the board of directors of the insurer shall be residents of, and actually reside in, this State.

[1969, c. 132, §1 (NEW) .]

2. The salary or compensation for services of the directors of the insurer shall be fixed by the policyholders at their annual meeting.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3626. ANNUAL STATEMENT BY DIRECTORS

The directors of every insurer shall cause a detailed account of its expenses for the year preceding, the amount of property actually insured at that time, the amount due on its premium notes and the amount of all debts due to and from the insurer to be laid before the policyholders at the annual meeting. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3627. AGENTS; LIABILITY

Any person who solicits insurance on behalf of any insurer or transmits for a person other than himself an application for, or a policy of, insurance to or from such insurer, or in any manner acts in the negotiation of such insurance, or in the inspection or valuation of the property insured shall be deemed the agent of the insurer, and except as otherwise provided, shall become liable to all the duties, requirements, liabilities and penalties to which an agent of any insurer is subject. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3628. AGENTS -- LICENSING

All agents of insurers subject to this chapter are subject to the applicable requirements of chapter 16, except that: [1997, c. 457, §45 (AMD); 1997, c. 457, §55 (AFF).]

1. No personal examination shall be required of the applicant and no examination fee shall be charged, as to an applicant for a license as an agent of an insurer writing insurance solely on the assessment plan, if on January 1, 1970 the applicant was also a director or officer of such insurer;

[1973, c. 625, §151 (AMD) .]

2. No fee shall be required by the superintendent for license as resident agent issued to any individual referred to in subsection 1, as agent of such an insurer.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §151 (AMD). 1997, c. 457, §45 (AMD). 1997, c. 457, §55 (AFF).

§3629. OTHER PROVISIONS APPLICABLE

The following chapters and provisions of this Title, where and to the extent not inconsistent with this chapter and the reasonable implications thereof, also apply as to domestic mutual assessment insurers which are subject to this chapter: [1969, c. 132, §1 (NEW).]

1. Chapter 1 (general definitions and provisions).

[1969, c. 132, §1 (NEW) .]

2. Chapter 3 (the insurance superintendent), except that an insurer transacting insurance only on the assessment plan shall not be subject to section 228 (examination expense), and shall not be required to pay the expense of examination of the insurer.

[1973, c. 585, §12 (AMD) .]

3. Chapter 5 (authorization of insurers and general requirements), except that the following sections or provisions shall not apply:

A. Section 410 (capital funds required); [1969, c. 132, §1 (NEW).]

B. Section 411 (insuring combinations without additional capital funds); [1969, c. 132, §1 (NEW).]

C. Section 413 (application for certificate of authority), to the extent that payment is required of a fee for application for or issuance of a certificate of authority of an insurer transacting insurance on the assessment plan only; [1969, c. 132, §1 (NEW).]

D. Section 415 (continuance, expiration, reinstatement of certificate of authority), to the extent that payment of fee for continuance of certificate of authority is required of an insurer transacting insurance on the assessment plan only; and [1969, c. 132, §1 (NEW).]

E. Section 423 (annual statement), to the extent that payment of a fee for filing the annual statement is required of an insurer transacting insurance on the assessment plan only. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

4. Chapter 7 (fees and taxes), except as otherwise expressly provided in this chapter, and that no fee shall be charged for the certificate of authority of an insurer transacting insurance on the assessment plan only.

[1969, c. 132, §1 (NEW) .]

5. Chapter 9 (kinds of insurance), except the following sections:

A. Section 702 ("life insurance" defined); [1969, c. 132, §1 (NEW).]

B. Section 709 ("title insurance" defined); and [1969, c. 132, §1 (NEW).]

C. Section 721 (limits of risk). [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

6.

[2001, c. 72, §17 (RP) .]

6-A. Section 901-A (statutory accounting principles);

[2001, c. 72, §18 (NEW) .]

7. Chapter 13 (investments).

[1969, c. 132, §1 (NEW) .]

8. Chapter 15 (administration of deposits).

[1969, c. 132, §1 (NEW) .]

9. Chapter 16;

[1997, c. 457, §46 (AMD); 1997, c. 457, §55 (AFF) .]

10. Chapter 23 (trade practices and frauds).

[1969, c. 132, §1 (NEW) .]

11. Chapter 25 (rates and rating organizations), except as provided in such chapter 25.

[1969, c. 132, §1 (NEW) .]

12. Chapter 27 (the insurance contract); except that section 2415 (charter, bylaw provisions) shall not apply as to insurance written on the mutual assessment plan.

[1969, c. 132, §1 (NEW) .]

13. Chapter 39 (casualty insurance contracts).

[1969, c. 132, §1 (NEW) .]

14. Chapter 41 (property insurance contracts).

[1969, c. 132, §1 (NEW) .]

15. Chapter 43 (surety insurance contracts).

[1969, c. 132, §1 (NEW) .]

16. Chapter 47 (organization, corporate powers, procedures of domestic legal reserve stock and mutual insurers), except as to the following sections:

A. Sections 3352 to 3358 (initial qualification, qualifying applications for insurance, guaranty capital, and related subjects); and [1969, c. 132, §1 (NEW).]

B. Sections 3364 to 3367 (provisions relative to contingent liability and nonassessable policies). [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

17. Chapter 49 (continuity of management).

[1969, c. 132, §1 (NEW) .]

18. Chapter 57 (delinquent insurers; rehabilitation and liquidation).

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §46 (AMD). 1997, c. 457, §55 (AFF). 2001, c. 72, §§17,18 (AMD).

Chapter 52: MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY

§3701. PURPOSE

The Maine Employers' Mutual Insurance Company is established for the purposes of providing workers' compensation insurance and employers' liability insurance incidental to and written in connection with workers' compensation coverage to employers of this State at the highest level of service and savings consistent with reasonable applicable actuarial standards and the sound financial integrity of the company. It is also the purpose of the company to encourage employer involvement and to be responsive to employer experience and advice. [2001, c. 350, §1 (AMD).]

SECTION HISTORY
1991, c. 615, §D1 (NEW). 1991, c. 885, §C1 (AMD). 1997, c. 661, §1 (AMD). 2001, c. 350, §1 (AMD).

§3702. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 615, Pt. D, §1 (NEW).]

1. **Board.** "Board" means the Board of Directors of the Maine Employers' Mutual Insurance Company.

[1991, c. 615, Pt. D, §1 (NEW) .]

2. **Company.** "Company" means the Maine Employers' Mutual Insurance Company created in section 3703.

[1991, c. 615, Pt. D, §1 (NEW) .]

3. **Division.**

[2001, c. 350, §2 (RP) .]

3-A. **Maine-based employer.** "Maine-based employer" means an employer with a principal place of business located in this State.

[1995, c. 551, §3 (NEW) .]

4. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1991, c. 885, Pt. C, §2 (NEW) .]

5. **Voluntary market.** "Voluntary market" means the workers' compensation insurance market in which insurance companies voluntarily offer coverage to applicants who meet the insurers' underwriting standards or guidelines.

[1991, c. 885, Pt. C, §2 (NEW) .]

6. **Workers' compensation residual market mechanism.** "Workers' compensation residual market mechanism" means the instrument to provide coverage to employers not able to obtain coverage in the voluntary market that immediately preceded the Maine Employers' Mutual Insurance Company.

[2001, c. 350, §3 (AMD) .]

SECTION HISTORY
1991, c. 615, §D1 (NEW). 1991, c. 885, §C2 (AMD). 1995, c. 551, §3 (AMD). 1997, c. 661, §2 (AMD). 2001, c. 350, §§2,3 (AMD).

§3703. ESTABLISHMENT

The Maine Employers' Mutual Insurance Company is established as an assessable domestic mutual insurance company subject to all the requirements and standards of this Title that are applicable to cash plan insurers unless specifically exempted from or which are clearly inconsistent with the provisions contained in this chapter. Notwithstanding any other law to the contrary, the company's authority to operate is limited as follows. [1991, c. 885, Pt. C, §3 (AMD).]

1. **Workers' compensation.** The company shall provide workers' compensation insurance and employers' liability insurance incidental to and written in connection with workers' compensation coverage to employers in this State. The company may provide employment practices liability insurance incidental to and written in connection with workers' compensation coverage for employers if the employment practices liability insurance is provided as an endorsement to workers' compensation coverage approved by the superintendent and is provided under terms and conditions, including reinsurance protection, approved by the superintendent. Rates for employment practices liability insurance are subject to chapter 25. The company may not write other lines of insurance. The company may reinsure workers' compensation and employers' liability insurance written by other insurers that are covering out-of-state employees of Maine-based employers that are insured by the company. For the purpose of providing insurance to Maine-based employers operating in other states, the company may apply to appropriate regulatory authorities in those states for authority to write workers' compensation, employers' liability and employment practices liability insurance for Maine-based employers' operations in those states. The company may form or acquire subsidiary insurers in other states that are authorized to write only workers' compensation insurance, employers' liability insurance and employment practices liability insurance as long as such coverage is incidental to and written in connection with workers' compensation coverage. The superintendent may authorize a subsidiary insurer formed or acquired by the company to write workers' compensation, employers' liability and employment practices liability insurance in this State as long as such coverage is incidental to and written in connection with coverage in the state in which the insured's principal place of business is located. The superintendent may not authorize a subsidiary insurer formed or acquired by the company to write any other line of insurance in this State.

[2009, c. 32, §1 (AMD) .]

2. **Exclusion from guaranty funds.** The company and its policyholders are exempt from participation and may not join or contribute financially to, nor be entitled to the protection of, any plan, pool, association or guaranty or insolvency fund authorized or required by this Title.

[1991, c. 615, Pt. D, §1 (NEW) .]

3. **Initial board of directors.**

[1991, c. 885, Pt. C, §3 (RP) .]

4. **Incorporation.**

[1997, c. 661, §4 (RP) .]

5. **Composition of the board.** The board consists of up to 9 members. Six members must be officers, directors, employees, partners or members of policyholders who purchase workers' compensation coverage from the Maine Employers' Mutual Insurance Company. Two members must be persons who represent the public interest of the company and must be appointed by the Governor within 30 days after a new board member is authorized or a vacancy occurs, subject to review and comment by the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. The designated committee shall complete its review within 15 days of the Governor's written notice of appointment. If the designated committee fails to act within the required 15 days, then the appointees put forward by the Governor become the required board members. One member must be an at-large policyholder member elected by the board. The remaining board member is the president and chief executive officer who shall serve on the board of directors while employed as president and chief executive officer. The reduction in the number of board members from 13 to 9 must be done by attrition. The first 4 appointments to expire after September 1, 1998 may not be filled.

A member of the board may not be a lobbyist required to be registered with the Commission on Governmental Ethics and Election Practices, a service provider to the workers' compensation system or a representative of a service provider to the workers' compensation system.

[2005, c. 683, Pt. B, §19 (AMD) .]

6. **Terms.** A full term on the board of directors is 3 years. An individual may not serve more than 4 consecutive full terms as a director, except for the president and chief executive officer. All members shall serve for the terms provided and until their successors are appointed or elected and qualified.

[2011, c. 105, §1 (AMD) .]

7. **Corporate governance.** The board of directors shall adopt bylaws consistent with section 3359. The bylaws must provide a schedule of meetings and rules specifically relating to the conduct of meetings and voting procedures.

[1997, c. 661, §6 (AMD) .]

8. **Annual report.** In addition to any other reports required by this Title, the company shall submit an annual report to the Governor and to the joint standing committee of the Legislature having jurisdiction over insurance matters that discloses the business transacted by the company during the previous year and states the resources and liabilities of the company together with other pertinent information considered appropriate by the board. The report must contain, at a minimum, a summary of the latest annual statement filing required to be filed under this Title with the Superintendent of Insurance prepared on a basis of statutory accounting precepts. Any variations between the annual statement and the annual report must be reconciled to clearly show variances and the basis for any different values.

[1993, c. 1, §64 (COR) .]

9. **Nominating committee.** The board shall create a nominating committee. The nominating committee shall present to the board nominees for the at-large and the policyholder board member positions.

[1997, c. 661, §6 (AMD) .]

SECTION HISTORY
1991, c. 615, §D1 (NEW). 1991, c. 885, §C3 (AMD). RR 1993, c. 1, §64 (COR). 1995, c. 551, §4 (AMD). 1997, c. 661, §§3-6 (AMD). 1999, c. 120, §1 (AMD). 2005, c. 683, §B19 (AMD). 2007, c. 125, §1 (AMD). 2009, c. 32, §1 (AMD). 2011, c. 105, §1 (AMD).

§3704. PREREQUISITES TO OPERATIONS

(REPEALED)

SECTION HISTORY
1991, c. 615, §D1 (NEW). 1991, c. 885, §C4 (RP).

§3704-A. INITIAL FUNDING AND OPERATION

(REPEALED)

SECTION HISTORY
1991, c. 885, §C5 (NEW). 1997, c. 661, §7 (RP).

§3705. NONSTATE AGENCY

The company is not considered a state agency or instrumentality of the State for any purpose. The company is not and may never be supported in any way by the State's General Fund or any guaranty by the State, any state agency or a division of the State. The State may not borrow or otherwise appropriate funds from the company. [1991, c. 885, Pt. C, §6 (AMD).]

SECTION HISTORY
1991, c. 615, §D1 (NEW). 1991, c. 885, §C6 (AMD).

§3706. REPORTS AND INFORMATION

1. **Annual report.** In addition to any other reports required by this Title, the board shall submit an annual report to the Governor and the joint standing committee of the Legislature having jurisdiction over insurance matters indicating the business done by the company during the previous year and containing a statement of the resources and liabilities of the fund and any other information considered appropriate by the board. The report must contain, at a minimum, a summary of the latest annual statement required to be filed with the superintendent prepared in accordance with statutory accounting principles.

[1991, c. 885, Pt. C, §7 (AMD) .]

2. **Statistical and actuarial data.** The company shall compile and maintain statistical and actuarial data related to the determination of proper premium rate levels, the incidence of work-related injuries, costs related to those injuries and any other data that the company considers desirable. The company shall provide this data to the Superintendent of Insurance, the Executive Director of the Workers' Compensation Board and the Department of Labor annually and upon request.

[2003, c. 608, §3 (AMD) .]

SECTION HISTORY
1991, c. 615, §D1 (NEW). 1991, c. 885, §C7 (AMD). 1991, c. 885, §D2 (AMD). 2003, c. 608, §3 (AMD).

§3707. POWERS OF THE BOARD

The board has full power, authority and jurisdiction over the company. [1991, c. 885, Pt. C, §8 (NEW).]

1. **General authority.** The board may perform all acts necessary or convenient in the exercise of any power, authority or jurisdiction over the company, either in the administration of the company or in connection with the business of the company to fulfill the purposes of this chapter.

[1997, c. 661, §8 (AMD) .]

2. **Standard of performance.** The board shall discharge its duties with the care, skill, prudence, and diligence as that of prudent directors acting in a similar enterprise and purpose.

[1991, c. 885, Pt. C, §8 (NEW) .]

3. **Personal liability.** The members of the board and officers or employees of the company are not liable personally, either jointly severally, for any debt or obligation created or incurred by the company.

[1991, c. 885, Pt. C, §8 (NEW) .]

4. **President.** The board shall appoint a president who shall serve as chief executive officer and may appoint other executive officers as it determines necessary.

[1991, c. 885, Pt. C, §8 (NEW) .]

5. **Investment managers.** The board shall appoint investment managers to oversee and manage the investment of assets of the corporation in a manner that safeguards the value of those assets and maximizes investment return commensurate with risk and liquidity restrictions contained in chapter 13.

A. An investment manager appointed by the board is subject to standards applicable to fiduciaries responsible for safeguarding assets of such a corporation. The investment manager must be appointed pursuant to a contract in writing that clearly establishes the fiduciary nature of the relationship of the fiduciary to the company. [1991, c. 885, Pt. C, §8 (NEW).]

B. The board shall set investment policy for the investment managers of the company through an investment committee composed of not less than 3 members nor more than 5 members of the board. Transactions in the sale or purchase of securities by an investment manager may be in a nominee name as designated by the board. Authority to acquire or sell securities for the company must be conveyed to the investment manager in writing by the investment committee. [1991, c. 885, Pt. C, §8 (NEW).]

C. In any agreement empowering the investment managers to act for or on behalf of the company, there must be provisions for periodic reporting by the managers respecting investments held in the name of the company, the yield received on such investments and any principal cash balances held by depositories or the investment managers. [1991, c. 885, Pt. C, §8 (NEW).]

D. Securities and property of the corporation must be held in a manner consistent with the requirements for mutual insurance companies set forth in this Title. [1991, c. 885, Pt. C, §8 (NEW).]

[1991, c. 885, Pt. C, §8 (NEW) .]

SECTION HISTORY
1991, c. 885, §C8 (NEW). 1997, c. 661, §8 (AMD).

§3708. GENERAL POWERS

1. **Powers.** For the specific purpose of exercising the responsibilities granted in this chapter and effectuating the purposes of this chapter, the company has the powers otherwise granted to a casualty insurer and may:

A. Hire employees or enter into contracts relating to the administration of a workers' compensation insurer; [1991, c. 885, Pt. C, §8 (NEW).]

B. Declare a dividend when there is an excess of assets over liabilities and surplus requirements established in this Title; and [1991, c. 885, Pt. C, §8 (NEW).]

C. Enter into agreements to reinsure all or part of the company's exposure to loss and to otherwise limit the risk to the company and manage its financial condition. [1991, c. 885, Pt. C, §8 (NEW).]

[1991, c. 885, Pt. C, §8 (NEW) .]

2. **Assessments; plan of operation.** The board shall:

A. Assess policyholders to cover its expenses, claims, obligations and other funding needs consistent with this chapter and Title; and [1991, c. 885, Pt. C, §8 (NEW).]

B. Develop and file with the superintendent for review and approval a plan of operation and any amendments to a plan of operation necessary or suitable to ensure the fair, reasonable and equitable administration of the company. [1991, c. 885, Pt. C, §8 (NEW).]

[1991, c. 885, Pt. C, §8 (NEW) .]

SECTION HISTORY
1991, c. 885, §C8 (NEW).

§3709. PRESIDENT AND CHIEF EXECUTIVE OFFICER

1. **Appointment.** The board shall appoint a president who shall serve as chief executive officer and who is responsible for the operation of the company. The president must be qualified by education and experience to manage an organization with financial and operational obligations to its policyholders and claimants.

[1991, c. 885, Pt. C, §8 (NEW) .]

2. **Term.** The president serves at the will of the board.

[1991, c. 885, Pt. C, §8 (NEW) .]

3. **Compensation.** The president is entitled to compensation as established by the board and is subject to any reasonable requirements, including bonding, established by the board.

[1991, c. 885, Pt. C, §8 (NEW) .]

4. **Board member.** The president is a member of the board, but may not be the chair of the board.

[1991, c. 885, Pt. C, §8 (NEW) .]

5. **Duties.** The board, as part of its plan of operation, shall designate the powers and duties of the president. The president may, with direction from the board, assist in the development of the plan of operation and other start-up functions.

[1991, c. 885, Pt. C, §8 (NEW) .]

SECTION HISTORY
1991, c. 885, §C8 (NEW).

§3710. FUNDING; SURPLUS

1. **Initial funding.**

[1997, c. 661, §9 (RP) .]

2. **Ongoing funding.** The company:

A. [2001, c. 350, §4 (RP).]

B. May assess its policyholders for additional funds to meet operating needs or as required by law; and [1995, c. 551, §5 (AMD).]

C. May provide premium payment plans and premium financing programs. [2001, c. 350, §4 (AMD).]

[2001, c. 350, §4 (AMD) .]

3. **Transition surplus, premium levels.**

[2001, c. 350, §4 (RP) .]

SECTION HISTORY
1991, c. 885, §C8 (NEW). 1995, c. 551, §§5,6 (AMD). 1997, c. 661, §9 (AMD). 2001, c. 350, §4 (AMD).

§3711. OPERATION OF THE COMPANY

1. **Coverage availability.** On or after January 1, 1993, the company shall provide workers' compensation and incidental employers' liability coverage to employers otherwise entitled to coverage, but not able to or not electing to purchase coverage in the voluntary insurance market, and not authorized, either individually or as part of a group, to self-insure. An authorized self-insured is eligible for coverage upon termination of self-insurance.

[1991, c. 885, Pt. C, §8 (NEW) .]

2. **Federal coverage.** The board shall authorize the availability of federal workers' compensation coverage under the Longshore and Harbor Workers' Compensation Act, 33 United States Code, Section 901, et seq., the Defense Base Act, 42 United States Code, Section 1651, et seq., the Federal Employers Liability Act, 45 United States Code, Section 51, et seq., and any federal maritime or admiralty coverage. The board is authorized to make available Outer Continental Shelf Lands Act, 43 United States Code, Section 1331, et seq., coverage, Nonappropriated Fund Instrumentalities Employees' Retirement Credit Act of 1986, 5 United States Code, Section 8171, et seq., coverage, and any other coverages by special endorsements that may be required of an insured by contract or other needs.

[1991, c. 885, Pt. C, §8 (NEW) .]

3. **Coverage denial.** The company shall deny coverage to any employer who owes undisputed premiums to a previous workers' compensation carrier or to the workers' compensation residual market mechanism, or fails to comply with reasonable safety requirements the company is legally authorized to establish.

[1991, c. 885, Pt. C, §8 (NEW) .]

SECTION HISTORY
1991, c. 885, §C8 (NEW).

§3712. DIVISIONS

(REPEALED)

SECTION HISTORY
1991, c. 885, §C8 (NEW). RR 1993, c. 1, §65 (COR). 1995, c. 560, §G9 (AMD). 1997, c. 661, §10 (RP).

§3712-A. DIVISIONS

(REPEALED)

SECTION HISTORY
1997, c. 661, §11 (NEW). 2001, c. 350, §5 (RP).

§3713. AUTHORITY TO CONTRACT WITH LICENSED PRODUCERS

The company may contract with licensed producers to submit applications and otherwise assist applicants and insureds. [1997, c. 661, §12 (AMD).]

SECTION HISTORY
1991, c. 885, §C8 (NEW). 1997, c. 661, §12 (AMD).

§3714. ACCOUNTING; ASSESSMENTS

The following provisions apply to the financial operation of the company. [2001, c. 350, §6 (AMD).]

1. **Separate accounting.**

[2001, c. 350, §7 (RP) .]

2. **Rates.** Rates developed and filed by the company must be in accordance with chapter 25, subchapter II-B.

Rates filed within the rate-band are considered voluntary for purposes of chapter 25, subchapter II-B. If a rate is filed outside the rate band, the superintendent may disapprove the rate if it is excessive, inadequate or unfairly discriminatory, using the standards set forth in section 2382.

"Rate band" means the range of rates from 85% to 145% of the benchmark rate. For the purposes of this subsection, "benchmark rate" is the pure premium rate filing filed by the State's advisory organization as defined in section 2381-C and currently approved by the superintendent.

[1997, c. 661, §13 (AMD) .]

3. **Deficit.**

[2001, c. 350, §8 (RP) .]

4. **Surplus.** The surplus of the company is indivisible and is available for the benefit of all policyholders once certified by the superintendent.

[1991, c. 885, Pt. C, §8 (NEW) .]

5. **Assessment.** Any assessment levied against policyholders is for the exclusive benefit of the policyholders subject to the assessment. Any policyholder not paying an undisputed assessment is not eligible for coverage from the company or in the voluntary market.

[1997, c. 661, §13 (AMD) .]

6. **Deficits in the high-risk division.**

[2001, c. 350, §9 (RP) .]

7. **High-risk program.** The company shall maintain a high-risk program subject to the following provisions.

A. An employer must be placed in the high-risk program if the employer has at least 2 lost-time claims, each greater than $10,000 of incurred loss, and a loss ratio greater than 1.0 during the previous 3-year experience rating period. Notwithstanding paragraph C, an employer may also be placed in the high-risk program during the term of a policy for noncompliance with reasonable safety standards. [2001, c. 350, §10 (NEW).]

B. The board, with the approval of the superintendent, may modify the eligibility standards for the high-risk program if those standards limit those in the program to employers who have measurably adverse loss experience, have a relatively high claim frequency record or have demonstrated an attitude or practice of noncompliance with reasonable safety requirements or claims management standards. [2001, c. 350, §10 (NEW).]

C. Eligibility requirements must be applied annually at the policy renewal date or, if the necessary claim history is not available at that time, 30 days after notice to the insured. [2001, c. 350, §10 (NEW).]

D. Deductibles in the high-risk program are subject to this paragraph.

(1) A deductible applies to all coverage for policyholders in the high-risk program that meet the following qualifications:

(a) A net annual premium of $20,000 or more, subject to adjustment pursuant to this paragraph, in the State;

(b) A premium not subject to retrospective rating; and

(c) The policyholder's threshold loss ratio is 1.0 or greater.

The deductible is $1,000 a claim but applies only to wage loss benefits paid on injuries occurring during the year of coverage. The sum of all deductibles in one year of coverage may not exceed the lesser of 15% of net annual payment for coverage or $25,000. Each loss to which a deductible applies must be paid in full by the company. After the year of coverage has expired, the policyholder shall reimburse the company the amount of the deductibles. This reimbursement is considered as payment for coverage for purposes of cancellation or nonrenewal.

The board shall adjust annually the $20,000 payment-of-coverage level established in this subparagraph to reflect any change in rates for the high-risk program and any change in wage levels in the preceding calendar year. Changes in wage levels are determined by reference to changes in the state average weekly wage, as computed by the Department of Labor. Any adjustment is rounded off to the nearest $1,000 increment.

(2) The board may modify, with the approval of the superintendent, the mandatory deductible elements. Any modification or elimination of this rating feature must consider the incentive impact on an employer, the reasonableness of the retained cost relative to the claim history, safety record or claims management practices of affected employers and the ability of all employers to absorb these costs. [2001, c. 350, §10 (NEW).]

E. The board may file with the superintendent retrospective rating plans that, after hearing, may be imposed on an employer with a demonstrated record of repeated serious violations of workplace health and safety rules and regulations such as those adopted under Title 26, chapter 6 or 29 United States Code, Chapter 15, whichever is applicable. [2001, c. 350, §10 (NEW).]

F. The board shall develop and file with the superintendent and, if not disapproved by the superintendent, make available to policyholders on a voluntary basis retrospective rating plans. [2001, c. 350, §10 (NEW).]

G. Not more than 30 days after assignment to the high-risk program, a policyholder may appeal the assignment in writing to the bureau. [2001, c. 350, §10 (NEW).]

H. The board, with the approval of the superintendent, shall implement a plan for surcharges for policyholders in the high-risk program based on the policyholder's specific loss experience beyond the uniform experience rating plan approved by the superintendent. Any plan of surcharges must consider the actual claims experience of the employer and must provide for rate adjustments reasonably related to the employer's risk of loss. [2001, c. 350, §10 (NEW).]

[2001, c. 350, §10 (NEW) .]

SECTION HISTORY
1991, c. 885, §C8 (NEW). RR 1993, c. 1, §66 (COR). 1997, c. 661, §13 (AMD). 2001, c. 350, §§6-10 (AMD).

Chapter 53: RECIPROCAL INSURERS

§3851. "RECIPROCAL" INSURANCE DEFINED

"Reciprocal" insurance is that resulting from an interchange among persons, known as "subscribers," of reciprocal agreements of indemnity, the interchange being effectuated through an "attorney-in-fact" common to all such persons. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3852. SCOPE OF CHAPTER -- EXISTING INSURERS

1. All authorized reciprocal insurers shall be governed by those sections of this chapter not expressly made applicable to domestic reciprocals.

[1969, c. 132, §1 (NEW) .]

2. Existing authorized reciprocal insurers shall after January 1, 1970 comply with this chapter, and shall make such amendments to their subscribers' agreement, power of attorney, policies and other documents and accounts and perform such other acts as may be required for such compliance.

[1973, c. 625, §152 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 625, §152 (AMD).

§3853. INSURING POWERS OF RECIPROCALS

1. A reciprocal insurer may, upon qualifying therefore as provided for by this Title, transact any kind or kinds of insurance defined by this Title, other than life or title insurances.

[1969, c. 132, §1 (NEW) .]

2. Such an insurer may purchase reinsurance upon the risk of any subscriber, and may grant reinsurance as to any kind of insurance it is authorized to transact direct.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3854. NAME; SUITS

A reciprocal insurer shall: [1969, c. 132, §1 (NEW).]

1. Have and use a business name. The name shall include the word "reciprocal," or "interinsurer," or "interinsurance," or "exchange," or "underwriters," or "underwriting" or "association."

[1969, c. 132, §1 (NEW) .]

2. Sue and be sued in its own name.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3855. ATTORNEY

1. "Attorney", as used in this chapter, refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm or corporation.

[1969, c. 132, §1 (NEW) .]

2. The attorney of a foreign reciprocal insurer, which insurer is duly authorized to transact insurance in this State, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer's transactions in this State, be thereby deemed to be doing business in this State within the meaning of any laws of this State applying to foreign persons, firms or corporations.

[1969, c. 132, §1 (NEW) .]

3. The subscribers and the attorney-in-fact comprise a reciprocal insurer and a single entity for the purposes of chapter 7 as to all operations under the insurer's certificate of authority.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3856. ORGANIZATION OF RECIPROCAL INSURER

1. Twenty-five or more persons domiciled in this State may organize a domestic reciprocal insurer and make application to the superintendent for a certificate of authority to transact insurance.

[1973, c. 585, §12 (AMD) .]

2. The proposed attorney shall fulfill the requirements of and shall execute and file with the superintendent when applying for a certificate of authority, a declaration setting forth:

A. The name of the insurer; [1969, c. 132, §1 (NEW).]

B. The location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this State; [1969, c. 132, §1 (NEW).]

C. The kinds of insurance proposed to be transacted; [1969, c. 132, §1 (NEW).]

D. The names and addresses of the original subscribers; [1969, c. 132, §1 (NEW).]

E. The designation and appointment of the proposed attorney and a copy of the power of attorney; [1969, c. 132, §1 (NEW).]

F. The names and addresses of the officers and directors of the attorney, if a corporation, or its members if a firm; [1969, c. 132, §1 (NEW).]

G. The powers of the subscribers' advisory committee; and the names and terms of office of the members thereof; [1969, c. 132, §1 (NEW).]

H. That all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement; [1969, c. 132, §1 (NEW).]

I. A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than 6 months at an adequate rate theretofore filed with and approved by the superintendent; [1973, c. 625, §12 (AMD).]

J. A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by section 410 is on hand; and [1969, c. 132, §1 (NEW).]

K. A copy of each policy, endorsement and application form it then proposes to issue or use. [1969, c. 132, §1 (NEW).]

[1973, c. 585, §12 (AMD) .]

The declaration shall be acknowledged by the attorney in the manner required for the acknowledgment of deeds. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3857. CERTIFICATE OF AUTHORITY

1. The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

[1969, c. 132, §1 (NEW) .]

2. The superintendent may refuse to grant a certificate of authority, and may file a complaint with the District Court seeking suspension or revocation of a certificate of authority, for failure of the attorney to comply with any applicable provision of this Title, in addition to other grounds for those sanctions.

[1977, c. 694, §429 (RPR); 1999, c. 547, Pt. B, §78 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §429 (AMD). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF).

§3858. POWER OF ATTORNEY

1. The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

[1969, c. 132, §1 (NEW) .]

2. The power of attorney must set forth:

A. The powers of the attorney; [1969, c. 132, §1 (NEW).]

B. If a domestic reciprocal insurer, that the attorney is empowered to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged; [1969, c. 132, §1 (NEW).]

C. The general services to be performed by the attorney; [1969, c. 132, §1 (NEW).]

D. The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses, to be paid by the insurer; and [1969, c. 132, §1 (NEW).]

E. Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount which amount shall be not less than one nor more than 10 times the premium or premium deposit stated in the policy. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. The power of attorney may:

A. Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder; [1969, c. 132, §1 (NEW).]

B. Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers; [1969, c. 132, §1 (NEW).]

C. Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and [1969, c. 132, §1 (NEW).]

D. Contain other lawful provisions deemed advisable. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

4. The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective in this State until approved by the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3859. MODIFICATIONS

Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively, nor as to any insurance contract issued prior thereto. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3860. ATTORNEY'S BOND

1. Concurrently with the filing of the declaration provided for in section 3856, the attorney of a domestic reciprocal insurer shall file with the superintendent a bond in favor of this State for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his bond as set forth in subsection 2. The bond shall be executed by the attorney and by an authorized corporate surety, and shall be subject to the superintendent's approval.

[1973, c. 585, §12 (AMD) .]

2. The bond shall be in the penal sum of $25,000, aggregate in form, conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into his hands, and that he will not withdraw or appropriate to his own use from the funds of the insurer, any moneys or property to which he is not entitled under the power of attorney.

[1969, c. 132, §1 (NEW) .]

3. The bond shall provide that it is not subject to cancellation unless 30 days' advance notice in writing of cancellation is given both the attorney and the superintendent.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3861. DEPOSIT IN LIEU OF BOND

In lieu of the bond required under section 3860, the attorney may maintain on deposit with the Treasurer of State through the office of the superintendent, a like amount in cash or in value of securities qualified under this Title as insurers' investments, and subject to the same conditions as the bond. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3862. ACTION ON BOND

Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by one or more subscribers suffering loss through a violation of its conditions, or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of such bond. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3863. SERVICE OF PROCESS; JUDGMENT

1. Legal process must be served upon a domestic reciprocal insurer by serving the insurer's attorney at that attorney's principal offices.

[1997, c. 457, §47 (AMD) .]

2. Any judgment based upon legal process so served shall be binding upon each of the insurer's subscribers as their respective interests may appear, but in an amount not exceeding their respective contingent liabilities, if any, the same as though personal service of process was had upon each such subscriber.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §47 (AMD).

§3864. CONTRIBUTIONS TO INSURER

The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms such funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer, and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No such withdrawal or repayment shall be made without the advance approval of the superintendent. This section does not apply to bank loans, or to other loans made upon security. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3865. FINANCIAL CONDITIONS; METHOD OF DETERMINING

In determining the financial condition of a reciprocal insurer the superintendent shall apply the following rules: [1973, c. 585, §12 (AMD).]

1. He shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis.

[1969, c. 132, §1 (NEW) .]

2. The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits delinquent for 90 days shall first be charged against such surplus deposit.

[1969, c. 132, §1 (NEW) .]

3. The surplus deposits of subscribers shall not be charged as a liability.

[1969, c. 132, §1 (NEW) .]

4. All premium deposits delinquent less than 90 days shall be allowed as assets.

[1969, c. 132, §1 (NEW) .]

5. An assessment levied upon subscribers, and not collected, shall not be allowed as an asset.

[1969, c. 132, §1 (NEW) .]

6. The contingent liability of subscribers shall not be allowed as an asset.

[1969, c. 132, §1 (NEW) .]

7. The computation of reserves shall be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of the attorney.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3866. WHO MAY BE SUBSCRIBERS

Individuals, partnerships and corporations of this State may make application, enter into agreement for and hold policies or contracts in or with and be a subscriber of any domestic, foreign or alien reciprocal insurer. Any corporation now or hereafter organized under the laws of this State shall, in addition to the

rights, powers, and franchises specified in its articles of incorporation, have full power and authority as a subscriber to exchange insurance contracts through such reciprocal insurer. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized and to be as fully granted as the rights and powers expressly conferred upon such corporations. Government or governmental agencies, state or political subdivisions thereof, boards, associations, estates, trustees or fiduciaries are authorized to exchange nonassessable reciprocal interinsurance contracts with each other and with individuals, partnerships and corporations to the same extent that individuals, partnerships and corporations are herein authorized to exchange reciprocal interinsurance contracts. Any officer, representative, trustee, receiver or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon such contract by reason of acting in such representative capacity. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3867. SUBSCRIBERS' ADVISORY COMMITTEE

1. The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

[1969, c. 132, §1 (NEW) .]

2. Not less than 2/3 of such committee shall be subscribers other than the attorney, or any person employed by, representing, or having a financial interest in the attorney.

[1969, c. 132, §1 (NEW) .]

3. The committee shall:

A. Supervise the finances of the insurer; [1969, c. 132, §1 (NEW).]

B. Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney; [1969, c. 132, §1 (NEW).]

C. Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and [1969, c. 132, §1 (NEW).]

D. Have such additional powers and functions as may be conferred by the subscribers' agreement. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3868. SUBSCRIBERS' LIABILITY

1. The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer shall be an individual, several and proportionate liability, and not joint.

[1969, c. 132, §1 (NEW) .]

2. Except as to a nonassessable policy, each subscriber shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his policy was in force. Such contingent liability may be at the rate of not less than one nor more than 10 times the premium or premium deposit stated in the policy, and the maximum aggregate thereof shall be computed in the manner set forth in section 3872.

[1969, c. 132, §1 (NEW) .]

3. Each assessable policy issued by the insurer shall contain a statement of the contingent liability, set in type of the same prominence as the insuring clause.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3869. SUBSCRIBERS' LIABILITY ON JUDGMENT

1. No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for 30 days.

[1969, c. 132, §1 (NEW) .]

2. Any such judgment shall be binding upon each subscriber only in such proportion as his interests may appear and in amount not exceeding his contingent liability, if any.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3870. ASSESSMENTS

1. Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer liable therefor under the terms of their policies by the attorney upon approval in advance by the subscribers' advisory committee and the superintendent; or by the superintendent in liquidation of the insurer.

[1973, c. 585, §12 (AMD) .]

2. Each subscriber's share of a deficiency for which an assessment is made, but not exceeding in any event his aggregate contingent liability as computed in accordance with section 3872, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during such period upon all policies subject to the assessment.

[1969, c. 132, §1 (NEW) .]

3. In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

[1969, c. 132, §1 (NEW) .]

4. No subscriber shall have an offset against any assessment for which he is liable, on account of any claim for unearned premium or losses payable.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3871. TIME LIMIT FOR ASSESSMENTS

Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for, and shall pay his share of any assessment, as computed and limited in accordance with this chapter, if: [1969, c. 132, §1 (NEW).]

1. While his policy is in force or within one year after its termination, he is notified by either the attorney or the superintendent of his intentions to levy such assessment, or

[1973, c. 585, §12 (AMD) .]

2. If an order to show cause why a receiver, conservator, rehabilitator or liquidator of the insurer should not be appointed is issued while his policy is in force or within one year after its termination.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3872. AGGREGATE LIABILITY

No one policy or subscriber as to such policy shall be assessed or charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year, in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon premium earned on such policy during that year. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§3873. NONASSESSABLE POLICIES

1. If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee the superintendent shall issue his certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this State, and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this State for so long as all such surplus remains unimpaired.

[1973, c. 585, §12 (AMD) .]

2. Upon impairment of such surplus, the superintendent shall forthwith revoke the certificate. Such revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid; but after such revocation no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

[1973, c. 585, §12 (AMD) .]

3. The superintendent shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualified to and does extinguish such liability of all its subscribers and in all such policies for all kinds of insurance transacted by it. Except, that if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire such policies in such state, and need not extinguish the contingent liability applicable to policies theretofore in force in such state.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3874. SUBSCRIBERS' SHARE IN ASSETS

Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus, and the return of any unused premium, savings or credits then standing on subscribers' accounts, shall be distributed to its subscribers who were such within the 12 months prior to the last termination of its certificate of authority, according to such reasonable formula as the superintendent may approve. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3875. MERGER OR CONVERSION

1. A domestic reciprocal insurer upon affirmative vote of not less than 2/3 of its subscribers who vote on such merger pursuant to due notice and the approval of the superintendent of the terms therefor, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

[1973, c. 585, §12 (AMD) .]

2. Such a stock or mutual insurer shall be subject to the same capital or surplus requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

[1969, c. 132, §1 (NEW) .]

3. The superintendent shall not approve any plan for such merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to his interest in the reciprocal insurer as determined in accordance with section 3874 and a reasonable length of time within which to exercise such right.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§3876. IMPAIRED RECIPROCALS

1. If the assets of a domestic reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall forthwith make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency; but subject to the limitation set forth in the power of attorney or policy.

[1969, c. 132, §1 (NEW) .]

2. If the attorney fails to make up such deficiency or to make the assessment within 30 days after the superintendent orders him to do so or if the deficiency is not fully made up within 60 days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this Title.

[1973, c. 585, §12 (AMD) .]

3. If liquidation of such an insurer is ordered, an assessment shall be levied upon the subscribers for such an amount, subject to limits as provided by this chapter, as the superintendent determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons, but including the reasonable cost of the liquidation.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

Chapter 54: MAINE INDIVIDUAL REINSURANCE ASSOCIATION

§3901. SHORT TITLE

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3902. DEFINITIONS

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3903. MAINE INDIVIDUAL REINSURANCE ASSOCIATION

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3904. LIABILITY AND INDEMNIFICATION

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3905. DUTIES AND POWERS OF THE ASSOCIATION

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3906. SELECTION OF PLAN ADMINISTRATOR

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3907. REINSURANCE ASSOCIATION RESERVE

(REPEALED)

SECTION HISTORY

2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3908. REINSURANCE

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

§3909. ACTIONS AGAINST ASSOCIATION OR MEMBERS BASED UPON JOINT OR COLLECTIVE ACTIONS

(REPEALED)

SECTION HISTORY
2007, c. 629, Pt. A, §8 (NEW). 2011, c. 90, Pt. B, §10 (AFF). 2011, c. 90, Pt. B, §7 (RP).

Chapter 54-A: MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION ACT

§3951. SHORT TITLE

This chapter may be known and cited as "the Maine Guaranteed Access Reinsurance Association Act." [2011, c. 90, Pt. B, §8 (NEW).]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW).

§3952. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2011, c. 90, Pt. B, §8 (NEW).]

1. **Association.** "Association" means the Maine Guaranteed Access Reinsurance Association under section 3953.

[2011, c. 90, Pt. B, §8 (NEW) .]

2. **Board.** "Board" means the Board of Directors of the Maine Guaranteed Access Reinsurance Association under section 3953, subsection 2.

[2011, c. 90, Pt. B, §8 (NEW) .]

3. **Covered person.** "Covered person" means an individual covered as a policyholder, participant or dependent under a plan, policy or contract of medical insurance.

[2011, c. 90, Pt. B, §8 (NEW) .]

4. **Dependent.** "Dependent" means a spouse, a domestic partner as defined in section 2832-A, subsection 1 or a child under 26 years of age.

[2011, c. 90, Pt. B, §8 (NEW) .]

5. **Health maintenance organization.** "Health maintenance organization" means an organization authorized under chapter 56 to operate a health maintenance organization in this State.

[2011, c. 90, Pt. B, §8 (NEW) .]

6. **Insurer.** "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. For the purposes of this chapter, "insurer" includes an insurance company, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insured employer subject to state regulation as described in section 2848-A, a 3rd-party administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in this State, a captive insurance company established pursuant to chapter 83 that insures the health coverage risks of its members, the Dirigo Health Program established in chapter 87 or any other state-sponsored health benefit program whether fully insured or self-funded.

[2011, c. 90, Pt. B, §8 (NEW) .]

7. **Medical insurance.** "Medical insurance" means a hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

[2011, c. 90, Pt. B, §8 (NEW) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

9. **Member insurer.** "Member insurer" means an insurer that offers individual health plans and is actively marketing individual health plans in this State.

[2011, c. 90, Pt. B, §8 (NEW) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

11. **Reinsurer.** "Reinsurer" means an insurer from whom a person providing health insurance for a resident procures insurance for itself with the insurer with respect to all or part of the medical insurance risk of the person. "Reinsurer" includes an insurer that provides employee benefits excess insurance.

[2011, c. 90, Pt. B, §8 (NEW) .]

12. **Resident.** "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2.

[2011, c. 90, Pt. B, §8 (NEW) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW).

§3953. MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION

1. **Guaranteed access reinsurance mechanism established.** The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business in the State, an insurer that has issued or administered medical insurance within the previous 12 months or is actively marketing a medical insurance policy or medical insurance administrative services in this State must participate in the association. The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association. Except as provided in section 3962, operations of the association are suspended and the association may not collect assessments as provided in section 3957, provide reinsurance for member insurers under section 3958 or provide reimbursement for

member insurers under section 3961 as of the date on which a transitional reinsurance program established under the authority of Section 1341 of the federal Affordable Care Act commences operations in this State through the date the federal program ceases operations in this State.

[2013, c. 273, §1 (AMD) .]

2. **Board of directors.** The association is governed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association established under Title 5, section 12004-G, subsection 14-H.

A. The board consists of 12 members appointed as described in this paragraph:

(1) Seven members appointed by the superintendent: 2 members chosen from the general public and who are not associated with the medical profession, a hospital , an insurer or a producer; 2 members who represent medical providers; one member who represents individual health insurance consumers who is not associated or formerly associated with the medical profession, a hospital, an insurer or a producer; one member who represents a statewide organization that represents small businesses; and one member who represents producers. A board member appointed by the superintendent may not be removed without cause; and

(2) Five members appointed by the member insurers, at least one of whom is a domestic insurer and at least one of whom is a 3rd-party administrator. [2013, c. 273, §2 (AMD).]

B. Members of the board serve for 3-year terms. Members of the board may serve up to 3 consecutive terms. [2011, c. 90, Pt. B, §8 (NEW).]

C. The board shall elect one of its members as chair. [2011, c. 90, Pt. B, §8 (NEW).]

D. Board members may be reimbursed from funds of the association for actual and necessary expenses incurred by them as members but may not otherwise be compensated for their services. [2011, c. 90, Pt. B, §8 (NEW).]

E. The board shall establish regular places and times for meetings and may meet at other times at the call of the chair. The board shall post notice of scheduled meetings, meeting agendas and minutes of meetings on a publicly accessible website maintained by the association. [2013, c. 273, §3 (NEW).]

F. The board shall establish a mechanism on its publicly accessible website for the public to submit comments on matters related to the operations of the association. [2013, c. 273, §3 (NEW).]

G. The board shall establish a process for taking public comment at selected board meetings to be held at such time and place as the board may determine. The opportunity for public comment must be made available not less often than quarterly. Except as specified in this paragraph, meetings of the board are not open to the public. [2013, c. 273, §3 (NEW).]

[2013, c. 273, §§2, 3 (AMD) .]

3. **Plan of operation; rules.** The board shall adopt a plan of operation in accordance with the requirements of this chapter and submit its articles, bylaws and operating rules to the superintendent for approval. If the board fails to adopt the plan of operation and suitable articles and bylaws within 90 days after the appointment of the board, the superintendent shall adopt rules to effectuate the requirements of this chapter and those rules remain in effect until superseded by a plan of operation and articles and bylaws submitted by the board and approved by the superintendent. Rules adopted by the superintendent pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 90, Pt. B, §8 (NEW) .]

4. **Immunity.** A board member is not liable and is immune from suit at law or equity for any conduct performed in good faith that is within the scope of the board's jurisdiction.

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW). 2013, c. 273, §§1-3 (AMD).

§3954. LIABILITY AND INDEMNIFICATION

1. **Liability.** The board and its employees may not be held liable for any obligations of the association. A cause of action may not arise against the association; the board, its agents or its employees; a member insurer or its agents, employees or producers; or the superintendent for any action or omission in the performance of powers and duties pursuant to this chapter.

[2011, c. 90, Pt. B, §8 (NEW) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW).

§3955. DUTIES AND POWERS OF ASSOCIATION

1. **Duties.** The association shall:

A. Establish administrative and accounting procedures for the operation of the association; [2011, c. 90, Pt. B, §8 (NEW).]

B. Select an association administrator in accordance with section 3956; [2011, c. 90, Pt. B, §8 (NEW).]

C. Collect the assessments provided in section 3957. The level of payments must be established by the board. Assessments must be collected pursuant to the plan of operation approved by the board and adopted pursuant to section 3953, subsection 3. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred before receipt of the first calendar year assessments; [2011, c. 90, Pt. B, §8 (NEW).]

D. Establish procedures for the handling and accounting of association assets; [2011, c. 90, Pt. B, §8 (NEW).]

E. Develop a health statement to be used in evaluating a person for designation for reinsurance pursuant to section 3959. Protected health information included in a health statement submitted to the association that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or covered by chapter 24 remains confidential and is not open to public inspection; and [2011, c. 621, §2 (AMD).]

F. Provide for reinsurance for member insurers pursuant to section 3958. [2011, c. 90, Pt. B, §8 (NEW).]

[2011, c. 621, §2 (AMD) .]

2. **Powers.** The association may:

A. Exercise powers granted to nonprofit corporations under the laws of this State; [2011, c. 90, Pt. B, §8 (NEW).]

B. Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter and may, with the approval of the superintendent, enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions; [2011, c. 90, Pt. B, §8 (NEW).]

C. Sue or be sued and may take legal actions necessary or proper to recover or collect assessments provided in section 3957 due the association; [2011, c. 90, Pt. B, §8 (NEW).]

D. Take legal actions necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association, to recover any amounts erroneously or improperly paid by the association, to recover amounts paid by the association as a result of mistake of fact or law or to recover other amounts due the association; [2011, c. 90, Pt. B, §8 (NEW).]

E. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance and any other function within the authority of the association; [2011, c. 90, Pt. B, §8 (NEW).]

F. Borrow money to effect the purposes of the association. Notes or other evidence of indebtedness of the association not in default must be legal investments for insurers and may be carried as admitted assets; [2011, c. 90, Pt. B, §8 (NEW).]

G. Provide for reinsurance of risks incurred by members of the association and purchase reinsurance retroceding those risks to the extent the board determines appropriate. The provision of reinsurance may not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers; and [2011, c. 90, Pt. B, §8 (NEW).]

H. Apply for funds or grants from public or private sources, including federal grants. [2011, c. 90, Pt. B, §8 (NEW).]

[2011, c. 90, Pt. B, §8 (NEW) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

4. **Review for solvency.** An annual review of the association for solvency must be performed by an independent certified public accountant using generally accepted accounting principles. The association shall submit the annual review to the superintendent. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to increase its assessments. If the superintendent determines that the funds of the association are insufficient, the superintendent may order the association to charge additional assessments.

[2011, c. 90, Pt. B, §8 (NEW) .]

5. **Annual report.** The association shall report annually to the joint standing committee of the Legislature having jurisdiction over health insurance matters by March 15th. The report must include information on the financial solvency of the association and the administrative expenses of the association.

[2011, c. 90, Pt. B, §8 (NEW) .]

6. **Audit.** The association must be audited at least annually by an independent certified public auditor. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW). 2011, c. 621, §2 (AMD).

§3956. SELECTION OF ADMINISTRATOR

1. **Selection of administrator.** The board shall select an insurer or 3rd-party administrator through a competitive bidding process to administer the reinsurance provided by the association.

[2011, c. 90, Pt. B, §8 (NEW) .]

2. **Contract with administrator.** The administrator selected pursuant to subsection 1 serves for a period of 3 years pursuant to a contract with the association. At least one year prior to the expiration of that 3-year period of service, the board shall invite all insurers, including the current administrator, to submit bids to serve as the administrator for the succeeding 3-year period. The board shall select the administrator for the succeeding period at least 6 months prior to the ending of the 3-year period.

[2011, c. 90, Pt. B, §8 (NEW) .]

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

A. Perform all administrative functions relating to the association; [2011, c. 90, Pt. B, §8 (NEW).]

B. Submit regular reports to the board regarding the operation of the association. The frequency, content and form of the reports must be as determined by the board; [2011, c. 90, Pt. B, §8 (NEW).]

C. Following the close of each calendar year, determine reinsurance premiums less any administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association and the incurred losses of the year, and report this information to the superintendent; and [2011, c. 90, Pt. B, §8 (NEW).]

D. Pay reinsurance amounts as provided for in the plan of operation under section 3953, subsection 3. [2011, c. 90, Pt. B, §8 (NEW).]

[2011, c. 90, Pt. B, §8 (NEW) .]

4. **Payment to administrator.** The administrator selected pursuant to subsection 1 must be paid, as provided in the contract of the association under subsection 2, for its direct and indirect expenses incurred in the performance of its services. As used in this subsection, "direct and indirect expenses" includes that portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the administrator that are approved by the board as allocable to the administration of the association and included in the bid specifications pursuant to subsection 1.

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW).

§3957. ASSESSMENTS AGAINST INSURERS

1. **Assessments.** For the purpose of providing the funds necessary to carry out the powers and duties of the association under section 3955, the board shall assess insurers at such a time and for such amounts as the board finds necessary. Assessments are due not less than 30 days after written notice to the insurers and accrue interest at 12% per annum on and after the due date.

[2011, c. 90, Pt. B, §8 (NEW) .]

2. **Maximum assessment.** The board shall assess each insurer an amount not to exceed $4 per month per covered person enrolled in medical insurance insured, reinsured or administered by the insurer. An insurer may not be assessed on policies or contracts insuring federal or state employees except for policies or contracts insuring Legislators and their dependents. For policies or contracts insuring Legislators and their dependents, Legislators shall pay the amount of the assessment to the insurer.

[2011, c. 452, §1 (AMD) .]

3. **Determination of assessment.** The board shall make reasonable efforts to ensure that each covered person is counted only once with respect to an assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all persons whose coverage is insured, in whole or in part, through excess or stop loss coverage. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this subsection. The board may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is not reported.

[2011, c. 90, Pt. B, §8 (NEW) .]

4. **Organizational assessments.** The board may assess insurers for the purpose of organizing the association. Organizational assessments must be equal in amount for all insurers but may not exceed $500 per insurer for all such assessments.

[2011, c. 90, Pt. B, §8 (NEW) .]

5. **Assessments to cover net losses.** In addition to the assessment described in subsections 1 to 3, the board shall assess insurers at such a time and for such amounts as the board finds necessary to cover any net loss in an amount not to exceed $2 per month per covered person enrolled in medical insurance insured, reinsured or administered by the insurer in accordance with this subsection.

A. Before April 1st of each year, the association shall determine and report to the superintendent the association's net losses for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses and an estimate of the assessments needed to cover the losses incurred by the association in the previous calendar year. [2011, c. 90, Pt. B, §8 (NEW).]

B. [2011, c. 621, §3 (RP).]

C. The association shall impose a penalty of interest on insurers for late payment of assessments. [2011, c. 90, Pt. B, §8 (NEW).]

D. An insurer may not be assessed on policies or contracts insuring federal or state employees, except for policies or contracts insuring Legislators and their dependents. Any assessment required under this subsection on policies or contracts insuring Legislators and their dependents must be paid as provided in subsection 2. [2011, c. 452, §2 (NEW).]

[2011, c. 621, §3 (AMD) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

7. **Excess funds.** If assessments and other receipts by the association, board or administrator selected pursuant to section 3956 exceed the actual losses and administrative expenses of the association, the board shall hold the excess as interest and shall use those excess funds to offset future losses or to reduce reinsurance premiums. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

[2011, c. 90, Pt. B, §8 (NEW) .]

8. **Failure to pay assessment.** The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the superintendent may levy a penalty on any insurer that fails to pay an assessment when due. In addition, the superintendent may use any power granted to the superintendent by this Title to collect any unpaid assessment.

[2011, c. 90, Pt. B, §8 (NEW) .]

9. **Federal funding; reduction of assessment.** The board shall work collaboratively with the Dirigo Health Program established pursuant to chapter 87 to develop a proposal to access unused funds from the State's allocation from the federal preexisting condition insurance plan established pursuant to the federal Affordable Care Act to be used to fund, in part, the operations of the association. Any federal funding obtained by the association must be used to reduce the assessment of member insurers required under this section. In developing the proposal, funds necessary for the federal preexisting condition insurance plan as currently administered by Dirigo Health have priority over any funds transferred to the association.

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW). 2011, c. 452, §§1, 2 (AMD). 2011, c. 621, §3 (AMD).

§3958. REINSURANCE; PREMIUM RATES

1. **Reinsurance amount.** A member insurer offering an individual health plan must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for the reinsurance premium rate established in accordance with subsection 2.

A. Beginning July 1, 2012, the association shall reimburse a member insurer for claims incurred with respect to a person designated for reinsurance by the member insurer pursuant to section 3959 or 3961 after the insurer has incurred an initial level of claims for that person of $7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The amount of reimbursement is 90% of the amount incurred between $7,500 and $32,500 and 100% of the amount incurred in excess of $32,500 for claims incurred in that calendar year with respect to that person. For calendar year 2012, only claims incurred on or after July 1st are considered in determining the member insurer's reimbursement. The association may annually adjust the initial level of claims and the maximum limit to be retained by the insurer to reflect increases in costs and utilization within the standard market for individual health plans within the State. The adjustments may not be less than the annual change in the Consumer Price Index for medical care services unless the superintendent approves a lower adjustment factor as requested by the association. [2011, c. 621, §4 (AMD).]

B. An insurer shall apply all managed care, utilization review, case management, preferred provider arrangements, claims processing and other methods of operation without regard to whether claims paid for coverage are reinsured under this subsection. [2011, c. 90, Pt. B, §8 (NEW).]

[2011, c. 621, §4 (AMD) .]

2. **Premium rates.** The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C, together with any additional rating factors the association determines to be appropriate. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that, together with other funds available to the association, will be sufficient to meet the anticipated costs of the association. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer.

[2011, c. 621, §5 (AMD) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW). 2011, c. 621, §§4, 5 (AMD).

§3959. DESIGNATION FOR REINSURANCE

1. **Designation.** The association shall provide reinsurance to a member insurer for a person designated for reinsurance by a member insurer, if the designation was made:

A. By using the health statement developed by the board pursuant to section 3955, subsection 1, paragraph E or by using the person's claims history or risk scores or any other reasonable means; [2011, c. 621, §6 (NEW).]

B. As a mandatory designation pursuant to subsection 2 on the basis of the existence or history of any medical or health condition on the list developed by the board pursuant to subsection 2; or [2011, c. 621, §6 (NEW).]

C. On the basis of an omission of material information from the health statement developed by the board pursuant to section 3955, subsection 1, paragraph E or misrepresentation of the person's health status on the health statement. [2011, c. 621, §6 (NEW).]

[2011, c. 621, §6 (AMD) .]

2. **Mandatory designation.** The board shall develop a list of medical or health conditions for which a person must be designated for reinsurance by a member insurer. If a person's health statement, claims history or risk scores demonstrate the existence or history of any medical or health conditions on the list developed by the board at the time the plan is issued or when the person is added to the plan, the member insurer shall designate the person for reinsurance. The board may amend the list from time to time as appropriate.

[2011, c. 621, §6 (AMD) .]

3. **Enrolling additional persons.** A member insurer may designate a person for reinsurance pursuant to this section when the person is added to an individual health plan.

[2011, c. 621, §6 (NEW) .]

4. **Designation effective date and premium.** The designation of a person for reinsurance is effective as of the effective date of the primary coverage provided by the member insurer, except that the earliest effective date for any reinsurance is July 1, 2012. A member insurer's premium for reinsurance begins to accrue as of the effective date of the designation.

[2011, c. 621, §6 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW). 2011, c. 621, §6 (AMD).

§3960. ACTIONS AGAINST ASSOCIATION OR INSURERS BASED UPON JOINT OR COLLECTIVE ACTIONS

Participation in the association, the establishment of reinsurance rates, forms or procedures or any other joint or collective action required by this chapter may not be the basis of any legal action or criminal or civil liability or penalty against the association or an insurer. [2011, c. 90, Pt. B, §8 (NEW).]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW).

§3961. REIMBURSEMENT OF MEMBER INSURER

1. **Reimbursement.** A member insurer may seek reimbursement from the association and the association shall reimburse the member insurer with respect to a person insured through a member insurer's closed book of business to the extent claims made by a covered person are eligible for reimbursement pursuant to section 3958, subsection 1, paragraph A, if:

A. The covered person is insured under a policy sold on or after December 1, 1993 and in force as of July 1, 2012, and the member insurer has closed its book of business for individual health plans sold between December 1, 1993 and July 1, 2012; [2011, c. 621, §7 (AMD).]

B. The member insurer is able to determine through the use of individual health statements, claims history, risk scores or any reasonable means that the covered person currently qualifies for designation by the member insurer pursuant to section 3959, subsection 1; and [2011, c. 621, §7 (AMD).]

C. The member insurer seeks to designate the covered person for reimbursement from the association by October 1, 2012. [2011, c. 621, §7 (NEW).]

This subsection applies only to the individual health plans described and is not intended to limit the ability of a member insurer to designate a covered person for reinsurance pursuant to section 3959.

[2011, c. 621, §7 (AMD) .]

1-A. **Premium.** A member insurer seeking reimbursement under subsection 1 is liable to the association for reinsurance premium rates determined in accordance with section 3958, subsection 2.

[2011, c. 621, §8 (NEW) .]

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

[2011, c. 90, Pt. B, §8 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. B, §8 (NEW). 2011, c. 621, §§7, 8 (AMD).

§3962. ACTIVITIES AUTHORIZED DURING SUSPENSION PERIOD

This section governs the suspension of operations of the association during the period in which the transitional reinsurance program pursuant to Section 1341 of the federal Affordable Care Act operates in this State and the authority of the association to conduct certain activities. [2013, c. 273, §4 (NEW).]

1. **Payment of claims.** The association shall pay claims eligible under sections 3958 and 3961 that were incurred prior to the commencement of the suspension of the association pursuant to section 3953, subsection 1.

[2013, c. 273, §4 (NEW) .]

2. **Additional assessment for net losses.** The association may impose any additional assessment necessary to fund net losses of the association pursuant to section 3957, subsection 5.

[2013, c. 273, §4 (NEW) .]

3. **Amended plan of operation.** Within 6 months following the implementation of the federal transitional reinsurance program in this State, the association shall submit an amended plan of operation as provided in section 3953, subsection 3 to the superintendent for approval. In amending the plan of operation, the association shall, at a minimum, include a plan for the application of any funds held by the association as of its suspension, the investment of any funds held by the association during its period of suspension, the reactivation of the association upon termination of the federal transitional reinsurance program and, if necessary, the distribution of any surplus funds not required for such purposes. Prior to approving an amended plan of operation submitted under this subsection, the superintendent shall post the amended plan of operation on the bureau's publicly accessible website and establish a comment period of at least 30 days during which the public may submit for consideration written and electronic comments on the amended plan of operation. At the time of approval of any amended plan of operation, the superintendent shall adopt a written statement addressing specific comments and concerns expressed about the amended plan of operation and state the superintendent's rationale for adopting or not adopting any changes to the amended plan of operation or making findings and recommendations that differ from those expressed about the amended plan of operation.

[2013, c. 273, §4 (NEW) .]

4. **Exception.** This section does not apply if federal law or regulation exempts the State from participation in the transitional reinsurance program pursuant to Section 1341 of the federal Affordable Care Act.

[2013, c. 273, §4 (NEW) .]

SECTION HISTORY

2013, c. 273, §4 (NEW).

Chapter 55: FRATERNAL BENEFIT SOCIETIES

§4101. FRATERNAL BENEFIT SOCIETIES DEFINED

1. Any incorporated society, order or supreme lodge, without capital stock, including one exempted under section 4142, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which makes provision for the payment of benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

[1969, c. 132, §1 (NEW) .]

2. When used in this chapter the word "society," unless otherwise indicated, shall mean fraternal benefit society.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4102. LODGE SYSTEM DEFINED

A society having a supreme legislative or governing body and subordinate lodges or branches by whatever name known, into which members are elected, initiated or admitted in accordance with its constitution, laws, ritual and rules, which subordinate lodges or branches shall be required by the laws of the society to hold regular meetings at least once in each month, shall be deemed to be operating on the lodge system. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4103. REPRESENTATIVE FORM OF GOVERNMENT DEFINED

A society shall be deemed to have a representative form of government when: [1969, c. 132, §1 (NEW).]

1. It provides in its constitution or laws for a supreme legislative or governing body, composed of representatives elected either by the members or by delegates elected directly or indirectly by the members, together with such other members of such body as may be prescribed by the society's constitution and laws;

[1969, c. 132, §1 (NEW) .]

2. The representatives elected constitute a majority in number and have not less than 2/3 of the votes nor less than the votes required to amend its constitution and laws;

[1969, c. 132, §1 (NEW) .]

3. The meetings of the supreme legislative or governing body and the election of officers, representatives or delegates are held as often as once in 4 calendar years;

[1969, c. 132, §1 (NEW) .]

4. The society has a board of directors charged with the responsibility for managing its affairs in the interim between meetings of its supreme legislative or governing body, subject to control by such body and having powers and duties delegated to it in the constitution or laws of the society;

[1969, c. 132, §1 (NEW) .]

5. Such board of directors is elected by the supreme legislative or governing body, except in case of filling a vacancy in the interim between meetings of such body;

[1969, c. 132, §1 (NEW) .]

6. The officers are elected either by the supreme legislative governing body or by the board of directors; and

[1969, c. 132, §1 (NEW) .]

7. The members, officers, representatives or delegates shall not vote by proxy.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4104. ORGANIZATION

The organization of a society shall be governed as follows. [1969, c. 132, §1 (NEW).]

1. Seven or more citizens of the United States, a majority of whom are citizens of this State, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

A. The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing; [1969, c. 132, §1 (NEW).]

B. The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter, provided that any lawful, social, intellectual, educational, charitable, benevolent, moral, fraternal or religious advantages may be set forth among the purposes of the society; and [1969, c. 132, §1 (NEW).]

C. The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme legislative or governing body, which election shall be held not later than one year from the date of the issuance of the permanent certificate. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. Such articles of incorporation, duly certified copies of the constitution, laws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the superintendent, who may require such further information as he deems necessary. The bond with sureties approved by the superintendent shall be in such amount, not less than $5,000 nor more than $25,000, as required by the superintendent. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of law

have been complied with, the superintendent shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate authorizing the society to solicit members as hereinafter provided.

[1973, c. 585, §12 (AMD) .]

3. No preliminary certificate granted under this section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the superintendent upon cause shown, unless the 500 applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

[1973, c. 585, §12 (AMD) .]

4. Upon receipt of a preliminary certificate from the superintendent, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates as provided by its constitution and laws, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow or offer or promise to pay or allow, any death or disability benefit to any person until:

A. Actual bona fide applications for death benefits have been secured aggregating at least $500,000 on not less than 500 lives; [1969, c. 132, §1 (NEW).]

B. All such applicants for death benefits shall have furnished evidence of insurability satisfactory to the society; [1969, c. 132, §1 (NEW).]

C. Certificates of examinations or acceptable declarations of insurability have been duly filed and approved by the chief medical examiner of the society; [1969, c. 132, §1 (NEW).]

D. Ten subordinate lodges or branches have been established into which the 500 applicants have been admitted; [1969, c. 132, §1 (NEW).]

E. There has been submitted to the superintendent, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate branch of which each applicant is a member, amount of benefits to be granted and premiums therefor; and [1973, c. 585, §12 (AMD).]

F. It shall have been shown to the superintendent by sworn statement of the treasurer, or corresponding officer of such society, that at least 500 applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least $2,500, all of which shall be credited to the fund or funds from which benefits are to be paid and no part of which may be used for expenses. The advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, as herein provided, such premiums shall be returned to the applicants. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

5. The superintendent may make such examination and require such further information as he deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, he shall issue to the society a certificate to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate shall be prima facie evidence of the

existence of the society at the date of such certificate. The superintendent shall cause a record of such certificate to be made. A certified copy of such record may be given in evidence with like effect as the original certificate.

[1973, c. 585, §12 (AMD) .]

6. Every society shall have the power to adopt a constitution and laws for the government of the society, the admission of its members, the management of its affairs and the fixing and readjusting of the rates of its members from time to time. It shall have the power to change, alter, add to or amend such constitution and laws and shall have such powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4105. CORPORATE POWERS RETAINED

Any incorporated society authorized to transact business in this State at the time this chapter becomes effective may thereafter exercise all the rights, powers and privileges prescribed in this chapter and in its charter or articles of incorporation as far as consistent with this chapter. A domestic society shall not be required to reincorporate. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4106. VOLUNTARY ASSOCIATIONS

No unincorporated or voluntary association shall be permitted to transact business in this State as a fraternal benefit society. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4107. LOCATION OF OFFICE -- PLACE OF MEETING

The principal office of any domestic society shall be located in this State. The meetings of its supreme legislative or governing body may be held in any state, district, province or territory wherein such society has at least 5 subordinate branches and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this State. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4108. CONSOLIDATIONS AND MERGERS

A domestic society may consolidate or merge with any other society by complying with the provisions of this section. [1969, c. 132, §1 (NEW).]

It shall file with the superintendent: [1973, c. 585, §12 (AMD).]

1. A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

[1969, c. 132, §1 (NEW) .]

2. A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the superintendent but not earlier than December 31, next preceding the date of the contract;

[1973, c. 585, §12 (AMD) .]

3. A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a 2/3 vote of the supreme legislative or governing body of each society; and

[1969, c. 132, §1 (NEW) .]

4. Evidence that at least 60 days prior to the action of the supreme legislative or governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official organ of each society.

[1969, c. 132, §1 (NEW) .]

If the superintendent finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, he shall approve the contract and issue his certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the superintendent or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the superintendent of such state or territory and a certificate of such approval filed with the superintendent of this State. [1973, c. 585, §12 (AMD).]

Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this State in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger. [1969, c. 132, §1 (NEW).]

The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4109. CONVERSION OF FRATERNAL BENEFIT SOCIETY INTO MUTUAL LIFE INSURANCE COMPANY

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of section 3352 if such plan of conversion has been approved by the superintendent. Such plan shall be prepared in writing setting forth in full the terms and conditions thereof. The board of directors shall submit such plan to the supreme legislative or governing body of such society at any regular or special meeting thereof by giving a full, true and complete copy of such plan with the notice of such meeting. Such notice shall be given as provided in the laws of the society for the convocation of a regular or special meeting of such body, as the case may be. The affirmative vote of 2/3 of all members of such body shall be necessary for the approval of such agreement. No such conversion shall

take effect unless and until approved by the superintendent who may give such approval if he finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4110. QUALIFICATIONS FOR MEMBERSHIP

A society may admit to benefit membership any person not less than 15 years of age, nearest birthday, who has furnished evidence of insurability acceptable to the society. Any such member who shall apply for additional benefits more than 6 months after becoming a benefit member shall furnish additional evidence of insurability acceptable to the society unless such additional benefits are issued pursuant to an existing contract under the terms of which such member is entitled to purchase such additional benefits without furnishing evidence of insurability. [1969, c. 132, §1 (NEW).]

Any person admitted prior to attaining the full age of 18 years shall be bound by the terms of the application and certificate and by all the laws and rules of the society and shall be entitled to all the rights and privileges of membership therein to the same extent as though the age of majority had been attained at the time of application. A society may also admit general or social members who shall have no voice or vote in the management of its insurance affairs. [1971, c. 598, §51 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 433, §63 (AMD). 1971, c. 598, §51 (AMD).

§4111. ARTICLES OF INCORPORATION, CONSTITUTION AND LAWS -- AMENDMENTS

A domestic society may amend its articles of incorporation, constitution or laws in accordance with the provisions thereof by action of its supreme legislative or governing body at any regular or special meeting thereof or, if its articles of incorporation, constitution or laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its articles of incorporation, constitution or laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges or branches. No amendment submitted for adoption by referendum shall be adopted unless, within 6 months from the date of submission thereof, a majority of all the voting members of the society shall have signified their consent to such amendment by one of the methods herein specified. [1969, c. 132, §1 (NEW).]

No amendment to the articles of incorporation, constitution or laws of any domestic society shall take effect unless approved by the superintendent, who shall approve such amendment if he finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this State or with the character, objects and purposes of the society. Unless the superintendent shall disapprove any such amendment within 60 days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the superintendent shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case he disapproves such amendment, the reasons therefor shall be stated in such written notice. [1973, c. 583, §12 (AMD).]

Within 90 days from the approval thereof by the superintendent, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official organ of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof have been furnished the addressee. [1973, c. 583, §12 (AMD).]

Every foreign or alien society authorized to do business in this State shall file with the superintendent a duly certified copy of all amendments of, or additions to, its articles of incorporation, constitution or laws within 90 days after the enactment of same. [1973, c. 583, §12 (AMD).]

Printed copies of the constitution or laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4112. INSTITUTIONS

It shall be lawful for a society to create, maintain and operate charitable, benevolent or educational institutions for the benefit of its members and their families and dependents and for the benefit of children insured by the society. For such purpose it may own, hold or lease personal property or real property located within or without this State, with necessary buildings thereon. Such property shall be reported in every annual statement but shall not be allowed as an admitted asset of such society. [1969, c. 132, §1 (NEW).]

Maintenance, treatment and proper attendance in any such institution may be furnished free or a reasonable charge may be made therefor, but no such institution shall be operated for profit. The society shall maintain a separate accounting of any income and disbursements under this section and report them in its annual statement. No society shall own or operate funeral homes or undertaking establishments. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4113. NO PERSONAL LIABILITY

The officers and members of the supreme, grand or any subordinate body of a society shall not be personally liable for payment of any benefits provided by a society. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4114. BENEFITS

1. A society authorized to do business in this State may provide for the payment of:

A. Death benefits in any form; [1969, c. 132, §1 (NEW).]

B. Endowment benefits; [1969, c. 132, §1 (NEW).]

C. Annuity benefits; [1969, c. 132, §1 (NEW).]

D. Temporary or permanent disability benefits as a result of disease or accident; [1969, c. 132, §1 (NEW).]

E. Hospital, medical or nursing benefits due to sickness or bodily infirmity or accident; and [1969, c. 132, §1 (NEW).]

F. Monument or tombstone benefits to the memory of deceased members not exceeding in any case the sum of $300. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. Such benefits may be provided on the lives of members or, upon application of a member, on the lives of the member's family, including the member, the member's spouse and minor children, in the same or separate certificates.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4115. BENEFITS ON LIVES OF CHILDREN

A society may provide for benefits on the lives of children under the minimum age for adult membership but not greater than 18 years of age at time of application therefor, upon the application of some adult person, as its laws or rules may provide, which benefits shall be in accordance with the provisions of section 4114, subsection 1. A society may, at its option, organize and operate branches for such children. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice in the management of the society. [1971, c. 598, §52 (AMD).]

A society shall have power to provide for the designation and changing of designation of beneficiaries in the certificates providing for such benefits and to provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 433, §64 (AMD). 1971, c. 598, §52 (AMD).

§4116. NONFORFEITURE BENEFITS, CASH SURRENDER VALUES, CERTIFICATE LOANS AND OTHER OPTIONS

A society may grant paid-up nonforfeiture benefits, cash surrender values, certificate loans and such other options as its laws may permit. As to certificates issued on and after January 1, 1970 a society shall grant at least one paid-up nonforfeiture benefit; except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term insurance contracts or contracts of term insurance of uniform amount of 15 years or less expiring before age 66. [1973, c. 625, §153 (AMD).]

In the case of certificates other than those for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table, the Commissioners 1958 Standard Ordinary Mortality Table, or such later tables as authorized for use by domestic life insurers, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the excess, if any, of 1 over 2 as follows: [1987, c. 606, §1 (AMD).]

1. The reserve under the certificate determined on the basis specified in the certificate; and

[1969, c. 132, §1 (NEW) .]

2. The sum of any indebtedness to the society on the certificate, including interest due and accrued, and a surrender charge equal to 2 1/2% of the face amount of the certificate, which, in the case of insurance on the lives of children, shall be the ultimate face amount of the certificate, if death benefits provided therein are graded.

[1969, c. 132, §1 (NEW) .]

However, in the case of certificates issued on a substandard basis or in the case of certificates, the reserves for which are computed upon the American Men Ultimate Table of Mortality, the term of any extended insurance benefit granted including accompanying pure endowment, if any, may be computed upon the rates of mortality not greater than 130% of those shown by the mortality table specified in the certificate for the computation of the reserve. [1969, c. 132, §1 (NEW).]

In the case of certificates for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table, the Commissioners 1958 Standard Ordinary Mortality Table, or such later tables as authorized for use by domestic life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the provisions of the laws of this State applicable to life insurers issuing policies containing like insurance benefits based upon such tables. [1987, c. 606, §1 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 625, §153 (AMD). 1987, c. 606, §1 (AMD).

§4117. BENEFICIARIES

The member shall have the right at all times to change the beneficiary or beneficiaries in accordance with the constitution, laws or rules of the society. Every society by its constitution, laws or rules may limit the scope of beneficiaries and shall provide that no beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the insurance contract. [1969, c. 132, §1 (NEW).]

A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of $500. [1969, c. 132, §1 (NEW).]

If, at the death of any member, there is no lawful beneficiary to whom the insurance benefits shall be payable, the amount of such benefits, except to the extent that funeral benefits may be paid as hereinbefore provided, shall be payable to the personal representative of the deceased member. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4118. BENEFITS NOT ATTACHABLE

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4119. THE CONTRACT

Every society authorized to do business in this State shall issue to each benefit member a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the charter or articles of incorporation, the constitution and laws of the society, the application for membership, and declaration of insurability, if any, signed by the applicant, and all

amendments to each thereof, shall constitute the agreement, as of the date of issuance, between the society and the member, and the certificate shall so state. A copy of the application for membership and of the declaration of insurability, if any, shall be endorsed upon or attached to the certificate. [1969, c. 132, §1 (NEW).]

All statements purporting to be made by the member shall be representations and not warranties. Any waiver of this provision shall be void. [1969, c. 132, §1 (NEW).]

Any changes, additions or amendments to the charter or articles of incorporation, constitution or laws duly made or enacted subsequent to the issuance of the certificate, shall bind the member and the beneficiaries, and shall govern and control the agreement in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for membership, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the member as of the date of issuance. [1969, c. 132, §1 (NEW).]

Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof. [1969, c. 132, §1 (NEW).]

A society shall provide in its constitution or laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the member to the society the amount of the member's equitable proportion of such deficiency as ascertained by its board, and that if the payment be not made it shall stand as an indebtedness against the certificate and draw interest not to exceed 5% per annum compounded annually. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4120. LIFE BENEFIT CERTIFICATE PROVISIONS, STANDARD AND PROHIBITED

No life benefit certificate may be delivered or issued for delivery in this State unless a copy of the form shall have been filed with the superintendent and approved by him as conforming to the requirements of this section and not inconsistent with any other provisions of law applicable thereto. For each such form filing, the society shall pay the superintendent a fee which shall be the same as for an insurer, as provided in section 601. A certificate shall be deemed approved unless disapproved by the superintendent within 60 days from the date of that filing. [1983, c. 419, §11 (AMD).]

1. The certificate shall contain in substance the following standard provisions or, in lieu thereof, provisions which are more favorable to the member:

A. Title on the face and filing page of the certificate clearly and correctly describing its form; [1969, c. 132, §1 (NEW).]

B. A provision stating the amount of rates, premiums or other required contributions, by whatever name known, which are payable by the insured under the certificate; [1969, c. 132, §1 (NEW).]

C. A provision that the member is entitled to a grace period of not less than a full month, or 30 days at the option of the society, in which the payment of any premium after the first may be made. During such grace period the certificate shall continue in full force, but in case the certificate becomes a claim during the grace period before the overdue payment is made, the amount of such overdue payment or payments may be deducted in any settlement under the certificate; [1969, c. 132, §1 (NEW).]

D. A provision that the member shall be entitled to have the certificate reinstated at any time within 3 years from the due date of the premium in default, unless the certificate has been completely terminated through the application of a nonforfeiture benefit, cash surrender value or certificate loan, upon the production of evidence of insurability satisfactory to the society and the payment of all overdue premiums with interest at a rate not exceeding 6% per annum compounded annually, and the payment

or reinstatement of any other indebtedness to the society upon the certificate with interest at a rate determined under the terms of the certificate in accordance with sections 2552 to 2554; [1981, c. 188, §5 (AMD).]

E. Except in the case of pure endowment, annuity or reversionary annuity contracts, reducing term insurance contracts, or contracts of term insurance of uniform amount of 15 years or less expiring before age 66, a provision that, in the event of default in payment of any premium after 3 full years' premiums have been paid or after premiums for a lesser period have been paid if the contract so provides, the society will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on the plan stipulated in the certificate, effective as of such due date, of such value as specified in this chapter. The certificate may provide, if the society's laws so specify or if the member shall so elect prior to the expiration of the grace period of any overdue premium, that default shall not occur so long as premiums can be paid under the provisions of an arrangement for automatic premium loan as may be set forth in the certificate; [1969, c. 132, §1 (NEW).]

F. A provision that one paid-up nonforfeiture benefit as specified in the certificate shall become effective automatically unless the member elects another available paid-up nonforfeiture benefit, not later than 60 days after the due date of the premium in default; [1969, c. 132, §1 (NEW).]

G. A statement of the mortality table and rate of interest used in determining all paid-up nonforfeiture benefits and cash surrender options available under the certificate, and a brief general statement of the method used in calculating such benefits; [1969, c. 132, §1 (NEW).]

H. A table showing in figures the value of every paid-up nonforfeiture benefit and cash surrender option available under the certificate for each certificate anniversary either during the first 20 certificate years or during the term of the certificate whichever is shorter; [1969, c. 132, §1 (NEW).]

I. A provision that the certificate shall be incontestable after it has been in force during the lifetime of the member for a period of 2 years from its date of issue except for nonpayment of premiums, violation of the provisions of the certificate relating to military, aviation or naval service and violation of the provisions relating to suspension or expulsion as substantially set forth in the certificate. At the option of the society, supplemental provisions relating to benefits in the event of temporary or permanent disability or hospitalization and provisions which grant additional insurance specifically against death by accident or accidental means may also be excepted. The certificate shall be incontestable on the ground of suicide after it has been in force during the lifetime of the member for a period of 2 years from date of issue. The certificate may provide, as to statements made to procure reinstatement, that the society shall have the right to contest a reinstated certificate within a period of 2 years from date of reinstatement with the same exceptions as herein provided; [1969, c. 132, §1 (NEW).]

J. A provision that in case the age or sex of the member or of any other person is considered in determining the premium and it is found at any time before final settlement under the certificate that the age or sex has been misstated, and the discrepancy and premium involved have not been adjusted, the amount payable shall be such as the premium would have purchased at the correct age and sex; but if the correct age or sex was not an insurable age or sex under the society's charter or laws, only the premiums paid to the society, less any payments previously made to the member, shall be returned or, at the option of the society, the amount payable under the certificate shall be such as the premium would have purchased at the correct age and sex according to the society's promulgated rates and any extension thereof based on actuarial principles; [1969, c. 132, §1 (NEW).]

K. A provision or provisions which recite fully, or which set forth the substance of, all sections of the charter, constitution, laws, rules or regulations of the society, in force at the time of issuance of the certificate, the violation of which will result in the termination of, or in the reduction of, the benefit or benefits payable under the certificate; and [1969, c. 132, §1 (NEW).]

L. If the constitution or laws of the society provide for explusion or suspension of a member, any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentations in such member's application for membership, shall have the privilege of maintaining his insurance in force by continuing payment of the required premium. [1969, c. 132, §1 (NEW).]

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance or because the certificate is an annuity certificate may to the extent inapplicable be omitted from the certificate.

[1981, c. 188, §5 (AMD) .]

2. No life benefit certificate may be delivered or issued for delivery in this State containing in substance any of the following provisions:

A. Any provision limiting the time within which any action at law or in equity may be commenced to less than 2 years after the cause of action shall accrue; [1969, c. 132, §1 (NEW).]

B. Any provision by which the certificate shall purport to be issued or to take effect more than 6 months before the original application for the certificate was made, except in case of transfer from one form of certificate to another in connection with which the member is to receive credit for any reserve accumulation under the form of certificate from which the transfer is made; [1989, c. 176, §7 (AMD).]

C. Any provision for forfeiture of the certificate for failure to repay any loan thereon or to pay interest on such loan while the total indebtedness, including interest, is less than the loan value of the certificate; or [1989, c. 176, §7 (AMD).]

D. Any provision providing more restrictive coverage or excluding coverage for death resulting from Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases except this provision shall not apply to death by accident or accidental means. [1989, c. 176, §7 (NEW).]

[1989, c. 176, §7 (AMD) .]

3. The word "premiums" as used in this chapter means premiums, rates or other required contributions by whatever name known.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1981, c. 188, §5 (AMD). 1983, c. 419, §11 (AMD). 1989, c. 176, §7 (AMD).

§4121. ACCIDENT AND HEALTH INSURANCE AND TOTAL AND PERMANENT DISABILITY INSURANCE CERTIFICATES

No society may issue or deliver in this State any certificate or other evidence of any contract or accident insurance or health insurance or of any total and permanent disability insurance contract unless and until the form thereof, together with the form of application and all riders or endorsements for use in connection therewith, has been filed with the superintendent and approved by him as conforming to reasonable rules from time to time made by him and as not inconsistent with any other provisions of law applicable thereto. For each such form filing, the society shall pay the superintendent a fee which shall be the same as for an insurer, as provided in section 601. The superintendent shall, within a reasonable time after the filing of any such form, notify the society filing the form either of his approval or of his disapproval of that form. The superintendent may approve any such form which in his opinion contains provisions on any one or more of the several requirements made by him which are more favorable to the members than the one or ones so required. The superintendent may make, alter and supersede reasonable regulations prescribing the required,

optional and prohibited provisions in such contracts, and such regulations shall conform, as far as practicable, to chapter 33. Where the superintendent deems inapplicable, either in part or in their entirety, the provisions of the foregoing sections, he may prescribe the portions or summary thereof of the contract to be printed on the certificate issued to the member. Any filing made under this section shall be deemed approved unless disapproved within 60 days from the date of such filing. The procedures governing all rules promulgated under authority of this section shall conform to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II. [1983, c. 419, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §430 (AMD). 1983, c. 419, §12 (AMD).

§4121-A. ACQUIRED IMMUNE DEFICIENCY SYNDROME

No certificate providing health insurance benefits delivered or issued for delivery in this State, other than a certificate providing benefits for specific diseases or accidental injuries only, may provide more restrictive coverage for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex or HIV related diseases than for any other disease or sickness or exclude coverage for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV related diseases except through an exclusion under which all sicknesses and diseases are treated the same. [1989, c. 176, §8 (NEW).]

SECTION HISTORY
1989, c. 176, §8 (NEW).

§4122. WAIVER

The constitution and laws of the society may provide that no subordinate body nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws and constitution of the society. Such provisions shall be binding on the society and every member and beneficiary of a member. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4123. REINSURANCE

A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this State, or if not so authorized, one which is approved by the superintendent, but no such society may reinsure substantially all of its insurance in force without the written permission of the superintendent. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after January 1, 1970, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society. [1973, c. 625, §154 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §154 (AMD).

§4124. LICENSES

A license must be issued to each fraternal benefit society that qualifies under this chapter. The license continues in full force and effect until suspended or revoked by the superintendent. Upon issuance of the license and annually thereafter the society shall pay the superintendent a fee that is the same as for an insurer as provided in section 601. A duly certified copy or duplicate of such license is prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter. On or before July 1st of each year, the superintendent shall forward to each fraternal benefit society an itemized bill of the amount due for the filing of the annual statement and the amount due for the certificate of authority annual fee. [1997, c. 592, §68 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §155 (AMD). 1977, c. 682, §5 (RPR). 1997, c. 592, §68 (AMD).

§4125. FOREIGN OR ALIEN SOCIETY -- ADMISSION

No foreign or alien society shall transact business in this State without a license issued by the superintendent. Any such society may be licensed to transact business in this State upon filing with the superintendent: [1973, c. 585, §12 (AMD).]

1. A duly certified copy of its charter or articles of incorporation;

[1969, c. 132, §1 (NEW) .]

2. A copy of its constitution and laws, certified by its secretary or corresponding officer;

[1969, c. 132, §1 (NEW) .]

3. A power of attorney to the superintendent as prescribed in section 4129;

[1973, c. 585, §12 (AMD) .]

4. A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the superintendent, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the superintendent of this State;

[1973, c. 585, §12 (AMD) .]

5. A certificate from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

[1969, c. 132, §1 (NEW) .]

6. Copies of its certificate forms; and

[1969, c. 132, §1 (NEW) .]

7. Such other information as he may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this chapter.

[1969, c. 132, §1 (NEW) .]

Any foreign or alien society desiring admission to this State shall have the qualifications required of domestic societies organized under this chapter. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4126. INJUNCTION -- LIQUIDATION -- RECEIVERSHIP OF DOMESTIC SOCIETY

1. When the superintendent upon investigation finds that a domestic society:

A. Has exceeded its powers; [1969, c. 132, §1 (NEW).]

B. Has failed to comply with any provision of this chapter; [1969, c. 132, §1 (NEW).]

C. Is not fulfilling its contracts in good faith; [1969, c. 132, §1 (NEW).]

D. Has a membership of less than 400 after an existence of 1 year or more; or [1969, c. 132, §1 (NEW).]

E. Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business; [1969, c. 132, §1 (NEW).]

he shall notify the society of such deficiency or deficiencies and state in writing the reasons for his dissatisfaction. He shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a 30-day period in which to comply with the superintendent's request for correction, and if the society fails to comply, the superintendent shall notify the society of his findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the superintendent may present the facts relating thereto to the Attorney General who shall, if he deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order.

[1973, c. 585, §12 (AMD) .]

2. No society so enjoined shall have the authority to do business until:

A. The superintendent finds that the violation complained of has been corrected; [1973, c. 585, §12 (AMD).]

B. The cost of such action shall have been paid by the society if the court finds that the society was in default as charged; [1969, c. 132, §1 (NEW).]

C. The court has dissolved its injunction; and [1969, c. 132, §1 (NEW).]

D. The society's certificate of authority has been reinstated. [1977, c. 694, §431 (RPR).]

[1977, c. 694, §431 (AMD) .]

3. If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

[1969, c. 132, §1 (NEW) .]

4. No action under this section shall be recognized in any court of this State unless brought by the Attorney General upon request of the superintendent. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the superintendent as such receiver.

[1973, c. 585, §12 (AMD) .]

5. The provisions of this section relating to hearing by the superintendent, action by the Attorney General at the request of the superintendent, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

[1973, c. 585, §12 (AMD) .]

6. Nothing in this section may be construed as limiting the superintendent's authority to take enforcement action under section 12-A in connection with violations of applicable provisions of this Title.

[2009, c. 13, §3 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §431 (AMD). 2009, c. 13, §3 (AMD).

§4127. PETITION FOR SUSPENSION, REVOCATION OR REFUSAL OF LICENSE OF FOREIGN OR ALIEN SOCIETY

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §432 (AMD). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF). 2009, c. 13, §4 (RP).

§4127-A. SUSPENSION, REVOCATION OR REFUSAL OF LICENSE OF FOREIGN OR ALIEN SOCIETY

The superintendent may suspend, revoke or refuse the license of a foreign or alien society transacting or applying to transact business in this State as set out in this section. [2009, c. 13, §5 (NEW).]

1. **Investigation.** If, upon investigation, the superintendent finds that a foreign or alien society transacting or applying to transact business in this State has exceeded its powers, has failed to comply with any of the provisions of this chapter, is not fulfilling its contracts in good faith or is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public, the superintendent shall notify the society of the deficiency or deficiencies and state in writing the reasons that warrant suspension, revocation or refusal of the society's license. The notice must require that the deficiency or deficiencies be corrected.

After receipt of the notice, the society has 30 days to comply with the superintendent's request for correction, and if the society fails to comply, the superintendent shall notify the society of the findings of noncompliance and require the society to show cause, on a date set by the superintendent, why its license should not be

suspended, revoked or refused. If on that date the society does not present good and sufficient reason why its authority to do business in this State should not be suspended, revoked or refused, the superintendent may suspend or refuse the license of the society to do business in this State until satisfactory evidence is furnished to the superintendent that the suspension or refusal should be withdrawn or the superintendent may revoke the authority of the society to do business in this State.

[2009, c. 13, §5 (NEW) .]

2. **Continue contracts.** Nothing in this section may be construed as preventing any foreign or alien society from continuing in good faith all contracts made in this State during the time the society was legally authorized to transact business in this State.

[2009, c. 13, §5 (NEW) .]

3. **Enforcement action.** Nothing in this section may be construed as limiting the superintendent's authority to take enforcement action under section 12-A in connection with violations of applicable provisions of this Title.

[2009, c. 13, §5 (NEW) .]

SECTION HISTORY
2009, c. 13, §5 (NEW).

§4128. LICENSING OF AGENTS

Insurance producers of societies must be licensed in accordance with chapter 16 provided the examination requirements of chapter 16 are not applicable to any insurance producer who was in the service of a society on January 1, 1978, and provided that no insurance producer's license is required of the following:
[1997, c. 457, §48 (AMD); 1997, c. 457, §55 (AFF).]

1. Officer devoting substantial time to activities other than solicitation or negotiation of insurance contracts. Any officer, employee or secretary of any such society or of any subordinate lodge or branch thereof who devotes substantially all of his time to activities other than the solicitation or negotiation of insurance contracts and who receives no commission or other compensation directly dependent upon the number or amount of contracts solicited or negotiated;

[1977, c. 446, §1 (RPR) .]

2. Agent devoting less than 50% of time to solicitation and procurement of insurance contracts. Any agent or representative of a society who devotes less than 50% of his time to the solicitation and procurement of insurance contracts for such society. Any person, who in the preceding calendar year has solicited and procured life insurance in excess of $200,000, face amount, or, in the case of any other kind or kinds of insurance which the society may write, on the persons of more than 25 individuals and who has received or will receive a commission or other compensation therefor, shall be presumed to be devoting 50% of his time to the solicitation or procurement of insurance contracts for such society; or

[1977, c. 446, §1 (RPR) .]

3. Persons who do not effect insurance. Any member of a society who does not effect insurance and whose solicitation or negotiation is incidental to securing new members for his society and whose only remuneration consists of prizes in the form of merchandise or payments of a nominal amount.

[1977, c. 446, §1 (RPR) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 446, §1 (RPR). 1997, c. 457, §48 (AMD). 1997, c. 457, §55 (AFF).

§4129. SERVICE OF PROCESS

Every society authorized to do business in this State shall appoint in writing an agent located in the State upon whom all lawful process in any action or proceeding against it is served and shall agree in writing that any lawful process against it that is served on the agent is of the same legal force and validity as if served upon the society and that the authority continues in force so long as any liability remains outstanding in this State. Copies of such appointment certified by the appointed agent are deemed sufficient evidence of the appointment and may be admitted in evidence with the same force and effect as the original. [1997, c. 592, §69 (AMD).]

Service may only be made upon the appointed agent or, if absent, upon the person in charge. It must be made in duplicate and constitutes sufficient service upon the society. When legal process against a society is served upon the appointed agent, the appointed agent shall forthwith forward one of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. Legal process may not be served upon a society except as provided in this section. [1997, c. 592, §69 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1969, c. 590, §40 (AMD). 1973, c. 585, §12 (AMD). 1997, c. 457, §49 (AMD). 1997, c. 592, §69 (AMD).

§4130. INJUNCTION

No application or petition for injunction against any domestic, foreign or alien society, or branch thereof, shall be recognized in any court of this State unless made by the Attorney General upon request of the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4131. REVIEW

All decisions and findings of the superintendent made under the provisions of this chapter shall be subject to review by proper proceedings in any court of competent jurisdiction in this State. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4132. FUNDS

All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment or the surrender of any part thereof, except as provided in the contract. [1969, c. 132, §1 (NEW).]

A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society. [1969, c. 132, §1 (NEW).]

Every society, the admitted assets of which are less than the sum of its accrued liabilities and reserves under all of its certificates when valued according to standards required for certificates issued after one year from the effective date of this chapter, shall, in every provision of the laws of the society for payments by

members of such society, in whatever form made, distinctly state the purpose of the same and the proportion thereof which may be used for expenses, and no part of the money collected for mortuary or disability purposes or the net accretions thereto shall be used for expenses. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4133. INVESTMENTS

A society shall invest its funds only in such investments as are authorized by the laws of this State for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this State which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4134. REPORTS AND VALUATIONS

Reports shall be filed and synopses of annual statements shall be published in accordance with the provisions of this section. [1969, c. 132, §1 (NEW).]

1. Every society transacting business in this State shall annually, on or before the first day of March, unless for cause shown such time has been extended by the superintendent, file with the superintendent a true statement of its financial condition, transactions and affairs for the preceding calendar year. The statement must be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the superintendent. The fee for filing the annual statement is the same as for an insurer as provided in section 601.

[1997, c. 592, §70 (AMD) .]

2. A synopsis of its annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society not later than June 1 of each year, or, in lieu thereof, such synopsis may be published in the society's official publication.

[1969, c. 132, §1 (NEW) .]

3. As a part of the annual statement herein required, each society shall, on or before the 1st day of March, file with the superintendent a valuation of its certificates in force on December 31 last preceding, provided the superintendent may, in his discretion for cause shown, extend the time for filing such valuation for not more than 2 calendar months. Such report of valuation shall show, as reserve liabilities, the difference between the present midyear value of the promised benefits provided in the certificates of such society in force and the present midyear value of the future net premiums as the same are in practice actually collected, not including therein any value for the right to make extra assessments and not including any amount by which the present midyear value of future net premiums exceeds the present midyear value of promised benefits on individual certificates. At the option of any society, in lieu of the above, the valuation may show the net tabular value. Such net tabular value as to certificates issued prior to one year after January 1, 1970 shall be determined in accordance with the provisions of law applicable prior to January 1, 1970 and as to certificates issued on or after one year from January 1, 1970 shall not be less than the reserves determined according to the superintendent's reserve valuation method as hereinafter defined. If the premium charged is

less than the tabular net premium according to the basis of valuation used, an additional reserve equal to the present value of the deficiency in such premiums shall be set up and maintained as a liability. The reserve liabilities shall be properly adjusted in the event that the midyear or tabular values are not appropriate.

[1973, c. 625, §156 (AMD) .]

4. Reserves according to the superintendent's reserve valuation method for the life insurance and endowment benefits of certificates providing for a uniform amount of insurance and requiring the payment of uniform premiums must be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such certificates, over the then present value of any future modified net premiums therefor. The modified net premiums for any such certificate must be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the certificate, of all such modified net premiums is equal to the sum of the then present value of such benefits provided for by the certificate and the excess of A over B, as follows:

A. A net level premium equal to the present value, at the date of issue, of such benefits provided for after the first certificate year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such certificate on which a premium falls due; provided however that such net level annual premium may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of such certificate; and [2013, c. 588, Pt. A, §28 (AMD).]

B. A net one-year term premium for such benefits provided for in the first certificate year. [2013, c. 588, Pt. A, §28 (AMD).]

Reserves according to the superintendent's reserve valuation method must be calculated by a method consistent with the principles of this subsection for life insurance benefits for varying amounts of benefits or requiring the payment of varying premiums; annuity and pure endowment benefits; disability and accidental death benefits in all certificates and contracts; and all other benefits except life insurance and endowment benefits.

[2013, c. 588, Pt. A, §28 (AMD) .]

5. The present value of deferred payments due under incurred claims or matured certificates shall be deemed a liability of the society and shall be computed upon mortality and interest standards prescribed in the following subsection.

[1969, c. 132, §1 (NEW) .]

6. Such valuation and underlying data shall be certified by a competent actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

A. The minimum standards of valuation for certificates issued prior to January 1, 1970 shall be those provided by the law applicable immediately prior to January 1, 1970 but not lower than the standards used in the calculating of rates for such certificates. [1973, c. 625, §157 (AMD).]

B. The minimum standard of valuation for certificates issued after January 1, 1970 shall be such interest assumptions and tables as authorized for use by domestic life insurers or 3 1/2% interest and the following tables:

(1) For certificates of life insurance: American Men Ultimate Table of Mortality, with Bowerman's or Davis' extension thereof or with the consent of the superintendent, the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Mortality Table or the Commissioners 1958 Standard Ordinary Mortality Table, using actual age of the insured for male risks and an age more than 3 years younger than the actual age of the insured for female risks;

(2) For annuity and pure endowment certificates, excluding any disability and accidental death benefits in such certificates: The 1937 Standard Annuity Mortality Table or the Annuity Mortality Table for 1949, ultimate, or any modification of either of these tables approved by the superintendent;

(3) For total and permanent disability benefits in or supplementary to life insurance certificates: Hunter's Disability Table, or the class III disability table (1926) modified to conform to the contractual waiting period, or the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the Society of Actuaries with due regard to the type of benefit. Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance certificates;

(4) For accidental death benefits in or supplementary to life insurance certificates: The Inter-company Double Indemnity Mortality Table or the 1959 Accidental Death Benefits Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance certificates; and

(5) For noncancellable accident and health benefits: The class III disability table (1926) with conference modifications or, with the consent of the superintendent, tables based upon the society's own experience. [1987, c. 606, §2 (AMD).]

The superintendent may, in his discretion, accept other standards for valuation if he finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The superintendent may, in his discretion, vary the standards of mortality applicable to all certificates of insurance on substandard lives or other extra hazardous lives by any society authorized to do business in this State. Whenever the mortality experience under all certificates valued on the same mortality table is in excess of the expected mortality according to such table for a period of 3 consecutive years, the superintendent may require additional reserves when deemed necessary in his judgment on account of such certificates.

Any society, with the consent of the insurance supervisory officer of the state of domicile of the society and under such conditions, if any, which he may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any insured member shall not be affected thereby.

[1987, c. 606, §2 (AMD) .]

7. A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit $100 for each day during which such neglect continues, and, upon notice by the superintendent to that effect, its authority to do business in this State shall cease while such default continues.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 585, §12 (AMD). 1973, c. 625, §§156-158 (AMD). 1987, c. 606, §2 (AMD). 1997, c. 592, §70 (AMD). 2013, c. 588, Pt. A, §28 (AMD).

§4135. EXAMINATION OF DOMESTIC SOCIETIES

The superintendent, or any person he may appoint, shall have the power of visitation and examination into the affairs of any domestic society and he shall make such examination at least once in every 3 years. He may employ assistants for the purpose of such examination, and he, or any person he may appoint, shall have free access to all books, papers and documents that relate to the business of the society. The minutes of the proceedings of the supreme legislative or governing body and of the board of directors or corresponding body of a society shall be in the English language. In making any such examination the superintendent

may summon and qualify as witnesses under oath and examine its officers, agents and employees or other persons in relation to the affairs, transactions and condition of the society. A summary of the report of the superintendent and such recommendations or statements of the superintendent as may accompany such report shall be read at the first meeting of the board of directors or corresponding body of the society following the receipt thereof, and if directed so to do by the superintendent, shall also be read at the first meeting of the supreme legislative or governing body of the society following the receipt thereof. A copy of the report, recommendations and statements of the superintendent shall be furnished by the society to each member of such board of directors or other governing body. The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4136. EXAMINATION OF FOREIGN AND ALIEN SOCIETIES

The superintendent, or any person whom he may appoint, may examine any foreign or alien society transacting or applying for admission to transact business in this State. He may employ assistants and he, or any person he may appoint, shall have free access to all books, papers and documents that relate to the business of the society. He may in his discretion accept, in lieu of such examination, the examination of the insurance department of the state, territory, district, province or country where such society is organized. The compensation and actual expenses of the examiners making any examination or general or special valuation shall be paid by the society examined or by the society whose certificate obligations have been valued, upon statements furnished by the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4137. NO ADVERSE PUBLICATIONS

Pending, during or after an examination or investigation of a society, either domestic, foreign or alien, the superintendent shall make public no financial statement, report or finding, nor shall he permit to become public any financial statement, report or finding affecting the status, standing or rights of any society, until a copy thereof shall have been served upon the society at its principal office and the society shall have been afforded a reasonable opportunity to answer any such financial statement, report or finding and to make such showing in connection therewith as it may desire. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4138. MISREPRESENTATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 797, §10 (AMD). 2001, c. 421, §§B91,92 (AMD). 2001, c. 421, §C1 (AFF). 2009, c. 13, §6 (RP).

§4138-A. ENFORCEMENT; UNFAIR METHODS OF COMPETITION AND UNFAIR AND DECEPTIVE ACTS AND PRACTICES

A society authorized to do business in this State is subject to the provisions of section 12-A and chapter 23. Nothing in such provisions may be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership or as applying to or affecting the offering of benefits

exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society or the offering of benefits only to its members. [2009, c. 13, §7 (NEW).]

SECTION HISTORY
2009, c. 13, §7 (NEW).

§4139. DISCRIMINATION AND REBATES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 2009, c. 13, §8 (RP).

§4139-A. FUNERAL SERVICE CONTRACTS

Every society is subject to the provisions of section 2176. [1989, c. 206, §3 (NEW).]

SECTION HISTORY
1989, c. 206, §3 (NEW).

§4140. TAXATION

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate and office equipment. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4141. EXEMPTIONS

Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this State, not only in governmental relations with the state, but for every other purpose. No law hereafter enacted shall apply to them, unless they be expressly designated therein. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4142. EXEMPTION OF CERTAIN SOCIETIES

Nothing contained in this chapter shall be so construed as to affect or apply to: [1969, c. 132, §1 (NEW).]

1. Grand or subordinate lodges of societies, orders or associations now doing business in this State which provide benefits exclusively through local or subordinate lodges;

[1969, c. 132, §1 (NEW) .]

2. Orders, societies or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

[1969, c. 132, §1 (NEW) .]

3. Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than $400 or disability benefits of not more than $350 to any person in any one year, or both; or

[1969, c. 132, §1 (NEW) .]

4. Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than $400 or for disability benefits of not more than $350 to any one person in any one year, or both.

[1969, c. 132, §1 (NEW) .]

Any such society or association described in subsections 3 or 4 supra which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subsection 4 which has more than 1,000 members, shall not be exempted from the provisions of this chapter but shall comply with all requirements thereof. [1969, c. 132, §1 (NEW).]

No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in subsection 2, shall give or allow, or promise to give or allow to any person any compensation for procuring new members. [1969, c. 132, §1 (NEW).]

Every society which provides for benefits in case of death or disability resulting solely from accident, and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this chapter except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society. [1969, c. 132, §1 (NEW).]

The superintendent may require from any society or association, by examination or otherwise, such information as will enable him to determine whether such society or association is exempt from this chapter. [1973, c. 585, §12 (AMD).]

Societies, exempted under this section, shall also be exempt from all other provisions of the insurance laws of this State. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4143. PENALTIES

1. **False or fraudulent statement in application.** A person who intentionally or knowingly makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society commits a Class E crime.

[2003, c. 452, Pt. M, §1 (NEW); 2003, c. 452, Pt. X, §2 (AFF) .]

2. **Perjury.** A person who intentionally or knowingly makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter or of any material fact contained in a sworn statement concerning the death or disability of a member for the purpose of procuring payment of a benefit named in the certificate commits the crime of perjury and is subject to the penalties prescribed by law.

[2003, c. 452, Pt. M, §1 (NEW); 2003, c. 452, Pt. X, §2 (AFF) .]

3. **Soliciting membership in society not licensed to do business.** A person who solicits membership for or in any manner assists in procuring membership in a society not licensed to do business in this State commits a civil violation for which a fine of not less than $50 and not more than $200 may be adjudged.

[2003, c. 452, Pt. M, §1 (NEW); 2003, c. 452, Pt. X, §2 (AFF) .]

4. **General penalty.** A person who intentionally or knowingly violates or neglects or refuses to comply with the provisions of this chapter for which a penalty is not otherwise prescribed is subject to the penalties under section 12-A.

[2003, c. 452, Pt. M, §1 (NEW); 2003, c. 452, Pt. X, §2 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 797, §11 (AMD). 2003, c. 452, §X2 (AFF). 2003, c. 452, §M1 (RPR).

Chapter 56: HEALTH MAINTENANCE ORGANIZATIONS

§4201. SHORT TITLE

This chapter may be cited as the Health Maintenance Organization Act of 1975. [1975, c. 503, (NEW).]

SECTION HISTORY
1975, c. 503, (NEW).

§4202. DEFINITIONS

(REPEALED)

SECTION HISTORY
1975, c. 503, (NEW). 1989, c. 842, §§1-3 (AMD). 1991, c. 709, §1 (RP).

§4202-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 709, §2 (NEW).]

1. **Basic health care services.** "Basic health care services" means health care services that an enrolled population might reasonably require in order to be maintained in good health and includes, at a minimum, emergency care, inpatient hospital care, inpatient physician services, outpatient physician services, ancillary services such as x-ray services and laboratory services and all benefits mandated by statute and mandated by rule applicable to health maintenance organizations. The superintendent may adopt rules defining "basic health care services" to be provided by health maintenance organizations. In adopting such rules, the superintendent shall consider the coverages that have traditionally been provided by health maintenance organizations; the need for flexibility in the marketplace; and the importance of providing multiple options to employers and consumers. The superintendent shall permit reasonable, but not excessive or unfairly discriminatory, variations in the copayment, coinsurance, deductible and other features of coverage, except that these features must meet or exceed those required in benefits mandated by statute. The superintendent shall permit deductible, coinsurance and copayment levels consistent with the deductible levels permitted for policies issued pursuant to chapter 33 or 35. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 90, Pt. F, §4 (AMD) .]

2. **Capitated basis.** "Capitated basis" has the following meanings.

A. "Capitated basis" means fixed per-member, per-month payments or percentage-of-premium payments pursuant to which the provider assumes full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities. [1991, c. 709, §2 (NEW).]

B. "Capitated basis," in the context of a point-of-service option plan, means prepayment that considers provision of in-plan covered services as described in paragraph A and that considers out-of-plan indemnity benefits reimbursed pursuant to the terms of a point-of-service product approved pursuant to section 4207-A. [1991, c. 709, §2 (NEW).]

[1991, c. 709, §2 (NEW) .]

3. **Carrier.** "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital, a medical service corporation or any other entity responsible for the payment of benefits or provision of services under a group contract.

[1991, c. 709, §2 (NEW) .]

4. **Copayment.** "Copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

[1991, c. 709, §2 (NEW) .]

5. **Deductible.** "Deductible" means the amount an enrollee is responsible to pay out of pocket before a health maintenance organization begins to pay the costs associated with treatment.

[1991, c. 709, §2 (NEW) .]

6. **Enrollee.** "Enrollee" means an individual who is enrolled in a health maintenance organization.

[1991, c. 709, §2 (NEW) .]

7. **Evidence of coverage.** "Evidence of coverage" means any certificate, agreement or contract issued to a group contract holder or an enrollee setting out the coverage to which an enrollee is entitled.

[1991, c. 709, §2 (NEW) .]

8. **Group contract holder.** "Group contract holder" means an entity or person that has purchased coverage from a health maintenance organization that provides, at a minimum, basic health care services to enrollees.

[1991, c. 709, §2 (NEW) .]

9. **Health care services.** "Health care services" means any services included in the furnishing of medical care, dental care or hospitalization to an individual, or any services incident to the furnishing of that care or hospitalization, as well as the furnishing of any other services to an individual to prevent, alleviate, cure or heal human illness or injury.

[1991, c. 709, §2 (NEW) .]

10. **Health maintenance organization.** "Health maintenance organization" means a public or private organization that is organized under the laws of the Federal Government, this State, another state or the District of Columbia or a component of such an organization, and that:

A. Provides, arranges or pays for, or reimburses the cost of, health care services, including, at a minimum, basic health care services to enrolled participants, except that health maintenance organizations contracting with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services they provide under the contracts consistent with the terms of those contracts if such basic health care services are provided to those populations by other means; [1995, c. 673, Pt. D, §1 (AMD).]

B. Is compensated, except for reasonable copayments, for basic health care services to enrolled participants solely on a predetermined periodic rate basis, except that the organization is not prohibited from having a provision in a group contract allowing an adjustment of premiums based upon the actual health services utilization of the enrollees covered under the contract, and except that such a contract may not be sold to an eligible group subject to the community rating requirements of section 2808-B; [1993, c. 645, Pt. A, §5 (AMD).]

C. Provides physicians' services primarily directly through physicians who are either employees or partners of that organization or through arrangements with individual physicians or one or more groups of physicians organized on a group-practice or individual-practice basis under which those physicians or groups are provided effective incentives to avoid unnecessary or unduly costly utilization, regardless of whether a physician is individually compensated primarily on a fee-for-service basis or otherwise. The organization may discharge its obligation through a point-of-service option product by reimbursing out-of-plan providers pursuant to the terms contained in the group contract holder's group contract. Receipt of out-of-plan covered services by an enrollee does not obligate the organization for an enrollee's responsibilities to meet copayments or deductibles; and [1991, c. 709, §2 (NEW).]

D. Ensures the availability, accessibility and quality, including effective utilization, of the health care services that it provides or makes available through clearly identifiable focal points of legal and administrative responsibility. [1991, c. 709, §2 (NEW).]

Nothing in this subsection prevents a health maintenance organization from providing fee-for-service health care services as well as health maintenance organization services. A health care provider or affiliated entity that does not offer health insurance or health benefit plans may not be or become a health maintenance organization subject to this chapter solely by reason of arrangements with insurers or hospital or medical service organizations for reimbursement in whole or in part on a capitated basis, the financial risk to the provider or affiliated entity associated with reimbursement arrangements with such 3rd-party payors or the furnishing by the provider or affiliated entity of utilization or case management services.

[1995, c. 673, Pt. D, §1 (AMD) .]

11. **In-plan covered services.** "In-plan covered services" means covered health care services obtained from providers who are employed by, under contract with, referred by or otherwise affiliated with the health maintenance organization. "In-plan covered services" includes emergency services.

[1991, c. 709, §2 (NEW) .]

12. **Nonprofit hospital or medical service organization.** "Nonprofit hospital or medical service organization" means any organization defined in and authorized to act under Title 24, chapter 19.

[1991, c. 709, §2 (NEW) .]

12-A. **NCQA accreditation survey report.** "NCQA accreditation survey report" means the unpublished, detailed survey report to a health maintenance organization by the National Committee for Quality Assurance upon completion of NCQA's accreditation survey of the health maintenance organization.

[1999, c. 256, Pt. Q, §1 (NEW) .]

13. **Out-of-plan covered services.** "Out-of-plan covered services" means nonemergency, covered health care services obtained without a referral from providers who are not otherwise employed by, under contract with or otherwise affiliated with the health maintenance organization or from affiliated specialists.

[1991, c. 709, §2 (NEW) .]

14. **Participating provider.** "Participating provider" means a provider as defined in subsection 18 that, under an express or implied contract with a health maintenance organization, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment, directly or indirectly from the health maintenance organization.

[1991, c. 709, §2 (NEW) .]

15. **Person.** "Person" means an individual, firm, partnership, corporation, association, syndicate, organization, society, business trust, attorney-in-fact or any legal entity.

[1991, c. 709, §2 (NEW) .]

16. **Point-of-service option.** "Point-of-service option" means a health maintenance organization product that allows an enrollee to select either the comprehensive health care benefits of the health maintenance organization or care from a provider of the enrollee's choice outside the health maintenance organization network with traditional indemnity benefits. A point-of-service option in which the risk for out-of-plan covered services of a health maintenance organization is shared with a reinsurer must meet the requirements of this chapter applicable to the indemnity benefits provided by a health maintenance organization.

[1991, c. 709, §2 (NEW) .]

17. **Point-of-service product.** "Point-of-service product" means a product that includes both in-plan covered services and out-of-plan covered services.

[1991, c. 709, §2 (NEW) .]

18. **Provider.** "Provider" means a physician, hospital or person that is licensed or otherwise authorized in this State to furnish health care services.

[1991, c. 709, §2 (NEW) .]

19. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1991, c. 709, §2 (NEW) .]

20. **Uncovered expenditures.** "Uncovered expenditures" means costs to a health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable.

[1991, c. 709, §2 (NEW) .]

SECTION HISTORY
1991, c. 709, §2 (NEW). 1993, c. 645, §A5 (AMD). 1995, c. 673, §D1 (AMD). 1999, c. 222, §1 (AMD). 1999, c. 256, §Q1 (AMD). 2001, c. 218, §1 (AMD). 2011, c. 90, Pt. F, §4 (AMD).

§4203. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

1. Subject to the Maine Certificate of Need Act of 2002, a person may apply to the superintendent for and obtain a certificate of authority to establish, maintain, own, merge with, organize or operate a health maintenance organization in compliance with this chapter. A person may not establish, maintain, own, merge with, organize or operate a health maintenance organization in this State either directly as a division or a line of business or indirectly through a subsidiary or affiliate, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with, a health maintenance organization without obtaining a certificate of authority under this chapter.

[2003, c. 510, Pt. A, §19 (AMD) .]

2. Every existing health maintenance organization as of the effective date of this chapter shall submit an application for a certificate of authority under subsection 3 within 30 days of the effective date of this chapter. Each such applicant may continue to operate until the superintendent acts upon the application. In the event that an application is denied under section 4204, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

[1975, c. 503, (NEW) .]

3. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the superintendent and shall set forth or be accompanied by the following:

A. A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto; [1975, c. 503, (NEW).]

B. A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant; [1975, c. 503, (NEW).]

C. A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation and the partners or members in the case of a partnership or association; [1975, c. 503, (NEW).]

D. A copy of any contract made or to be made between any providers or persons listed in paragraph C and the applicant; [1975, c. 503, (NEW).]

E. A statement generally describing the health maintenance organization, its health care services, facilities and personnel; [1975, c. 503, (NEW).]

F. A copy of the form of evidence of coverage to be issued to the enrollees; [1975, c. 503, (NEW).]

G. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations; [1975, c. 503, (NEW).]

H. Financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement, unless the superintendent directs that additional or more recent financial information is required for the proper administration of this chapter; [1975, c. 503, (NEW).]

I. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the State, income and expense statements anticipated from the start of operations until the organization has had net income for at least one year and a statement of the sources of working capital and any other sources of funding; [1989, c. 842, §4 (RPR).]

J. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the superintendent and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served; [1975, c. 503, (NEW).]

K. A statement reasonably describing the geographic area or areas to be served; [1975, c. 503, (NEW).]

L. A description of the complaint and grievance procedures to be utilized as required under section 4303, subsection 4 and section 4211; [1995, c. 673, Pt. D, §2 (AMD).]

M. A description of the proposed quality assurance program, including the formal organization structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified; [1989, c. 842, §5 (RPR).]

N. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 4206, subsection 2; [1975, c. 503, (NEW).]

O. A schedule of rates with supporting actuarial and other data; [1975, c. 503, (NEW).]

P. A description of a procedure to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner of Human Services; [1975, c. 503, (NEW).]

Q. Such other information as the superintendent may reasonably require to make the determinations required in section 4204; [1989, c. 842, §6 (AMD).]

R. A description of procedures to be implemented to meet the protection against insolvency requirements in section 4204, subsection 2-A, paragraph D and section 4204-A; and [1989, c. 842, §7 (NEW).]

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered. [2011, c. 90, Pt. F, §5 (AMD).]

[2011, c. 90, Pt. F, §5 (AMD) .]

4. Each application for a certificate of authority shall be made in duplicate. Upon receipt of an application for a certificate of authority, the superintendent shall immediately transfer one copy to the Commissioner of Health and Human Services.

[1981, c. 501, §48 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY
1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 1979, c. 216, §1 (AMD). 1981, c. 501, §48 (AMD). 1989, c. 842, §§4-7 (AMD). 1993, c. 702, §A11 (AMD). 1995, c. 332, §O1 (AMD). 1995, c. 673, §D2 (AMD). 1997, c. 370, §F1 (AMD). 2003, c. 469, §E18 (AMD). 2003, c. 510, §A19 (AMD). 2003, c. 689, §B7 (REV). 2011, c. 90, Pt. F, §5 (AMD).

§4204. ISSUANCE OF CERTIFICATE OF AUTHORITY

1. Procedure upon receipt of an application for issuance of a certificate of authority.

A. Concurrently with filing an application for issuance of certificate of authority with the superintendent, the applicant shall also file an application for a certificate of need pursuant to Title 22, chapter 103-A. [2003, c. 510, Pt. A, §20 (AMD).]

B. The superintendent shall take no final action with regard to the application until he has been informed by the Department of Health and Human Services whether or not the application for the certificate of need has been approved, denied or deemed not to be required. The Department of Health and

Human Services shall transmit to the superintendent a copy of its written decision on the application for a certificate of need. [1981, c. 501, §49 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 510, Pt. A, §20 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

2.

[1981, c. 501, §50 (RP) .]

2-A. The superintendent shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 50 business days of receipt of the notice from the Department of Health and Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required, within 50 business days of receipt of notice from the Department of Health and Human Services that the applicant is in compliance with the requirements of paragraph B. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met.

A. The Commissioner of Health and Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103-A. [2003, c. 510, Pt. A, §21 (AMD); 2003, c. 689, Pt. B, §7 (REV).]

B. If the Commissioner of Health and Human Services has determined that a certificate of need is not required, the commissioner makes a determination and provides a certification to the superintendent that the following requirements have been met.

(4) The health maintenance organization must establish and maintain procedures to ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. These procedures must include mechanisms to ensure availability, accessibility and continuity of care.

(5) The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services including primary and specialist physician services, ancillary and preventive health care services across all institutional and noninstitutional settings. The program must include, at a minimum, the following:

(a) A written statement of goals and objectives that emphasizes improved health outcomes in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan that describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

(ii) The organizational structure responsible for quality assurance activities;

(iii) Contractual arrangements, in appropriate instances, for delegation of quality assurance activities;

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

(vii) A system for reviewing and evaluating provider credentials for acceptance and performing peer review activities; and

(viii) Duties and responsibilities of the designated physician supervising the quality assurance activities;

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

(ii) Corrective action, monitoring evaluation and reassessment; and

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation and report format; and

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

(6) The health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the Commissioner of Health and Human Services.

(7) The health maintenance organization shall ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information to permit evaluation by the health maintenance organization of the continuity and coordination of patient care and the assessment of the quality of health and medical care provided to enrollees.

(8) Enrollee clinical records must be available to the Commissioner of Health and Human Services or an authorized designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Health and Human Services.

(9) The organization must establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

The Commissioner of Health and Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required. If the commissioner certifies that the health maintenance organization does not meet all of the requirements of this paragraph, the commissioner shall specify in what respects the health maintenance organization is deficient. [2013, c. 588, Pt. A, §29 (AMD).]

C. The health maintenance organization conforms to the definition under section 4202-A, subsection 10. [1991, c. 709, §3 (AMD).]

D. The health maintenance organization is financially responsible, complies with the minimum surplus requirements of section 4204-A and, among other factors, can reasonably be expected to meet its obligations to enrollees and prospective enrollees.

(1) In a determination of minimum surplus requirements, the following terms have the following meanings.

(a) "Admitted assets" means assets recognized by the superintendent pursuant to section 901-A. For purposes of this chapter, the asset value is that contained in the annual statement of the corporation as of December 31st of the year preceding the making of the investment or contained in any audited financial report, as defined in section 221-A, of more current origin.

(b) "Reserves" means those reserves held by corporations subject to this chapter for the protection of subscribers. For purposes of this chapter, the reserve value is that contained in the annual statement of the corporation as of December 31st of the preceding year or any audited financial report, as defined in section 221-A, of more current origin.

(2) In making the determination whether the health maintenance organization is financially responsible, the superintendent may also consider:

(a) The financial soundness of the health maintenance organization's arrangements for health care services and the schedule of charges used;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a nonprofit hospital or medical service corporation, a government or any other organization for insuring or providing the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(d) Any agreement with providers for the provision of health care services that contains a covenant consistent with subsection 6; and

(e) Any arrangements for insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care services. [2007, c. 466, Pt. D, §7 (AMD).]

E. The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to section 4206. [1981, c. 501, §51 (NEW).]

F. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 4203 or by independent investigation, is contrary to the public interest. [1981, c. 501, §51 (NEW).]

G. Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of that organization shall be responsible for those funds in a fiduciary relationship to the organization. [1989, c. 842, §10 (NEW).]

H. The health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on those employees and officers of the health maintenance organization who have duties as described in paragraph G, in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the superintendent. [1989, c. 842, §10 (NEW).]

I. If any agreement, as set forth in paragraph D, subparagraph (2), division (c), is made by the health maintenance organization, the entity executing the agreement with the health maintenance organization must demonstrate to the superintendent's satisfaction that the entity has sufficient unencumbered surplus funds to cover the assured payments under the agreement, otherwise the superintendent shall disallow the agreement. In considering approval of such an agreement, the superintendent shall consider the entity's record of earnings for the most recent 3 years, the risk characteristics of its investments and whether its investments and other assets are reasonably liquid and available to make payments for health services. [1995, c. 332, Pt. O, §2 (AMD).]

J. [2001, c. 410, Pt. A, §8 (RP).]

K. The health maintenance organization provides a spectrum of providers and services that meet patient demand. [1993, c. 702, Pt. B, §1 (NEW).]

L. The health maintenance organization meets the requirements of section 4303, subsection 1. [1995, c. 673, Pt. D, §3 (RPR).]

M. The health maintenance organization demonstrates a plan for providing services for rural and underserved populations and for developing relationships with essential community providers within the area of the proposed certificate. The health maintenance organization must make an annual report to the superintendent regarding the plan. [1993, c. 702, Pt. B, §1 (NEW).]

N. [2011, c. 90, Pt. F, §6 (RP).]

O. Each health maintenance organization shall provide basic health care services. [1999, c. 222, §2 (NEW).]

The applicant shall furnish, upon request of the superintendent, any information necessary to make any determination required pursuant to this subsection.

[2013, c. 588, Pt. A, §29 (AMD) .]

3.

[1989, c. 842, §11 (RP) .]

3-A. **Investments.** The health maintenance organization shall invest funds only in accordance with chapter 13-A, except as follows.

A. The health maintenance organization shall maintain asset valuation reserves consistent with industry standards for management of investments by life and health insurers. [1993, c. 702, Pt. A, §12 (NEW).]

B. Notwithstanding any limitation stated in section 1156, subsection 2, paragraph D, a health maintenance organization may invest in real property or interests in real property located in the United States, held directly or evidenced by partnership interests, stock of corporations, trust certificates or other instruments and acquired:

(1) As an investment for the production of income or to be improved or developed for that investment purpose; or

(2) For the convenient accommodation of the organization's business.

After giving effect to any of those investments, the aggregate amount of investments made under subparagraph (1) may not exceed 20% of the health maintenance organization's total admitted assets; the aggregate amount of investments made under subparagraph (2) may not exceed 15% of the organization's total admitted assets; and the aggregate amount of investments made under this paragraph may not exceed 25% of the organization's total admitted assets. Investments under subparagraph (1) in any single property, including improvements on that property, may not in the aggregate exceed 2% of the corporation's total admitted assets. [1993, c. 702, Pt. A, §12 (NEW).]

C. In addition to the investments permitted under paragraph B, a health maintenance organization may invest in real estate, including leasehold estates, for the convenient accommodation of its business, including hospitals, medical clinics, medical professional buildings and any other facility that is to be used in the provision of health care services, or real estate for rental to an affiliated health care provider or any other health care provider under contract with the health maintenance organization to provide health care services, and that facility must be used in the provision of health care services to members of the health maintenance organization by that provider.

(1) A parcel of real estate acquired under this subsection may include excess space for rent to others if it is reasonably anticipated that that excess will be required by the health maintenance organization for expansion or if the excess is reasonably required in order to have one or more buildings that function as an economic unit.

(2) Real estate subject to this subsection may be subject to a mortgage.

(3) The admitted value of the investment may not exceed the greater of the health maintenance organization's equity or 20% of the corporation's admitted assets, and the aggregate investment in real estate held under paragraph B and under this paragraph may not exceed 40% of the corporation's admitted assets, except with the approval of the superintendent if the superintendent finds that those percentages of the corporation's admitted assets are insufficient to provide for the convenient accommodation of the health maintenance organization's business. Investments under this subsection in any single property, including improvements on that property, may not in the aggregate exceed 5% of the corporation's total admitted assets. [1993, c. 702, Pt. A, §12 (NEW).]

D. Notwithstanding any provisions of this section and chapter 13-A allowing other investments, a health maintenance organization shall maintain cash or investment grade obligations, as defined in section 1151-A, that at all times have a fair market value of not less than 100% of the organization's liability for claims payable and incurred, but not reported, claims, unearned premiums, unpaid claims adjustment expenses and, as applicable, any statutory, special or additional reserves provided by the health maintenance organization for the benefit of members as of the most recent calendar quarter

prepared on the basis of statutory accounting principles. If the organization's liability for claims payable and incurred, but not reported, claims increased more than 10% prior to the end of the calendar quarter, the organization must, within 10 days of the determination, reallocate its investments to ensure compliance with this paragraph. The investments required by this paragraph constitute admitted assets of the organization. [1999, c. 715, §19 (AMD).]

E. The superintendent may establish risk-based capital standards for health maintenance organizations, their subsidiaries and controlled affiliates that engage in health care related business activities that the parent corporation conducts. [1993, c. 702, Pt. A, §12 (NEW).]

[1999, c. 715, §19 (AMD) .]

4. **Uncovered expenditures involving deposit.** A health maintenance organization shall deposit with the superintendent or, at the discretion of the superintendent, with any organization or trustee acceptable to the superintendent through which a custodial or controlled account is maintained, cash or securities that are acceptable to the superintendent and that at all times are maintained in a fair market value of not less than an amount equal to the greater of $100,000 or 120% of the health maintenance organization's liability for uncovered expenditures for enrollees as of the end of the most recent calendar quarter, including but not limited to, liability for incurred but not reported claims. If the health maintenance organization's liability for uncovered expenditures increases more than 10% prior to the end of the calendar quarter, the health maintenance organization must, within 10 days of the determination, deposit an amount sufficient to ensure compliance with this section. In the case of domestic health maintenance organizations, "enrollees" for purposes of this subsection means all enrollees of the organization regardless of residence. In the case of foreign health maintenance organizations, "enrollees" for purposes of this subsection means only those enrollees who are residents of this State.

A. The deposit required by this subsection constitutes an admitted asset of the health maintenance organization for purposes of determination of surplus. [1989, c. 842, §13 (NEW).]

B. A health maintenance organization that has made a deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash or securities of equal amount and value. There may also be withdrawn any part of the deposit in excess of the fair market value of the amount of the required deposit. Deposits, substitutions or withdrawals may be made only with the prior written approval of the superintendent. [1989, c. 842, §13 (NEW).]

C. The deposit required by this subsection must be held in trust and must be used only as provided under this section. The superintendent may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees for uncovered expenditures. [1989, c. 842, §13 (NEW).]

D. The superintendent may by rule or order require a health maintenance organization to file annual, quarterly or more frequent reports of a health maintenance organization's liability for uncovered expenditures. The superintendent may require that the reports include an audit opinion. [1989, c. 842, §13 (NEW).]

E. The superintendent may reduce or eliminate the deposit required by this subsection if the health maintenance organization deposits cash or securities with the Treasurer of State, an insurance supervisory official in the state or jurisdiction of domicile or other official body of that state for the protection of all subscribers and enrollees in a manner substantially similar to that required by this subsection and delivers to the superintendent a certificate to that effect, authenticated by the appropriate state official holding the deposit. [1989, c. 842, §13 (NEW).]

F. The superintendent may require a health maintenance organization to continue to maintain the deposit required under this subsection after the health maintenance organization has withdrawn from the market in accordance with section 415-A. [2001, c. 88, §1 (NEW).]

[2001, c. 88, §1 (AMD) .]

5. **Liabilities.** Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid, and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of those claims.

These liabilities must be computed in accordance with rules promulgated by the superintendent upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

[1989, c. 842, §13 (NEW) .]

6. **Hold harmless.** Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee may not be liable to the provider for any sums owed by the health maintenance organization.

A. If the participating provider contract has not been reduced to writing as required by this subsection or the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. [1989, c. 842, §13 (NEW).]

B. No participating provider or agent, trustee or assignee of the participating provider, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization. [1989, c. 842, §13 (NEW).]

C. In addition to the other provisions in this subsection, if a petition to liquidate an insolvent health maintenance organization is filed with a court of competent jurisdiction, then after the date of filing the petition for liquidation:

(1) Any provider who has rendered a covered service for a subscriber or enrollee of the insolvent health maintenance organization is prohibited from collecting or attempting to collect from the subscriber or enrollee amounts normally payable by the insolvent health maintenance organization; and

(2) A provider or agent, trustee or assignee of the provider may not maintain any action at law against a subscriber or enrollee of the insolvent health maintenance organization to collect amounts for covered services normally payable by the insolvent health maintenance organization.

Nothing in this subsection prohibits a provider from collecting or attempting to collect from a subscriber or enrollee any amounts for services not normally payable by the insolvent health maintenance organization, including applicable copayments or deductibles. [2001, c. 88, §2 (NEW).]

[2001, c. 88, §2 (AMD) .]

7. **Continuation of benefits.** The superintendent shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until those covered persons are discharged or upon expiration of benefits. In considering such a plan, the superintendent may require:

A. Insurance adequate to cover the expenses to be paid for continued benefits after an insolvency; [1989, c. 842, §13 (NEW).]

B. That the provider contract obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities; [1989, c. 842, §13 (NEW).]

C. That insolvency reserves be provided and maintained for that period of claims exposure of a health maintenance organization during which a provider's termination of services is pending pursuant to subsection 8; and [1989, c. 842, §13 (NEW).]

D. Any other arrangements to ensure that benefits are continued as specified in this section. [1989, c. 842, §13 (NEW).]

[1989, c. 842, §13 (NEW) .]

8. **Notice of termination.** An agreement to provide health care services between a provider and a health maintenance organization must require that, if the provider terminates that agreement, the provider shall give the health maintenance organization not less than 60 days' notice in advance of termination. That agreement must not require more than 90 days' notice after an initial participation period not to exceed 6 months. If the health maintenance organization has a net loss of 5 or more primary care physicians in any county in any 30-day period, the health maintenance organization shall notify the Bureau of Insurance in writing within 10 days of acquiring knowledge of that loss.

[1989, c. 842, §13 (NEW) .]

9. **Denial.** A certificate of authority may be denied only after compliance with the requirements of section 4219.

[1989, c. 842, §13 (NEW) .]

SECTION HISTORY
1975, c. 293, §5 (AMD). 1975, c. 503, (NEW). 1979, c. 216, §§2-5 (AMD). 1981, c. 501, §§49-51 (AMD). 1985, c. 704, §6 (AMD). 1989, c. 345, §1 (AMD). 1989, c. 842, §§8-13 (AMD). 1991, c. 709, §3 (AMD). RR 1993, c. 1, §67 (COR). 1993, c. 313, §32 (AMD). 1993, c. 702, §§A12,B1 (AMD). 1995, c. 332, §§I1,2,O2 (AMD). 1995, c. 673, §D3 (AMD). 1999, c. 222, §2 (AMD). 1999, c. 715, §19 (AMD). 2001, c. 72, §19 (AMD). 2001, c. 88, §§1,2 (AMD). 2001, c. 410, §A8 (AMD). 2003, c. 510, §§A20,21 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 466, Pt. D, §7 (AMD). 2011, c. 90, Pt. F, §6 (AMD). 2013, c. 588, Pt. A, §29 (AMD).

§4204-A. SURPLUS REQUIREMENTS

1. **Initial minimum surplus.** To qualify for authority as a health maintenance organization, an organization shall have an initial minimum surplus of $1,500,000.

[1989, c. 842, §14 (NEW) .]

2. **Surplus maintained.** Except as provided in this section, every health maintenance organization must maintain a minimum surplus equal to the greater of:

A. One million dollars; [1989, c. 842, §14 (NEW).]

B. Two percent of annual premium revenues as reported in the annual financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent on the first $150,000,000 of premium and 1% of annual premium on the premium in excess of $150,000,000; [1989, c. 842, §14 (NEW).]

C. An amount equal to the sum of 3 months uncovered health care expenditures as reported on the financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent; [2001, c. 88, §3 (AMD).]

D. An amount equal to 8% of annual health care expenditures, except those paid on a capitated basis as reported on the financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent; or [2001, c. 88, §4 (RPR).]

E. An amount equal to the company action level risk-based capital as defined in chapter 79. [2001, c. 88, §5 (NEW).]

[2001, c. 88, §§3-5 (AMD) .]

2-A. **Additional surplus.** A health maintenance organization that otherwise possesses surplus funds as required under this section shall also maintain surplus in a reasonable amount as determined by the superintendent in relation to indemnity risks assumed through the issuance of a point-of-service product, net of any applicable reinsurance.

[1991, c. 709, §4 (NEW) .]

3. **Exceptions.** A health maintenance organization licensed before the effective date of this section must maintain a minimum surplus of:

A. Forty percent of the amount required by subsection 2 until December 31, 1991; [1989, c. 842, §14 (NEW).]

B. Sixty percent of the amount required by subsection 2 until December 31, 1992; [1989, c. 842, §14 (NEW).]

C. Eighty percent of the amount required by subsection 2 until December 31, 1993; and [1989, c. 842, §14 (NEW).]

D. One hundred percent of the amount required by subsection 2 until December 31, 1994. [1989, c. 842, §14 (NEW).]

[1989, c. 842, §14 (NEW) .]

4. **Subordinated debt.** Any health maintenance organization that issues a subordinated debt instrument shall structure the debt as follows.

A. In determining surplus, debt may not be considered fully subordinated unless the subordination clause is in a form approved by the superintendent. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated. [1989, c. 842, §14 (NEW).]

B. Any debt incurred by a note that meets the requirements of this section, and is otherwise acceptable to the superintendent, may not be considered a liability and must be recorded as equity. [1989, c. 842, §14 (NEW).]

[1989, c. 842, §14 (NEW) .]

SECTION HISTORY
1989, c. 842, §14 (NEW). 1991, c. 709, §4 (AMD). 2001, c. 88, §§3-5 (AMD).

§4205. POWERS OF HEALTH MAINTENANCE ORGANIZATIONS

1. The powers of health maintenance organizations include, but are not limited to the following:

A. Subject to such licensure laws or regulations as are applicable, the purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization; [1975, c. 503, (NEW).]

B. The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees; [1975, c. 503, (NEW).]

C. The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization; [1975, c. 503, (NEW).]

D. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration; [1975, c. 503, (NEW).]

E. The contracting with an insurance company licensed in this State for the provision of insurance or indemnity or with a nonprofit hospital or medical service organization for reimbursement against the cost of health care services provided by the health maintenance organization; [1975, c. 503, (NEW).]

F. The offering, in addition to basic health care services, of:

(1) Additional health care services;

(2) Indemnity benefits covering out-of-area services;

(3) Indemnity benefits, in addition to those relating to out-of-area services. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

SECTION HISTORY
1975, c. 503, (NEW).

§4205-A. CONTINUITY OF LICENSURE; BUSINESS COMBINATIONS

When a health maintenance organization authorized pursuant to this chapter merges or consolidates with an insurer or a nonprofit hospital, medical or health care service organization and operations of the surviving entity include those of a health maintenance organization, the surviving entity succeeds on a continuing basis to the authority possessed by the merging entities if: [1993, c. 702, Pt. A, §13 (NEW).]

1. **Plan approved.** The superintendent has approved the plan of merger or consolidation, pursuant to section 4203, subsection 1;

[1993, c. 702, Pt. A, §13 (NEW) .]

2. **Entity financially qualified.** The entity is financially qualified pursuant to the provisions of sections 410 and 4204-A; and

[1993, c. 702, Pt. A, §13 (NEW) .]

3. **Entity otherwise qualified.** The entity is otherwise qualified pursuant to this chapter.

[1993, c. 702, Pt. A, §13 (NEW) .]

SECTION HISTORY
1993, c. 702, §A13 (NEW).

§4206. GOVERNING BODY

1. The governing body of any health maintenance organization may include providers, other individuals, or both.

[1975, c. 503, (NEW) .]

2. Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions or through the use of other mechanisms.

[1975, c. 503, (NEW) .]

SECTION HISTORY
1975, c. 503, (NEW).

§4207. EVIDENCE OF COVERAGE AND CHARGES FOR HEALTH CARE SERVICES

1. Every person who has enrolled as a legal resident of this State in a health maintenance organization is entitled to evidence of coverage. If the enrollee obtains coverage under a health maintenance organization through an insurance policy or contract whether by option or otherwise, the insurer, nonprofit hospital and medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

[1975, c. 503, (NEW) .]

2. No evidence of coverage, or amendment thereto, or underlying contract may be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, amendment thereto and any underlying contract, has been filed with and approved by the superintendent. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 14, §6 (AMD) .]

3. An evidence of coverage shall contain:

A. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in section 4212; and [1975, c. 503, (NEW).]

B. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner information is available as to how services may be obtained;

(4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts or an indication whether the plan is contributory or noncontributory with respect to group certificates; and

(5) A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints.

Any subsequent change shall be evidenced in a separate document issued to the enrollee prior to the change. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

4. A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto shall be subject to the filing and approval requirements of this section unless it is subject to the jurisdiction of the superintendent under the laws governing health insurance, or nonprofit hospital or medical service organization, in which event the filing and approval provisions of such laws shall apply.

[1975, c. 503, (NEW) .]

5. A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with section 2736, 2808-B or 2839, whichever is applicable.

[2003, c. 469, Pt. E, §19 (AMD) .]

6. Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate or unfairly discriminatory. A certification, by a qualified actuary, to the appropriateness of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

[1975, c. 503, (NEW) .]

7. The superintendent shall, within a reasonable period, approve any form and any schedule of charges if the requirements of this section are met. It shall be unlawful to issue such form or to use such schedule of charges until approved. If the superintendent disapproves such filing, he shall notify the filer. In the notice, the superintendent shall specify the reasons for his disapproval. A hearing will be granted within 10 days after a request in writing by the person filing. If the superintendent does not disapprove any form or schedule of charges within 30 days of the filing of such form or charges, they shall be deemed approved.

[1975, c. 503, (NEW) .]

8. The superintendent may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

[1975, c. 503, (NEW) .]

9. A health maintenance organization may issue a Medicare supplement policy. Chapter 67 and any rules adopted pursuant to that chapter shall apply to health maintenance organizations issuing Medicare supplement policies, except when that application is inconsistent with that chapter.

[1989, c. 27, §2 (NEW) .]

SECTION HISTORY
1975, c. 503, (NEW). 1989, c. 27, §2 (AMD). 1993, c. 645, §A6 (AMD). 1995, c. 332, §O3 (AMD). 2003, c. 469, §E19 (AMD). 2009, c. 14, §6 (AMD).

§4207-A. POINT-OF-SERVICE PRODUCTS

1. **Product design; mandatory requirements.** A point-of-service product, filed and approved for use subject to the requirements of section 4207, subsection 4, at a minimum must:

A. Provide all services required by law to be provided by health maintenance organizations as in-plan covered services, including emergency services; [1991, c. 709, §5 (NEW).]

B. Provide incentives for enrollees to use in-plan covered services; and [1991, c. 709, §5 (NEW).]

C. Offer out-of-plan covered services only if those services are provided by the point-of-service product on an in-plan basis. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

2. **Product design; optional provisions.** A point-of-service product may:

A. Limit or exclude specific types of services from coverage when obtained out of plan; [1991, c. 709, §5 (NEW).]

B. Include annual out-of-pocket limits and annual and lifetime maximum benefit allowances for out-of-plan covered services that are separate from any limits and allowances applied to in-plan covered services; [1991, c. 709, §5 (NEW).]

C. Limit the groups to which the point-of-service product is offered. If the point-of-service product is offered to a group, it must be offered to all eligible members of that group; and [1991, c. 709, §5 (NEW).]

D. Include those services that an enrollee obtains from a participating physician for which proper authorization was not given. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

3. **Product limitations and exclusions.** A health maintenance organization is subject to the following requirements as to its point-of-service product.

A. A health maintenance organization may not expend more than 20% of its total annual health care expenditures for out-of-plan covered services. [1991, c. 709, §5 (NEW).]

B. If compliance with the amount specified in paragraph A is not demonstrated on a quarterly basis in a health maintenance organization's quarterly financial report, the superintendent may prohibit the health maintenance organization from offering a point-of-service product for new issues or for the renewal of existing contracts until compliance has been demonstrated. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

4. **Plan requirements.** A health maintenance organization may not issue a point-of-service product until it has filed and has had approved by the superintendent a plan to comply with this section, including, in addition to any other requirements of this section, group contracts, subscriber contracts and other materials used by enrollees.

A. Marketing materials must be filed upon request of the superintendent. Member handbooks must be filed for approval only when the initial point-of-service plan is filed and when substantial modifications are made in the point-of-service plan that change policy terms respecting benefits or change the manner in which enrollees may access provider services. [1991, c. 709, §5 (NEW).]

B. The plan must include, but is not limited to, provisions demonstrating that the health maintenance organization will:

(1) Design the benefit levels for in-plan covered services and out-of-plan covered services to achieve the desired level of in-plan utilization; and

(2) Provide or arrange for the provision of adequate systems to:

(a) Process and pay claims for out-of-plan covered services;

(b) Meet the requirements of a point-of-service product as set by this section or by rule of the superintendent; and

(c) Generate accurate financial and regulatory reports on a timely basis in order for the superintendent to evaluate experience with the point-of-service product and monitor compliance with point-of-service product provisions. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

5. **Claims processing.** Explanation of benefits given to an enrollee of a point-of-service plan must contain an explanation of coverage for self-referral health care services that is adequate to permit an enrollee to determine claims liability under the plan.

[1991, c. 709, §5 (NEW) .]

5-A. **Assignment of benefits.** All point-of-service contracts and certificates must contain a provision permitting the insured to assign any benefits provided for medical or dental care on an expense-incurred basis to the provider of the care. An assignment of benefits under this subsection does not affect or limit the payment of benefits otherwise payable under the contract or certificate.

[1999, c. 21, §4 (AMD) .]

6. **Disclosure.** All marketing materials, subscriber contracts, member handbooks or other material used by enrollees must contain a clear and concise explanation of point-of-service health care services. The explanation must include:

A. The method of reimbursement; [1991, c. 709, §5 (NEW).]

B. Applicable copayments and deductibles; [1991, c. 709, §5 (NEW).]

C. Other uncovered costs or charges; [1991, c. 709, §5 (NEW).]

D. The services that an enrollee is permitted to obtain on a self-referral basis; and [1991, c. 709, §5 (NEW).]

E. Instructions regarding submission of claims for self-referred health care services. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

SECTION HISTORY
1991, c. 709, §5 (NEW). 1997, c. 604, §E4 (AMD). 1999, c. 21, §4 (AMD).

§4208. ANNUAL REPORT

1. Every health maintenance organization shall file annually, on or before March 1st or within any reasonable extension of time that the superintendent for good cause shown may have granted on or before March 1st, with the superintendent a full and true statement of its financial condition, transactions and affairs as of December 31st of the preceding year, verified by at least 3 principal officers and shall provide a copy of that statement to the Commissioner of Human Services. The superintendent may by rule or order require the filing of quarterly or more frequent reports, which may be required to include liability for uncovered expenditures as well as an audit opinion.

[1993, c. 313, §33 (AMD) .]

2.

[1993, c. 313, §34 (RP) .]

3. The annual statement must be prepared in accordance with the National Association of Insurance Commissioners annual statement instructions and must follow practices and procedures prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual for health maintenance organizations. The annual statement must include:

A. A summary of information compiled pursuant to section 4204 in the form required by the Commissioner of Human Services; and [1993, c. 313, §35 (NEW).]

B. Other information related to the performance of the health maintenance organization that is necessary to enable the superintendent to carry out the superintendent's duties under this chapter. [1993, c. 313, §35 (NEW).]

[1993, c. 313, §35 (NEW) .]

4. The superintendent may refuse to continue or may suspend or revoke the certificate of authority of a health maintenance organization failing to file an annual statement when due.

[1993, c. 313, §35 (NEW) .]

SECTION HISTORY
1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 1991, c. 709, §6 (AMD). 1993, c. 313, §§33-35 (AMD).

§4209. INFORMATION TO ENROLLEES

1. **Information provided annually.** Every health maintenance organization must annually provide to its enrollees:

A. The most recent annual statement of financial condition including a balance sheet and a statement of operations; [1989, c. 842, §15 (NEW).]

B. A description of the organizational structure and operation of the health maintenance organization, including the kind and extent of enrollee participation and a summary of any material changes since the issuance of the last report; and [1995, c. 673, Pt. D, §4 (AMD).]

C. [1995, c. 673, Pt. D, §5 (RP).]

D. [1995, c. 673, Pt. D, §5 (RP).]

E. A description of the plan as required under section 4302, subsection 1. [1995, c. 673, Pt. D, §6 (NEW).]

[1995, c. 673, Pt. D, §4-6 (AMD) .]

2. **List of providers.** The health maintenance organization must provide to its subscribers, upon enrollment and reenrollment, a list of providers.

[1989, c. 842, §15 (RPR) .]

3. **Notice of material change.** Every health maintenance organization must provide 30 days' advance notice to its subscribers of any material change in the operation of the organization that will directly affect the subscribers.

[1989, c. 842, §15 (RPR) .]

4. **Notice of termination of primary care provider.** An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider that provided health care services to that enrollee. The health maintenance organization must provide assistance to the enrollee in transferring to another participating primary care provider.

[1989, c. 842, §15 (RPR) .]

5. **Access to services.** The health maintenance organization shall provide to its subscribers information on how services may be obtained, where additional information on access to services is obtained and a toll free telephone number for calls within the service area of the health maintenance organization.

[1989, c. 842, §15 (NEW) .]

6. **Notification of cancellation.** A health maintenance organization may not cancel or refuse to renew any group contract until it has provided by first class mail at least 10 days' prior notification according to this section. The notice must include the date of cancellation of coverage and the time period for exercising contract conversion rights. The notice also must include an explanation of any applicable grace period. Notification is not required when the health maintenance organization has received written notice from the group contract holder that replacement coverage has been obtained.

A. Notice must be mailed to the group contract holder or subgroup sponsor. [1995, c. 189, §3 (NEW); 1995, c. 189, §4 (AFF).]

B. [2003, c. 156, §5 (RP).]

B-1. At the time of notification under paragraph A, notice must be mailed to the individual enrollee at the last address provided to the health maintenance organization by the subgroup sponsor, the group contract holder or the individual enrollee. If the health maintenance organization does not have an address on file for the individual enrollee, the notice must be mailed to the office of the subgroup sponsor, if any, or the group contract holder. The notice must also include information to the individual enrollee about the availability of individual coverage as described in section 2809-A, subsection 1-B. [2003, c. 428, Pt. B, §3 (AMD).]

C. [2003, c. 428, Pt. B, §3 (RP).]

[2003, c. 428, Pt. B, §3 (AMD) .]

SECTION HISTORY
1975, c. 503, (NEW). 1989, c. 842, §15 (RPR). 1995, c. 189, §3 (AMD). 1995, c. 189, §4 (AFF). 1995, c. 673, §§D4-6 (AMD). 2003, c. 156, §5 (AMD). 2003, c. 428, §B3 (AMD).

§4210. OPEN ENROLLMENT

1. After a health maintenance organization has been in operation 24 months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. To the extent not inconsistent with the requirements of chapter 36 and sections 2736-C and 2808-B as qualified by section 4222-B, subsection 3, a health maintenance organization may apply to the superintendent for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The superintendent shall approve or deny the application within 10 days of the receipt of that application from the health maintenance organization.

[1995, c. 332, Pt. O, §4 (AMD) .]

2. Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment provided for in this section to all members of the group or groups covered by such contracts.

[1975, c. 503, (NEW) .]

SECTION HISTORY
1975, c. 503, (NEW). 1995, c. 332, §O4 (AMD).

§4210-A. CONTINUITY OF HEALTH INSURANCE COVERAGE

(REPEALED)

SECTION HISTORY
1989, c. 867, §§9,10 (NEW). 1995, c. 332, §O5 (RP).

§4211. COMPLAINT SYSTEM

1. Every health maintenance organization shall establish and maintain a complaint system which has been approved by the superintendent, after consultation with the Commissioner of Health and Human Services, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services and general operating procedures.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

2. Each health maintenance organization shall submit to the superintendent and the Commissioner of Health and Human Services an annual report in a form prescribed by the superintendent after consultation with the Commissioner of Health and Human Services that includes:

A. A description of the procedures of such complaint system; [1975, c. 503, (NEW).]

B. The total number and disposition of complaints handled through the complaint system and a compilation of causes underlying the complaints filed. Complaints concerning access to chiropractic providers and the results of those complaints must be separately identified; and [1993, c. 669, §4 (AMD).]

C. The number, amount and disposition of malpractice claims settled during the year by the health maintenance organization. [1975, c. 503, (NEW).]

[2003, c. 2, §87 (COR) .]

3. The health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the superintendent a summary report at such times and in such format as the superintendent may require. Such complaints involving other persons shall be referred to such persons with a copy to the superintendent.

[1975, c. 503, (NEW) .]

4. The superintendent and the Commissioner of Health and Human Services may examine such complaint system.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY
1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 1993, c. 669, §4 (AMD).
RR 2003, c. 2, §87 (COR). 2003, c. 689, §B7 (REV).

§4212. PROHIBITED PRACTICES

1. No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this chapter:

A. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health maintenance organization; [1975, c. 503, (NEW).]

B. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist; [1975, c. 503, (NEW).]

C. An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health maintenance organizations and evidences of coverage therefor, to expect benefits, services, charges or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

2. An enrollee may not be cancelled nor denied renewal except for the following:

A. Fraud or material misrepresentation; [1995, c. 332, Pt. O, §6 (NEW).]

B. Failure to pay the charge for coverage; [1995, c. 332, Pt. O, §6 (NEW).]

C. When the provisions of the State's community rating law are applicable, as provided by section 2736-C, subsection 3, paragraph B and section 2808-B, subsection 4, paragraph B; or [1995, c. 332, Pt. O, §6 (NEW).]

D. Other reasons promulgated by the superintendent. [1995, c. 332, Pt. O, §6 (NEW).]

[1995, c. 332, Pt. O, §6 (RPR) .]

3. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts or literature any of the words "insurance", "casualty", "surety", "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

[1975, c. 503, (NEW) .]

SECTION HISTORY
1975, c. 503, (NEW). 1995, c. 332, §O6 (AMD).

§4213. REGULATION OF AGENTS

The superintendent may, after notice and hearing pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents. An agent means a person directly or indirectly associated with a health maintenance organization who engages in solicitation or enrollment. [1977, c. 694, §433 (AMD).]

SECTION HISTORY
1975, c. 503, (NEW). 1977, c. 694, §433 (AMD).

§4214. POWERS OF INSURERS AND NONPROFIT HOSPITAL OR MEDICAL SERVICE CORPORATIONS

1. Subject to the provisions of sections 222, 3479 to 3482 and chapters 13 and 13-A, an insurance company licensed in this State or a nonprofit hospital, medical or health care service organization may establish, maintain, own, merge with, organize and operate a health maintenance organization under this chapter, either directly as a division or line of business, or indirectly through a subsidiary or affiliate. Subject to the provisions of section 222 and chapters 13 and 13-A, 2 or more such insurance companies, or nonprofit hospital, medical or health care service organizations, or subsidiaries or affiliates, may jointly organize and operate a health maintenance organization. The business of an insurer or hospital or medical service corporation that establishes, maintains, owns, merges with, organizes or operates a health maintenance organization is considered to include the providing of health care by a health maintenance organization.

[1993, c. 702, Pt. A, §14 (AMD) .]

1-A. A domestic insurer that establishes, maintains, merges with or organizes and operates a health maintenance organization as a division or line of business is governed in its investment of funds allocated to that line of business by the provisions of section 4204, subsection 3-A.

[1993, c. 702, Pt. A, §15 (NEW) .]

2. Notwithstanding any provision of this Title, an insurer or a nonprofit hospital and medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

[1975, c. 503, (NEW) .]

3. The enrollees of a health maintenance organization constitute a permissible group, under such laws, and shall not be counted as part of any group for the purposes of chapter 35. Among other things, under such contracts, the insurer or nonprofit hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health maintenance organization.

[1975, c. 503, (NEW) .]

4.

[1989, c. 842, §16 (RP) .]

SECTION HISTORY
1975, c. 503, (NEW). 1989, c. 842, §16 (AMD). 1993, c. 702, §§A14,15 (AMD).

§4215. EXAMINATIONS

1. The superintendent may make an examination of the affairs of any health maintenance organization as often as he deems it necessary for the protection of the interests of the people of this State, but not less frequently than once every 3 years.

[1975, c. 503, (NEW) .]

2. The Commissioner of Health and Human Services may make an examination concerning the quality of health care services of any health maintenance organization as often as he deems it necessary for the protection of the interests of the people of this State, but not less frequently than once every 3 years.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

3. Every health maintenance organization shall submit its books and records relating to health care services to such examinations and in every way facilitate them. For the purpose of examinations, the superintendent and the Commissioner of Health and Human Services may administer oaths to and examine the officers and agents of the health maintenance organization.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

4. The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the superintendent or the Commissioner of Health and Human Services for whom the examination is being conducted.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

5. In lieu of such examination, the superintendent or Commissioner of Health and Human Services may accept the report of an examination made by persons holding comparable office of another state.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY
1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 2003, c. 689, §B7 (REV).

§4216. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY

1. Notwithstanding Title 4, chapter 5 and Title 5, section 10051, the superintendent may suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter if the superintendent finds that any of the following conditions exist after a hearing held in accordance with Title 5, chapter 375, subchapter IV:

A. The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 4203, unless amendments to such submissions have been filed with and approved by the superintendent; [1975, c. 503, (NEW).]

B. The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services that do not comply with the requirements of section 4207; [1997, c. 592, §71 (AMD).]

C. The health maintenance organization does not provide or arrange for basic health care services; [1975, c. 503, (NEW).]

D. The Commissioner of Health and Human Services certifies to the superintendent that:

(1) The health maintenance organization does not meet the requirements of section 4204, subsection 2-A, paragraph B; or

(2) The health maintenance organization is unable to fulfill its obligations to furnish health care services; [1997, c. 683, Pt. B, §14 (AMD); 2003, c. 689, Pt. B, §7 (REV).]

E. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees; [1975, c. 503, (NEW).]

F. The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 4206; [1975, c. 503, (NEW).]

G. The health maintenance organization has failed to implement the complaint system required by section 4211 in a manner to reasonably resolve valid complaints; [1975, c. 503, (NEW).]

H. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner; [1975, c. 503, (NEW).]

I. The continued operation of the health maintenance organization would be hazardous to its enrollees; [1975, c. 503, (NEW).]

I-1. The health maintenance organization has failed to meet the surplus requirements of section 4204-A; or [1989, c. 842, §17 (NEW).]

J. The health maintenance organization has otherwise failed to substantially comply with this chapter. [1975, c. 503, (NEW).]

[1999, c. 547, Pt. B, §46 (AMD); 1999, c. 547, Pt. B, §80 (AFF); 2003, c. 689, Pt. B, §7 (REV) .]

2. A certificate of authority shall be suspended or revoked only after compliance with the requirements of section 4219.

[1975, c. 503, (NEW) .]

3. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

[1975, c. 503, (NEW) .]

4. When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The superintendent may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

[1975, c. 503, (NEW) .]

SECTION HISTORY

1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 1977, c. 694, §434 (AMD). 1989, c. 842, §17 (AMD). 1997, c. 592, §71 (AMD). 1997, c. 683, §B14 (AMD). 1999, c. 547, §B46 (AMD). 1999, c. 547, §B80 (AFF). 2003, c. 689, §B7 (REV).

§4217. REHABILITATION, LIQUIDATION OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATIONS

Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the superintendent pursuant to the laws governing the rehabilitation, liquidation or conservation of insurance companies. The superintendent may institute summary proceedings in the same manner as provided in the laws governing delinquent insurers, and he may apply for an order directing him to rehabilitate, liquidate or conserve a health maintenance organization when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State. [1975, c. 503, (NEW).]

SECTION HISTORY
1975, c. 503, (NEW).

§4218. REGULATIONS

The superintendent may, after notice and hearing pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, promulgate reasonable rules and regulations as are necessary or proper to carry out this chapter. Such rules and regulations shall be subject to review in accordance with sections 229 to 236. [1977, c. 694, §435 (AMD).]

SECTION HISTORY
1975, c. 503, (NEW). 1977, c. 694, §435 (AMD).

§4218-A. COMPLIANCE WITH THE AFFORDABLE CARE ACT

The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments to rules adopted pursuant to this section, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 364, §19 (NEW).]

SECTION HISTORY
2011, c. 364, §19 (NEW).

§4219. ADMINISTRATIVE PROCEDURES

1. When the superintendent has cause to believe that grounds exist for the suspension or revocation of a certificate of authority, the superintendent shall notify the health maintenance organization and the Commissioner of Health and Human Services in writing specifically stating the grounds for suspension or revocation. The Commissioner of Health and Human Services, or the commissioner's designated representative, shall participate in any disciplinary proceedings. In the process of determining whether grounds for suspension or revocation exist the findings of the commissioner with respect to matters relating to the quality of health care services provided are conclusive and binding upon the Superintendent of Insurance. The duration of and conditions attached to any suspension are determined by the superintendent after a hearing held in accordance with Title 5, chapter 375, subchapter IV.

[1997, c. 592, §72 (AMD); 2003, c. 689, Pt. B, §7 (REV) .]

2. The Superintendent of Insurance, acting in concert with the Commissioner of Health and Human Services, has the authority to amend, modify or refuse to renew any certificate of authority for cause, pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV.

[1977, c. 694, §436 (RPR); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY
1975, c. 503, (NEW). 1977, c. 694, §436 (RPR). 1997, c. 592, §72 (AMD). 2003, c. 689, §B7 (REV).

§4220. FEES

1. Every health maintenance organization subject to this chapter shall pay to the superintendent the following fees:

A. For filing an initial application for a certificate of authority, $500; [1975, c. 503, (NEW).]

B. For filing each annual report, $50. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

2. Fees charged under this section shall be distributed as follows: 50% to the superintendent and 50% to the Commissioner of Health and Human Services.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY
1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 2003, c. 689, §B7 (REV).

§4221. PENALTIES AND ENFORCEMENT

1. The superintendent may levy an administrative penalty in an amount not less than $100 nor more than $500, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The superintendent may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

[1977, c. 694, §437 (AMD) .]

2. If the superintendent or the Commissioner of Health and Human Services shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the superintendent or Commissioner of Health and Human Services may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the superintendent or the Commissioner of Health and Human Services may deem appropriate under the circumstances.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

3. The superintendent may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of this chapter.

Within 10 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred.

[1975, c. 503, (NEW) .]

4. In the case of any violation under this chapter, if the superintendent elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to this section, the superintendent may apply to the Superior Court to issue an injunction restraining the company in whole or in part from proceeding further with its business, or he may apply for an order of the court to command performance consistent with contractual obligations of the health maintenance organization.

[1975, c. 503, (NEW) .]

SECTION HISTORY
1975, c. 293, §5 (AMD). 1975, c. 503, (NEW). 1977, c. 694, §437 (AMD). 2003, c. 689, §B7 (REV).

§4222. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS

1. Except as otherwise specifically provided, provisions of the insurance law and the laws relating to hospital or medical service corporations do not apply to a health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws of this State except with respect to its health maintenance organization activities, whether those activities are conducted through a subsidiary or as a division or line of business, authorized and regulated pursuant to this chapter.

[1993, c. 702, Pt. A, §16 (AMD) .]

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

[1975, c. 503, (NEW) .]

3. Any health maintenance organization authorized under this chapter is not deemed to be practicing medicine and is exempt from provisions of law relating to the practice of medicine, except that this subsection may not be asserted by a health maintenance organization as a defense to any action brought by an enrollee pursuant to section 4313.

[1999, c. 742, §1 (AMD) .]

4.

[1995, c. 625, Pt. A, §26 (RP) .]

SECTION HISTORY
1975, c. 503, (NEW). 1991, c. 861, §3 (AMD). 1991, c. 861, §4 (AFF). 1993, c. 702, §A16 (AMD). 1995, c. 332, §§L2,O7 (AMD). 1995, c. 625, §A26 (AMD). 1999, c. 742, §1 (AMD).

§4222-A. RULES

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may make, adopt, amend and rescind reasonable rules to aid the administration or effectuation of any provisions of this chapter. [1993, c. 702, Pt. A, §17 (NEW).]

SECTION HISTORY
1993, c. 702, §A17 (NEW).

§4222-B. APPLICABILITY

1. Every health maintenance organization licensed under this chapter is considered an insurer for purposes of those provisions of the insurance laws that do not expressly reference health maintenance organizations, but are applicable to health maintenance organizations under this chapter.

[1995, c. 332, Pt. O, §8 (NEW) .]

2. The requirements of chapter 36, continuity of health insurance coverage law, apply to health maintenance organizations.

[1995, c. 332, Pt. O, §8 (NEW) .]

3. The requirements of sections 2736-C and 2808-B, community rating law, apply to health maintenance organizations, except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group or individual located outside the health maintenance organization's approved service area.

[1995, c. 332, Pt. O, §8 (NEW) .]

4. The requirements of chapter 23 and any rules adopted pursuant to it, to the extent not inconsistent with this chapter and the reasonable implications of this chapter, apply to health maintenance organizations.

[1995, c. 332, Pt. O, §8 (NEW) .]

5. The requirements of section 222, subsections 2 to 9, subsections 11-A and 11-B and subsections 13 to 18 apply to domestic health maintenance organizations.

[2001, c. 88, §6 (AMD) .]

6. The requirements of chapter 57, subchapters I and II apply to health maintenance organizations.

[2001, c. 88, §6 (AMD) .]

7. The requirements of section 421 apply to health maintenance organizations.

[1997, c. 457, §50 (AMD) .]

8. The requirements of chapter 32, the Preferred Provider Arrangement Act of 1986, apply to health maintenance organizations only with respect to activities that are not otherwise authorized by chapter 56.

[1995, c. 332, Pt. O, §8 (NEW) .]

9. The requirements of chapter 56-A and any rules adopted pursuant to that chapter apply to health maintenance organizations.

[1995, c. 673, Pt. D, §7 (NEW) .]

10. The requirements of section 237 apply to health maintenance organizations, including those operated and organized as a division or line of business of a nonprofit hospital, medical or health care service organization.

[1997, c. 79, §3 (NEW) .]

11. The requirements of sections 2834 and 2834-B apply to health maintenance organizations.

[1997, c. 445, §31 (NEW); 1997, c. 445, §32 (AFF) .]

12. The requirements of chapter 24 and any rules adopted pursuant to that chapter apply to health maintenance organizations.

[1997, c. 677, §4 (NEW) .]

13. The requirements of sections 2436 and 2436-A apply to health maintenance organizations.

[1999, c. 256, Pt. F, §1 (NEW) .]

14. The requirement of filing a report of experience of claims payment for alcoholism and drug dependency treatment in the format prescribed by section 2842, subsection 9; for chiropractic services in the format prescribed by section 2748, subsection 3 and section 2840-A, subsection 3; and for breast cancer screening services in the format prescribed by section 2745-A, subsection 4 and section 2837-A, subsection 4 applies to health maintenance organizations.

[2001, c. 258, Pt. G, §3 (AMD) .]

15. The requirements of section 415-A apply to health maintenance organizations.

[2001, c. 88, §7 (NEW) .]

15. (REALLOCATED TO T. 24-A, §4222-B, sub-§20)

[2001, c. 1, §35 (RAL) .]

16. The requirements of sections 3483 and 3484 apply to health maintenance organizations.

[2001, c. 88, §7 (NEW) .]

17. Section 2803-A, relating to disclosure of loss information, applies to health maintenance organizations.

[2001, c. 410, Pt. B, §3 (NEW) .]

18. The requirement of section 2809-A, subsection 11 to continue group coverage under certain circumstances applies to health maintenance organizations.

[2001, c. 410, Pt. B, §3 (NEW) .]

19. Section 12-A, relating to penalties, applies to health maintenance organizations.

[2001, c. 410, Pt. B, §3 (NEW) .]

20. (REALLOCATED FROM T. 24-A, §4222-B, sub-§15) Sections 2735-A and 2839-A, relating to notice of rate filings and rate increases, apply to health maintenance organizations.

[2001, c. 1, §35 (RAL) .]

21. Section 2723-A, subsection 3 and section 2844, subsection 3 apply to health maintenance organizations.

[2005, c. 121, Pt. D, §4 (NEW) .]

22. Sections 2713-A and 2823-A, relating to explanation and notice to parents, apply to health maintenance organizations.

[2009, c. 244, Pt. B, §3 (NEW) .]

SECTION HISTORY
1995, c. 332, §O8 (NEW). 1995, c. 673, §D7 (AMD). 1997, c. 79, §3 (AMD). 1997, c. 445, §31 (AMD). 1997, c. 445, §32 (AFF). 1997, c. 457, §50 (AMD). 1997, c. 677, §4 (AMD). 1999, c. 256, §F1 (AMD). RR 2001, c. 1, §35 (COR). 2001, c. 88, §§6,7 (AMD). 2001, c. 258, §G3 (AMD). 2001, c. 410, §B3 (AMD). 2001, c. 432, §8 (AMD). 2005, c. 121, §D4 (AMD). 2009, c. 244, Pt. B, §3 (AMD).

§4223. FILINGS AND REPORTS AS PUBLIC DOCUMENTS

All applications, filings and reports required under this chapter shall be treated as public documents subject to limitations and exceptions provided in Title 1, chapter 13, subchapter I. [1985, c. 704, §7 (AMD).]

SECTION HISTORY
1975, c. 503, (NEW). 1985, c. 704, §7 (AMD).

§4224. CONFIDENTIALITY; LIABILITY; ACCESS TO RECORDS

1. **Confidentiality.** Any data or information pertaining to the diagnosis, treatment or health of an enrollee or applicant obtained from that enrollee or applicant or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except: to the extent that it may be necessary to carry out the purposes of this chapter; upon the express consent of the enrollee or applicant; pursuant to statute or court order for the production of evidence or the discovery of evidence; or in the event of claim or litigation between that enrollee or applicant and the health maintenance organization when such data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against such disclosure that the provider who furnished such information to the health maintenance organization is entitled to claim.

[1991, c. 709, §7 (NEW) .]

2. **Liability.** A person who, in good faith and without malice, as a member, agent or employee of a quality assurance committee, assists in the origination, investigation or preparation of a report or information related to treatment previously rendered, submits that report or information to a health maintenance organization or appropriate state licensing board, or assists the committee in carrying out any of its duties under this chapter is not subject to civil liability for damages as a consequence of those actions, nor is the

health maintenance organization that established that committee or the officers, directors, employees or agents of that health maintenance organization liable for the activities of that person. This section may not be construed to relieve any person of liability arising from treatment of a patient.

A. The information considered by a quality assurance committee and the records of its actions and proceedings are confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal, if permitted, from the findings or recommendations of the committee. A member of a quality assurance committee or an officer, director, staff person or other member of a health maintenance organization engaged in assisting the committee or any person assisting or furnishing information to the committee may not be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities. [1991, c. 709, §7 (NEW).]

B. Information considered by a quality assurance committee and the records and proceedings of that committee used pursuant to paragraph A by a state licensing or certifying agency or in an appeal must be kept confidential and are subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of the health care review committee. [1991, c. 709, §7 (NEW).]

[1991, c. 709, §7 (NEW) .]

3. **Access to records.** To fulfill the obligations of a health maintenance organization under section 4204, subsection 2-A, paragraph B, a health maintenance organization must have access to treatment records and other information pertaining to the diagnosis, treatment and health status of any enrollee.

[1991, c. 709, §7 (NEW) .]

SECTION HISTORY
1975, c. 503, (NEW). 1991, c. 709, §7 (RPR).

§4224-A. LOSS INFORMATION

(REPEALED)

SECTION HISTORY
1995, c. 71, §3 (NEW). 1997, c. 370, §E7 (AMD). 2001, c. 410, §B4 (RP).

§4225. COMMISSIONER OF HEALTH AND HUMAN SERVICES' AUTHORITY TO CONTRACT

The Commissioner of Health and Human Services, in carrying out his obligations under sections 4204, subsection 1, paragraph B, 4215 and 4216, subsection 1, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the Commissioner of Health and Human Services. [1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV).]

SECTION HISTORY
1975, c. 293, §4 (AMD). 1975, c. 503, (NEW). 2003, c. 689, §B7 (REV).

§4226. FEDERAL LEGISLATION

Nothing in this chapter shall prohibit any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or certification or to enroll beneficiaries assisted by federal funds. [1975, c. 503, (NEW).]

SECTION HISTORY
1975, c. 503, (NEW).

§4227. CHOICE OF ALTERNATIVE COVERAGE

Any employer of more than 50 employees who offers a health maintenance organization, as defined in section 4202-A, shall also offer its employees, at the time of offering and renewal of the health maintenance organization, the option of selecting alternative health benefits coverage that does not restrict the ability of the covered persons to obtain health care services from the providers of their choice. [1991, c. 709, §8 (AMD).]

Any employer subject to this section shall contribute to the alternative health benefits coverage to the same extent as it contributes to the health maintenance organization. [1985, c. 704, §8 (NEW).]

An employer may not be required to pay more for health benefits as a result of the application of this section than would otherwise be paid. [1991, c. 709, §8 (AMD).]

An employer may satisfy the requirements of this section by offering a point-of-service option but may not satisfy the requirements of this section by contributing to the cost of an individual health plan. [1997, c. 370, Pt. B, §4 (AMD).]

SECTION HISTORY
1985, c. 704, §8 (NEW). 1991, c. 709, §8 (AMD). 1997, c. 370, §B4 (AMD).

§4228. UTILIZATION REVIEW DATA

1. **Report required.** On or before April 1st of each year, each health maintenance organization which issues a program of contract in this State that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed.

(1) For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service.

(2) The report must separately identify the number of evaluations performed in which the health care services requested or provided include chiropractic services and the results of those evaluations; [1993, c. 669, §5 (AMD).]

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the health maintenance organization; [1987, c. 168, §5 (NEW).]

C. The number and result of any appeals by patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [1987, c. 168, §5 (NEW).]

D. Any complaints filed in a court of competent jurisdiction and served upon a health maintenance organization filing under this section stating a cause of action against that organization on the basis of damages to patients alleged to have been proximately caused by a delay, reduction or denial of medical benefits by the organization, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint. [1987, c. 168, §5 (NEW).]

[1993, c. 669, §5 (AMD) .]

2. **Maine residents.** This section is applicable to evaluations, appeals and complaints relating to Maine residents only.

[1987, c. 168, §5 (NEW) .]

3. **Confidentiality.** Any information provided pursuant to this section shall not identify the names of patients.

[1987, c. 168, §5 (NEW) .]

SECTION HISTORY
1987, c. 168, §5 (NEW). 1993, c. 669, §5 (AMD).

§4229. ACQUIRED IMMUNE DEFICIENCY SYNDROME

No policy, contract or certificate delivered or issued for delivery in this State may provide more restrictive coverage for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex or HIV related diseases than for any other disease or sickness or exclude coverage for AIDS, ARC or HIV related diseases except through an exclusion under which all sicknesses and diseases are treated the same. [1989, c. 176, §9 (NEW).]

SECTION HISTORY
1989, c. 176, §9 (NEW).

§4230. TRADE PRACTICES AND FRAUDS

(REPEALED)

SECTION HISTORY
1989, c. 345, §2 (NEW). 1995, c. 332, §09 (RP).

§4231. INSOLVENCY OR WITHDRAWAL; ALTERNATIVE COVERAGE

1. **Continuation of coverage by other carriers.** In the event of an insolvency of a health maintenance organization and if satisfactory arrangements for the performance of its obligations have not been made as provided for in section 4214, all other carriers that made an offer of coverage to any group contract holder of the insolvent health maintenance organization at the most recent purchase or renewal of coverage, upon order of the superintendent, shall offer the enrollees in the group covered by that contract a 30-day enrollment period that begins on the date of insolvency.

Each carrier shall offer the group's enrollees the same coverage and rates that the carrier had offered to those enrollees at the most recent purchase or renewal of coverage prior to the insolvency, except that a successor health maintenance organization may increase the group's rate to the extent justified by including the new enrollees in a recalculation of rates using the existing method of rate calculation of the successor carrier or, if the group was covered under a multiple-year contract, to the extent justified to take into account increased health care costs, as approved by the superintendent.

[2001, c. 88, §8 (AMD) .]

2. **Allocation of enrollees.** If no other carrier had offered coverage to a group contract holder in the insolvent health maintenance organization, or if the superintendent determines that the other health benefit plan or plans lack sufficient health care delivery resources to ensure that health care services will be available and reasonably accessible to all of that group's enrollees in the insolvent health maintenance organization, then the superintendent shall allocate equitably the insolvent health maintenance organization's group contracts among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

[1989, c. 842, §18 (NEW) .]

3. **Nongroup enrollees.**

[1995, c. 332, Pt. O, §10 (RP) .]

4. **Allocation upon withdrawal.** If any group contract holder of a withdrawing health maintenance organization is unable to obtain replacement coverage subsequent to a withdrawal pursuant to section 415-A, the superintendent may allocate equitably the withdrawing health maintenance organization's group contract holders among all health maintenance organizations that operate within a portion of the withdrawing health maintenance organization's service area in accordance with subsection 2.

[2001, c. 88, §9 (NEW) .]

SECTION HISTORY
1989, c. 842, §18 (NEW). 1995, c. 332, §O10 (AMD). 2001, c. 88, §§8,9 (AMD).

§4232. REPLACEMENT COVERAGE

1. **Group hospital, medical or surgical expenses, or service benefits.** Any insurer or nonprofit health insurance plan that issues replacement coverage with respect to group hospital, medical or surgical expenses or service benefits within a period of 60 days from the date of discontinuance of a prior health maintenance organization contract or policy providing the hospital, medical or surgical expenses or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding insurer's or nonprofit health insurance plan's contract, regardless of any provisions in that contract relating to active employment, hospital confinement or pregnancy.

[1989, c. 842, §18 (NEW) .]

2. **Preexisting conditions.** No provision in a succeeding insurer's or nonprofit hospital or medical service corporation's contract of replacement coverage may reduce or exclude benefits to enrollees covered under the prior health maintenance organization's contract on the date of discontinuance, on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding contract, except to the extent that benefits for the condition would have been reduced or excluded under the prior contract.

[1989, c. 842, §18 (NEW) .]

SECTION HISTORY
1989, c. 842, §18 (NEW).

§4233. REGISTRATION, REGULATION AND SUPERVISION OF HOLDING COMPANY SYSTEMS

1.

[1995, c. 332, Pt. O, §11 (RP) .]

2. Every domestic health maintenance organization is subject to the requirements of section 221-A. At the superintendent's request, a domestic health maintenance organization must make available to the superintendent the audit work papers of any accountant who has audited that health maintenance organization.

Upon timely notice to a health maintenance organization, the superintendent may review, photocopy or otherwise record the audit work papers generated by any accountant who has audited that health maintenance organization.

Health maintenance organization work papers under the superintendent's custody or control are confidential and not subject to public inspection.

The work papers of a health maintenance organization's parent, subsidiaries or other corporate affiliates are deemed to be the work papers of that health maintenance organization to the extent the work papers affect the health maintenance organization's final equity determination and reference any transaction between the health maintenance organization and its parent, subsidiaries or corporate affiliates.

As a condition of engaging an auditing accountant, the health maintenance organization shall require the accountant to:

A. Retain for a period of at least 6 years any work papers prepared in connection with the accountant's audit of that health maintenance organization; and [1993, c. 313, §36 (NEW).]

B. Provide, at the request of the health maintenance organization, the original or copies of any work papers created by the accountant in connection with an audit of that health maintenance organization. [1993, c. 313, §36 (NEW).]

For purposes of this subsection, the term "work papers" includes, but is not limited to, originals or copies of any schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, company records or other documents prepared or obtained by the accountant and the accountant's employees in the course of conducting an audit of the health maintenance organization.

[1993, c. 313, §36 (NEW) .]

SECTION HISTORY
1989, c. 842, §18 (NEW). 1993, c. 313, §36 (RPR). 1995, c. 332, §O11 (AMD).

§4233-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN

An individual or group health maintenance organization contract that provides coverage for a dependent child at certain ages only if the child is a student must continue that coverage if the child is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury. This coverage may be terminated at the age at which coverage for students terminates under the terms of the contract. A health maintenance organization may require, as a condition of eligibility for continued coverage in accordance with this section, that the student provide written documentation from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury. [2007, c. 115, §3 (AMD); 2007, c. 115, §5 (AFF).]

SECTION HISTORY
2005, c. 532, §3 (NEW). 2007, c. 115, §3 (AMD). 2007, c. 115, §5 (AFF).

§4233-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE

1. **Dependent child; definition.** As used in this section, "dependent child" means the child of a person covered under an individual or group health maintenance organization contract when that child:

A. Is unmarried; [2007, c. 115, §4 (NEW); 2007, c. 115, §5 (AFF).]

B. Has no dependent of the child's own; and [2007, c. 514, §11 (AMD).]

C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education. [2007, c. 514, §12 (AMD).]

D. [2007, c. 514, §13 (RP).]

[2007, c. 514, §§11-13 (AMD) .]

2. **Offer of coverage.** An individual or group health maintenance organization contract that offers coverage for a dependent child shall offer such coverage, at the option of the contract holder, until the dependent child is 25 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

[2007, c. 514, §14 (AMD) .]

3. **Notice.**

[2007, c. 514, §15 (NEW); T. 24-A, §4233-B, sub-§3 (RP) .]

SECTION HISTORY
2007, c. 115, §4 (NEW). 2007, c. 115, §5 (AFF). 2007, c. 514, §§11-15 (AMD).

§4234. CHILD COVERAGE

1. **Definitions.** For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the enrollee, member or spouse of the enrollee or member. [1993, c. 666, Pt. A, §7 (NEW).]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [1993, c. 666, Pt. A, §7 (NEW).]

[1993, c. 666, Pt. A, §7 (RPR) .]

2. **Coverage.** All individual or group coverage subject to this chapter must provide unmarried enrollees with the same benefits or option of benefits for dependent children as is extended to dependent children of married enrollees, at appropriate rates and under the same terms and conditions.

[1991, c. 200, Pt. B, §5 (NEW) .]

3. **Financial dependency.** Financial dependency of dependent children on the enrollee or the spouse of the enrollee may not be required as a condition for eligibility for coverage.

[1991, c. 200, Pt. B, §5 (NEW) .]

4. **Adopted children.** All individual or group contracts issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the enrollee or spouse of the enrollee under the same terms and conditions as apply to natural dependent children or stepchildren of the enrollee or spouse of the enrollee, irrespective of whether the adoption has become final.

[1993, c. 666, Pt. A, §8 (NEW) .]

5. **Medicaid.** Health maintenance organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," when considering coverage eligibility or benefit calculations for enrollees and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the enrollee or family member to payment by the health maintenance organization for those health care items or services. Upon presentation of proof that the Medicaid program has paid for covered items or services, the health maintenance organization shall make payment to the Medicaid program according to the coverage provided in the contract or certificate. [1993, c. 666, Pt. B, §3 (NEW).]

B. A health maintenance organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid and covered by an enrollee contract that are different from requirements applicable to an agent or assignee of any other covered individual. [1993, c. 666, Pt. B, §3 (NEW).]

[1993, c. 666, Pt. B, §3 (NEW) .]

SECTION HISTORY
1991, c. 200, §B5 (NEW). 1993, c. 666, §§A7,8,B3 (AMD).

§4234-A. MENTAL HEALTH SERVICES COVERAGE

1. **Findings.** The Legislature finds that:

A. Mental illness affects nearly 170,000 people of this State each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families; [1995, c. 407, §10 (NEW).]

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by businesses in the State in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs; [1995, c. 407, §10 (NEW).]

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and [1995, c. 407, §10 (NEW).]

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment. [1995, c. 407, §10 (NEW).]

[1995, c. 407, §10 (NEW) .]

2. **Policy and purpose.** The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness including mental and emotional disorders that are of significant consequence to the health of people of the State and that can be treated in a cost-effective manner; [1995, c. 407, §10 (NEW).]

B. Ensure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in the least restrictive settings; [1995, c. 407, §10 (NEW).]

C. Ensure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and [1995, c. 407, §10 (NEW).]

D. Ensure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits must be provided. [1995, c. 407, §10 (NEW).]

[1995, c. 407, §10 (NEW) .]

3. **Definitions.** For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes necessary to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours a day. [1995, c. 407, §10 (NEW).]

A-1. "Diagnostic and Statistical Manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association. [2003, c. 20, Pt. VV, §16 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

(1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;

(2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and

(3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §16 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes used in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or in an accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting. [1995, c. 407, §10 (NEW).]

B-1. "Medically necessary health care" has the same meaning as in section 4301-A, subsection 10-A. [2003, c. 20, Pt. VV, §17 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups. [1995, c. 407, §10 (NEW).]

D. "Person suffering from a mental illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the area of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life.

The person manifests an impaired capacity to maintain acceptable levels of functioning in the area of intellect, emotion or physical well-being. [2003, c. 20, Pt. VV, §18 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

E. "Provider" means an individual included in section 2744, subsection 1, a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Health and Human Services. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist. [1999, c. 256, Pt. O, §3 (AMD); 2001, c. 354, §3 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 20, Pt. VV, §§16-18 (AMD); 2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

4. **Requirement.** Every health maintenance organization that issues individual or group health care contracts providing coverage to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

[2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5. **Services.** Each individual or group contract must provide for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness:

A. Inpatient services; [1995, c. 407, §10 (NEW).]

B. Day treatment services; [2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

C. Outpatient services; and [2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

D. Home health care services. [2003, c. 20, Pt. VV, §19 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

6. **Coverage for treatment of certain mental illnesses.** Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A. [2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 20, Pt. VV, §20 (RP).]

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those designated as "V" codes in the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;

(2) Dissociative disorders;

(3) Mood disorders;

(4) Anxiety disorders;

(5) Personality disorders;

(6) Paraphilias;

(7) Attention deficit and disruptive behavior disorders;

(8) Pervasive developmental disorders;

(9) Tic disorders;

(10) Eating disorders, including bulimia and anorexia; and

(11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §20 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must provide benefits that meet the requirements of this paragraph.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage for the treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits. [2003, c. 20, Pt. VV, §20 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

This subsection does not apply to policies, contracts or certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

[2003, c. 20, Pt. VV, §20 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

7. **Mandated offer of coverage for certain mental illnesses.** Except as provided in subsection 6, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder. [2003, c. 20, Pt. VV, §21 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must make available coverage providing benefits that meet the requirements of this paragraph.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract. [2003, c. 20, Pt. VV, §21 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §21 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

8. **Contracts; providers.** A health maintenance organization incorporated under this chapter shall allow providers, pursuant to sections 2744 and 2835, to contract for and receive payment, subject to the health maintenance organization's credentialling policy, for the provision of mental health services within the scope of the provider's licensure.

[2003, c. 65, §3 (AMD); 2003, c. 65, §5 (AFF) .]

8-A. **Mental health services provided by counseling professionals.** A health maintenance organization that issues individual or group health care contracts providing coverage for mental health services shall offer coverage for those services when performed by a counseling professional who is licensed by the State pursuant to Title 32, chapter 119 to assess and treat interpersonal and intrapersonal problems, has at least a master's degree in counseling or a related field from an accredited educational institution and has been employed as counselor for at least 2 years. Any contract providing coverage for the services of counseling professionals pursuant to this subsection may be subject to any reasonable limitations, maximum benefits, coinsurance, deductibles or exclusion provisions applicable to overall benefits under the contract.

[2003, c. 20, Pt. VV, §23 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

9. **Limits; coinsurance; deductibles.** A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1995, c. 407, §10 (NEW) .]

10. **Reports to the superintendent.** Every health maintenance organization subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid

in this State for the services required by this section and the total amount of claims paid in this State for individual and group health care contracts, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

[1995, c. 407, §10 (NEW) .]

11. **Application.** Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. Contracts entered into with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services provided under such contracts consistent with the terms of those contracts if mental health services are provided to these populations by other means.

[2003, c. 20, Pt. VV, §24 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

SECTION HISTORY
1995, c. 407, §10 (NEW). 1995, c. 560, §K82 (AMD). 1995, c. 560, §K83 (AFF). 1995, c. 637, §§6,7 (AMD). 1995, c. 673, §D8 (AMD). 1997, c. 174, §1 (AMD). 1999, c. 256, §O3 (AMD). 2001, c. 354, §3 (AMD). 2003, c. 20, §§VV16-24 (AMD). 2003, c. 20, §VV25 (AFF). 2003, c. 65, §3 (AMD). 2003, c. 65, §5 (AFF). 2003, c. 689, §B6 (REV).

§4234-B. MATERNITY AND ROUTINE NEWBORN CARE

Individual and group contracts and certificates issued by a health maintenance organization that provide maternity benefits, including benefits for childbirth, shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. [2003, c. 517, Pt. B, §23 (AMD).]

SECTION HISTORY
1995, c. 615, §4 (NEW). 2001, c. 258, §A4 (AMD). 2003, c. 517, §B23 (AMD).

§4234-C. NEWBORN CHILDREN COVERAGE

All individual and group health maintenance organization contracts must provide that benefits are payable with respect to a newly born child from the moment of birth. [1997, c. 604, Pt. C, §4 (NEW).]

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the contract, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [1997, c. 604, Pt. C, §4 (NEW).]

If payment of a specific premium or subscription fee is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization within 31 days after the date of birth

in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 4234-B must be paid regardless of whether coverage under this section is elected. [1997, c. 604, Pt. C, §4 (NEW).]

The requirements of this section apply to all contracts delivered or issued for delivery in this State on or after the effective date of this Act. [1997, c. 604, Pt. C, §4 (NEW).]

SECTION HISTORY
1997, c. 604, §C4 (NEW).

§4234-D. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER

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

A. "Medically accepted indication" includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is supported by one or more citations in the standard reference compendia or if the health maintenance organization involved, based upon guidance provided by the federal Department of Health and Human Services Medicare program pursuant to 42 United States Code, Section 1395x(t), determines that that use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. [1997, c. 701, §4 (NEW).]

B. "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §4 (NEW).]

C. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §4 (NEW).]

D. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

2. **Required coverage for off-label use.** All health maintenance organization individual and group contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Health maintenance organization individual and group contracts that provide coverage for prescription drugs may not exclude coverage of any such drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that use of that drug is a medically accepted indication for the treatment of cancer. [1997, c. 701, §4 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §4 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §4 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §4 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 701, §4 (NEW) .]

SECTION HISTORY
1997, c. 701, §4 (NEW).

§4234-E. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR HIV OR AIDS

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

A. "Off-label use" means the prescription and use of drugs for indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §4 (NEW).]

B. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §4 (NEW).]

C. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

2. **Required coverage for off-label use.** All health maintenance organization individual and group contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Health maintenance organization individual and group contracts that provide coverage for prescription drugs may not exclude coverage of any such drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature. [1997, c. 701, §4 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §4 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §4 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §4 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 701, §4 (NEW) .]

SECTION HISTORY
1997, c. 701, §4 (NEW).

§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. [2005, c. 97, §4 (AMD).]

SECTION HISTORY
1993, c. 477, §D12 (NEW). 1993, c. 477, §F1 (AFF). 2003, c. 218, §8 (AMD). 2003, c. 469, §D8 (AMD). 2003, c. 469, §D9 (AFF). 2005, c. 97, §4 (AMD).

§4236. CHIROPRACTORS IN HEALTH MAINTENANCE ORGANIZATIONS

Every health maintenance organization shall include in every plan for health care services chiropractic services delivered by qualified chiropractic providers in accordance with this section. [1993, c. 669, §6 (NEW).]

1. **Qualifications of chiropractic providers.** The health maintenance organization shall determine the qualifications of chiropractic providers using reasonable standards that are similar to and consistent with the standards applied to other providers.

[1993, c. 669, §6 (NEW) .]

2. **Benefits.** The health maintenance organization shall provide benefits covering care by chiropractic providers at least equal to and consistent with the benefits paid to other health care providers treating similar neuro-musculoskeletal conditions.

[1993, c. 669, §6 (NEW) .]

3. **Self-referrals for chiropractic care.** A health maintenance organization must provide benefits to an enrollee who utilizes the services of a chiropractic provider by self-referral under the following conditions.

A. An enrollee may utilize the services of a participating chiropractic provider within the enrollee's health maintenance organization for 3 weeks or a maximum of 12 visits, whichever occurs first, of acute care treatment without the prior approval of a primary care provider of the health maintenance organization. For purposes of this subsection, "acute care treatment" means treatment for accidental bodily injury or sudden, severe pain that affects the ability of the enrollee to engage in the normal activities, duties or responsibilities of daily living. [1995, c. 350, §1 (NEW).]

B. Within 3 working days of the first consultation, the participating chiropractic provider shall send to the primary care provider a report containing the enrollee's complaint, related history, examination, initial diagnosis and treatment plan. If the chiropractic provider fails to send a report to the primary care provider within 3 working days, the health maintenance organization is not obligated to provide benefits for chiropractic care and the enrollee is not liable to the chiropractic provider for any unpaid fees. [1995, c. 350, §1 (NEW).]

C. If the enrollee and the participating chiropractic provider determine that the condition of the enrollee has not improved after 3 weeks of treatment or a maximum of 12 visits the participating chiropractic provider shall discontinue treatment and refer the enrollee to the primary care provider. [1995, c. 350, §1 (NEW).]

D. If the chiropractic provider recommends treatment beyond 3 weeks or a maximum of 12 visits, the participating chiropractic provider shall send to the primary care provider a report containing information on the enrollee's progress and outlining a treatment plan for extended chiropractic care of up to 5 more weeks or a maximum of 12 more visits, whichever occurs first. [1995, c. 350, §1 (NEW).]

E. Without the approval of the primary care provider, an enrollee may not receive benefits for more than 36 visits to a participating chiropractic provider in a 12-month period. After a maximum of 36 visits, an enrollee's continuing chiropractic treatment must be authorized by the primary care provider. [1995, c. 350, §1 (NEW).]

In the provision of chiropractic services under this subsection, a participating chiropractic provider is liable for a professional diagnosis of a mental or physical condition that has resulted or may result in the chiropractic provider performing duties in a manner that endangers the health or safety of an enrollee.

The provisions of this subsection apply to all health maintenance organization contracts, except a contract between a health maintenance organization and the State Employee Health Insurance Program.

This subsection takes effect January 1, 1996.

[1997, c. 99, §1 (AMD) .]

SECTION HISTORY
1993, c. 669, §6 (NEW). 1995, c. 350, §1 (AMD). 1997, c. 99, §1 (AMD).

§4237. COVERAGE FOR BREAST CANCER TREATMENT

1. **Inpatient care.** All individual and group coverage subject to this chapter that provides coverage for medical and surgical benefits must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group coverage subject to this subsection must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

[1997, c. 408, §7 (NEW); 1997, c. 408, §8 (AFF) .]

2. **Reconstruction.** All individual and group coverage subject to this chapter that provides coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

[1997, c. 408, §7 (NEW); 1997, c. 408, §8 (AFF) .]

3. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §24 (NEW) .]

SECTION HISTORY
RR 1995, c. 1, §19 (COR). RR 1995, c. 1, §21 (COR). 1995, c. 295, §5 (NEW). 1995, c. 369, §4 (NEW). 1995, c. 418, §C4 (NEW). 1997, c. 408, §8 (AFF). 1997, c. 408, §7 (RPR). 2003, c. 517, §B24 (AMD).

§4237-A. SCREENING MAMMOGRAMS

1. **Definition.** For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

[2007, c. 153, §3 (AMD); 2007, c. 153, §5 (AFF) .]

2. **Required coverage.** All individual and group coverage subject to this chapter must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

[1997, c. 408, §7 (NEW); 1997, c. 408, §8 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

3. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §25 (NEW) .]

SECTION HISTORY
1997, c. 408, §7 (NEW). 1997, c. 408, §8 (AFF). 2003, c. 517, §B25 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 153, §3 (AMD). 2007, c. 153, §5 (AFF).

§4238. MEDICAL FOOD COVERAGE FOR INBORN ERROR OF METABOLISM

1. **Inborn error of metabolism; special modified low-protein food product.** As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

[1995, c. 369, §4 (NEW) .]

2. **Required coverage.** All health maintenance organization individual and group contracts must provide coverage for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. The contracts must reimburse:

A. For metabolic formula; and [1995, c. 369, §4 (NEW).]

B. Up to $3,000 per year for special modified low-protein food products. [1995, c. 369, §4 (NEW).]

[1995, c. 369, §4 (NEW) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1995, c. 369, §4 (NEW) .]

SECTION HISTORY
RR 1995, c. 1, §19 (RNU). 1995, c. 369, §4 (NEW).

§4239. MEDICAL CHILD SUPPORT

A health maintenance organization must comply with 42 United States Code, Section 1396g-1. [1995, c. 418, Pt. C, §4 (NEW).]

SECTION HISTORY
RR 1995, c. 1, §21 (RNU). 1995, c. 418, §C4 (NEW).

§4240. COVERAGE FOR DIABETES SUPPLIES

All health maintenance organization individual and group health contracts and certificates must provide coverage for the medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: [2003, c. 517, Pt. A, §10 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

1. **Certification of medical necessity.** The enrollee's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and

[1995, c. 592, §4 (NEW) .]

2. **Provision of medical services.** The diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

[1995, c. 592, §4 (NEW) .]

The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. [2003, c. 517, Pt. A, §10 (NEW); 2003, c. 517, Pt. A, §13 (AFF).]

§4240. Coverage for Pap tests

(As enacted by PL 1995, c. 617, §5 is REALLOCATED TO TITLE 24-A, SECTION 4242)

SECTION HISTORY
RR 1995, c. 2, §53 (RAL). 1995, c. 592, §4 (NEW). 1995, c. 617, §5 (NEW). 1995, c. 617, §6 (AFF). 2003, c. 517, §A10 (AMD). 2003, c. 517, §A13 (AFF).

§4241. GYNECOLOGICAL AND OBSTETRICAL SERVICES

1. **Coverage in managed care plans.** With respect to managed care plans that require enrollees to select primary care physicians, a health maintenance organization that issues group policies, contracts and certificates must meet the following requirements.

A. The health maintenance organization must permit a physician who specializes in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the organization's credentialling policy. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

B. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

C. If the examination specified in paragraph B reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner or certified nurse midwife to secure from the patient's primary care physician a referral to the participating physician, certified nurse practitioner or certified nurse midwife from whom such care may be obtained. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

[2003, c. 517, Pt. A, §11 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

2. **Application.** This section applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. A, §11 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

This section does not prohibit a carrier from requiring a physician, certified nurse practitioner or certified nurse midwife participating in the plan to inform a woman's primary care physician prior to each treatment pursuant to this section. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

SECTION HISTORY
1995, c. 617, §5 (NEW). 1995, c. 617, §6 (AFF). 2003, c. 517, §A11 (AMD). 2003, c. 517, §A13 (AFF).

§4242. COVERAGE FOR PAP TESTS

(REALLOCATED FROM TITLE 24-A, SECTION 4240)

All health maintenance organization plan contracts and certificates must provide coverage for screening Pap tests recommended by a physician. [2003, c. 517, Pt. A, §12 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY
RR 1995, c. 2, §53 (RAL). 2003, c. 517, §A12 (AMD). 2003, c. 517, §A13 (AFF).

§4243. LIMITS ON PRIORITY LIENS; SUBROGATION

An individual or group contract subject to this chapter may not provide for subrogation or priority over the enrollee of payment for any hospital, nursing, medical or surgical services or of any expenses paid or reimbursed under the coverage, in the event the enrollee is entitled to receive payment or reimbursement from any other person as a result of legal action or claim, except as provided in this section. [1997, c. 369, §3 (NEW).]

The coverage may contain a provision that allows the payments, if that provision is approved by the superintendent and if that provision required the prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. A "just and equitable basis" means that any factors that diminish the potential value of the enrollee's claim may likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors include, but are not limited to: [1997, c. 369, §3 (NEW).]

1. **Legal defenses.** Questions of liability and comparative negligence or other legal defenses;

[1997, c. 369, §3 (NEW) .]

2. **Exigencies of trial.** Exigencies of trial that reduce a settlement or award in order to resolve the claim; and

[1997, c. 369, §3 (NEW) .]

3. **Limits of coverage.** Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured.

[1997, c. 369, §3 (NEW) .]

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, that dispute must be determined, if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute. [1997, c. 369, §3 (NEW).]

§4243. Coverage for prostate cancer screening

(As enacted by PL 1997, c. 754, §4 is REALLOCATED TO TITLE 24-A, SECTION 4244)

SECTION HISTORY
RR 1997, c. 2, §53 (RAL). 1997, c. 369, §3 (NEW). 1997, c. 754, §4 (NEW).

§4244. COVERAGE FOR PROSTATE CANCER SCREENING

(REALLOCATED FROM TITLE 24-A, SECTION 4243)

1. **Definition.** As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:

A. A digital rectal examination; and [1997, c. 2, §53 (RAL).]

B. A prostate-specific antigen test. [1997, c. 2, §53 (RAL).]

[1997, c. 2, §53 (RAL) .]

2. **Required coverage for prostate cancer screening.** All health maintenance organization individual and group contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.

[1997, c. 2, §53 (RAL) .]

3. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 2, §53 (RAL) .]

SECTION HISTORY
RR 1997, c. 2, §53 (RAL).

§4245. NCQA ACCREDITATION SURVEY REPORT

1. **Access and confidentiality.** The superintendent or the Commissioner of Health and Human Services may require a health maintenance organization to submit its NCQA accreditation survey report. An NCQA accreditation survey report obtained by or submitted to the superintendent or the Commissioner of Health and Human Services is confidential, is not subject to subpoena and may not be made public by the superintendent or the Commissioner of Health and Human Services except as otherwise provided in this section.

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

2. **Use in examination.** In conducting an examination of a health maintenance organization pursuant to section 4215, the superintendent or the Commissioner of Health and Human Services has the discretion to adopt relevant findings in the NCQA accreditation survey report in whole or in part as the examiner's conclusions, if the examiner determines that the NCQA survey, by itself or in combination with the examiner's own findings, sufficiently demonstrates that the health maintenance organization has satisfied the pertinent requirements of this chapter. If the NCQA accreditation survey report indicates that the health maintenance organization may not be in compliance with one or more requirements of this chapter, the examiner may investigate and make independent findings.

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

3. **Examination report.** The information from the NCQA accreditation survey report that sufficiently demonstrates that the health maintenance organization has satisfied the pertinent requirements of this section as adopted by the superintendent or the Commissioner of Health and Human Services pursuant to subsection 2 may be incorporated into an examination report, which is a public record except for any information relating to an individual applicant or enrollee.

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

§4245. Coverage for contraceptives

4. **Use of information for regulatory purposes.** The confidentiality of the NCQA accreditation survey report does not prohibit its use by the superintendent or the Commissioner of Health and Human Services for regulatory or law enforcement purposes subject to the restrictions of section 216, subsection 5 and section 226, subsection 7.

(As enacted by PL 1999, c. 341, §4 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 4247)

§4245. Coverage for services of certified nurse practitioners; certified nurse midwives

(As enacted by PL 1999, c. 396, §4 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 4248)

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY
RR 1999, c. 1, §§37,38 (RAL). 1999, c. 256, §Q2 (NEW). 1999, c. 341, §4 (NEW). 1999, c. 341, §5 (AFF). 1999, c. 396, §4 (NEW). 1999, c. 396, §7 (AFF). 2003, c. 689, §B7 (REV).

§4246. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS

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

A. "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and postoperative nursing care to surgical patients. [1999, c. 412, §4 (NEW).]

B. "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistants as established by the Association of Operating Room Nurses or its successor organization. [1999, c. 412, §4 (NEW).]

C. "Registered nurse first assistant," or "RNFA," means a person who:

(1) Is licensed as a registered nurse under Title 32, chapter 31;

(2) Is experienced in perioperative nursing; and

(3) Has successfully completed a recognized program. [1999, c. 412, §4 (NEW).]

[1999, c. 412, §4 (NEW) .]

2. **Institutional powers.** Each health care institution, as defined in Title 22, chapter 405, may establish specific procedures for the appointment and reappointment of registered nurse first assistants and for granting, renewing and revising their clinical privileges.

[1999, c. 412, §4 (NEW) .]

3. **Required coverage for services.** Notwithstanding any other provisions of this chapter, a health maintenance organization that issues individual and group health care contracts that provide coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed those services is used as a substitute.

[1999, c. 412, §4 (NEW) .]

4. **Limits; coinsurance; deductibles.** Any contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 412, §4 (NEW) .]

5. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 617, Pt. B, §26 (NEW) .]

SECTION HISTORY
1999, c. 412, §4 (NEW). 2003, c. 517, §B26 (AMD).

§4247. COVERAGE FOR CONTRACEPTIVES

(REALLOCATED FROM TITLE 24-A, SECTION 4245)

1. **Coverage requirements.** All health maintenance organization individual and group health contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services. For purposes of this section, the term "outpatient contraceptive services"

means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy.

[1999, c. 1, §37 (RAL) .]

2. **Exclusion for religious employer.** A religious employer may request and a health maintenance organization shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective insureds and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing a health maintenance organization to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121 (w) (3) (A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c) (3).

[1999, c. 1, §37 (RAL) .]

3. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §27 (NEW) .]

SECTION HISTORY
RR 1999, c. 1, §37 (RAL). 2003, c. 517, §B27 (AMD).

§4248. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES

(REALLOCATED FROM TITLE 24-A, SECTION 4245)

1. **Required coverage for services upon referral of primary care provider.** A health maintenance organization that issues individual and group health care contracts shall provide coverage under those contracts for services performed by a participating certified nurse practitioner or participating certified nurse midwife to a patient who is referred to the participating certified nurse practitioner or participating certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the participating certified nurse practitioner or participating certified nurse midwife.

[1999, c. 1, §38 (RAL) .]

2. **Required coverage for self-referred services.** With respect to individual and group health care contracts that do not require the selection of a primary care provider, a health maintenance organization shall provide coverage under those contracts for services performed by a participating certified nurse practitioner or participating certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the participating certified nurse practitioner or participating certified nurse midwife.

[1999, c. 1, §38 (RAL) .]

3. **Limits; coinsurance; deductibles.** Any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 1, §38 (RAL) .]

4. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §28 (NEW) .]

SECTION HISTORY
RR 1999, c. 1, §38 (RAL). 2003, c. 517, §B28 (AMD).

§4249. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS

1. **Definition.** As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of an enrollee or member who:

A. Is a mentally competent adult as is the enrollee or member; [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the enrollee or member for at least 12 months; [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the enrollee or member and expects to remain so; and [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the enrollee or member for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property. [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

2. **Mandated offer of domestic partner benefits.** All individual or group policies or contracts issued by any health maintenance organization operating pursuant to this chapter must make available to an individual or group policyholder the option for additional benefits for the domestic partner of an enrollee or member, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married enrollees or members covered under a health maintenance organization individual or group contract.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

3. **Financial dependency.** Financial dependency of a domestic partner on the enrollee or member may not be required as a condition for eligibility for coverage.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

4. **Evidence of domestic partnership.** As a condition of eligibility for coverage, a health maintenance organization or group policyholder may require an enrollee or member and the enrollee's or member's domestic partner to sign an affidavit attesting that the enrollee or member and enrollee's or member's domestic

partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

5. **Preexisting conditions.** A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of an enrollee or member.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

6. **Termination of domestic partner benefits.** A health maintenance organization may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of an enrollee or member upon notification by the enrollee or member that the domestic partner relationship has terminated. An enrollee or member may not enroll another individual as a domestic partner under an individual or group contract until 12 months after the termination of coverage for a prior domestic partner.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

7. **Construction.** This section does not prohibit a health maintenance organization from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

§4249. Coverage for hospice care services

(As enacted by PL 2001, c. 358, Pt. LL, §4 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 4250)

§4249. Coverage for general anesthesia for dentistry

(As enacted by PL 2001, c. 423, §4 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 4251)

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

SECTION HISTORY
RR 2001, c. 1, §§36,37 (RAL). 2001, c. 347, §4 (NEW). 2001, c. 347, §5 (AFF). 2001, c. 358, §LL4 (NEW). 2001, c. 358, §LL5 (AFF). 2001, c. 423, §4 (NEW). 2001, c. 423, §5 (AFF).

§4250. COVERAGE FOR HOSPICE CARE SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 4249)

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

A. "Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to a person who is terminally ill and that person's family. "Hospice care services" includes, but is not limited to, physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services. [2001, c. 1, §36 (RAL).]

B. "Person who is terminally ill" means a person that has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course. [2001, c. 1, §36 (RAL).]

[2001, c. 1, §36 (RAL) .]

2. **Coverage for hospice care services.** All health maintenance organization individual and group health contracts must provide coverage for hospice care services to a person who is terminally ill. Hospice care services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Coverage for hospice care services must be provided whether the services are provided in a home setting or an inpatient setting.

[2001, c. 1, §36 (RAL) .]

3. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §29 (NEW) .]

SECTION HISTORY
RR 2001, c. 1, §36 (RAL). 2003, c. 517, §B29 (AMD).

§4251. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY

(REALLOCATED FROM TITLE 24-A, SECTION 4249)

1. **Enrollee defined.** For the purposes of this section, unless the context otherwise indicates, "enrollee" means a person who is covered under an individual or group contract provided by a health maintenance organization.

[2001, c. 1, §37 (RAL) .]

2. **General anesthesia and associated facility charges.** All individual and group health maintenance organization contracts must provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

[2001, c. 1, §37 (RAL) .]

3. **Limitations on coverage.** This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; [2001, c. 1, §37 (RAL).]

B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [2001, c. 1, §37 (RAL).]

C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and [2001, c. 1, §37 (RAL).]

D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [2001, c. 1, §37 (RAL).]

[2001, c. 1, §37 (RAL) .]

4. **Dental procedures and dentist's fee not covered.** This section does not require a health maintenance organization to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual or group contract that apply generally to other benefits.

[2001, c. 1, §37 (RAL) .]

5. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the health maintenance organization providing health coverage is the secondary payer.

[2001, c. 1, §37 (RAL) .]

6. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §30 (NEW) .]

SECTION HISTORY
RR 2001, c. 1, §37 (RAL). 2003, c. 517, §B30 (AMD).

§4252. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY

All health maintenance organization individual and group health insurance policies, contracts and certificates must make available coverage for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary health care as defined in section 4301-A, subsection 10-A. [2005, c. 128, §4 (NEW); 2005, c. 128, §5 (AFF).]

SECTION HISTORY
2005, c. 128, §4 (NEW). 2005, c. 128, §5 (AFF).

§4253. ENROLLMENT FOR INDIVIDUALS OR FAMILIES ESTABLISHING ELIGIBILITY FOR MAINECARE

When an individual or family is eligible for MaineCare and is also eligible for health maintenance organization coverage provided by an employer through a health maintenance organization, the health maintenance organization must permit the individual or family to enroll in the health maintenance organization coverage without regard to any enrollment season restrictions. [2007, c. 448, §12 (NEW).]

§4253. Coverage for hearing aids

(As enacted by PL 2007, c. 452, §4 is REALLOCATED TO TITLE 24-A, SECTION 4255)

SECTION HISTORY
2007, c. 448, §12 (NEW). 2007, c. 452, §4 (NEW). 2007, c. 695, Pt. A, §30 (RAL).

§4254. COVERAGE FOR COLORECTAL CANCER SCREENING

1. **Colorectal cancer screening.** For the purposes of this section, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

[2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

2. **Required coverage.** All health maintenance organization individual and group health insurance policies, contracts and certificates must provide coverage for colorectal cancer screening for asymptomatic individuals who are:

A. Fifty years of age or older; or [2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF).]

B. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. [2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF).]

[2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

3. **Billing.** If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure.

§4254. Coverage for medically necessary infant formula

(As enacted by PL 2007, c. 595, §4 is REALLOCATED TO TITLE 24-A, SECTION 4256)

[2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

SECTION HISTORY
2007, c. 516, §4 (NEW). 2007, c. 516, §5 (AFF). 2007, c. 595, §4 (NEW). 2007, c. 595, §5 (AFF). 2007, c. 695, Pt. C, §16 (RAL).

§4255. COVERAGE FOR HEARING AIDS

(REALLOCATED FROM TITLE 24-A, SECTION 4253)

1. **Hearing aid; definition.** For purposes of this section, "hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

[2007, c. 695, Pt. A, §30 (RAL) .]

2. **Required coverage.** In accordance with the application of coverage set forth in subsection 3, all health maintenance organization individual and group health insurance contracts must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate who is 18 years of age or under in accordance with the following requirements.

A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77. [2007, c. 695, Pt. A, §30 (RAL).]

B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A. [2007, c. 695, Pt. A, §30 (RAL).]

C. The policy, contract or certificate may limit coverage to $1,400 per hearing aid for each hearing-impaired ear every 36 months. [2007, c. 695, Pt. A, §30 (RAL).]

[2007, c. 695, Pt. A, §30 (RAL) .]

3. **Application of coverage.** The requirements of subsection 2 apply to an individual:

A. From birth to 5 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2008; [2007, c. 695, Pt. A, §30 (RAL).]

B. From 6 to 13 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2009; and [2007, c. 695, Pt. A, §30 (RAL).]

C. From 14 to 18 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2010. [2007, c. 695, Pt. A, §30 (RAL).]

[2007, c. 695, Pt. A, §30 (RAL) .]

4. **Limits; coinsurance; deductibles.** Except as otherwise provided in this section, any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2007, c. 695, Pt. A, §30 (RAL) .]

SECTION HISTORY
2007, c. 695, Pt. A, §30 (RAL).

§4256. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA

(REALLOCATED FROM TITLE 24-A, SECTION 4254)

All individual and group health maintenance organization policies, contracts and certificates must provide coverage for amino acid-based elemental infant formula for children 2 years of age and under in accordance with this section. [2007, c. 695, Pt. C, §16 (RAL).]

1. **Determination of medical necessity.** Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A, subsection 10-A, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing medical necessity at least annually.

[2007, c. 695, Pt. C, §16 (RAL) .]

2. **Method of delivery.** Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

[2007, c. 695, Pt. C, §16 (RAL) .]

3. **Required diagnosis.** Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis; [2007, c. 695, Pt. C, §16 (RAL).]

B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; [2007, c. 695, Pt. C, §16 (RAL).]

C. A history of anaphylaxis; [2007, c. 695, Pt. C, §16 (RAL).]

D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; [2007, c. 695, Pt. C, §16 (RAL).]

E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; [2007, c. 695, Pt. C, §16 (RAL).]

F. Cystic fibrosis; or [2007, c. 695, Pt. C, §16 (RAL).]

G. Malabsorption of cow milk-based or soy milk-based infant formula. [2007, c. 695, Pt. C, §16 (RAL).]

[2007, c. 695, Pt. C, §16 (RAL) .]

4. **Health savings accounts.** Coverage for amino acid-based elemental infant formula under a health insurance policy, contract or certificate issued in connection with a health savings account as authorized under Title XII of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate.

[2007, c. 695, Pt. C, §16 (RAL) .]

SECTION HISTORY
2007, c. 695, Pt. C, §16 (RAL).

§4257. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST

1. **Services provided by independent practice dental hygienist.** All individual and group health maintenance organization contracts that include coverage for dental services shall provide coverage for dental services performed by an independent practice dental hygienist licensed under Title 32, chapter 16, subchapter 3-B when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

2. **Limits; coinsurance; deductibles.** A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

3. **Coordination of benefits with dental insurance.** If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health maintenance organization policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the health maintenance organization providing health coverage is the secondary payer.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

4. **Application.** The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

SECTION HISTORY
2009, c. 307, §4 (NEW). 2009, c. 307, §6 (AFF).

§4258. COVERAGE FOR CHILDREN'S EARLY INTERVENTION SERVICES

1. **Definition.** For purposes of this section, "children's early intervention services" means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20 United States Code, Section 1411, et seq.

[2009, c. 634, §4 (NEW); 2009, c. 634, §5 (AFF) .]

2. **Required coverage.** All individual and group health maintenance organization policies, contracts and certificates must provide coverage for children's early intervention services in accordance with this subsection.

A. A referral from the child's primary care provider is required. [2009, c. 634, §4 (NEW); 2009, c. 634, §5 (AFF).]

B. The policy, contract or certificate may limit coverage to $3,200 per year for each child not to exceed $9,600 by the child's 3rd birthday. [2009, c. 634, §4 (NEW); 2009, c. 634, §5 (AFF).]

C. The policy, contract or certificate may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section. [2009, c. 634, §4 (NEW); 2009, c. 634, §5 (AFF).]

§4258. Coverage for the diagnosis and treatment of autism spectrum disorders

(As enacted by PL 2009, c. 635, §4; §6 is REALLOCATED TO TITLE 24-A, SECTION 4259)

[2009, c. 634, §4 (NEW); 2009, c. 634, §5 (AFF) .]

SECTION HISTORY
2009, c. 634, §4 (NEW). 2009, c. 634, §5 (AFF). 2009, c. 635, §4 (NEW). 2009, c. 635, §6 (AFF). 2011, c. 420, Pt. A, §27 (RAL).

§4259. COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS

(REALLOCATED FROM TITLE 24-A, §4258)

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

A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. [2011, c. 420, Pt. A, §27 (RAL).]

B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. [2011, c. 420, Pt. A, §27 (RAL).]

C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

(3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist. [2011, c. 420, Pt. A, §27 (RAL).]

[2011, c. 420, Pt. A, §27 (RAL) .]

2. **Required coverage.** All individual and group health maintenance organization contracts must provide coverage for autism spectrum disorders for an individual covered under a contract who is 10 years of age or under in accordance with the following.

A. The contract must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. [2011, c. 420, Pt. A, §27 (RAL).]

B. The contract must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this section at least annually. [2011, c. 420, Pt. A, §27 (RAL).]

C. The contract may not include any limits on the number of visits. [2011, c. 420, Pt. A, §27 (RAL).]

D. Notwithstanding section 4234-A and to the extent allowed by federal law for group contracts, the contract may limit coverage for applied behavior analysis to $36,000 per year. A health maintenance organization may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. [2011, c. 420, Pt. A, §27 (RAL).]

E. This subsection may not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the contract. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the contract. [2011, c. 420, Pt. A, §27 (RAL).]

[2013, c. 597, §3 (AMD); 2013, c. 597, §4 (AFF) .]

3. **Limits; coinsurance; deductibles.** Except as otherwise provided in this section, any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2011, c. 420, Pt. A, §27 (RAL) .]

4. **Individualized education plan.** This section may not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized education plan or an individualized family service plan.

[2011, c. 420, Pt. A, §27 (RAL) .]

SECTION HISTORY
2011, c. 420, Pt. A, §27 (RAL). 2013, c. 597, §3 (AMD). 2013, c. 597, §4 (AFF).

Chapter 56-A: HEALTH PLAN IMPROVEMENT ACT

Subchapter 1: HEALTH PLAN REQUIREMENTS
HEADING: PL 1997, C. 792, §2 (NEW)

§4301. DEFINITIONS

(REPEALED)

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1997, c. 604, §A1 (AMD). 1999, c. 256, §A1 (AMD). 1999, c. 609, §19 (AMD). 1999, c. 742, §2 (RP). 2001, c. 471, §A28 (RP).

§4301-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 742, §3 (NEW).]

1. **Adverse health care treatment decision.** "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal Affordable Care Act.

[2011, c. 364, §20 (AMD) .]

2. **Authorized representative.** "Authorized representative" means:

A. A person to whom an enrollee has given express written consent to represent the enrollee in an external review; [1999, c. 742, §3 (NEW).]

B. A person authorized by law to provide consent to request an external review for an enrollee; or [1999, c. 742, §3 (NEW).]

C. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review. [1999, c. 742, §3 (NEW).]

[1999, c. 742, §3 (NEW) .]

3. **Carrier.** "Carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance; [1999, c. 742, §3 (NEW).]

B. A health maintenance organization licensed pursuant to chapter 56; [1999, c. 742, §3 (NEW).]

C. A preferred provider arrangement administrator registered pursuant to chapter 32; [1999, c. 742, §3 (NEW).]

D. A fraternal benefit society, as defined by section 4101; [1999, c. 742, §3 (NEW).]

E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; [1999, c. 742, §3 (NEW).]

F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; [2011, c. 364, §21 (AMD).]

G. A self-insured employer subject to state regulation as described in section 2848-A; or [2011, c. 364, §21 (AMD).]

H. Notwithstanding any other provision of this Title, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act. [2011, c. 364, §22 (NEW).]

An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

[2011, c. 364, §§21, 22 (AMD) .]

4. **Clinical peer.** "Clinical peer" means a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, or other physician or health care practitioner with demonstrable expertise necessary to review a case.

[1999, c. 742, §3 (NEW) .]

5. **Enrollee.** "Enrollee" means an individual who is enrolled in a health plan or a managed care plan.

[1999, c. 742, §3 (NEW) .]

6. **Health care treatment decision.** "Health care treatment decision" means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

[2001, c. 288, §1 (AMD) .]

7. **Health plan.** "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage not subject to the requirements of the federal Affordable Care Act. A plan that is subject to the requirements of the federal Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Affordable Care Act, is a health plan for purposes of this chapter.

[2011, c. 364, §23 (AMD) .]

8. **Independent review organization.** "Independent review organization" means an entity that conducts independent external reviews of adverse health care treatment decisions.

[1999, c. 742, §3 (NEW) .]

9. **Managed care plan.** "Managed care plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services; and [1999, c. 742, §3 (NEW).]

B. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan. [1999, c. 742, §3 (NEW).]

A return to work program developed for the management of workers' compensation claims may not be considered a managed care plan.

[1999, c. 742, §3 (NEW) .]

10. **Medically appropriate health care.**

[2001, c. 288, §2 (RP) .]

10-A. **Medically necessary health care.** "Medically necessary health care" means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

A. Consistent with generally accepted standards of medical practice; [2001, c. 288, §3 (NEW).]

B. Clinically appropriate in terms of type, frequency, extent, site and duration; [2001, c. 288, §3 (NEW).]

C. Demonstrated through scientific evidence to be effective in improving health outcomes; [2001, c. 288, §3 (NEW).]

D. Representative of "best practices" in the medical profession; and [2001, c. 288, §3 (NEW).]

E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. [2001, c. 288, §3 (NEW).]

[2001, c. 288, §3 (NEW) .]

11. **Medical necessity.**

[2001, c. 288, §4 (RP) .]

12. **Ordinary care.** "Ordinary care" means, in the case of a carrier, the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances. For a person who is an agent of a carrier, "ordinary care" means the degree of care that a person of ordinary prudence would use under the same or similar circumstances.

[1999, c. 742, §3 (NEW) .]

13. **Participating provider.** "Participating provider" means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan.

[1999, c. 742, §3 (NEW) .]

14. **Peer-reviewed medical literature.** "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present supporting data that the proposed use of a drug or device is safe and effective.

[1999, c. 742, §3 (NEW) .]

15. **Plan sponsor.** "Plan sponsor" means an employer, association, public agency or any other entity providing a health plan.

[1999, c. 742, §3 (NEW) .]

16. **Provider.** "Provider" means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.

[1999, c. 742, §3 (NEW) .]

16-A. **Provider profiling program.** "Provider profiling program" means a program that uses provider data in order to rate or rank provider quality, cost or efficiency of care by the use of a grade, star, tier, rating or any other form of designation that provides an enrollee with an incentive to use a designated provider based on quality, cost or efficiency of care.

[2013, c. 383, §3 (AMD) .]

17. **Religious nonmedical provider.** "Religious nonmedical provider" means a provider who provides only religious nonmedical treatment or religious nonmedical nursing care.

[1999, c. 742, §3 (NEW) .]

18. **Special condition.** "Special condition" means a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.

[1999, c. 742, §3 (NEW) .]

19. **Specialist.** "Specialist" means an appropriately licensed and credentialed health care provider with specialized training and clinical expertise.

[1999, c. 742, §3 (NEW) .]

20. **Standard reference compendia.** "Standard reference compendia" means:

A. The United States Pharmacopeia Drug Information or information published by its successor organization; or [1999, c. 742, §3 (NEW).]

B. The American Hospital Formulary Service Drug Information or information published by its successor organization. [1999, c. 742, §3 (NEW).]

[1999, c. 742, §3 (NEW) .]

SECTION HISTORY
1999, c. 742, §3 (NEW). 2001, c. 288, §§1-4 (AMD). 2007, c. 199, Pt. B, §1 (AMD). 2009, c. 439, Pt. B, §1 (AMD). 2011, c. 364, §§20-23 (AMD). 2013, c. 383, §3 (AMD).

§4302. REPORTING REQUIREMENTS

To offer or renew a health plan in this State, a carrier must comply with the following requirements. [2007, c. 199, Pt. B, §2 (AMD).]

1. **Description of plan.** A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type;

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics; [2009, c. 439, Pt. A, §2 (AMD).]

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisting conditions and waiting periods; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary; [1999, c. 742, §4 (AMD).]

I. Information on where and in what manner health care services may be obtained; [1999, c. 742, §4 (AMD).]

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; [2009, c. 439, Pt. B, §2 (AMD).]

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended; and [2009, c. 439, Pt. B, §3 (AMD).]

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating. [2009, c. 439, Pt. B, §4 (NEW).]

[2009, c. 439, Pt. A, §2 (AMD); 2009, c. 439, Pt. B, §§2-4 (AMD) .]

2. **Plan complaint; adverse decisions; prior authorization statistics.** A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints, adverse decisions and prior authorization statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed; [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

[2007, c. 199, Pt. B, §3 (AMD) .]

3. **Acceptable methods of providing information.** A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973, 42 United States Code, Sections 280c and 300e to 300e-17 (1988), or any other applicable state or federal law or any accrediting organization recognized by the superintendent, as long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a meaningful comparison between health plans. When the superintendent determines that it is feasible and appropriate, the information

required by this section must be provided by geographic region, age, gender and type of employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

4. **Claims data.** By February 1st of each year, a carrier that provides only administrative services for a plan sponsor shall annually file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid for each plan sponsor and the total dollar amount of claims paid for each plan sponsor.

[2001, c. 457, §23 (NEW) .]

5. **Annual report; claims for diagnosis and treatment of Lyme disease and other tick-borne illnesses.** By February 1st of each year, all carriers shall file with the superintendent for the most recent calendar year for all covered individuals in the State the total claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The filing must include information on the number of claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses, the total dollar amount of those claims, the number of claim denials and the reasons for those denials, the number and outcome of internal appeals and the number of external appeals related to the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The superintendent shall compile from all carriers this data in an annual report and submit the report by March 15th of each year to the joint standing committee of the Legislature having jurisdiction over health insurance matters. The superintendent shall consult with the Department of Health and Human Services, Maine Center for Disease Control and Prevention to determine any additional information to be collected from carriers, beginning with data for calendar year 2011.

[2009, c. 494, §5 (AMD) .]

6. **Reporting required pursuant to the Affordable Care Act.** Notwithstanding any other requirements of this Title, a carrier shall provide to the Secretary of the United States Department of Health and Human Services, and make available to the public when required by federal law, any information required by the federal Affordable Care Act. Carriers shall provide the information to the superintendent upon request.

[2011, c. 364, §24 (NEW) .]

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§4,5 (AMD). 2001, c. 457, §23 (AMD). 2007, c. 199, Pt. B, §§2, 3 (AMD). 2007, c. 561, §2 (AMD). 2009, c. 439, Pt. A, §2 (AMD). 2009, c. 439, Pt. B, §§2-4 (AMD). 2009, c. 494, §5 (AMD). 2011, c. 364, §24 (AMD).

§4303. PLAN REQUIREMENTS

A carrier offering or renewing a health plan in this State must meet the following requirements. [2007, c. 199, Pt. B, §4 (AMD).]

1. **Demonstration of adequate access to providers.** A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services. A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.

A. [2007, c. 199, Pt. B, §5 (AMD); T.24-A, §4303, sub-1, ¶A (RP).]

B. [2011, c. 90, Pt. F, §7 (RP).]

C. [2011, c. 90, Pt. F, §7 (RP).]

[2011, c. 90, Pt. F, §7 (RPR) .]

2. **Credentialling.** The credentialling of providers by a carrier is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialling. A carrier shall consult with appropriately qualified health care professionals in developing its credentialling standards. [1997, c. 163, §1 (AMD).]

B. All credentialling decisions, including those granting, denying or withdrawing credentials, must be in writing. The provider must be provided with all reasons for the denial of an application for credentialling or the withdrawal of credentials. A withdrawal of credentials must be treated as a provider termination and is subject to the requirements of subsection 3-A. [1997, c. 163, §1 (AMD).]

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialling for not meeting the objective credentialling standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider or between a carrier and a provider network if a carrier does not contract with providers individually. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

D. A carrier shall make credentialling decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialling application from a provider. The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following submission of a completed application stating that information contained in the application requires additional time for verification. All credentialling decisions must be made within 180 days of receipt of a completed application. For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialling application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. A carrier shall review the entire application before returning it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. [2003, c. 108, §1 (NEW).]

E. [2013, c. 383, §4 (RP).]

[2013, c. 383, §4 (AMD) .]

3. **Provider's right to advocate for medically appropriate care.** A carrier offering or renewing a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

[2007, c. 199, Pt. B, §6 (AMD) .]

3-A. **Termination of participating providers.** A carrier offering or renewing a managed care plan may not terminate or nonrenew a contract with a participating provider unless the carrier provides the provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed contract termination or nonrenewal and provides an opportunity for a review or hearing in accordance with this subsection. The existence of a termination without cause provision in a carrier's contract with a provider does not supersede the requirements of this subsection. This subsection does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a provider to practice. A review or hearing of proposed contract termination must meet the following requirements.

A. The notice of the proposed contract termination or nonrenewal provided by the carrier to the participating provider must include:

(1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond;

(2) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action. A carrier shall permit a provider to review this evidence and documentation upon request;

(3) Notice that the provider has the right to request a review or hearing before a panel appointed by the carrier;

(4) A time limit of not less than 30 days from the date the provider receives the notice within which a provider may request a review or hearing; and

(5) A time limit for a hearing date that must be not less than 30 days after the date of receipt of a request for a hearing.

Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. [1997, c. 163, §2 (NEW).]

B. A hearing panel must be composed of at least 3 persons appointed by the carrier and one person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty of the provider under review. A hearing panel may be composed of more than 3 persons if the number of clinical peers on the hearing panel constitutes 1/3 or more of the total membership of the panel. [1997, c. 163, §2 (NEW).]

C. A hearing panel shall render a written decision on the proposed action in a timely manner. This decision must be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier or the termination or nonrenewal of the provider. [1997, c. 163, §2 (NEW).]

D. A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than 60 days after the receipt by the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier. [1997, c. 163, §2 (NEW).]

[2007, c. 199, Pt. B, §7 (AMD) .]

3-B. **Prohibition on financial incentives.** A carrier offering or renewing a managed care plan may not offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary health care services covered under the

plan to an enrollee. This subsection may not be construed to prohibit pilot projects authorized pursuant to section 4320-H or to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees.

[2011, c. 1, §41 (COR) .]

4. **Grievance procedure for enrollees.** A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;

(3) Procedures for the submission of relevant information and enrollee participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance. [2007, c. 199, Pt. B, §9 (AMD).]

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. [1999, c. 742, §9 (NEW).]

D. Notwithstanding this subsection, a group health plan sponsored by an agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision.

Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312. [2003, c. 309, §1 (NEW).]

E. Health plans subject to the requirements of the federal Affordable Care Act must comply with federal claims and appeal requirements, including, but not limited to, the requirement that benefits for an ongoing course of treatment may not be reduced or terminated without advance notice and an opportunity for advance review, consistent with the requirements of the federal Affordable Care Act. [2011, c. 364, §25 (NEW).]

[2011, c. 364, §25 (AMD) .]

5. **Identification of services provided by certified nurse practitioners and certified nurse midwives.** All claims for coverage of services provided by certified nurse practitioners and certified nurse midwives must identify the certified nurse practitioners and certified nurse midwives who provided those services. A carrier offering or renewing a health plan in this State shall assign identification numbers or codes to certified nurse practitioners and certified nurse midwives who provide covered services for enrollees covered under that plan. A claim submitted for payment to a carrier by a health care provider or facility must include the identification number or code of the certified nurse practitioner or certified nurse midwife who provided the service and may not be submitted using the identification number or code of a physician or other health care provider who did not provide the covered service.

[2007, c. 199, Pt. B, §10 (AMD) .]

6. **Standing referrals to specialists.** A carrier shall establish and maintain a procedure to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition. If the carrier or the enrollee's primary care provider, in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall ensure that the enrollee receives such a referral to a specialist. If a specialist able to treat the enrollee's special condition does not participate in the carrier's network, then the carrier shall ensure that the enrollee receives a standing referral to a nonparticipating specialist. A standing referral must be made pursuant to a treatment plan approved by the carrier's medical director in consultation with the enrollee's primary care provider. After the standing referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan.

[1999, c. 742, §10 (NEW) .]

7. **Continuity of care.** If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. This section does not apply to provider terminations exempt from the requirements of subsection 3-A.

If a managed care contract for the provision of health insurance coverage between a plan sponsor and a carrier is replaced within the meaning of section 2849 with a different managed care contract and a health care provider that has been providing health care services to an enrollee is not in the replacement carrier's network, the replacement carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C in the same manner as if the provider had been terminated from the replacement carrier's network as of the date of the policy replacement, but only with respect to benefits that are covered under the replacement contract.

A. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The

notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment. [1999, c. 742, §10 (NEW).]

B. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination except that if an enrollee is in the 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy. [1999, c. 742, §10 (NEW).]

C. A carrier may make coverage of continued treatment by a provider under paragraph B conditional upon the provider's agreeing to the following terms and conditions.

(1) The provider agrees to accept reimbursement from the carrier at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier. [1999, c. 742, §10 (NEW).]

[1999, c. 742, §10 (NEW) .]

7-A. **Continuity of prescriptions.** If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee’s coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee’s prescribing provider. Policies must include a notice of the right to request a review with the enrollee’s provider, and the replacing carrier must honor the prior carrier’s authorization for a period not to exceed 6 months if the enrollee’s provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.

[2009, c. 439, Pt. F, §1 (NEW) .]

8. **Maximum allowable charges.** All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

(1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and

(2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. [2001, c. 410, Pt. B, §5 (NEW).]

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service. [2001, c. 410, Pt. B, §5 (NEW).]

[2001, c. 410, Pt. B, §5 (NEW) .]

8-A. **Protection from balance billing by participating providers.** An enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection.

A. The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. [2011, c. 238, Pt. A, §1 (NEW).]

B. Every provider agreement with a participating provider must be in writing and must set forth that if the carrier fails to pay for health care services as set forth in the contract, the enrollee is not liable to the provider for any sums owed by the carrier. [2011, c. 238, Pt. A, §1 (NEW).]

C. A participating provider may not collect or attempt to collect any charge from an enrollee for covered health care beyond the amount permitted by the terms of the plan, notwithstanding the carrier's insolvency, the carrier's failure to pay the amount owed by the carrier, any other breach by the carrier of the provider agreement or the failure of the provider agreement to include the written hold harmless provision required by paragraph B. [2011, c. 238, Pt. A, §1 (NEW).]

[2011, c. 238, Pt. A, §1 (NEW) .]

9. (REALLOCATED TO T. 24-A, §4303, sub-§11) **Absolute discretion clauses.**

[2003, c. 1, §21 (RAL); 2003, c. 110, §1 (NEW) .]

9. **Notice of amendments to provider agreements.** A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment.

[2007, c. 199, Pt. B, §11 (AMD) .]

10. **Limits on retrospective denials.** A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and [2003, c. 218, §9 (NEW).]

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action. [2007, c. 106, §1 (AMD).]

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.

[2007, c. 106, §1 (AMD) .]

11. (REALLOCATED FROM T. 24-A, §4303, sub-§9) **Absolute discretion clauses.** The use and enforcement of an absolute discretion clause is governed by this subsection.

A. A policy, contract, certificate or agreement offered, delivered, issued or renewed for delivery in this State by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may not contain a provision purporting to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [2003, c. 1, §21 (RAL).]

B. A carrier may not enforce a provision in a policy, contract, certificate or agreement that was offered, delivered or issued for delivery in this State and has been continued or renewed by a group policy holder or individual enrollee in this State that purports to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [2003, c. 1, §21 (RAL).]

[2003, c. 1, §21 (RAL) .]

12. **Publication of policies by carriers.** A carrier must publish at least 5 individual health plans with the highest level of enrollment and at least 5 small group health plans with the highest level of enrollment on the carrier’s publicly accessible website in a manner that will allow consumers to review the coverage offered under each policy. The policies posted on the website must be updated when changes are made to the policies by the carrier. The appearance of the policy on the website must duplicate the appearance of a paper copy of the policy. The bureau shall provide a link from its website to each carrier’s website. A carrier must review annually which policies to post and make any necessary changes on its website. A carrier must post the required policies on its website within 90 days after the effective date of this subsection.

[2009, c. 439, Pt. A, §3 (NEW) .]

13. **Explanation of benefits.** A carrier offering an individual expense-incurred health plan to residents of this State or an expense-incurred group health plan to an employer in this State shall provide individual policyholders and group certificate holders with clear written explanations of benefit documents in response to the filing of any claim providing for coverage of hospital or medical expenses. The explanation of benefits must include all of the following information:

A. The date of service; [2009, c. 439, Pt. A, §4 (NEW).]

B. The provider of the service; [2009, c. 439, Pt. A, §4 (NEW).]

C. An identification of the service for which the claim is made; [2009, c. 439, Pt. A, §4 (NEW).]

D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance; [2009, c. 439, Pt. A, §4 (NEW).]

E. A telephone number and address where the insured may obtain clarification of the explanation of benefits; [2009, c. 439, Pt. A, §4 (NEW).]

F. A notice of appeal rights; and [2009, c. 439, Pt. A, §4 (NEW).]

G. A notice of the right to file a complaint with the bureau after exhausting any appeals under a carrier's internal appeals process. [2009, c. 439, Pt. A, §4 (NEW).]

The superintendent shall establish by rule the minimum information and standards for explanation of benefits forms used by carriers, taking into consideration any input from stakeholders and any national standards for explanation of benefits forms. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. This subsection applies to any explanation of benefits form issued on or after January 1, 2010.

[2009, c. 439, Pt. A, §4 (NEW) .]

14. **Policy terms.** The superintendent may by rule define standard policy terms that must be used in all policies issued by carriers offering health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 439, Pt. A, §5 (NEW) .]

15. **Uniform explanation of coverage documents and standardized definitions.** A carrier offering a health plan in this State shall:

A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; and [2011, c. 364, §26 (NEW).]

B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act. [2011, c. 364, §26 (NEW).]

(Subsection 15 as enacted by PL 2011, c. 451, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 17)

[2011, c. 364, §26 (NEW) .]

16. **Language and culture.** All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act.

[2011, c. 364, §27 (NEW) .]

17. (REALLOCATED FROM T. 24-A, §4303, sub-§15) **Prohibition on "most favored nation" clauses.** Participation agreements between carriers and providers are governed by this subsection.

A. A participation agreement between a carrier and a provider may not include a provision, commonly referred to as a "most favored nation" clause, that:

(1) Prohibits, or grants the carrier an option to prohibit, the provider from entering into a participation agreement with another carrier to provide services at a lower price than the payment specified in the participation agreement;

(2) Requires, or grants the carrier an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other carrier at a lower price;

(3) Requires, or grants the carrier an option of, termination or renegotiation of the existing participation agreement in the event the provider agrees to provide services to any other carrier at a lower price; or

(4) Requires the provider to disclose its reimbursement rates from other carriers. [2011, c. 1, §42 (RAL).]

B. The superintendent may grant a waiver to paragraph A on application by either a carrier or a provider. A carrier or provider requesting a waiver for more than one participation agreement must file a separate application for each requested waiver. The superintendent may grant a waiver only after issuing a finding that the inclusion in the participation agreement of a most favored nation clause as described in paragraph A is not anticompetitive. A carrier or provider requesting a waiver may request a hearing on the application for a waiver in accordance with section 229. The findings and decision of the superintendent are final agency actions for the purposes of Title 5, chapter 375, subchapter 7 and, notwithstanding section 236, subsection 2, may be appealed regardless of whether a hearing was held. The superintendent's review under this paragraph is limited to the most favored nation clause, and any decision under this paragraph is for purposes of this subsection only and may not be construed as a finding or decision regarding the legality of the provision under other applicable law. [2011, c. 1, §42 (RAL).]

C. Prior to the issuance of the superintendent's findings and decision on an application for a waiver pursuant to this subsection, any contract, proposal or draft legal instrument submitted to the superintendent in an application for a waiver is not a public record for the purposes of Title 1, chapter 13, except that the name and business address of the parties to an application for a waiver are public information. After the issuance of the superintendent's findings and decision, the superintendent may disclose any information that the superintendent determines is not proprietary information. For the purposes of this paragraph, "proprietary information" means information that is a trade secret or production, commercial or financial information the disclosure of which would impair the competitive position of the carrier or provider submitting the information and would make available information not otherwise publicly available. [2011, c. 1, §42 (RAL).]

D. A carrier may not discriminate or retaliate against a provider for filing or opposing an application for a waiver under this subsection. [2011, c. 1, §42 (RAL).]

E. A provider may not discriminate or retaliate against a carrier for filing or opposing an application for a waiver under this subsection. [2011, c. 1, §42 (RAL).]

F. For the purposes of this subsection, the factors the superintendent may consider in determining whether to grant a waiver based on a finding that the inclusion of a most favored nation clause as described in paragraph A is not anticompetitive include, but are not limited to:

(1) Any reduction or limit on competition among carriers or providers;

(2) The impact on quality and availability of health care services, including the geographic distribution of providers;

(3) The size of the provider and the type of any specialty;

(4) The market share of the carrier and the provider;

(5) The impact on the price and stability of health insurance and health care services to consumers; and

(6) The impact on reimbursement rates in the provider marketplace. [2011, c. 1, §42 (RAL).]

[2011, c. 1, §42 (RAL) .]

18. **Provider contract requirements.** A carrier offering a health plan must meet the requirements of this subsection with respect to a contract offered by the carrier to a provider, including a contract offered through a preferred provider arrangement, as defined in section 2671, subsection 7. This subsection does not apply to dental or vision plans.

A. If the contract for a preferred provider arrangement includes a reference to policies or procedures to which a contracting provider would be bound, all such policies and procedures must be provided to the provider for review in an easily accessible manner upon the provider's request at the time the contract is offered. [2013, c. 399, §1 (NEW).]

B. Upon the provider's request at the time a contract for a preferred provider arrangement is offered, the following must be provided to a provider for review:

(1) The fee schedule or, if there is not a fee schedule for one or more of the services covered under the contract, the terms under which payment is determined. A carrier may require a provider to execute a nondisclosure agreement covering the information provided under this subparagraph; and

(2) The identity of all carriers for which the provider is agreeing to provide services to health plan enrollees. [2013, c. 399, §1 (NEW).]

C. As a condition of participation in one of the carrier's preferred provider arrangements, a contract offered by a carrier may not require a provider to participate in any other carrier's network subsequently offered by the carrier or by a carrier's preferred provider arrangement. [2013, c. 399, §1 (NEW).]

D. Without the provider's prior written consent, a provider's contractual participation in a carrier's preferred provider arrangement may not:

(1) Subject the provider to health plan payor requirements or fee schedules that materially differ from the terms of the provider's contract with the carrier, unless those materially different terms are set out in writing in a separate section of the contract, such as an exhibit or amendment; or

(2) Permit the terms of the provider's existing preferred provider arrangement contract to be superseded by a carrier's subsequent contract with a health plan payor. [2013, c. 399, §1 (NEW).]

E. A preferred provider arrangement contract may not require a provider providing a service to an enrollee under a health plan included in the provider's contract to obtain preauthorization if the enrollee's health plan does not require prior authorization as a condition of coverage. [2013, c. 399, §1 (NEW).]

F. Explanation of remittance advices or comparable documents, whether in paper or electronic form, that accompany and identify payment of a provider's claims under a carrier's contract, including contracts offered through a preferred provider arrangement, must identify the administrator and payor of the provider's claims and include contact information. [2013, c. 399, §1 (NEW).]

The requirements of this subsection do not apply to a carrier offering a health plan with respect to preferred provider arrangement contracts with a hospital or pharmacy.

[2013, c. 399, §1 (NEW) .]

19. **Information about provider networks.** A carrier offering a managed care plan shall prominently disclose to applicants, prospective enrollees and enrollees information about the carrier's provider network for the applicable managed care plan, including whether there are hospitals, health care facilities, physicians or other providers not included in the plan's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The superintendent may adopt rules that set forth the manner, content and required disclosure of the information in accordance with this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 535, §1 (NEW) .]

SECTION HISTORY
1995, c. 673, Pt. C, §1 (NEW). 1995, c. 673, Pt. C, §2 (AFF). 1997, c. 163, §§1, 2 (AMD). 1999, c. 396, §5 (AMD). 1999, c. 396, §7 (AFF). 1999, c. 742, §§6-10 (AMD). 2001, c. 288, §5 (AMD). 2001, c. 410, Pt. B, §5 (AMD). RR 2003, c. 1, §21 (COR). 2003, c. 108, §1 (AMD). 2003, c. 110, §1 (AMD). 2003, c. 218, §9 (AMD). 2003, c. 309, §1 (AMD). 2003, c. 469, Pt. E, §20 (AMD). 2003, c. 689, Pt. B, §6 (REV). 2007, c. 106, §1 (AMD). 2007, c. 199, Pt. B, §§4-11 (AMD). 2009, c. 357, §1 (AMD). 2009, c. 439, Pt. A, §§3-5 (AMD). 2009, c. 439, Pt. B, §5 (AMD). 2009, c. 439, Pt. F, §1 (AMD). 2009, c. 652, Pt. A, §33 (AMD). RR 2011, c. 1, §§41, 42 (COR). 2011, c. 90, Pt. F, §7 (AMD). 2011, c. 238, Pt. A, §1 (AMD). 2011, c. 270, §1 (AMD). 2011, c. 364, §§25-27 (AMD). 2011, c. 451, §1 (AMD). 2011, c. 451, §2 (AFF). 2013, c. 383, §4 (AMD). 2013, c. 399, §1 (AMD). 2013, c. 535, §1 (AMD).

§4303-A. PROVIDER PROFILING PROGRAMS

1. **Disclosure.** At least 60 days prior to using or publicly disclosing the results of the provider profiling program, a carrier with a provider profiling program shall disclose to providers the methodologies, criteria, data and analysis used to evaluate provider quality, performance and cost, including but not limited to unit cost, price and cost-efficiency ratings. For the purposes of this subsection, the disclosure of data is satisfied by the provision by a carrier of a description of the data used in the evaluation, the source of the data, the time period subject to evaluation and, if applicable, the types of claims used in the evaluation including any adjustments to the data and exclusion from the data.

[2013, c. 383, §5 (NEW) .]

2. **Provider profile.** A carrier shall create and share with providers their provider profile at least 60 days prior to using or publicly disclosing the results of the provider profiling program.

[2013, c. 383, §5 (NEW) .]

3. **Request for data.** A provider may request a copy of its data within 30 days of the carrier's disclosure to a provider as required by subsection 2, and, upon request from a provider, a carrier shall provide to that provider the data associated with the requesting provider and all adjustments to the data used to evaluate that provider as part of the carrier's provider profiling program. The bureau shall adopt rules to establish requirements for the disclosure of data by a carrier to a provider in accordance with this subsection. The bureau shall provide in the rules for a time and manner of disclosure consistent with a carrier's ability to adopt, revise and develop an effective provider profiling program.

[2013, c. 383, §5 (NEW) .]

4. **Appeals.** A carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days of being provided with its provider profile pursuant to subsection 2. The appeal process must:

A. Afford the provider the opportunity to correct material errors, submit additional information for consideration and seek review of data and performance ratings; [2013, c. 383, §5 (NEW).]

B. Afford the provider the opportunity to review any information or evaluation prepared by a 3rd party and used by the carrier as part of its provider profiling program; however, if the 3rd party provides the right to review and correct that data, any appeal pursuant to this paragraph is limited to whether the carrier accurately portrayed the information and not to the underlying determination made by the 3rd party; and [2013, c. 383, §5 (NEW).]

C. Allow the provider to request reconsideration of its provider profiling result and submit supplemental information, including information demonstrating any computational or data errors. [2013, c. 383, §5 (NEW).]

[2013, c. 383, §5 (NEW) .]

5. **Out-of-network providers.** If a carrier has a provider profiling program that includes out-of-network providers, a carrier must meet the requirements of this section with regard to an out-of-network provider as well as for a provider in a carrier's network.

[2013, c. 383, §5 (NEW) .]

6. **Rules.** The bureau shall adopt rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 383, §5 (NEW) .]

SECTION HISTORY
2013, c. 383, §5 (NEW).

§4303-B. DISCLOSURE RELATED TO PROVIDER NETWORKS

1. **Disclosure.** Upon request, a carrier shall provide to a provider to which the carrier has decided not to offer the opportunity to participate or that the carrier has decided not to include as a participating provider in any of the carrier's provider networks a written explanation of the reason for the carrier's decision. The written explanation provided by the carrier must indicate whether the reason for not offering the provider the opportunity to contract or for not including the provider in any network was related to the provider's performance with respect to quality, cost or cost-efficiency.

[2013, c. 535, §2 (NEW) .]

2. **No right of action.** A provider has no right of action as the result of a disclosure made in accordance with this section.

[2013, c. 535, §2 (NEW) .]

SECTION HISTORY
2013, c. 535, §2 (NEW).

§4304. UTILIZATION REVIEW

The following requirements apply to health plans doing business in this State that require prior authorization by the plan of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering or renewing a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34. [2007, c. 199, Pt. B, §12 (AMD).]

1. **Requirements for medical review or utilization review practices.** A carrier must appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers or renews. A carrier's medical review or utilization review practices must be governed by the standard of medically necessary health care as defined in this chapter.

[2007, c. 199, Pt. B, §13 (AMD) .]

2. **Prior authorization of nonemergency services.** Requests by a provider for prior authorization of a nonemergency service must be answered by a carrier within 2 business days. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the information submitted is insufficient to make a decision, the carrier shall notify the provider within 2 business days of the additional information necessary to render a decision. If the carrier determines that outside consultation is necessary, the carrier shall notify the provider and the enrollee for whom the service was requested within 2 business days. The carrier shall make a good faith estimate of when the final determination will be made and contact the enrollee and the provider as soon as practicable. Notification requirements under this subsection are satisfied by written notification postmarked within the time limit specified.

[1999, c. 742, §12 (AMD) .]

3. **Background information; affirmative duty of provider.** A provider has an affirmative duty to submit to the carrier the background information necessary for the carrier to complete its review and render a decision within the time period required in subsection 2. If the provider needs additional time to submit that required information, the provider must inform the carrier in a timely manner. Nothing in this section requires a provider to submit confidential information without a signed consent from the enrollee.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

4. **Revocation of prior authorization.** When prior approval for a service or other covered item is granted, a carrier may not retrospectively deny coverage or payment for the originally approved service unless fraudulent or materially incorrect information was provided at the time prior approval for the service was granted.

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

5. **Emergency services.** When conducting utilization review or making a benefit determination for emergency services, a carrier shall provide benefits for emergency services consistent with the requirements of any applicable bureau rule.

[1999, c. 742, §13 (NEW) .]

6. **Notice.** A notice issued by a carrier or its contracted utilization review entity in response to a request by or on behalf of an insured or enrollee for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under

the policy or contract under which the insured or enrollee is covered. Nothing in this subsection requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan.

[2001, c. 410, Pt. B, §6 (NEW) .]

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§11-13 (AMD). 2001, c. 288, §6 (AMD). 2001, c. 410, §B6 (AMD). 2007, c. 199, Pt. B, §§12, 13 (AMD).

§4305. QUALITY OF CARE

A carrier offering or renewing a health plan that subjects payment of benefits for otherwise covered services to review for clinical necessity, appropriateness, efficacy or efficiency must meet the following requirements relating to quality of care. [2007, c. 199, Pt. B, §14 (AMD).]

1. **Internal quality assurance program.** A health plan must have an ongoing quality assurance program for the health care services provided or reimbursed by the health plan.

[1995, c. 673, §1 (NEW); 1995, c. 673, §2 (AFF) .]

2. **Written standards.** The standards of quality of care must be described in a written document, which must be available for examination by the superintendent or by the Department of Health and Human Services.

[1995, c. 673, §1 (NEW); 1995, c. 673, §2 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

3. **Coverage decisions.** Following a determination that a particular service is covered, a carrier may not deny payment for that service based on the enrollee's age, nature of disability or degree of medical dependency.

[1995, c. 673, §1 (NEW); 1995, c. 673, §2 (AFF) .]

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §14 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 199, Pt. B, §14 (AMD).

§4306. ENROLLEE CHOICE OF PRIMARY CARE PROVIDER

A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A to serve as primary care providers for managed care plans. A carrier is not required to contract with certified nurse practitioners or physicians as primary care providers in any manner that exceeds the access and provider network standards required in this chapter or chapter 56, or any rules adopted pursuant to those chapters. A carrier shall allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides. [2011, c. 364, §28 (AMD).]

SECTION HISTORY

1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 396, §6 (AMD). 1999, c. 396, §7 (AFF). 1999, c. 742, §15 (AMD). 2007, c. 199, Pt. B, §15 (AMD). 2011, c. 364, §28 (AMD).

§4306-A. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State subject to the requirements of the federal Affordable Care Act: [2011, c. 364, §29 (NEW).]

1. **Authorization or referral not required.** May not require authorization or referral by the carrier or any other person, including a primary care provider, in the case of a female enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology. The health care professional shall agree to otherwise adhere to the health plan's or carrier's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier; and

[2011, c. 364, §29 (NEW) .]

2. **Treated as primary care.** Shall treat the provision of obstetrical and gynecological care by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology, pursuant to subsection 1, as authorized by the primary care provider and the authorization of related obstetrical and gynecological items and services by that professional as the authorization of the primary care provider.

[2011, c. 364, §29 (NEW) .]

SECTION HISTORY
2011, c. 364, §29 (NEW).

§4307. CONSTRUCTION

Nothing in this chapter may be construed to: [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

1. **Purchase services with own funds.** Prohibit an individual from purchasing any health care services with that individual's own funds, whether these services are covered within the individual's benefit package or from another health care provider or plan, except as otherwise provided by federal or state law;

[1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF) .]

2. **Additional benefits.** Prohibit any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter;

[1999, c. 742, §16 (AMD) .]

3. **Provider participation.** Require a carrier to admit to a managed care plan a provider willing to abide by the terms and conditions of the managed care plan; or

[1999, c. 742, §16 (AMD) .]

4. **Treatment by religious nonmedical providers.** With respect to coverage of treatment by religious nonmedical providers:

A. Restrict or limit the right of a carrier to include a religious nonmedical provider as a participating provider in a managed care plan; [1999, c. 742, §17 (NEW).]

B. Require a carrier to:

(1) Utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(2) Use medical professionals or criteria to decide enrollee access to religious nonmedical providers;

(3) Utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(4) Compel an enrollee to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious nonmedical provider; or [1999, c. 742, §17 (NEW).]

C. Require a carrier to exclude religious nonmedical providers because the providers do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider. [1999, c. 742, §17 (NEW).]

[1999, c. 742, §17 (NEW) .]

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §§16,17 (AMD).

§4308. INDEMNIFICATION

A contract between a carrier offering or renewing a health plan and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with a claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct. [2007, c. 199, Pt. B, §16 (AMD).]

1. Indemnification.

[1999, c. 742, §18 (RP) .]

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF). 1999, c. 742, §18 (RPR). 2007, c. 199, Pt. B, §16 (AMD).

§4309. ADOPTION OF RULES

The superintendent shall adopt rules and establish standards for health plans in order to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter II-A. [1995, c. 673, Pt. C, §1 (NEW); 1995, c. 673, Pt. C, §2 (AFF).]

SECTION HISTORY
1995, c. 673, §C1 (NEW). 1995, c. 673, §C2 (AFF).

§4309-A. COMPLIANCE WITH THE AFFORDABLE CARE ACT

1. **Carriers.** A carrier shall comply with all applicable requirements of the federal Affordable Care Act.

[2011, c. 364, §30 (NEW) .]

2. **Superintendent.** The superintendent may enforce and administer this section through all powers provided under this Title and Title 24. The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments adopted pursuant to this subsection, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 364, §30 (NEW) .]

SECTION HISTORY
2011, c. 364, §30 (NEW).

§4310. ACCESS TO CLINICAL TRIALS

1. **Qualified enrollee.** An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

A. The enrollee has a life-threatening illness for which no standard treatment is effective; [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness; [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C. [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

2. **Coverage.** A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

3. **Payment.** A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

4. **Approved clinical trial.** For the purposes of this section, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

5. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §31 (NEW) .]

SECTION HISTORY
1999, c. 742, §19 (NEW). 1999, c. 742, §21 (AFF). 2003, c. 517, §B31 (AMD).

§4311. ACCESS TO PRESCRIPTION DRUGS

1. **Formulary.** If a health plan provides coverage for prescription drugs but the coverage limits such benefits to drugs included in a formulary, a carrier shall:

A. Ensure participation of participating physicians and pharmacists in the development of the formulary; and [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

B. Provide exceptions to the formulary limitation when a nonformulary alternative is medically indicated, consistent with the utilization review standards in section 4304. [1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF).]

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

2. **Coverage of approved drugs and medical devices.** A carrier that provides coverage for prescription drugs and medical devices may not deny coverage of a prescribed drug or medical device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

3. **Construction.** This section may not be construed to require a carrier to provide coverage of prescription drugs or medical devices.

[1999, c. 742, §19 (NEW); 1999, c. 742, §21 (AFF) .]

4. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §32 (NEW) .]

SECTION HISTORY
1999, c. 742, §19 (NEW). 1999, c. 742, §21 (AFF). 2003, c. 517, §B32 (AMD).

§4312. INDEPENDENT EXTERNAL REVIEW

An enrollee has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section. [2007, c. 199, Pt. B, §17 (AMD).]

1. **Request for external review.** An enrollee or the enrollee's authorized representative shall make a written request for external review of an adverse health care treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not make a request for external review under a group plan until the enrollee has exhausted all levels of a carrier's internal grievance procedure and may not make a request for external review under an individual plan until the enrollee has exhausted one level of a carrier's internal grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under a carrier's internal grievance procedure. An enrollee may not be required to pay any filing fee as a condition of processing a request for external review.

[2011, c. 364, §31 (AMD) .]

2. **Expedited request for external review.** An enrollee or an enrollee's authorized representative is not required to exhaust a carrier's internal grievance procedure in accordance with subsection 1 before filing a request for external review if:

A. The carrier has failed to make a decision on an internal grievance within the time period required or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal; [2011, c. 364, §32 (AMD).]

B. The carrier and the enrollee mutually agree to bypass the internal grievance procedure; [1999, c. 742, §19 (NEW).]

C. The life or health of the enrollee is in serious jeopardy; [2011, c. 364, §32 (AMD).]

D. The enrollee has died; or [2011, c. 364, §32 (AMD).]

E. The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services. [2011, c. 364, §32 (NEW).]

[2011, c. 364, §32 (AMD) .]

3. **Notice to enrollees.** A carrier shall notify an enrollee of the enrollee's right to request an external review in large type and easy-to-read language in a conspicuous location on the written notice of an adverse health care treatment decision. The notice must include:

A. A description of the external review procedure and the requirements for making a request for external review; [1999, c. 742, §19 (NEW).]

B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier; [1999, c. 742, §19 (NEW).]

C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and [1999, c. 742, §19 (NEW).]

D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

4. **Independent external review; bureau oversight.** The bureau shall oversee the external review process required under this section and shall contract with approved independent review organizations to conduct an external review and render an external review decision. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who are clinical peers with respect to the adverse health care treatment decision under review and who have no professional, familial or financial conflict of interest relating to a carrier, enrollee, enrollee's authorized representative or health care provider involved in the external review.

[1999, c. 742, §19 (NEW) .]

5. **Independent external review decision; timelines.** An external review decision must be made in accordance with the following requirements.

A. In rendering an external review decision, the independent review organization must give consideration to the appropriateness of the requested covered service based on the following:

(1) All relevant clinical information relating to the enrollee's physical and mental condition, including any competing clinical information;

(2) Any concerns expressed by the enrollee concerning the enrollee's health status; and

(3) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the carrier or the carrier's utilization review entity. [1999, c. 742, §19 (NEW).]

B. An external review decision must be issued in writing and must be based on the evidence presented by the carrier and the enrollee or the enrollee's authorized representative. An enrollee may submit and obtain evidence relating to the adverse health care treatment decision under review, attend the external review, ask questions of any representative of the carrier present at the external review and use outside assistance during the review process at the enrollee's own expense. [1999, c. 742, §19 (NEW).]

C. Except as provided in paragraph D, an external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau. [1999, c. 742, §19 (NEW).]

D. An external review decision must be made as expeditiously as an enrollee's medical condition requires but in no event more than 72 hours after receipt of a completed request for external review if the time frame for review required under paragraph C would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function. [1999, c. 742, §19 (NEW).]

E. The carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an external review under this section. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

6. **Binding nature of decision.** An external review decision is binding on the carrier. An enrollee or the enrollee's authorized representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the enrollee has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.

[1999, c. 742, §19 (NEW) .]

7. **Funding.** A carrier against which a request for external review has been filed shall pay the cost of the independent external review to the bureau.

[1999, c. 742, §19 (NEW) .]

7-A. **Confidentiality.** Except as provided in this subsection, all records of the bureau or an independent review organization relating to an external review request or external review proceeding are confidential and not a public record under Title 1, chapter 13.

A. A party to an external review may obtain from the independent review organization a transcript or recording of the external review hearing and a copy of any evidence introduced by the opposing party. [2013, c. 274, §1 (NEW).]

B. The superintendent shall disseminate to the Legislature and to the public aggregate information related to external reviews conducted by independent review organizations on an annual basis, including:

(1) The number of external review requests by carrier, the number of decisions in favor of the enrollee, the number of decisions upholding the carrier's benefit determination and the number of external review requests resolved prior to the issuance of a decision; and

(2) The categories of external review requests by carrier. The categories may not include personally identifiable information or specific medical condition. The categories must include, but are not limited to, medical necessity, out-of-network referrals, inpatient care, behavioral health, prescription drugs and experimental or investigational treatment. [2013, c. 274, §1 (NEW).]

[2013, c. 274, §1 (NEW) .]

8. **Rules.** The bureau may adopt rules necessary to carry out the requirements of this section, including, without limitation, criteria for determining when multiple denials of benefits to the same enrollee for the same or similar reasons are considered the same adverse health care treatment decision. Notwithstanding the requirements of section 4309, rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 742, §19 (NEW) .]

9. **Rights.** This section may not be construed to remove or limit any legal rights or remedies of an enrollee or other person under state or federal law, including the right to file judicial actions to enforce rights.

[1999, c. 742, §19 (NEW) .]

10. **Applicability.** Decisions relating to the following health care services are subject to review pursuant to other review processes provided by applicable federal or state law and may not be reviewed pursuant to this section:

A. Health care services provided through Medicaid, Medicare, Title XXI of the Social Security Act or services provided under these programs through contracted health care providers; [1999, c. 742, §19 (NEW).]

B. Health care services provided to inmates by the Department of Corrections; or [1999, c. 742, §19 (NEW).]

C. Health care services provided pursuant to a health plan not subject to regulation by the State. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

SECTION HISTORY
1999, c. 742, §19 (NEW). 2007, c. 199, Pt. B, §17 (AMD). 2011, c. 364, §§31, 32 (AMD). 2013, c. 274, §1 (AMD).

§4313. CARRIER LIABILITY; CAUSE OF ACTION

1. **Duty of ordinary care; cause of action.** An enrollee may maintain a cause of action against a carrier offering or renewing a health plan in accordance with the following.

A. A carrier has the duty to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee and is liable for damages as provided in this section for harm to an enrollee proximately caused by the failure of the carrier or its agents to exercise such ordinary care. [1999, c. 742, §19 (NEW).]

B. A carrier is also liable for damages as provided in this section for harm to an enrollee proximately caused by the health care treatment decisions made by its agents who are acting on the carrier's behalf and over whom the carrier exercised control or influence in the health care treatment decisions that result in the failure to exercise ordinary care. [1999, c. 742, §19 (NEW).]

[2007, c. 199, Pt. B, §18 (AMD) .]

2. **Exhaustion of internal and external review.** An enrollee may not maintain a cause of action under this section unless the enrollee or the enrollee's representative:

A. Has exhausted all levels of the carrier's internal grievance procedure in accordance with this chapter; and [1999, c. 742, §19 (NEW).]

B. Has completed the independent external review process required under section 4312. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

3. **Limitation on cause of action.** An action under this section must be initiated within 3 years from the earlier of the date of issuance of the written external review decision under section 4312 or the date of issuance of the underlying adverse first-level appeal or first-level grievance determination notice.

[1999, c. 742, §19 (NEW) .]

4. **Jurisdiction; notice and filing.** The Superior Court has original jurisdiction over a cause of action under this section. The requirements for notice and filing of a cause of action under this section are governed by the Maine Rules of Civil Procedure.

[1999, c. 742, §19 (NEW) .]

5. **Corporate practice of medicine.** Section 4222, subsection 3 or any other law in this State prohibiting a carrier from practicing medicine or being licensed to practice medicine may not be asserted as a defense by a carrier in any action brought pursuant to this section.

[1999, c. 742, §19 (NEW) .]

6. **No obligation for benefits.** This section does not create any obligation on the part of a carrier to provide an enrollee any health care treatment or service that is not covered by the enrollee's health plan policy or contract.

[1999, c. 742, §19 (NEW) .]

7. **Admissibility of external review decision.** An external review decision is admissible in an action under this section.

[1999, c. 742, §19 (NEW) .]

8. **Affirmative defense.** It is an affirmative defense to any action asserted against a carrier under this section that the carrier or any agent for whose conduct the carrier is liable did not control, influence or participate in the health care treatment decision.

[1999, c. 742, §19 (NEW) .]

9. **Damages.** In a cause of action under this section, the award of damages must be made in accordance with this subsection.

A. Actual or compensatory damages may be awarded. [1999, c. 742, §19 (NEW).]

B. Noneconomic damages awarded may not exceed $400,000. [1999, c. 742, §19 (NEW).]

C. Punitive damages may not be awarded. [1999, c. 742, §19 (NEW).]

[1999, c. 742, §19 (NEW) .]

10. **Professional negligence.** This section does not create any new or additional liability on the part of a carrier for harm caused to an enrollee that is attributable to the professional negligence of a treating physician or other health care practitioner.

[1999, c. 742, §19 (NEW) .]

11. **Employer liability.** This section does not create any liability on the part of an employer that assumes risk on behalf of its employees or an employer group purchasing organization.

[1999, c. 742, §19 (NEW) .]

12. **Exemption.** This section does not apply to workers' compensation, medical malpractice, fidelity, suretyship, boiler and machinery, property or casualty insurance.

[1999, c. 742, §19 (NEW) .]

13. **Limitation on remedy.** The cause of action under this section is the sole and exclusive private remedy under state law for an enrollee against a carrier for its health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee, except that this subsection may not be construed to prohibit an enrollee or an enrollee's authorized representative from seeking other remedies specifically available under other provisions of this Title.

[1999, c. 742, §19 (NEW) .]

14. **Wrongful death action.** Notwithstanding subsection 13, an enrollee or an enrollee's authorized representative may bring a cause of action against a carrier for its health care treatment decisions to seek a remedy under either this section or under Title 18-A, section 2-804, but may not seek remedies under both this section and Title 18-A, section 2-804.

[1999, c. 742, §19 (NEW) .]

SECTION HISTORY
1999, c. 742, §19 (NEW). 2007, c. 199, Pt. B, §18 (AMD).

§4314. ACCESS TO EYE CARE PROVIDERS

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

A. "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to Title 32, chapter 34-A, or an ophthalmologist licensed to practice medicine pursuant to Title 32, chapter 48. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

B. "Eye care services" means those urgent health care services related to the examination, diagnosis, treatment and management of conditions, illnesses and diseases of the eye and related structures that are provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

2. **Coverage of eye care services.** A carrier that provides coverage for eye care services as part of a health plan shall provide coverage for eye care services in accordance with the following.

A. An enrollee may receive eye care services from an eye care provider participating in the enrollee's health plan without the prior approval or authorization of the enrollee's primary care provider for a maximum of 2 visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care as described in subsection 1, paragraph B. A carrier may not retrospectively deny coverage under this section on the basis that the eye care services received by the enrollee did not meet the requirements of subsection 1, paragraph B. In order to receive continuing benefits for treatment related to the initial visit, an enrollee must receive the approval of the enrollee's primary care provider for any visit after the 2nd visit. Within 3 working days of the initial visit, the eye care provider shall send to the enrollee's primary care provider a report containing the enrollee's complaint, related history, examination results, initial diagnosis and recommendations for treatment. If the eye care provider does not send a report to the primary care provider within 3 working days, the carrier is not obligated to provide benefits for the self-referred visits under this paragraph and the enrollee is not liable to the eye care provider for any unpaid fees. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

B. A carrier shall ensure that all eye care providers participating in the carrier's health plans are included on any publicly accessible list of participating providers for the carrier. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

C. A carrier shall allow each eye care provider participating in the carrier's health plans to furnish covered eye care services to enrollees without discrimination between classes of eye care providers and to provide the eye care services permitted by the eye care provider's license. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

3. **Prohibitions.** A carrier may not:

A. Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other health care services under a health plan; or [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

B. Require an eye care provider to hold hospital privileges as a condition of participation as a provider under a health plan. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

4. **Construction.** This section may not be construed as:

A. Requiring coverage for routine eye examinations; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

B. Creating coverage for any health care service that is not otherwise covered under the terms of a health plan; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

C. Requiring a carrier to include as a participating provider every willing provider or health care professional who meets the terms and conditions of a health plan; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

D. Preventing an enrollee from seeking eye care services from the enrollee's primary care provider in accordance with the terms of the enrollee's health plan; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

E. Increasing or decreasing the scope of practice of optometry or ophthalmology as defined in Title 32; [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

F. Requiring eye care services to be provided in a hospital or similar health care facility; or [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

G. Notwithstanding the definition of eye care services in subsection 1, paragraph B, prohibiting a carrier from requiring an enrollee to receive prior approval or authorization from a primary care provider for any subsequent surgical procedures. [2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF).]

[2001, c. 408, §1 (NEW); 2001, c. 408, §2 (AFF) .]

5. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §33 (NEW) .]

SECTION HISTORY
2001, c. 408, §1 (NEW). 2001, c. 408, §2 (AFF). 2003, c. 517, §B33 (AMD).

§4315. COVERAGE OF PROSTHETIC DEVICES

1. **Definition.** As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

2. **Required coverage.** A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee.

[2003, c. 688, Pt. I, §1 (AMD) .]

3. **Prior authorization.** A carrier may require prior authorization for prosthetic devices in the same manner as prior authorization is required for any other covered benefit.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

4. **Repair or replacement.** Coverage under this section must also be provided for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by the enrollee's provider.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

5. **Coverage under managed care plan.** If coverage under this section is provided through a managed care plan, a carrier may require that prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device be provided by a vendor designated by the carrier.

[2003, c. 459, §1 (NEW); 2003, c. 459, §2 (AFF) .]

6. **Exclusions.** Coverage is not required pursuant to this section for a prosthetic device that is designed exclusively for athletic purposes.

[2009, c. 603, §1 (AMD); 2009, c. 603, §2 (AFF) .]

7. **Application.** The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §34 (NEW) .]

8. **Health savings accounts.** Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.

[2003, c. 688, Pt. I, §2 (NEW) .]

SECTION HISTORY
2003, c. 459, §1 (NEW). 2003, c. 459, §2 (AFF). 2003, c. 517, §B34 (AMD). 2003, c. 688, §§I1,2 (AMD). 2009, c. 603, §1 (AMD). 2009, c. 603, §2 (AFF).

§4316. COVERAGE FOR TELEMEDICINE SERVICES

1. **Definition.** For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile machine or e-mail.

[2009, c. 169, §1 (NEW) .]

2. **Coverage of telemedicine services.** A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

[2009, c. 169, §1 (NEW) .]

SECTION HISTORY
2009, c. 169, §1 (NEW).

§4317. PHARMACY PROVIDERS

1. **Contracts with pharmacy providers.** Notwithstanding section 2672, section 4307, subsection 3 and Title 32, chapter 117, subchapter 8, a carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers.

This subsection may not be construed to limit a carrier's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the carrier makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.

[2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

2. **Prompt payment of claims.** Notwithstanding section 2436, the following provisions apply to the payment of claims submitted to a carrier by a pharmacy provider.

A. For purposes of this subsection, the following terms have the following meanings.

(1) "Applicable number of calendar days" means:

(a) With respect to claims submitted electronically, 21 days; and

(b) With respect to claims submitted otherwise, 30 days.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

B. A contract entered into by a carrier with a pharmacy provider with respect to a prescription drug plan offered by a carrier must provide that payment is issued, mailed or otherwise transmitted with respect to all clean claims submitted by a pharmacy provider, other than a pharmacy that dispenses drugs by mail order only or a pharmacy located in, or under contract with, a long-term care facility, within the applicable number of calendar days after the date on which the claim is received. For purposes of this subsection, a claim is considered to have been received:

(1) With respect to claims submitted electronically, on the date on which the claim is transferred; and

(2) With respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission of the claim. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

C. If payment is not issued, mailed or otherwise transmitted by the carrier within the applicable number of calendar days after a clean claim is received, the carrier shall pay interest to the pharmacy provider at the rate of 18% per annum. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

D. A claim is considered to be a clean claim if the carrier involved does not provide notice to the pharmacy provider of any deficiency in the claim within 10 days after the date on which an electronically submitted claim is received or within 15 days after the date on which a claim submitted otherwise is received. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

E. If a carrier determines that a submitted claim is not a clean claim, the carrier shall immediately notify the pharmacy provider of the determination. The notice must specify all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim. If a pharmacy provider receives notice from a carrier that a claim has been determined

to not be a clean claim, the pharmacy provider shall take steps to correct that claim and then resubmit the claim to the carrier for payment. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

F. A claim resubmitted to a carrier with additional information pursuant to paragraph E is considered to be a clean claim if the carrier does not provide notice to the pharmacy provider of any defect or impropriety in the claim within 10 days of the date on which additional information is received if the claim is resubmitted electronically or within 15 days of the date on which additional information is received if the claim is resubmitted otherwise. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

G. A claim submitted to a carrier that is not paid by the carrier or contested by the plan sponsor within the applicable number of calendar days after the date on which the claim is received by the carrier is considered to be a clean claim and must be paid by the carrier. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

H. Payment of a clean claim under this subsection is considered to have been made on the date on which the payment is transferred with respect to claims paid electronically and on the date on which the payment is submitted to the United States Postal Service or common carrier for delivery with respect to claims paid otherwise. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

I. A carrier shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy provider so requests or has so requested previously. In the case when the payment is made electronically, remittance may be made by the carrier electronically. [2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF).]

[2009, c. 519, §1 (NEW); 2009, c. 519, §2 (AFF) .]

3. **Exception.** Subsections 1 and 2 do not apply to any medical assistance or public health programs administered by the Department of Health and Human Services, including, but not limited to, the Medicaid program and the elderly low-cost drug program under Title 22, section 254-D.

[2011, c. 443, §5 (AMD) .]

4. **Participation in contracts** . A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one network in order to participate in another network. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in one network solely because the pharmacist or pharmacy declined to participate in another network managed by the pharmacy benefits manager.

[2011, c. 443, §6 (NEW) .]

5. **Prohibition.** The written contract between a carrier and a pharmacy benefits manager may not provide that the pharmacist or pharmacy is responsible for the actions of the insurer or a pharmacy benefits manager.

[2011, c. 443, §6 (NEW) .]

6. **Pharmacy benefits manager duties.** All contracts must provide that, when the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager shall distribute the funds in accordance with the time frames provided in this subchapter.

[2011, c. 691, Pt. A, §23 (AMD) .]

7. **Complaints, grievances and appeals.** A pharmacy benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy solely as a result of the pharmacist's or pharmacy's filing of a complaint, grievance or appeal. This subsection is not intended to restrict the pharmacy's and pharmacy benefits manager's ability to enter into agreements that allow for mutual termination without cause.

[2011, c. 443, §6 (NEW) .]

8. **Denial or limitation of benefits.** A pharmacy's benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy for expressing disagreement with a carrier's decision to deny or limit benefits to an enrollee or because the pharmacist or pharmacy assists the enrollee to seek reconsideration of the carrier's decision or because the pharmacist or pharmacy discusses alternative medications.

[2011, c. 443, §6 (NEW) .]

9. **Written notice required.** At least 60 days before a pharmacy's benefits manager terminates a pharmacy's or pharmacist's participation in the pharmacy benefits manager's plan or network, the pharmacy benefits manager shall give the pharmacy or pharmacist a written explanation of the reason for the termination, unless the termination is based on:

A. The loss of the pharmacy's license or the pharmacist's license to practice pharmacy or cancellation of professional liability insurance; or [2011, c. 443, §6 (NEW).]

B. A finding of fraud. [2011, c. 443, §6 (NEW).]

At least 60 days before a pharmacy or pharmacist terminates its participation in a pharmacy benefits manager's plan or network, the pharmacy or pharmacist shall give the pharmacy benefits manager a written explanation of the reason for the termination.

[2011, c. 443, §6 (NEW) .]

10. **Audits.** Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria.

A. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, unless the projected overpayment or denial is a part of a settlement agreed to by the pharmacy or pharmacist. [2011, c. 443, §6 (NEW).]

B. The auditor may not use extrapolation in calculating recoupments or penalties. [2011, c. 443, §6 (NEW).]

C. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist. [2011, c. 443, §6 (NEW).]

D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity. [2011, c. 443, §6 (NEW).]

E. This subsection does not apply to any audit, review or investigation that is initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse. [2011, c. 443, §6 (NEW).]

F. Prior to an audit, the entity conducting an audit shall give the pharmacy 10 days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit. [2013, c. 71, §1 (NEW).]

G. A pharmacy has the right to request mediation by a private mediator, agreed upon by the pharmacy and the pharmacy benefits manager, to resolve any disagreements. A request for mediation does not waive any existing rights of appeal available to a pharmacy under this subsection or subsection 11. [2013, c. 71, §1 (NEW).]

H. The requirements of section 4303, subsection 10 apply to claims audited under this subsection. [2013, c. 71, §1 (NEW).]

[2013, c. 71, §1 (AMD) .]

11. **Audit information and reports.** A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit under subsection 10. A pharmacy must be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeal process provided by the pharmacy benefits manager has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity.

§4317. Prohibition against maximum aggregate benefit provisions

(As enacted by PL 2009, c. 588, §1 and affected by §3 is REALLOCATED TO TITLE 24-A, SECTION 4318)

[2011, c. 443, §6 (NEW) .]

SECTION HISTORY
RR 2009, c. 2, §70 (RAL). 2009, c. 519, §1 (NEW). 2009, c. 519, §2 (AFF). 2009, c. 588, §1 (NEW). 2009, c. 588, §3 (AFF). 2011, c. 443, §§5, 6 (AMD). 2011, c. 691, Pt. A, §23 (AMD). 2013, c. 71, §1 (AMD).

§4317-A. PRESCRIPTION DRUG COVERAGE; OUT-OF-POCKET EXPENSES FOR COINSURANCE

1. **Out-of-pocket expenses for coinsurance within health plan's total limit.** If a carrier that provides coverage for prescription drugs does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits provided under a health plan, the carrier shall establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

2. **Adjustment of out-of-pocket limits.** A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

3. **Construction.** This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in accordance with this chapter.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

4. **Terms consistent with federal law.** For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.

[2011, c. 611, §1 (NEW); 2011, c. 611, §2 (AFF) .]

SECTION HISTORY
2011, c. 611, §1 (NEW). 2011, c. 611, §2 (AFF).

§4317-B. ORALLY ADMINISTERED CANCER THERAPY

1. **Coverage.** A carrier that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section.

[2013, c. 449, §1 (NEW); 2013, c. 449, §2 (AFF) .]

2. **Construction.** This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication.

[2013, c. 449, §1 (NEW); 2013, c. 449, §2 (AFF) .]

SECTION HISTORY
2013, c. 449, §1 (NEW). 2013, c. 449, §2 (AFF).

§4318. PROHIBITION AGAINST MAXIMUM AGGREGATE BENEFIT PROVISIONS

(REALLOCATED FROM TITLE 24-A, SECTION 4317)

1. **Prohibition.** An individual or group health plan issued or renewed by a carrier on or after the effective date of this section may not include a provision in a policy, contract, certificate or agreement that purports to terminate payment of any additional claims for coverage of health care services after a defined maximum aggregate dollar amount of claims for coverage of health care services on an annual, lifetime or other basis has been paid under the health plan for coverage of an insured individual, family or group.

[2009, c. 2, §70 (RAL) .]

2. **Specific benefits.** This section may not be construed to limit the ability of a carrier to offer a health plan that limits benefits under the health plan for specified health care services on an annual basis.

[2009, c. 2, §70 (RAL) .]

3. **Exceptions.** This section does not apply to:

A. An individual health plan in effect on the effective date of this section with an annual or lifetime maximum aggregate benefit limit of less than $1,000,000; [2009, c. 2, §70 (RAL).]

B. A health plan designed for an employee who works on a part-time, temporary or seasonal basis or designed as short-term coverage for an employee who is fulfilling a waiting period for coverage under another employer-sponsored benefit plan; [2009, c. 2, §70 (RAL).]

C. An individual health plan in effect on the effective date of this section issued pursuant to a conversion privilege in a group health insurance policy subject to section 2809-A; [2009, c. 2, §70 (RAL).]

D. A pilot project to offer an individual health plan to a person under 30 years of age pursuant to section 2736-C, subsection 10; and [2009, c. 2, §70 (RAL).]

E. Blanket health insurance as defined in section 2813. [2009, c. 2, §70 (RAL).]

[2009, c. 2, §70 (RAL) .]

4. **Disclosure.** A health plan issued after the effective date of this section that includes an annual or lifetime maximum aggregate benefit limit as permitted under subsection 3 and under section 4320 must include a disclosure of the applicable limit on the face page of the individual policy or group certificate. The disclosure must be printed in a font that is larger or bolder than the font used in the body of the face page.

[2011, c. 364, §33 (AMD) .]

SECTION HISTORY
RR 2009, c. 2, §70 (RAL). 2011, c. 364, §33 (AMD).

§4319. REBATES

1. **Rebates required.** Carriers must provide rebates in the large group, small group and individual markets to the extent required by the federal Affordable Care Act and federal regulations adopted pursuant thereto if the medical loss ratio under subsection 2 is less than the minimum medical loss ratio under subsection 3.

[2011, c. 90, Pt. D, §5 (NEW) .]

2. **Medical loss ratio.** For purposes of this section, the medical loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively, plus any credibility adjustment. The period for which the medical loss ratio is determined and the meaning of all terms used in this subsection must be in accordance with the federal Affordable Care Act and federal regulations adopted pursuant thereto. For the purposes of this subsection:

A. The numerator is the amount expended on reimbursement for clinical services provided to enrollees and activities that improve health care quality; and [2011, c. 90, Pt. D, §5 (NEW).]

B. The denominator is the total amount of premium revenue excluding federal and state taxes and licensing and regulatory fees paid and after accounting for payments or receipts for risk adjustment, risk corridors and reinsurance pursuant to federal law. [2011, c. 90, Pt. D, §5 (NEW).]

[2011, c. 90, Pt. D, §5 (NEW) .]

3. **Minimum medical loss ratio.** The minimum medical loss ratio is:

A. In the large group market, 85%; [2011, c. 90, Pt. D, §5 (NEW).]

B. In the small group market, 80%; and [2011, c. 90, Pt. D, §5 (NEW).]

C. In the individual market, 80% or such lower minimum medical loss ratio as the Secretary of the United States Department of Health and Human Services determines based on a finding, pursuant to the federal Affordable Care Act and federal regulations adopted pursuant thereto, that an 80% minimum medical loss ratio might destabilize the individual market in this State. [2011, c. 90, Pt. D, §5 (NEW).]

[2011, c. 90, Pt. D, §5 (NEW) .]

SECTION HISTORY
2011, c. 90, Pt. D, §5 (NEW).

§4320. NO LIFETIME OR ANNUAL LIMITS ON HEALTH PLANS SUBJECT TO THE AFFORDABLE CARE ACT

Notwithstanding the requirements of section 4318, a carrier offering a health plan subject to the federal Affordable Care Act may not: [2011, c. 364, §34 (NEW).]

1. **Establish lifetime limits.** Establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or

[2011, c. 364, §34 (NEW) .]

2. **Establish annual limits.** Establish annual limits on the dollar value of essential benefits, except that, prior to January 1, 2014, health plans may include restricted annual limits on essential benefits consistent with the requirements of the federal Affordable Care Act and may establish annual limits consistent with waivers granted by the Secretary of the United States Department of Health and Human Services.

§4320. Payment reform pilot projects

(As enacted by PL 2011, c. 270, §2 is REALLOCATED TO TITLE 24-A, SECTION 4320-H)

[2011, c. 364, §34 (NEW) .]

SECTION HISTORY
RR 2011, c. 1, §43 (RAL). 2011, c. 270, §2 (NEW). 2011, c. 364, §34 (NEW).

§4320-A. COVERAGE OF PREVENTIVE HEALTH SERVICES

Notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the federal Affordable Care Act shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive services as required by the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-B. EXTENSION OF DEPENDENT COVERAGE

A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-C. EMERGENCY SERVICES

If a carrier offering a health plan subject to the requirements of the federal Affordable Care Act provides or covers any benefits with respect to services in an emergency department of a hospital, the plan must cover emergency services in accordance with the requirements of the federal Affordable Care Act, including requirements that emergency services be covered without prior authorization and that cost-sharing requirements, expressed as a copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network. [2011, c. 364, §34 (NEW).]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-D. COMPREHENSIVE HEALTH COVERAGE

Notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the requirements of the federal Affordable Care Act shall, at a minimum, provide coverage that incorporates essential benefits and cost-sharing limitations consistent with the requirements of the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-E. REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT

1. **Transitional reinsurance program.** The superintendent shall establish a transitional reinsurance program for calendar years 2014, 2015 and 2016 as required by Section 1341 of the federal Affordable Care Act.

[2011, c. 364, §34 (NEW) .]

2. **Risk corridors.** A carrier shall make any payments required under the risk corridors program established by the Secretary of the United States Department of Health and Human Services for calendar years 2014, 2015 and 2016 as required by Section 1342 of the federal Affordable Care Act.

[2011, c. 364, §34 (NEW) .]

3. **Risk adjustment.** The superintendent shall establish a risk adjustment program as required by Section 1343 of the federal Affordable Care Act.

[2011, c. 364, §34 (NEW) .]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-F. OVERSIGHT OF PLANS OFFERED ON THE AMERICAN HEALTH BENEFIT EXCHANGE AND THE SHOP EXCHANGE

1. **Superintendent's authority preserved.** Except as otherwise expressly provided by applicable law, the requirements established by this Title, Title 24 and rules adopted by the superintendent continue to apply to carriers and health plans and are not extinguished or modified in any way by:

A. Certification of a health plan as a qualified health plan or any other determination made by the American Health Benefit Exchange or the SHOP Exchange pursuant to the federal Affordable Care Act; or [2011, c. 364, §34 (NEW).]

B. Recognition by the applicable federal agency of a carrier as a qualified nonprofit health insurance issuer or as an issuer of multistate qualified health plans, or of a health plan as a multistate qualified health plan, pursuant to the federal Affordable Care Act. [2011, c. 364, §34 (NEW).]

[2011, c. 364, §34 (NEW) .]

2. **Coordination with exchanges.** The superintendent has all additional powers and duties conferred upon a state insurance regulator with respect to the American Health Benefit Exchange and the SHOP Exchange by the federal Affordable Care Act. The superintendent may enter into agreements with the American Health Benefit Exchange and the SHOP Exchange relating to coordination of responsibilities, and such agreements may provide for the superintendent to assume additional authority relating to the certification of qualified health plans or the authorization of a carrier to participate in the American Health Benefit Exchange or the SHOP Exchange.

[2011, c. 364, §34 (NEW) .]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-G. APPLICABILITY TO HEALTH PLANS GRANDFATHERED UNDER THE AFFORDABLE CARE ACT

A health plan that is exempt from certain requirements of the federal Affordable Care Act because it has grandfathered status is also exempt, to the same extent, from substantially similar provisions in this Title and Title 24 enacted after January 1, 2011, except to the extent that those provisions state that they apply to grandfathered health plans. [2011, c. 364, §34 (NEW).]

SECTION HISTORY
2011, c. 364, §34 (NEW).

§4320-H. PAYMENT REFORM PILOT PROJECTS

(REALLOCATED FROM TITLE 24-A, SECTION 4320)

1. **Pilot projects.** Beginning March 1, 2012, the superintendent may authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers health plans in this State to implement payment reform strategies with providers through an accountable care organization to reduce costs and improve the quality of patient care. For purposes of this section, "accountable care organization" means a group of health care providers operating under a payment agreement to provide health care services to a defined set of individuals with established benchmarks for the quality and cost of those health care services consistent with federal law and regulation.

A. The superintendent may approve a pilot project between a carrier and an accountable care organization that utilizes payment methodologies and purchasing strategies, including, but not limited to: alternatives to fee-for-service models, such as blended capitation rates, episodes-of-care payments, medical home models and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies. [2011, c. 1, §43 (RAL).]

B. Prior to approving a pilot project, the superintendent shall consider whether the proposed pilot project is consistent with the principles for payment reform developed by the Advisory Council on Health Systems Development established under former Title 2, section 104. [2011, c. 1, §43 (RAL).]

[2011, c. 1, §43 (RAL) .]

2. **Rulemaking.** The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this section, including, but not limited to, a process for a health insurance carrier's submitting a pilot project proposal and minimum requirements for approval of a pilot project. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than December 1, 2011.

[2011, c. 1, §43 (RAL) .]

3. **Report.** Beginning in 2013, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the status of any pilot project approved by the superintendent pursuant to this section. The report must include an analysis of the cost and benefits of any approved pilot project in reducing health care costs, including any impact on premiums, and in improving the quality of care.

[2011, c. 1, §43 (RAL) .]

4. **Evaluation.** During the First Regular Session of the 129th Legislature, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall conduct an evaluation of the effectiveness of any pilot project approved by the superintendent pursuant to this section and make a determination whether to continue, amend or repeal the authorization for the pilot project. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out a bill based on the evaluation to the First Regular Session of the 129th Legislature.

[2011, c. 1, §43 (RAL) .]

5. **Construction.** This section may not be construed to restrict or limit the right of a carrier to engage in activities expressly permitted by this Title or to require a carrier to obtain prior approval as a pilot project to engage in those activities.

[2011, c. 1, §43 (RAL) .]

SECTION HISTORY
RR 2011, c. 1, §43 (RAL).

§4320-I. COVERAGE FOR THE COST OF TESTING FOR BONE MARROW DONATION SUITABILITY

1. **Required coverage.** A carrier offering a health plan in this State shall provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The enrollee covered under the health plan must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization; [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a; [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

C. At the time of the testing, the enrollee covered under the health plan must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; and [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

D. The carrier may limit each enrollee to one test per lifetime. [2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF).]

[2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF) .]

2. **Prohibition on cost-sharing.** A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section.

[2013, c. 603, §1 (NEW); 2013, c. 603, §2 (AFF) .]

SECTION HISTORY
2013, c. 603, §1 (NEW). 2013, c. 603, §2 (AFF).

Subchapter 2: CONSUMER HEALTH CARE
DIVISION HEADING: PL 1997, C. 792, §3 (NEW)

§4321. CONSUMER HEALTH CARE DIVISION

1. **Division established.** The Consumer Health Care Division, referred to in this section as the "division," is established within the Bureau of Insurance. The division shall work in coordination with other bureau sections and staff to accomplish the duties set forth in subsection 4.

[1997, c. 792, §3 (NEW) .]

2. **Director.** The Director of the Consumer Health Care Division, referred to in this section as the "director," is the head of the Consumer Health Care Division. The director is appointed by the superintendent and is subject to the approval of the Commissioner of Professional and Financial Regulation. The director is subject to the Civil Service Law.

[2005, c. 294, §23 (AMD) .]

3. **Staff.** The superintendent may hire or assign personnel as determined necessary to perform the duties of the division subject to the approval of the Commissioner of Professional and Financial Regulation and subject to the Civil Service Law. The personnel are supervised by the director in consultation with the superintendent. The qualifications of those personnel must reflect the needs and responsibilities relating to the division's duties under this subchapter.

[1997, c. 792, §3 (NEW) .]

4. **Duties.** The duties of the division include:

A. Providing access to the division through a toll-free number; [1997, c. 792, §3 (NEW).]

B. Providing information to consumers regarding health care plan options and obtaining health care coverage and services. The division may not make any specific recommendations regarding commercially offered products; [1997, c. 792, §3 (NEW).]

C. Assisting enrollees to understand their rights and responsibilities under health care plans; [1997, c. 792, §3 (NEW).]

D. Providing information to consumers on health care plan performance by distributing materials and utilizing existing resources relating to health care plan performance; [1997, c. 792, §3 (NEW).]

E. Providing assistance to enrollees with complaints relating to health care plans, when appropriate. The division may assist enrollees with quality-of-care complaints by coordinating with the appropriate state health professional licensing boards and other appropriate state and federal oversight bodies with authority over quality-of-care complaints. The division shall defer any issues of professional competence to the appropriate state health professional licensing boards; [1997, c. 792, §3 (NEW).]

F. Collecting and disseminating information regarding health care plans, quality assurance programs and quality improvement and coordinating information with other public entities or agencies involved in the delivery, funding or regulation of health care; [1997, c. 792, §3 (NEW).]

G. Acting as an information resource in the development of policies and programs that protect consumer interests and rights under health care plans by:

(1) Analyzing, evaluating and monitoring the development and implementation of federal, state and local laws, regulations, rules and other governmental policies and actions that pertain to the health, safety, welfare and rights of health care consumers; and

(2) Identifying practices and policies that may affect access to quality health care, including, but not limited to, practices relating to marketing of health care plans and accessibility of services and resources for under-served areas and vulnerable populations. The division may refer these issues to the appropriate state or federal regulatory agency with jurisdiction over these practices and policies; [1997, c. 792, §3 (NEW).]

H. Promoting coordination between the division and other organizations that assist consumers, including, but not limited to, legal assistance providers serving low-income health care consumers and other health care consumers, health insurance counseling assistance programs, the long-term care ombudsman program pursuant to Title 22, section 5106, subsection 11-C and assistance programs for individuals with disabilities established under federal or state law; [1997, c. 792, §3 (NEW).]

I. Collecting and disseminating information regarding the activities of the division; [1997, c. 792, §3 (NEW).]

J. Submitting an annual report by January 1st of each year to the Commissioner of Professional and Financial Regulation, the Consumer Health Care Division Advisory Council and the joint standing committee of the Legislature having jurisdiction over insurance matters describing the activities carried out by the division in the year for which the report is prepared, analyzing the data available to the division and evaluating the problems experienced by consumers; and [1997, c. 792, §3 (NEW).]

K. Performing other duties as the superintendent may prescribe. [1997, c. 792, §3 (NEW).]

[1997, c. 792, §3 (NEW) .]

SECTION HISTORY
1997, c. 792, §3 (NEW). 2005, c. 294, §23 (AMD).

§4322. CONSUMER HEALTH CARE DIVISION ADVISORY COUNCIL

(REPEALED)

SECTION HISTORY
1997, c. 792, §3 (NEW). 2003, c. 689, §B7 (REV). 2005, c. 294, §24 (RP).

Subchapter 3: DOWNSTREAM RISK HEADING: PL 1999, C. 609, §20 (NEW)

§4331. DEFINITIONS

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 609, §20 (NEW).]

1. **Bonus.** "Bonus" means a payment a carrier makes to a downstream entity beyond any salary, fee-for-service payment, capitation or returned withhold.

[1999, c. 609, §20 (NEW) .]

2. **Capitation.** "Capitation" means a set dollar payment per patient per unit of time, usually per month, that a carrier pays a health care practitioner, institutional provider or downstream entity to cover a specified set of services and administrative costs without regard to the actual number or nature of services provided. The services covered may include the downstream entity's own services, referral services or all medical services.

[1999, c. 609, §20 (NEW) .]

3. **Downstream entity.** "Downstream entity" means a person other than a carrier that has assumed all or part of the insurance risk of one or more health plans under a contractual relationship with a carrier or another downstream entity. An employer exempt from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a downstream entity.

[1999, c. 609, §20 (NEW) .]

4. **Downstream risk arrangement.** "Downstream risk arrangement" means an arrangement that transfers insurance risk from a carrier to a downstream entity.

[2003, c. 428, Pt. H, §6 (AMD) .]

5. **Payments.** "Payments" means any amounts the carrier pays the downstream entity for services the downstream entity furnishes directly, plus amounts paid for administration and amounts paid in whole or in part based on use and costs of referral services such as withhold amounts, bonuses based on referral levels and any other compensation to the downstream entity to influence the use of referral services. Bonuses and other compensation that are not based on referral levels, such as bonuses based solely on quality of care furnished, patient satisfaction and participation on committees, are not considered payments for purposes of this subchapter.

[1999, c. 609, §20 (NEW) .]

6. **Physician group.** "Physician group" means a partnership, association, corporation, individual practice association or other group of physicians that distributes income from the practice among members. An individual practice association is a physician group only if the association is composed of individual physicians and has no subcontracts with physician groups.

[1999, c. 609, §20 (NEW) .]

7. **Potential payments.** "Potential payments" means the maximum anticipated total amount, based on the most recent year's utilization and experience and any current or anticipated factors that may affect costs, to be paid for a defined set of referral services for the carrier's subscribers and for which the downstream entity assumes by contract financial risk, to some extent, for the costs of such services. The methodology for determining potential payments must be filed by the carrier with the bureau.

[1999, c. 609, §20 (NEW) .]

8. **Referral services.** "Referral services" means any specialty, inpatient, outpatient or laboratory services that a downstream entity orders or arranges, but does not furnish directly.

[1999, c. 609, §20 (NEW) .]

9. **Risk-sharing arrangement.** "Risk-sharing arrangement" means an arrangement between a carrier and a downstream entity in which the carrier continues to pay providers for a defined set of services subject to an annual reconciliation process in which costs incurred by the carrier are compared with budgeted or targeted amounts for such services and that may, if payments are different than the budgeted amount, create financial liability of the downstream entity to the carrier or the carrier to the downstream entity provided the carrier holds or retains control of any funds in excess of those required to satisfy current claims obligations or direct payment to providers for services rendered pending reconciliation.

[1999, c. 609, §20 (NEW) .]

10. **Risk threshold.** "Risk threshold" means the maximum risk, if the risk is based on referral services, to which a downstream entity may be exposed under a downstream risk arrangement without being at substantial financial risk.

[1999, c. 609, §20 (NEW) .]

11. **Withhold.** "Withhold" means a percentage of payments or set dollar amounts that a carrier deducts from a downstream entity's service fee, capitation or salary payment and that may or may not be returned to the downstream entity, depending on specific predetermined factors.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW). 2003, c. 428, §H6 (AMD).

§4332. SAFE HARBOR AND WAIVER

1. **Authority for safe harbor.** Notwithstanding any other provisions of this Title or Title 24, including, without limitation, sections 4341 and 4342, an arrangement between a carrier and a downstream entity with which the carrier has contracted to provide or arrange for the provision of services that allows the downstream entity to accept a limited degree of insurance risk is permitted and such a risk arrangement is deemed not to be engaging in the business of insurance by the downstream entity if:

A. The arrangement does not involve substantial insurance risk or substantial enrollment risk as described in section 4334; and [1999, c. 609, §20 (NEW).]

B. The arrangement meets the requirements of sections 4335 and 4336. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

2. **Waiver for downstream risk arrangements that exceed risk threshold described in section 4334.** Carriers and downstream entities that wish to develop downstream risk arrangements that exceed the risk threshold described in section 4334 may jointly request that the superintendent grant a waiver that allows the downstream entity to accept a limited degree of insurance risk without being licensed as an insurer, a health maintenance organization or an insurance administrator. The joint request for a waiver must include a plan for managing financial exposure, based upon reasonable enrollment and utilization projections and upon the contracts, parties and features proposed, sufficient to quantify in dollars per quarter and per annum all elements of downstream risk to be assumed by the downstream entity. All other risk arrangements are prohibited unless the arrangements meet the appropriate licensing standards or are expressly permitted by the superintendent.

[1999, c. 609, §20 (NEW) .]

3. **Continuing obligation to subscribers.** A carrier contracting with a downstream entity remains obligated to its subscribers for the delivery of health care benefits consistent with existing state law. The carrier remains responsible for compliance with all applicable laws.

[1999, c. 609, §20 (NEW) .]

4. **Certain incentives prohibited.** A downstream risk arrangement may not contain incentives for the downstream entity or participating provider to limit or deny medically necessary care to enrollees.

[1999, c. 609, §20 (NEW) .]

5. **Requirements still applicable.** The application of the safe harbor provisions in subsection 1 or a waiver of licensing requirements granted pursuant to this section does not exempt the downstream entity from any other licensure or prior approval requirements applicable to activities conducted by the downstream entity, including, but not limited to, utilization review licensure, insurance administrator licensure or preferred provider arrangement registration.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4333. REQUIREMENTS FOR DOWNSTREAM RISK ARRANGEMENTS

1. **Permissible downstream risk arrangements.** Downstream entities that do not exceed the risk threshold described in section 4334 may enter into downstream risk arrangements only if:

A. The requirements of section 4332, subsection 1 and sections 4335 and 4336 are met; and [1999, c. 609, §20 (NEW).]

B. No specific payment is made directly or indirectly under the plan to a provider as an inducement to reduce or limit medically necessary services furnished to an enrollee. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

2. **Prohibited downstream risk payments.** A specific payment of any kind may not be made directly or indirectly under the incentive plan to a downstream entity as an inducement to reduce or limit covered medically necessary services under the carrier's contract furnished to an enrollee. Indirect payments include offerings of monetary value such as stock options or waivers of debt measured in the present or future.

[1999, c. 609, §20 (NEW) .]

3. **Applicability.** This section applies to risk arrangements between carriers and downstream entities with which they contract to provide medical services to enrollees. This section also applies to subcontracting arrangements.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4334. SUBSTANTIAL INSURANCE RISK; SUBSTANTIAL ENROLLMENT RISK

1. **Substantial insurance risk.** Substantial insurance risk is risk based on the use or costs of referral services only, when the downstream entity is at risk for more than 25% of potential payments by the carrier to the downstream entity.

[1999, c. 609, §20 (NEW) .]

2. **Substantial enrollment risk.** Substantial enrollment risk exists when a carrier enters into a risk arrangement with a downstream entity involving more than 25% of the enrollees served by the carrier in the State unless the risk arrangement is a risk-sharing arrangement.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4335. CONTRACTUAL PROVISIONS

Full copies of contracts and summary descriptions of contracts must be provided to the superintendent. The following provisions must be included in contracts between a carrier and a downstream entity: [1999, c. 609, §20 (NEW).]

1. **Enrollee not liable.** A provision in all relevant contracts between a carrier and a downstream entity or between a downstream entity and a participating provider of health care services stating that if the carrier fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the carrier;

[1999, c. 609, §20 (NEW) .]

2. **Maintenance of books, accounts and records.** A provision for the maintenance of books, accounts and records by the downstream entity and the carrier to verify that transactions, including the risk transfer, are clearly, accurately and completely recorded, in accordance with generally accepted accounting principles and disclosed in writing;

[1999, c. 609, §20 (NEW) .]

3. **Prohibition on assignment of rights or obligations.** A provision prohibiting the assignment of any rights or obligations under the contract in the absence of the consent of the carrier;

[1999, c. 609, §20 (NEW) .]

4. **Right to object to subcontractor.** A provision granting the carrier the right to be advised of and the right to object to any subcontractor with whom the downstream entity proposes to contract with respect to services required to be performed by the downstream entity under its contract with the carrier;

[1999, c. 609, §20 (NEW) .]

5. **Termination of contract.** A provision for the termination of the contract, including the right to immediately terminate the contract upon a valid order issued by the superintendent or another lawful authority;

[1999, c. 609, §20 (NEW) .]

6. **Compliance with utilization review laws, rules and licensing requirements.** A provision requiring the downstream entity to comply with utilization review laws, rules and licensing requirements appropriate to the functions the downstream entity has contracted to undertake on behalf of the carrier;

[1999, c. 609, §20 (NEW) .]

7. **Ability to perform.** A provision requiring the downstream entity to advise the carrier in a timely manner of relevant matters that may have a material effect on the downstream entity's ability to perform under the contract, including, but not limited to:

A. Whether the downstream entity or participating provider is subject to an administrative order, a cease and desist order, a fine or a license suspension; and [1999, c. 609, §20 (NEW).]

B. Whether legal action has been taken that may have a material effect on the downstream entity's financial condition or the downstream entity's ability to perform under the contract; and [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

8. **Incorporation by reference.** A provision requiring the contract between a carrier and a downstream entity to be attached to all contracts between the downstream entity and those of the entity's participating providers contractually obligated to provide services to the carrier's enrollees under the contract between the carrier and the downstream entity.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4336. DISCLOSURE REQUIREMENTS FOR ORGANIZATIONS WITH DOWNSTREAM RISK ARRANGEMENTS

1. **Disclosure to superintendent.** Each carrier shall provide information concerning the carrier's downstream risk arrangements as required or requested by the superintendent. The disclosure must contain the following information in sufficient detail to enable the superintendent to determine whether the risk arrangement complies with the following requirements:

A. Whether services not furnished by the downstream entity are covered by the risk arrangement. If the services furnished by the downstream entity are covered by the risk arrangement, disclosure of other aspects of the plan need not be made; [1999, c. 609, §20 (NEW).]

B. The type of risk arrangement; for example, withhold, bonus, capitation; [1999, c. 609, §20 (NEW).]

C. If the risk arrangement involves a withhold or bonus, the percent of the withhold or bonus; [1999, c. 609, §20 (NEW).]

D. The panel size, the number of enrollees covered by the downstream entity and the total number of enrollees covered by the carrier in the State; and [1999, c. 609, §20 (NEW).]

E. In the case of capitated downstream entities, capitation payments paid to primary care providers for the most recent year broken down by percent for primary care services, referral services to specialists, hospital services and other types of provider services, including, but not limited to, nursing home and home health agency services. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

2. **Annual disclosure.** A carrier shall provide this information to the superintendent at least annually. A carrier shall provide the capitation data required under subsection 1 for the previous calendar year to the superintendent by April 1st of each year.

[1999, c. 609, §20 (NEW) .]

3. **Disclosure to enrollees.** A carrier shall provide the following information to any enrollee upon request:

A. Whether the prepaid plan uses a downstream risk arrangement that affects the use of referral services; and [1999, c. 609, §20 (NEW).]

B. The type of risk arrangement. [1999, c. 609, §20 (NEW).]

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4337. REQUIREMENTS RELATED TO SUBCONTRACTING ARRANGEMENTS

1. **Physician groups.** A carrier that contracts with a downstream entity that places the individual physician members at substantial financial risk for services they do not furnish shall disclose to the superintendent any incentive plan between the downstream entity and the entity's individual physicians that bases compensation to the physician on the use or cost of services furnished to enrollees. The disclosure must include the information specified in section 4336, subsection 1.

[1999, c. 609, §20 (NEW) .]

2. **Intermediate entities.** A carrier that contracts with a downstream entity, other than a physician group, for the provision of services to enrollees shall disclose to the superintendent any risk arrangement between the entity and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to enrollees. The disclosure must include the information required to be disclosed under section 4336, subsection 1.

[1999, c. 609, §20 (NEW) .]

3. **Sanctions against the carrier.** The superintendent may apply intermediate sanctions if the superintendent determines that a carrier fails to comply with the requirements of this section.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4338. DOWNSTREAM RISK ARRANGEMENTS THAT EXCEED RISK THRESHOLD DESCRIBED IN SECTION 4334

The superintendent may waive downstream risk arrangements from licensure requirements that exceed the risk threshold described in section 4334 if the downstream risk arrangement meets the contractual and disclosure requirements established under section 4332 and the criteria set forth in sections 4339 to 4342 and is determined by the superintendent not to prejudice enrollee interests. [1999, c. 609, §20 (NEW).]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4339. CONTRACTUAL PROVISIONS TO DEMONSTRATE FINANCIAL VIABILITY

If a carrier applies for a waiver under section 4332, subsection 2, the carrier may demonstrate the financial viability and condition of the downstream entity through the terms of the contract, including one or more of the following: [1999, c. 609, §20 (NEW).]

1. **Books, accounts and records.** A contractual provision authorizing the carrier to access the downstream entity's books, accounts and records according to terms and conditions on which the carrier and the downstream entity agree;

[1999, c. 609, §20 (NEW) .]

2. **Financial statements.** A contractual provision requiring the downstream entity to provide to the carrier interim unaudited financial statements on a regular and ongoing basis as well as an annual financial statement, accompanied by a certified public accountant's opinion, appropriate to the magnitude of risk involved;

[1999, c. 609, §20 (NEW) .]

3. **Reserves.** A contractual provision authorizing the carrier to receive information regarding the downstream entity's reserves;

[1999, c. 609, §20 (NEW) .]

4. **Letter of credit.** A contractual provision requiring the downstream entity to post a letter of credit or other acceptable financial security;

[1999, c. 609, §20 (NEW) .]

5. **Fees.** A contractual provision under which the carrier withholds fees payable to the downstream entity or to the providers for which it acts;

[1999, c. 609, §20 (NEW) .]

6. **General liability insurance.** A contractual provision requiring the downstream entity to carry general liability insurance and requiring participating providers to carry professional liability insurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity;

[1999, c. 609, §20 (NEW) .]

7. **Surety bond.** A contractual provision requiring the downstream entity to secure a surety bond to cover the downstream entity's performance under the contract; or

[1999, c. 609, §20 (NEW) .]

8. **Excess of loss insurance.** A contractual provision requiring the downstream entity to secure excess of loss insurance or reinsurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4340. FINANCIAL VIABILITY

Each carrier and downstream entity requesting a waiver shall file with the superintendent a plan for managing financial exposure under those downstream risk arrangement contracts and thereafter operate in substantial conformance with the terms of that plan and of the corresponding waiver. At least 60 days before any material change in a filed and approved exposure management plan, the carrier and downstream entity shall file for the superintendent's review and approval a modified plan, along with any changes in related contracts. [1999, c. 609, §20 (NEW).]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4341. LIMITATIONS ON PREMIUM TRANSFER

The superintendent may deny a request for waiver based on any of the following characteristics: [1999, c. 609, §20 (NEW).]

1. **Transfer of 30% of annual aggregate premium.** A contract by which 30% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to a single downstream entity. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments; or

[1999, c. 609, §20 (NEW) .]

2. **Transfer of 75% of annual aggregate premium.** Multiple contracts by which 75% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to one or more downstream entities. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4342. RELATED PROVISIONS

The superintendent may deny a request for waiver based on any of the following characteristics: [1999, c. 609, §20 (NEW).]

1. **Carrier controlled.** An arrangement with a downstream entity that has control of the carrier. "Control" has the same meaning as defined in section 222, subsection 2, paragraph B;

[1999, c. 609, §20 (NEW) .]

2. **Transfer of claims processing, payment or adjudication.** An arrangement by which the claims processing, claims payment or claims adjudication functions are transferred to the downstream entity from the carrier. This section may not be construed to authorize the superintendent to deny a request based on the transfer of utilization review functions from the carrier to the downstream entity;

[1999, c. 609, §20 (NEW) .]

3. **Transfer of managerial control.** An arrangement by which managerial control of the carrier's information system is transferred to the downstream entity;

[1999, c. 609, §20 (NEW) .]

4. **Overlap between officers or directors.** An arrangement in which there is overlap between the officers or directors of the downstream entity and the carrier; or

[1999, c. 609, §20 (NEW) .]

5. **Transfer of more than 1/12 of annual capitated payments.** An arrangement that transfers more than 1/12 of the annual capitated payments at one time to the downstream entity.

[1999, c. 609, §20 (NEW) .]

SECTION HISTORY
1999, c. 609, §20 (NEW).

§4343. RULES

The superintendent may adopt rules establishing application procedures and specific standards for meeting the requirements pursuant to this subchapter. Rules adopted pursuant to this subchapter are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. [1999, c. 609, §20 (NEW).]

SECTION HISTORY
1999, c. 609, §20 (NEW).

Chapter 56-B: MAINE CONSUMER CHOICE HEALTH PLAN

§4346. MAINE CONSUMER CHOICE HEALTH PLAN

(REPEALED)

SECTION HISTORY
2001, c. 708, §3 (NEW). 2001, c. 714, §II2 (AMD). 2007, c. 395, §28 (RP). MRSA T.24A ., §4346/17 (AMD).

Chapter 57: DELINQUENT INSURERS

Subchapter 1: REHABILITATION AND LIQUIDATION

§4351. SCOPE OF PROVISIONS

The applicable provisions of this chapter shall apply as to: [1969, c. 132, §1 (NEW).]

1. All insurers authorized to transact insurance in this State;

[1969, c. 132, §1 (NEW) .]

2. All insurers having policyholders resident in this State;

[1969, c. 132, §1 (NEW) .]

3. All insurers against whom a claim under an insurance contract may arise in this State;

[1969, c. 132, §1 (NEW) .]

4. All persons in process of organization, or holding themselves out as organizing, or proposing to organize in this State for the purpose of becoming an insurer;

[2001, c. 88, §10 (AMD) .]

5. All other persons as to whom such provisions are otherwise expressly made applicable by law; and

[2001, c. 88, §10 (AMD) .]

6. Health maintenance organizations, which are considered insurers for the purposes of this subchapter and subchapter II.

[2001, c. 88, §11 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 88, §§10,11 (AMD).

§4352. SHORT TITLE

This chapter constitutes and may be cited as the "Insurance Rehabilitation and Liquidation Law." [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4353. DEFINITIONS

For the purposes of this chapter: [1969, c. 132, §1 (NEW).]

1. "Insurer," in addition to persons so defined under section 4, includes also persons purporting to be insurers, or organizing or holding themselves out as organizing in this State for the purpose of becoming an insurer.

[1969, c. 132, §1 (NEW) .]

2. "Delinquency proceeding" means any proceeding commenced against an insurer pursuant to sections 4351 to 4385 for the purpose of conserving, rehabilitating, reorganizing or liquidating the insurer, or the proceedings authorized by sections 4401 to 4407.

[1969, c. 132, §1 (NEW) .]

3. "State" has the meaning ascribed in section 7.

[1969, c. 132, §1 (NEW) .]

4. "Domiciliary state" means the state in which an insurer is incorporated or organized, or as to an alien insurer, the state in which, at the commencement of delinquency proceedings the larger amount of the insurer's assets are held in trust or on deposit for the benefit of policyholders and creditors in the United States of America.

[1969, c. 132, §1 (NEW) .]

5. "Ancillary state" means any state other than a domiciliary state.

[1969, c. 132, §1 (NEW) .]

6. "Reciprocal state" means any state other than this State in which in substance and effect the uniform insurers liquidation act, as defined in section 4363, is in force, including provisions requiring that the Insurance Superintendent or equivalent insurance supervisory official be the receiver of a delinquent insurer, and in which effective provisions exist for avoidance of fraudulent conveyances and unlawful preferential transfers.

[1973, c. 585, §12 (AMD) .]

7. "Foreign country" means territory not in any state.

[1969, c. 132, §1 (NEW) .]

8. "Impairment" exists as to a stock insurer when the insurer's assets do not at least equal the sum of its liabilities and its paid-in capital stock; and as to a mutual insurer when the insurer's assets do not at least equal the sum of the insurer's liabilities and the minimum basic surplus required under this Title to be maintained for authority to transact the kinds of insurance transacted.

[1969, c. 132, §1 (NEW) .]

9. "Insolvency" exists when the insurer fails to meet its obligations as they mature or when a stock insurer's assets are less than the sum of its liabilities and the minimum paid-in capital stock required for its authority to transact insurance in this State; or when a mutual insurer's assets are less than the sum of its liabilities and the minimum basic surplus required to be maintained by the insurer under this Title for authority to transact the kinds of insurance transacted; or as otherwise expressly provided in this Title.

[1969, c. 132, §1 (NEW) .]

10. "General assets" means all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons; and as to such specifically encumbered property, the term includes all such property or

its proceeds in excess of the amount necessary to discharge the sums secured thereby. Assets held in trust or on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States of America are deemed general assets.

[1969, c. 132, §1 (NEW) .]

11. "Preferred claim" means any claim accorded priority of payment from the insurer's general assets under applicable law.

[1969, c. 132, §1 (NEW) .]

12. "Special deposit claim" means any claim secured by deposit made under statute for the security or benefit of a limited class or classes of persons, but not including any general assets.

[1969, c. 132, §1 (NEW) .]

13. "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets through judicial process and not invalidated.

[1969, c. 132, §1 (NEW) .]

14. "Receiver" means receiver, liquidator, rehabilitator or conservator, as context requires.

[1969, c. 132, §1 (NEW) .]

15. "Creditor" means a person having a claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, or absolute, fixed or contingent.

[1969, c. 132, §1 (NEW) .]

16. **Fair consideration.** "Fair consideration" is given for property or an obligation:

A. When in exchange for that property or obligation, as a fair equivalent for the property or obligation and in good faith, property is conveyed, services are rendered, an obligation is incurred or an antecedent debt is satisfied; or [1991, c. 828, §25 (NEW).]

B. When that property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained. [1991, c. 828, §25 (NEW).]

[1991, c. 828, §25 (NEW) .]

17. **Guaranty association.** "Guaranty association" means the Maine Insurance Guaranty Association established by chapter 57, subchapter III, the Life and Health Insurance Guaranty Association established by chapter 62 and any other similar entity created by the laws of this State for the payment of claims of insolvent insurers.

[1991, c. 828, §25 (NEW) .]

18. **Foreign guaranty association.** "Foreign guaranty association" means a guaranty association created by the legislature of any other state.

[1991, c. 828, §25 (NEW) .]

19. **Transfer.** "Transfer" includes the sale and every other direct or indirect method of disposing of or of parting with property or an interest in property or with the possession of property or of fixing a lien upon property or upon an interest in property, absolutely or conditionally, voluntarily or by or without judicial proceedings. The retention of a security interest in property delivered to a debtor is a transfer suffered by the debtor.

[1991, c. 828, §25 (NEW) .]

20. **Netting agreement.** "Netting agreement" means:

A. A contract or agreement, including terms and conditions incorporated by reference into a contract or agreement, including a master agreement, that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration or closeout under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements under one or more qualified financial contracts, including liquidation or close-out values relating to such obligations or entitlements among the parties to the netting agreement; [2011, c. 107, §1 (NEW).]

B. Any master agreement or bridge agreement for one or more master agreements described in paragraph A; or [2011, c. 107, §1 (NEW).]

C. Any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation related to any contract or agreement described in paragraph A or B. [2011, c. 107, §1 (NEW).]

A contract or agreement described in paragraph A or B relating to agreements or transactions that are not qualified financial contracts is considered to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts. For the purposes of this subsection, a master agreement together with all schedules, confirmations, definitions and addenda to the master agreement and transactions under any master agreement, is treated as one netting agreement.

[2011, c. 107, §1 (NEW) .]

21. **Qualified financial contract.** "Qualified financial contract" means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the superintendent determines to be a qualified financial contract.

A. "Commodity contract" means:

(1) A contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the federal Commodity Exchange Act or a board of trade outside the United States;

(2) An agreement that is subject to regulation under Section 23 of the federal Commodity Exchange Act and that is commonly known to the commodities trade as a margin account, margin contract, leverage account or leverage contract;

(3) An agreement or transaction that is subject to regulation under Section 4c(b) of the federal Commodity Exchange Act and that is commonly known to the commodities trade as a commodity option;

(4) Any combination of the agreements or transactions referred to in this paragraph; or

(5) Any option to enter into an agreement or transaction referred to in this paragraph. [2011, c. 107, §2 (NEW).]

B. "Forward contract," "repurchase agreement," "securities contract" and "swap agreement" have the meanings set forth in the Federal Deposit Insurance Act, 12 United States Code, Section 1821(e)(8)(D), as amended from time to time. [2011, c. 107, §2 (NEW).]

[2011, c. 107, §2 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §25 (AMD). 2011, c. 107, §§1, 2 (AMD).

§4354. JURISDICTION OF DELINQUENCY PROCEEDINGS; VENUE; EXCLUSIVENESS OF REMEDY; APPEAL

1. The Superior Court has original jurisdiction of delinquency proceedings under this chapter, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this chapter. A delinquency proceeding may not be commenced under this chapter by anyone other than the superintendent.

[1991, c. 828, §26 (AMD) .]

2. The venue of delinquency proceedings against a domestic insurer shall be in the county in this State of the insurer's principal place of business; or, if the principal place of business is located in another state, in any county in this State selected by the superintendent for the purpose. The venue of proceedings against foreign insurers shall be in any county in this State selected by the superintendent for the purpose.

[1973, c. 585, §12 (AMD) .]

3. At any time after commencement of a proceeding the superintendent or any other party may apply to the court for an order changing the venue of, and removing, the proceeding to any other county of this State in which the proceeding may most conveniently, economically and efficiently be conducted.

[1973, c. 585, §12 (AMD) .]

4. No court shall have jurisdiction to entertain, hear or determine any petition or complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer, or for an injunction or restraining order or other relief preliminary, incidental or relating to such proceedings, other than in accordance with this chapter.

[1969, c. 132, §1 (NEW) .]

5. An appeal shall lie to the Supreme Judicial Court from any court granting or refusing rehabilitation, liquidation, conservation or receivership and from every order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §26 (AMD).

§4355. JURISDICTION OVER RELATED PERSONS AND TRANSACTIONS

1. A court of this State, in which an order of rehabilitation or liquidation has been entered in delinquency proceedings against a domestic insurer or alien insurer domiciled in this State, has jurisdiction also over persons, served as provided in subsection 2, in an action brought by the insurer's receiver on or arising out of such obligation or relationship, as follows:

A. Persons obligated to the insurer as a result of agency or brokerage or transactions between such persons and the insurer; [1969, c. 132, §1 (NEW).]

B. Reinsurers of the insurer, and their representatives; [1991, c. 828, §27 (AMD).]

C. Past or present officers, managers, trustees, directors, organizers and promoters of the insurer, and other persons in positions of similar responsibility with the insurer; [1991, c. 828, §27 (AMD).]

D. Persons served who are or were at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; and [1991, c. 828, §28 (NEW).]

E. Persons served who are obligated to the insurer in any way whatsoever, in any action on or incident to the obligation. [1991, c. 828, §28 (NEW).]

[1991, c. 828, §§27, 28 (AMD) .]

2. As to those of such persons who are in this State, personal service of process shall be made as in other civil actions. As to those of such persons who cannot be found in this State at the time process is to be served, personal service of process shall be made thereon by a public officer of the jurisdiction in which such person may be found, in the same manner as personal service of process is required to be made within this State under the laws of this State; and the affidavit or certificate under oath setting forth the facts of such service shall be filed in the court in this State in which the action is pending.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 828, §27 (AMD). 1991, c. 828, §28 (AMD).

§4356. GROUNDS FOR REHABILITATION OF DOMESTIC INSURER OR DOMICILED ALIEN INSURER

The superintendent may petition for an order directing him to rehabilitate a domestic insurer or an alien insurer domiciled in this State on any one or more of the following grounds: [1973, c. 585, §12 (AMD).]

1. On any ground for liquidation of the insurer under section 4357, if the superintendent believes rehabilitation possible without substantial increase of risk to creditors, policyholders or the public;

[1973, c. 585, §12 (AMD) .]

2. If the insurer is in unsound condition, or is using or has been subject to, such methods and practices in conduct of its business as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, or creditors, or the public;

[1969, c. 132, §1 (NEW) .]

3. If the insurer's solvency is endangered by illegal action;

[1969, c. 132, §1 (NEW) .]

4. For material falsification of the insurer's records, reports or financial condition;

[1969, c. 132, §1 (NEW) .]

5. If the superintendent finds after hearing that any individual exercising executive power with respect to or otherwise materially influencing or controlling the insurer, directly or indirectly, is dishonest or untrustworthy in matters affecting the insurer, and has not been or cannot effectively and permanently be removed from such power, influence or control;

[1973, c. 585, §12 (AMD) .]

6. For unlawful concealment or removal by the insurer of any of its records or assets;

[1969, c. 132, §1 (NEW) .]

7. For failure of the insurer, or its parent corporation, or subsidiary or affiliated person controlled by the insurer, to submit its books, accounts, records and affairs to the reasonable inspection or examination of the superintendent or his examiner as authorized under this Title; or if any individual exercising any executive authority in the affairs of the insurer or parent corporation or subsidiary or affiliated person has refused to be examined under oath, by the superintendent or his examiner thereunto duly authorized, whether within this State or otherwise, concerning the pertinent affairs of the insurer or parent corporation or subsidiary or affiliated person, or if examined under oath refuses to divulge pertinent information reasonably known to him; or for failure of officers, employees and other representatives of the insurer or parent corporation or subsidiary or affiliated person to comply promptly with the reasonable requests of the superintendent or his examiner for the purposes of and during the conduct of any such examination;

[1973, c. 585, §12 (AMD) .]

8. That a deadlock exists in the insurer's board of directors relative to the general management of the insurer's affairs, that the insurer's stockholders or members, as to a mutual insurer, are unable to break the deadlock, and that the same threatens irreparable injury to the insurer or its creditors or its policyholders or to the public;

[1969, c. 132, §1 (NEW) .]

9. If the insurer has transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge or consolidate substantially its entire property or business in that of any other insurer, without first having obtained the written approval of the superintendent as required under this Title;

[1973, c. 585, §12 (AMD) .]

10. If the controlling stock of the insurer has been transferred to others without compliance with the requirements of section 3476 (acquisition of controlling stock), except where such transfer is by testamentary bequest or inheritance;

[1969, c. 132, §1 (NEW) .]

11. If the insurer has willfully violated its charter or a law of this State, or has willfully exceeded its corporate powers;

[1969, c. 132, §1 (NEW) .]

12. If the insurer has requested or consented to rehabilitation by vote or written authorization of a majority of its directors or stockholders, or members, as to mutual insurers;

[2013, c. 238, Pt. A, §32 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

13. If the insurer has failed to pay any valid judgment against it within 30 days after the same became final; or

[2013, c. 238, Pt. A, §32 (AMD); 2013, c. 238, Pt. A, §34 (AFF) .]

14. If a violation of section 222, subsection 4-C prevents the superintendent from sufficiently understanding the enterprise risk to the insurer posed by its affiliates or by its insurance holding company system.

[2013, c. 238, Pt. A, §33 (NEW); 2013, c. 238, Pt. A, §34 (AFF) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 2013, c. 238, Pt. A, §§32, 33 (AMD). 2013, c. 238, Pt. A, §34 (AFF).

§4357. GROUNDS FOR LIQUIDATION OF DOMESTIC INSURER OR DOMICILED ALIEN INSURER

The superintendent may apply to the court for an order appointing him as receiver, if his appointment as receiver is not then in effect, and directing him to liquidate the business of a domestic insurer or of the United States branch of an alien insurer having trusteed assets in this State, whether or not there has been a prior order directing him to rehabilitate the insurer, upon any one or more of the following grounds: [1973, c. 585, §12 (AMD).]

1. That the insurer has failed to cure an impairment of surplus or capital or assets within the time allowed therefor by any lawful order of the superintendent;

[1973, c. 585, §12 (AMD) .]

2. That the insurer is insolvent, or has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute or is the object, in this State or elsewhere, of any action of proceeding to liquidate its business or affairs or to dissolve its corporate charter or to procure the appointment of a receiver, trustee, custodian or sequestrator under any law except this Title. This provision shall not apply as to the conversion of a stock insurer to an ordinary business corporation as authorized under section 3473 or to voluntary dissolution of the insurer pursuant to section 3484;

[1969, c. 132, §1 (NEW) .]

3. That the insurer has ceased for a period of one year to transact insurance business;

[1969, c. 132, §1 (NEW) .]

4. If a proposed insurer has not completed its organization and obtained a certificate of authority as an insurer within the time allowed therefor under any applicable law;

[1969, c. 132, §1 (NEW) .]

5. That efforts to rehabilitate the insurer and remove the causes or adverse effects thereof for which rehabilitation was instituted have failed despite all reasonable efforts by the superintendent, or cannot be continued without material increase of risk of loss to the insurer's creditors or policyholders; or

[1973, c. 585, §12 (AMD) .]

6. If the insurer has requested or consented to liquidation by vote or written authorization of a majority of its directors or stockholders, or members if a mutual insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4358. GROUND FOR CONSERVATION, FOREIGN AND ALIEN INSURERS

The superintendent may apply to the court for an order appointing him as receiver or ancillary receiver, and directing him to conserve the assets within this State, of a foreign or alien insurer upon any of the applicable ground specified in sections 4356 or 4357, or upon the ground that the insurer's property has been sequestrated in its domiciliary sovereignty or in any other sovereignty; or, in the case of an alien insurer that the insurer has failed to make good an impairment of its trusteed funds within the time required therefor by order of the superintendent. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4359. GROUNDS FOR ANCILLARY LIQUIDATION, FOREIGN AND ALIEN INSURERS

The superintendent may apply to the court for an order appointing him to liquidate the business of a foreign or alien insurer having assets, business or claims in this State upon the appointment in the domiciliary sovereignty of such insurer of a receiver, liquidator, conservator, rehabilitator or other officer by whatever name called for the purpose of liquidating the business of the insurer. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4360. COMMENCEMENT OF PROCEEDING

1. The superintendent shall commence a delinquency proceeding authorized under this chapter, the Attorney General representing him, by filing a petition in a court of proper jurisdiction praying for appointment of the superintendent as receiver of the insurer.

[1973, c. 585, §12 (AMD) .]

2. Upon the filing of the petition, the court shall issue an order directing the insurer to appear in court on the day fixed in the order and show cause why the petition should not be granted. Unless good cause is shown for a shorter period, the order shall require the insurer to so show cause not less than 15 or more than 30 days from date of the order.

[1969, c. 132, §1 (NEW) .]

3. The order to show cause and service thereof on the insurer shall constitute due and legal process and shall be in lieu of any other process otherwise provided by law.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4361. SERVICE OF PROCESS

A certified copy of any order to show cause issued under section 4360, and a copy of the petition upon which the same is made, must be served upon the insurer by delivering the same to its president, vice-president, secretary, treasurer, director or to its managing agent or attorney in fact, if a reciprocal insurer; or if no such officer or functionary can readily be found in this State, then such process may be served upon the insurer by service thereof upon the superintendent pursuant to section 421. [1997, c. 457, §51 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §51 (AMD).

§4362. INJUNCTIONS

1. Upon application by the superintendent for such an order to show cause, or at any time thereafter, the court may without notice issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court.

[1973, c. 585, §12 (AMD) .]

2. The court may at any time during a proceeding under this chapter issue such other injunctions or orders as may be deemed necessary to prevent interference with the superintendent or the proceeding, or waste of the assets of the insurer, or the commencement or prosecution of any actions, or the obtaining of preferences, judgments, attachments or other liens, or the making of any levy against the insurer or against its assets or any part thereof.

[1973, c. 585, §12 (AMD) .]

3. Notwithstanding any other provision of law, no bond shall be required of the superintendent as a prerequisite for the issuance of any injunction or restraining order pursuant to this section.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4362-A. DISSOLUTION OF DOMESTIC INSURER

The superintendent, upon application for an order of liquidation of a domestic insurer for any of the reasons specified in section 4357 or at any time thereafter, may apply for an order of dissolution of the domestic insurer. Upon the filing of the application, the court shall issue an order directing the insurer to appear in court on the day fixed in the order and show cause why the application should not be granted. The order to show cause and notice thereof shall conform to the requirements applicable to an order to show cause set forth in section 4360, subsections 2 and 3, and section 4361. Unless cause is shown why the application should not be granted, the court, after hearing, shall order that the corporate existence of such domestic insurer be dissolved. [1983, c. 603, §1 (NEW).]

SECTION HISTORY
1983, c. 603, §1 (NEW).

§4363. UNIFORM INSURERS LIQUIDATION ACT; SEVERABILITY; INTERPRETATION

1. This section, section 4353 (definitions), and sections 4364 to 4369 comprise and may be cited as the Uniform Insurers Liquidation Act.

[1969, c. 132, §1 (NEW) .]

2. If any provision of the Uniform Insurers Liquidation Act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

[1969, c. 132, §1 (NEW) .]

3. This Uniform Insurers Liquidation Act shall be so interpreted as to effectuate its general purpose to make uniform the laws of those states which enact it. To the extent that its provisions, when applicable, conflict with other provisions of this Title, the Uniform Insurers Liquidation Act shall control.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4364. CONDUCT OF DELINQUENCY PROCEEDINGS AGAINST DOMESTIC INSURERS AND CERTAIN ALIEN INSURERS

1. Whenever under this chapter a receiver is to be appointed in delinquency proceedings for an insurer, the court shall appoint the superintendent as such receiver. The court shall order the superintendent forthwith to take possession of the assets of the insurer and to administer the same under the orders of the court.

[1973, c. 585, §12 (AMD) .]

2. As a domiciliary receiver, the superintendent shall be vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records of the insurer, wherever located, as of the date of entry of the order directing him to rehabilitate or liquidate a domestic insurer or to liquidate the United States branch of an alien insurer domiciled in this State, and he shall have the right to

recover the same and reduce the same to possession; except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are herein prescribed for ancillary receivers appointed in this State as to assets located in this State.

[1973, c. 585, §12 (AMD) .]

3. The filing or recording of the order directing possession to be taken, or a certified copy thereof, in any office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale or other evidence of title duly filed or recorded.

[1969, c. 132, §1 (NEW) .]

4. The superintendent as domiciliary receiver shall be responsible for the proper administration of all assets coming into his possession or control. The court may at any time require a bond from him or his deputies, if deemed desirable for the protection of such assets.

[1973, c. 585, §12 (AMD) .]

5. Upon taking possession of the assets of an insurer, the domiciliary receiver shall immediately proceed to conduct the business of the insurer or to take such steps as are authorized by this chapter for the purpose of rehabilitating, liquidating or conserving the affairs or assets of the insurer.

[1969, c. 132, §1 (NEW) .]

6. In connection with delinquency proceedings, the superintendent may appoint one or more special deputy superintendents to act for him and he may employ such counsel, clerks and assistants as he deems necessary. The compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the receiver and shall be paid out of the funds or assets of the insurer. Within the limits of duties imposed upon them, special deputies shall possess all the powers given to and, in the exercise of those powers, shall be subject to all of the duties imposed upon the receiver with respect to such proceedings.

[1973, c. 585, §12 (AMD) .]

7. During such receivership the superintendent shall file in the court, at regular intervals not less frequently than quarterly, his true reports in summary form of the insurer's affairs under the receivership, and of progress being made in accomplishing the objectives of the receivership. All such reports, together with such additional or special reports as the court may reasonably require, shall be subject to review by the court; and all actions of the receiver therein reported shall be subject to the court's approval, but the court shall not withhold approval or disapprove any such action unless found by the court after a hearing thereon in open court to be unlawful, or arbitrary, or capricious.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4365. CONDUCT OF DELINQUENCY PROCEEDINGS AGAINST FOREIGN INSURERS

1. Whenever under this chapter an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this State, the court shall appoint the superintendent as ancillary receiver. The superintendent shall file a petition requesting the appointment on the grounds set forth in sections 4358 or 4359:

A. If he finds that there are sufficient assets of the insurer located in this State to justify the appointment of an ancillary receiver, or [1969, c. 132, §1 (NEW).]

B. If 10 or more persons resident in this State having claims against such insurer file a petition with the superintendent requesting the appointment of such ancillary receiver. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

2. The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer located in this State and he shall have the immediate right to recover balances due from local agents and to obtain possession of any books and records of the insurer found in this State. He shall also be entitled to recover the other assets of the insurer located in this State, except that upon the appointment of an ancillary receiver in this State, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this State, and shall pay the necessary expenses of the proceedings. All remaining assets he shall promptly transfer to the domiciliary receiver. Subject to the foregoing provisions, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of such assets as a receiver of an insurer domiciled in this State.

[1969, c. 132, §1 (NEW) .]

3. The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this State to recover any assets of such insurer to which he may be entitled under the laws of this State.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4366. CLAIMS OF NONRESIDENTS AGAINST DOMESTIC INSURERS

1. In a delinquency proceeding begun in this State against a domestic insurer, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver, but claimants residing in foreign countries or in states not reciprocal states must file claims in this State. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

[1991, c. 828, §29 (AMD) .]

2. Controverted claims belonging to claimants residing in reciprocal states may either:

A. Be proved in this State, or [1969, c. 132, §1 (NEW).]

B. If ancillary proceedings have been commenced in such reciprocal states, may be proved in those proceedings. In the event a claimant elects to prove his claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this State, as provided in section 4367 with respect to ancillary proceedings in this State, the final allowance of such

claim by the courts in the ancillary state shall be accepted in this State as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1991, c. 828, §29 (AMD).

§4367. CLAIMS AGAINST FOREIGN INSURERS

1. In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this State may file claims either with the ancillary receiver, if any, appointed in this State, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

[1969, c. 132, §1 (NEW) .]

2. Controverted claims belonging to claimants residing in this State may either:

A. Be proved in the domiciliary state as provided by the law of that state, or [1969, c. 132, §1 (NEW).]

B. If ancillary proceedings have been commenced in this State, be proved in those proceedings. In the event that any such claimant elects to prove his claim in this State, he shall file his claim with the ancillary receiver and shall give notice in writing to the receiver in the domiciliary state, either by registered or certified mail or by personal service at least 40 days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based and the priorities asserted, if any. If the domiciliary receiver within 30 days after the giving of such notice shall give notice in writing to the ancillary receiver and to the claimant, either by registered or certified mail or by personal service, of his intention to contest such claim, he shall be entitled to appear or to be represented in any proceeding in this State involving adjudication of the claim. The final allowance of the claim by the courts of this State shall be accepted as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this State. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4368. FORM OF CLAIM; NOTICE; HEARING

1. All claims against an insurer against which delinquency proceedings have been begun shall set forth in reasonable detail the amount of the claim, or the basis upon which such amount can be ascertained, the facts upon which the claim is based, and the priorities asserted, if any. All such claims shall be verified by the affidavit of the claimant or someone authorized to act on his behalf and having knowledge of the facts, and shall be supported by such documents as may be material thereto.

[1969, c. 132, §1 (NEW) .]

2. All claims filed in this State shall be filed with the receiver, whether domiciliary or ancillary, in this State, on or before the last date for filing as specified in this chapter.

[1969, c. 132, §1 (NEW) .]

3. Within 10 days of the receipt of any claim, or within such further period as the court may fix for good cause shown, the receiver shall report the claim to the court, specifying in such report his recommendation with respect to the action to be taken thereon. Upon receipt of such report, the court shall fix a time for hearing the claim and shall direct that the claimant or the receiver, as the court shall specify, shall give such notice as the court shall determine to such persons as shall appear to the court to be interested therein. All such notices shall specify the time and place of the hearing and shall concisely state the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with reference thereto.

[1969, c. 132, §1 (NEW) .]

4. At the hearing, all persons interested shall be entitled to appear and the court shall enter an order allowing, allowing in part, or disallowing the claim. Any such order shall be deemed to be an appealable order.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4369. ATTACHMENT AND GARNISHMENT OF ASSETS

During the pendency of delinquency proceedings in this or any reciprocal state, no action or proceeding in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this State against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4370. LIMITATIONS ON APPOINTMENT OF RECEIVER; ACTION BY JUDGMENT CREDITOR

No order, judgment or decree enjoining, restraining or interfering with the prosecution of the business of any insurer or for the appointment of a temporary or permanent receiver of a domestic insurer shall be made or granted otherwise than upon the petition of the superintendent represented by the Attorney General as provided in this chapter. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4371. DEPOSIT OF MONIES

The monies collected by the superintendent in a proceeding under this chapter shall be from time to time deposited in one or more state or national banks, savings banks or trust companies, and in the case of the insolvency or voluntary or involuntary liquidation of any such depositary which is an institution organized and supervised under the laws of this State, such deposits shall be entitled to priority of payment on an equality with any other priority given by the banking laws of this State. The superintendent may in his discretion deposit such monies or any part thereof in a national bank or trust company as a trust fund. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4372. EXEMPTION FROM FEES

The superintendent shall not be required to pay any fee to any public officer in this State for service of process, filing, recording, issuing a transcript or certificate or authenticating any paper or instrument pertaining to the exercise by the superintendent of any of the powers or duties conferred upon him under this chapter, whether or not such paper or instrument be executed by the superintendent or his deputies, employees or attorneys of record and whether or not it is connected with the commencement of any action or proceeding by or against the superintendent, or with the subsequent conduct of such action or proceeding. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4373. ESCROWING ON PLEDGE OF ASSETS

For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this chapter, the superintendent may, subject to the approval of the court, borrow money and execute, acknowledge and deliver notes or other evidences of indebtedness therefor and secure the repayment of the same by the mortgage, pledge, assignment, transfer in trust, or hypothecation of any or all of the property, whether real, personal or mixed, of such insurer, and the superintendent subject to the approval of the court shall have power to take any and all other action necessary and proper to consummate any such loan and to provide for the repayment thereof. The superintendent shall be under no obligation personally or in his official capacity to repay any loan made pursuant to this section. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4374. TERMINATION OF REHABILITATION

If at any time the court finds, after hearing in open court, upon petition of the superintendent or of the insurer or of his own motion, that the objectives of an order to rehabilitate a domestic insurer or an alien insurer domiciled in this State have been accomplished, and that the insurer can be returned to its own management without further jeopardy to the insurer and its creditors or policyholders or stockholders or to the public, the court may, upon a full report and accounting by the superintendent relative to the conduct of the insurer's affairs during the rehabilitation and of the insurer's current financial condition, terminate the rehabilitation and by order return the insurer, its assets and affairs, to the insurer's management. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4375. PROHIBITED AND VOIDABLE TRANSFERS, LIENS
(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §30 (RP).

§4375-A. VOIDABLE PROPERTY TRANSFERS AND LIENS

1. **Fraudulent transfers prior to petition.** Fraudulent transfers prior to petition are governed by this subsection.

A. A transfer made or suffered and an obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter that is fraudulent according to the terms of this section may be avoided by the receiver except as to a person who in good faith is a purchaser, lienor or obligee for a present fair equivalent value, but any purchaser, lienor or obligee who in good faith has given a consideration less than fair for such transfer, lien, or obligation may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver succeeds to and may enforce the rights of the purchaser, lienor or obligee. [1991, c. 828, §31 (NEW).]

B. The determination of when a transfer is made is governed by the following rules.

(1) A transfer of property other than real property is deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract may become superior to the rights of the transferee.

(2) A transfer of real property is deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer may obtain rights superior to the rights of the transferee.

(3) A transfer that creates an equitable lien may not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation is deemed to be made immediately before the filing of the successful petition.

(5) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy, but does not include liens that under applicable law are given a special priority over other liens that are prior in time.

(6) A lien obtainable by legal or equitable proceedings may become superior to the rights of a transferee, or a purchaser may obtain rights superior to the rights of a transferee within the meaning of this paragraph if those consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials, but not if any acts subsequent to the obtaining of the lien or subsequent to the purchase require the agreement or concurrence of any 3rd party or require any further judicial action or ruling.

(7) The provisions of this paragraph apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers. [1991, c. 828, §31 (NEW).]

C. Any transaction of the insurer with a reinsurer is deemed fraudulent and may be avoided by the receiver under paragraph A if:

(1) The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction unless the reinsurer gives a present fair equivalent value for the release; and

(2) Any part of the transaction takes place within one year prior to the date of filing of the petition through which the receivership is commenced. [1991, c. 828, §31 (NEW).]

D. A person receiving any property from the insurer or a benefit from possession or use of the property that is fraudulently transferred is personally liable for the value of the preference and shall account to the liquidator. [1991, c. 828, §31 (NEW).]

[1991, c. 828, §31 (NEW) .]

2. **Fraudulent transfers after petition.** Fraudulent transfers after petition are governed by this subsection.

A. After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith is valid against the receiver if made for a present fair equivalent value or, if the transfer was not made for a present fair equivalent value, then it is valid only to the extent of the present consideration actually paid for the property, for which amount the transferee has a lien on the property so transferred. Constructive notice of the commencement of a proceeding in rehabilitation or liquidation is deemed to be given upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the register of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state is not impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale. [1991, c. 828, §31 (NEW).]

B. After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted the following rules apply.

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith is valid against the receiver if made for a present fair equivalent value or, if not made for a present fair equivalent value, then the transfer is valid only to the extent of the present consideration actually paid, for which amount the transferee has a lien on the property so transferred.

(2) A person acting in good faith who is indebted to the insurer or holding property of the insurer may pay the indebtedness or deliver the property or any part of the property to the insurer with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation who effectuates a transfer of any of the property of the insurer or who benefits by the transfer is deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section has the burden of proof. Except as elsewhere provided in this section, a transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator is not valid against the liquidator. [1991, c. 828, §31 (NEW).]

C. A person receiving any property from the insurer or a benefit from possession or use of the property that is fraudulently transferred under this subsection is personally liable for the value of the preference and shall account to the liquidator. [1991, c. 828, §31 (NEW).]

[1991, c. 828, §31 (NEW) .]

3. **Voidable preferences.** Voidable preferences and liens are governed by this subsection.

A. A preference is a transfer that is made or suffered by the insurer of any of the property of an insurer to or for the benefit of a creditor for or on account of an antecedent debt if the effect of the transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive and the transfer is made within one year before the filing of a successful petition for liquidation under this chapter or, if a liquidation order is entered while the insurer is already subject to

a rehabilitation order, if made or suffered within one year before the filing of the successful petition for rehabilitation or within 2 years before the filing of the successful petition for liquidation, whichever time is shorter. [1991, c. 828, §31 (NEW).]

B. Any preference may be avoided by the liquidator if:

(1) The insurer was insolvent at the time of the transfer;

(2) The transfer was made within 4 months before the filing of the petition;

(3) The creditor receiving it or to be benefitted by it or the creditor's agent had reasonable cause to believe that the insurer was insolvent or was about to become insolvent when the transfer was made; or

(4) The creditor receiving it was an officer of the insurer or any employee or attorney or other person who was in fact in a position of comparable influence with the insurer whether or not that person held such a position, or any shareholder holding directly or indirectly more than 5% of any class of any equity security issued by the insurer, or any other person, firm, corporation, association or aggregation of persons with whom the insurer did not deal at arm's length. [1991, c. 828, §31 (NEW).]

C. Where the preference is voidable, the liquidator may recover the property or its value if it has been converted from any person who received or converted the property, except that, where a bona fide purchaser or lienor has given less than fair equivalent value, that person is deemed to have a lien upon the property to the extent of the consideration actually given. When a preference by way of lien or security interest is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title passes to the liquidator. [1991, c. 828, §31 (NEW).]

D. The determination of when a transfer is made is governed by subsection 1, paragraph B. [1991, c. 828, §31 (NEW).]

E. A transfer of property for or on account of a new and contemporaneous consideration, which is considered under subsection 1, paragraph B to be made or suffered after the transfer because of delay in perfecting it, does not become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within 21 days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, has the same effect as a transfer for or on account of a new and contemporaneous consideration. [1991, c. 828, §31 (NEW).]

F. If any lien considered voidable under paragraph B is dissolved by the furnishing of a bond or other obligation, the surety that was indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this chapter that results in a liquidation order, the indemnifying transfer or lien is also voidable. [1991, c. 828, §31 (NEW).]

G. The property affected by any lien considered voidable under this subsection must be discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety must pass to the liquidator; except that, the court may on due notice order a lien to be preserved for the benefit of the estate and the court may direct that a conveyance be executed as may be proper or adequate to evidence the title of the liquidator. [1991, c. 828, §31 (NEW).]

H. The court has summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding must be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien. If the court finds that the value is less than the amount for which the property is held as

indemnity or the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment to the liquidator of its value as ascertained by the court within a reasonable time as fixed by the court. [1991, c. 828, §31 (NEW).]

I. The liability of the surety under a releasing bond or other like obligation must be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator or, when the property is retained under paragraph H, to the extent of the amount paid to the liquidator. [1991, c. 828, §31 (NEW).]

J. If a creditor has been preferred and afterward in good faith gives the insurer further credit for property that becomes a part of the insurer's estate without security of any kind, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference that would otherwise be recoverable. [1991, c. 828, §31 (NEW).]

K. If, within 4 months before the filing of a successful petition for liquidation under this chapter or at any time in contemplation of a proceeding to liquidate an insurer, the insurer pays money or transfers property, directly or indirectly, to an attorney-at-law for services rendered or to be rendered, the transactions may be examined by the court on its own motion and must be examined by the court on petition of the liquidator and may be held valid only to the extent they are reasonable in amount as determined by the court. Any excess may be recovered by the liquidator for the benefit of the estate; except that, where the attorney is in a position of influence in the insurer or an affiliate of the insurer, payment of any money or the transfer of any property to the attorney for services rendered or to be rendered is governed by the provisions of paragraph B, subparagraph (4). [1991, c. 828, §31 (NEW).]

L. An officer, manager, employee, shareholder, member, subscriber, attorney or any other person acting on behalf of the insurer who knowingly participates in giving any preference when that person has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference is personally liable to the liquidator for the amount of the preference. If the transfer was made within 4 months before the date of filing of a successful petition for liquidation, a presumption arises that there was reasonable cause to believe the insurer was or was about to become insolvent. [1991, c. 828, §31 (NEW).]

M. A person receiving any property from the insurer or a benefit from possession or use of the property as a preference voidable under this subsection is personally liable for the value of that preference and shall account to the liquidator. [1991, c. 828, §31 (NEW).]

N. Nothing in this subsection prejudices any other claim by the liquidator against any person. [1991, c. 828, §31 (NEW).]

[1991, c. 828, §31 (NEW) .]

4. **Claims of holders of void or voidable rights.** Claims of holders of void or voidable rights are governed by this subsection.

A. A claim of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under this section is not allowed unless the claimant surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment is entered, the claim is not allowed unless the money is paid or the property is delivered to the liquidator within 30 days from the date of the entering of the final judgment; except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding. [1991, c. 828, §31 (NEW).]

B. A claim allowable under paragraph A by reason of the avoidance, whether voluntary or involuntary, of a preference, lien, conveyance, transfer, assignment or encumbrance may be filed as an excused late filing if filed within 30 days from the date of the avoidance or within any further time allowed by the court under paragraph A. [1991, c. 828, §31 (NEW).]

[1991, c. 828, §31 (NEW) .]

5. **Negotiable instruments.** Nothing in this section impairs the negotiability of currency or negotiable instruments.

[1991, c. 828, §31 (NEW) .]

SECTION HISTORY
1991, c. 828, §31 (NEW).

§4376. DATE RIGHTS FIXED ON LIQUIDATION

The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers and all other persons interested in its estate shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which made the order, subject to this chapter with respect to the rights of claimants holding contingent claims. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4377. TIME TO FILE CLAIMS

1. If upon the entry of an order of liquidation under this chapter or at any time thereafter during liquidation proceedings the insurer is not clearly solvent, the court shall, upon hearing after such notice as it deems proper, make and enter an order adjudging the insurer to be solvent.

[1969, c. 132, §1 (NEW) .]

2. After the entry of the order of insolvency, regardless of any prior notice that may have been given to creditors, the superintendent shall notify all persons who may have claims against the insurer to file such claims with him, at a place and within the time specified in the notice, or that such claims shall be forever barred. The time specified in the notice shall be as fixed by the court for filing of claims and which shall be not less than 6 months after the entry of the order of insolvency. The notice shall be given in such manner and for such reasonable period of time as may be ordered by the court.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4378. ALLOWANCE OF CONTINGENT AND OTHER CLAIMS

1. No contingent claim shall share in a distribution of assets of an insurer which has been adjudicated to be insolvent by an order made pursuant to section 4377, except that such claims shall be considered, if properly presented, and may be allowed to share where:

A. The claim becomes absolute against the insurer on or before the last day fixed for filing of proofs of claim against the assets of the insurer, or [1969, c. 132, §1 (NEW).]

B. There is a surplus and the liquidation is thereafter conducted upon the basis that the insurer is solvent. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

2. Where an insurer has been so adjudicated to be insolvent, any person who has a cause of action against an insured of the insurer, shall have the right to file a claim in the liquidation proceeding, regardless of the fact that the claim may be contingent, and the claim may be allowed:

A. If it may be reasonably inferred from the proof presented upon the claim that such person would be able to obtain a judgment upon such cause of action against such insured; and [1969, c. 132, §1 (NEW).]

B. If such person shall furnish suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claims against the insurer arising out of his cause of action other than those already presented can be made; and [1969, c. 132, §1 (NEW).]

C. If the total liability of the insurer to all claimants arising out of the same act of its insured shall be no greater than its maximum liability would be were it not in liquidation. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

3. No judgment against such an insurer, referred to in subsection 2, taken after the date of the entry of the liquidation order shall be considered in the liquidation proceedings as evidence of liability, or of the amount of damages, and no judgment against an insured taken by default, inquest or by collusion prior to the entry of the liquidation order shall be considered as conclusive evidence in the liquidation proceeding either of the liability of the insured to such person upon such cause of action or of the amount of damages to which such person is therein entitled.

[1969, c. 132, §1 (NEW) .]

4. No claim of any secured claimant shall be allowed at a sum greater than the difference between the value of the claim without security and the value of the security itself as of the date of the entry of the order of liquidation or such other date set by the court for the fixation of rights and liabilities as provided in section 4376 unless the claimant shall surrender his security to the liquidator and in which event the claim shall be allowed in the full amount for which it is valued.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4379. PRIORITIES IN DISTRIBUTION OF ASSETS

The priorities in distribution of assets from the insurer's estate shall be in the order as shown in this section. The first $50 of the amount allowed on each claim in the classes under subsections 2 to 6 shall be deducted from the claim and included in the class under subsection 8. Claims shall not be cumulated by assignment to avoid application on the $50 deductible provision. Subject to the $50 deductible provision, every claim in each class shall be paid in full or adequate funds retained for the payment thereof before claims of the next succeeding class receive any payment. No subclasses shall be established within any class: [1969, c. 132, §1 (NEW).]

1. **Administration costs.** The costs and expenses of administration, including but not limited to the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; and reasonable attorney's fees. Any provider or member claims for covered services under a health maintenance organization contract, including a point-of-service contract, incurred between the date a petition of liquidation is filed and the date coverage terminates may be treated as administration costs under this subsection.

[2001, c. 88, §12 (AMD) .]

2. **Wages.** Debts due to employees of the insurer, other than officers, for services performed, not to exceed $1,000 to each employee and earned within 1 year immediately prior to the filing of the petition for liquidation. This priority shall be in lieu of any other similar priority authorized by law as to wages or compensation of such employees.

[1969, c. 132, §1 (NEW) .]

3. **Loss claims.** All claims under policies for losses incurred, including 3rd-party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies, except the first $200 of losses otherwise payable to any claimant under this subsection. All claims under life insurance policies and annuity contracts, whether for death proceeds, annuity proceeds or investment values, must be treated as loss claims. Claims may not be cumulated by assignment to avoid application of the $200 deductible provision. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to an employee may be treated as a gratuity. Any provider or member claims for covered services under a health maintenance organization contract, including a point-of-service contract, not paid under subsection 1 are included in this class. Obligations of an insolvent insurer arising out of reinsurance contracts are excluded from this subsection.

[2003, c. 202, §1 (AMD) .]

4. **Unearned premiums and small loss claims.** Claims under nonassessable policies for unearned premiums or other premium refunds and the first $200 or loss excepted by the deductible provision in subsection 3, except that, if the receiver fails to prorate a premium due to the insurer based on a termination of coverage under this chapter, any resulting unearned premium must be paid to the insured under subsection 1 as an expense of the administration.

[2001, c. 88, §12 (AMD) .]

5. **Residual classification.** All other claims, including claims of the federal or any state or local government, not falling within other classes under this section. Claims, including those of any governmental body, for a penalty or forfeiture shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection 8.

[1969, c. 132, §1 (NEW) .]

6. **Judgments.** Claims based solely on judgments. If a claimant files a claim and bases it both on the judgment and on the underlying facts, the claim shall be considered by the liquidator who shall give the judgment such weight as he deems appropriate. The claim as allowed shall receive the priority it would have received in the absence of the judgment. If the judgment is larger than the allowance on the underlying claim, the remaining portion of the judgment shall be treated as if it were a claim based solely on a judgment.

[1969, c. 132, §1 (NEW) .]

7. **Interest on claims already paid.** Interest at the legal rate compounded annually on all claims in the classes under subsections 1 through 6 from the date of the petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared. The liquidator, with the court's approval, may make reasonable classifications of claims for purpose of computing interest, may make approximate computations and may ignore certain classifications and time periods as de minimis.

[1969, c. 132, §1 (NEW) .]

8. **Miscellaneous subordinated claims.** The remaining claims or portions of claims not already paid, with interest as in subsection 7:

A. The first $50 of each claim in the classes under subsections 2 through 6 subordinated under this section; [1969, c. 132, §1 (NEW).]

B. Claims subordinated by section 4380 (subordination of claims for noncooperation); [1969, c. 132, §1 (NEW).]

C. Claims filed late; [1969, c. 132, §1 (NEW).]

D. Portions of claims subordinated under subsection 5; and [1969, c. 132, §1 (NEW).]

E. Claims or portions of claims payment of which is provided by other benefits or advantages recovered or recoverable by the claimant. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

9. **Preferred ownership claims.** Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Interest at the legal rate shall be added to each claim, as in subsections 7 and 8.

[1969, c. 132, §1 (NEW) .]

10. **Proprietary claims.** The claims of stockholders or other owners of the insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 2001, c. 88, §12 (AMD). 2003, c. 202, §1 (AMD).

§4380. SUBORDINATION OF CLAIMS FOR NONCOOPERATION

If an ancillary receiver, by whatever name called, in another state or foreign country fails to transfer to the domiciliary liquidator in this State any assets within his control other than special deposits, diminished only by the expenses, if any, of the ancillary receivership, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under section 4379, subsection 8. [1969, c. 132, §1 (NEW).]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4381. OFFSETS

1. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection 2.

[1969, c. 132, §1 (NEW) .]

2. No offset shall be allowed in favor of any such person where:

A. The obligation of the insurer to such person would not at the date of the entry of any liquidation order or otherwise, as provided in section 4376, entitle him to share as a claimant in the assets of the insurer, or [1969, c. 132, §1 (NEW).]

B. The obligation of the insurer to such person was purchased by or transferred to such person with a view of its being used as an offset, or [1969, c. 132, §1 (NEW).]

C. The obligation of such person is to pay an assessment levied against the members of a mutual insurer, or against the subscribers of a reciprocal insurer, or is to pay a balance upon the subscription to the capital stock of a stock insurer. [1969, c. 132, §1 (NEW).]

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4382. REPORT AND PETITION FOR ASSESSMENT

Within 3 years after the date of the entry of an order of rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer, the superintendent may make and file his report and petition to the court setting forth: [1973, c. 585, §12 (AMD).]

1. The reasonable value of the assets of the insurer;

[1969, c. 132, §1 (NEW) .]

2. The liabilities of the insurer to the extent thus far ascertained by the superintendent;

[1973, c. 585, §12 (AMD) .]

3. The aggregate amount of the assessment, if any, which the superintendent deems reasonably necessary to pay all claims, the costs and expenses of the collection of the assessments and the costs and expenses of the delinquency proceedings in full; and

[1973, c. 585, §12 (AMD) .]

4. Any other information relative to the affairs or property of the insurer that the superintendent deems material.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4383. ORDER AND LEVY OF ASSESSMENT

1. Upon the filing and reading of the report and petition provided for in section 4382, the court, ex parte, may order the superintendent to assess all members or subscribers of the insurer who may be subject to such an assessment, in such an aggregate amount as the court finds reasonably necessary to pay all valid claims as may be timely filed and proved in the delinquency proceedings, together with the costs and expenses of levying and collecting assessments and the costs and expenses of the delinquency proceedings in full. Any such order shall require the superintendent to assess each such member or subscriber for his proportion of the aggregate assessment, according to such reasonable classification of such members or subscribers and formula as may be made by the superintendent and approved by the court.

[1973, c. 585, §12 (AMD) .]

2. The court may order additional assessments upon the filing and reading of any amendment or supplement to the report and petition referred to in subsection 1, if such amendment or supplement is filed within 3 years after the date of the entry of the order of rehabilitation or liquidation.

[1969, c. 132, §1 (NEW) .]

3. After the entry of the order to levy and assess members or subscribers of an insurer referred to in subsections 1 and 2, the superintendent shall levy and assess members or subscribers in accordance with the order.

[1973, c. 585, §12 (AMD) .]

4. The total of all assessments against any member or subscriber with respect to any policy, whether levied pursuant to any other provision of this Title, shall be for no greater amount than that specified in the policy or policies of the member or subscriber and as limited under this Title, except as to any policy which was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, in which event the assessment against any such policyholder shall be upon the basis of the minimum rate for such risk.

[1969, c. 132, §1 (NEW) .]

5. No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with this Title.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4384. ASSESSMENT PRIMA FACIE CORRECT; NOTICE; PAYMENT; PROCEEDINGS TO COLLECT

1. Any assessment of a subscriber or member of an insurer made by the superintendent pursuant to the order of court fixing the aggregate amount of the assessment against all members or subscribers and approving the classification and formula made by the superintendent under section 4383, subsection 1 shall be prima facie correct.

[1973, c. 585, §12 (AMD) .]

2. Each member or subscriber shall be notified of the amount of assessment to be paid by him by written notice mailed to the address of the member or subscriber last of record with the insurer. Failure of the member or subscriber to receive the notice so mailed, within the time specified therein or at all, shall be no defense in any proceeding to collect the assessment.

[1969, c. 132, §1 (NEW) .]

3. If any such member or subscriber fails to pay the assessment within the period specified in the notice, which period shall not be less than 20 days after mailing, the superintendent may obtain an order in the delinquency proceedings requiring the member or subscriber to show cause at a time and place fixed by the court why judgment should not be entered against such member or subscriber for the amount of the assessment together with all costs, and a copy of the order and a copy of the petition therefor shall be served upon the member or subscriber within the time and in the manner designated in the order.

[1973, c. 585, §12 (AMD) .]

4. If the subscriber or member after due service of a copy of the order and petition referred to in subsection 3 is made upon him:

A. Fails to appear at the time and place specified in the order, judgment shall be entered against him as prayed for in the petition; or [1969, c. 132, §1 (NEW).]

B. Appears in the manner and form required by law in response to the order, the court shall hear and determine the matter and enter a judgment in accordance with its decision. [1969, c. 132, §1 (NEW).]

5. The superintendent may collect any such assessment through any other lawful means.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4385. FEDERAL RECEIVERSHIP

1. Whenever in the superintendent's opinion liquidation of a domestic insurer or an alien insurer domiciled in this State would be facilitated by a federal receivership, and when any ground exists upon which the superintendent might petition the court for an order of rehabilitation or liquidation of the insurer under this chapter, or if such an order has already been entered, the superintendent may request another superintendent or other resident of another state to petition any appropriate federal district court for the appointment of a federal receiver. The superintendent may intervene in any such action to support or oppose the petition, and may accept appointment as the receiver if so designated. This chapter applies to the receivership except to the extent that the court determines that the insurance rehabilitation and liquidation laws of another state are applicable in any part. Upon the superintendent's motion, the courts of this State shall relinquish all jurisdiction over the insurer for purposes of rehabilitation or liquidation. No federal law governing proceedings in bankruptcy may be applied to proceedings under this section.

[1991, c. 828, §32 (AMD) .]

2. If he is appointed receiver under this section, the superintendent shall comply with requirements necessary to give him title to and control over the assets and affairs of the insurer.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1991, c. 828, §32 (AMD).

§4386. APPLICATION FOR APPROVAL

1. **Insolvency; assets disbursed.** Within 120 days of a final determination of insolvency of a company by a court of competent jurisdiction of this State, the receiver shall make application to the court for approval of a proposal to disburse assets out of the company's marshaled assets, from time to time as those assets become available, to the Maine Insurance Guaranty Association and to any similar organization in another state. The Maine Insurance Guaranty Association and any similar organizations in other states shall be referred to, collectively, as the associations.

[1981, c. 347, (NEW) .]

2. **Proposals.** The proposals shall at least include provisions for:

A. Reserving amounts for the payment of the expenses of administration and the claims falling within the priorities established in section 4379, subsections 1 and 2; [1981, c. 347, (NEW).]

B. Disbursement of the assets marshaled to date and subsequent disbursements of assets as they become available; [1981, c. 347, (NEW).]

C. Equitable allocation of disbursements to each of the associations entitled thereto; and [1981, c. 347, (NEW).]

D. The securing by the receiver from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the receiver the assets, and interest earned thereon, previously disbursed as may be required to pay claims as secured creditors and claims falling within the priorities established in section 4379, subsections 1 to 6, in accordance with those priorities. [1981, c. 347, (NEW).]

[1981, c. 347, (NEW) .]

3. **Disbursements to associations.** The receiver's proposal shall provide for disbursements to the associations in amounts at least equal to the payments made or to be made thereby for which the association could assert claims against the receiver and shall further provide that if the assets available for disbursement, from time to time, do not equal or exceed the amounts of the payments made or to be made by the associations, then disbursements shall be in the amount of available assets.

[1981, c. 347, (NEW) .]

4. **Notice.** Notice of the application shall be given to the associations in, and to the commissioners of insurance of, each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least 30 days prior to submission of the application to the court. Action on the application may be taken by the court provided the notice has been given and provided further that the receiver's proposal complies with subsection 2, paragraphs A and D.

[1981, c. 347, (NEW) .]

SECTION HISTORY
1981, c. 347, (NEW).

§4387. QUALIFIED FINANCIAL CONTRACTS

1. **Qualified financial contracts.** Notwithstanding any other provision of this chapter, including any other provision of this chapter permitting the modification of contracts, or other provision of law to the contrary, a person may not be stayed or prohibited from exercising:

A. A contractual right to cause the termination, liquidation, acceleration or closeout of obligations under or in connection with any netting agreement or qualified financial contract with an insurer because of:

(1) The insolvency, financial condition or default of the insurer at any time, if the right is enforceable under applicable law other than this chapter; or

(2) The commencement of a formal delinquency proceeding under this chapter; [2011, c. 107, §3 (NEW).]

B. Any right under a pledge, security, collateral, reimbursement or guarantee agreement or arrangement or any other similar security agreement or arrangement or other credit enhancement relating to one or more netting agreements or qualified financial contracts; [2011, c. 107, §3 (NEW).]

C. Subject to section 4381, subsection 2, any right to offset, set off or net out any termination value, payment amount or other transfer obligation arising under or in connection with one or more qualified financial contracts when the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting; or [2011, c. 107, §3 (NEW).]

D. If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this chapter terminates, liquidates, closes out or accelerates the agreement or contract, damages must be measured as of the date or dates of termination, liquidation, closeout or acceleration. The amount of a claim for damages is the actual direct compensatory damages calculated in accordance with subsection 6. [2011, c. 107, §3 (NEW).]

[2011, c. 107, §3 (NEW) .]

2. **Termination of contract.** Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer that is the subject of a delinquency proceeding under this chapter must be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract. For purposes of this subsection, "walkaway clause" means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party's position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a nondefaulting party. Any limited 2-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted is considered to be a full 2-way payment or 2nd method provision as against the defaulting insurer. Any such property or amount, except to the extent it is subject to one or more secondary liens or encumbrances or rights of netting, offset or setoff, must be a general asset of the insurer.

[2011, c. 107, §3 (NEW) .]

3. **Transfer of contract.** In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this chapter, the receiver shall either:

A. Transfer to one party, other than an insurer subject to a delinquency proceeding under this chapter, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

(1) All rights and obligations of each party under each netting agreement and qualified financial contract; and

(2) All property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or [2011, c. 107, §3 (NEW).]

B. Transfer none of the netting agreements, qualified financial contracts, rights, obligations or property referred to in paragraph A with respect to the counterparty and any affiliate of the counterparty. [2011, c. 107, §3 (NEW).]

[2011, c. 107, §3 (NEW) .]

4. **Notice.** If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, then the receiver must use its best efforts to notify any person who is a party to the netting agreements or qualified financial contracts of the transfer by noon, the receiver's local time, on the business day following the transfer. For purposes of this subsection, "business day" means a day other than a Saturday, Sunday or any day on which the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

[2011, c. 107, §3 (NEW) .]

5. **Transfer prior to delinquency.** Notwithstanding any other provision of this chapter and except as provided in this subsection, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract or any pledge, security, collateral or

guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract that is made before the commencement of a delinquency proceeding under this chapter. A transfer may be avoided under section 4375-A, subsection 1, paragraph A if the transfer was made with actual intent to hinder, delay or defraud the insurer, a receiver appointed for the insurer or existing or future creditors.

[2011, c. 107, §3 (NEW) .]

6. **Rights of disaffirmance or repudiation.** Disaffirmance or repudiation is governed by this subsection.

A. In exercising the rights of disaffirmance or repudiation of a receiver with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

(1) Disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding; or

(2) Disaffirm or repudiate none of the netting agreements and qualified financial contracts referred to in subparagraph (1) with respect to the person or any affiliate of the person. [2011, c. 107, §3 (NEW).]

B. Notwithstanding any other provision of this chapter, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding rehabilitation proceeding must be determined and either allowed or disallowed:

(1) As if the claim had arisen before the date of the filing of the petition for liquidation;

(2) If a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for rehabilitation; or

(3) As if the claim had arisen before the issuance of any order or the commencement of any summary proceeding under this chapter.

The amount of the claim is the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. "Actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity or damages for pain and suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages used in the derivatives, securities or other market for the contract and agreement claims. [2011, c. 107, §3 (NEW).]

[2011, c. 107, §3 (NEW) .]

7. **Contractual right defined.** "Contractual right," as used in this section, includes any right set forth in a rule or bylaw of a derivatives clearing organization as defined in the federal Commodity Exchange Act, a multilateral clearing organization as defined in the Federal Deposit Insurance Corporation Improvement Act of 1991, a national securities exchange, a national securities association, a securities clearing agency or a contract market designated under the federal Commodity Exchange Act, a derivatives transaction execution facility registered under the federal Commodity Exchange Act, or a board of trade as defined in the federal Commodity Exchange Act or in a resolution of the governing board thereof and any right, whether or not evidenced in writing, arising under statutory or common law, or under law merchant, or by reason of normal business practice.

[2011, c. 107, §3 (NEW) .]

8. **Affiliates.** This section does not apply to any persons who are affiliates of the insurer that is the subject of the proceeding.

[2011, c. 107, §3 (NEW) .]

9. **Rights of counterparties.** All rights of counterparties under this chapter apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

[2011, c. 107, §3 (NEW) .]

SECTION HISTORY
2011, c. 107, §3 (NEW).

Subchapter 2: SUMMARY PROCEEDINGS

§4401. SUMMARY PROCEEDINGS; SUPERINTENDENT'S CORRECTIVE ORDERS AUTHORIZED

1. If the superintendent determines after a hearing that any insurer has committed or engaged in, or is committing or engaging in, or is about to commit or engage in any act, practice or transaction that would subject it to formal delinquency proceedings under section 4351 to 4407, he may make and serve upon the insurer and other persons involved such orders, other than seizure orders under sections 4404 and 4405, as he deems reasonably necessary to correct, eliminate or remedy such conduct, condition or ground. Orders to cure impairment of capital or surplus of a domestic insurer are subject to sections 3423 and 3424.

[1973, c. 585, §12 (AMD) .]

2. If the superintendent believes that irreparable harm to the insurer or its policyholders, creditors or the public may occur unless his order is issued with immediate effect, he may make and serve his order without notice and before hearing, and shall simultaneously therewith serve upon the insurer and other persons involved the notice of hearing as required under subsection 3.

[1973, c. 585, §12 (AMD) .]

3. The superintendent's order and notice of hearing thereunder shall be served in such a manner as conforms with the notice provisions of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV.

[1977, c. 694, §438 (RPR) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §438 (AMD).

§4402. -- APPEAL FROM SUPERINTENDENT'S ORDER

If the superintendent has issued a summary order before hearing as provided in section 4401, subsection 2, any person upon whom such order is served may waive the superintendent hearing and apply for any immediate judicial relief available under law and without first exhausting administrative remedies. Section 236 (appeal from superintendent) shall apply as to appeals from the superintendent's order made after hearing. [1973, c. 585, §12 (AMD).]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4403. -- ENFORCEMENT, PENALTY

1. The superintendent may apply for and any Superior Court may grant such restraining orders, temporary and permanent injunctions and other orders as may be deemed necessary to enforce the superintendent's order.

[1973, c. 585, §12 (AMD) .]

2. Violation of any order of the superintendent issued under section 4401 by any person as to whom the order is in effect shall subject such person to a penalty of not to exceed $10,000, to be collected in a civil action brought by the Attorney General in the name of the State of Maine. The Attorney General shall deposit all funds so collected with the Treasurer of State to the credit of the Insurance Division Regulatory Revolving Fund.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4404. -- SEIZURE UNDER COURT ORDER

1. Upon filing by the superintendent in any Superior Court of this State of his verified petition alleging any ground for a formal delinquency proceeding against an insurer under sections 4351 to 4385 and that the interests of the insurer's policyholders or creditors or the public will be jeopardized by delay, and setting forth the order deemed necessary by the superintendent, the court shall, ex parte and without notice or hearing, issue the requested order. The requested order may:

A. Direct the superintendent to take possession and control of all or part of the property, books, accounts and records of the insurer and the premises occupied by it for transaction of its business; and [1973, c. 585, §12 (AMD).]

B. Until further order of court, enjoin the insurer and its officers, managers, agents and employees from removal, concealment or other disposition of its property, and from transaction of its business, except with the superintendent's written consent. [1973, c. 585, §12 (AMD).]

[1973, c. 585, §12 (AMD) .]

2. The court's order shall be for such duration, specified in the order, as the court deems necessary to enable the superintendent to ascertain the insurer's condition. On motion of any party or on its own motion, the court may hold such hearings as it deems desirable after such notice as it deems appropriate, and extend or shorten the duration or modify the terms of the order. The court shall vacate the seizure order if the superintendent fails to commence a formal proceeding under sections 4351 to 4385 after reasonable opportunity to do so; and a seizure order is automatically vacated by issuance of the court's order pursuant to formal delinquency proceedings under such sections of this chapter.

[1973, c. 585, §12 (AMD) .]

3. Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY

1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4405. -- SEIZURE UNDER THE SUPERINTENDENT'S ORDER

1. If it appears to the superintendent that the interests of policyholders, creditors or the public will be jeopardized by delay incident to requesting a court seizure order, then on any ground which would justify a court seizure order under section 4404, and without notice and without applying to the court, the superintendent may issue a seizure order which must contain a statement verified by him of the grounds of his action. As directed by the seizure order, the superintendent's representatives shall forthwith take possession and control of all or part of the property, books, accounts and records of the insurer, and of the premises occupied by the insurer for transaction of its business. The superintendent shall retain possession and control until the order is vacated or is replaced by an order of court pursuant to subsection 2 or pursuant to a formal proceeding under this chapter.

[1973, c. 585, §12 (AMD) .]

2. At any time after seizure under subsection 1 the insurer may apply to the Superior Court for Kennebec County or for the county in this State in which the insurer's principal office is located. The court shall thereupon order the superintendent to appear forthwith and shall thereafter proceed as if the order were a court seizure order issued under section 4404.

[1973, c. 585, §12 (AMD) .]

3. Every law enforcement officer of this State shall assist the superintendent in making and enforcing any such seizure, and every sheriff's and police department shall furnish him with such deputies, patrolmen or officers as are necessary for the purpose.

[1973, c. 585, §12 (AMD) .]

4. Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4406. -- CONDUCT OF HEARINGS, BOTH ADMINISTRATIVE AND BY THE COURT, IN SUMMARY PROCEEDINGS

1. The superintendent shall hold all hearings in summary proceedings privately unless the insurer requests a public hearing, in which case the hearing shall be public.

[1973, c. 585, §12 (AMD) .]

2. The court may hold all hearings in summary proceedings and judicial reviews thereof privately in chambers, and shall do so on request of the insurer proceeded against.

[1969, c. 132, §1 (NEW) .]

3. In all summary proceedings and judicial reviews thereof, all records of the insurer, other documents, and all insurance bureau files and court records and papers, so far as they pertain to or are part of the record of the summary proceedings, shall be and remain confidential except as necessary to obtain compliance

therewith, unless the court after hearing arguments by the parties in chambers shall order otherwise, or unless the insurer requests that the matter be made public. Until the court otherwise orders, all papers filed with the clerk of court shall be held by him in a confidential file.

[1973, c. 585, §12 (AMD) .]

4. If at any time it appears to the court that any person whose interest is or will be substantially affected by an order did not appear at the hearing and has not been served, the court may order that notice be given and the proceedings be adjourned to give such person opportunity to appear, on such terms as may be reasonable and just.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

§4407. -- PENALTY FOR REFUSAL TO DELIVER PROPERTY, ETC.

Any person having possession or custody of and refusing to deliver to the superintendent or his representative upon request any of the property, books, accounts, documents or other records of an insurer against which a seizure order or a summary order has been issued by the superintendent or by the court, as provided under sections 4401 to 4406, shall upon conviction thereof be subject to a fine of not over $10,000 or imprisonment for less than one year, or by both such fine and imprisonment. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD).

Subchapter 3: MAINE INSURANCE GUARANTY ASSOCIATION

§4431. SHORT TITLE

This subchapter shall be known and may be cited as the Maine Insurance Guaranty Association Act. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW).

§4432. PURPOSE

The purpose of this subchapter is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW).

§4433. SCOPE

1. **Application.** This subchapter shall apply only as to the following kinds of insurance:

A. Property insurance, as defined in section 705; [1969, c. 561, (NEW).]

B. Surety insurance, as defined in section 706; [1969, c. 561, (NEW).]

C. Casualty insurance, as defined in section 707; and [1969, c. 561, (NEW).]

D. Marine and transportation insurance, as defined in section 708, excluding wet marine insurance, as defined in section 708, subsection 2, but not excluding marine protection and indemnity insurance. [1989, c. 751, §1 (AMD).]

[1989, c. 751, §1 (AMD) .]

2. Exceptions. This subchapter shall not apply as to:

A. Contracts of reinsurance; [1969, c. 561, (NEW).]

B. Mortgage guaranty insurance; [1985, c. 279, §1 (AMD).]

C. Credit insurance, vendors single-interest insurance, collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction; [2001, c. 478, §1 (AMD); 2001, c. 478, §11 (AFF).]

D. Insurance contracts procured as surplus lines coverage pursuant to chapter 19; [1987, c. 707, §5 (AMD).]

E. Title insurance; [1989, c. 67, §1 (AMD).]

F. Financial guaranty insurance or other forms of insurance offering protection against investment risks; [2001, c. 478, §2 (AMD); 2001, c. 478, §11 (AFF).]

G. Contracts of workers' compensation excess insurance issued to workers' compensation self-insurers approved under former Title 39, section 23 or under Title 39-A, section 403 by any insurer after the effective date of this paragraph, or in the case of a contract that automatically renews, not later than one year after the effective date of this paragraph; [2001, c. 478, §3 (AMD); 2001, c. 478, §11 (AFF).]

H. Life, annuity, health or disability insurance; [2001, c. 478, §4 (NEW); 2001, c. 478, §11 (AFF).]

I. Insurance of warranties or service contracts, including insurance that provides for the repair, replacement or service of goods or property, or indemnification of repair, replacement or service; for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear; or for reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits; [2001, c. 478, §4 (NEW); 2001, c. 478, §11 (AFF).]

J. A transaction or combination of transactions between a person, including affiliates of that person, and an insurer, including affiliates of that insurer, that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; and [2001, c. 478, §4 (NEW); 2001, c. 478, §11 (AFF).]

K. Insurance provided by or guaranteed by a governmental entity. [2001, c. 478, §4 (NEW); 2001, c. 478, §11 (AFF).]

[2001, c. 478, §§1-4 (AMD); 2001, c. 478, §11 (AFF) .]

SECTION HISTORY
1969, c. 561, (NEW). 1985, c. 279, §1 (AMD). 1987, c. 707, §§3-6 (AMD). 1989, c. 67, §1 (AMD). 1989, c. 751, §1 (AMD). 1991, c. 885, §E32 (AMD). 1991, c. 885, §E47 (AFF). 2001, c. 478, §§1-4 (AMD). 2001, c. 478, §11 (AFF).

§4434. CONSTRUCTION

This subchapter shall be liberally construed to effect the purpose stated under section 4432, which shall constitute an aid and guide to interpretation. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW).

§4435. DEFINITIONS

As used in this subchapter, unless context otherwise requires: [1969, c. 561, (NEW).]

1. **Account.** "Account" means any one of the 3 accounts created by section 4436.

[1969, c. 561, (NEW) .]

1-A. **Affiliate.** "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by or is under common control with an insolvent insurer on December 31st of the year immediately before the year in which the insurer becomes an insolvent insurer.

[1989, c. 751, §2 (NEW) .]

2. **Association.** "Association" means the Maine Insurance Guaranty Association created under section 4436.

[1969, c. 561, (NEW) .]

3. **Board of directors.** "Board of directors" means the board of directors of the association.

[1969, c. 561, (NEW) .]

4. **Covered claim.** "Covered claim" means an unpaid claim, including one for unearned premiums but excluding one for punitive damages, arising under and within the coverage and applicable limits of a policy of a kind of insurance referred to in section 4433 to which this subchapter applies issued by an insurer that becomes an insolvent insurer after May 9, 1970, and where:

A. The claimant or insured is a resident of this State at the time of the insured event; or [1969, c. 561, (NEW).]

B. The property from which the claim arises is permanently located in this State. [1969, c. 561, (NEW).]

"Covered claim" does not include any amount due any insurer, reinsurer, affiliate, insurance pool or underwriting association, as subrogation recoveries or otherwise, except that any payment made to the workers' compensation residual market pool pursuant to section 4438, subsection 1, paragraph A-1 must be included as a covered claim. "Covered claim" does not include any first-party claims by an insured whose net worth exceeds $25,000,000 on December 31st of the year prior to the year in which the member insurer becomes an insolvent insurer. An insured's net worth on that date is deemed to include the aggregate net worth of the insured and all its subsidiaries as calculated on a consolidated basis.

[2001, c. 478, §5 (AMD); 2001, c. 478, §11 (AFF) .]

5. **Insolvent insurer.** "Insolvent insurer" means a member insurer:

A. Authorized to transact insurance in this State either at the time the policy was issued or when the insured event occurred; and [1995, c. 289, §13 (AMD).]

B. Against whom a final order of liquidation has been entered with a finding of insolvency by a court of competent jurisdiction. [2001, c. 478, §6 (AMD); 2001, c. 478, §11 (AFF).]

Effective July 1, 1995, the workers' compensation residual market pool, as created by the Bureau of Insurance Rules, Chapter 440, is deemed an insolvent insurer.

[2001, c. 478, §6 (AMD); 2001, c. 478, §11 (AFF) .]

6. **Member insurer.** "Member insurer" means any authorized insurer that writes any kind of insurance to which this subchapter applies and that is not a risk retention group as defined in section 6093, subsection 13. If an insurer is authorized at the time of an insolvency and subsequently is approved to withdraw its license authority for the kinds of insurance covered by any account to which claims relating to the insolvency are allocated, the withdrawn insurer shall continue to be a member of each account solely for purposes of assessments relating to claims resulting from the insolvency until these claims are paid or otherwise extinguished.

[2013, c. 238, Pt. E, §2 (AMD) .]

7. **Net direct written premiums.** "Net direct written premiums" means direct gross premiums written on insurance policies to which this subchapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers or premiums written through the United States Government Flood Insurance Program.

[1999, c. 790, Pt. A, §29 (AMD) .]

8. **Insurer.** "Insurer" means any insurer as defined in section 4.

[1981, c. 484, §1 (AMD) .]

9. **Line of credit.** "Line of credit" means an irrevocable stand-by commitment whereby the association or member insurer and a qualified financial institution or group of qualified financial institutions enter into a formal and binding contract in which the qualified financial institution or group of qualified financial institutions agree to lend a certain amount of money within a stated period of time. The terms and conditions of any line of credit shall be established by rules adopted jointly by the Bureau of Financial Institutions and the Bureau of Insurance.

[1989, c. 67, §4 (NEW); 2001, c. 44, §11 (AMD); 2001, c. 44, §14 (AFF) .]

9-A. **Person.** "Person" means an individual or legal entity, including a governmental entity.

[2001, c. 478, §7 (NEW); 2001, c. 478, §11 (AFF) .]

10. **Qualified financial institution.** "Qualified financial institution" means one which is insured by the Federal Deposit Insurance Corporation, Federal Savings and Loan Insurance Corporation or a successor federal deposit insurance agency or agencies, and has an equity capital to assets ratio of 6.5% or greater, as determined in accordance with generally accepted accounting principles.

[1989, c. 67, §4 (NEW) .]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 625, §159 (AMD). 1979, c. 658, §§3,4 (AMD). 1981, c. 484, §1 (AMD). 1985, c. 279, §2 (AMD). 1987, c. 769, §B5 (AMD). 1989, c. 67, §§2-4 (AMD). 1989, c. 751, §§2,3 (AMD). 1991,

c. 885, §E33 (AMD). 1991, c. 885, §E47 (AFF). 1995, c. 289, §§12,13 (AMD). 1999, c. 790, §A29 (AMD). 2001, c. 44, §11 (AMD). 2001, c. 44, §14 (AFF). 2001, c. 478, §§5-7 (AMD). 2001, c. 478, §11 (AFF). 2013, c. 238, Pt. E, §2 (AMD).

§4436. CREATION OF THE ASSOCIATION

There is created a nonprofit unincorporated legal entity to be known as the Maine Insurance Guaranty Association. All insurers defined as member insurers in section 4435 shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under section 4439 and shall exercise its powers through a board of directors established under section 4437. For purposes of administration and assessment, the association shall be divided into 3 separate accounts: [1969, c. 561, (NEW).]

1. The workers' compensation insurance account;

[1987, c. 707, §7 (AMD) .]

2. The automobile insurance account; except those insurers writing only automobile physical damage insurance, which shall be included in the all other insurance account; and

[1969, c. 561, (NEW) .]

3. The account for all other insurance to which this subchapter applies.

[1969, c. 561, (NEW) .]

SECTION HISTORY
1969, c. 561, (NEW). 1987, c. 707, §7 (AMD).

§4437. BOARD OF DIRECTORS

The board of directors of the association must consist of not less than 7 persons serving terms as established in the plan of operation, and not less than 3 of the persons must represent members of the association that are domiciled in the State. The members of the board must be selected by member insurers subject to the approval of the superintendent. A member insurer serving on the board must resign if the member insurer ceases writing new insurance business in the State. Vacancies on the board must be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the superintendent. [2009, c. 116, §1 (AMD).]

In approving selections to the board, the superintendent shall consider among other things whether all member insurers are fairly represented. [1973, c. 585, §12 (AMD).]

Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §160 (AMD). 1985, c. 279, §3 (AMD). 2009, c. 116, §1 (AMD).

§4438. POWERS AND DUTIES OF THE ASSOCIATION

1. **Powers and duties.** The association shall:

A. Be obligated to pay covered claims existing prior to the determination of the insolvency or arising within 30 days after the determination of insolvency, or before the policy expiration date if less than 30 days after the determination of insolvency, or before the insured replaces the policy or causes its cancellation, if within 30 days of the determination. The obligation must be satisfied by paying to the claimant:

(1) Except as provided in this paragraph, the full amount of a covered claim for benefits, including interest and all penalties payable to a claimant under the Maine Workers' Compensation Act of 1992, or unearned premium under workers' compensation insurance coverage;

(2) An amount not exceeding $25,000 per policy for a covered claim for the return of an unearned premium; or

(3) An amount not exceeding $300,000 per claim for all other covered claims.

In no event is the association obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. The association shall pay only that amount of unearned premium in excess of $50. Notwithstanding any other provisions of this subchapter, a covered claim does not include any claim filed with the association after the earlier of 24 months after the date of the order of liquidation or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The association, in its discretion, may accept a late filed claim as a covered claim when the claimant demonstrates good cause. The demonstration of good cause by a claimant includes showing that the existence of the claim was not known to the claimant prior to the bar date and that the claimant filed the claim within 60 days of learning of the claim; [2009, c. 129, §1 (AMD); 2009, c. 129, §13 (AFF).]

A-1. Pay to the workers' compensation residual market pool the sum of $1,538,039 on or before February 15th, May 15th, August 15th and November 15th of each year beginning August 15, 1996 and continuing for 40 consecutive calendar quarters. Each payment made under this paragraph must be treated as the payment of a covered claim except that the association may not seek reimbursement or recoupment from any source other than by assessments to member insurers. Member insurers are allowed to recognize assessments made pursuant to this paragraph in rates and premiums as provided in section 4447; [1995, c. 289, §14 (NEW).]

B. Be deemed the insurer to the extent of its obligation on covered claims, and to such extent the association shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent; [1969, c. 561, (NEW).]

C. Allocate claims paid and expenses incurred among the 3 accounts separately; and assess member insurers separately for each account in amounts necessary to pay:

(1) The obligations of the association under paragraph A, subsequent to an insolvency, the obligations of the accounts for shortfalls under section 4440-A, and for preinsolvency assessments, if required by section 4440, subsection 3, paragraph B, and the obligations of the association under paragraph A-1;

(2) The expenses of handling covered claims subsequent to an insolvency;

(3) The cost of examinations under section 4445; and

(4) Other expenses authorized by this subchapter; [1995, c. 289, §15 (AMD).]

D. Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. The association shall pay covered claims in any reasonable order, including the payment of claims as such are received from the claimants or in groups or categories of claims. The association may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested; [1985, c. 279, §5 (AMD).]

E. Notify such persons as the superintendent directs under section 4441, subsection 2, paragraph A; [1973, c. 585, §12 (AMD).]

F. Handle claims through its employees or through one or more insurers licensed in the State or other persons using employees licensed as adjusters in the State designated as servicing facilities. Designation of a servicing facility is subject to the approval of the superintendent, but designation of a member insurer as a servicing facility may be declined by such insurer; [2009, c. 129, §2 (AMD); 2009, c. 129, §13 (AFF).]

G. Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association; [1969, c. 561, (NEW).]

H. Pay the other expenses of the association authorized by this subchapter; and [2009, c. 129, §3 (AMD); 2009, c. 129, §13 (AFF).]

I. Pay all penalties, sanctions, forfeitures and fines provided for under the Maine Workers' Compensation Act of 1992 including penalties payable to the Workers' Compensation Board and the General Fund, except the penalty provided for in Title 39-A, section 359, subsection 2. No penalty, fine, forfeiture, attorney's fees or other sanction may be imposed on the association if:

(1) The Workers' Compensation Board finds that the association was prevented from complying with the Maine Workers' Compensation Act of 1992 because the association was unable in the exercise of reasonable diligence to obtain the records of the insolvent insurer; or

(2) The Workers' Compensation Board finds that the association was prevented from complying with the Maine Workers' Compensation Act of 1992 because of circumstances beyond its reasonable control. [2009, c. 129, §4 (NEW); 2009, c. 129, §13 (AFF).]

[2009, c. 129, §§1-4 (AMD); 2009, c. 129, §13 (AFF) .]

2. **Permission.** The association may:

A. Employ or retain such persons as are necessary to handle claims and perform other duties of the association; [1969, c. 561, (NEW).]

B. Borrow funds necessary to effect the purposes of this subchapter in accord with the plan of operation; [1969, c. 561, (NEW).]

C. Sue or be sued and may intervene as a party before any court in this State that has jurisdiction over an insolvent insurer as defined by this subchapter; [2001, c. 478, §9 (AMD); 2001, c. 478, §11 (AFF).]

D. Negotiate and become a party to such contracts as are necessary to carry out the purpose of this subchapter; [1969, c. 561, (NEW).]

E. Perform such other acts as are necessary or proper to effectuate the purpose of this subchapter; [1969, c. 561, (NEW).]

F. Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year. [1969, c. 561, (NEW).]

[2001, c. 478, §9 (AMD); 2001, c. 478, §11 (AFF) .]

SECTION HISTORY

1969, c. 561, (NEW). 1973, c. 585, §12 (AMD). 1981, c. 17, (AMD). 1985, c. 279, §§4,5 (AMD). 1987, c. 707, §8 (AMD). 1989, c. 67, §5 (AMD). 1989, c. 751, §4 (AMD). 1995, c. 289, §§14,15 (AMD). 2001, c. 478, §§8-9 (AMD). 2001, c. 478, §11 (AFF). 2005, c. 603, §1 (AMD). 2009, c. 129, §§1-4 (AMD). 2009, c. 129, §13 (AFF).

§4439. PLAN OF OPERATION

1. **Submission.**

A. The association shall submit to the superintendent a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the superintendent. [1973, c. 585, §12 (AMD).]

B. If the association fails to submit a suitable plan of operation within 90 days following May 9, 1970 or if at any time thereafter the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate this subchapter. Such rules shall continue in force until modified by the superintendent or superseded by a plan submitted by the association and approved by the superintendent. [1973, c. 625, §161 (AMD).]

[1973, c. 625, §161 (AMD) .]

2. **Complying.** All member insurers shall comply with the plan of operation.

[1969, c. 561, (NEW) .]

3. **Plan.** The plan of operation shall:

A. Establish the procedures whereby all the powers and duties of the association under section 4438 will be performed. [1969, c. 561, (NEW).]

B. Establish procedures for handling assets of the association. [1969, c. 561, (NEW).]

C. Establish the amount and method of reimbursing members of the board of directors under section 4437. [1969, c. 561, (NEW).]

D. Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator. [1969, c. 561, (NEW).]

E. Establish regular places and times for meetings of the board of directors. [1969, c. 561, (NEW).]

F. Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors. [1969, c. 561, (NEW).]

G. Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the superintendent within 30 days after the action or decision. [1973, c. 585, §12 (AMD).]

H. Establish the procedures whereby selections for the board of directors will be submitted to the superintendent. [1973, c. 585, §12 (AMD).]

I. Contain additional provisions necessary or proper for the execution of the powers and duties of the association. [1969, c. 561, (NEW).]

[1973, c. 585, §12 (AMD) .]

4. **Provisions.** The plan of operation may provide that any or all powers and duties of the association, except those under section 4438, subsection 1, paragraph C, and section 4438, subsection 2, paragraph B, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association, or its equivalent, in 2 or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the superintendent, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this subchapter.

[1973, c. 585, §12 (AMD) .]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §161 (AMD).

§4440. ASSESSMENT OF MEMBER INSURERS

1. **Proportion.** The assessments of each member insurer provided for under section 4438 must be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the same calendar year on the kinds of insurance in the account, except that assessments to cover a shortfall in any account are determined in accordance with section 4440-A. In the case of a withdrawn insurer, the average of its net direct written premium for the 5 calendar years prior to withdrawal, excluding premium on business written as a workers' compensation residual market servicing carrier for assessments made on or after January 1, 1996, must be used as its assessment base for any year following withdrawal in which the insurer has no net direct written premium.

[1995, c. 289, §16 (AMD) .]

2. **Notification.** Each member insurer shall be notified of the assessment not later than 30 days before it is due.

[1969, c. 561, (NEW) .]

3. **Limitation; types of assessments.** Assessments shall be made as follows.

A. Each member insurer may be assessed in any calendar year on any account an amount up to 2% of that member insurer's net direct written premiums for the next preceding calendar year on the kinds of insurance in the account for purposes of paying claims and expenses of that account. [1989, c. 67, §7 (NEW).]

B. To the extent that the maximum 2% has not been assessed, an assessment of up to that member's proportionate share of the applicable maximum as set forth in this paragraph shall be assessed when immediately necessary for the payment of claims and expenses. Any amount drawn by the association under any line of credit shall be considered a payment toward the member insurer's obligation provided for in this section. The maximum line of credit or preinsolvency assessment for each account shall be as follows:

Account	Maximum
Workers' compensation	$2,000,000
Automobile	$1,700,000

All other	$1,300,000

(1) The association shall obtain a line of credit for the benefit of each account, in an amount not to exceed the applicable maximum to ensure the immediate availability of funds for purposes of future claims and expenses attributable to an insurer insolvency in that account. The line of credit shall be obtained from qualified financial institutions. At no time may a qualified financial institution participate in the line of credit in excess of 20% of its equity capital. The line of credit shall provide for a 30-day notice of termination or nonrenewal to the superintendent and the association and shall provide funding to the association within one business day of receipt of written notice from the superintendent of an insolvent insurer in that account as defined in section 4435, subsection 5. Each member insurer upon receipt of notice from the association shall make immediate payment for its proportionate share of the amount borrowed based on the premium for the preceding calendar year. The line of credit provided for in this paragraph shall be subject to prior review and approval by the superintendent at the time of origination and any subsequent renewal.

(2) If the association cannot obtain a line of credit, a member insurer may obtain a line of credit from a qualified financial institution or may extend a line of credit itself directly to and for the benefit of the member insurer's account by submitting to the association a duly authorized and executed line of credit agreement providing that the member insurer shall provide funding to the association under the line of credit within one business day of receipt of a written notice from the superintendent of an insolvent insurer as defined in section 4435, subsection 5, and receipt of a written request from the association for a drawdown under the line of credit. The line of credit agreement shall be subject to prior review and approval by the superintendent at the time of origination and any subsequent renewal. It shall include such commercially reasonable provisions as the association or the superintendent may deem advisable, including a provision that the line of credit is irrevocable or for a stated period of time and provides for a 30-day notice to the association and the superintendent that the line is being terminated or not renewed. Any line of credit issued under this paragraph may be replaced with another line of credit and the existing line of credit shall be released by the association once a substitute line of credit has been provided or the assessment provided for in this paragraph has been paid.

(3) If a line of credit is not given as provided for in subparagraph (2), the member insurer shall be responsible for payment of an assessment of up to that member's proportionate share of the applicable maximum as set forth in this paragraph which shall be paid into a preinsolvency assessment fund in each account. Funds in each account shall only be used for the payment of claims and expenses of an insolvent insurer in that account.

(4) All materials and information submitted or considered under this paragraph shall be matters of public record. [1989, c. 67, §7 (NEW).]

[1989, c. 67, §7 (RPR) .]

4. **Exemptions.** The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. It is a condition of any deferral that during the period of deferment no dividends may be paid by the member insurer to its shareholders or policyholders. A deferred assessment is paid when payment will not reduce capital or surplus below required levels, and the association shall then refund to its other member insurers an amount equal to the deferred assessment in the proportions corresponding to the increases in their assessments by virtue of that deferment.

[1985, c. 279, §6 (AMD) .]

5. **Set off.** Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer, if they are chargeable to the account for which the assessment is made.

[1969, c. 561, (NEW) .]

6. **Delinquency.** Delinquent assessments, except as provided in subsection 4, shall bear interest at the rate of 8% per annum, computed from the due date of the assessment.

[1969, c. 561, (NEW) .]

SECTION HISTORY
1969, c. 561, (NEW). 1985, c. 279, §6 (AMD). 1989, c. 67, §§6,7 (AMD). 1995, c. 289, §16 (AMD).

§4440-A. SPECIAL ASSESSMENT

1. **Special assessment.** If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the shortfall shall be assessed as an obligation of the other accounts of the association, with each member insurer's assessment to be in the proportion that its net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the accounts to be assessed bears to the total net direct written premiums of all member insurers for the same calendar year on the kinds of insurance in those accounts. The total of assessments against a member insurer under this section and section 4440 for any account in any one calendar year shall not exceed 2% of that member's net direct written premium on the kinds of insurance written in that account for the next preceding calendar year.

[1989, c. 67, §8 (NEW) .]

2. **Limit on assessment.** Subject to the 2% limitation, an assessment made under this section may not exceed 5% of the average of a member insurer's net income of the 3 years prior to the year in which the assessment is made for any member insurer:

A. That has surplus of less than $15,000,000 and either a ratio of total net direct written premium to total surplus greater than 2 or net income of less than $250,000 for the year preceding the assessment. For purposes of this subsection, "net income" means the sum of underwriting income and investment income, net of dividends to policyholders and federal and foreign income taxes incurred, as reported on the insurer's annual statement filed with the superintendent. "Total surplus" means surplus as regards policyholders, as reported on the insurer's annual statement filed with the superintendent; or [1995, c. 289, §17 (AMD).]

B. That has a surplus of less than $15,000,000 and has fewer than 3,000 policyholders. [1995, c. 289, §17 (AMD).]

[1995, c. 289, §17 (AMD) .]

3. **Repealer.**

[1989, c. 67, §8 (NEW); 1989, c. 751, §5 (RP) .]

4. **Notification to Legislature.** Within 7 days after the board of directors votes to levy an assessment under this section, the chair of the board of directors shall notify the chairs of the legislative committee having jurisdiction over insurance matters that the association has voted to make such an assessment. The notification must:

A. Be in writing; and [1989, c. 751, §6 (NEW).]

B. Include the total amount to be assessed against each account and the name of the account to which the assessed funds will be credited. [1989, c. 751, §6 (NEW).]

[1989, c. 751, §6 (NEW) .]

SECTION HISTORY
1989, c. 67, §8 (NEW). 1989, c. 641, §§1,2 (AMD). 1989, c. 751, §§5,6 (AMD). 1995, c. 289, §17 (AMD).

§4440-B. ASSESSMENT OF EXCESS INSURERS

(REPEALED)

SECTION HISTORY
1989, c. 67, §8 (NEW). MRSA T. 24-A, §4440-B (RP).

§4441. DUTIES AND POWERS OF THE SUPERINTENDENT

1. **Duties and powers.** The superintendent shall:

A. Notify the association of the existence of an insolvent insurer not later than 3 days after the superintendent receives notice of the determination of the insolvency. The association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member insurer which is domiciled in this State at the same time that the complaint is filed with a court of competent jurisdiction; and [1987, c. 707, §9 (AMD).]

B. Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer. [1969, c. 561, (NEW).]

[1987, c. 707, §9 (AMD) .]

2. **Permission.** The superintendent may:

A. Require that the association notify the insureds of the insolvent insurer and any other interested parties of the order of liquidation with a finding of insolvency and of their rights under this subchapter. Such notifications must be by mail at their last known addresses, where available, but if required information for notification by mail is not available, notice by publication in a newspaper of general circulation in this State is sufficient. Any notification given under this paragraph must prominently display the date by which all claims must be filed with the association. [2001, c. 478, §10 (AMD); 2001, c. 478, §11 (AFF).]

B. Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. [1969, c. 561, (NEW).]

C. Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily. [1969, c. 561, (NEW).]

[2001, c. 478, §10 (AMD); 2001, c. 478, §11 (AFF) .]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD). 1987, c. 707, §9 (AMD). 2001, c. 478, §10 (AMD). 2001, c. 478, §11 (AFF).

§4442. EFFECT OF PAID CLAIMS

Any person recovering on a covered claim under this subchapter shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this subchapter shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payment of claims by the association shall not operate to reduce the liability of insureds to the receiver, liquidator or statutory successor for unpaid assessments. [1969, c. 561, (NEW).]

The receiver, liquidator or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this subchapter against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses. [1969, c. 561, (NEW).]

The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent insurer. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW).

§4443. NONDUPLICATION OF RECOVERY

1. **Insurance policy.** Any person having a claim against an insurer under any provision in an insurance policy, other than that of an insolvent insurer, which is also a covered claim, shall be required to exhaust first the person's right under the policy. Any amount otherwise payable on a covered claim under this subchapter shall be reduced by the amount of any recovery under the insurance policy.

[1987, c. 707, §10 (NEW) .]

2. **Governmental insurance.** Any person having a claim or legal right of recovery under any governmental insurance, which is also a covered claim, shall be required to exhaust first that person's right under that insurance. Any amount payable on a covered claim under this subchapter shall be reduced by the amount of any recovery under that insurance.

[1987, c. 707, §10 (NEW) .]

3. **Insurance guaranty association.** Any person having a claim which may be recovered from more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that, if it is a first party claim for damage to property with a permanent location, that person shall seek recovery first from the association of the location of the property, and, if it is a workers' compensation claim, that person shall seek recovery first from the association of the residence of the claimant. Any recovery under this subchapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

[1987, c. 707, §10 (NEW) .]

SECTION HISTORY
1969, c. 561, (NEW). 1987, c. 707, §10 (RPR).

§4444. PREVENTION OF INSOLVENCIES

To aid in the detection and prevention of insurer insolvencies: [1969, c. 561, (NEW).]

1. **Notification.** The board of directors, upon majority vote, shall notify the superintendent of any information indicating that any member insurer may be insolvent or in a financial condition hazardous to policyholders or the public.

[1973, c. 585, §12 (AMD) .]

2. **Examination.** The board of directors may, upon majority vote, request that the superintendent order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to policyholders or the public. Within 30 days of the receipt of such request, the superintendent shall begin such examination. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report, or any portion thereof, be released to the board of directors prior to its release to the public, but this shall not preclude the superintendent from complying with subsection 3. The superintendent shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the superintendent but shall not be open to public inspection prior to the release of the examination report, or part thereof to the public, in accordance with section 227.

[1973, c. 585, §12 (AMD) .]

3. **Report.** The superintendent shall report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to policyholders or the public.

[1973, c. 585, §12 (AMD) .]

4. **Recommendations.** The board of directors may, upon majority vote, make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents or be open to public inspection.

[1973, c. 585, §12 (AMD) .]

5. **Prevention.** The board of directors may, upon majority vote, make recommendations to the superintendent for the detection and prevention of insurer insolvencies.

[1973, c. 585, §12 (AMD) .]

6. **Report.** The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the superintendent.

[1987, c. 707, §11 (AMD) .]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD). 1985, c. 279, §7 (AMD). 1987, c. 707, §11 (AMD).

§4445. EXAMINATION OF THE ASSOCIATION

The association shall be subject to examination and regulation by the superintendent. The board of directors shall submit, not later than March 30th of each year, a financial report for the preceding calendar year in a form approved by the superintendent. [1973, c. 585, §12 (AMD).]

The association is also subject to audit, enforcement and monitoring by the Workers' Compensation Board with respect to workers' compensation claims as provided for in the Maine Workers' Compensation Act of 1992. Notwithstanding any other provision of law, the association is liable for the payment of any compensation, interest, penalty or other obligation determined to be due by the Workers' Compensation Board as provided for in the Maine Workers' Compensation Act of 1992. The Workers' Compensation Board may not assess the association penalties for the acts or omissions of insolvent insurers. [2005, c. 603, §2 (NEW).]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD). 2005, c. 603, §2 (AMD).

§4446. TAX EXEMPTION

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions except taxes levied on real or personal property. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW).

§4447. RECOGNITION OF ASSESSMENT IN RATES

The rates and premiums charged for insurance policies to which this subchapter applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer. [1969, c. 561, (NEW).]

SECTION HISTORY
1969, c. 561, (NEW).

§4448. IMMUNITY

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors, or the superintendent or his representatives for any action taken by them in the performance of their powers and duties under this subchapter. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD).

§4449. STAY OF PROCEEDINGS; REOPENING OF DEFAULT JUDGMENTS

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this State shall be stayed for 60 days from the date the insolvency is determined, and may be stayed by the Superior Court for additional time solely as is deemed necessary to permit proper defense by the association of all pending causes of action. The association shall provide to the superintendent a copy of any such request for stay and supporting documents filed with the court. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of such insured may apply to have such

judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits. [1985, c. 279, §8 (AMD).]

The liquidator, receiver or statutory successor of an insolvent insurer covered by this subchapter shall permit access by the board of directors, or its authorized representative, to those records of the insolvent insurer which are necessary for the board to carry out its functions under this subchapter with regard to covered claims. The liquidator, receiver or statutory successor shall provide the board or its representative with copies of these records upon request by the board and at the expense of the board. [1987, c. 707, §12 (NEW).]

This section does not authorize a stay of proceedings before the Workers' Compensation Board, or of proceedings in Superior Court to enforce orders of the Workers' Compensation Board. A stay of workers' compensation proceedings before the Workers' Compensation Board or the Superior Court may be granted if otherwise authorized by law, provided that good cause for a stay exists and that reasonable diligence was exhibited by the insurer, the employer, the association and their counsel to proceed with the proceeding prior to the insolvency. [1989, c. 67, §9 (NEW); 1991, c. 885, Pt. D, §2 (AMD).]

SECTION HISTORY
1969, c. 561, (NEW). 1985, c. 279, §8 (AMD). 1987, c. 707, §12 (NEW). 1987, c. 707, §12 (AMD). 1989, c. 67, §9 (AMD). 1991, c. 885, §D2 (AMD).

§4450. TERMINATION OF ASSOCIATION

The superintendent shall by order terminate the operation of the association as to any kind of insurance with respect to which he has found, after notice and hearing, that there is in effect a statutory plan of the United States Government to avoid excessive delay or financial loss to claimants or policyholders because of insurer insolvency and which provides for protection and benefits to residents of this State not materially less favorable than provided under this subchapter. Such order for termination shall continue the operation of this subchapter with respect to prior insurer insolvencies not covered by such plan. The order shall also provide for a proportionate distribution of the assets of the association to insurers which will cease to be members of the association on the effective date of the order. [1973, c. 585, §12 (AMD).]

SECTION HISTORY
1969, c. 561, (NEW). 1973, c. 585, §12 (AMD).

§4451. ADVERTISING RESTRICTIONS

Any person who makes, publishes or circulates, or causes to be made, published or circulated, any statement which uses the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance shall be deemed to have committed an unfair trade practice which is subject to a cease and desist order pursuant to section 2165 and to any applicable penalty provided by this Title. [1985, c. 279, §9 (NEW).]

SECTION HISTORY
1985, c. 279, §9 (NEW).

§4452. REPORT TO LEGISLATURE

At the end of each calendar year, the association shall submit a report of its activities to the joint standing committee of the Legislature having jurisdiction over banking and insurance matters. The report must include the amount of assessments made against each account, the name of the insolvent insurer to which the assessments are attributable and the amount of funds borrowed, if any, by the association and the repayment date of any loan. [1989, c. 751, §7 (NEW).]

SECTION HISTORY
1989, c. 751, §7 (NEW).

Chapter 59: INSURANCE OF PUBLIC EMPLOYEES AND PROPERTY

§4501. INSURANCE, ANNUITIES, PENSIONS FOR PUBLIC EMPLOYEES; PAYMENT OF PREMIUMS AND CHARGES

1. The State, any county, city or town may make contracts of insurance with any insurer authorized to transact such business within the State insuring its employees or any class or classes thereof under a policy or policies of group insurance covering life, health or accident insurance and may contract with any such insurer granting annuities or pensions for the pensioning of such employees and for such purposes may agree to pay part or all of the premiums or charges for carrying such contract, raise money by taxation therefor and appropriate out of its treasury money necessary to pay such premiums or charges or portions thereof.

[1969, c. 132, §1 (NEW) .]

2. Like authority to make contracts of insurance and appropriate out of its treasury, money necessary to pay such premiums or charges or portions thereof, is granted to any water district or other quasi-municipal corporation chartered and organized as such under the laws of this State. Any such water district or other quasi-municipal corporation may provide for the retirement and pensioning of its employees and for such purpose may create and set aside out of its treasury funds for a reserve or reserves, or it may contract with any insurer authorized to transact such business within the State and grant annuities for the retirement and pensioning of its employees, and for such purposes may agree to pay a part or all of the premiums or annual charges for carrying out such contracts or for creating such annuity reserves.

[1969, c. 132, §1 (NEW) .]

SECTION HISTORY
1969, c. 132, §1 (NEW).

§4502. TAX SHELTERED ANNUITIES FOR SCHOOL EMPLOYEES

1. In order to extend to the employees of any school administrative unit, school or educational institution located in the State and to certified employees of the Department of Education the benefits of tax sheltered annuities available under the Internal Revenue Code, it is declared to be the policy of the Legislature that any such school administrative unit, school, institution or the Department of Education may contract with any insurer authorized to contract such business within the State to provide one or more individual or group annuities for the pensioning of any employees of such unit, school, institution or Department of Education and for such purposes may agree to pay part or all of the premiums or charges for carrying such contracts, raise money by taxation therefor where otherwise lawful and appropriate out of its treasury money necessary to pay such premiums or charges or portions thereof.

[1989, c. 700, Pt. A, §99 (AMD) .]

2. It is the intent of the Legislature that employees of any school administrative unit, school, educational institution or Department of Education located in the State shall be extended the opportunity to share in the benefits of tax sheltered annuities and all laws and regulations of the State shall be construed liberally to enable such employees to come within the Internal Revenue Code, section 403(b) without loss to

themselves, or to the school administrative unit, school, educational institution or Department of Education to which they belong, of any benefits, subsidies or opportunities therefor that they might otherwise be entitled to under the laws of the State of Maine.

[1989, c. 700, Pt. A, §99 (AMD) .]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1971, c. 374, (AMD). 1973, c. 571, §57 (AMD). 1989, c. 700, §A99 (AMD).

Chapter 61: UNCLAIMED FUNDS OF LIFE INSURERS

§4551. DISPOSITION OF UNCLAIMED FUNDS

All unclaimed money held and owing by any life insurer doing business in this State must be disposed of according to Title 33, chapter 41. [2003, c. 20, Pt. T, §14 (AMD).]

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 707, §7 (RPR). 2003, c. 20, §T14 (AMD).

§4552. SCOPE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 707, §7 (RP).

§4553. DEFINITIONS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1977, c. 707, §7 (RP).

§4554. REPORTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1973, c. 625, §162 (AMD). 1977, c. 707, §7 (RP).

§4555. NOTICE OF UNCLAIMED FUNDS; PUBLICATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4556. PAYMENT TO SUPERINTENDENT

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4557. CUSTODY OF UNCLAIMED FUNDS IN STATE; INSURERS INDEMNIFIED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4558. REIMBURSEMENT FOR CLAIMS PAID BY INSURERS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4559. SPECIAL TRUST FUND; ADMINISTRATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4560. DETERMINATION AND REVIEW OF CLAIMS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4561. PAYMENT OF ALLOWED CLAIMS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4562. RECORDS REQUIRED

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 707, §7 (RP).

§4563. INAPPLICABILITY OF OTHER STATUTES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 625, §163 (AMD). 1977, c. 707, §7 (RP).

Chapter 62: MAINE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

§4601. SHORT TITLE

This chapter may be known and cited as the Maine Life and Health Insurance Guaranty Association Act. [2005, c. 346, §1 (AMD); 2005, c. 346, §16 (AFF).]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §1 (AMD). 2005, c. 346, §16 (AFF).

§4602. PURPOSE

The purpose of this chapter, subject to certain limitations, is to maintain public confidence in the promises of insurers by providing a mechanism for protecting policyholders, insureds, beneficiaries, annuitants, payees and assignees of life insurance policies, health insurance policies, annuity contracts and supplemental contracts against failure in the performance of fair and equitable contractual obligations due to the impairment or insolvency of the member insurer issuing these policies or contracts. To provide this protection: [2005, c. 346, §1 (AMD); 2005, c. 346, §16 (AFF).]

1. **Creation of association.** An association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages as limited by this chapter;

[2005, c. 346, §1 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Assessment of members.** Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter; and

[1983, c. 846, (NEW) .]

3. **Assistance to superintendent.** The association is authorized to assist the superintendent, in the prescribed manner, in the detection and prevention of insurer impairments and insolvencies.

[2005, c. 346, §1 (AMD); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §1 (AMD). 2005, c. 346, §16 (AFF).

§4603. SCOPE

1. **Application.** This chapter applies to direct nongroup life insurance policies, health insurance policies, annuity contracts and contracts supplemental to life and health insurance policies and annuity contracts and to certificates under direct group life insurance policies, health insurance policies and annuity contracts, except as limited by this chapter. For the purposes of this chapter, annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

[2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF) .]

1-A. **Persons covered.** This chapter provides coverage for the policies and contracts specified in subsection 1:

A. To any person, regardless of where the person resides, except for a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee or payee of a person covered under paragraph B; [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

B. To any person who owns, or is a certificate holder under, a policy or contract specified in subsection 1, other than a structured settlement annuity, who:

(1) Is a resident; or

(2) Is not a resident, if all the following conditions are met:

(a) The insurer that issued the policy or contract is domiciled in this State;

(b) The insurer never held a license or certificate of authority in the state in which the person resides;

(c) The state in which the person resides has an association similar to the Maine Life and Health Insurance Guaranty Association; and

(d) The person is not eligible for coverage by the association in that state; and [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

C. To any person who is a payee under a structured settlement annuity, or to a beneficiary or beneficiaries of a payee if the payee is deceased, if the payee:

(1) Is a resident, regardless of where the contract owner resides; or

(2) Is not a resident, if all of the conditions of either division (a) or (b) are met:

(a) The contract owner of the structured settlement annuity is a resident; or

(b) The contract owner of the structured settlement annuity is not a resident, but:

(i) The insurer that issued the structured settlement annuity is domiciled in this State;

(ii) The state in which the contract owner resides has an association similar to the association created by this chapter; and

(iii) The payee or beneficiary and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

This chapter does not provide coverage to a person who is a payee or beneficiary of a contract owner who is a resident of this State if the payee or beneficiary is afforded any coverage by a similar association of another state. [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

This chapter is intended to provide coverage to a person who is a resident, and, in special circumstances as provided by this section, to a person who is not a resident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, that person may not be provided coverage under this chapter. In determining the application of the provisions of this subsection in a situation in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary or assignee, this chapter must be construed in conjunction with other state laws to result in coverage by only one association.

[2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Exceptions.** This chapter does not apply to:

A. That portion of a policy or contract not guaranteed by an insurer; [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

B. Any policies or contracts, or any part of these policies or contracts, under which the risk is borne by the policyholder; [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

C. Any contract of reinsurance, other than reinsurance for which assumption certificates have been issued; [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

D. Any policy or contract issued by assessment mutuals and nonprofit hospital and medical service plans; [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

E. Any portion of a policy or contract to the extent that the rate of interest on which it is based, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(1) Averaged over a period of 4 years before the date on which the member insurer becomes an impaired insurer or becomes an insolvent insurer under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged over the same 4-year period or for a lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired insurer or becomes an insolvent insurer, whichever is earlier; and

(2) On or after the date on which the member insurer becomes an impaired insurer or becomes an insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available; [2005, c. 346, §2 (AMD); 2005, c. 346, §16 (AFF).]

F. Any portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:

(1) A multiple employer welfare arrangement as defined in 29 United States Code, Section 1144;

(2) A minimum premium group insurance plan;

(3) A stop loss group insurance plan; or

(4) An administrative-services-only contract; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

G. Any portion of a policy or contract to the extent that it provides for:

(1) Dividends or experience rating credits;

(2) Voting rights; or

(3) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

H. Any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this State; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

I. Any portion of a policy or contract to the extent that the assessments required by section 4609 with respect to the policy or contract are preempted by federal or state law; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

J. Any obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(1) Claims based on marketing materials;

(2) Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(3) Misrepresentations of or regarding policy benefits;

(4) Extra-contractual claims; or

(5) Claims for penalties or consequential or incidental damages; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

K. Any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, neither of which is an affiliate of the member insurer; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

L. Any unallocated annuity contract, except any annuity, whether allocated or unallocated, issued to a governmental retirement benefit plan established under the United States Internal Revenue Code, 26 United States Code, Section 401, 403(b) or 457; and [2009, c. 118, §1 (AMD); 2009, c. 118, §5 (AFF).]

M. Any portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or becomes an insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture. [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

[2009, c. 118, §1 (AMD); 2009, c. 118, §5 (AFF) .]

3. **Benefits; limitations of coverage.** The benefits that the association may become obligated to cover may not exceed the least of:

A. The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

B. With respect to one life, regardless of the number of policies or contracts:

(1) Three hundred thousand dollars in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(2) The following limits for health insurance benefits:

(a) Three hundred thousand dollars for coverages not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance, including any net cash surrender and net cash withdrawal values;

(b) Three hundred thousand dollars for disability and long-term care insurance; or

(c) Five hundred thousand dollars for basic hospital, medical and surgical insurance or major medical insurance; or

(3) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; [2009, c. 652, Pt. A, §34 (RPR).]

C. With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values; and [2009, c. 652, Pt. A, §35 (RPR).]

D. With respect to each individual participating in a governmental retirement benefit plan established under the United States Internal Revenue Code, 26 United States Code, Section 401, 403(b) or 457, or the beneficiaries of each individual if deceased, the financial interest of such participant allocated to an annuity contract by either the member insurer that issued the annuity or the plan, but not to exceed in

the aggregate $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values under all such annuities issued by the same member insurer. [2009, c. 118, §4 (NEW); 2009, c. 118, §5 (AFF).]

[2009, c. 652, Pt. A, §§34, 35 (AMD) .]

4. **Maximum obligation in benefits.** Notwithstanding subsection 3, the association is not in any event obligated to cover more than:

A. An aggregate of $300,000 in benefits with respect to any one life under subsection 3, paragraph B except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance under subsection 3, paragraph B, subparagraph (2), in which case the aggregate liability of the association may not exceed $500,000 with respect to any one individual; or [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

B. Five million dollars in benefits, regardless of the number of policies and contracts held by the owner, with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons. [2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF) .]

5. **Subrogation and assignment rights.** The limitations set forth in subsections 3 and 4 are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

[2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF) .]

6. **Material economic benefits; contractual obligations.** In performing its obligations to provide coverage under section 4608, the association is not required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

[2005, c. 346, §2 (NEW); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 1989, c. 751, §§8-10 (AMD). 2005, c. 346, §2 (AMD). 2005, c. 346, §16 (AFF). 2009, c. 77, §§1, 2 (AMD). 2009, c. 118, §§1-4 (AMD). 2009, c. 118, §5 (AFF). 2009, c. 652, Pt. A, §§34, 35 (AMD).

§4604. CONSTRUCTION

This chapter must be construed to effect the purpose under section 4602. [2005, c. 346, §3 (AMD); 2005, c. 346, §16 (AFF).]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §3 (AMD). 2005, c. 346, §16 (AFF).

§4605. DEFINITIONS

(REPEALED)

SECTION HISTORY
1983, c. 846, (NEW). 1989, c. 67, §§10,11 (AMD). 1989, c. 751, §11 (AMD). 2001, c. 44, §11 (AMD). 2001, c. 44, §14 (AFF). 2005, c. 346, §16 (AFF). 2005, c. 346, §4 (RP).

§4605-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

1. **Account.** "Account" means any one of the 3 accounts created under section 4606.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

2. **Association.** "Association" means the Maine Life and Health Insurance Guaranty Association created under section 4606.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

3. **Authorized assessment.** "Authorized assessment" or "authorized" when used in the context of assessments means that a resolution by the board of directors of the association has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount; an assessment is authorized when the resolution is passed.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

4. **Benefit plan.** "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

5. **Board of directors.** "Board of directors" means the board of directors of the association.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

6. **Called assessment.** "Called assessment" or "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice; an authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

7. **Contractual obligation.** "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under section 4603.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

8. **Covered policy.** "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under section 4603.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

9. **Extra-contractual claims.** "Extra-contractual claims" includes, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

10. **Impaired insurer.** "Impaired insurer" means a member insurer that, after the effective date of this section, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

11. **Insolvent insurer.** "Insolvent insurer" means a member insurer that, after the effective date of this section, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

12. **Member insurer.** "Member insurer" means an insurer that is licensed or that holds a certificate of authority to transact in this State any kind of insurance for which coverage is provided under section 4603 and includes an insurer whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

A. A hospital or medical service organization, whether profit or nonprofit; [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

B. A health maintenance organization; [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

C. A fraternal benefit society; [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

D. A mandatory state pooling plan; [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

E. A mutual assessment company or other person that operates on an assessment basis; [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

F. An insurance exchange; [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

G. An organization that has a certificate or license limited to the issuance of charitable gift annuities under this Title; or [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

H. An entity similar to any of those listed in this subsection. [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

13. **Moody's Corporate Bond Yield Average.** "Moody's Corporate Bond Yield Average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor to that index.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

14. **Owner.** "Owner" with respect to a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the

terms of the policy or contract and properly recorded as the owner on the books of the insurer. "Owner," "contract owner" and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

15. **Person.** "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

16. **Premiums.** "Premiums" means amounts or considerations by whatever name called received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under section 4603, except that assessable premiums may not be reduced on account of the provisions of section 4603 relating to interest limitations and relating to limitations with respect to one individual, one participant and one contract owner. "Premiums" does not include:

A. Premiums on an unallocated annuity contract; or [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

B. With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner. [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

17. **Principal place of business.** "Principal place of business" has the following meaning.

A. "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(1) The state in which the primary executive and administrative headquarters of the entity is located;

(2) The state in which the principal office of the chief executive officer of the entity is located;

(3) The state in which the board of directors of the entity or similar governing body of the entity conducts the majority of its meetings;

(4) The state in which the executive or management committee of the board of directors of the entity or similar governing body of the entity conducts the majority of its meetings;

(5) The state from which the management of the overall operations of the entity is directed; and

(6) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors listed in subparagraphs (1) to (5). However, in the case of a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, that state is deemed to be the principal place of business of the plan sponsor. [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

B. The principal place of business of a plan sponsor of a benefit plan is deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan, which, in lieu of a specific or clear designation

of a principal place of business, is deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question. [2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

18. **Receivership court.** "Receivership court" means the court in the impaired or insolvent insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

19. **Resident.** "Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this chapter are deemed residents of the state of domicile of the insurer that issued the policies or contracts.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

20. **Structured settlement annuity.** "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

21. **State.** "State" means a state, the District of Columbia, Puerto Rico or a United States possession, territory or protectorate.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

22. **Supplemental contract.** "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

23. **Unallocated annuity contract.** "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

[2005, c. 346, §5 (NEW); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
2005, c. 346, §5 (NEW). 2005, c. 346, §16 (AFF).

§4606. CREATION OF THE ASSOCIATION

1. **Creation.** There is created a nonprofit legal entity to be known as the Maine Life and Health Insurance Guaranty Association. All member insurers must be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under the plan of operation established and approved under section 4610 and shall exercise its powers through a board of directors established under section 4607. For purposes of administration and assessment, the association shall maintain 3 accounts:

A. The health insurance account; [1983, c. 846, (NEW).]

B. The life insurance account; and [1983, c. 846, (NEW).]

C. The annuity account, which must include annuity contracts owned by a governmental retirement plan or its trustee established under Section 401, Section 403(b) or Section 457 of the United States Internal Revenue Code. [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Supervision of association.** The association is under the immediate supervision of the superintendent and is subject to the applicable provisions of the insurance laws of this State. Meetings or records of the association may be open to the public upon majority vote of the board of directors of the association.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §6 (AMD). 2005, c. 346, §16 (AFF).

§4607. BOARD OF DIRECTORS

1. **Membership.** The board of directors of the association must consist of not less than 5 nor more than 9 members representing member insurers serving terms as established in the plan of operation pursuant to section 4610. The members of the board are selected by member insurers subject to the approval of the superintendent. Vacancies on the board must be filled for the remaining period of the term in the manner described in the plan of operation. To select the initial board of directors and initially organize the association, the superintendent shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer is entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the superintendent may appoint the initial members.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Appointments; representation of member insurers.** In approving selections or in appointing members to the board, the superintendent shall consider, among other things, whether all member insurers are fairly represented.

[1983, c. 846, (NEW) .]

3. **Reimbursement.** Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board may not otherwise be compensated by the association for their services.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §6 (AMD). 2005, c. 346, §16 (AFF).

§4608. POWERS AND DUTIES OF THE ASSOCIATION

In addition to the powers and duties enumerated in other sections of this chapter: [1983, c. 846, (NEW).]

1. **Impaired insurer; association action.** If a member insurer is an impaired insurer, the association may, subject to any fair and equitable conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the superintendent:

A. Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured all the covered policies of the impaired insurer; or [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

B. Provide such money, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph A and assure payment of the appropriate contractual obligations of the impaired insurer pending action under paragraph A. [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

C. [2005, c. 346, §16 (AFF); 2005, c. 346, §6 (RP).]

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Foreign or alien impaired insurer; association action prior to final order of liquidation, rehabilitation or conservation.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §6 (RP) .]

3. **Domestic impaired insurer under final order of liquidation or rehabilitation; association action.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §6 (RP) .]

3-A. **Impaired and insolvent insurer; association action.** If a member insurer is an insolvent insurer, the association may, in its discretion, either:

A. Take the following actions:

(1) Guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured the policies or contracts of the insolvent insurer, or assure payment of the contractual obligations of the insolvent insurer; and

(2) Provide money, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

B. Provide benefits and coverages in accordance with this paragraph.

(1) With respect to life and health insurance policies and annuities, the association shall assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(a) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts; and

(b) With respect to nongroup policies, contracts and annuities, not later than the earlier of the next renewal date if any under the policies or contracts and one year, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies or contracts.

(2) The association shall make diligent efforts to provide all known insureds or annuitants for nongroup policies and contracts, or group policy owners with respect to group policies and contracts, 30 days' notice of the termination of the benefits provided.

(3) With respect to nongroup life and health insurance policies and annuities covered by the association, the association shall make available to each known insured or annuitant, or owner if other than the insured or annuitant, and, with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (4), if the insureds or annuitants had a right under law or the terminated policy or

annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(4) In providing substitute coverage, the association may offer either to reissue the terminated coverage or to issue an alternative policy in accordance with the following:

(a) Alternative or reissued policies must be offered without requiring evidence of insurability and may not provide for any waiting period or exclusion that would not have applied under the terminated policy;

(b) The association may reinsure any alternative or reissued policy;

(c) Alternative policies adopted by the association are subject to the approval of the superintendent and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

(d) Alternative policies must contain at least the minimum statutory provisions required in this State and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it adopts. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy was last underwritten; and

(e) Any alternative policy issued by the association must provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(5) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium must be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the superintendent and the receivership court.

(6) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy must cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association.

(7) When proceeding under this paragraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 4603.

(8) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with the provisions of this chapter.

(9) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(10) The protection provided by this chapter does not apply when any guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

4. **Foreign or alien impaired insurer under final order of liquidation, rehabilitation or conservation; association action.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §6 (RP) .]

5. **Policy liens; contract liens; moratoriums on payments.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §6 (RP) .]

5-A. **Policy liens; contract liens; moratoriums on payments.** In carrying out its duties under subsection 3-A, the association may:

A. Subject to approval by a court in this State, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest; and [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

B. Subject to approval by a court in this State, impose temporary moratoriums or liens on payments of cash values and policy loans or on any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

6. **Association liability.** The association has no liability under this section for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides by statute for residents of this State protection substantially similar to that provided by this chapter for residents of other states.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

6-A. **Failure to act.** If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection 3-A, the superintendent has the powers and duties of the association under this chapter with respect to the insolvent insurer.

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

6-B. **Retention of deposit; final order of liquidation or rehabilitation plan.** A deposit in this State, held pursuant to law or required by the superintendent for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this State or in a reciprocal state, pursuant to this Title must be promptly paid to the association. The association is entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this State related to that insolvency and shall remit to the domiciliary receiver the amount so

paid to the association and not retained pursuant to this subsection. Any amount so paid to the association less the amount not retained by it must be treated as a distribution of estate assets pursuant to chapter 57 or similar provision of the state of domicile of the impaired or insolvent insurer.

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

7. **Assistance and advice to superintendent.** The association may render assistance and advice to the superintendent, upon the superintendent's request, concerning rehabilitation, payment of claims, continuations of coverage or the performance of other contractual obligations of any impaired or insolvent insurer.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

8. **Standing to appear before court.** The association has standing to appear or intervene before any court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise. This standing extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the covered policies or contracts and contractual obligations of the impaired or insolvent insurer and the determination of the covered policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

9. **Subrogation rights.** Any person receiving benefits under this chapter is deemed to have assigned that person's rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of these rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon that person. The association is subrogated to these rights against the assets of any impaired or insolvent insurer.

The subrogation rights of the association under this subsection must have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

In addition, the association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130 of the federal Internal Revenue Code.

If the provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or portion thereof covered by the association.

If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or portion thereof covered by the association.

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

10. **Association's contractual obligation; impaired insurer.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §6 (RP) .]

11. **Other powers.** The association may:

A. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter; [1983, c. 846, (NEW).]

B. Subject to the provisions of section 4617, sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 4609 or to settle claims or potential claims against it; [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

C. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets; [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

D. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this chapter; [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

E. Negotiate and contract with any liquidator, rehabilitator, conservator or ancillary receiver to carry out the powers and duties of the association; [1983, c. 846, (NEW).]

F. Take such legal action as may be necessary to avoid or recover payment of improper claims; [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

G. Exercise, for the purposes of this chapter and to the extent approved by the superintendent, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired insurer; [2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF).]

H. Organize itself as a corporation or in other legal form permitted by the laws of this State; [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

I. Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

J. Join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association; and [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

K. Take necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §6 (AMD); 2005, c. 346, §16 (AFF) .]

12. **Reinsurance of obligations; election by association.** At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of the member insurer that accrue on or after the coverage date and that relate to contracts covered in whole or in part by the association under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the

association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election is effected by a notice to the receiver, rehabilitator or liquidator and to the affected reinsurers. If the association makes an election, the following requirements apply with respect to the agreements selected by the association.

A. For contracts covered in whole or in part by the association, the association is responsible for all unpaid premiums due under the agreements for periods both before and after the coverage date and for the performance of all other obligations to be performed after the coverage date. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

B. The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association in whole or in part, except that, upon receipt of any such amounts, the association is obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of the amount received by the association over the benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent insurer applicable to the loss or event. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

C. Within 30 days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer or its receiver, rehabilitator or liquidator or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other within 5 days of the completion of the calculation. If the receiver, rehabilitator or liquidator has received any amounts due the association pursuant to paragraph B, the receiver, rehabilitator or liquidator shall remit them to the association as promptly as practicable. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

D. If the association, within 60 days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association in whole or in part, the reinsurer is not entitled to terminate the reinsurance agreements insofar as the agreements relate to contracts covered by the association in whole or in part and is not entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

E. In the event the association transfers its obligations to another insurer and if the association and the other insurer agree, the other insurer must succeed to the rights and obligations of the association under this chapter effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in this subsection, except that:

(1) The indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary; and

(2) The obligations described in this chapter no longer apply on and after the date the indemnity reinsurance agreement is transferred to the 3rd-party insurer.

This paragraph does not apply if the association has previously expressly determined in writing that it will not exercise the election. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

F. This subsection supersedes the provisions of any law of this State or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator or rehabilitator of an insolvent insurer. The receiver, rehabilitator or liquidator is entitled to any amounts payable by the

reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date subject to applicable set-off provisions. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

G. Except as otherwise expressly provided, this subsection does not alter or modify the terms and conditions of the indemnity reinsurance agreements of an insolvent insurer. This subsection may not be construed to abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. This subsection may not be construed to give a policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

13. **Discretion.** The board of directors of the association has discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner.

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

14. **No additional benefits.** When the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

15. **Venue.** Venue in a suit against the association arising under this chapter is Kennebec County. The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

16. **Issuance of substitute coverage.** In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with this subsection.

A. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract must provide for:

(1) A fixed interest rate;

(2) Payment or dividends with minimum guarantees; or

(3) A different method for calculating interest or changes in value. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

B. There may not be a requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

C. The alternative policy or contract must be substantially similar to the replaced policy or contract in all other material terms. [2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §6 (NEW); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §6 (AMD). 2005, c. 346, §16 (AFF).

§4609. ASSESSMENTS

1. **Assessments; collection.** For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers and accrue interest at 10% annually on and after the due date.

[2005, c. 346, §7 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Classes of assessments.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §7 (RP) .]

2-A. **Classes of assessments.** There are 2 classes of assessments, as set out in this subsection.

A. Class A assessments are authorized and called for the purpose of meeting administrative costs and other general expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer. [2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF).]

B. Class B assessments are authorized and called to the extent necessary to carry out the powers and duties of the association under section 4608 with regard to an impaired or an insolvent insurer. [2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF) .]

3. **Determination of assessments.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §7 (RP) .]

3-A. **Determination of assessments.** Assessments must be determined as follows:

A. The amount of any Class A assessment, as described in subsection 2-A, for each account must be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. The amount of any Class B assessment, as described in subsection 2-A, must be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board in its sole discretion as being fair and reasonable under the circumstances. This paragraph may not be a factor in the determination as to whether the protection provided by laws for residents of this State by the domiciliary jurisdiction of a foreign or alien insurer is or is not substantially similar to the protection provided by this chapter for residents of other states. [2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF).]

B. Class A assessments, as described in subsection 2-A, against member insurers for each account must be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the calendar year for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the calendar year for which information is available preceding the year in

which the insurer became impaired bears to premiums received on business in this State for the calendar year by all assessed member insurers. [2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF).]

C. Class B assessments, as described in subsection 2-A, against member insurers for each account must be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the calendar year for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the calendar year for which information is available preceding the year in which the insurer became impaired bears to premiums received on business in this State for the calendar year by all assessed member insurers. [2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF).]

D. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection 2-A and computation of assessments under this paragraph must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. [2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF) .]

4. **Abatement or deferral of assessments.** The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association. The total of all assessments upon a member insurer for each account may not in any one calendar year exceed 2% of the insurer's premiums in this State on the policies covered by the account.

[2005, c. 346, §7 (AMD); 2005, c. 346, §16 (AFF) .]

5. **Additional assessment for abatements or deferrals.** In the event an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in subsection 4, the amount by which the assessment is abated or deferred must be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

[2005, c. 346, §7 (AMD); 2005, c. 346, §16 (AFF) .]

6. **Refunds.** The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

[2005, c. 346, §7 (AMD); 2005, c. 346, §16 (AFF) .]

7. **Consideration of assessments in determining premium rates and dividends.** It is proper for any member insurer in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

[2005, c. 346, §7 (AMD); 2005, c. 346, §16 (AFF) .]

8. **Assessment shortfalls.** If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any one account an amount sufficient to make all necessary payments from that account, the shortfall must be assessed as an obligation of the other accounts of the association. Each member insurer's assessment must be in the proportion that its premium for the calendar year preceding the assessment on the kinds of insurance in the accounts to be assessed bears to the total premium of all member insurers for the same calendar year on the kinds of insurance in those accounts. The total of assessments against a member insurer for shortfalls under this section and section 4440 in any one calendar year may not exceed 2% of that member insurer's premiums in this State or for policies covered by the account.

[2005, c. 346, §7 (AMD); 2005, c. 346, §16 (AFF) .]

9. **Certificate of contribution.** The association shall issue to each insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the superintendent, for the amount of the assessment so paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue.

[2005, c. 346, §7 (NEW); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 1989, c. 67, §§12-15 (AMD). 1989, c. 751, §12 (AMD). 2005, c. 346, §7 (AMD). 2005, c. 346, §16 (AFF).

§4610. PLAN OF OPERATION

1. **Establishment of plan.** A plan of operation shall be established as follows.

A. The association shall submit to the superintendent a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the superintendent. [1983, c. 846, (NEW).]

B. If the association fails to submit a suitable plan of operation within 180 days following the effective date of this chapter or if at any time thereafter the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. These rules shall continue in force until modified by the superintendent or superseded by a plan submitted by the association and approved by the superintendent. [1983, c. 846, (NEW).]

[1983, c. 846, (NEW) .]

2. **Compliance.** All member insurers shall comply with the plan of operation.

[1983, c. 846, (NEW) .]

3. **Requirements of plan.** The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

A. Establish procedures for handling the assets of the association; [1983, c. 846, (NEW).]

B. Establish the amount and method of reimbursing members of the board of directors under section 4607; [1983, c. 846, (NEW).]

C. Establish regular places and times for meetings of the board of directors; [1983, c. 846, (NEW).]

D. Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors; [1983, c. 846, (NEW).]

E. Establish the procedures whereby selections for the board of directors will be made and submitted to the superintendent; [1983, c. 846, (NEW).]

F. Establish any additional procedures for assessments under section 4609; and [1983, c. 846, (NEW).]

G. Contain additional provisions necessary or proper for the execution of the powers and duties of the association. [1983, c. 846, (NEW).]

[1983, c. 846, (NEW) .]

4. **Delegation of association powers and duties.** The plan of operation may provide that any or all powers and duties of the association, except those under section 4608, subsection 11, paragraph C and section 4609, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in 2 or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this paragraph shall take effect only with the approval of both the board of directors and the superintendent and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this chapter.

[1983, c. 846, (NEW) .]

SECTION HISTORY
1983, c. 846, (NEW).

§4611. DUTIES AND POWERS OF THE SUPERINTENDENT

In addition to the duties and powers enumerated elsewhere in this chapter: [1983, c. 846, (NEW).]

1. **Powers and duties.** The superintendent shall:

A. Notify the board of directors of the existence of an impaired insurer not later than 3 days after a determination of impairment or insolvency is made or the superintendent has received the notice of impairment or insolvency; [2005, c. 346, §8 (AMD); 2005, c. 346, §16 (AFF).]

B. Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer; [1983, c. 846, (NEW).]

C. When an impairment is determined, as defined in section 4605-A, subsection 10, and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of its powers and duties under this chapter; and [2005, c. 346, §8 (AMD); 2005, c. 346, §16 (AFF).]

D. In any liquidation or rehabilitation proceeding involving a domestic insurer, the superintendent shall be appointed as the liquidator or rehabilitator, pursuant to chapter 57. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry other than this State, the superintendent may be appointed conservator or an ancillary receiver. [1983, c. 846, (NEW).]

[2005, c. 346, §8 (AMD); 2005, c. 346, §16 (AFF) .]

2. **Suspension or revocation of certificate of authority to transact insurance.** The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of

operation. In lieu of such suspension or revocation, any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation may be punished by a fine not to exceed the greater of 5% of the unpaid assessment per month or $100 per month.

[1983, c. 846, (NEW) .]

3. **Appeal of actions of board of directors or association.** Any final action of the board of directors or the association may be appealed to the superintendent by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the superintendent is subject to judicial review pursuant to chapter 3.

[2005, c. 346, §9 (AMD); 2005, c. 346, §16 (AFF) .]

4. **Notification of interested persons.** The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

[1983, c. 846, (NEW) .]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §§8,9 (AMD). 2005, c. 346, §16 (AFF).

§4612. PREVENTION OF IMPAIRMENTS

(REPEALED)

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §16 (AFF). 2005, c. 346, §10 (RP).

§4612-A. PREVENTION OF IMPAIRMENTS AND INSOLVENCIES

To aid in the detection and prevention of insurer impairments and insolvencies, the following provisions apply. [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

1. **Action by superintendent.** The superintendent shall:

A. Notify the insurance commissioners of all the other states, territories of the United States and the District of Columbia, within 30 days following the action taken or the date the action occurs, when the superintendent takes any of the following actions against a member insurer:

(1) Revokes a license;

(2) Suspends a license; or

(3) Makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business or increase capital, surplus or any other account for the security of policy owners or creditors. [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

B. Report to the board of directors when the superintendent has taken any of the actions set forth in paragraph A or has received a report from any other insurance commissioner indicating that any such action has been taken in another state. The report to the board of directors must contain all significant details of the action taken or the report received from another commissioner. [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

C. Report to the board of directors when the superintendent has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer. [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

D. Furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios. The board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein must be kept confidential by the board until such time as made public by the superintendent or other lawful authority. [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF) .]

2. **Advice and recommendations.** The superintendent may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the superintendent regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this State.

[2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF) .]

3. **Action by board of directors.** The board of directors, upon majority ballot vote, shall:

A. Notify the superintendent of any information indicating any member insurer may be an impaired or insolvent insurer; [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

B. Make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this State. These reports and recommendations must be treated as confidential by the superintendent; and [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

C. Make recommendations to the superintendent for the detection and prevention of insurer insolvencies. [2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §11 (NEW); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
2005, c. 346, §11 (NEW). 2005, c. 346, §16 (AFF).

§4613. APPOINTMENT OF ASSOCIATION NOMINEE

The association may recommend a natural person to serve as a special deputy to act for the superintendent and under his supervision in the liquidation, rehabilitation or conservation of any member insurer. [1983, c. 846, (NEW).]

SECTION HISTORY
1983, c. 846, (NEW).

§4614. MISCELLANEOUS PROVISIONS

1. **Liability for unpaid assessments of insureds of an impaired insurer.** Nothing in this chapter may be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with assessment liability.

[1983, c. 846, (NEW) .]

2. **Records.** Records must be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 4608. Records of the negotiations or meetings may be made public only upon the termination of

a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the association to render a report of its activities under section 4615.

[2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF) .]

3. **Association deemed to be creditor of impaired or insolvent insurer.** For the purpose of carrying out its obligations under this chapter, the association is deemed to be a creditor of the impaired insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 4608, subsection 9. All assets of the impaired insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired insurer as required by this chapter. Assets attributable to covered policies, as used in this subsection, are to be construed as that proportion of the assets that the reserves that should have been established for these policies bear to the reserve that should have been established for all policies of insurance written by the impaired insurer.

As creditors of the impaired or insolvent insurer, the association and other similar associations are entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association is entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

[2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF) .]

4. **Factors considered in distributing assets.** In distributing assets, the following factors must be considered.

A. Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the impaired or insolvent insurer and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired or insolvent insurer. In such a determination, consideration must be given to the welfare of the policy owners of the continuing or successor insurer. [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

B. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of assessments levied by the association with respect to the insurer have been fully recovered by the association. [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF) .]

5. **Unfair trade practice.**

[2005, c. 346, §16 (AFF); 2005, c. 346, §12 (RP) .]

6. **Recovery procedure; provisions.** The recovery procedure must provide that:

A. If an order for liquidation or rehabilitation of an insurer domiciled in this State has been entered, the receiver appointed under that order has a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs B to D; [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

B. No distribution may be recoverable if the insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations; [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

C. Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared is liable up to the amount of distributions the person would have received if they had been paid immediately. If 2 or more persons are liable with respect to the same distributions they are jointly and severally liable; [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

D. The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer on a fair and equitable basis; and [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

E. If any person liable under paragraph C is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

[2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §12 (AMD). 2005, c. 346, §16 (AFF).

§4615. EXAMINATION OF THE ASSOCIATION; ANNUAL REPORT

The association shall be subject to examination and regulation by the superintendent. The board of directors shall submit to the superintendent, not later than May 1st of each year, a financial report for the preceding calendar year in a form approved by the superintendent and a report of its activities during the preceding calendar year. [1983, c. 846, (NEW).]

SECTION HISTORY
1983, c. 846, (NEW).

§4616. TAX EXEMPTIONS

The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real or personal property. [1983, c. 846, (NEW).]

SECTION HISTORY
1983, c. 846, (NEW).

§4617. IMMUNITY

There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, the board of directors or any member of the board or the superintendent or the superintendent's representatives, for any act or omission by them in the performance of their powers and duties under this chapter. Immunity extends to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. [2005, c. 346, §12 (AMD); 2005, c. 346, §16 (AFF).]

SECTION HISTORY
1983, c. 846, (NEW). 2005, c. 346, §12 (AMD). 2005, c. 346, §16 (AFF).

§4618. STAY OF PROCEEDINGS; REOPENING DEFAULT JUDGMENTS

All proceedings in which the impaired insurer is a party in any court in this State shall be stayed 60 days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits. [1983, c. 846, (NEW).]

SECTION HISTORY
1983, c. 846, (NEW).

§4619. REPORT TO LEGISLATURE

(REPEALED)

SECTION HISTORY
1989, c. 751, §13 (NEW). 2005, c. 346, §16 (AFF). 2005, c. 346, §13 (RP).

§4620. PROHIBITED ADVERTISEMENT OF ASSOCIATION IN INSURANCE SALES

A person, including an insurer or an agent or affiliate of an insurer, may not make, publish, disseminate, circulate or place before the public or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public in any newspaper, magazine or publication or in the form of a notice, circular, pamphlet, letter or poster or over any radio station or television station or in any other way any advertisement, announcement or statement, written or oral, that uses the existence of the association for the purpose of sales, solicitation or inducement to purchases of any form of insurance covered by this chapter. This section does not apply to the Maine Life and Health Insurance Guaranty Association or any other entity that does not sell or solicit insurance. [2005, c. 346, §14 (NEW); 2005, c. 346, §16 (AFF).]

SECTION HISTORY
2005, c. 346, §14 (NEW). 2005, c. 346, §16 (AFF).

§4621. CREDITS FOR ASSESSMENTS PAID; TAX OFFSETS

1. **Credit allowed.** A member insurer may offset against its premium tax liability to this State an assessment described in section 4609, subsection 2-A, paragraph B and for which a certificate under section 4609, subsection 9 is issued, to the extent of 20% of the amount of the assessment for each of the 5 calendar years following the year in which the assessment was paid. In the event a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

[2005, c. 346, §14 (NEW); 2005, c. 346, §16 (AFF) .]

2. **Refunds.** Any sums that are acquired by refund, pursuant to section 4609, subsection 6, from the association by member insurers, and that have been offset against premium taxes as provided in subsection 1, must be recaptured in such manner as required by the State Tax Assessor under Title 36. The association shall notify the superintendent and the State Tax Assessor that refunds have been made. The association also shall provide the State Tax Assessor with a list of all members who were issued refunds and the dates and amounts of such refunds.

[2005, c. 346, §14 (NEW); 2005, c. 346, §16 (AFF) .]

3. **Application.** This section applies to assessments paid to the association by a member insurer on or after January 1, 2005.

[2005, c. 346, §14 (NEW); 2005, c. 346, §16 (AFF) .]

SECTION HISTORY
2005, c. 346, §14 (NEW). 2005, c. 346, §16 (AFF).

Chapter 63: ROAD OR TOURIST SERVICE

§4701. LICENSED COMPANIES ONLY

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §52 (RP).

§4702. LICENSES; FEE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 767, §22 (AMD). 1997, c. 457, §52 (RP).

§4703. AGENTS

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1997, c. 457, §52 (RP).

§4704. AGENT'S LICENSE; FEE

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1975, c. 767, §23 (AMD). 1997, c. 457, §52 (RP).

§4705. PETITION FOR REVOCATION

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1973, c. 585, §12 (AMD). 1977, c. 694, §439 (RPR). 1997, c. 457, §52 (RP).

§4706. PENALTIES

(REPEALED)

SECTION HISTORY
1969, c. 132, §1 (NEW). 1997, c. 457, §52 (RP).

Chapter 65: STRIKES OF INSURANCE AGENTS

§4751. LIFE, NONCANCELLABLE HEALTH, HOSPITAL EXPENSE AND HOSPITAL AND SURGICAL EXPENSE INSURANCE CONTRACTS; DEFAULT IN PAYMENT OF PREMIUM DURING STRIKE OF INSURANCE AGENTS

1. **Default.** No contract of life, noncancellable health, hospital expense or hospital and surgical expense, insurance which goes into effect in this State on or after the 30th day after January 2, 1970 shall lapse during any 30-day period immediately following the inception of a strike by reason of any default in the payment of any premium during a strike of insurance agents employed by an insurer authorized to transact business in this State, if

A. The collection of the contract premium was, at commencement of the strike, a duty, charge or obligation of any of such agents, according to the records, books, instructions, practice or organization of the insurer, and [1969, c. 374, (NEW).]

B. Such agents are represented for purposes of collective bargaining by a labor organization which has been so recognized or certified or has been a party to any collective bargaining agreement with the insurer. [1969, c. 374, (NEW).]

[1969, c. 374, (NEW) .]

2. **Definitions.** For the purpose of this section:

A. Lapse. "Lapse" shall mean lapse, be terminated or in any way modified or qualified as to the obligations of the insurer and the right of the insured. [1969, c. 374, (NEW).]

B. Premium. "Premium" shall mean premium, interest, assessment or any other payment or charge for or in connection with the insurance which would be due to the insurer under the insurance contract during the strike of agents, except for the operation of this section. [1969, c. 374, (NEW).]

C. Strike. "Strike" shall mean strike or other concerted stoppage of work by employees, including a stoppage by reason of the expiration of a collective bargaining agreement, so long as any of the foregoing is authorized by the labor organization according to the labor organization's own interpretation and application of its applicable internal rules and procedures. [1969, c. 374, (NEW).]

[1969, c. 374, (NEW) .]

3. **Claims.** If a claim under any insurance contract covered by this section arises during a 30-day period immediately following the inception of a strike, the insurer may deduct from any amounts payable on account of the claim any premiums which are thus in default.

[1969, c. 374, (NEW) .]

4. **Notice.** Within 10 days from the inception of a strike, notice of same containing instructions to make payment of premiums by mail shall be mailed to each affected insured by the insurer.

[1969, c. 374, (NEW) .]

SECTION HISTORY
1969, c. 374, (NEW).

Chapter 67: MEDICARE SUPPLEMENT INSURANCE POLICIES

§5001. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1981, c. 234, §4 (NEW).]

1. **Applicant.** "Applicant" means:

A. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and [1991, c. 740, §1 (AMD).]

B. In the case of a group Medicare supplement policy, the proposed certificate holder. [1991, c. 740, §1 (AMD).]

[1991, c. 740, §1 (AMD) .]

2. **Certificate.** "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

[1991, c. 740, §1 (AMD) .]

2-A. **Certificate form.** "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

[1991, c. 740, §1 (NEW) .]

2-B. **Issuer.** "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

[1991, c. 740, §1 (NEW) .]

3. **Medicare.** "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended.

[1991, c. 740, §1 (AMD) .]

4. **Medicare supplement policy.** "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan or health maintenance organization other than a policy issued pursuant to a contract under the federal Social Security Act, 42 United States Code, Section 1395, et seq. or Section 1876 or an issued policy under a demonstration project specified in the 42 United States Code, Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

A. [1991, c. 740, §1 (RP).]

B. [1991, c. 740, §1 (RP).]

C. [1991, c. 740, §1 (RP).]

[1995, c. 332, Pt. E, §1 (AMD) .]

4-A. **Policy form.** "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

[1991, c. 740, §1 (NEW) .]

4-B. **Open enrollment period.** "Open enrollment period" means the 6-month period beginning when an individual of any age first enrolls for benefits under Medicare Part B and the 6-month period beginning on the 65th birthday of an individual who has enrolled for benefits under Medicare Part B before turning 65 years of age.

[2001, c. 258, Pt. F, §1 (NEW) .]

5. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1981, c. 234, §4 (NEW) .]

SECTION HISTORY
1981, c. 234, §4 (NEW). 1991, c. 740, §1 (AMD). 1993, c. 154, §1 (AMD). 1995, c. 332, §E1 (AMD). 2001, c. 258, §F1 (AMD).

§5001-A. APPLICABILITY AND SCOPE

1. **Application.** Except as otherwise specifically provided in section 5013, this chapter applies to:

A. All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this section; and [1991, c. 740, §2 (NEW).]

B. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State. [1991, c. 740, §2 (NEW).]

[1995, c. 332, Pt. E, §2 (AMD) .]

2. **Employers or labor organizations.** This chapter does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

[1991, c. 740, §2 (NEW) .]

3. **Plans not marketed as Medicare supplements.** Except as otherwise provided in section 5005, subsection 3-A, the provisions of this chapter are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held to be Medicare supplement policies or benefit plans.

[1995, c. 332, Pt. E, §2 (AMD) .]

SECTION HISTORY
1991, c. 740, §2 (NEW). 1995, c. 332, §E2 (AMD).

§5002. STANDARDS FOR POLICY PROVISIONS

(REPEALED)

SECTION HISTORY
1981, c. 234, §4 (NEW). 1989, c. 27, §3 (AMD). 1991, c. 24, §1 (AMD). 1991, c. 48, §3 (AMD). 1991, c. 740, §3 (RP).

§5002-A. STANDARDS FOR POLICY PROVISIONS AND AUTHORITY TO ADOPT RULES

1. **Duplicate benefits.** A Medicare supplement policy or certificate in force in the State may not contain benefits that duplicate benefits provided by Medicare.

[1991, c. 740, §4 (NEW) .]

2. **Standardization.** The superintendent may adopt rules specifying the minimum Medicare supplement contract benefits required in the State and the new and innovative benefits available for sale in the State. All other benefits or options are prohibited in a Medicare supplement contract subject to this chapter.

[1993, c. 154, §2 (AMD) .]

3. **Preexisting conditions.** Notwithstanding any other provision of law of this State, a Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the medical condition involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

[1991, c. 740, §4 (NEW) .]

4. **Specific standards.** The superintendent shall adopt rules to establish specific standards for policy provisions of Medicare supplement policies and certificates. These standards must be in addition to and in accordance with applicable laws of this State. No requirement of the insurance laws relating to minimum required policy benefits, other than the minimum standards contained in this chapter, applies to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

A. Terms of renewability; [1991, c. 740, §4 (NEW).]

B. Initial and subsequent conditions of eligibility; [1991, c. 740, §4 (NEW).]

C. Nonduplication of coverage; [1991, c. 740, §4 (NEW).]

D. Probationary periods; [1991, c. 740, §4 (NEW).]

E. Benefit limitations, exceptions and reductions, which may not be more restrictive than those of Medicare for any type of care covered under the policy; [1991, c. 740, §4 (NEW).]

F. Elimination periods; [1991, c. 740, §4 (NEW).]

G. Requirements for replacement; [1991, c. 740, §4 (NEW).]

H. Recurrent conditions; and [1991, c. 740, §4 (NEW).]

I. Definitions of terms. [1991, c. 740, §4 (NEW).]

[1991, c. 740, §4 (NEW) .]

5. **Minimum standards for benefits, claims, marketing, compensation and reporting.** The superintendent shall adopt reasonable rules to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices for Medicare supplement policies and certificates.

[1991, c. 740, §4 (NEW) .]

6. **Other policies not prohibited.** Nothing in this section may be construed to prohibit the sale of insurance policies or contracts to persons eligible for Medicare by reason of age because those policies or contracts fail to meet the requirements of this chapter. Such policies may not be advertised, marketed or designed as Medicare supplement policies.

[1991, c. 740, §4 (NEW) .]

7. **Method of identification.** The superintendent shall prescribe the method of identification of Medicare supplement policies. The superintendent shall prescribe a method of identification of health insurance policies other than Medicare supplement policies or contracts that are advertised, marketed or designed for persons eligible for Medicare by reason of age. That method may include, but is not limited to, a requirement that such policies clearly indicate they are limited benefit health coverage policies and clearly specify that they do not meet the minimum standards for Medicare supplement policies.

[1991, c. 740, §4 (NEW) .]

8. **Conformance of policies to federal law.** The superintendent may adopt from time to time such reasonable rules as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and rules adopted pursuant to federal law, including but not limited to:

A. Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements; [1991, c. 740, §4 (NEW).]

B. Establishing a uniform methodology for calculating and reporting loss ratios; [1991, c. 740, §4 (NEW).]

C. Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance; [1991, c. 740, §4 (NEW).]

D. Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; [1991, c. 740, §4 (NEW).]

E. Establishing a policy for holding public hearings prior to approval of premium increases; and [1991, c. 740, §4 (NEW).]

F. Establishing standards for Medicare select policies and certificates. [1991, c. 740, §4 (NEW).]

[1991, c. 740, §4 (NEW) .]

9. **Prohibited policy provisions.** The superintendent may adopt reasonable rules that prohibit policy provisions not specifically authorized by statute that in the opinion of the superintendent are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

[1991, c. 740, §4 (NEW) .]

SECTION HISTORY
1991, c. 740, §4 (NEW). 1993, c. 154, §2 (AMD).

§5002-B. CONTINUITY OF COVERAGE

1. **Persons provided continuity of coverage.** This section provides continuity of coverage for a person who has a Medicare supplement policy and seeks coverage under a new Medicare supplement policy with the same or lesser benefits if:

A. That person, including a person entitled to Medicare benefits due to disability, has been covered under a policy that supplemented benefits under Medicare or has been covered under a Medicare Advantage plan with no gap in coverage greater than 90 days beginning with the person's open enrollment period. A policy supplementing benefits payable under Medicare may include an individual health policy, a group health plan, a Medicare supplement policy or other coverage issued by the same or a different carrier. [2009, c. 244, Pt. A, §1 (AMD).]

B. [2003, c. 157, §1 (RP).]

C. [2003, c. 157, §1 (RP).]

[2009, c. 244, Pt. A, §1 (AMD) .]

2. **Prohibition against discontinuity.** The insurer shall, for any person described in subsection 1, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under the prior Medicare supplement policy and any earlier Medicare supplement policy if those policies were still in effect. This subsection does not require the succeeding insurer to pay any benefits that are not within the terms of coverage of the succeeding policy solely because they would have been paid by the prior policy.

[2003, c. 157, §1 (AMD) .]

2-A. **Low-cost drugs for the elderly or disabled program.**

[2013, c. 94, §1 (RP) .]

3. **Determination of benefits.** When a determination of benefits under the prior policy is required, the issuer of the prior policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior policy are determined in accordance with the definitions, conditions and covered expense provisions of that policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.

[1999, c. 36, §4 (NEW) .]

4. **Rulemaking.** The superintendent shall adopt rules concerning guaranteed issuance and continuity of Medicare supplement policies for certain eligible persons. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 36, §4 (NEW) .]

SECTION HISTORY
1999, c. 36, §4 (NEW). 2001, c. 410, Pt. B, §7 (AMD). 2003, c. 157, §1 (AMD). 2005, c. 401, Pt. C, §7 (AMD). 2009, c. 244, Pt. A, §1 (AMD). 2013, c. 94, §1 (AMD).

§5003. MINIMUM STANDARDS FOR BENEFITS

(REPEALED)

SECTION HISTORY
1981, c. 234, §4 (NEW). 1989, c. 852, §1 (AMD). 1991, c. 740, §5 (RP).

§5004. LOSS RATIO STANDARDS

1. Any Medicare supplement policy or contract is subject to the minimum loss ratio standards of section 2413, subsection 1, paragraph F, as well as any other laws of this State as apply to rate filings with respect to health insurance and nonprofit hospital and medical service organizations and nonprofit health care plan contracts.

[1989, c. 27, §4 (NEW) .]

2. Medicare supplement policies must return to policyholders benefits that are reasonable in relation to the premium charged. The superintendent shall issue reasonable rules to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

[2001, c. 258, Pt. F, §2 (AMD) .]

3.

[1989, c. 852, §3 (AFF); 1989, c. 852, §2 (RP) .]

SECTION HISTORY
1981, c. 234, §4 (NEW). 1989, c. 27, §4 (RPR). 1989, c. 852, §§2,3 (AMD). 1991, c. 740, §6 (AMD). 2001, c. 258, §F2 (AMD).

§5005. DISCLOSURE STANDARDS

1. **Delivery of outline of coverage.** In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate may be delivered in this State, unless an outline of coverage is delivered to the applicant at the time application is made.

[1991, c. 740, §7 (AMD) .]

2. **Format; content or outline.** The superintendent shall prescribe the format and content of the outline of coverage required by subsection 1. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. The outline of coverage must include:

A. A description of the principal benefits and coverage provided in the policy; [1981, c. 234, §4 (NEW).]

B. [1991, c. 740, §7 (RP).]

C. A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and [1991, c. 740, §7 (AMD).]

D. A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions. [1981, c. 234, §4 (NEW).]

[1991, c. 740, §7 (AMD) .]

3. **Standard form; contents of informational brochure.** The superintendent may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the superintendent may

require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with the delivery of the outline of coverage. With respect to direct response insurance policies, the superintendent may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

[1991, c. 740, §7 (AMD) .]

3-A. **Captions or notice requirements.** The superintendent may adopt rules for captions or notice requirements determined to be in the public interest and designed to inform the prospective insureds that particular insurance coverages are not Medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for Medicare other than:

A. Medicare supplement policies; or [1995, c. 332, Pt. E, §3 (AMD).]

B. Disability income policies. [1995, c. 332, Pt. E, §3 (AMD).]

C. [1995, c. 332, Pt. E, §3 (RP).]

D. [1995, c. 332, Pt. E, §3 (RP).]

[1995, c. 332, Pt. E, §3 (AMD) .]

3-B. **Application forms; health statements.** Additional disclosure is required in applications or enrollment forms employed on or after January 1, 1993.

A. An issuer including health status questions in an application or enrollment form employed during an applicant's open enrollment period shall disclose that coverage in any plan offered by the issuer is guaranteed to be issued and will be provided without regard to health status. [1991, c. 740, §7 (NEW).]

B. An issuer including health status questions in an application or enrollment form shall disclose to applicants enrolling after their open enrollment period, including applicants replacing coverage, that enrollment in standard Medicare Supplement Plan A is guaranteed to be issued during the annual guaranteed issue period and will be provided without regard to health status. [1991, c. 740, §7 (NEW).]

C. Enrollment or application forms employed to effect the replacement of coverage provided by section 5010 must disclose that:

(1) For all persons, coverage in the standardized Medicare supplement plans that do not contain an outpatient prescription drug benefit is guaranteed to be issued and will be provided without regard to health status and without preexisting conditions exclusions, waiting periods, elimination periods or probationary periods for similar benefits to the extent time was spent under prior coverage; and

(2) For persons with existing prescription drug coverage, coverage in the standardized Medicare supplement plans that do not contain an outpatient prescription drug benefit greater than that provided by the plan that is in force is guaranteed to be issued and will be provided without regard to health status and without preexisting conditions exclusions, waiting periods, elimination periods or probationary periods for similar benefits to the extent time was spent under prior coverage. [1991, c. 740, §7 (NEW).]

D. [2001, c. 258, Pt. F, §3 (RP).]

[2001, c. 258, Pt. F, §3 (AMD) .]

4. **Rules.** The superintendent may adopt reasonable rules to govern the full and fair disclosure of information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

[1991, c. 740, §7 (AMD) .]

SECTION HISTORY
1981, c. 234, §4 (NEW). 1991, c. 740, §7 (AMD). 1995, c. 332, §E3 (AMD). 2001, c. 258, §F3 (AMD).

§5006. PREEXISTING CONDITIONS

(REPEALED)

SECTION HISTORY
1981, c. 234, §4 (NEW). 1991, c. 740, §8 (RP).

§5006-A. FILING REQUIREMENTS FOR ADVERTISING

Every issuer of Medicare supplement insurance policies or certificates in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State, whether through written, radio or television medium, to the superintendent for review or approval by the superintendent at least 30 days prior to the date the advertisement will be used in this State. [1991, c. 740, §9 (NEW).]

SECTION HISTORY
1991, c. 740, §9 (NEW).

§5007. NOTICE OF FREE EXAMINATION

Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached to the policy or certificate, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section must be paid directly to the applicant by the issuer in a timely manner. [1991, c. 740, §10 (AMD).]

SECTION HISTORY
1981, c. 605, (NEW). 1989, c. 27, §5 (AMD). 1991, c. 740, §10 (AMD).

§5008. MINIMUM STANDARDS FOR BENEFITS AND CLAIMS PAYMENT

(REPEALED)

SECTION HISTORY
1989, c. 27, §6 (NEW). 1991, c. 740, §11 (RP).

§5009. FILING REQUIREMENTS FOR ADVERTISING

(REPEALED)

SECTION HISTORY
1989, c. 27, §6 (NEW). 1991, c. 740, §12 (RP).

§5010. REPLACEMENT OF POLICIES ISSUED PRIOR TO JANUARY 1, 1992

1. **Applicability.** This section applies to individual policies and group certificates and policies issued in Maine or covering Maine residents.

[1991, c. 740, §13 (NEW) .]

2. **Insured's right to replace coverage.** Insureds under Medicare supplement policies issued prior to January 1, 1992 shall be permitted at any time to replace their coverage with any of the standardized plans offered by the same insurer, subject to the following conditions.

A. The issuer may decline to issue a particular standardized plan to an existing insured if:

(1) The standardized plan includes coverage of prescription drugs greater than that in the plan being replaced; and

(2) The insured does not otherwise qualify for the standardized plan. [1991, c. 740, §13 (NEW).]

B. If the standardized plan is rated on the basis of age at issue, the issuer shall use the insured's age at the time of issue of the prior policy. [1991, c. 740, §13 (NEW).]

C. The issuer shall provide at each policy anniversary, and at the time of any rate increase, a notice describing the standardized plans which are available and the rates for those plans. [1991, c. 740, §13 (NEW).]

[1993, c. 154, §3 (AMD) .]

3. **Mandatory replacement.** Prior to October 1, 1992, all issuers shall submit to the superintendent a copy of each Medicare supplement policy form for which policies issued prior to January 1, 1992 are in force in Maine and a list of standardized plans offered on the effective date of this section. The issuer shall designate the standardized plan, if any, that has substantially similar benefits to the policy issued prior to January 1, 1992. For any of the policies that the superintendent determines are substantially similar to one of the offered standardized plans, the issuer shall replace the policy with the similar standardized plan or, at the option of the insured, one of the other standardized plans selected by the insured pursuant to subsection 2, on or before the first policy anniversary after June 30, 1993.

[1993, c. 154, §3 (AMD) .]

SECTION HISTORY
1991, c. 740, §13 (NEW). 1993, c. 154, §3 (AMD).

§5010-A. COVERAGE OF THE DISABLED

An issuer offering coverage under a Medicare supplement policy in this State shall offer coverage under its standardized plans to all individuals, regardless of age, who are entitled to Medicare benefits due to disability. An issuer shall offer such coverage during an individual's open enrollment period under any of the policies offered by the issuer to persons eligible for Medicare benefits due to age. An issuer shall also offer standardized Medicare Supplement Plan A to persons entitled to Medicare benefits due to disability during the guaranteed issue period as set forth in section 5012. An individual who is entitled to Medicare benefits due to disability must be provided continuity of coverage in accordance with section 5002-B. Issuers shall give notice of Medicare supplement coverage to individuals enrolled in Medicare in advertising of Medicare supplement policies intended for use in this State. By January 1, 1994, the superintendent shall establish rules to ensure that the notice of the availability of coverage for the disabled is sufficiently advertised. [2003, c. 157, §2 (AMD).]

SECTION HISTORY

1993, c. 304, §1 (NEW). 1993, c. 547, §5 (AMD). 2003, c. 157, §2 (AMD).

§5011. RATING RESTRICTIONS

1. **Community rating.** This subsection applies to any policy delivered or issued for delivery on or after January 1, 1993. It also applies, as of the first policy or certificate anniversary on or after January 1, 1993, to policies or certificates delivered or issued for delivery in 1992.

A. Rates for policies subject to this subsection may not vary based on age, gender, health status, claims experience, policy duration, industry or occupation. [1991, c. 740, §13 (NEW).]

B. In revising rates for standardized plans, an issuer shall pool all experience for standardized plans under individual policies. Experience may be pooled separately for each standardized plan or experience for similar benefits in different standardized plans may be pooled, including, but not limited to, basing the component of the rate for skilled nursing coinsurance on the pooled experience of all standardized plans that include that benefit. Group plans may be rated separately. A group with credible experience may be rated differently than other groups. [2001, c. 258, Pt. F, §4 (AMD).]

C. An issuer that offers both group and individual plans may not use stricter medical underwriting standards for any group plan than it uses for individual plans. [2001, c. 258, Pt. F, §5 (NEW).]

D. An issuer may not use stricter medical underwriting standards than any affiliated issuer uses for its individual plans. [2001, c. 258, Pt. F, §5 (NEW).]

[2001, c. 258, Pt. F, §§4, 5 (AMD) .]

2. **Discounts.** Issuers that do not vary rates for a standardized plan based on age, gender, health status, claims experience, policy duration, industry or occupation, and that do not refuse issue of that plan to any individual or group based on health status, may provide discounts on that plan to individuals who purchase coverage during their initial period of enrollment in Medicare Part B at or after 65 years of age, subject to approval by the superintendent. The superintendent may adopt rules governing the appropriate use of discounts.

[2003, c. 428, Pt. H, §7 (AMD) .]

SECTION HISTORY
1991, c. 740, §13 (NEW). 2001, c. 258, §§F4,5 (AMD). 2003, c. 428, §H7 (AMD).

§5012. ANNUAL GUARANTEED ISSUE PERIOD

During a guaranteed issue period of at least one month each calendar year, as established by the issuer, every issuer shall offer standardized Medicare Supplement Plan A, as defined by rule, to all applicants on a basis that does not deny coverage to any individual or group based on health status, claims experience, receipt of health care, or medical condition. [1991, c. 740, §13 (NEW).]

SECTION HISTORY
1991, c. 740, §13 (NEW).

§5013. NOTICE REGARDING POLICIES THAT ARE NOT MEDICARE SUPPLEMENT POLICIES

Any individual accident and sickness insurance policy or group insurance certificate, including the contract of a nonprofit hospital and medical service or health care plan issued for delivery in this State to persons eligible for Medicare, must notify insureds that the policy or certificate is not a Medicare supplement

policy or certificate. The notice must be either printed on or attached to the first page of the outline of coverage delivered to insureds or, if no outline of coverage is delivered, to the first page of the policy or certificate. The notice must be in no less than 12-point type and must contain the following language:

> "THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. If you have a Medicare supplement policy or major medical policy, this coverage may be more than you need. For information call the Bureau of Insurance at (toll-free phone number)."

[1995, c. 570, §8 (AMD).]

This section does not apply to a Medicare supplement policy; a policy issued pursuant to a contract under the Federal Social Security Act, 42 United States Code, Section 1395, et seq., Section 1876; a disability income policy; or a policy identified in section 5001-A, subsection 2. [1995, c. 570, §8 (AMD).]

SECTION HISTORY
1991, c. 740, §13 (NEW). 1993, c. 154, §4 (AMD). 1995, c. 570, §8 (AMD).

§5014. ADDITIONAL PENALTIES

1. **Penalties.** In addition to any other applicable penalties for violations of this Title or Title 24, the superintendent may order issuers violating any provision of this chapter or any rule adopted pursuant to this chapter to:

A. Comply with the provisions of this chapter; or [1995, c. 570, §9 (NEW).]

B. Cease marketing any Medicare supplement policy or certificate in this State that is directly or indirectly related to a violation. [1995, c. 570, §9 (NEW).]

[1995, c. 570, §9 (NEW) .]

2. **Election of penalty options.** The superintendent may exercise any of the penalty options provided by this section, in combination or in sequence, as the superintendent considers appropriate.

[1995, c. 570, §9 (NEW) .]

SECTION HISTORY
1995, c. 570, §9 (NEW).

§5015. RIGHT TO REPURCHASE

(REPEALED)

SECTION HISTORY
1997, c. 370, §D1 (NEW). 1999, c. 36, §5 (RP).

§5016. NOTIFICATION PRIOR TO CANCELLATION; RESTRICTIONS ON LAPSE OR TERMINATION DUE TO COGNITIVE IMPAIRMENT OR FUNCTIONAL INCAPACITY

1. **Notice of cancellation.** An insurer that issues Medicare supplement policies shall provide notification to the insured person and another person, if designated by the insured, prior to cancellation of a Medicare supplement policy for nonpayment of premiums.

[2011, c. 123, §4 (NEW); 2011, c. 123, §5 (AFF) .]

2. **Right to reinstatement.** Within 90 days after cancellation, termination or lapse of coverage due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under the policy may request reinstatement of the policy on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity. An insurer may require a medical demonstration that the policyholder suffered from cognitive impairment or functional incapacity at the time of cancellation, termination or lapse. If the medical demonstration is waived or substantiates the existence of a cognitive impairment or functional incapacity at the time of policy cancellation to the satisfaction of the insurer, the policy must be reinstated. The medical demonstration may be at the expense of the policyholder.

A policy reinstated pursuant to this subsection must cover any loss or claim occurring from the date of the termination, cancellation or lapse and must be issued without any evidence of insurability. Within 15 days after request from an insurer, a policyholder of a policy reinstated pursuant to this subsection shall pay any unpaid premium from the date of the last premium payment at the rate that would have been in effect had the policy remained in force. If the premium is not paid as required, the policy may not be reinstated and the insurer is not responsible for claims incurred after the initial date of cancellation. If an insurer denies a request for reinstatement, the insurer shall notify the policyholder that the policyholder may request a hearing before the superintendent.

[2011, c. 123, §4 (NEW); 2011, c. 123, §5 (AFF) .]

3. **Rules.** The superintendent may adopt rules to implement the requirements of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The requirements of this section apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State.

[2011, c. 123, §4 (NEW); 2011, c. 123, §5 (AFF) .]

SECTION HISTORY
2011, c. 123, §4 (NEW). 2011, c. 123, §5 (AFF).

Chapter 68: NURSING HOME CARE AND LONG-TERM CARE INSURANCE POLICIES

§5051. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [1985, c. 648, §12 (NEW).]

1. **Long-term care policy.** "Long-term care policy" means a group or individual policy of health insurance, a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan or a life insurance rider which is advertised, marketed or designed primarily to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred basis, indemnity basis, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67; [1985, c. 648, §12 (NEW).]

B. A policy or contract issued prior to October 1, 1990, to one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations; [1989, c. 556, Pt. B, §1 (AMD).]

C. A policy or contract issued prior to October 1, 1990, to any professional, trade or occupational association for its members, former members or retired members or combination of all members, if the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; and [1989, c. 556, Pt. B, §1 (AMD).]

D. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when that group or individual policy or contract:

(1) Was issued prior to October 1, 1990; and

(2) Includes provisions which are inconsistent with the requirements of this chapter; and [1989, c. 556, Pt. B, §1 (RPR).]

E. A policy or contract offered primarily to provide basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection, accident-only coverage, specified disease or specified accident coverage, home health care coverage or limited benefit health coverage. [1997, c. 604, Pt. D, §1 (AMD).]

[1997, c. 604, Pt. D, §1 (AMD) .]

2. **Nursing home.** "Nursing home" means any facility located in this State which is licensed by the Department of Health and Human Services as a skilled nursing facility or intermediate care facility and any equivalent facility located in another state or country and licensed according to the laws of that jurisdiction.

[1985, c. 648, §12 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

3. **Nursing home care policy.** "Nursing home care policy" means a group or individual policy of health insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan which is advertised, marketed or designed primarily to provide benefits on either an expense-incurred or indemnity basis for confinements or costs associated with confinements of a covered person in a nursing home. For purposes of this definition, a policy is deemed to primarily provide nursing home benefits if 50% or more of benefits payable or anticipated to be payable under the policy are related to nursing home confinements. The term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67; [1985, c. 648, §12 (NEW).]

B. A policy or contract issued to one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations; [1985, c. 648, §12 (NEW).]

C. A policy or contract issued to any professional, trade or occupational association for its members, former members or retired members, or combination of members if, the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; or [1985, c. 648, §12 (NEW).]

D. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance, when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter. [1985, c. 648, §12 (NEW).]

[1985, c. 648, §12 (NEW) .]

3-A. **Home health care policy.** "Home health care policy" means a group or individual policy of health insurance or a subscriber contract of a nonprofit hospital or medical service organization or nonprofit health care plan that is advertised, marketed or designed primarily to provide benefits on either an expense-incurred or indemnity basis for confinements or costs associated with home health care services. For purposes of this definition, a policy is deemed to provide primarily home health care benefits if 50% or more of benefits payable or anticipated to be payable under the policy are related to home health care services. The term does not include:

A. A policy or contract defined as Medicare supplement insurance pursuant to chapter 67; [1997, c. 604, Pt. D, §2 (NEW).]

B. A policy or contract issued to one or more employers or labor organizations or to the trustees of a fund established by one or more employers or labor organizations, or combination of both, or for members or former members, or combination of both, of the labor organizations; [1997, c. 604, Pt. D, §2 (NEW).]

C. A policy or contract issued to any professional, trade or occupational association for its members, former members or retired members, or combination of members, if the association:

(1) Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of the policy or plan to its members; or [1997, c. 604, Pt. D, §2 (NEW).]

D. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance, when that group or individual policy or contract includes provisions that are inconsistent with the requirements of this chapter. [1997, c. 604, Pt. D, §2 (NEW).]

[1997, c. 604, Pt. D, §2 (NEW) .]

4. **Home health care provider.** "Home health care provider" has the same meaning as set forth in section 2745.

[1989, c. 556, Pt. B, §2 (NEW) .]

5. **Home health care services.** "Home health care services" has the same meaning as set forth in section 2745, subsections 1 and 2, except that the requirements of section 2745, subsection 1, paragraph A shall not apply.

[1989, c. 556, Pt. B, §2 (NEW) .]

SECTION HISTORY
1985, c. 648, §12 (NEW). 1989, c. 556, §§B1,B2 (AMD). 1997, c. 604, §§D1,2 (AMD). 2003, c. 689, §B6 (REV).

§5051-A. REQUIRED AND PROHIBITED PROVISIONS

1. **Prohibited provisions.** A long-term care policy may not:

A. Contain coverage for skilled nursing facilities only; [1989, c. 556, Pt. B, §3 (NEW).]

B. Exclude coverage for skilled, intermediate or custodial care received by a resident of a skilled nursing or intermediate care facility; [1989, c. 556, Pt. B, §3 (NEW).]

C. Require a prior hospital stay as a condition for any policy benefits; [1989, c. 556, Pt. B, §3 (NEW).]

D. Require a prior skilled nursing facility stay as a condition for intermediate care facility benefits; or [1989, c. 556, Pt. B, §3 (NEW).]

E. Require prior institutionalization as a condition of receipt of home health care benefits. [1989, c. 556, Pt. B, §3 (NEW).]

[1989, c. 556, Pt. B, §3 (NEW) .]

2. **Required provisions.** A long-term care policy must provide:

A. Custodial care benefits that are at least 50% of those provided for skilled nursing care in a nursing facility provided that the benefits need not exceed usual, customary and reasonable charges; [1989, c. 556, Pt. B, §3 (NEW).]

B. Benefits for home health care services rendered by a home health care provider; [1989, c. 556, Pt. B, §3 (NEW).]

C. Home health care coverage for at least 90 visits in any continuous 12-month period during which coverage is in force; and [1989, c. 556, Pt. B, §3 (NEW).]

D. Per visit benefits for home health care services which are at least 50% of the daily benefit for skilled nursing facility confinement provided that the benefit need not exceed usual, customary and reasonable charges. [1989, c. 556, Pt. B, §3 (NEW).]

[1989, c. 556, Pt. B, §3 (NEW) .]

SECTION HISTORY
1989, c. 556, §B3 (NEW).

§5051-B. ALTERNATIVE POLICIES

1. **Innovative long-term care products permitted.** Notwithstanding section 5051-A, an insurer, organization or plan may offer a long-term care policy, within the meaning of section 5051, subsection 1, which does not meet one or more of the requirements of section 5051-A if the Superintendent of Insurance finds that:

A. For each requirement of section 5051-A which is not satisfied, there is a valid reason why that requirement is inappropriate for the policy design in question; [1989, c. 556, Pt. B, §3 (NEW).]

B. The total package of benefits provided is at least as comprehensive as that required by section 5051-A; and [1989, c. 556, Pt. B, §3 (NEW).]

C. Availability of the policy would be in the best interest of the public taking into consideration the following factors:

(1) Whether the policy accomplishes the goal of providing dependable benefits for long-term care; and

(2) Whether the plans for marketing the policy contain adequate safeguards to minimize any confusion that may be caused to consumers by the failure of the policy to fall within the established guidelines of this section. [1989, c. 556, Pt. B, §3 (NEW).]

[1989, c. 556, Pt. B, §3 (NEW) .]

2. **Qualifications for tax incentives.** If the superintendent finds that a policy meets the criteria of subsection 1, the superintendent, in determining whether to certify the policy for tax incentives under section 5054, shall consider the policy to comply with each of the requirements of section 5051-A.

[1989, c. 556, Pt. B, §3 (NEW) .]

SECTION HISTORY
1989, c. 556, §B3 (NEW).

§5052. SPECIFIC STANDARDS

1. **Standards for long-term care, home health care and nursing home care policies.** The superintendent may adopt rules to establish specific standards for policy provisions of long-term care, home health care and nursing home care policies. The standards must be in addition to and in accordance with applicable laws of this State, including chapters 33 and 35, and may include, but are not limited to:

A. Terms of renewability; [1985, c. 648, §12 (NEW).]

B. Initial and subsequent conditions of eligibility; [1985, c. 648, §12 (NEW).]

C. Nonduplication of coverage; [1985, c. 648, §12 (NEW).]

D. Probationary periods; [1985, c. 648, §12 (NEW).]

E. Benefit limitations, exceptions and reductions; [1985, c. 648, §12 (NEW).]

F. Elimination periods; [1985, c. 648, §12 (NEW).]

G. Requirements for replacement; [1985, c. 648, §12 (NEW).]

H. Recurrent confinements; and [1985, c. 648, §12 (NEW).]

I. Definition of terms. [1985, c. 648, §12 (NEW).]

[1997, c. 604, Pt. D, §3 (AMD) .]

2. **Prohibited policy provision.** The superintendent may adopt rules that specify prohibited provisions not otherwise specifically authorized by law that, in the opinion of the superintendent, are unjust, unfair, inequitable or unfairly discriminatory to any person insured or proposed for coverage under a long-term care, home health care or nursing home care policy.

[1997, c. 604, Pt. D, §3 (AMD) .]

SECTION HISTORY
1985, c. 648, §12 (NEW). 1997, c. 604, §D3 (AMD).

§5052-A. TRIAL EXAMINATION PERIOD

Nursing home care, home health care and long-term care policies must have a notice prominently printed on the first page of the policy or certificate or attached to the first page stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if for any reason, after examination of the policy or certificate, the applicant is not satisfied. [1997, c. 604, Pt. D, §4 (AMD).]

SECTION HISTORY
1991, c. 200, §C1 (NEW). 1997, c. 604, §D4 (AMD).

§5053. RULEMAKING, DISCLOSURE STANDARDS, COMPENSATION

The superintendent may adopt reasonable rules to provide for the full and fair disclosure of information in connection with the sale of long-term care, home health care and nursing home care policies, including, but not limited to, an outline of coverage requirements and requirements relating to the replacement sale of the policies and compensation or commission to an agent or representative for the sale of a nursing home care, home health care or long-term care policy or certificate. [1997, c. 604, Pt. D, §5 (AMD).]

The superintendent may adopt reasonable rules setting or limiting the rate of compensation or commission to an agent or other representative for the sale of a nursing home care, home health care or long-term care policy or certificate and regarding replacement sale of a nursing home care, home health care or long-term care policy or certificate. [1997, c. 604, Pt. D, §5 (AMD).]

SECTION HISTORY
1985, c. 648, §12 (NEW). 1991, c. 200, §C2 (AMD). 1997, c. 604, §D5 (AMD).

§5054. CERTIFICATION BY SUPERINTENDENT

1. **Filing of form.** Any insurer, nonprofit hospital or medical service organization, or nonprofit health care plan may, at the time it files a policy or contract for approval for issuance or delivery in the State, or at any time thereafter, request that the superintendent certify the policy or contract as a long-term care policy within the meaning of section 5051.

Within 60 days of receipt of a request for certification, the superintendent shall:

A. Certify in writing that the policy or contract complies with this section; [1989, c. 556, Pt. B, §4 (NEW).]

B. Deny the request in writing, stating the reasons for denial; or [1989, c. 556, Pt. B, §4 (NEW).]

C. Notify the insurer or nonprofit hospital or medical service organization or nonprofit health care plan, in writing, that an insufficient basis exists for determining whether a certification should be made, indicating in what respects the request was insufficient. [1997, c. 604, Pt. D, §6 (AMD).]

[1997, c. 604, Pt. D, §6 (AMD) .]

2. **Standards for compliance.** The superintendent shall certify a policy or contract submitted for review under this section as a long-term care policy if the superintendent finds that the policy or contract:

A. Is a long-term care policy within the meaning of section 5051; and [1989, c. 556, Pt. B, §4 (NEW).]

B. Complies with all standards applicable to long-term care policies as set forth in this chapter and in chapters 27, 33 and 35 and in rules adopted pursuant to any of those chapters by the superintendent. Waivers granted under the rules shall be taken into consideration. [1989, c. 556, Pt. B, §4 (NEW).]

[1989, c. 556, Pt. B, §4 (NEW) .]

SECTION HISTORY
1989, c. 556, §B4 (NEW). 1997, c. 604, §D6 (AMD).

§5055. TAX INCENTIVES AVAILABLE

1. **Reduced premium tax.** Any insurance company choosing to offer an insurance policy which is certified by the superintendent as a long-term care policy shall qualify for the reduced tax on premiums collected under Title 36, section 2513.

[1989, c. 556, Pt. B, §4 (NEW) .]

2. **Income tax reduction.** Any person paying premiums for a policy or contract which is certified by the superintendent as a long-term care policy shall qualify for the income tax deduction provided for in Title 36, section 5122.

[1989, c. 556, Pt. B, §4 (NEW) .]

3. **Credit for employers.** An employer providing long-term care benefits to its employees may qualify for the tax credit provided by Title 36, section 2525 or 5217-B.

[1989, c. 556, Pt. B, §4 (NEW) .]

4. **Life insurance riders.** With respect to life insurance riders that qualify as long-term care policies, the tax incentives provided by this section shall apply only to that portion of the premium attributable to the rider.

[1989, c. 556, Pt. B, §4 (NEW) .]

5. **Provision of records.** Any person who holds a group long-term care policy pursuant to or under which premiums are paid in whole or in part by certificate holders or other 3rd parties shall provide to those certificate holders or 3rd parties adequate and timely records to enable those persons to have knowledge of the tax reduction to which they may be entitled under subsection 2 and under Title 36, section 5122.

[1989, c. 556, Pt. B, §4 (NEW) .]

SECTION HISTORY
1989, c. 556, §B4 (NEW).

§5056. STANDARDS FOR MARKETING

Every insurer, health care service plan or other entity marketing nursing home care, home health care or long-term care insurance coverage in this State, directly or through its producers, shall: [1997, c. 604, Pt. D, §7 (AMD).]

1. **Policy comparison.** Establish marketing procedures to ensure that any comparison of policies by its agents or other producers is fair and accurate;

[1991, c. 200, Pt. C, §3 (NEW) .]

2. **Excessive insurance.** Establish marketing procedures to ensure that excessive insurance is not sold or issued. The procedures must include a specific standard for persons covered by Medicaid;

[1991, c. 200, Pt. C, §3 (NEW) .]

3. **Replacement policy.** Establish marketing procedures that set forth a mechanism or formula for determining whether a replacement policy or certificate contains benefits clearly and substantially greater than the benefits under the replaced policy; and

[1991, c. 200, Pt. C, §3 (NEW) .]

4. **Compliance procedures.** Establish auditable procedures for verifying compliance with the standards set out in this section.

[1991, c. 200, Pt. C, §3 (NEW) .]

SECTION HISTORY
1991, c. 200, §C3 (NEW). 1997, c. 604, §D7 (AMD).

§5057. APPLICABILITY

This chapter applies only to policies and certificates issued before January 1, 2000. [1999, c. 292, §1 (NEW).]

SECTION HISTORY
1999, c. 292, §1 (NEW).

Chapter 68-A: LONG-TERM CARE INSURANCE

§5071. SCOPE

This chapter applies to long-term care insurance policies or certificates delivered or issued for delivery in this State on or after January 1, 2000, except it does not apply to certificates issued under policies issued in other states to employer groups as described in section 2804 and labor union groups as described in section 2805. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws to the extent that these laws are not inconsistent with the requirements of this chapter, except that laws and rules designed and intended to apply to Medicare supplement insurance may not be applied to long-term care insurance. Notwithstanding this chapter, any product advertised, marketed or offered as long-term care insurance is subject to this chapter. [1999, c. 292, §2 (NEW).]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5072. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1999, c. 292, §2 (NEW).]

1. **Applicant.** "Applicant" means:

A. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; or [1999, c. 292, §2 (NEW).]

B. In the case of a group long-term care insurance policy, the proposed certificate holder. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

2. **Certificate.** "Certificate" means any certificate issued under a group long-term care insurance policy.

[1999, c. 292, §2 (NEW) .]

3. **Group long-term care insurance policy.** "Group long-term care insurance policy" means a long-term care insurance policy that is delivered or issued for delivery in this State to an employer group, private purchasing alliance, labor union group, association group, trustee group, credit union group or other group as described in chapter 35.

[1999, c. 292, §2 (NEW) .]

4. **Long-term care insurance policy.** "Long-term care insurance policy" means any individual or group insurance policy or rider offered by a life or health insurer, fraternal benefit society, nonprofit hospital and medical service organization, nonprofit health care service organization, prepaid health plan organization, health maintenance organization or other similar organization authorized to issue life or health insurance that is advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred basis, indemnity basis, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. "Long-term care insurance policy" includes individual and group annuities and life insurance policies or riders that directly provide or that supplement coverage for long-term care insurance and a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. "Long-term care insurance policy" does not include:

A. An insurance policy or contract described as Medicare supplement insurance under chapter 67; [1999, c. 292, §2 (NEW).]

B. An insurance policy or contract offered primarily to provide basic hospital expense coverage, basic medical surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage; and [1999, c. 292, §2 (NEW).]

C. With regard to life insurance, an insurance policy or contract that accelerates the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and that provides the option of a lump sum payment for those benefits and does not condition the benefits or the eligibility for those benefits upon the receipt of long-term care. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5073. EXTRATERRITORIAL JURISDICTION; GROUP LONG-TERM CARE INSURANCE

1. **Groups other than employer, union, trustee and association groups.** A group long-term care insurance policy may not be offered to a resident of this State under a group policy issued in another state to a group other than an employer group as described in section 2804, a labor union group as described in section 2805, a trustee group as described in section 2806 or an association group as described in section 2805-A unless the superintendent has made a determination that the requirements of this chapter have been met.

[1999, c. 292, §2 (NEW) .]

2. **Trustee groups.** Group long-term care insurance may not be offered to an employee of an employer covered under a group policy issued in another state to a trustee group as described in section 2806 if a plurality of the employer's employees are based in this State unless the superintendent has made a determination that the requirements of this chapter have been met.

[1999, c. 292, §2 (NEW) .]

3. **Association groups.** The following applies to group long-term care insurance coverage issued to association groups.

A. Group long-term care insurance coverage may not be offered to a resident of this State under a group policy issued in another state to an association group as described in section 2805-A, other than an association of employers, unless the superintendent has made a determination that the requirements of this chapter have been met. [1999, c. 292, §2 (NEW).]

B. Group long-term care insurance may not be offered to an employee of an employer covered under a group policy issued in another state to an association of employers if a plurality of the employer's employees are based in this State unless the superintendent has made a determination that the requirements of this chapter have been met. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5074. DISCLOSURE STANDARDS FOR LONG-TERM CARE INSURANCE

The following standards apply to disclosures relating to long-term care insurance. [1999, c. 292, §2 (NEW).]

1. **Disclosures.** The superintendent may adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies and certificates; terms of renewability; initial and subsequent conditions of eligibility; nonduplication of coverage provisions; coverage of dependents; preexisting conditions; termination of insurance; continuation or conversion; probationary periods; limitations, exceptions and reductions; elimination periods; requirements for replacement; recurrent conditions; and definitions of terms. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 292, §2 (NEW) .]

2. **Outline of coverage.** An outline of coverage must be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose. In the case of producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form. In the case of a policy issued to an employer group as described in section 2804, a labor union group as described in section 2805 or a trustee group as described in section 2806, an outline of coverage is not required to be provided if the information described in this subsection is contained in other materials relating to enrollment that have been filed with and approved by the superintendent. The outline of coverage must be in a standard format, including style, arrangement, overall appearance and content, prescribed by the superintendent and must include the following information:

A. A description of the principal benefits and coverage provided in the policy or certificate; [1999, c. 292, §2 (NEW).]

B. A statement of the principal exclusions, reductions and limitations contained in the policy or certificate; [1999, c. 292, §2 (NEW).]

C. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage must be specifically described; [1999, c. 292, §2 (NEW).]

D. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions; [1999, c. 292, §2 (NEW).]

E. A description of the terms under which the policy or certificate may be returned and premium refunded; [1999, c. 292, §2 (NEW).]

F. A statement as to whether the policy or certificate is intended to be qualified for purposes of federal and state individual income taxes; and [1999, c. 292, §2 (NEW).]

G. A brief description of the relationship of cost of care and benefits. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

3. **Qualification for purposes of federal and state individual income taxes.** The face page of all long-term care insurance policies and certificates must contain a prominent statement as to whether the policy or certificate is intended to be qualified for purposes of federal and state individual income taxes.

[1999, c. 292, §2 (NEW) .]

4. **Individual life insurance policy that provides long-term care benefits.** At the time of policy or certificate delivery, a policy summary must be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request but, regardless of a request, the insurer shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary also must include:

A. An explanation of how the long-term care benefits interact with other components of the policy, including deductions from death benefits; [1999, c. 292, §2 (NEW).]

B. An illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person; [1999, c. 292, §2 (NEW).]

C. Any exclusions, reductions and limitations on benefits of long-term care; [1999, c. 292, §2 (NEW).]

D. A statement indicating whether any long-term care inflation protection option required by law is available under this policy; and [1999, c. 292, §2 (NEW).]

E. If applicable to the policy or certificate type, the summary must also include:

(1) A disclosure of the effects of exercising other rights under the policy;

(2) A disclosure of guarantees related to long-term care costs of insurance charges; and

(3) Current and projected maximum lifetime benefits. [1999, c. 292, §2 (NEW).]

The provisions of the policy or certificate summary listed in this subsection may be incorporated into a basic illustration required to be delivered in accordance with the life insurance policy summary that is required to be delivered in accordance with this Title governing life insurance policy summaries or with comparable statutory requirements in any other state.

[1999, c. 292, §2 (NEW) .]

5. **Certificates of group long-term care insurance.** A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this State must include:

A. A description of the principal benefits and coverage provided in the policy; [1999, c. 292, §2 (NEW).]

B. A statement of the principal exclusions, reductions and limitations contained in the policy; and [1999, c. 292, §2 (NEW).]

C. A statement that the group master policy determines governing contractual provisions and that the policy is available for viewing in the offices of the policyholder and will be copied for the certificate holder upon request at no cost. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5075. REQUIRED PROVISIONS; PROHIBITIONS; LOSS RATIO STANDARDS FOR LONG-TERM CARE INSURANCE

1. **Prohibitions.** A long-term care insurance policy or certificate may not:

A. Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual; [1999, c. 292, §2 (NEW).]

B. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or [1999, c. 292, §2 (NEW).]

C. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than for lower levels of care. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

2. **Preexisting condition.** A long-term care insurance policy or certificate must provide coverage for preexisting conditions in accordance with the following.

A. A policy or certificate may not define "preexisting condition" in a manner that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person. [1999, c. 292, §2 (NEW).]

B. A policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person. [1999, c. 292, §2 (NEW).]

C. The definition of "preexisting condition" in paragraph A does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph B expires. A long-term care insurance policy or certificate may not exclude, or use waivers or riders of any kind to exclude, limit or reduce, coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph B. [1999, c. 292, §2 (NEW).]

D. The superintendent may extend the limitation periods set forth in paragraphs A and B with regard to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

3. **Prior hospitalization or institutionalization.** A long-term care insurance policy or certificate that contains provisions regarding prior hospitalization or institutionalization must comply with the following requirements.

A. A long-term care insurance policy or certificate may not be delivered or issued for delivery in this State if the policy:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement;

(2) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(3) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement. [1999, c. 292, §2 (NEW).]

B. A long-term care insurance policy or certificate containing post-confinement, post-acute care or recuperative benefits must clearly label such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits." [1999, c. 292, §2 (NEW).]

C. A long-term care insurance policy, certificate or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days. [1999, c. 292, §2 (NEW).]

D. The superintendent may adopt rules further restricting the use of prior institutionalization requirements. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

4. **Free-look provision.** Applicants for long-term care insurance have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A long-term care insurance policy or certificate must have a notice prominently printed on the first page or attached to the policy or certificate stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

[1999, c. 292, §2 (NEW) .]

5. **Benefit payment status report on long-term care benefits.** Any time a long-term care benefit that is funded through a life insurance policy or certificate by the acceleration of the death benefit is in benefit payment status, a monthly report must be provided to the policyholder or certificate holder. The report must include:

A. Any long-term care benefits paid out during the month; [1999, c. 292, §2 (NEW).]

B. An explanation of any changes in the policy, including changes in death benefits or cash values, due to long-term care benefits being paid out; and [1999, c. 292, §2 (NEW).]

C. The amount of long-term care benefits existing or remaining. [1999, c. 292, §2 (NEW).]

[1999, c. 292, §2 (NEW) .]

6. **Loss ratios.** The superintendent may adopt rules establishing loss ratio standards for long-term care insurance policies if a specific reference to long-term care insurance policies or certificates is contained in the rules. Any loss ratio standards for employer groups as described in section 2804 and labor union groups as described in section 2805 apply to the group policy and not to certificates. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 292, §2 (NEW) .]

7. **Marketing as long-term care or nursing home insurance.** This chapter applies to any policy, certificate or rider advertised, marketed or offered as long-term care or nursing home insurance.

[1999, c. 292, §2 (NEW) .]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5075-A. CERTIFICATION BY SUPERINTENDENT

1. **Filing of form.** An insurer, nonprofit hospital or medical service organization or nonprofit health care plan may request, at the time it files a policy or contract for approval for issuance or delivery in the State or at any time thereafter, that the superintendent certify the policy or contract as a long-term care insurance policy.

[2001, c. 679, §1 (NEW); 2001, c. 679, §6 (AFF) .]

2. **Determination.** Within 60 days after receipt of a request for certification, the superintendent shall in writing:

A. Certify that the policy or contract complies with this section; [2001, c. 679, §1 (NEW); 2001, c. 679, §6 (AFF).]

B. Deny the request and state the reasons for the denial; or [2001, c. 679, §1 (NEW); 2001, c. 679, §6 (AFF).]

C. Notify the insurer, nonprofit hospital or medical service organization or nonprofit health care plan that an insufficient basis exists for determining whether a certification should be made and indicate the nature of the insufficiency. [2001, c. 679, §1 (NEW); 2001, c. 679, §6 (AFF).]

[2001, c. 679, §1 (NEW); 2001, c. 679, §6 (AFF) .]

3. **Standards for compliance.** The superintendent shall certify a policy or contract submitted for review under this section as a long-term care insurance policy if the superintendent finds that the policy or contract complies with all the standards applicable to long-term care policies set forth in this chapter and in chapters 27, 33 and 35 and rules adopted pursuant to those chapters by the superintendent. Waivers granted under the rules must be taken into consideration.

[2001, c. 679, §1 (NEW); 2001, c. 679, §6 (AFF) .]

SECTION HISTORY
2001, c. 679, §1 (NEW). 2001, c. 679, §6 (AFF).

§5076. INCONTESTABILITY PERIOD

1. **Policies or certificates in effect for less than 6 months.** For a policy or certificate that has been in effect for less than 6 months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that was material to the acceptance for coverage.

[1999, c. 292, §2 (NEW) .]

2. **Policies or certificates in effect for more than 6 months but less than 2 years.** For a policy or certificate that has been in effect for at least 6 months but less than 2 years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that was both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.

[1999, c. 292, §2 (NEW) .]

3. **Policies or certificates in effect for 2 years or more.** After a policy or certificate has been in effect for at least 2 years, the policy or certificate may not be contested upon the grounds of misrepresentation alone. The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

[1999, c. 292, §2 (NEW) .]

4. **Field-issued policies or certificates.** A long-term care insurance policy or certificate may not be field-issued if the compensation to the field issuer is based on the number of policies or certificates issued. For the purposes of this subsection, "field-issued" means a policy or certificate issued by a producer or a 3rd-party administrator pursuant to the underwriting authority granted to the producer or 3rd-party administrator by an insurer using the insurer's underwriting guidelines.

[2007, c. 232, §1 (AMD) .]

5. **Recovery of benefit payments by the insurer.** If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer if the policy or certificate is rescinded.

[1999, c. 292, §2 (NEW) .]

6. **Death of the insured.** Upon the death of the insured, this section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care and the remaining death benefits under these policies are governed by sections 2507 and 2615 relating to the incontestability requirements for individual and group life insurance. In all other events, this section applies to life insurance policies that accelerate benefits for long-term care.

[1999, c. 292, §2 (NEW) .]

SECTION HISTORY
1999, c. 292, §2 (NEW). 2007, c. 232, §1 (AMD).

§5077. NONFORFEITURE BENEFITS

1. **Offer required.** Except as provided in subsection 2, a long-term care insurance policy or certificate may not be delivered or issued for delivery in this State unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be made available for a specified period of time following a substantial increase in premium rates.

[1999, c. 292, §2 (NEW) .]

2. **Group policyholders.** When a group long-term care insurance policy is issued, the offer required in subsection 1 must be made to the group policyholder. If the group long-term care insurance policy is issued to a group described in section 2808 other than to a continuing care retirement community or other similar entity, the offer must be made to each proposed certificate holder.

[1999, c. 292, §2 (NEW) .]

3. **Rules.** The superintendent shall adopt rules specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits and the standards regarding contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse is available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection 1. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[1999, c. 292, §2 (NEW) .]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5078. RULEMAKING

The superintendent shall adopt rules to promote premium adequacy, to protect a policyholder and a certificate holder in the event of substantial rate increases and to establish minimum standards for marketing practices, insurance producer compensation, insurance producer education, insurance producer testing, penalties and reporting practices for long-term care insurance. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2007, c. 232, §2 (AMD).]

SECTION HISTORY
1999, c. 292, §2 (NEW). 2007, c. 232, §2 (AMD).

§5079. PENALTIES

In addition to any other penalties provided by this Title or the laws of this State, an insurer or insurance producer that violates any requirement of this chapter or rule adopted pursuant to this chapter relating to the regulation of long-term care insurance or the marketing of such insurance is subject to a fine of up to the greater of 3 times the amount of commissions paid for each policy involved in the violation or $10,000. [1999, c. 292, §2 (NEW).]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5080. APPLICABILITY

This chapter applies to long-term care policies and certificates issued or delivered in this State on or after January 1, 2000. Policies and certificates issued prior to January 1, 2000 and remaining in effect on that date are subject to the requirements of chapter 68. Those policies and any certificates issued pursuant to those policies prior to January 1, 2000 continue in effect subsequent to the enactment of this chapter. [1999, c. 292, §2 (NEW).]

All certificates of coverage issued or delivered to residents of this State after January 1, 2000 must meet the requirements of this chapter and any rules adopted pursuant to this chapter, except that long-term care policies or certificates issued pursuant to a provision included in a policy approved in accordance with chapter 68 giving a policyholder or certificate holder a right to purchase or increase coverage at a later date may be issued with benefits consistent with chapter 68 after January 1, 2000. [1999, c. 292, §2 (NEW).]

SECTION HISTORY
1999, c. 292, §2 (NEW).

§5081. PRODUCER TRAINING REQUIREMENTS

1. **Training required.** An individual may not sell, solicit or negotiate long-term care insurance unless:

A. The individual is licensed as a life or health insurance producer; [2007, c. 232, §3 (NEW).]

B. The individual has completed a one-time training course that is no less than 8 hours in length; and [2007, c. 232, §3 (NEW).]

C. The individual completes ongoing training of no less than 4 hours every 24 months thereafter. [2007, c. 232, §3 (NEW).]

An individual licensed as a life or health insurance provider and who is actively selling, soliciting or negotiating long-term care insurance as of the effective date of this section must complete a one-time training course by July 1, 2008 and ongoing training every 24 months thereafter in order to continue selling, soliciting or negotiating long-term care insurance.

The training required by this subsection must meet the requirements set forth in subsection 2. The training requirements of subsection 2 may be approved as continuing education courses under chapter 16, subchapter 7.

[2007, c. 232, §3 (NEW) .]

2. **Content of training.** The one-time training required by this section must consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to:

A. State and federal regulations and requirements and the relationship between the Long-term Care Partnership Program established in Title 22, section 3174-GG and other public and private coverage of long-term care services, including Medicaid; [2007, c. 232, §3 (NEW).]

B. Available long-term care services and providers; [2007, c. 232, §3 (NEW).]

C. Changes or improvements in long-term care services or providers; [2007, c. 232, §3 (NEW).]

D. Alternatives to the purchase of private long-term care insurance; [2007, c. 232, §3 (NEW).]

E. The effect of inflation on benefits and the importance of inflation protection; and [2007, c. 232, §3 (NEW).]

F. Consumer suitability standards and guidelines. [2007, c. 232, §3 (NEW).]

The training required by this section may not include training that is specific to an insurer or company product or that includes any sales or marketing information, materials or training other than that required by state or federal law.

[2007, c. 232, §3 (NEW) .]

3. **Verification.** An insurer shall:

A. Obtain verification that a producer has received training required by this section before the producer may sell, solicit or negotiate the insurer's long-term care insurance products; [2007, c. 232, §3 (NEW).]

B. Maintain records of the verification under paragraph A for at least 3 years; and [2007, c. 232, §3 (NEW).]

C. Make verification records available to the superintendent upon request. [2007, c. 232, §3 (NEW).]

[2007, c. 232, §3 (NEW) .]

4. **Records.** An insurer shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the superintendent to provide assurance to the Department of Health and Human Services that producers have received the training required by this section and that its producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State. The records must be maintained for a period of at least 3 years after each producer has received the training required by this section and must be made available to the superintendent upon request.

[2007, c. 232, §3 (NEW) .]

5. **Reciprocity.** The satisfaction of training requirements in this section in another state is considered to satisfy the training requirements in this section.

[2007, c. 232, §3 (NEW) .]

SECTION HISTORY
2007, c. 232, §3 (NEW).

§5082. LONG-TERM CARE PARTNERSHIP PROGRAM; AVAILABILITY OF QUALIFIED POLICIES

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

A. "Eligible policyholder" means:

(1) An individual who holds a qualified individual policy issued before or during the notice period by an insurer that actively markets individual partnership policies in this State on or after the effective date of this section and is not receiving benefits or in a waiting period to receive benefits; or

(2) An employer or other group policyholder that holds a qualified group policy issued before or during the notice period by an insurer that actively markets group partnership policies in this State on or after the effective date of this section. [2011, c. 198, §1 (NEW).]

B. "Long-term Care Partnership Program" means the Long-term Care Partnership Program established in Title 22, section 3174-GG. [2011, c. 198, §1 (NEW).]

C. "Notice period" means the period between July 1, 2004 and the date an insurer begins actively marketing partnership policies in this State. [2011, c. 198, §1 (NEW).]

D. "Partnership policy" means a long-term care insurance policy with an effective date of July 1, 2009 or later that is offered with the intent to meet the requirements of the Long-term Care Partnership Program. [2011, c. 198, §1 (NEW).]

E. "Qualified policy" means a long-term care insurance policy that is offered with the intent to meet the requirements of 26 United States Code, Section 7702B(b). [2011, c. 198, §1 (NEW).]

[2011, c. 198, §1 (NEW) .]

2. **Notice.** The following provisions apply to an insurer that actively markets a partnership policy in this State on or after the effective date of this section. With respect to an employer group, an insurer shall provide any notice required under this section to the employer that is the policyholder of a qualified policy.

A. An insurer that actively markets partnership policies in this State as of the effective date of this section shall provide notice to an eligible policyholder that purchased a qualified policy during the notice period that the policyholder may be able to participate in the Long-term Care Partnership Program. The insurer shall initiate the exchange process in accordance with subsection 4 within 12 months of the effective date of this section. [2011, c. 198, §1 (NEW).]

B. An insurer that begins to actively market partnership policies in this State after the effective date of this section shall provide notice to an eligible policyholder that purchased a qualified policy during the notice period that the policyholder may be able to participate in the Long-term Care Partnership Program. The insurer shall initiate the exchange process in accordance with subsection 4 within 12 months of the date the insurer begins to market partnership policies in this State. [2011, c. 198, §1 (NEW).]

[2011, c. 198, §1 (NEW) .]

3. **Request for review.** In addition to the requirements of subsection 2, at the request of an eligible policyholder of a qualified policy issued prior to the notice period, an insurer that actively markets partnership policies in this State shall review the qualified policy to identify whether the qualified policy meets the requirements of the Long-term Care Partnership Program and take an action described in subsection 4, paragraph A or B. If a request for review under this subsection is made more than 12 months after the effective date of this section, the insurer has no obligation to review the policy.

[2011, c. 198, §1 (NEW) .]

4. **Exchange process.** An insurer that actively markets partnership policies in this State shall identify those qualified policies issued during the notice period that currently meet all the requirements of the Long-term Care Partnership Program as specified in Bureau of Insurance Bulletin 368 dated January 22, 2010 for use with the Long-term Care Partnership Program and those that do not meet all of the requirements and:

A. For those qualified policies that currently meet all of the requirements, issue to each policyholder the Important Notice Regarding Your Policy's Long-term Care Insurance Partnership Status, as prescribed in the Appendix of Bureau of Insurance Bulletin 368 dated January 22, 2010, along with a policy amendment reflecting the effective date of the partnership status; and [2011, c. 198, §1 (NEW).]

B. For those qualified policies that do not meet all of the requirements, notify each policyholder that the policy may be eligible for an exchange to a partnership policy. The insurer shall also notify the policyholder that the exchange is subject to underwriting and that the premium for the new policy is based on the policyholder's attained age on the date of the exchange. The policyholder has 60 days from the date of the notice to consider this offer. If the policyholder accepts the offer after 60 days, the insurer is not obligated to process an exchange. If the policyholder requests additional coverage, the additional coverage is also subject to underwriting and the premium for the additional coverage must be based on the policyholder's attained age on the date the changes take effect. [2011, c. 198, §1 (NEW).]

[2011, c. 198, §1 (NEW) .]

5. **Individual policyholder no longer receiving benefits.** If an individual policyholder is not an eligible policyholder because the policyholder is receiving benefits or is in a waiting period to receive benefits, that individual policyholder has 12 months from the expiration of any waiting period after which the policyholder does not begin to receive benefits or from the expiration of any period when benefits have ended to request a review by an insurer as otherwise provided under subsection 3.

[2011, c. 198, §1 (NEW) .]

6. **Applicability.** If an insurer does not actively market both individual and group partnership policies in this State, this section applies to that insurer only with respect to the particular market in which the insurer actively markets partnership policies.

[2011, c. 198, §1 (NEW) .]

SECTION HISTORY
2011, c. 198, §1 (NEW).

§5083. PAYMENT OF CLAIMS

1. **Notice of claim for benefits; response by insured.** Notwithstanding any other provision of this Title, upon receipt of a notice of claim for benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State, an insurer, whether actively marketing or renewing long-term care insurance in this State, shall provide the insured a written statement with sufficient detail to permit the

insured to understand and respond with the documentation specified in subsection 2. The written statement must be provided by the insurer within 10 business days following receipt of the notice of claim. For purposes of this section, "insured" includes a person designated by the insured as the insured's representative.

[2013, c. 278, §2 (NEW) .]

2. **Documentation.** The documentation an insurer may require of an insured for the payment of a claim for benefits under a policy or certificate of long-term care insurance includes, but is not limited to:

A. A statement from the insured making the claim for benefits; [2013, c. 278, §2 (NEW).]

B. A signed release permitting the insurer to obtain personal health care information about the insured pursuant to the federal Health Insurance Portability and Accountability Act of 1996; [2013, c. 278, §2 (NEW).]

C. A statement from the insured's physician, including the appropriate diagnosis and a treatment and care plan for the insured; [2013, c. 278, §2 (NEW).]

D. A statement from the long-term care provider rendering services to the insured, including an itemized bill for services, the provider's license number and any daily nursing notes; and [2013, c. 278, §2 (NEW).]

E. A copy of any power of attorney executed by the insured. [2013, c. 278, §2 (NEW).]

Except for information solely in the possession of the insured, the burden is on the insurer to obtain any information other than that described in paragraphs A to E that is reasonably necessary to pay or continue paying the claim. The insured has a continuing obligation to cooperate with the insurer in order for the insurer to obtain needed information.

[2013, c. 278, §2 (NEW) .]

3. **Payment of claim.** A claim for payment of benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State is payable within 30 days after the documentation and information identified in subsection 2 as reasonably necessary to pay the claim for benefits have been received by the insurer. Within 30 days after receipt of that documentation and information, the insurer shall either pay the claim or issue a written notice to the insured declining to pay all or part of the claim and the specific reason for denial in accordance with this subsection.

A. An insurer may not extend the time for payment of a claim beyond 30 days after receipt of documentation and information related to a technical issue as designated in rules adopted by the bureau. [2013, c. 278, §2 (NEW).]

B. Except as provided in paragraph A, an insurer may delay payment of a claim and request additional documentation and information related to a substantive issue as designated in rules adopted by the bureau. [2013, c. 278, §2 (NEW).]

[2013, c. 278, §2 (NEW) .]

4. **Ongoing claim.** Except for information solely in the possession of the insured, if, during the course of an ongoing claim for benefits paid on a monthly or recurring basis, the insurer identifies the need for additional reasonable documentation to ensure the insured remains entitled to benefits under the policy or certificate of long-term care insurance, the burden is on the insurer to obtain that information. The insured has a continuing obligation to cooperate with the insurer in order for the insurer to obtain needed information.

[2013, c. 278, §2 (NEW) .]

5. **Appeals of claims denials.** An insured who receives a claims denial in accordance with this section has the right to internal appeal and, after exhausting an insurer's internal appeals process, the right to request an external review. The superintendent shall adopt rules to determine the standards for internal appeal

and external review in a manner consistent with model legislation adopted by the National Association of Insurance Commissioners, or its successor organization. The written notice to the insured declining to pay all or part of the claim as required by subsection 3 must include a statement informing the insured of the insured's rights to internal appeal and external review and a statement of the insured's right to seek assistance or file a complaint with the bureau and the toll-free telephone number of the bureau.

[2013, c. 278, §2 (NEW) .]

6. **Interest on overdue claim.** An undisputed claim that is not paid within 30 days is overdue. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date.

[2013, c. 278, §2 (NEW) .]

7. **Attorney's fees.** Reasonable attorney's fees for advising and representing a claimant on an overdue claim or action for an overdue claim must be paid by the insurer if overdue benefits are recovered in an action against the insurer or if overdue benefits are paid after receipt of notice of the attorney's representation.

[2013, c. 278, §2 (NEW) .]

8. **No limitation on action by insured.** This section does not prohibit or limit any claim or action for a claim that the insured has against the insurer.

[2013, c. 278, §2 (NEW) .]

9. **Rules.** The superintendent may adopt or amend rules in order to carry out the purposes of this section. Rules adopted pursuant to this section, including amendments to existing rules designated as major substantive, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 278, §2 (NEW) .]

SECTION HISTORY
2013, c. 278, §2 (NEW).

Chapter 69: MAINE PRODUCT LIABILITY RISK RETENTION ACT

§6001. SHORT TITLE

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6002. DEFINITIONS

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6003. RISK RETENTION GROUPS ORGANIZED IN THIS STATE

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6004. RISK RETENTION GROUPS NOT CHARTERED IN THIS STATE

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6005. AGENTS AND BROKERS

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6006. TAXES

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6007. RESTRICTIONS

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6008. EXEMPTION FROM COMPULSORY ASSOCIATIONS

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6009. EXAMINATION FOR FINANCIAL IMPAIRMENT

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6010. DELINQUENCY PROCEEDINGS

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6011. PENALTIES

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

§6012. RULES

(REPEALED)

SECTION HISTORY
1985, c. 524, §5 (NEW). 1987, c. 481, §2 (RP).

Chapter 71: MAINE HIGH-RISK INSURANCE ORGANIZATION

§6051. DEFINITIONS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1989, c. 308, §1 (AMD). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6052. CREATION OF THE ORGANIZATION AND BOARD OF DIRECTORS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1989, c. 308, §2 (AMD). 1991, c. 528, §Q5 (AMD). 1991, c. 528, §RRR (AFF). 1991, c. 578, §1 (AMD). 1991, c. 591, §Q5 (AMD). 1991, c. 837, §§A51,52 (AMD). 1991, c. 837, §A85 (AFF). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6053. DUTIES OF THE BOARD OF DIRECTORS; REPORTING REQUIREMENTS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1991, c. 578, §2 (AMD). 1991, c. 837, §§A53-55 (AMD). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6054. THE AUTHORITY OF THE ORGANIZATION

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6055. PROGRAM ADMINISTRATOR

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1989, c. 308, §3 (AMD). 1991, c. 578, §3 (AMD). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6056. ASSESSMENTS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). RR 1993, c. 1, §68 (COR). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6057. ELIGIBILITY

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1989, c. 308, §4 (AMD). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6058. BENEFITS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1989, c. 875, §H1 (AMD). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6058-A. EMPLOYER RESPONSIBILITIES

(REPEALED)

SECTION HISTORY
1991, c. 877, §1 (NEW). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6059. PREMIUMS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1991, c. 578, §4 (AMD). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6059-A. COMMUNITY RATING

(REPEALED)

SECTION HISTORY
1991, c. 578, §5 (NEW). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6060. DUTY OF HEALTH INSURANCE AGENTS AND BROKERS OR INSURERS

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1993, c. 410, §R4 (AFF). 1993, c. 410, §R3 (RP).

§6061. SUNSET PROVISION

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1989, c. 875, §H2 (AMD). 1991, c. 837, §A56 (RP).

Chapter 72: SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

§6071. COMMISSION ESTABLISHED

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1991, c. 622, §L10 (RP).

§6072. MEMBERSHIP; APPOINTMENT; DUTIES

(REPEALED)

SECTION HISTORY
1987, c. 542, §§H5,H8 (NEW). 1991, c. 622, §L10 (RP).

Chapter 72-A: MAINE LIABILITY RISK RETENTION ACT

§6091. SHORT TITLE

This chapter shall be known and may be cited as the Maine Liability Risk Retention Act. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6092. PURPOSE

The purpose of this Act is to regulate the formation and operation of risk retention groups and purchasing groups in this State formed pursuant to the provisions of the Risk Retention Amendments of 1986, United States Code, Title 15, Section 3901, et seq., to the extent permitted by that law. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6093. DEFINITIONS

As used in this Act, unless the context indicates otherwise, the following terms have the following meanings. [1987, c. 481, §3 (NEW).]

1. **Completed operations liability.** "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:

A. Any person who performs that work; or [1987, c. 481, §3 (NEW).]

B. Any person who hires an independent contractor to perform that work, but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

2. **Domicile.** "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

A. For a corporation, the state in which the purchasing group is incorporated; and [1987, c. 481, §3 (NEW).]

B. For an unincorporated entity, the state of its principal place of business. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

3. **Hazardous financial condition.** "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

A. To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or [1987, c. 481, §3 (NEW).]

B. To pay other obligations in the normal course of business. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

4. **Impairment.** "Impairment," as to a risk retention group, exists when:

A. If a stock corporation, the sum of the group's liabilities and paid-in capital stock exceeds its assets; [1987, c. 481, §3 (NEW).]

B. If a mutual company, the sum of its liabilities and required minimum basic surplus exceeds its assets; and [1987, c. 481, §3 (NEW).]

C. If other than a stock or mutual company, the sum of liabilities and any fund balance equal to the amount of basic surplus required of a mutual company exceeds its assets. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

5. **Insurance.** "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this State.

[1987, c. 481, §3 (NEW) .]

6. **Liability.** "Liability" means:

A. Legal liability for damages, including costs of defense, legal costs and fees and other claims expenses, because of injuries to other persons, damage to their property or other damage or loss to such other persons resulting from or arising out of:

(1) Any business, whether profit or nonprofit, trade, product, services, including professional services, premises or operations; or

(2) Any activity of any state or local government or any agency or political subdivision of state or local government; and [1987, c. 481, §3 (NEW).]

B. Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act, United States Code, Title 45, Section 51, et seq. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

7. **Personal risk liability.** "Personal risk liability" means liability for damages because of injury to any person, damage to property or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in subsection 6.

[1987, c. 481, §3 (NEW) .]

8. **Plan of operation or feasibility study.** "Plan of operation or feasibility study" means an analysis which presents the expected activities and results of a risk retention group, including, at a minimum:

A. Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which the members are exposed by virtue of any related, similar or consumer business, trade, product, services, premises or operation; [1987, c. 481, §3 (NEW).]

B. The coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer; [1987, c. 481, §3 (NEW).]

C. Historical and expected loss experience, to the extent available, of the proposed members and national experience of similar exposures; [1987, c. 481, §3 (NEW).]

D. Pro forma financial statements and projections; [1987, c. 481, §3 (NEW).]

E. Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition; [1987, c. 481, §3 (NEW).]

F. Identification of management, underwriting and claim procedures, marketing methods, managerial oversight methods and investment policies; and [1987, c. 481, §3 (NEW).]

G. Such other matters as may be prescribed by the superintendent for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

9. **Product liability.** "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage, including damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

[1987, c. 481, §3 (NEW) .]

10. **Product Liability Risk Retention Act of 1981.** "Product Liability Risk Retention Act of 1981" means the United States Public Law 97-45, the United States Code, Title 15, Section 3901, et seq.

[1987, c. 481, §3 (NEW) .]

11. **Purchasing group.** "Purchasing group" means any group which:

A. Has, as one of its purposes, the purchase of liability insurance on a group basis; [1987, c. 481, §3 (NEW).]

B. Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in paragraph C; [1987, c. 481, §3 (NEW).]

C. Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and [1987, c. 481, §3 (NEW).]

D. Is domiciled in any state. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

12. **Risk Retention Amendments of 1986.** "Risk Retention Amendments of 1986" means United States Public Law 99-563, United States Code, Title 15, Section 3901, et seq.

[2009, c. 2, §71 (COR) .]

13. **Risk retention group.** "Risk retention group" means any corporation or other limited liability association:

A. Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members; [1987, c. 481, §3 (NEW).]

B. Which is organized for the primary purpose of conducting the activity described under paragraph A; [1987, c. 481, §3 (NEW).]

C. Which:

(1) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(2) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance superintendent of at least one state, which certification was accepted, that it satisfied the capitalization requirements of that state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the Product Liability Risk Retention Act of 1981, before the date of the enactment of the Risk Retention Amendments of 1986; [1987, c. 481, §3 (NEW).]

D. Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person; [1987, c. 481, §3 (NEW).]

E. Which:

(1) Has, as its owners, only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

(2) Has, as its sole owner, an organization which:

(a) Has as its members only persons who comprise the membership of the risk retention group; and

(b) Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such groups; [1987, c. 481, §3 (NEW).]

F. Whose members are engaged in businesses or activities similar or related, with respect to the liability of which those members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; [1987, c. 481, §3 (NEW).]

G. Whose activities do not include the provision of insurance other than:

(1) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(2) Reinsurance with respect to the liability of any other risk retention group, or any members of such other group, which is engaged in businesses or activities so that this group or member meets the requirement described in paragraph F for membership in the risk retention group which provides that reinsurance; and [1987, c. 481, §3 (NEW).]

H. The name of which includes the phrase "Risk Retention Group." [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

14. **State.** "State" means any state of the United States or the District of Columbia.

[1987, c. 481, §3 (NEW) .]

15. **Superintendent.** "Superintendent" means the Superintendent of Insurance of this State or the commissioner, director or superintendent of insurance in any other state.

[1987, c. 481, §3 (NEW) .]

SECTION HISTORY
1987, c. 481, §3 (NEW). RR 2009, c. 2, §71 (COR).

§6094. RISK RETENTION GROUPS CHARTERED IN THIS STATE

A risk retention group shall be chartered and authorized, pursuant to the provisions of this title, as a liability insurer to write only liability insurance pursuant to this Act and, except as provided elsewhere in this Act, must comply with all the laws, rules and requirements applicable to insurers chartered and licensed in this State and with section 6095 to the extent these requirements are not a limitation on laws, rules or requirements of this State. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the superintendent a plan of operation or a feasibility study and revisions of that plan or study if the group intends to offer any additional lines of liability insurance. The group shall not offer any additional kinds of liability insurance in this State or in any other state, until a revision of such plan or study is approved by the superintendent. [1987, c. 481, §3 (NEW).]

In addition to other requirements for licensure, the risk retention group shall, at the time of filing its application for license, provide to the superintendent in summary form the following information: The identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount, source and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of the information the superintendent shall forward it to the National Association of Insurance Commissioners. This notification shall not be deemed to satisfy other requirements of this chapter. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6095. RISK RETENTION GROUPS NOT CHARTERED IN THIS STATE

Risk retention groups chartered and licensed in states other than this State and seeking to do business as a risk retention group in this State must comply with the laws of this State in the following manner. [1987, c. 481, §3 (NEW).]

1. **Notice of operations and designation of agent for service of process.** Before offering insurance in this State, a risk retention group shall submit to the superintendent:

A. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, the date of chartering and organization, its principal place of business and such other information, including information on its membership, as the superintendent may require to verify that the risk retention group is qualified under section 6093, subsection 13; [1987, c. 481, §3 (NEW).]

B. A copy of its plan of operation or a feasibility study and applicable revisions of the plan or study submitted to its state of domicile, provided that the provision relating to the submission of a plan of operation or a feasibility study does not apply with respect to any line or classification of liability insurance that was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986 and was offered before that date by any risk retention group that had been chartered and operating for not less than 3 years before that date; and [1997, c. 592, §73 (AMD).]

C. A designation of an agent for the purpose of receiving service of legal documents or process. That designation is subject to the provisions of section 421, except that the appointment of a private agent is optional. A risk retention group that does not elect to designate an agent in accordance with section 421, subsection 1 shall appoint the superintendent as its agent. [2013, c. 238, Pt. E, §3 (AMD).]

[2013, c. 238, Pt. E, §3 (AMD) .]

2. **Financial condition.** Any risk retention group transacting business in this State shall submit to the superintendent:

A. Annually, on or before March 1st, a copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries who is qualified to certify casualty loss reserves; [1987, c. 481, §3 (NEW).]

B. A copy of each report of examination of the risk retention group as certified by the superintendent or public official conducting the examination; [1987, c. 481, §3 (NEW).]

C. Upon request by the superintendent, a copy of any audit performed with respect to the risk retention group; and [1987, c. 481, §3 (NEW).]

D. Such information as may be required to verify its continuing qualification as a risk retention group under section 6093, subsection 13. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

3. **Taxation.** Each risk retention group shall be responsible for the payment of premium tax in accordance with Title 36, section 2513-A.

[1987, c. 481, §3 (NEW) .]

4. **Deceptive, false or fraudulent practices.** To the extent not preempted by the Risk Retention Amendments of 1986, any risk retention group shall be subject to the provisions of chapter 23, and Title 5, chapter 10.

[1987, c. 481, §3 (NEW) .]

5. **Examination regarding financial condition.** Any risk retention group must submit to an examination by the superintendent to determine its financial condition if the superintendent of the jurisdiction in which the group is chartered and licensed has not performed a timely examination or does not initiate an examination within 90 days after a request by the superintendent. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioner's Examiner Handbook, as applicable.

[1987, c. 481, §3 (NEW) .]

6. **Notice to purchasers.** Any policy issued by a risk retention group shall contain in 10 point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

[1987, c. 481, §3 (NEW) .]

7. **Prohibited acts regarding solicitation or sale.** The following acts by a risk retention group are prohibited:

A. The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in those groups; and [1987, c. 481, §3 (NEW).]

B. The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired. [1987, c. 481, §3 (NEW).]

[1987, c. 481, §3 (NEW) .]

8. **Prohibition on ownership by an insurance company.** No risk retention group shall be allowed to do business in this State if an insurance company is directly or indirectly a member or owner of that risk retention group, other than in the case of a risk retention group, all of whose members are insurance companies.

[1987, c. 481, §3 (NEW) .]

9. **Prohibited coverage.** No risk retention group may offer insurance policy coverage prohibited by the laws of this State or by the Risk Retention Amendments of 1986.

[1987, c. 481, §3 (NEW) .]

10. **Delinquency proceedings.** A risk retention group not chartered in this State and doing business in this State must comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance superintendent if there has been a finding of financial impairment after an examination under subsection 5.

[1987, c. 481, §3 (NEW) .]

SECTION HISTORY
1987, c. 481, §3 (NEW). 1997, c. 592, §73 (AMD). 2013, c. 238, Pt. E, §3 (AMD).

§6096. COMPULSORY ASSOCIATIONS

1. **Financial contribution.** No risk retention group may be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this State, nor may any risk retention group or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by the risk retention group.

[1987, c. 481, §3 (NEW) .]

2. **Insurer not authorized.** When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this State or a risk retention group, these risks, wherever resident or located, shall not be covered by any insurance guaranty fund or similar mechanism in this State.

[1987, c. 481, §3 (NEW) .]

3. **Authorized insurer.** When a purchasing group obtains insurance covering its members' risks from an insurer authorized in this State, only risks resident or located in this State shall be covered by the Maine Insurance Guaranty Association subject to chapter 57, subchapter III.

[1987, c. 481, §3 (NEW) .]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6097. PURCHASING GROUPS; EXEMPTION FROM CERTAIN LAWS RELATING TO THE GROUP PURCHASE OF INSURANCE

Any purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Amendments of 1986 is exempt from any law of this State relating to the creation of groups for the purchase of insurance, prohibition of group purchasing or any law that discriminates against a purchasing group or its members. In addition, an insurer is exempt from any law of this State that prohibits providing,

or offering to provide, to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters. A purchasing group and any insurer that provides coverage to a purchasing group with Maine members are subject to all other applicable laws of this State, including, but not limited to, chapters 25, 27 and 39. [1991, c. 2, §93 (COR).]

SECTION HISTORY
1987, c. 481, §3 (NEW). 1989, c. 724, §1 (AMD). RR 1991, c. 2, §93 (COR).

§6098. NOTICE AND REGISTRATION REQUIREMENTS OF PURCHASING GROUPS

1. **Notice.** A purchasing group that intends to do business in this State shall, prior to doing business, pay the appropriate fee at the rate specified in section 601 and furnish notice to the superintendent to:

A. Identify the state in which the group is domiciled; [1987, c. 481, §3 (NEW).]

B. Specify the lines and classifications of liability insurance that the purchasing group intends to purchase; [1993, c. 221, §30 (AMD).]

C. Identify the insurance company from which the group intends to purchase its insurance and the domicile of that company; [1987, c. 481, §3 (NEW).]

D. Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this State; [1987, c. 481, §3 (NEW).]

E. Identify the principal place of business of the group; and [1987, c. 481, §3 (NEW).]

F. Provide such other information as may be required by the superintendent to verify that the purchasing group is qualified under section 6093, subsection 11 to determine where the purchasing group is located and to determine appropriate tax treatment. [1993, c. 313, §37 (AMD).]

[1993, c. 313, §37 (AMD) .]

2. **Registration.** The purchasing group shall register with the superintendent and designate the superintendent as its agent solely for the purpose of receiving service of legal documents or process, except that the requirements do not apply in the case of a purchasing group:

A. That in any state of the United States:

(1) Was domiciled before April 2, 1986; and

(2) Is domiciled on and after October 27, 1986; [1997, c. 592, §74 (AMD).]

B. That:

(1) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and

(2) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; [1997, c. 592, §74 (AMD).]

C. That was a purchasing group under the requirements of the Product Liability Retention Act of 1981 before October 27, 1986; and [1997, c. 592, §74 (AMD).]

D. That does not purchase insurance that was not authorized for purposes of an exemption under that Act, as in effect before October 27, 1986. That designation shall be subject to section 421. [1997, c. 592, §74 (AMD).]

[2013, c. 238, Pt. E, §4 (AMD) .]

3. **Application of law.** Any purchasing group which was doing business in this State prior to the enactment of this Act shall within 30 days after the effective date of this Act furnish notice to the superintendent pursuant to the requirement of subsection 1 and shall comply with the requirements of subsection 2.

[1987, c. 481, §3 (NEW) .]

4. **Notice of change.** A purchasing group that intends to do business or is doing business in this State shall notify the superintendent within 10 days of any subsequent changes in any information or other items provided pursuant to this section.

[1993, c. 313, §38 (AMD) .]

SECTION HISTORY
1987, c. 481, §3 (NEW). 1993, c. 221, §30 (AMD). 1993, c. 313, §§37,38 (AMD). 1997, c. 592, §74 (AMD). 2013, c. 238, Pt. E, §4 (AMD).

§6099. RESTRICTIONS ON INSURANCE PURCHASED BY PURCHASING GROUPS

1. **Purchase from risk retention group; insurer; licensed agent or broker.** A purchasing group may purchase insurance from a risk retention group that is chartered in a state or, in the case of product liability or completed operations liability coverage, that qualifies under section 6093, subsection 13, paragraph C, subparagraph (2); from an insurer admitted in this State; or from a licensed agent or broker acting pursuant to the surplus lines laws and regulations of this State.

[1989, c. 724, §2 (AMD) .]

2. **Notice of nonprotected risk.** A purchasing group which obtains liability insurance from an insurer not authorized in this State or a risk retention group shall inform each of the members of the purchasing group which have a risk resident or located in this State that such risk is not protected by an insurance insolvency guaranty fund in this State, and that the risk retention group or the insurer may not be subject to all insurance laws and regulations of this State.

[1987, c. 481, §3 (NEW) .]

3. **Prohibition on retention of risk.** A purchasing group may not purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however coverage may provide for a deductible or self-insured retention applicable to individual members.

[1995, c. 540, §1 (AMD) .]

SECTION HISTORY
1987, c. 481, §3 (NEW). 1989, c. 724, §2 (AMD). 1993, c. 313, §39 (AMD). 1995, c. 540, §1 (AMD).

§6100. ADMINISTRATIVE AND PROCEDURAL AUTHORITY REGARDING RISK RETENTION GROUPS AND PURCHASING GROUPS

The superintendent is authorized to make use of any of the powers established under the Maine Insurance Code as long as those powers are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986. This includes, but is not limited to, the superintendent's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders and impose penalties. With regard to any investigation, administrative proceedings

or litigation, the superintendent can rely on the procedural laws and rules of the State. The superintendent's injunctive authority in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6101. PENALTIES

A risk retention group which violates any provision of this Act will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license or the right to do business in this State. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6102. DUTY OF AGENTS OR BROKERS TO OBTAIN LICENSE

Any person acting, or offering to act, as an agent or broker for a risk retention group or purchasing group, which solicits members, sells insurance coverage, purchases coverage for its members located within the State or otherwise does business in this State shall, before commencing any such activity, obtain an appropriate license from the superintendent. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6103. BINDING EFFECTS OF ORDERS ISSUED IN THE UNITED STATES DISTRICT COURT

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state, or in all states or in any territory or possession of the United States, upon a finding that such a group is in a hazardous financial condition, shall be enforceable in the courts of this State. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

§6104. RULES

The superintendent may establish and from time to time amend such rules relating to risk retention groups as may be necessary or desirable to carry out the provisions of this Act. [1987, c. 481, §3 (NEW).]

SECTION HISTORY
1987, c. 481, §3 (NEW).

Chapter 73: CONTINUING CARE RETIREMENT COMMUNITIES

§6201. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [1987, c. 482, §1 (NEW).]

1. **Actuary.** "Actuary" means a member of the American Academy of Actuaries who is also a member of the Society of Actuaries or the Casualty Actuarial Society and is qualified to sign a statement of actuarial opinion.

[1987, c. 482, §1 (NEW) .]

2. **Continuing care.** "Continuing care" means furnishing shelter for the life of the individual or for a period in excess of one year and either health care, supportive services, or both, under an agreement requiring prepayment as defined in subsection 12, whether or not the shelter and services are provided at the same location, to 3 or more older individuals not related by blood or marriage to the providers.

[1987, c. 482, §1 (NEW) .]

3. **Continuing care agreement.** "Continuing care agreement" means the contract or contracts which create the obligation to provide continuing care, including, but not limited to, mutually terminable contracts.

[1987, c. 482, §1 (NEW) .]

4. **Department.** "Department" means the Department of Health and Human Services.

[1987, c. 482, §1 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

5. **Entrance fee.** "Entrance fee" means an initial payment of a sum of money or any other consideration that assures a subscriber a place in a facility for a term of years or for life. An accommodation fee, admission fee, entrance loan or other fee of similar form and application, even if refundable in whole or in part at the termination of the subscriber's contract, is considered to be an entrance fee. The purchase price of a condominium, or of a share or shares of or membership in, a consumer cooperative subject to Title 13, chapter 85, subchapter I or a cooperative affordable housing corporation subject to Title 13, chapter 85, subchapter I-A is not considered an entrance fee.

[1995, c. 452, §2 (AMD) .]

6. **Facility.** "Facility" means a physical plant in which continuing care is provided in accordance with this chapter.

[1987, c. 482, §1 (NEW) .]

7. **Fiscal year.** "Fiscal year" means the provider's fiscal year.

[1987, c. 482, §1 (NEW) .]

8. **Health care.** "Health care" means the provision of any one or more of the following services:

A. Physician services; [1987, c. 482, §1 (NEW).]

B. Home health services; [1987, c. 482, §1 (NEW).]

C. Access to or provision of nursing home care; or [1987, c. 482, §1 (NEW).]

D. Hospital care. [1987, c. 482, §1 (NEW).]

[1987, c. 482, §1 (NEW) .]

9. **Home health services.** "Home health services" means those services performed by home health care providers required to be licensed under Title 22, chapter 419.

[1987, c. 482, §1 (NEW) .]

10. **Maintenance fee.** "Maintenance fee" means any fee which a subscriber is required to pay to the provider on a regular basis to cover the cost of shelter, health care or supportive services, or any combination thereof, provided to the subscriber.

[1987, c. 769, Pt. A, §101 (AMD) .]

11. **Operational facility.** "Operational facility" means a facility for which the provider has obtained a final certificate of authority from the superintendent and 60% of the residential units are occupied by subscribers.

[1987, c. 482, §1 (NEW); 1989, c. 343, §1 (AMD); 1989, c. 343, §23 (AFF) .]

11-A. **Preliminary marketing.** "Preliminary marketing" means, for the purpose of evaluating market demand for a proposed facility:

A. Advertising of a proposed facility; [1995, c. 452, §3 (NEW).]

B. Entering of reservation agreements, which are cancelable at the option of either the prospective subscriber or the prospective provider; [1995, c. 452, §3 (NEW).]

C. Soliciting, collecting or receiving reservation fees, which:

(1) Are sums of money not in excess of $1,000 per prospective resident paid by a prospective resident for deposit in escrow in an interest-bearing account with interest accruing for the benefit of the prospective resident and in accordance with section 6203-B, subsection 1, paragraphs A, C, D, E and F;

(2) Are refundable on request of a prospective subscriber; and

(3) Are not considered deposits for purposes of this chapter; and [1995, c. 452, §3 (NEW).]

D. Constructing and maintaining a sales office and model units. [1995, c. 452, §3 (NEW).]

[1995, c. 452, §3 (NEW) .]

12. **Prepayment.** "Prepayment" means funding shelter, supportive services or health care entirely or in part by entrance fees or by maintenance fees paid more than one year prior to the time the shelter or service is rendered. Prepayment of health care also includes funding by entrance fees or by maintenance fees which do not vary with the level of care provided.

[1987, c. 482, §1 (NEW) .]

13. **Provider.** "Provider" means the owner of an institution, building, residence or other place, whether operated for profit or not, in which the owner undertakes to provide continuing care. If the facility is owned by the subscribers, then "provider" means the operator of the facility.

[1995, c. 452, §4 (AMD) .]

14. **Records.** "Records" means the financial and other information and personnel data maintained by the provider for the proper operation of the facility pursuant to this chapter.

[1987, c. 482, §1 (NEW) .]

14-A. **Residential unit.**

[1989, c. 343, §23 (RP); 1989, c. 343, §2 (NEW) .]

14-B. **Residential unit.** "Residential unit" means an apartment, room or other area within a facility set aside for the exclusive and independent living use of one or more identified subscribers.

[1995, c. 452, §5 (NEW) .]

15. **Subscriber.** "Subscriber" means a purchaser or beneficiary of a continuing care agreement.

[1987, c. 482, §1 (NEW) .]

16. **Supportive services.** "Supportive services" means providing assistance in the activities of daily living or other social services, or both. Supportive services does not refer to services of the type commonly provided to tenants in a conventional apartment building.

[1987, c. 769, Pt. A, §101 (AMD) .]

17. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1987, c. 769, §A101 (AMD). 1989, c. 343, §§1,2,23 (AMD). 1995, c. 452, §§2-5 (AMD). 2003, c. 689, §B6 (REV).

§6202. CERTIFICATE OF AUTHORITY REQUIRED

1. **Requirement.** No person or entity may offer continuing care in this State except a provider having obtained an appropriate certificate of authority issued by the superintendent pursuant to this chapter and then in full force and effect.

[1987, c. 482, §1 (NEW) .]

2. **Use of name.** No natural person, partnership, unincorporated association, trust or corporation may use the names "continuing care retirement community" or "life-care community" unless the appropriate certificate of authority has been issued by the superintendent. A life-care community may use either name or both.

[1987, c. 482, §1 (NEW) .]

3. **Kinds of communities.** There are 2 kinds of communities that qualify for certification.

A. To qualify for certification as a life-care community, the provider shall offer a continuing care agreement that explicitly provides all of the following:

(1) Full and lifetime prepaid health care, prepaid supportive services and shelter, as prescribed by the department by rule, which include a true continuum of care from independent living through nursing home care;

(2) The maintenance fee may not increase, regardless of the level of services provided or a change in accommodations, with the following exceptions:

(a) Annual increases in the maintenance fee applicable to all subscribers; and

(b) Any increase in the maintenance fee applicable to a specific subscriber resulting from the voluntary selection of an optional service by that subscriber. An optional service is a service or change in accommodations that is not required to be offered in order to qualify for certification as a life-care community under the department's rules;

(3) With the exception of maintenance fees and insurance premiums, neither the subscriber nor any 3rd party, other than the subscriber's insurer, is liable for the cost of health care or supportive services other than optional services as defined in subparagraph (2); and

(4) The provider shall continue to provide full and lifetime health care, supportive services and shelter without diminution to a subscriber who has not intentionally depleted that subscriber's resources. [1995, c. 452, §6 (AMD).]

B. A provider offering a continuing care agreement that does not qualify for certification as a life-care community, as defined in paragraph A, must be certified as a continuing care retirement community if it complies with the other applicable provisions of this chapter. [1995, c. 452, §6 (AMD).]

[1995, c. 452, §6 (AMD) .]

4. **Reasonable time to comply.** Any provider who is providing continuing care when this chapter takes effect shall be given a reasonable time to comply with this chapter and the rules promulgated pursuant to this chapter, but not later than one year after the effective date of this chapter.

[1987, c. 482, §1 (NEW); 1989, c. 343, §3 (AMD); 1989, c. 343, §23 (AFF) .]

5. **Statement of withdrawal.** Any provider who, as of the effective date of this chapter, has offered continuing care agreements prior to that date and intends not to offer new continuing care agreements or to renew those agreements shall file a statement to that effect with the superintendent.

[1987, c. 482, §1 (NEW) .]

6. **Preliminary marketing.** Upon written approval by the superintendent of the proposed forms of the reservation agreement and the reservation fee escrow agreement referred to in section 6201, subsection 11-A, and prior to applying for a preliminary certificate of authority or a certificate of authority, a prospective provider may engage in preliminary marketing.

[1995, c. 452, §7 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1989, c. 343, §§3,23 (AMD). 1995, c. 452, §§6,7 (AMD).

§6203. REQUIREMENTS FOR ISSUANCE OF CERTIFICATE

1. **Preliminary certificate of authority.** The superintendent shall issue a preliminary certificate of authority, which shall be valid for no more than 12 months, but which the superintendent may extend for such reasonable time as necessary when the following conditions have been met.

A. The provider has submitted to the department an application for a certificate of need, if required under Title 22, section 329, and the department has submitted a preliminary report of a recommendation for approval of a certificate of need and the provider has applied for any other licenses or permits required prior to operation. [2003, c. 510, Pt. A, §22 (AMD).]

B. The provider has submitted an application in duplicate to the superintendent. The superintendent shall immediately forward one copy to the department. The application shall consist of the following items:

(1) A copy of the provider's continuing care agreement;

(2) A copy of the disclosure statement required by section 6209;

(3) Financial statements of current origin prepared in accordance with generally accepted accounting principles showing the provider's assets, liabilities and surplus position. These financial statements shall include as supplementary data a description of the sources of financial support. A copy of the provider's most recent regular certified financial statement shall be deemed to satisfy this requirement, unless the superintendent directs that additional or more recent financial information is required for the proper administration of this chapter;

(4) A copy of the basic organizational document of the provider such as articles of incorporation, articles of agreement, certificate of organization or incorporation or charter and all amendments thereto;

(5) A copy of the provider's bylaws, certified by the corporate secretary;

(6) A list of the names and addresses of stockholders and those persons who hold official positions responsible for the conduct of the affairs of the provider, including all members of the board of directors, the principal officers and persons having a 10% or greater equity or beneficial interest in the provider. Section 222, including the requirement of approval of the superintendent, the submission of tender offers or acquisitions materials, information as to acquisitions or tender offers and examination of accounts, records, documents and transactions, is also applicable in the event of either:

(a) Any tender offer for, or a request or invitation for tenders of, or an agreement to exchange securities for, or otherwise acquire any voting security of a provider or of any person controlling a provider if, as a result of the consummation thereof, the person making the tender offer, request or agreement would directly or indirectly acquire control of the provider or controlling person; or

(b) Any purchase, exchange, merger or acquisition of control of a provider;

(7) A description of any action within the past 10 years for which the provider or any of the persons described in subparagraph (6):

(a) Is presently under indictment or has been convicted of a Class A, B, C or D crime that relates to the business activities, including health care activities of the provider or that person; or

(b) Has had any state or federal license or permit related to the business activities, including health care activities of the provider or that person, suspended or revoked as a result of an action brought by a governmental agency or department;

(8) All principal officers and directors of the provider shall disclose in statements attested under oath any real or potential conflict of interest. This disclosure shall extend to provider - management relationships, although such relationships may be a part of the operational plan. Any employment contracts, deferred compensation contracts or other pecuniary interests shall be listed in this regard;

(9) A copy of any management agreement between the provider and the person or persons responsible for the daily management of the facility, if other than the provider;

(10) All contracts executed by the provider with 3rd parties which provide for the performance of health care or supportive services for the benefit of subscribers;

(11) A descriptive statement of the provider's proposed operation, including an organizational chart setting out the position classifications of personnel responsible for health care and administration;

(12) Proof of fidelity bonding of all individuals who handle the funds of continuing care retirement communities. The actual amount of the fidelity bonding required will be determined by the superintendent, but the face amount of the bond may not be less than $100,000;

(13) A description of the proposed method of marketing the plan for continuing care and a copy of any market research study performed;

(14) A copy of all advertising materials;

(15) A description of the mechanism by which subscribers will be afforded participation in policy matters of the organization;

(16) A description of the procedures developed by the provider to provide for the resolution of complaints initiated by subscribers concerning health care services and general operating procedures;

(17) A power of attorney duly executed by the provider, if not domiciled in the State, appointing an agent for service of process in any legal action brought;

(18) An actuarial study, certified by an actuary, demonstrating that the anticipated revenues and other available financial resources will be sufficient to provide the services promised by the contract and indicating the method by which the reserve required by section 6215-A will be calculated;

(19) A demonstration of the provider's ability to respond to claims for malpractice, employer's liability, workers' compensation coverages and all property and liability insurance relating to the facility, including fidelity bonds;

(20) Pro forma projected financial statements for the provider for the coming 10 years, including notes of the statements, presented in conformity with guidelines for forecasting as prescribed by the American Institute of Certified Public Accountants;

(21) A copy of any application form which prospective subscribers will be required to complete;

(23) A copy of the preliminary deposit agreement described in subsection 3, paragraph B, subparagraph (1); and

(24) A copy of the escrow agreement described in subsection 3, paragraph E. [1997, c. 592, §75 (AMD).]

C. The superintendent has determined that the continuing care agreement meets the requirements of section 6206, subsection 1. [1987, c. 482, §1 (NEW).]

D. The superintendent has approved the application form, escrow agreement and the preliminary deposit agreement. [1987, c. 482, §1 (NEW); 1989, c. 343, §5 (AMD); 1989, c. 343, §23 (AFF).]

E. The provider has met all other requirements for a preliminary certificate of authority which the superintendent may prescribe in rules promulgated pursuant to this chapter. [1987, c. 482, §1 (NEW).]

F. The department has certified that:

(1) The advertising materials related to the continuing care agreements are not untrue or misleading;

(2) The proposed continuing care agreement meets the requirement of section 6206, subsection 2; and

(3) The disclosure statement meets the requirement of section 6209. [1987, c. 482, §1 (NEW).]

G. The department has approved the adequacy of all services proposed under the continuing care agreement not otherwise reviewed under the certificate of need process. [1995, c. 452, §11 (NEW).]

H. The superintendent finds that the provider has met the requirements under this chapter and that the provider has furnished evidence satisfactory to the superintendent that the provider's methods of operation do not make its proposed operation hazardous to the public or its subscribers in this State. [1995, c. 452, §11 (NEW).]

I. The department certifies to the superintendent that the provider has demonstrated the willingness and potential ability to ensure that the health care services or supportive services, or both, will be provided in a manner to ensure availability, accessibility and continuity of services. [1995, c. 452, §11 (NEW).]

[2003, c. 510, Pt. A, §22 (AMD) .]

2. **Final certificate of authority.** The superintendent shall issue a final certificate of authority, subject to annual renewal, when:

A. The provider has obtained any required certificate of need or other permits or licenses required prior to construction of the facility; [1987, c. 482, §1 (NEW).]

B. [1995, c. 452, §12 (RP).]

C. The superintendent is satisfied that the provider has demonstrated that it is financially responsible and shall reasonably be expected to meet its obligations to subscribers or prospective subscribers; [1987, c. 482, §1 (NEW).]

C-1. [1989, c. 343, §23 (RP); 1989, c. 343, §6 (NEW).]

D. The superintendent has determined that the provider's continuing care agreement meets the requirements of section 6206, subsection 3, and the rules promulgated in this chapter; and [1995, c. 452, §13 (AMD).]

E. [1995, c. 452, §14 (RP).]

F. [1995, c. 452, §15 (RP).]

G. The provider certifies to the superintendent either:

(1) That preliminary continuing care agreements have been entered and deposits of not less than 10% of the entrance fee have been received either:

(a) From subscribers with respect to 70% of the residential units, including names and addresses of the subscribers, for which entrance fees will be charged; or

(b) From subscribers with respect to 70% of the total entrance fees due or expected at full occupancy of the community; or

(2) That preliminary continuing care agreements have been entered and deposits of not less than 25% of the entrance fee received from either:

(a) Subscribers with respect to 60% of the residential units, including names and addresses of the subscribers, for which entrance fees will be charged; or

(b) Subscribers with respect to 60% of the total entrance fees due or expected at full occupancy of the community. [1995, c. 452, §16 (RPR).]

Within 120 days after determining that the application to the superintendent and the department is complete, the superintendent shall issue or deny a final certificate of authority to the provider, unless a certificate of need is required, in which case the final certificate of authority shall be issued or denied in accordance with the certificate of need schedule.

[1995, c. 452, §§12-16 (AMD) .]

3. **Deposits.** Deposits shall apply as follows.

A. A provider who has applied for a preliminary certificate of authority may advertise, solicit and collect deposits, not to exceed $1,000 per prospective subscriber, provided that:

(1) The provider shall furnish the prospective subscriber a signed receipt stating that:

(a) The deposit, with interest earned on it, will be refunded in full if:

(i) The preliminary or final certificate of authority is not granted or if the continuing care retirement community does not become operational;

(ii) The prospective subscriber requests a refund for any reason; or

(iii) The provider determines that the subscriber is ineligible for entrance into the facility because of the subscriber's physical, mental or financial condition;

(b) There is a nonrefundable application fee and the amount of that fee; and

(c) Neither the continuing care agreement nor the disclosure statement has been approved by the superintendent and both are subject to change;

(2) At least 10 days prior to collecting an initial deposit, the provider shall furnish the prospective subscriber:

(a) A copy of the proposed continuing care agreement;

(b) A copy of the proposed disclosure statement described in section 6209;

(c) An unsigned copy of the receipt described in subparagraph (1); and

(d) A copy of the escrow agreement required by paragraph E; and

(3) The superintendent has approved the receipt required by subparagraph (1) and the escrow agreement required by paragraph E. [1987, c. 563, §1 (AMD); 1989, c. 343, §23 (AFF); 1989, c. 343, §9 (RP).]

B. A provider who has been issued a preliminary certificate of authority may advertise, solicit and collect deposits of not less than 10% nor more than 50% of the entrance fee, if:

(1) The provider furnishes the prospective subscriber a signed deposit agreement stating that:

(a) The provider has a preliminary certificate of authority and the deposit is received subject to the issuance by the superintendent to the provider of a final certificate of authority;

(b) Both the proposed continuing care agreement and the disclosure statement are subject to change;

(c) The provider will refund the prospective subscriber's deposit with interest earned on it:

(i) Within one month of notification of the superintendent's decision not to issue the final certificate of authority;

(ii) At the request of the prospective subscriber any time 3 years or more after the deposit was paid, if the community has not become operational;

(iii) If the prospective subscriber requests a refund due to a material difference between the proposed continuing care agreement furnished at the time the deposit is paid and the agreement as finally approved by the superintendent;

(iv) In the event of the death of the prospective subscriber prior to the execution of the continuing care agreement, unless the surviving spouse is also a prospective subscriber and still wishes to occupy the unit; or

(v) If the provider determines that the subscriber is ineligible for entrance into the facility because of the subscriber's physical, mental or financial condition;

(d) The provider will refund the deposit, without interest, if the community becomes operational and the subscriber chooses not to join for any reason other than that listed in division (c) and the refund will be paid on the receipt by the provider of the same percentage deposit of the entrance fee from another subscriber for a residential unit that is the same as or similar to the residential unit to which the cancelled deposit agreement applied;

(e) There is a nonrefundable application fee and the amount of that fee; and

(f) The subscriber may cancel the deposit agreement by written notice to the provider within 10 days from the date on which the subscriber signed the deposit agreement, in which event the provider will refund the prospective subscriber's deposit in full together with any interest earned on the deposit; and

(2) At least 10 days prior to collecting a preliminary deposit, the provider furnishes the prospective subscriber:

(a) A copy of the proposed continuing care agreement;

(b) A copy of the proposed disclosure statement described in section 6209;

(c) An unsigned copy of the preliminary deposit agreement described in subparagraph (1); and

(d) A copy of the escrow agreement required by paragraph E. [1995, c. 2, §54 (COR).]

C. After the community is operational, the provider may advertise, solicit and collect deposits of not less than 10% of the entrance fee and not to exceed 50% of the entrance fee, provided that:

(1) The provider shall furnish the prospective subscriber a signed deposit agreement stating that:

(a) The provider will refund the deposit, without interest, if the subscriber chooses not to join for any reason other than those listed in division (b), and the refund will be paid on the receipt by the provider of the same percentage deposit of the entrance fee from another subscriber for a residential unit that is the same as or similar to the residential unit to which the cancelled deposit agreement applied;

(b) The provider will refund the deposit with interest earned on it:

(i) In the event of the death of the prospective subscriber prior to the execution of the final continuing care agreement, unless the surviving spouse is also a subscriber and still wishes to occupy the unit; or

(ii) If the provider determines, prior to occupation by the subscriber, that the subscriber is ineligible for entrance into the facility because of the subscriber's physical, mental or financial condition;

(c) There is a nonrefundable application fee and the amount of that fee; and

(d) The subscriber may cancel the deposit agreement by written notice to the provider within 10 days from the date on which the subscriber signed the deposit agreement, in which event the provider will refund the prospective subscriber's deposit in full together with any interest earned on the deposit; and

(2) At least 10 days prior to collecting a deposit, the provider furnishes the prospective subscriber:

(a) A copy of the continuing care agreement;

(b) A copy of the disclosure statement described in section 6209;

(c) An unsigned copy of the deposit agreement described in subparagraph (1); and

(d) A copy of the escrow agreement required by paragraph E. [1995, c. 2, §55 (COR).]

D. At the time the prospective subscriber first makes an initial, preliminary or other deposit, the provider may also collect a nonrefundable application fee not to exceed $500. [1987, c. 482, §1 (NEW); 1989, c. 343, §12 (AMD); 1989, c. 343, §23 (AFF).]

E. Any deposit must be deposited to an interest-bearing escrow account. The escrow agreement establishing the terms of deposit of funds shall be filed with and approved by the superintendent prior to collection of funds. The provider shall furnish the superintendent with documentation of the name of the institution with which the provider has established the escrow account and the account number. The escrowed money shall not be applied until a final certificate of authority has been issued, the facility is operational and the subscriber has occupied the unit. When a subscriber's deposit and interest earned on it are applied, the interest shall be credited to reduce the unpaid portion of that subscriber's entrance fee. [1987, c. 563, §4 (AMD); 1989, c. 343, §13 (AMD); 1989, c. 343, §23 (AFF).]

F. Payments in excess of those deposits and fees under paragraphs A to D may be collected from a subscriber after a final certificate of authority has been issued by the superintendent and the subscriber has occupied the unit. Payments collected before the facility is operational must be held in the escrow account until the facility becomes operational. [1987, c. 482, §1 (NEW); 1989, c. 343, §23 (AFF); 1989, c. 343, §14 (RP).]

G. [1989, c. 343, §23 (RP); 1989, c. 343, §15 (NEW).]

H. Notwithstanding paragraph E and section 6203-B, deposits may be released from escrow to a provider that is organized as a nonprofit corporation subject to Title 13-B, as a consumer cooperative subject to Title 13, chapter 85, subchapter I or as a cooperative affordable housing corporation subject to Title 13, chapter 85, subchapter I-A, and any such provider may pledge the deposits as security for a loan to acquire, construct and develop a facility or may use the deposits to pay costs to acquire, construct and develop a facility, if:

(1) Either of the following applies:

(a) Deposits for at least 10% of the entrance fee have been received from prospective subscribers for not less than 70% of the facility's residential units for which entrance fees will be charged or not less than 70% of the total entrance fees due or expected at full occupancy and the prospective subscribers have agreed in writing to such use of the deposits; or

(b) Deposits for at least 25% of the entrance fee have been received from prospective subscribers for not less than 60% of the facility's residential units for which entrance fees will be charged or not less than 60% of the total entrance fees due or expected at full occupancy and the prospective subscribers have agreed in writing to such use of the deposits;

(2) The superintendent has issued a final certificate of authority to the provider;

(3) The superintendent is satisfied that the provider has demonstrated an ability to finance and complete construction in a reasonable manner, without limitation, by showing that:

(a) The deposits together with other funds held by or loaned to the provider are reasonably expected to be sufficient to pay for all costs of construction and equipping of the facility; and

(b) The provider has obtained or has the benefit of performance and payment bonds with respect to construction of the facility; and

(4) The superintendent is satisfied that the provider has obtained all necessary governmental permits and approvals necessary to construct the facility in accordance with all applicable laws, regulations, building codes and ordinances. [1995, c. 452, §19 (NEW).]

[1995, c. 2, §§54, 55 (COR) .]

4. **Separate facilities.** If the provider intends to provide continuing care at more than one facility, the provider must obtain a separate certificate of authority for each facility at which the provider intends to provide continuing care. With the exception of unencumbered surplus funds, funds collected by one facility may not be expended for the benefit of any other facility.

[1987, c. 482, §1 (NEW) .]

5. **Material changes.** Within 60 days prior to any change in the approved continuing care agreement, any other approved form or the health care or supportive services offered, the provider shall submit the proposed change in duplicate to the superintendent for approval. The superintendent shall forward one copy to the department.

[1987, c. 482, §1 (NEW) .]

6. **Provision of services to nonresidents.** The final certificate of authority must state whether any skilled nursing facility that is part of a life-care community or a continuing care retirement community may provide services to persons who have not been bona fide residents of the community prior to admission to the skilled nursing facility. If the life-care community or the continuing care retirement community admits to its skilled nursing facility only persons who have been bona fide residents of the community prior to admission to the skilled nursing facility, then the community is exempt from the provisions of Title 22, chapter 103-A, but is subject to the licensing provisions of Title 22, chapter 405, and is entitled to only one skilled nursing facility bed for every 4 residential units in the community. Any community exempted under Title 22, chapter 103-A may admit nonresidents of the community to its skilled nursing facility only during the first 3 years of operation. For purposes of this subsection, a "bona fide resident" means a person who has been a resident of the community for a period of not less than 180 consecutive days immediately preceding admission to the nursing facility or has been a resident of the community for less than 180 consecutive days but who has been medically admitted to the nursing facility resulting from an illness or accident that occurred subsequent to residence in the community. Any community exempted under Title 22, chapter 103-A is not entitled to and may not seek any reimbursement or financial assistance under the MaineCare program from any state or federal agency and, as a consequence, that community must continue to provide nursing facility services to any person who has been admitted to the facility.

Notwithstanding this subsection, a life-care community that holds a final certificate of authority from the superintendent and that was operational on November 18, 2002 and that is barred from seeking reimbursement or financial assistance under the MaineCare program from a state or federal agency may continue to admit nonresidents of the community to its skilled nursing facility after its first 3 years of operation with the approval of the superintendent. A life-care community that admits nonresidents to its skilled nursing facility as permitted under this subsection may continue to admit nonresidents after its first 3 years of operation only for such period as approved by the superintendent after the superintendent's consideration of the financial impact on the life-care community and the impact on the contractual rights of subscribers of the community.

[2003, c. 155, §1 (AMD) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1987, c. 563, §§1-4 (AMD). 1987, c. 769, §A102 (AMD). 1989, c. 343, §§4-15,23 (AMD). RR 1995, c. 2, §55 (COR). RR 1995, c. 2, §54 (COR). 1995, c. 452, §§8-20 (AMD). 1995, c. 625, §A27 (AMD). 1997, c. 478, §1 (AMD). 1997, c. 592, §75 (AMD). 2003, c. 155, §1 (AMD). 2003, c. 510, §A22 (AMD).

§6203-A. ESCROW ACCOUNT

(REPEALED)

SECTION HISTORY
1989, c. 343, §16 (NEW). 1989, c. 343, §23 (RP).

§6203-B. ESCROW ACCOUNT

1. **Deposit of funds.** When funds are required to be deposited in an escrow account pursuant to section 6203, the following apply.

A. The escrow account must be established in a bank or trust company authorized to do business in this State within the meaning of Title 9-B, section 131, subsection 2 and acceptable to the superintendent. The funds deposited in the escrow account must be kept and maintained in an account separate from the provider's business accounts. [1995, c. 452, §21 (NEW).]

B. An escrow agreement must be entered into between the bank or trust company and the provider of the facility. The agreement must state that its purpose is to protect the subscriber or the prospective subscriber. Upon presentation of evidence to the superintendent of compliance with applicable portions of this chapter, or upon order of a court of competent jurisdiction, the escrow agent shall release and pay over the funds or portions of the funds together with any interest accrued on the funds or earned from investment of the funds to the provider or subscriber as directed. [1995, c. 452, §21 (NEW).]

C. When funds are received from a prospective subscriber, the provider shall deliver to the subscriber a copy of the executed deposit agreement. The deposit agreement must state the payor's name and address, the date, the price of the care agreement and the amount of money paid. A copy of each agreement together with the funds must be deposited with the escrow agent. [1995, c. 452, §21 (NEW).]

D. Checks, drafts and money orders for deposit from prospective subscribers may be made payable only to the escrow agent. At the request of a prospective subscriber of a facility, the escrow agent shall issue a statement indicating the status of the subscriber's portion of the escrow account. [1995, c. 452, §21 (NEW).]

E. All funds deposited in the escrow account remain the property of the subscriber until released to the provider in accordance with this chapter. The funds are not subject to any liens or charges by the escrow agent or judgments, garnishments or creditor's claims against the provider or facility. [1995, c. 452, §21 (NEW).]

F. At the request of either the provider or the superintendent, the escrow agent shall issue a statement indicating the status of an escrow account. [1995, c. 452, §21 (NEW).]

G. Upon determining that the requirements of section 6203, subsection 3, paragraph E have been met, the superintendent shall authorize the escrow agent to release, and the escrow agent shall release, to the provider the amount of escrowed funds received from prospective subscribers and deposited in the account while the provider was operating under a preliminary certificate of authority. [1995, c. 452, §21 (NEW).]

[1995, c. 452, §21 (NEW) .]

2. **Agreement.** Any agreement establishing an escrow account required under the provisions of this chapter is subject to approval by the superintendent. The agreement must be in writing and contain, in addition to any other provisions required by law, a provision by which the escrow agent agrees to abide by the duties imposed under this section.

[1995, c. 452, §21 (NEW) .]

3. **Monthly statement; withdrawal of funds.** The agreement must require the escrow agent to furnish the provider with a monthly statement indicating the amount of any disbursements from or deposits to the escrow account and the condition of the account during the monthly period covered by the statement. On or before the 20th day of the month following the month for which the monthly statement is due, the provider shall file with the superintendent a copy of the escrow agent's monthly statement.

The escrow agent or the escrow agent's designee and the provider shall notify the superintendent in writing 10 days before the payment to the provider of any portion of any funds required to be escrowed under the provisions of this chapter.

[1995, c. 452, §21 (NEW) .]

SECTION HISTORY
1995, c. 452, §21 (NEW).

§6204. WITHDRAWAL PLAN

Any provider who has obtained a certificate of authority from the superintendent and who plans neither to renew existing agreements nor to offer new agreements shall submit a withdrawal plan to the superintendent at least 60 days prior to implementing its proposed plan. The plan shall include, but not be limited to, requirements and procedures for meeting the provider's existing contractural obligations, providing security in the event of a subsequent insolvency and meeting any applicable statutory obligations. The plan shall also comply with any further terms and conditions which are prescribed by rules adopted by the superintendent. The plan shall not be implemented without the approval of the superintendent. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6205. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY

1. **Complaint to District Court.** The superintendent may file a complaint with the District Court seeking the suspension or revocation of any certificate of authority issued to a provider under this chapter if he finds, or the department certifies, that any of the following conditions exist:

A. The provider is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under this chapter, unless amendments to those submissions have been filed with and approved by the superintendent; [1987, c. 482, §1 (NEW).]

B. The provider charges an entrance fee, maintenance fee or other amount not consistent with the continuing care contract approved pursuant to section 6206; [1987, c. 482, §1 (NEW).]

C. The department certifies to the superintendent that the provider is unable to fulfill its obligations to furnish shelter, health care or supportive services; [1987, c. 482, §1 (NEW).]

D. The provider is no longer financially responsible and may not reasonably be expected to meet its obligations to subscribers or prospective subscribers; [1987, c. 482, §1 (NEW).]

E. The provider has failed to implement a mechanism affording the subscribers an opportunity to participate in matters of policy and operation; [1989, c. 502, Pt. A, §100 (AMD).]

F. The provider has failed to implement the complaint system in a manner to reasonably resolve valid complaints; [1987, c. 482, §1 (NEW).]

G. The provider or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner; [1987, c. 482, §1 (NEW).]

H. The continued operation of the provider will be hazardous to its subscribers; [1987, c. 482, §1 (NEW).]

I. The provider has submitted false financial statements, organizational statements or documents; or [1987, c. 482, §1 (NEW); 1989, c. 343, §17 (AMD); 1989, c. 343, §23 (AFF).]

J. The provider has otherwise failed to substantially comply with this chapter or any rules issued by the superintendent or the department pursuant to this chapter. [1987, c. 482, §1 (NEW); 1989, c. 343, §17 (AMD); 1989, c. 343, §23 (AFF).]

K. [1989, c. 343, §18 (NEW); 1989, c. 343, §23 (RP).]

[1989, c. 502, Pt. A, §100 (AMD); 1999, c. 547, Pt. B, §78 (AMD); 1999, c. 547, Pt. B, §80 (AFF) .]

2. **Governing procedure.** The proceedings governing the appeal of a revocation or suspension shall be conducted in accordance with the requirements of the Maine Administrative Procedure Act, Title 5, chapter 375.

[1987, c. 482, §1 (NEW) .]

3. **Suspension.** When the certificate of authority of a provider is suspended, the provider shall not, during the period of that suspension, enroll any additional subscribers and shall not engage in any advertising or solicitation.

[1987, c. 482, §1 (NEW) .]

4. **Revocation.** When the certificate of authority of a provider is revoked, that organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business, except as may be essential to the orderly conclusion of the affairs of that organization. It shall engage in no further advertising or solicitation.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1989, c. 343, §§17,18,23 (AMD). 1989, c. 502, §A100 (AMD). 1999, c. 547, §B78 (AMD). 1999, c. 547, §B80 (AFF).

§6206. REQUIRED PROVISIONS OF A CONTINUING CARE AGREEMENT

1. **General provisions.** In addition to such other provisions as may be prescribed by rules promulgated under this chapter, each continuing care agreement executed between a subscriber and a provider shall:

A. State the name and business address of the provider; [1987, c. 482, §1 (NEW).]

B. State the name and address of the facility; [1987, c. 482, §1 (NEW).]

C. Show the total consideration paid by the subscriber for continuing care, including the value of all property transferred, donations, entrance fees, subscriptions, maintenance fees and any other fees paid or payable by or on behalf of a subscriber; [1987, c. 482, §1 (NEW).]

D. Specify all health care or supportive services which are to be provided by the provider or by a 3rd party to each subscriber, including in detail all items which each subscriber will receive and whether the items will be provided for a designated time period or for life; [1987, c. 482, §1 (NEW).]

E. State whether the provider requires the subscriber to purchase or maintain supplemental insurance; [1987, c. 482, §1 (NEW).]

F. Provide in clear and understandable language, in print no smaller than the largest type used in the body of the agreement, the terms governing the refund of any portion of the entrance fee in the event of rescission or termination of the agreement by the provider or by the subscriber; [1987, c. 482, §1 (NEW).]

G. State the terms under which an agreement is canceled by the death of the subscriber; [1987, c. 482, §1 (NEW).]

H. Provide in clear and understandable language in print no smaller than the largest type used in the agreement whether or not periodic fees, if charged, will be subject to periodic increases; [1987, c. 482, §1 (NEW).]

I. State the extent of funeral and burial services which will be provided by the provider; [1987, c. 482, §1 (NEW).]

J. Provide a description of the unit which the subscriber will occupy; [1987, c. 482, §1 (NEW).]

K. State the conditions, if any, under which a unit may be assigned to the use of another by the subscriber; [1987, c. 482, §1 (NEW).]

L. State the subscriber's and provider's respective rights and obligations as to the use of the facility and as to real and personal property of the subscriber placed in the custody of the provider; [1987, c. 482, §1 (NEW).]

M. State that the subscribers shall have the right to organize and operate a subscriber organization at the facility and to meet privately to conduct business; [1987, c. 482, §1 (NEW).]

N. State what, if any, fee adjustments will be made if the subscriber is voluntarily absent from the facility for an extended period of time; [1987, c. 482, §1 (NEW).]

O. Contain in capital letters in print no smaller than the largest type used in the agreement and underlined: "A preliminary or final certificate of authority is not an endorsement or guarantee of this facility by the State of Maine. The Superintendent of Insurance urges you to consult with an attorney and a suitable financial advisor before signing any documents."; [1987, c. 482, §1 (NEW).]

P. State that the subscriber will annually receive a financial and organizational disclosure statement; and [1987, c. 482, §1 (NEW).]

Q. Provide that the provider shall make available to the subscriber, upon request, any certified financial statement transmitted to the superintendent. [1987, c. 482, §1 (NEW).]

[1987, c. 482, §1 (NEW) .]

2. **Additional specific provisions.** Each continuing care agreement shall contain the following provisions:

A. A description of the procedures to be followed by the provider when the provider temporarily or permanently changes the subscriber's accommodation within the facility, transfers the subscriber pursuant to section 6228 or transfers the subscriber to another health facility. A subscriber's accommodations may be changed only for the protection of the health or safety of the subscriber or the general welfare of the residents; [1995, c. 452, §22 (AMD).]

B. A description of the policies that will be implemented if the subscriber becomes unable to meet the fees; [1987, c. 482, §1 (NEW).]

C. A policy statement of the provider with regard to changes in accommodations and the procedure to be followed to implement that policy in the event of an increase or decrease in the number of persons occupying an individual unit, including a reasonable grievance procedure and a description of the circumstances whereby the provider may cancel the agreement prior to occupancy; [1995, c. 452, §23 (AMD).]

D. Specifications of the circumstances, if any, under which the subscriber will be required to apply for Medicare, Social Security or any other state or federal insurance or pension benefits; and [1995, c. 452, §23 (AMD).]

E. A statement of the rights of residents of continuing care retirement communities granted by section 6227. [1995, c. 452, §24 (NEW).]

[1995, c. 452, §§22-24 (AMD) .]

3. **Filing and approval.** Continuing care agreements must be submitted in duplicate to the superintendent, who shall immediately forward one copy to the department. The department shall review the continuing care agreement for compliance with the requirements of subsection 2. The superintendent shall review the continuing care agreement for compliance with the requirements of subsection 1.

[1987, c. 482, §1 (NEW) .]

No contract, or amendment to a contract, may be issued or delivered to any person in this State until a copy of the contract, or amendment to the contract, has been filed with and approved by the superintendent. A contract shall contain no provisions or statements which are untrue, unjust, unfair, inequitable, misleading, deceptive or which encourage misrepresentation. [1987, c. 482, §1 (NEW).]

The contract, or amendment to the contract, shall be deemed approved by the superintendent 30 days following the date filed with the superintendent unless, prior to that date, it has been affirmatively approved or disapproved by the superintendent or unless the superintendent has not issued a final certificate of authority. The superintendent may not extend the period upon which he may affirmatively approve or disapprove any contract or amendment more than an additional 30 days. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1995, c. 452, §§22-24 (AMD).

§6207. CONTINUING CARE AGREEMENT; CONDOMINIUM

Pursuant to a continuing care agreement, a subscriber may purchase or may be the beneficiary of a purchase of a condominium as defined in Title 33, section 1601-103, subsection 7. With respect to a continuing care agreement pursuant to which a condominium will be purchased the following provisions are applicable: [1987, c. 482, §1 (NEW).]

1. **Copy of declaration; filing.** A copy of the declaration prepared pursuant to the Maine Condominium Act, Title 33, chapter 31, along with a copy of any registration statement filed with the United States Securities and Exchange Commission or the Office of Securities, must be filed with the superintendent prior to the sale of any of the condominium units; and

[2001, c. 182, §7 (AMD) .]

2. **Bylaws and rules; filing.** The bylaws and rules of the unit owners' association shall be filed with the superintendent for informational purposes.

[1987, c. 482, §1 (NEW) .]

Any materials required to be filed with the superintendent pursuant to this chapter and contained in the declaration, public offering statements, bylaws or rules of the unit owners' association may be submitted in that format to the superintendent. Any disclosure requirements contained in this chapter may be satisfied

by the timely delivery of the documents described in this section to the subscriber, supplemented where necessary by any additional information required pursuant to this chapter. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW). 2001, c. 182, §7 (AMD).

§6208. CONTINUING CARE AGREEMENT; CONSUMER COOPERATIVE

As part of the continuing care agreement, a subscriber may purchase or acquire or be the beneficiary of a purchase or acquisition of a membership interest or share or shares in an incorporated or unincorporated group organized on a cooperative basis subject to the requirements of Title 13, chapter 85, subchapter I, governing consumer cooperatives or Title 13, chapter 85, subchapter I-A, governing cooperative affordable housing corporations. [1995, c. 452, §25 (AMD).]

If a registration statement for the cooperative is filed with the Office of Securities, pursuant to the Maine Uniform Securities Act, Title 32, chapter 135, a copy must be simultaneously filed with the superintendent and a copy must be given to every purchaser of a membership interest or share in the cooperative at least 10 days prior to the sale of the interest or share. Any information required to be filed with the superintendent pursuant to this chapter and contained in the referenced registration materials may be filed in that format with the superintendent and need not be submitted under separate cover. If a registration statement is not filed with the Office of Securities, a disclosure statement containing, to the extent applicable, all the information required to register a security by qualification, pursuant to Title 32, section 16304, must be filed with the superintendent and given to every subscriber at least 10 days prior to the sale. In the alternative, a provider may elect to provide each subscriber a disclosure statement containing those provisions stated in section 6209 determined to be required by the superintendent. [2005, c. 65, Pt. C, §13 (AMD).]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1995, c. 452, §25 (AMD). 2001, c. 182, §8 (AMD). 2005, c. 65, §C13 (AMD).

§6209. DISCLOSURE STATEMENT

1. **Disclosure statement required.** A provider shall provide a disclosure statement to a prospective subscriber or the person with whom the provider shall enter into an agreement to provide continuing care for the benefit of a prospective subscriber at least 10 days prior to the transfer of any money or other property to the provider by or on behalf of the prospective subscriber. The disclosure statement shall contain the date on which the disclosure was provided to the prospective subscriber and shall be written in a clear and coherent manner using words with common and everyday meanings.

[1987, c. 482, §1 (NEW) .]

2. **Required contents.** Each disclosure statement shall contain:

A. The name, business address and form of organization of the provider; and [1987, c. 482, §1 (NEW).]

B. A statement in bold print at the top of the first page which reads:

> "This matter involves a substantial financial commitment and a legally binding contract. In evaluating this disclosure statement and this contract prior to any commitment being made by you, it is recommended that you consult with an attorney and financial advisor of your choice, who can review these documents with you."

[1987, c. 482, §1 (NEW).]

[1987, c. 482, §1 (NEW) .]

3. **Conditionally required contents.** The disclosure statement shall contain the following information, unless such information is already contained in the continuing care agreement or other materials provided to the subscriber or the person with whom the provider will enter into a continuing care agreement:

A. The state or foreign jurisdiction and date of the providers' organization, the general character and location of its business and a description of its physical properties or equipment; [1987, c. 482, §1 (NEW).]

B. The names and business addresses of the officers, directors and any persons or entities having a 10% or greater equity or beneficial interest in the provider and a description of that person's interest in or occupation with the provider; [1987, c. 482, §1 (NEW).]

C. The identity of any 3rd-party operator if the facility is to be managed on a day-to-day basis by some party other than the provider or a person directly employed by the provider; [1987, c. 482, §1 (NEW).]

D. A statement of the extent to which any affiliated organization is responsible for the financial and contractual obligations of the provider and a statement of the provisions of the United States Internal Revenue Code, if any, under which the provider or an affiliate is exempt from payment of income tax; [1987, c. 482, §1 (NEW).]

E. The location and description of the physical property of the facility, both existing and proposed, and, with respect to a proposed facility or improvement, the estimated completion date, the date construction began or shall begin and the contingencies subject to which construction may be deferred; [1987, c. 482, §1 (NEW).]

F. The provisions that have been made or will be made, if any, to provide any type of reserve funding which will enable the provider to fully perform its obligations under contracts to provide continuing care, including, but not limited to, the establishment of escrow accounts, trusts or reserve accounts, the manner in which the funds shall be invested and the names and experience of persons who will make the investment decisions on these funds; [1987, c. 482, §1 (NEW).]

G. Certified financial statements of current origin prepared in accordance with generally accepted accounting principles showing the provider's assets, liabilities and surplus position. These financial statements shall include as supplementary data a description of the sources of financial support; [1987, c. 482, §1 (NEW).]

H. An examined pro forma projected financial statement for the coming 5 years, including notes of that statement, presented in conformity with guidelines for forecasting as prescribed by the American Institute of Certified Public Accountants and including a narrative description of the basis of assumptions utilized. The pro forma projected financial statement need not be included in the disclosure statement after the facility has commenced operations; [1995, c. 452, §26 (AMD).]

I. If the facility is already in operation or, if the provider or operator operates one or more similar facilities within the State, tables showing the frequency and average dollar amount of each increase in periodic rates at each facility for the previous 5 years, or as many years as the facility has been operated by the provider or operator, whichever is less; [1995, c. 452, §27 (AMD).]

J. Any other material information that the provider wishes to include in the disclosure statement or that the superintendent or department requires by rule; and [1995, c. 452, §27 (AMD).]

K. Whether the provider has misappropriated funds or otherwise breached the terms of a deposit agreement to the detriment of a subscriber. [1995, c. 452, §28 (NEW).]

[1995, c. 452, §§26-28 (AMD) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1995, c. 452, §§26-28 (AMD).

§6210. TERMINATION OF CONTINUING CARE AGREEMENT

1. **Right to terminate.** A subscriber shall have the right to terminate a continuing care agreement for any reason prior to the date of occupancy by the subscriber or up to one year after the date of occupancy. The provider may reserve the right to terminate the agreement as specified in subsection 3.

[1987, c. 482, §1 (NEW) .]

2. **Termination by the subscriber.** If, prior to the subscriber occupying a unit or within one year after that date, the subscriber dies and does not have a surviving spouse who is also a subscriber and who still wishes to occupy the unit, or the subscriber elects to terminate the continuing care agreement for any reason, the subscriber or the subscriber's legal representative shall receive within 30 days a refund of all money paid to the provider without interest, except:

A. Those special additional costs incurred by the provider due to modifications in the structure or furnishings of the unit specifically requested by the subscriber and set forth in writing in a separate addendum to the agreement and signed by the subscriber; [1987, c. 482, §1 (NEW).]

B. In the case of the death of the subscriber, interest earned upon funds in escrow; [1987, c. 563, §5 (AMD).]

C. The application fee; [1987, c. 482, §1 (NEW).]

D. A maximum of 2% of the entrance fee for each month of occupancy, if any, which refund, in the case of a subscriber who terminates the continuing care agreement for any reason other than death, will be paid on the receipt by the provider of the same percentage deposit of the entrance fee from another subscriber for a residential unit that is the same as or similar to the residential unit to which the cancelled continuing care agreement applied; and [1995, c. 452, §29 (AMD).]

E. Costs to the provider of repairing damage caused by the subscriber to the subscriber's unit, other than reasonable wear and tear to the unit. [1987, c. 482, §1 (NEW).]

This subsection shall not be construed in a manner inconsistent with the real estate interest acquired by the purchaser of a condominium.

[1995, c. 452, §29 (AMD) .]

3. **Termination by the provider.** If, prior to occupancy by the subscriber, the provider determines that the subscriber is ineligible for entrance into the facility because of a substantial change in the subscriber's physical, mental or financial condition or because of materially false statements made by the subscriber or for other just cause, the provider may terminate the agreement, provided that:

A. The continuing care agreement contains a provision allowing the termination; and [1987, c. 482, §1 (NEW).]

B. A refund of all money paid by the subscriber, plus interest earned on escrowed funds shall be refunded, less an application fee not to exceed $500, is made at the time the agreement is terminated. [1987, c. 563, §6 (AMD).]

[1987, c. 563, §6 (AMD) .]

4. **Rescission damages.** A subscriber may rescind a continuing care agreement at any time if the terms of the agreement are in violation of the terms of this chapter and the subscriber is injured by the violation. In those instances when a violation of this chapter results from the fraudulent actions of the provider, the subscriber shall be entitled to treble damages for injuries arising from the violation.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1987, c. 563, §§5,6 (AMD). 1989, c. 343, §§19,23 (AMD). 1995, c. 452, §29 (AMD).

§6211. WAIVER OF CERTAIN CONTINUING CARE AGREEMENT PROVISIONS PROHIBITED

No act, agreement or statement of any subscriber constitutes a valid waiver of any of the provisions of this chapter, or any rules under this chapter, intended for the benefit or protection of the subscriber. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6212. DISCHARGE OF SUBSCRIBER PRIOR TO EXPIRATION OF AGREEMENT

No agreement for continuing care shall permit dismissal or permanent discharge of the subscriber from the facility providing care prior to the expiration of the agreement without just cause for such a removal and without providing at least 60 days' advance notice in writing to the subscriber. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6213. ACTIONS FOR DAMAGES OR EQUITABLE RELIEF

1. **Action for damages.** Any subscriber injured by a violation of this chapter may bring an action for the recovery of damages in any court of competent jurisdiction. In those cases, the court may award reasonable attorneys fees to a subscriber in whose favor a judgment is rendered.

[1987, c. 482, §1 (NEW) .]

2. **Equitable relief.** Any subscriber injured by a violation of this chapter may institute an action for an appropriate temporary restraining order or injunction.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6214. ADMINISTRATIVE RULES

The superintendent and the department, as provided in this section, shall administer this chapter and may: [1987, c. 482, §1 (NEW).]

1. **Forms.** Prescribe, prepare and furnish all necessary forms;

[1987, c. 482, §1 (NEW) .]

2. **Fees.** Establish and collect reasonable fees under this chapter; and

[1987, c. 482, §1 (NEW) .]

3. **Rules.** Adopt, amend or repeal, as necessary, rules to implement and interpret this chapter.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6215. RESERVES

(REPEALED)

SECTION HISTORY
1987, c. 482, §1 (NEW). 1989, c. 343, §§20,23 (RPR). 1995, c. 452, §30 (RPR). 1995, c. 625, §A28 (RP).

§6215-A. RESERVES

A provider shall establish and maintain the following reserves: [1995, c. 625, Pt. A, §29 (NEW).]

1. **Mortgage debt.** A liquid amount equal to the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, which reserve may be held by a lender, mortgagee or trustee for bondholders in a debt service reserve fund or similar fund, including, without limitation, any reserve fund of the Maine Health and Higher Educational Facilities Authority established pursuant to Title 22, chapter 413;

[1995, c. 625, Pt. A, §29 (NEW) .]

2. **Operating reserve.** A liquid amount equal to 20% of the total cash operating expenses, other than principal and interest payments on any mortgage loan or other long-term financing of the facility, projected for the forthcoming 12-month period, which reserve may be held by the provider in an operating fund; provided, however, that the percentage of the total cash operating expenses must be increased from 20% to 25% in the case of a provider who offers an extensive health care guarantee. For purposes of this section, "extensive health care guarantee" means a term in a continuing care agreement requiring the provision of health care to the subscriber on a prepaid basis for more than one year; and

[1995, c. 625, Pt. A, §29 (NEW) .]

3. **Reserve liabilities; actuarial value.** Each provider shall establish and maintain reserve liabilities that place a sound value on the provider's liabilities under its contracts with subscribers. The reserve must equal the excess of the present value of future benefits promised under the continuing care agreement over the present value of future revenues and any other available resources, based on conservative actuarial assumptions. The provider shall provide every 3 years to the superintendent an actuarial valuation or statement of actuarial opinion as to the adequacy of the reserve, signed by a qualified actuary, that, based on reasonable assumptions, the continuing care retirement community's assets, including the present value of estimated future maintenance fees and any other available resources, are at least equal to the present value of estimated future liabilities.

Unless otherwise approved by the superintendent, the actuarial opinion must be based on reasonable assumptions with the following provisions and margins.

A. The liabilities of a continuing care retirement community must include, but not be limited to:

(1) An amount equal to the present value of future health care expenses guaranteed pursuant to the continuing care contract; and

(2) The liabilities under this section must be calculated for the continuing care retirement community population existing on the valuation date under assumptions that, in the actuary's opinion, fairly represent the expected value of future costs and population decrements adjusted by the margins specified in paragraph B. [1995, c. 625, Pt. A, §29 (NEW).]

B. Margins required to be included in the valuation assumptions to be added to the actuary's best estimate assumptions are as follows.

(1) Health care costs per resident or per health care facility bed must be assumed to increase at a rate at least one percentage point higher than the general inflation rate.

(2) A mortality margin of 5% must be subtracted from that assumed for active residents and 10% subtracted from those in the health care facilities.

(3) A health care utilization margin of 5% must be added to the assumed rates at which residents require permanent transfer to a health care facility.

(4) The discount rate used to calculate present values may not be more than 2 1/2 percentage points higher than the rate used in the valuation of long-term life insurance contracts to be issued in the year of valuation in this State.

(5) All other assumptions must include margins that are adequate in the opinion of the actuary. [1995, c. 625, Pt. A, §29 (NEW).]

[1995, c. 625, Pt. A, §29 (NEW) .]

The superintendent may adopt reasonable rules further defining the standards contained in this section. [1995, c. 625, Pt. A, §29 (NEW).]

SECTION HISTORY
1995, c. 625, §A29 (NEW).

§6216. SALE OR TRANSFER OF OWNERSHIP

Any provider desiring to sell or transfer ownership of a continuing care facility shall notify the superintendent and the acquiring interest shall obtain the superintendent's advance approval of the sale or transfer. The certificate of authority is nontransferable. The new owner must apply for a new certificate of authority to continue to provide continuing care at the facility. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6217. PENALTIES AND ENFORCEMENT

1. **Cease and desist order.** The superintendent may issue an order directing a provider to cease and desist from engaging in any act or practice in violation of this chapter.

[1987, c. 482, §1 (NEW) .]

2. **Superior Court.** In the case of any violation under this chapter, if the superintendent elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order issued pursuant to this section, the superintendent may apply to the Superior Court to issue an injunction restraining the company in whole or in part from proceeding further with its business or may apply for an order of the court to command performance consistent with contractual obligations of the provider.

[1987, c. 482, §1 (NEW) .]

3. **Civil penalties.** A person or organization in violation of this chapter shall be subject to a civil penalty of not more than $1,000 for each violation, payable to the State, to be recovered in a civil action. If a violation is willful, the person or organization shall be subject to a civil penalty of not more than $10,000 for each violation, payable to the State, to be recovered in a civil action. These penalties may be in addition to any other penalty provided by law. A separate violation may be held to exist for each day that the violation continues.

[1987, c. 482, §1 (NEW) .]

4. **Class E crime.** Any person that violates any provision of this chapter commits a Class E crime. Each violation of this chapter shall constitute a separate offense.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6218. FINANCIAL AND ORGANIZATIONAL DISCLOSURE STATEMENTS

Every provider shall provide to its subscribers within 120 days following the close of its first fiscal year of operation: [1987, c. 482, §1 (NEW).]

1. **Statement of financial condition.** The most recent certified annual statement of financial condition, including a balance sheet and summary of receipts and disbursements, including notes of that statement;

[1987, c. 482, §1 (NEW) .]

2. **Description of structure and operation.** A description of the organizational structure and operation of the provider, including the kind and extent of subscriber participation and a summary of any material changes since the issuance of the last report;

[1987, c. 482, §1 (NEW) .]

3. **Description of services.** A description of services and information as to where and how to secure them; and

[1987, c. 482, §1 (NEW) .]

4. **Method of subscriber complaints.** A clear and understandable description of the provider's method for resolving subscriber complaints.

[1987, c. 482, §1 (NEW) .]

On an annual basis, material changes in the information required to be provided pursuant to this section shall be furnished to all subscribers. [1987, c. 482, §1 (NEW).]

SECTION HISTORY

1987, c. 482, §1 (NEW).

§6219. INVESTMENTS

The provider shall conform its investment strategy to the standards adopted by the superintendent by rule. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6220. FILINGS AND REPORTS AS PUBLIC DOCUMENTS

All applications, filings and reports required under this chapter shall be treated as public documents, subject to limitations and exceptions provided in Title 1, chapter 13, subchapter I. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6221. FEES

Every provider subject to this chapter shall pay to the superintendent the following fees: [1987, c. 482, §1 (NEW).]

1. **Initial application.** For filing an initial application for a certificate of authority, $1,500; and

[1987, c. 482, §1 (NEW) .]

2. **Annual report.** For filing each annual report, $100.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6222. EXAMINATIONS

1. **Examination by superintendent.** The superintendent may make an examination of the affairs of any provider as often as he deems it necessary for the protection of the interests of the people of this State, but not less frequently than once every 3 years.

[1987, c. 482, §1 (NEW) .]

2. **Examination by department.** The department may make an examination concerning the quality of health and supportive services of any provider as often as the department deems it necessary for the protection of the interests of the people of this State, but not less frequently than once every year.

[1987, c. 482, §1 (NEW) .]

3. **Records.** Every provider shall submit its books and records relating to health and supportive services to such examinations and in every way facilitate the examination. For the purpose of examinations, the superintendent and the department may administer oaths to and examine the officers and agents of the provider.

[1987, c. 482, §1 (NEW) .]

4. **Expenses.** The reasonable expenses of examinations performed by the superintendent under this section shall be assessed against the organization being examined and remitted to the superintendent.

[1987, c. 482, §1 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6223. ANNUAL REPORT

The provider shall submit an annual report to the superintendent within 120 days after the end of the provider's fiscal year. The annual report shall include: [1987, c. 482, §1 (NEW).]

1. **Financial statements.** Financial statements of the provider, including, as a minimum, a balance sheet, income statement and a statement of changes in financial position, presented in conformance with generally accepted accounting principles and certified by an independent certified public accountant;

[1987, c. 482, §1 (NEW); 1989, c. 343, §21 (AMD); 1989, c. 343, §23 (AFF) .]

1-A. **Financial information.**

[1989, c. 343, §23 (RP); 1989, c. 343, §22 (NEW) .]

2. **Material changes.** Any material changes in the information submitted pursuant to this chapter;

[1995, c. 452, §31 (AMD) .]

3. **Report.** A report of the total number and disposition of complaints handled through the provider complaint system and a compilation of causes underlying the complaints; and

[1995, c. 452, §31 (AMD) .]

4. **Statement of financial condition.** A full and true statement of the provider's financial condition, transactions and affairs as of the end of its fiscal year. The report must be in the general form and context of, and require information as called for by, the form of the annual statement as currently in general and customary use in the United States for the type of provider and kind of community to be reported upon, with any useful or necessary modification or adaptation thereof and as supplemented by additional information required by the superintendent. The statement must be verified by either the provider's president or vice-president, and either the secretary or actuary, as applicable, or in the absence of the foregoing, by 2 other principal officers.

The superintendent may adopt rules that prescribe accounting standards applicable to statements filed pursuant to this section. These rules may permit or require any provider to conform its financial presentations to the standards of preparation prescribed in the accounting practices and procedures manual of the National Association of Insurance Commissioners.

[1995, c. 452, §32 (NEW) .]

SECTION HISTORY
1987, c. 482, §1 (NEW). 1989, c. 343, §§21-23 (AMD). 1995, c. 452, §§31,32 (AMD).

§6224. REMOVAL OF RECORDS OR ASSETS FROM THE STATE

No records or assets of the provider related to the organization of the facility and the provision of services under the continuing care agreement may be removed from this State by the provider, except that the superintendent may consent in writing to the removal of those records. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6225. REHABILITATION, LIQUIDATION OR CONSERVATION OF PROVIDERS

Any rehabilitation, liquidation or conservation of a provider shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the superintendent pursuant to the laws governing the rehabilitation, liquidation or conservation of insurance companies. The superintendent may institute summary proceedings in the same manner as provided in the laws governing delinquent insurers and he may apply for an order directing him to rehabilitate, liquidate or conserve a provider when, in his opinion, the continued operation of the provider will be hazardous either to the enrollees or to the people of this State. [1987, c. 482, §1 (NEW).]

SECTION HISTORY
1987, c. 482, §1 (NEW).

§6226. CONTINUING CARE RETIREMENT COMMUNITY - CERTIFICATE OF NEED DEMONSTRATION PROJECT

The following provisions apply to applicants seeking to obtain a Certificate of Need from the department for the first Continuing Care Retirement Community Demonstration Project, pursuant to Title 22, chapter 103, and the Demonstration Project Rules as adopted by the department on April 16, 1987. [1987, c. 563, §7 (NEW).]

1. **Initial deposits.** After the disclosure statement, the escrow agreement, the receipt and the continuing care agreement have been reviewed on a preliminary basis by the department's Certificate of Need staff, the department shall forward the documents with recommendations, if any, to the superintendent. All provisions of section 6203, including approval of the receipt and the escrow agreement by the superintendent, remain applicable. Thereafter the limit on deposits that may be collected may not exceed an amount equal to 10% of the entrance fee. Following issuance by the department of a Certificate of Need, any unsuccessful applicant for the first demonstration project shall refund amounts collected from subscribers with interest earned thereon pursuant to this chapter. The refunds must be made no later than 10 days after notification by the department to the unsuccessful applicant unless the unsuccessful applicant appeals the decision of the department as provided by former Title 22, chapter 103. If the applicant appeals and the appeal is denied, then refunds must be made no later than 10 days after notification of the denial.

[2003, c. 510, Pt. A, §23 (AMD) .]

2. **Exception.** Except as specifically addressed in this section, all other requirements of this chapter shall apply.

[1987, c. 563, §7 (NEW) .]

SECTION HISTORY
1987, c. 563, §7 (NEW). 2003, c. 510, §A23 (AMD).

§6227. RIGHTS OF RESIDENTS

1. **Individual rights.** All residents of continuing care retirement communities have the following rights:

A. The right to self-organize; [1995, c. 452, §33 (NEW).]

B. The right to be represented by an individual of their own choice; [1995, c. 452, §33 (NEW).]

C. The right to engage in concerted activities for their own purposes; [1995, c. 452, §33 (NEW).]

D. The right, individually and severally, to obtain outside advice, consultation and services of their own choosing and at their own expense on any matter, including, but not limited to, medical, legal and financial matters; and [1995, c. 452, §33 (NEW).]

E. The right to independence, dignity, individuality, privacy, choice and a home-like environment. These rights also include, but are not limited to, the following:

(1) A recognition of the resident's rights, responsibilities, needs and preferences;

(2) Assurances that the resident is free to select or refuse services and to accept responsibility for the consequences;

(3) Freedom to develop and maintain social ties with opportunities for meaningful interaction and involvement with the community;

(4) Recognition of personal space and the furnishing and decorating of personal space as private;

(5) Recognition that ensuring a resident's well-being does not violate a resident's civil rights;

(6) Freedom of a resident to set the resident's own schedule, have visitors and leave the facility;

(7) Acknowledgment that a resident is entitled to a "bill of rights" including methods of resolving resident complaints and freedom from abuse, neglect and the use of chemical and physical restraints;

(8) Assurances that methods of preventing and responding to incidents involving injury, loss of property, abuse and neglect will be identified and implemented; and

(9) Recognition of a resident's transfer rights under section 6228. [1995, c. 452, §33 (NEW).]

The department may adopt reasonable rules further defining the rights contained in this subsection. Nothing in this subsection affects the rights of nursing facility residents or residential care residents as currently provided by state or federal law or regulation.

[1995, c. 452, §33 (NEW) .]

2. **Meetings with provider.** A provider must be available for meetings with residents and their representatives at least once every 3 months. These meetings are for the purpose of providing a forum for free and open discussion of any point the residents or the provider wishes to discuss. At least 2 weeks' notice of each meeting must be given to residents.

[1995, c. 452, §33 (NEW) .]

SECTION HISTORY
1995, c. 452, §33 (NEW).

§6228. TRANSFER OF RESIDENTS

A resident of a continuing care retirement community may be transferred to a residential care unit or a bed within the skilled nursing facility under the following conditions: [1995, c. 452, §34 (NEW).]

1. **Written consent.** With the written consent of the resident or the resident's authorized representative; or

[1995, c. 452, §34 (NEW) .]

2. **Health or safety danger.** Upon a finding that the resident poses a health or safety danger to other residents or a change in a resident's health status or abilities necessitates a move to a higher level of care. A decision to transfer or change a resident's accommodations may be made only after extended consultation between the provider's interdisciplinary team, including, but not limited to, medical personnel, social workers and therapists of the community, and the resident, the resident's treating physician and the resident's family or other representative. The decision may also consider all reasonable care alternatives. A written decision to transfer or change a resident's accommodations must describe why the resident's health care needs can not be met at the resident's present location. The resident may appeal this determination to the department pursuant to rules prescribed by the department.

[1995, c. 452, §34 (NEW) .]

SECTION HISTORY
1995, c. 452, §34 (NEW).

Chapter 75: RURAL MEDICAL ACCESS PROGRAM

§6301. SHORT TITLE

This chapter is known and may be cited as the "Rural Medical Access Program." [1989, c. 931, §5 (NEW).]

SECTION HISTORY
1989, c. 931, §5 (NEW).

§6302. PURPOSE

The purpose of this chapter is to promote perinatal services in underserved areas of the State. [1991, c. 734, §2 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §2 (AMD).

§6303. DEFINITIONS

For purposes of this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1989, c. 931, §5 (NEW).]

1. **Insurer.** "Insurer" means any insurer authorized to transact insurance in this State and any insurer authorized as a surplus lines insurer pursuant to chapter 19.

[1989, c. 931, §5 (NEW) .]

2. **Physician's employer.** "Physician's employer" means any hospital, health care facility, clinic or other entity that employs a physician and pays for or otherwise provides professional liability insurance for the physician.

[1989, c. 931, §5 (NEW) .]

2-A. **Program.** "Program" means the Rural Medical Access Program.

[1991, c. 734, §3 (NEW) .]

3. **Self-insured.** "Self-insured" means any physician, hospital or physician's employer insured against the physician's professional negligence or the hospital's professional liability through any entity other than an insurer as defined in subsection 1. For purposes of this chapter, a physician, hospital or physician's employer that does not purchase insurance is considered self-insured.

[2005, c. 122, §1 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §3 (AMD). 2005, c. 122, §1 (AMD).

§6304. ASSESSMENTS AUTHORIZED

To provide funds for the Rural Medical Access Program, insurers may collect pursuant to this chapter assessments from physicians licensed and practicing medicine in this State and hospitals and physician's employers located in the State. [2005, c. 122, §2 (AMD).]

1. **Assessment from policyholders and self-insureds.** With respect to professional liability insurance policies for physicians and hospitals issued on or after July 1, 1990, each insurer shall collect an assessment from each policyholder. With respect to professional liability insurance for self-insureds issued on or after July 1, 1990, each self-insured shall pay an assessment as directed by the superintendent. The superintendent shall determine the amount of the assessment in accordance with this chapter. Notwithstanding any provision of law, assessments made and collected pursuant to this chapter do not constitute premium, as defined in section 2403, for purposes of any laws of this State relating to taxation, filing of insurance rates or assessment purposes other than as expressly provided under this chapter. The assessments are considered as premium only for purposes of any laws of this State relating to cancellation or nonrenewal of insurance coverage and the determination of hospital financial requirements under Title 22, chapter 107.

[1989, c. 931, §5 (NEW) .]

2. **Required support.** Every insured and self-insured physician, hospital, and physician's employer shall support the Rural Medical Access Program as provided in this chapter. Any physician, hospital or physician's employer that fails to pay the assessment required by this chapter is subject to a civil penalty not to exceed $2,000, payable to the bureau, to be recovered in a civil action.

[1989, c. 931, §5 (NEW) .]

3. **Assistance from boards and Department of Health and Human Services; insure through other means.** The Board of Licensure in Medicine and the Board of Osteopathic Licensure shall assist the superintendent in identifying those physicians who insure against professional negligence by means other than through insurers defined in section 6303. The Department of Health and Human Services shall assist the superintendent in determining the insuring entity for any licensed hospital or physician's employer, in identifying those hospitals and physician's employers that insure against professional negligence by means other than through insurers defined in section 6303 and in identifying the individual or entity who makes the insurance payment for each physician.

[1993, c. 600, Pt. B, §§21,22 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

4. **Determination of assessments paid.** After review of the records provided by the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Department of Health and Human Services, Division of Licensure and Certification, and the assessment receipts of the malpractice insurers, the superintendent shall determine those physicians, hospitals and physician's employers that have paid the required assessments.

[2005, c. 122, §3 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §4 (AMD). 1993, c. 600, §§B21,22 (AMD). 2003, c. 689, §B6 (REV). 2005, c. 122, §§2,3 (AMD).

§6305. AMOUNT OF ASSESSMENT DETERMINED

1. **Determination of assessment based on anticipated savings.** The amount of the assessment is calculated as follows.

A. For policy years beginning on or after July 1, 1990, the superintendent shall determine the amount of the savings in professional liability insurance claims and claim settlement costs to insurers anticipated in each 12-month period as a result of the Medical Liability Demonstration Project established in Title 24, chapter 21, subchapter IX and reform of the collateral source rule. [1989, c. 931, §5 (NEW).]

B. The amount of the assessment for policy years beginning on or after July 1, 1990, but before July 1, 1991, is equal to the total of:

(1) One hundred percent of the first $250,000 of savings determined under paragraph A;

(2) No portion of the savings determined under paragraph A that exceeds $250,000 but does not exceed $500,000; and

(3) Fifty percent of the portion of the savings determined under paragraph A that exceeds $500,000 but does not exceed $1,000,000. [1989, c. 931, §5 (NEW).]

C. [2005, c. 122, §4 (AMD); T. 24-A, §6305, sub-§1, ¶ C (RP).]

D. [2005, c. 122, §5 (RP).]

E. Each insurer shall assess the surcharge against its insureds as a percentage of premium unless the superintendent prescribes a different basis by rule or order. [1989, c. 931, §5 (NEW).]

F. Every self-insured physician or physician's employer and every self-insured hospital shall remit the assessment required by this section to the principal writer of physicians malpractice insurance in this State. Remittance by self-insured physicians or hospitals may be made on their behalf by a self-insurer. The superintendent shall prescribe by rule a method to calculate and collect the assessment from self-insured physicians, hospitals and physicians' employers. [1989, c. 931, §5 (NEW).]

[2005, c. 122, §§4, 5 (AMD) .]

2. **Final evaluation of savings.**

[2005, c. 122, §6 (RP) .]

3. **Assessment rates; program fund balance.** For assessment years prior to July 1, 2006, the assessment is 1.25% of premium. For assessment years commencing July 1, 2006 and after, the assessment is 0.75% of premium unless adjusted pursuant to rules adopted in accordance with subsection 4. The assessment rate is intended to result in collections no greater than $500,000 per assessment year. The superintendent shall notify affected parties of any assessment rate adjustment and the effective date of that adjustment.

The program fund balance may be used to pay assistance to qualified eligible physicians in prior years for which there were insufficient funds. If all prior years' eligible qualified physicians have received assistance, any excess funds must be carried forward to subsequent plan years as part of the program fund balance. Excess funds must be applied first to the assessment year commencing July 1, 1998 and then to each successive assessment year.

For the purposes of this section, "program fund balance" means the total funds collected in excess of assistance paid for all years.

[2013, c. 170, §1 (AMD) .]

4. **Establishment of assessment rate by rule.** The superintendent may adopt rules pursuant to section 6311 establishing an assessment rate or a methodology for calculating an assessment rate designed to provide an adequate and reliable funding source for the program and allow for the orderly and prudent drawdown of any long-term fund balance in excess of reasonable program needs. The assessment rate may not result in expected collections exceeding $500,000 per assessment year and may not exceed 0.75% of premium unless the program fund balance is $50,000 or less, in which case the assessment rate must be set to a higher rate but may not exceed 1% of premium.

[2013, c. 170, §2 (NEW) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1995, c. 570, §10 (AMD). 1999, c. 668, §113 (AMD). 2005, c. 122, §§4-7 (AMD). 2013, c. 170, §§1, 2 (AMD).

§6306. FUNDS HELD BY INSURERS

Insurers shall invest assessments collected subject to chapter 13. Interest earned on investments must be credited to the Rural Medical Access Program. [2005, c. 122, §8 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 2005, c. 122, §8 (AMD).

§6307. QUALIFICATIONS FOR PREMIUM ASSISTANCE

1. **Eligibility qualifications.** A physician is a qualified physician eligible to participate in the program if that physician:

A. Is licensed to practice medicine in the State; [1989, c. 931, §5 (NEW).]

B. Accepts and serves Medicaid patients; [1989, c. 931, §5 (NEW).]

C. Provides complete obstetrical care for patients, including prenatal care and delivery, provided that physicians in an underserved area without a facility for obstetrical delivery are still eligible if they provide only prenatal care and have referral agreements for delivery with a physician meeting the requirements of paragraphs A and B; and [1989, c. 931, §5 (NEW).]

D. Practices at least 50% of the time in areas of the State that are underserved areas for obstetrical and prenatal medical services as determined by the Department of Human Services. [1989, c. 931, §5 (NEW).]

The Commissioner of Health and Human Services shall determine those physicians who meet the requirements of this subsection. The commissioner shall adopt rules, pursuant to the Maine Administrative Procedure Act, determining underserved areas with respect to obstetrical and prenatal care. "Underserved areas" includes medically underserved areas, health manpower shortage areas and other priority areas determined by the commissioner. The commissioner may adopt rules pursuant to the Maine Administrative Procedure Act defining the scope of services that must be provided to meet the requirements of paragraphs B and C and the method of prioritizing underserved areas for purposes of distribution of the funds authorized by section 6308.

[1991, c. 734, §5 (AMD); 2003, c. 689, Pt. B, §7 (REV) .]

2. **Ineligible if premium owed.** Any physician or physician's employer who owes premiums to any insurer for any policy year prior to the year that participation in the program is sought is not eligible to participate.

[1991, c. 734, §5 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §5 (AMD). 2003, c. 689, §B7 (REV).

§6308. FUNDING OF THE PROGRAM

The amount of funds available for the program is determined as follows. [1991, c. 734, §5 (AMD).]

1. **Available funds.** The amount available for the program for policy years beginning on or after July 1, 1990, but before July 1, 1991, is 1/2 of the amount of the assessment determined under section 6305 for that year. For policy years beginning on or after July 1, 1991, the Bureau of Insurance shall determine the amount available, except that the amount may be no less than the assessment determined for that year.

[1991, c. 734, §5 (AMD) .]

2. **Determination of participants in the program.** The superintendent shall apply the standards of prioritization adopted by the Commissioner of Health and Human Services to determine the physicians who are eligible for the program. The funding available for each qualified physician is the amount equal to the difference between the physician's medical malpractice insurance premiums with obstetrical care coverage and the physician's premiums without obstetrical care coverage; however, the funding must be at least $5,000 but may not be more than $15,000 as determined by the superintendent. Program payments must be made to the individual or entity paying the medical malpractice premium for the qualified physician.

[2005, c. 122, §9 (AMD) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §5 (AMD). 2003, c. 689, §B7 (REV). 2005, c. 122, §9 (AMD).

§6309. INTERCORPORATE TRANSFERS

The superintendent may order intercorporate transfers of funds to balance assessments and program payments on an equitable basis among insurers and to provide for payments to eligible self-insureds. [1991, c. 734, §5 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 1991, c. 734, §5 (AMD).

§6310. APPEALS

1. **Assessments.** Physicians, hospitals and physicians' employers aggrieved by an insurer's application of the assessment provided for in this chapter may request a hearing before the superintendent. The hearing must be held in accordance with chapter 3, the Maine Administrative Procedure Act and procedural rules of the bureau.

[1989, c. 931, §5 (NEW) .]

2. **Eligibility.** Physicians aggrieved by an eligibility determination by the Department of Health and Human Services under section 6307 may request a hearing under the Maine Administrative Procedure Act.

[1989, c. 931, §5 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

SECTION HISTORY
1989, c. 931, §5 (NEW). 2003, c. 689, §B6 (REV).

§6311. RULES

The superintendent and the Commissioner of Health and Human Services may adopt rules in accordance with the Maine Administrative Procedure Act to carry out this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2013, c. 170, §3 (AMD).]

SECTION HISTORY
1989, c. 931, §5 (NEW). 2003, c. 689, Pt. B, §7 (REV). 2013, c. 170, §3 (AMD).

Chapter 77: BUSINESS TRANSACTED WITH BROKER-CONTROLLED PROPERTY OR CASUALTY INSURER

§6401. SHORT TITLE

This chapter may be known and cited as the "Maine Business Transacted with Broker-Controlled Insurer Act." [1991, c. 828, §33 (NEW).]

SECTION HISTORY
1991, c. 828, §33 (NEW).

§6402. DEFINITIONS

As used in this Act, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 828, §33 (NEW).]

1. **Accredited state.** "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established by the National Association of Insurance Commissioners.

[1991, c. 828, §33 (NEW) .]

2. **Broker.** "Broker" means any person who is not an agent of the insurer and as an independent contractor solicits, negotiates or procures insurance or annuity contracts or the renewal or continuation of those contracts on behalf of insureds or prospective insureds other than the broker.

[1991, c. 828, §33 (NEW) .]

3. **Control or controlled.** "Control" or "controlled" has the same meaning as set out in section 222, subsection 2, paragraph B.

[1991, c. 828, §33 (NEW) .]

4. **Controlling broker.** "Controlling broker" means a broker who directly or indirectly controls an insurer.

[1991, c. 828, §33 (NEW) .]

5. **Controlled insurer.** "Controlled insurer" means a licensed insurer that is controlled directly or indirectly by a broker.

[1991, c. 828, §33 (NEW) .]

6. **Licensed insurer or insurer.** "Licensed insurer" or "insurer" means any person licensed to transact a property or casualty insurance business, or both, in this State. The following, inter alia, are not licensed insurers for the purposes of this chapter:

A. All risk retention groups as defined in the federal Superfund Amendments Reauthorization Act of 1986, Public Law No. 99-499, 100 Stat. 1613 (1986) and the Risk Retention Act, 15 United States Code, Section 3901 et seq. and the Maine Liability Risk Retention Act; [1991, c. 828, §33 (NEW).]

B. All residual market pools and joint underwriting authorities or associations; and [1991, c. 828, §33 (NEW).]

C. All captive insurers, which for the purposes of this chapter are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates. [1991, c. 828, §33 (NEW).]

[1991, c. 828, §33 (NEW) .]

7. **Producer.** "Producer" means an insurance producer licensed pursuant to chapter 16.

[1997, c. 457, §53 (AMD); 1997, c. 457, §55 (AFF) .]

8. **Subproducer.** "Subproducer" means a producer who, for shared commission or other recompense, places business with a controlled insurer through a controlling broker.

[1991, c. 828, §33 (NEW) .]

SECTION HISTORY
1991, c. 828, §33 (NEW). 1997, c. 457, §53 (AMD). 1997, c. 457, §55 (AFF).

§6403. APPLICABILITY

This Act applies to licensed insurers as defined in section 6402, either domiciled in this State or domiciled in a state that is not an accredited state with a substantially similar law in effect. Section 222, to the extent not modified by this chapter, continues to apply to all parties within holding company systems subject to this chapter. [1991, c. 828, §33 (NEW).]

SECTION HISTORY
1991, c. 828, §33 (NEW).

§6404. MINIMUM STANDARDS

1. **Applicability.** This section applies as follows.

A. This section applies if, in any calendar year, the aggregated amount of gross written premium on business placed with a controlled insurer by a controlling broker is equal to or greater than 5% of the admitted assets of the controlled insurer as of September 30th of the preceding year, as reported in the controlled insurer's quarterly statement. [1991, c. 828, §33 (NEW).]

B. Notwithstanding paragraph A, this section does not apply if:

(1) The controlling broker:

(a) Places insurance only with the controlled insurer, only with the controlled insurer and a member or members of the controlled insurer's holding company system or only with the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(b) Accepts insurance placements only from nonaffiliated subproducers and not directly from insureds; and

(2) The controlled insurer, except for insurance business written through a residual market facility such as the workers' compensation residual market mechanism or the State's automobile assigned risk plan, accepts insurance business only from a controlling broker, a producer controlled by the controlled insurer or a producer that is a subsidiary of the controlled insurer. [1991, c. 828, §33 (NEW).]

[1991, c. 828, §33 (NEW) .]

2. **Required contract provisions.** A controlled insurer may not accept business from a controlling broker and a controlling broker may not place business with a controlled insurer unless there is a written contract between the controlling broker and the controlled insurer specifying the responsibilities of each party. The contract must be approved by the board of directors of the insurer and must contain the following minimum provisions.

A. The controlled insurer may terminate the contract for cause upon written notice to the controlling broker. The controlled insurer shall suspend the authority of the controlling broker to write business during the pendency of any dispute regarding the cause for the termination. [1991, c. 828, §33 (NEW).]

B. The controlling broker shall render timely accounts to the controlled insurer detailing all material transactions including information necessary to support all commissions, charges and other fees received by or owed to the controlling broker. [1991, c. 828, §33 (NEW).]

C. The controlling broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date must be fixed so that premiums or installments of premiums collected are remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under the contract. [1991, c. 828, §33 (NEW).]

D. All funds collected for the controlled insurer's account must be held in trust by the controlling broker in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with applicable insurance laws. Funds of a controlling broker not licensed in this State must be maintained in compliance with the requirements of the controlling broker's domiciliary jurisdiction. [1991, c. 828, §33 (NEW).]

E. The controlling broker shall maintain separately identifiable records of business written for the controlled insurer. The controlled insurer must have access and may copy all accounts and records related to its business in a form usable by the insurer. The records must be retained according to section 3408. [1991, c. 828, §33 (NEW).]

F. The contract may not be assigned in whole or in part by the controlling broker. [1991, c. 828, §33 (NEW).]

G. The controlled insurer shall provide the controlling broker with its underwriting standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions must be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling broker. [1991, c. 828, §33 (NEW).]

H. The rates of the controlling broker's commissions, charges and other fees may not be greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling brokers. For purposes of this paragraph and paragraph G, examples of "comparable business" include the same lines of insurance, the same kinds of insurance, the same kinds of risks, similar policy limits and similar quality of business. [1991, c. 828, §33 (NEW).]

I. If the contract provides that the controlling broker, on insurance business placed with the insurer, must be compensated contingent upon the insurer's profits on that business, then that compensation may not be determined and paid until at least 5 years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. The commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims are independently verified pursuant to subsection 3. [1991, c. 828, §33 (NEW).]

J. The controlled insurer shall place a limit on the controlling broker's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling broker when the applicable limit is approached and may not accept business from the controlling broker if the limit is reached. The controlling broker may not place business with the controlled insurer if notified by the controlled insurer that the limit has been reached. [1991, c. 828, §33 (NEW).]

K. The controlling broker may negotiate but may not bind reinsurance on behalf of the controlled insurer on business the controlling broker places with the controlled insurer, except that the controlling broker may bind facultative reinsurance contracts pursuant to obligatory facultative agreements. All such contracts with the controlled insurer must contain underwriting guidelines including, for reinsurance both assumed and ceded, a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and schedules of the commissions allowed. [1991, c. 828, §33 (NEW).]

[1991, c. 828, §33 (NEW) .]

3. **Audit committee.** Every controlled insurer must have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants and an independent casualty actuary acceptable to the superintendent to review the adequacy of the insurer's loss reserves.

[1991, c. 828, §33 (NEW) .]

4. **Reporting requirements.** A controlled insurer shall make the following reports.

A. In addition to any other required loss reserve certification, by April 1st of each year, the controlled insurer shall file with the superintendent an opinion of an independent casualty actuary acceptable to the superintendent reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding at the preceding year end, including incurred but not reported losses, on business placed by the controlled broker. [1991, c. 828, §33 (NEW).]

B. The controlled insurer shall report annually to the superintendent the amount of commissions paid to the controlling broker, the percentage that amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placement of the same kinds of insurance. [1991, c. 828, §33 (NEW).]

[1991, c. 828, §33 (NEW) .]

SECTION HISTORY
1991, c. 828, §33 (NEW).

§6405. DISCLOSURE

Prior to the effective date of the policy, the controlling insurer shall cause the controlling broker to deliver written notice to the prospective insured disclosing the relationship between the broker and the controlled insurer, except that if the business is placed through a subproducer who is not a controlling broker, the controlling insurer shall cause the controlling broker to retain a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the controlling broker and that the subproducer has notified or will notify the insured. [1991, c. 2, §94 (COR).]

SECTION HISTORY
RR 1991, c. 2, §94 (COR). 1991, c. 828, §33 (NEW).

§6406. PENALTIES

1. **Superintendent.** The superintendent may take the following actions.

A. If the superintendent finds, after a hearing held in conformity with the Maine Administrative Procedure Act, that the controlling broker or any other person has not complied with this chapter or any rule or order made under this chapter, the superintendent may order the controlling insurer to cease placing business through that controlled broker. [1991, c. 828, §33 (NEW).]

B. If the superintendent further finds that because of that noncompliance the controlled insurer or any policyholder of the controlled insurer has suffered any loss or damage, the superintendent may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages or other appropriate relief for the benefit of the insurer or policyholder. [1991, c. 828, §33 (NEW).]

[1991, c. 828, §33 (NEW) .]

2. **Civil action.** If an order for liquidation or rehabilitation of the controlled insurer is entered pursuant to chapter 57 and a receiver is appointed, and the superintendent finds pursuant to subsection 1 that the controlling broker or any other person has not complied with this chapter or any rule or order made under this chapter and that the insurer suffered any loss or damage because of that noncompliance, the receiver appointed under that order may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

[1991, c. 828, §33 (NEW) .]

3. **Other action.** Nothing contained in this section affects the right of the superintendent to impose any other penalties provided for in this Title.

[1991, c. 828, §33 (NEW) .]

4. **Other parties.** Nothing contained in this section in any manner alters or affects the rights of policyholders, claimants, creditors or other 3rd parties.

[1991, c. 828, §33 (NEW) .]

SECTION HISTORY
1991, c. 828, §33 (NEW).

§6407. EFFECTIVE DATE

This Act takes effect January 1, 1993. Controlled insurers and controlling brokers who are not in compliance with section 6404 on that date have 60 days to come into compliance and shall comply with section 6405 beginning with all policies written or renewed on or after March 1, 1993. [1991, c. 828, §33 (NEW).]

SECTION HISTORY
1991, c. 828, §33 (NEW).

Chapter 79: RISK-BASED CAPITAL STANDARDS

§6451. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1993, c. 634, Pt. A, §1 (NEW).]

1. **Adjusted risk-based capital report.** "Adjusted risk-based capital report" means a risk-based capital report that has been adjusted by the superintendent in accordance with section 6452, subsection 3.

[1993, c. 634, Pt. A, §1 (NEW) .]

2. **Corrective order.** "Corrective order" means an order issued by the superintendent specifying corrective actions that the superintendent has determined are required.

[1993, c. 634, Pt. A, §1 (NEW) .]

3. **Domestic insurer.** "Domestic insurer" means any insurance company domiciled in this State.

[1997, c. 81, §1 (AMD) .]

4. **Foreign insurer.** "Foreign insurer" means any insurance company that is authorized to do business in this State under section 404 but is not domiciled in this State.

[1997, c. 81, §1 (AMD) .]

4-A. **Life or health insurer.** "Life or health insurer" means any insurance company described in section 409, subsection 3 and authorized to do business in this State under section 410, or a licensed property and casualty insurer writing only accident and health insurance.

[1997, c. 81, §2 (NEW) .]

5. **NAIC.** "NAIC" means the National Association of Insurance Commissioners.

[1993, c. 634, Pt. A, §1 (NEW) .]

6. **Negative trend.** "Negative trend" means:

A. With respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the risk-based capital instructions; and [2013, c. 238, Pt. D, §1 (NEW).]

B. With respect to a property and casualty insurer, a trend that meets the triggering criteria, as determined in accordance with the trend test calculation included in the risk-based capital instructions. [2013, c. 238, Pt. D, §1 (NEW).]

[2013, c. 238, Pt. D, §1 (RPR) .]

6-A. **Property and casualty insurer.** "Property and casualty insurer" means any insurance company authorized to do business in this State under section 410 except a life or health insurer or single line mortgage guaranty insurer, financial guaranty insurer or title insurer.

[1997, c. 81, §4 (NEW) .]

7. **Risk-based capital instructions.** "Risk-based capital instructions" means the risk-based capital instructions adopted by the NAIC, as such risk-based capital instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

[1993, c. 634, Pt. A, §1 (NEW) .]

8. **Risk-based capital level.** "Risk-based capital level" means an insurer's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital or mandatory control level risk-based capital where:

A. "Company action level risk-based capital" means, with respect to any insurer, the product of 2.0 and its authorized control level risk-based capital; [1993, c. 634, Pt. A, §1 (NEW).]

B. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital; [1993, c. 634, Pt. A, §1 (NEW).]

C. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions; and [1993, c. 634, Pt. A, §1 (NEW).]

D. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

9. **Risk-based capital plan.** "Risk-based capital plan" means a comprehensive financial plan containing the elements specified in section 6453, subsection 2. If the superintendent rejects the risk-based capital plan and it is revised by the insurer, with or without the superintendent's recommendation, the plan is called the revised risk-based capital plan.

[1993, c. 634, Pt. A, §1 (NEW) .]

10. **Risk-based capital report.** "Risk-based capital report" means the report required in section 6452.

[1993, c. 634, Pt. A, §1 (NEW) .]

11. **Total adjusted capital.** "Total adjusted capital" means the sum of:

A. An insurer's statutory capital and surplus; and [1993, c. 634, Pt. A, §1 (NEW).]

B. Such other items, if any, as the risk-based capital instructions provide. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

SECTION HISTORY
1993, c. 634, Pt. A, §1 (NEW). 1997, c. 81, §§1-4 (AMD). 2013, c. 238, Pt. D, §1 (AMD).

§6451-A. APPLICABILITY TO OTHER REGULATED ENTITIES

This chapter applies to fraternal benefit societies authorized to do business in this State pursuant to section 4124, to health maintenance organizations authorized to do business in this State pursuant to section 4204 and to nonprofit hospital or medical service organizations authorized to do business in this State pursuant to Title 24, section 2305. [2009, c. 511, Pt. E, §1 (RPR).]

1. **Fraternal benefit societies providing life or annuity benefits.** Fraternal benefit societies providing life or annuity benefits are subject to the provisions of this chapter applicable to life or health insurers.

[2009, c. 511, Pt. E, §1 (NEW) .]

2. **Fraternal benefit societies providing health benefits.** Fraternal benefit societies providing health benefits are considered health organizations for purposes of this chapter.

[2009, c. 511, Pt. E, §1 (NEW) .]

3. **Other licensees.** Health maintenance organizations and nonprofit hospital or medical service organizations are considered health organizations for purposes of this chapter.

[2009, c. 511, Pt. E, §1 (NEW) .]

3-A. **Qualified nonprofit health insurance issuers.** Qualified nonprofit health insurance issuers as defined in Section 1322 of the federal Affordable Care Act are considered health organizations for purposes of this chapter.

[2011, c. 364, §35 (NEW) .]

4. **Provisions applicable to health organizations.** Except as otherwise expressly provided in this chapter, health organizations are subject to the provisions of this chapter applicable to property and casualty insurers.

[2009, c. 511, Pt. E, §1 (NEW) .]

SECTION HISTORY
1999, c. 113, §24 (NEW). 2009, c. 511, Pt. E, §1 (RPR). 2011, c. 364, §35 (AMD).

§6452. RISK-BASED CAPITAL REPORTS

1. **Duty to file.** A domestic insurer shall, on or before March 1st, submit to the superintendent a report of its risk-based capital levels as of the end of the previous calendar year, in a form and containing such information as is required by the risk-based capital instructions. In addition, a domestic insurer shall file its risk-based capital report:

A. With the NAIC in accordance with the risk-based capital instructions; and [1993, c. 634, Pt. A, §1 (NEW).]

B. With the insurance regulator in any state in which the insurer is authorized to do business, if that regulator has notified the insurer of its request for the filing in writing, in which case the insurer shall file its risk-based capital report not later than the later of:

(1) Fifteen days after the receipt of notice to file its risk-based capital report with that state; or

(2) The filing date. [1999, c. 113, §25 (AMD).]

[1999, c. 113, §25 (AMD) .]

2. **Determination of a life or health insurer's risk-based capital.** A life or health insurer's risk-based capital must be determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take into account, and may adjust for the covariance between, the following:

A. The risk with respect to the insurer's assets; [1993, c. 634, Pt. A, §1 (NEW).]

B. The risk of adverse insurance experience with respect to the insurer's liabilities and obligations; [1993, c. 634, Pt. A, §1 (NEW).]

C. The interest rate risk with respect to the insurer's business; and [1993, c. 634, Pt. A, §1 (NEW).]

D. All other business risks and such other relevant risks as are set forth in the risk-based capital instructions, determined in each case by applying the factors in the manner set forth in the risk-based capital instructions. [1993, c. 634, Pt. A, §1 (NEW).]

[1997, c. 81, §5 (AMD) .]

3. **Filing of inaccurate report.** If a domestic insurer files a risk-based capital report that in the judgment of the superintendent is inaccurate, then the superintendent shall adjust the risk-based capital report to correct the inaccuracy and notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. A risk-based capital report so adjusted is referred to as an adjusted risk-based capital report.

[1993, c. 634, Pt. A, §1 (NEW) .]

4. **Determination of a property and casualty insurer's risk-based capital.** A property and casualty insurer's risk-based capital is determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take into account and may adjust for the covariance between the following:

A. Asset risk; [1997, c. 81, §6 (NEW).]

B. Credit risk; [1997, c. 81, §6 (NEW).]

C. Underwriting risk; and [1997, c. 81, §6 (NEW).]

D. All other business risks and such other relevant risks as are set forth in the risk-based capital instructions, determined in each case by applying the factors set forth in the risk-based capital instructions. [1997, c. 81, §6 (NEW).]

[1997, c. 81, §6 (NEW) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW). 1997, c. 81, §§5,6 (AMD). 1999, c. 113, §25 (AMD).

§6453. COMPANY ACTION LEVEL EVENT

1. **Company action level event; defined.** "Company action level event" means any of the following events:

A. The filing of a risk-based capital report by an insurer that indicates that:

(1) The insurer's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital; or

(2) The insurer has total adjusted capital that is greater than or equal to its company action level risk-based capital but has a negative trend, if its total adjusted capital is less than the product of its authorized control level risk-based capital and 3.0.

[2013, c. 238, Pt. D, §2 (AMD).]

B. Provided the insurer does not challenge the adjusted risk-based capital report under section 6457, the notification by the superintendent to the insurer of an adjusted risk-based capital report that indicates the event in paragraph A; or [1993, c. 634, Pt. A, §1 (NEW).]

C. If the insurer, under section 6457, challenges the adjusted risk-based capital report that indicates the event in paragraph A, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge. [1993, c. 634, Pt. A, §1 (NEW).]

[2013, c. 238, Pt. D, §2 (AMD) .]

2. **Contents of risk-based capital plan.** When a company action level event occurs, the insurer shall submit to the superintendent a risk-based capital plan that must:

A. Identify the conditions in the insurer's business that contribute to the company action level event; [1993, c. 634, Pt. A, §1 (NEW).]

B. Contain proposals of corrective actions that the insurer intends to take and that are expected to result in the elimination of the company action level event; [1993, c. 634, Pt. A, §1 (NEW).]

C. Provide projections of the insurer's financial results in the current year and at least the 4 succeeding years, with consideration given to the effect of implementing and not implementing the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. The projections for new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component; [1993, c. 634, Pt. A, §1 (NEW).]

D. Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and [1993, c. 634, Pt. A, §1 (NEW).]

E. Identify the quality of, and the problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance in each case, if any. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

3. **Submission of risk-based capital plan.** The risk-based capital plan must be submitted:

A. Within 45 days after the company action level event; or [1999, c. 113, §26 (AMD).]

B. If the insurer challenges an adjusted risk-based capital report under section 6457, within 45 days after notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge. [1993, c. 634, Pt. A, §1 (NEW).]

[1999, c. 113, §26 (AMD) .]

4. **Review by superintendent.** Within 60 days after the submission by an insurer of a risk-based capital plan to the superintendent pursuant to this section, the superintendent shall notify the insurer whether the risk-based capital plan may be implemented or is, in the judgment of the superintendent, unsatisfactory. If the superintendent determines the risk-based capital plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may set forth proposed revisions that will render the risk-based capital plan satisfactory, in the judgment of the superintendent. Upon notification from the superintendent, the insurer shall prepare a revised risk-based capital plan, which may incorporate by reference any revisions proposed by the superintendent, and shall submit the revised risk-based capital plan to the superintendent:

A. Within 45 days after the notification from the superintendent; or [1993, c. 634, Pt. A, §1 (NEW).]

B. If the insurer challenges the notification from the superintendent under section 6457, within 45 days after a notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

5. **Notification that plan is unsatisfactory.** In the event of a notification by the superintendent to an insurer that the insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the superintendent may at the superintendent's discretion, subject to the insurer's right to a hearing under section 6457, specify in the notification that the notification constitutes a regulatory action level event.

[1993, c. 634, Pt. A, §1 (NEW) .]

6. **Duty to file copies of plan with other states.** A domestic insurer that files a risk-based capital plan or revised risk-based capital plan with the superintendent pursuant to this section shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance regulator in any state in which the insurer is authorized to do business if:

A. That state has a risk-based capital provision substantially similar to that required by this chapter; and [1993, c. 634, Pt. A, §1 (NEW).]

B. The insurance regulator of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the risk-based capital plan or revised risk-based capital plan in that state no later than the later of:

(1) Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(2) The date on which the risk-based capital plan or revised risk-based capital plan is filed with the superintendent. [1999, c. 113, §27 (AMD).]

[1999, c. 113, §27 (AMD) .]

SECTION HISTORY
1993, c. 634, Pt. A, §1 (NEW). 1997, c. 81, §7 (AMD). 1999, c. 113, §§26, 27 (AMD). 2009, c. 511, Pt. E, §2 (AMD). 2013, c. 238, Pt. D, §2 (AMD).

§6454. REGULATORY ACTION LEVEL EVENT

1. **Regulatory action level event; defined.** "Regulatory action level event" means, with respect to any insurer, any of the following events:

A. The filing of a risk-based capital report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital; [1993, c. 634, Pt. A, §1 (NEW).]

B. Provided the insurer does not challenge the adjusted risk-based capital report under section 6457, the notification by the superintendent to an insurer of an adjusted risk-based capital report that indicates the event in paragraph A; [1993, c. 634, Pt. A, §1 (NEW).]

C. If the insurer, under section 6457, challenges an adjusted risk-based capital report that indicates the event in paragraph A, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge; [1993, c. 634, Pt. A, §1 (NEW).]

D. The failure of the insurer to file a risk-based capital report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the superintendent and has cured the failure within 10 days after the filing date; [1993, c. 634, Pt. A, §1 (NEW).]

E. The failure of the insurer to submit a risk-based capital plan to the superintendent within the time period set forth in section 6453, subsection 3; [1993, c. 634, Pt. A, §1 (NEW).]

F. Provided the insurer has not challenged the determination under section 6457, the notification by the superintendent to the insurer that:

(1) The risk-based capital plan or revised risk-based capital plan submitted by the insurer is, in the judgment of the superintendent, unsatisfactory; and

(2) The superintendent's finding unless vacated or stayed constitutes a regulatory action level event with respect to the insurer; [1999, c. 113, §28 (AMD).]

G. If the insurer, under section 6457, challenges a determination by the superintendent under paragraph F, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected that challenge; [1993, c. 634, Pt. A, §1 (NEW).]

H. Provided the insurer has not challenged the determination under section 6457, the notification by the superintendent to the insurer that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if that failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event or regulatory action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the superintendent has so stated in the notification; or [1999, c. 113, §28 (AMD).]

I. If the insurer, under section 6457, challenges a determination by the superintendent under paragraph H, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the challenge unless the failure of the insurer to adhere to its risk-based capital plan or revised risk-based capital plan has no substantial adverse effect on the ability of the insurer to eliminate the company action level event or regulatory action level event with respect to the insurer. [1999, c. 113, §28 (AMD).]

[1999, c. 113, §28 (AMD) .]

2. **Superintendent duties; regulatory action level event.** When a regulatory action level event occurs, the superintendent shall:

A. Require the insurer to submit a risk-based capital plan or, if applicable, a revised risk-based capital plan; [1993, c. 634, Pt. A, §1 (NEW).]

B. Perform such examination or analysis as the superintendent considers necessary of the assets, liabilities and operations of the insurer, including a review of its risk-based capital plan or revised risk-based capital plan; and [1993, c. 634, Pt. A, §1 (NEW).]

C. Subsequent to the examination or analysis, issue a corrective order specifying corrective actions that the superintendent considers necessary. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

3. **Determination of corrective actions.** In determining corrective actions, the superintendent may take into account those factors that the superintendent considers relevant with respect to the insurer based upon the superintendent's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan must be submitted:

A. Within 45 days after the occurrence of the regulatory action level event; [1993, c. 634, Pt. A, §1 (NEW).]

B. If the insurer challenges an adjusted risk-based capital report under section 6457 and the challenge is not, in the judgment of the superintendent, frivolous, within 45 days after the notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge; or [1993, c. 634, Pt. A, §1 (NEW).]

C. If the insurer challenges a revised risk-based capital plan under section 6457, within 45 days after notification to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

4. **Consultants.** The superintendent may retain actuaries, investment experts and other consultants as may be necessary in the judgment of the superintendent to review the insurer's risk-based capital plan or revised risk-based capital plan; examine or analyze the assets, liabilities and operations of the insurer; and formulate the corrective order with respect to the insurer. For insurers offering managed care plans as defined in section 4301-A, the analysis of the insurer's operations may include an analysis of its contractual relationships with providers and the ability of the providers to fulfill their contractual obligations. The fees, costs and expenses relating to consultants must be borne by the affected insurer or such other party as directed by the superintendent.

[2001, c. 1, §38 (COR) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW). 1999, c. 113, §§28,29 (AMD). RR 2001, c. 1, §38 (COR).

§6455. AUTHORIZED CONTROL LEVEL EVENT

1. **Authorized control level event; defined.** "Authorized control level event" means any of the following events:

A. The filing of a risk-based capital report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital; [1993, c. 634, Pt. A, §1 (NEW).]

B. Provided the insurer does not challenge the adjusted risk-based capital report under section 6457, the notification by the superintendent to the insurer of an adjusted risk-based capital report that indicates the event in paragraph A; [1993, c. 634, Pt. A, §1 (NEW).]

C. If the insurer, under section 6457, challenges an adjusted risk-based capital report that indicates the event in paragraph A, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge; [1993, c. 634, Pt. A, §1 (NEW).]

D. Provided the insurer has not challenged the corrective order under section 6457, the failure of the insurer to respond, in a manner satisfactory to the superintendent, to a corrective order; or [1993, c. 634, Pt. A, §1 (NEW).]

E. If the insurer has challenged a corrective order under section 6457 and the superintendent has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the superintendent, to the corrective order subsequent to rejection or modification by the superintendent. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

2. **Superintendent duties; authorized control level event.** When an authorized control level event occurs, the superintendent shall:

A. Take those actions that are required under section 6454 regarding an insurer with respect to which a regulatory action level event has occurred; or [1993, c. 634, Pt. A, §1 (NEW).]

B. If the superintendent considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take those actions that are necessary to cause the insurer to be placed under regulatory control under chapter 57. If the commissioner takes those actions, the authorized control level event is deemed sufficient grounds for the superintendent to take action under chapter 57, and the superintendent has the rights, powers and duties with respect to the insurer as are set forth in chapter 57.

If the superintendent takes actions under this paragraph pursuant to an adjusted risk-based capital report, the insurer is entitled to those protections that are afforded to insurers under the provisions of chapter 57, subchapter II pertaining to summary proceedings. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW).

§6456. MANDATORY CONTROL LEVEL EVENT

1. **Mandatory control level event; defined.** "Mandatory control level event" means any of the following events:

A. The filing of a risk-based capital report that indicates that the insurer's total adjusted capital is less than its mandatory control level risk-based capital; [1993, c. 634, Pt. A, §1 (NEW).]

B. Provided the insurer does not challenge the adjusted risk-based capital report under section 6457, the notification by the superintendent to the insurer of an adjusted risk-based capital report that indicates the event in paragraph A; or [1993, c. 634, Pt. A, §1 (NEW).]

C. If the insurer, under section 6457, challenges an adjusted risk-based capital report that indicates the event in paragraph A, the notification by the superintendent to the insurer that the superintendent has, after a hearing, rejected the insurer's challenge. [1993, c. 634, Pt. A, §1 (NEW).]

[1993, c. 634, Pt. A, §1 (NEW) .]

2. **Superintendent duties; mandatory control level event.** When a mandatory control level event occurs, the superintendent shall take those actions that are necessary to cause the insurer to be placed under regulatory control under chapter 57. If the superintendent takes those actions, the mandatory control level event is deemed sufficient grounds for the superintendent to take action under chapter 57, and the superintendent has the rights, powers and duties with respect to the insurer as are set forth in chapter 57. If the superintendent takes actions pursuant to an adjusted risk-based capital report, the insurer is entitled to those protections that are afforded to insurers under the provisions of chapter 57, subchapter II pertaining to summary proceedings. Notwithstanding any provision of this section to the contrary, the superintendent may forego action for up to 90 days after the mandatory control level event if the superintendent finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period, or, in the case of a property and casualty insurer that is not authorized to write new business, the superintendent may allow the insurer to continue to run off its existing business under the superintendent's supervision.

[1997, c. 81, §8 (AMD) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW). 1997, c. 81, §8 (AMD).

§6457. HEARINGS

1. **Right to hearing.** An insurer has the right to a departmental hearing, on record, at which the insurer may challenge any determination or action by the superintendent upon:

A. Notification to an insurer by the superintendent of an adjusted risk-based capital report; [1993, c. 634, Pt. A, §1 (NEW).]

B. Notification to an insurer by the superintendent that:

(1) The insurer's risk-based capital plan or revised risk-based capital plan is unsatisfactory; and

(2) That notification constitutes a regulatory action level event with respect to the insurer; [1993, c. 634, Pt. A, §1 (NEW).]

C. Notification to any insurer by the superintendent that the insurer has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its risk-based capital plan or revised risk-based capital plan; or [1993, c. 634, Pt. A, §1 (NEW).]

D. Notification to an insurer by the superintendent of a corrective order with respect to the insurer. [1993, c. 634, Pt. A, §1 (NEW).]

The insurer must notify the superintendent of its request for a hearing within 5 days after the notification by the superintendent under paragraph A, B, C or D. Upon receipt of the insurer's request for a hearing, the superintendent shall set a date for the hearing, which may not be less than 10 or more than 30 days after the date of the insurer's request.

[1993, c. 634, Pt. A, §1 (NEW) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW).

§6458. CONFIDENTIALITY AND PROHIBITION ON ANNOUNCEMENTS

1. **Confidentiality.** The following constitute information that might be damaging to the insurer if made available to its competitors and must be kept confidential by the superintendent:

A. Risk-based capital reports, with respect to any domestic insurer or foreign insurer, that are filed with the superintendent, to the extent that the information in the reports is not required to be set forth in a publicly available annual statement schedule; and [1993, c. 634, Pt. A, §1 (NEW).]

B. Risk-based capital plans, with respect to any domestic insurer or foreign insurer, that are filed with the superintendent, including the results or report of any examination or analysis of an insurer performed pursuant to this chapter and any corrective order issued by the superintendent pursuant to the examination or analysis. [1993, c. 634, Pt. A, §1 (NEW).]

The information listed in paragraph A or B may not be made public or be subject to subpoena, other than by the superintendent and then only for the purpose of enforcement actions taken by the superintendent pursuant to this chapter or any other provision of the insurance laws of this State.

[1993, c. 634, Pt. A, §1 (NEW) .]

2. **Prohibition on dissemination of information regarding risk-based capital levels.** Except as otherwise required under this chapter, making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion or representation with regard to the risk-based capital levels of any insurer, or of any component derived in the calculation of risk-based capital levels, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is prohibited; provided, however, that if any materially false statement with respect to the comparison between an insurer's total adjusted capital to its risk-based capital levels or an inappropriate comparison of any other amount to the insurer's risk-based capital levels is published in any written publication and the insurer is able to demonstrate

to the superintendent with substantial proof the falsity of that statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

[1993, c. 634, Pt. A, §1 (NEW) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW).

§6459. SUPPLEMENTAL PROVISIONS

1. **Existing authority supplemented.** The provisions of this chapter are supplemental to any other provisions of the laws of this State and do not preclude or limit any other powers or duties of the superintendent under those laws, including, but not limited to, sections 417, 3423 and 3424 and chapter 57.

[1997, c. 81, §9 (NEW) .]

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

[1997, c. 81, §9 (NEW) .]

3. **Exemptions.** The superintendent may exempt from the application of this chapter any domestic property and casualty insurer that:

A. Writes business only in the State; [1997, c. 81, §9 (NEW).]

B. Writes direct annual premium of $2,000,000 or less; and [1997, c. 81, §9 (NEW).]

C. Assumes no reinsurance in excess of 5% of direct premium written. [1997, c. 81, §9 (NEW).]

[1997, c. 81, §9 (NEW) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW). 1997, c. 81, §9 (RPR).

§6460. FOREIGN INSURERS

1. **Submission of risk-based capital report.** Upon the written request of the superintendent, a foreign insurer shall submit to the superintendent a risk-based capital report as of the end of the previous calendar year by the later of:

A. The date a risk-based capital report would be required to be filed by a domestic insurer under this chapter; or [1993, c. 634, Pt. A, §1 (NEW).]

B. Fifteen days after the request is received by the foreign insurer. [1993, c. 634, Pt. A, §1 (NEW).]

At the written request of the superintendent, a foreign insurer shall promptly submit to the superintendent a copy of any risk-based capital plan that is filed with the insurance superintendent of any other state.

[1993, c. 634, Pt. A, §1 (NEW) .]

2. **Company action level event or regulatory action level event.** When a company action level event or regulatory action level event with respect to a foreign insurer occurs, as determined under laws governing risk-based capital applicable in the state of domicile of the insurer, or, if no such risk-based capital provision

is in force in that state, under the provisions of this chapter, if the insurance superintendent of the state of domicile of the foreign insurer fails to require the foreign insurer to file a risk-based capital plan in the manner specified under the laws governing risk-based capital in that state, or, if no such risk-based capital provision is in force in that state, under this chapter, the superintendent may require the foreign insurer to file a risk-based capital plan with the superintendent. In this event, the failure of the foreign insurer to file a risk-based capital plan with the superintendent is grounds to order the insurer to desist from writing new insurance business in this State.

[1993, c. 634, Pt. A, §1 (NEW) .]

3. **Mandatory control level event.** When a mandatory control level event with respect to any foreign insurer occurs, if a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the superintendent may make application to the Superior Court under chapter 57 with respect to the liquidation of property of foreign insurers in this State, and the occurrence of the mandatory control level event is considered adequate grounds for the application.

[1993, c. 634, Pt. A, §1 (NEW) .]

SECTION HISTORY
1993, c. 634, §A1 (NEW).

§6461. NOTICES

A notice by the superintendent to an insurer that may result in regulatory action under this chapter is effective upon dispatch if transmitted by registered or certified mail or, in the case of any other transmission, is effective upon the insurer's receipt of the notice. [1993, c. 634, Pt. A, §1 (NEW).]

SECTION HISTORY
1993, c. 634, §A1 (NEW).

Chapter 81: MULTIPLE-EMPLOYER WELFARE ARRANGEMENTS

§6601. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1993, c. 688, §1 (NEW).]

1. **Declaration of trust.** "Declaration of trust" means a joint statement of those participating employers composing a multiple-employer welfare arrangement in which the purposes, plan of administration, rights and duties of the participants and the manner of funding obligations arising under the arrangement are established.

[1993, c. 688, §1 (NEW) .]

2. **Fund balance.** "Fund balance" means the total assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the multiple-employer welfare arrangement are not included in the fund balance. "Fund balance" includes other contributed capital, retained earnings and subordinated debt.

[1993, c. 688, §1 (NEW) .]

3. **Funded trust.** "Funded trust" means that legal entity created to receive, hold and administer contributions of employers participating in the arrangement that is composed of assets acceptable to the superintendent equal to or in excess of loss reserves and all other liabilities of the arrangement. A trust is not fully funded if any part of the corpus consists of a surety bond.

[1993, c. 688, §1 (NEW) .]

4. **Insolvent or impaired condition.** A multiple-employer welfare arrangement is "insolvent" or in an "impaired condition" when the fund balance is in a deficit position.

[1993, c. 688, §1 (NEW) .]

5. **Multiple-employer welfare arrangement.** "Multiple-employer welfare arrangement" or "arrangement" means an employer welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers or to their beneficiaries. For the purposes of this chapter only, an employer welfare benefit plan or any other arrangement that, after April 30, 1996, is established or maintained for the purpose of offering or providing health benefits to employees leased to client companies by an employee leasing company required to be registered under Title 32, chapter 125 must be treated as a multiple-employer welfare arrangement within the meaning of this chapter. "Multiple-employer welfare arrangement" does not include a plan or arrangement established or maintained before January 1, 1993 by the State, a political subdivision of the State or an association composed of political subdivisions of the State primarily to cover its employees, former employees or their dependents, nor does it include a plan or arrangement established or maintained under or pursuant to one or more agreements deemed collective bargaining agreements under the federal Employee Retirement Income Security Act of 1974, Section 3(40)(A)(i), as amended. For purposes of this chapter, 2 or more trades or businesses, whether or not incorporated, are deemed a single employer if those trades or businesses are under common ownership or within the same control group as defined under the federal Employee Retirement Income Security Act of 1974, Section 3(40)(B). For the purposes of this chapter only, each of an employee leasing company's client companies, as defined in Title 32, section 14051, is considered a separate employer as long as it is not deemed a single employer under this subsection.

[1995, c. 618, §5 (AMD) .]

6. **Participation agreement.** "Participation agreement" means the document pursuant to which an employer undertakes and agrees to fulfill the obligation of employers imposed by the declaration of trust.

[1993, c. 688, §1 (NEW) .]

7. **Qualified financial institution.** "Qualified financial institution" means an institution that is organized, or in the case of a United States branch or agency office of a foreign banking organization is licensed under the laws of the United States or any state, and has been granted authority to operate with fiduciary powers and is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

[1993, c. 688, §1 (NEW) .]

8. **Third-party administrator.** "Third-party administrator" or "administrator" means an administrator licensed pursuant to chapter 18.

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §5 (AMD).

§6602. SCOPE

1. **Multiple-employer welfare arrangement; approval required.** A person may not commence operations after January 1, 1995 of a multiple-employer welfare arrangement unless that arrangement is approved by the superintendent. A person may not operate after January 1, 1995 a multiple-employer welfare arrangement in existence before January 1, 1995 unless that arrangement has been submitted for approval in compliance with this chapter.

[1993, c. 688, §1 (NEW) .]

2. **Insurer authorized to transact health insurance.** This chapter does not apply to a multiple-employer welfare arrangement that offers or provides benefits that are fully insured by an insurer authorized to transact health insurance in the State.

[1993, c. 688, §1 (NEW) .]

3. **Application.** Section 6608 does not apply to a multiple-employer welfare arrangement that:

A. Meets the general eligibility requirements of section 6603, subsection 1; [1993, c. 688, §1 (NEW).]

B. Is administered primarily from a principal place of business located within the State; and [1993, c. 688, §1 (NEW).]

C. Has provided employee health benefits for a continuous period since on or before January 1, 1984. [1993, c. 688, §1 (NEW).]

[1993, c. 688, §1 (NEW) .]

4. **Application for approval; filing required.** If a multiple-employer welfare arrangement does not satisfy the requirements of subsection 3, the arrangement shall file with the superintendent within 60 days of the effective date of this subsection a complete application for authorization under section 6604.

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6603. GENERAL ELIGIBILITY

This section governs all multiple-employer welfare arrangements except for those offered by a registered employee leasing company complying with the requirements of section 6603-A. [1995, c. 618, §6 (NEW).]

1. **Requirements for approval.** To meet the requirements for approval and to maintain a multiple-employer welfare arrangement, an arrangement:

A. Must be nonprofit; [1993, c. 688, §1 (NEW).]

B. Except for those associations meeting the criteria of subsection 1-A, must be established by a trade association, industry association, political subdivision of the State, religious organization or professional association of employers or professionals that has a constitution or bylaws and that has been organized and maintained in good faith for a continuous period of one year for purposes other than that of obtaining or providing insurance; [2001, c. 570, §1 (AMD).]

C. Must be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the arrangement and that is responsible for all operations of the arrangement. The trustees selected must be owners, partners, officers, directors or employees of one or more employers in the arrangement. A trustee may not be an owner, officer or employee of the administrator or service company of the arrangement. The trustees have the authority to approve applications of association members for participation in the arrangement and to contract with a licensed administrator or service company to administer the day-to-day affairs of the arrangement; [2003, c. 374, §1 (AMD).]

D. May not be offered, advertised or available to employers or other members of the public generally, except as allowed under subsection 1-A; [2001, c. 570, §1 (AMD).]

E. Must be operated in accordance with sound actuarial principles; [1993, c. 688, §1 (NEW).]

F. Must comply with the requirements of chapter 36, governing continuity of health insurance coverage; [1993, c. 688, §1 (NEW).]

F-1. Must comply with the requirements of section 2809-A, subsection 11, concerning continued coverage in the event of an employee's being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under workers' compensation; [2005, c. 121, Pt. A, §1 (NEW).]

G. May not deny coverage to any otherwise eligible employer, employee or dependent on the basis of health status or claims experience; and [1993, c. 688, §1 (NEW).]

H. May issue only health care benefit plans that comply with the requirements of section 2808-B with regard to rating practices, coverage for late enrollees and guaranteed renewal. An arrangement may not provide health care benefits that do not meet or exceed the requirements for mandated benefits applicable to comparable insured plans. [2001, c. 410, Pt. A, §9 (AMD).]

[2005, c. 121, Pt. A, §1 (AMD) .]

1-A. **Eligibility based on geographic association.** To meet the requirements for approval and to maintain a multiple-employer welfare arrangement, an arrangement based on geographic association:

A. Must be established by an association with a principal office in a location within a 40-mile radius of the principal place of business of eligible employers; [2001, c. 570, §2 (NEW).]

B. Must permit eligibility for an employer that has employed an average of 100 or fewer full-time employees during the preceding calendar year, more of whom are employed in this State than any other state, and for an employer that is a licensed nonprofit hospital if the employer or hospital is located within a 40-mile radius of the association; [2001, c. 570, §2 (NEW).]

C. May establish eligibility standards for membership in the association, except that an association may not deny eligibility to an otherwise eligible employer or hospital on the basis of health status or claims experience; and [2001, c. 570, §2 (NEW).]

D. Must meet the requirements for approval in subsection 1, except as provided in subsection 1, paragraphs B and D. [2001, c. 570, §2 (NEW).]

[2001, c. 570, §2 (NEW) .]

2. **Evidence of benefits; issuance to covered employee.** The arrangement shall issue to each covered employee a contract, certificate, summary plan description or other evidence of the benefits and coverages provided. This evidence of the benefits and coverages provided must contain in boldface print in a conspicuous location the following statement: "The benefits and coverages described herein are provided through a trust fund established and funded by a group of employers." Arrangements in existence before October 1, 1993 that have previously issued benefit descriptions to employees may meet the disclosure requirements under this chapter by issuing to each employee additional written material necessary to meet the requirements of this subsection.

[1993, c. 688, §1 (NEW) .]

3. **Maintenance of specific excess insurance.** Each arrangement shall maintain specific excess insurance with a retention level determined in accordance with sound actuarial principles and approved by the superintendent. The superintendent may also require the arrangement to purchase aggregate excess insurance.

[1993, c. 688, §1 (NEW) .]

4. **Maintenance of appropriate loss reserves.** Each arrangement shall establish and maintain appropriate loss and loss expense reserves determined in accordance with sound actuarial principles and shall fund obligations by depositing assets that will yield in a time frame matching maturing liabilities of the arrangement sufficient funds to discharge claims and other expense payments.

[1993, c. 688, §1 (NEW) .]

5. **Funds held in trust.** All funds of a multiple-employer welfare arrangement must be held in trust in this State in the name of the arrangement in a qualified financial institution by state or federally chartered financial institutions until such time as they are disbursed.

[2003, c. 374, §2 (AMD) .]

6. **Replacement of trustee.** The superintendent may not grant or continue approval until the arrangement replaces any trustee found by the superintendent:

A. To be incompetent, untrustworthy or financially irresponsible; [1993, c. 688, §1 (NEW).]

B. To be guilty of or to have pled guilty or no contest in any state or country to a criminal offense for which incarceration for one year or more may be imposed or for which incarceration of one year or more could be imposed had the offense occurred in this State, or that involves moral turpitude, dishonesty, false statement or misappropriation or conversion of property or funds; [1993, c. 688, §1 (NEW).]

C. To have had any type of insurance license revoked in this State or any other state; or [1993, c. 688, §1 (NEW).]

D. To have improperly manipulated assets, accounts or specific excess insurance or to have otherwise acted in bad faith. [1993, c. 688, §1 (NEW).]

[1993, c. 688, §1 (NEW) .]

7. **Contracts available for inspection.** To qualify for and retain approval to transact business, an arrangement must make all contracts with administrators or service companies available for inspection by the bureau initially and thereafter upon reasonable notice.

[1993, c. 688, §1 (NEW) .]

8. **Suspension or revocation of approval.** Failure to maintain compliance with applicable eligibility or filing requirements established by this section is grounds for suspension or revocation of authority of an arrangement. However, with respect to deficiencies other than an impairment, the arrangement has 60 days after notification by the superintendent to take action necessary to correct the deficiency.

[1993, c. 688, §1 (NEW) .]

9. **Access to health care services.**

[2011, c. 90, Pt. F, §8 (RP) .]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §6 (AMD). 1999, c. 256, §R1 (AMD). 2001, c. 410, §A9 (AMD). 2001, c. 570, §1 (AMD). 2001, c. 570, §2 (AMD). 2003, c. 374, §§1,2 (AMD). 2005, c. 121, §A1 (AMD). 2007, c. 278, §1 (AMD). 2011, c. 90, Pt. F, §8 (AMD).

§6603-A. EMPLOYEE LEASING COMPANIES

An employee leasing company that provides health benefits on other than a fully insured basis for employees leased to client companies shall comply with the requirements of this section. [1995, c. 618, §7 (NEW).]

1. **Requirements for approval.** The arrangement must meet the requirements of this subsection to obtain approval to establish a multiple-employer welfare arrangement or to maintain operations of a multiple-employer welfare arrangement.

A. The employee leasing company must be registered in this State in accordance with Title 32, chapter 125. [1995, c. 618, §7 (NEW).]

B. Within 4 months of the end of each fiscal year or within such extension of time as the superintendent for good cause may grant, the arrangement shall file with the superintendent an annual financial report certified by an independent certified public accountant. The report must include a letter of qualification from the accountant that meets the requirements of section 6611, subsection 1-A. The report must provide the name and address of the insurer providing excess insurance and it must also include an analysis of the adequacy of reserves and contributions or premiums charged based on a review of past and projected claims and expenses. [1995, c. 618, §7 (NEW).]

C. Within 45 days of the end of each fiscal quarter, the arrangement shall file with the superintendent a letter from an independent certified public accountant attesting to the following:

(1) That the employees have been paid in a timely fashion;

(2) That all payroll taxes and income taxes withheld have been paid to the appropriate state or federal agency in a timely fashion;

(3) With respect to any health care benefits provided on other than a fully insured basis, that specific excess insurance is maintained with a retention level adequate for the plan; and

(4) With respect to any health care benefits provided on other than a fully insured basis, that appropriate loss and loss expense reserves are maintained that are adequate for the plan. [1995, c. 618, §7 (NEW).]

D. Any necessary excess insurance must be purchased from an insurer licensed to transact health or casualty insurance in the State. [1995, c. 618, §7 (NEW).]

E. The arrangement shall issue to each covered employee a contract, certificate, summary plan description or other evidence of the benefits and coverages provided. This evidence of the benefits and coverages provided must contain in boldface print in a conspicuous location the following statement: "The benefits and coverages described herein are provided by [name of employee leasing company] on a self-insured basis, not through a contract with a commercial insurance carrier." If the benefit plan or arrangement was in existence before April 30, 1996 and had previously issued benefit descriptions to the covered employees, the arrangement shall issue to each employee the additional written material necessary to meet the requirements of this paragraph. [1995, c. 618, §7 (NEW).]

F. The arrangement must pay the filing fee specified in section 601 at the time of the application for approval. [1995, c. 618, §7 (NEW).]

[1995, c. 618, §7 (NEW) .]

2. **Application for approval.** To obtain approval, an arrangement must submit a letter of application to the Superintendent that includes or has attached the material required by subsection 1. If any information is not available at the time of application, the arrangement shall specify in the letter when that information will be provided. The superintendent, in the superintendent's discretion, may grant approval of an arrangement conditioned upon the timely receipt of the required information if the superintendent determines that the arrangement is funded at a level consistent with the purposes of this chapter.

[1995, c. 618, §7 (NEW) .]

3. **Other provisions.** An arrangement approved pursuant to the requirements of this section is also subject to the requirements of sections 6606, 6607, 6610, 6614 and 6616.

[1995, c. 618, §7 (NEW) .]

4. **Grounds for denial, suspension or revocation of arrangement.** The superintendent, in the superintendent's discretion, may deny, suspend or revoke the authorization granted pursuant to this section if the superintendent finds that the arrangement has failed to meet the requirements of this section, has refused to produce the required financial information or has refused to correct a deficiency determined pursuant to section 6606. When failure to maintain compliance with the requirements of this section is the grounds for suspension or revocation of authority of an arrangement, the arrangement has 60 days after notification by the superintendent to take action necessary to correct the deficiency.

[1995, c. 618, §7 (NEW) .]

SECTION HISTORY
1995, c. 618, §7 (NEW).

§6604. FILING REQUIREMENTS

The sponsoring association shall file with the superintendent an application for authorization of the arrangement upon a form to be furnished by the superintendent. The application must include or have attached the following: [1993, c. 688, §1 (NEW).]

1. **Constitution or bylaws.** A copy of the constitution or bylaws of the association;

[1993, c. 688, §1 (NEW) .]

2. **Identification of trustees.** The names and addresses of the trustees of the arrangement;

[1993, c. 688, §1 (NEW) .]

3. **Document governing operation.** A copy of the declaration of trust, trust agreement and any other documents that govern the operation of the arrangement;

[1993, c. 688, §1 (NEW) .]

4. **Evidence of benefits provided.** A copy of the employer participation agreement and the certificate, summary plan description or other evidence of the benefits and coverage provided to covered employees;

[1993, c. 688, §1 (NEW) .]

5. **Proof of deposit or surety bond.** Proof of deposit or a copy of the surety bond required pursuant to section 6607;

[1993, c. 688, §1 (NEW) .]

6. **Excess insurance agreement.** A copy of the arrangement's excess insurance agreement;

[1993, c. 688, §1 (NEW) .]

7. **Evidence of sound actuarial principles.** Evidence satisfactory to the superintendent showing that the arrangement will be operated in accordance with sound actuarial principles. The superintendent may not approve the arrangement unless the superintendent determines that the plan is designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles;

[1995, c. 618, §8 (AMD) .]

8. **Additional information.** Additional information that the superintendent may reasonably require; and

[1995, c. 618, §8 (AMD) .]

9. **Filing fee.** The filing fee specified in section 601.

[1995, c. 618, §8 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §§8,9 (AMD).

§6605. FUND BALANCE

Each multiple-employer welfare arrangement shall maintain a positive fund balance. [1993, c. 688, §1 (NEW).]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6606. DEFICIENCY IN RESERVES, ASSETS OR REINSURANCE

1. **Examination of finances.** The superintendent may conduct, upon reasonable notice, an examination to determine the financial condition of an arrangement. For arrangements subject to the requirements of section 6603-A, the examination must be limited to the work of the certified public accountant conducting the annual audit or submitting the quarterly filings required by that section. For all other arrangements, examiners duly qualified by the superintendent may examine the loss reserves, assets, liabilities, excess insurance and working capital of a multiple-employer welfare arrangement. If the superintendent finds that the reserves, excess insurance or assets may be inadequate, or that the arrangement does not have working capital in an amount establishing the financial strength and liquidity of the arrangement to pay claims promptly and showing evidence of the financial ability of the arrangement to meet its obligations to covered employees, the superintendent shall notify the arrangement of the inadequacy. Upon notification, the arrangement shall file within 30 days with the superintendent its written plan specifying remedial action to be taken and the time for implementation of that plan.

[1995, c. 618, §10 (AMD) .]

2. **Correction of deficiency.** If the superintendent determines, after reviewing the information filed, that a hazardous financial condition exists, the arrangement shall implement within 30 days its plan to correct any deficiencies and shall file with the superintendent proof of remedial action taken within 60 days. If the superintendent is satisfied that the plan submitted to improve the inadequate condition of the arrangement is sufficient, the superintendent shall notify the arrangement. The arrangement shall report monthly to the superintendent until any deficiencies and their causes have been corrected.

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §10 (AMD).

§6607. TRUST DEPOSIT OR SURETY BOND

If the superintendent determines that a multiple-employer welfare arrangement has failed to establish or maintain the actuarially indicated level of funding as required, the superintendent may require the arrangement to file a security deposit or a surety bond in accordance with this section. [1995, c. 618, §11 (AMD).]

1. **Deposit.** If required, deposit funds, which may consist of cash, securities or any combination of cash and securities acceptable to the superintendent, must be filed with the superintendent for deposit with the Treasurer of State in an amount equal to the greater of either 25% of the immediately preceding 12 months' health care claims expenditures or 15% of the expected gross annual contributions for the current year. In no case may the amount of the deposit be less than $50,000 or more than $1,000,000 except that the superintendent, after due notice to all interested parties and opportunity for hearing, and after consideration of the records, may prescribe an amount in excess of $1,000,000. All income from deposits belongs to the depositing arrangement and must be paid to it when received. An arrangement that has made a security deposit, subject to approval of the superintendent, may withdraw that deposit or any part of that deposit after

making a substitute deposit of cash, securities or any combination of cash and securities of equal amount and value. A judgment creditor or other claimant of a multiple-employer welfare arrangement may not levy upon any of the assets or securities held in this State as a deposit under this section.

[1993, c. 688, §1 (NEW) .]

2. **Surety bond in lieu of deposit.** In lieu of the deposit required under subsection 1, an arrangement may file with the superintendent a surety bond in like amount. The bond must be one issued by an authorized surety insurer, must be for the same purpose as the deposit in lieu of which it is filed and must be in a form prescribed by the superintendent. A bond may not be canceled or subject to cancellation unless at least 60 days' advance notice of cancellation in writing is filed with the superintendent and the chair of the trustees.

[1993, c. 688, §1 (NEW) .]

3. **Insolvency termination.** In the event of a termination of an arrangement due to insolvency, a determination of impairment or the failure of the arrangement to pay any final judgment rendered against it in this State within 30 days after the judgment becomes final, the deposit held by the superintendent pursuant to subsection 1 or the bond held by the superintendent pursuant to subsection 2 must be applied to the extent of the insolvency or to the extent of any default in payment of benefit claims. Any deposit funds remaining in excess of the amount needed to make the arrangement solvent must be distributed in accordance with section 6610.

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §11 (AMD).

§6608. FORMS

1. **Approval of forms by superintendent required.** A participation agreement or contract form, application form, certificate, rider, endorsement, summary plan description or other evidence of coverage may not be issued by an arrangement unless the form and all changes to the form have been filed with the superintendent by or on behalf of the arrangement that proposes to use the form and have been approved by the superintendent.

[1993, c. 688, §1 (NEW) .]

2. **Grounds for disapproval of forms by superintendent.** The superintendent may disapprove a form filed under this section or withdraw previous approval of a form only if the form:

A. Violates or does not comply with this chapter; [1993, c. 688, §1 (NEW).]

B. Contains or incorporates by reference inconsistent, ambiguous or misleading clauses or exceptions and conditions that deceptively affect the risk proposed to be assumed in the general coverage of the contract; [1993, c. 688, §1 (NEW).]

C. Has any title, heading or other indication of its provisions that is misleading; [1993, c. 688, §1 (NEW).]

D. Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible; or [1993, c. 688, §1 (NEW).]

E. Contains provisions that are unfair, inequitable or encourage misrepresentation. [1993, c. 688, §1 (NEW).]

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6609. LIABILITY OF PARTICIPANTS

1. **Liability of each employer participant.** The liability of each employer participant for the obligations of the multiple-employer welfare arrangement is joint and several.

[1993, c. 688, §1 (NEW) .]

2. **Contingent assessment liability.** Each employer participant has a contingent assessment liability pursuant to section 6610 for payment of actual losses and expenses incurred while the participation agreement was in force.

[1993, c. 688, §1 (NEW) .]

3. **Statement of contingent liability.** Each participation agreement or contract issued by the arrangement must contain a statement of the contingent liability of employer participants. Both the application for participation and the participation agreement must contain, in contrasting color and not less than 10-point type, the following statement: "This is a fully assessable contract. In the event the arrangement is unable to pay its obligations, participating employers will be required to contribute through an equitable assessment the money necessary to meet any unfulfilled obligations."

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6610. TERMINATION

If an arrangement is terminated for any reason, the trust may not be dissolved until all outstanding claims, debts and obligations of the arrangement are paid. The arrangement may retain sufficient funds to provide coverage for an additional period as the trustees of the arrangement consider prudent. In addition, the trustees may purchase additional insurance they consider necessary for protection against potential future claims. Any funds remaining in the arrangement after satisfaction of all obligations must be paid to participating employers or covered employees in an equitable manner meeting with the approval of the superintendent, including, without ruling out other alternatives, equally on a per capita basis to each participating employer or employee who is covered under the arrangement as of the effective date of termination. Written notice of the termination of the arrangement must be provided to each covered employee, the Department of Labor, Bureau of Labor Standards and the superintendent at least 10 days before the effective date of the termination. [1995, c. 618, §12 (AMD).]

If an arrangement provided by a registered employee leasing company is terminated for any reason, written notice of the termination of the arrangement must be provided by the employee leasing company to each covered employee, the client companies involved, the Department of Labor, Bureau of Labor Standards and the superintendent at least 10 days before the effective date of the termination. [1995, c. 618, §12 (NEW).]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §12 (AMD).

§6611. ANNUAL REPORT; ACTUARIAL REPORT

1. **Filing required.** Annually within 4 months of the end of the fiscal year or within such extension of time as the superintendent for good cause may grant, every arrangement shall file a report with the superintendent, verified by the oath of the chair of the board of trustees. The report must summarize the business activities of the trust for the immediately preceding year and must contain a financial statement of the arrangement, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant. The report must also include an analysis of the adequacy of reserves and contributions or premiums charged based on a review of past and projected claims and expenses.

[1993, c. 688, §1 (NEW) .]

1-A. **Accountant's letter or qualification.** The annual financial statement of the arrangement must include a letter of qualification from the certifying accountant stating:

A. That the accountant is independent with respect to the arrangement and conforms to the standards of the accountant's profession as contained in the code of professional ethics and pronouncements of the American Institute of Certified Public Accountants and the rules of professional conduct of the appropriate state Board of Accountancy or similar code; [1995, c. 618, §13 (NEW).]

B. The background and experience in general and the experience in audits or arrangements of the staff assigned to the engagement and whether each is an independent certified public accountant. This requirement may not be construed as prohibiting the accountant from utilizing staff as the accountant considers appropriate where that is consistent with the standards prescribed by generally accepted auditing standards; [1995, c. 618, §13 (NEW).]

C. That the accountant understands the annual audited financial report and the accountant's opinion will be filed in compliance with this requirement and that the accountant knows the superintendent will be relying on this information in the monitoring and regulation of the financial position of the arrangement; [1995, c. 618, §13 (NEW).]

D. That the accountant consents and agrees to make available for review by the superintendent or the superintendent's designee or appointed agent, the accountant's workpapers relating to the arrangement. For purposes of this paragraph, workpapers are the records kept by the accountant of the procedures followed, the tests performed, the information obtained and the conclusions reached pertinent to the accountant's examination of the financial statements of the arrangement. Workpapers may include audit planning documents, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of arrangement documents and schedules or commentaries prepared or obtained by the accounts in the course of the accountant's examination; and [1995, c. 618, §13 (NEW).]

E. A representation that the accountant is properly licensed by an appropriate state licensing authority and that the accountant is a member in good standing in the American Institute of Certified Public Accountants. [1995, c. 618, §13 (NEW).]

[1995, c. 618, §13 (NEW) .]

2. **Actuarial report.** At least once every 2 years each arrangement must have a report prepared by an actuary who is an associate or fellow of the Society of Actuaries and the American Academy of Actuaries as to the actuarial soundness of the arrangement. After an arrangement has filed 2 actuarial reports pursuant to this subsection, an arrangement may request that the superintendent grant a waiver of the filing requirement to the arrangement. If required, the report must be filed with the superintendent. The report must consist of at least the following:

A. An assessment of the adequacy of contribution rates in meeting the level of benefits provided and changes, if any, needed in the contribution rates to achieve or preserve a level of funding adequate to enable payment of the benefit amounts provided under the arrangement, which must include a valuation

of present assets, valued in accordance with insurance accounting precepts, and prospective assets and liabilities of the plan and the extent of unfunded accrued liabilities; [1993, c. 688, §1 (NEW).]

B. A plan and schedule to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities; [1993, c. 688, §1 (NEW).]

C. A description and explanation of actuarial assumptions; [1993, c. 688, §1 (NEW).]

D. A comparative review illustrating the level of funds available to the arrangement from rates, investment income and other sources realized over the period covered by the report indicating the assumptions used; [1993, c. 688, §1 (NEW).]

E. A certification by the actuary that the report is complete and accurate and that in the actuary's opinion the techniques and assumptions used are reasonable, make good and sufficient provision to meet the obligations of the arrangement and meet the requirements and intent of this chapter; and [1993, c. 688, §1 (NEW).]

F. Other factors or statements as may be reasonably required by the superintendent in order to determine the actuarial soundness of the plan. [1993, c. 688, §1 (NEW).]

[2001, c. 570, §3 (AMD) .]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §13 (AMD). 2001, c. 570, §3 (AMD).

§6612. PLACE OF BUSINESS; RECORDS MAINTENANCE

Each arrangement must have and maintain its principal place of business in the State and must make available to the superintendent complete records of its assets, transactions and affairs in accordance with such methods and systems as are customary for or suitable to the kind or kinds of business transacted. [1993, c. 688, §1 (NEW).]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6613. GROUNDS FOR DENIAL, SUSPENSION OR REVOCATION OF ARRANGEMENT

1. **Mandatory denial, suspension or revocation.** Subject to other provisions of this chapter, the superintendent shall deny, suspend or revoke an arrangement's authorization if the superintendent finds that the arrangement:

A. Is impaired within the meaning of section 6601, subsection 3; [1993, c. 688, §1 (NEW).]

B. Has refused to be examined or to produce its accounts, records and files for examination, or if any of its officers has refused to give information with respect to its affairs or to perform any other legal obligation as to such examination when required by the superintendent; [1993, c. 688, §1 (NEW).]

C. Has failed to pay a judgment rendered against it in the State within 30 days after the judgment becomes final; or [1993, c. 688, §1 (NEW).]

D. No longer meets the requirements for the authority originally granted. [1993, c. 688, §1 (NEW).]

[1993, c. 688, §1 (NEW) .]

2. **Discretionary denial, suspension or revocation.** The superintendent, in the superintendent's discretion, may deny, suspend or revoke the authorization of an arrangement if the superintendent finds that the arrangement:

A. Has violated this chapter or a lawful order or rule of the superintendent; [1993, c. 688, §1 (NEW).]

B. Has refused to be examined or to produce its accounts, records and files for examination, or if any of its officers have refused to give information with respect to its affairs or to perform any other legal obligation as to such examination when required by the superintendent; or [1993, c. 688, §1 (NEW).]

C. Has failed to correct any deficiency determined pursuant to section 6610. [1993, c. 688, §1 (NEW).]

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6614. VIOLATIONS

In addition to any other penalties provided for by this Title and subject to this chapter: [1993, c. 688, §1 (NEW).]

1. **Civil penalty.** An arrangement that fails to obtain and maintain a valid approval from the superintendent while operating or maintaining a multiple-employer welfare arrangement is subject to a civil penalty of not less than $5,000 or more than $50,000 for each violation; and

[1993, c. 688, §1 (NEW) .]

2. **Cease and desist order.** The superintendent may issue a cease and desist order if the superintendent finds a person operating or maintaining a multiple-employer welfare arrangement without a currently effective certificate of approval.

[1993, c. 688, §1 (NEW) .]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6615. DELINQUENCY PROCEEDINGS

The rehabilitation, liquidation, conservation or dissolution of a multiple-employer welfare arrangement must be conducted under the supervision of the superintendent, who has all power with regard to the rehabilitation, liquidation, conservation or dissolution of a multiple-employer welfare arrangement granted to the superintendent under the laws governing the rehabilitation, liquidation, conservation or dissolution of insurers. [1993, c. 688, §1 (NEW).]

SECTION HISTORY
1993, c. 688, §1 (NEW).

§6616. REGULATORY AUTHORITY

The superintendent may adopt, pursuant to Title 5, chapter 375, subchapter II, rules that the superintendent determines reasonable and necessary to carry out properly the functions and responsibilities assigned under the laws of this State. Rules adopted to implement the provisions of this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1995, c. 618, §14 (AMD).]

SECTION HISTORY
1993, c. 688, §1 (NEW). 1995, c. 618, §14 (AMD).

Chapter 83: CAPTIVE INSURANCE COMPANIES

§6701. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1997, c. 435, §1 (NEW).]

1. **Affiliated company.** "Affiliated company" means any company in the same corporate system as a parent or a member organization by virtue of common ownership, control, operation or management.

[1997, c. 435, §1 (NEW) .]

2. **Association.** "Association" means any legal association of individuals, corporations, limited liability companies, partnerships or associations that have been in continuous existence for at least one year, the member organizations of which:

A. Own, control or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer; [2009, c. 335, §1 (AMD).]

B. Have complete voting control over an association captive insurance company incorporated as a mutual or reciprocal insurer; or [2009, c. 335, §1 (AMD).]

C. Constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer. [2009, c. 335, §1 (NEW).]

[2009, c. 335, §1 (AMD) .]

3. **Association captive insurance company.** "Association captive insurance company" means any company that insures risks of the member organizations of the association and their affiliated companies.

[1997, c. 435, §1 (NEW) .]

4. **Captive insurance company.** "Captive insurance company" means any pure captive insurance company, sponsored captive insurance company, association captive insurance company or industrial insured captive insurance company formed or licensed under this chapter.

[2009, c. 335, §2 (AMD) .]

5. **Controlled unaffiliated business.** "Controlled unaffiliated business" means a company that:

A. Is not in the corporate system of a parent and affiliated companies; [1997, c. 435, §1 (NEW).]

B. Has an existing contractual relationship with a parent or affiliated company; and [1997, c. 435, §1 (NEW).]

C. [2009, c. 335, §3 (RP).]

D. Has all its risks managed by a pure captive insurance company in accordance with this chapter. [2009, c. 335, §4 (NEW).]

[2009, c. 335, §§3, 4 (AMD) .]

6. **Industrial insured.** "Industrial insured" means an insured:

A. Who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer; [1997, c. 435, §1 (NEW).]

B. Whose aggregate annual premium for insurance on all risks totals at least $25,000; and [1997, c. 435, §1 (NEW).]

C. Who has at least 25 full-time employees. [1997, c. 435, §1 (NEW).]

[1997, c. 435, §1 (NEW) .]

7. **Industrial insured captive insurance company.** "Industrial insured captive insurance company" means any company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies.

[1997, c. 435, §1 (NEW) .]

8. **Industrial insured group.** "Industrial insured group" means any group that meets either of the following criteria:

A. A group of industrial insureds that collectively:

(1) Owns, controls or holds with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer;

(2) Has complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer; or

(3) Constitutes all of the subscribers of an industrial insured captive insurance company formed as a reciprocal insurer; or [2009, c. 335, §5 (AMD).]

B. Any group created under the Product Liability Risk Retention Act of 1981, 15 United States Code, Section 3901 et seq., as amended, as a corporation or other limited liability association taxable as a stock insurance company or a mutual insurer under the laws of the State. [1997, c. 435, §1 (NEW).]

[2009, c. 335, §5 (AMD) .]

9. **Member organization.** "Member organization" means any individual, corporation, limited liability company, partnership or association that belongs to an association.

[2009, c. 335, §6 (AMD) .]

10. **Parent.** "Parent" means a corporation, limited liability company, partnership or individual that directly or indirectly owns, controls or holds with power to vote more than 50% of the outstanding voting securities of a pure captive insurance company organized as a stock corporation or 50% of the membership interests of a pure captive insurance company organized as a nonprofit corporation.

[2009, c. 335, §7 (AMD) .]

11. **Pure captive insurance company.** "Pure captive insurance company" means any company that insures risks of its parent and affiliated companies or controlled unaffiliated businesses but does not include those insurers that otherwise qualify for and elect to hold a certificate of authority as an insurer under section 414. "Pure captive insurance company" includes, with respect to operations in this State unless otherwise restricted by the superintendent, a branch captive insurance company.

[2009, c. 335, §8 (AMD) .]

12. **Pure nonprofit captive insurance company.** "Pure nonprofit captive insurance company" means a pure captive insurance company formed without capital stock as a nonprofit corporation, whose voting of membership interest is held by a parent organization formed under a nonprofit law or by a nonprofit parent, its or controlled unaffiliated business affiliated companies but does not include those insurers otherwise qualifying for a certificate of authority as an insurer.

[1997, c. 435, §1 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §§1-8 (AMD).

§6702. LICENSING; AUTHORITY

1. **Authority.** A captive insurance company may not engage in the business of insurance in this State unless the company:

A. Obtains a license from the superintendent authorizing the company to do insurance business in this State; [1997, c. 435, §1 (NEW).]

B. Holds at least one meeting of its board of directors, or other governing body, each year in this State. For pure captive insurance companies and pure nonprofit captive insurance companies, the annual in-state meeting requirement may be satisfied by a teleconferenced or videoconferenced meeting if at least one Maine resident member of the board of directors, or other governing body, participates in the meeting from this State; [1997, c. 583, §1 (AMD).]

C. Maintains its principal place of business in this State; and [1997, c. 435, §1 (NEW).]

D. Appoints a resident agent to accept service of process and to otherwise act on its behalf in this State. [1997, c. 435, §1 (NEW).]

[1997, c. 583, §1 (AMD) .]

2. **Charter and bylaws.** In order to receive a license, a captive insurance company must file with the superintendent a certified copy of its charter and bylaws, a statement under oath of its president and secretary showing its financial condition and any other statements or documents required by the superintendent.

[1997, c. 435, §1 (NEW) .]

3. **Information required.** In addition to the information required by subsection 2, an applicant captive insurance company must file with the superintendent evidence of the following:

A. The amount and liquidity of its assets relative to the risks to be assumed; [1997, c. 435, §1 (NEW).]

B. The adequacy of the expertise, experience and character of the person or persons who will manage it; [1997, c. 435, §1 (NEW).]

C. The overall soundness of its plan of operation; [1997, c. 435, §1 (NEW).]

D. The adequacy of the loss prevention programs of its parent or member organizations, as applicable; [1997, c. 435, §1 (NEW).]

E. The character, reputation, financial standing and purposes of the incorporators; [1997, c. 435, §1 (NEW).]

F. The character, reputation, financial responsibility, insurance experience and business qualifications of the officers and directors; and [1997, c. 435, §1 (NEW).]

G. Any other factors determined relevant by the superintendent in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations. [1997, c. 435, §1 (NEW).]

[1997, c. 435, §1 (NEW) .]

4. **License.** If the superintendent is satisfied that the documents and statements filed by the captive insurance company under subsections 2 and 3 comply with this chapter, the superintendent may grant a license authorizing it to do insurance business in accordance with this subsection.

A. A captive insurance company shall comply with all applicable federal laws. A captive insurance company, other than an association captive insurance company preliminarily conditionally approved for a license before January 1, 2012 and that elects to secure coverage in accordance with section 6706, subsection 2-A, shall comply with state and federal laws relating to the risks insured pursuant to the license granted by the superintendent to the extent provided in rules adopted pursuant to this chapter. [2011, c. 90, Pt. I, §1 (NEW).]

B. An association captive insurance company insuring the health coverage risks of its members shall comply with the requirements for community rating and guaranteed issuance and renewal for association members pursuant to section 2808-B and any requirements for mandated benefits that apply to small group health plans. [2011, c. 90, Pt. I, §1 (NEW).]

C. The superintendent shall grant a license to an association captive insurance company that files an application in accordance with this section and satisfies the following requirements:

(1) The association captive insurance company insures only health risks and requires participating association members to be jointly and severally liable in accordance with section 6706, subsection 2-A;

(2) The association captive insurance company's plan of operation is fiscally sound and establishes dispute resolution mechanisms acceptable to the superintendent in accordance with this section and designates a 3rd-party administrator approved by the superintendent; and

(3) The superintendent determines that the association members have an aggregate net worth of at least $100,000,000. [2011, c. 90, Pt. I, §1 (NEW).]

[2011, c. 90, Pt. I, §1 (AMD) .]

5. **Fees.** A captive insurance company shall pay filing, issuance, annual continuation and reinstatement fees as provided for domestic insurers pursuant to section 601, subsection 1.

[1997, c. 435, §1 (NEW) .]

6. **Activities.**

[2009, c. 335, §9 (RP) .]

7. **Permitted activities.** A captive insurance company, when permitted by its articles of association or charter, may apply to the superintendent for a license to provide any insurance described in this Title, including annuities, except that:

A. A pure captive insurance company may not insure or reinsure any risks other than those of its parent and affiliated companies or controlled unaffiliated businesses; [2009, c. 335, §9 (AMD).]

B. An association captive insurance company may not insure or reinsure any risks other than those of the member organizations of its association and their affiliated companies; [2009, c. 335, §9 (AMD).]

C. An industrial insured captive insurance company may not insure or reinsure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies; [2009, c. 335, §9 (AMD).]

D. A captive insurance company may not provide personal motor vehicle or homeowner's insurance coverage or individual health insurance coverage or any component thereof; [2011, c. 90, Pt. I, §2 (AMD).]

E. A captive insurance company may not accept or cede reinsurance except as provided in section 6711; and [2009, c. 335, §9 (AMD).]

F. A captive insurance company may not provide workers' compensation insurance except for reinsurance of workers' compensation risk as permitted in section 6711. [2009, c. 335, §9 (NEW).]

[2011, c. 90, Pt. I, §2 (AMD) .]

8. **Certificate of good standing.** Prior to its organization or incorporation with the Secretary of State, the organizers or incorporators of a captive insurance company shall petition the superintendent to issue a certificate stating the superintendent's finding that the establishment and continued existence of the proposed captive insurance company, however organized, will promote the general good of the State. In making such a finding, the superintendent shall consider:

A. The character, reputation, financial standing and purpose of the organizers or incorporators; [2009, c. 335, §9 (NEW).]

B. The character, reputation, financial responsibility, insurance experience and business qualifications of the officers and directors of the proposed captive insurance company; and [2009, c. 335, §9 (NEW).]

C. Any other relevant information determined by the superintendent. [2009, c. 335, §9 (NEW).]

Any certificate issued by the superintendent pursuant to this subsection must be filed with the Secretary of State to be recorded with the articles of incorporation of the captive insurance company.

[2009, c. 335, §9 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 1997, c. 583, §§1-3 (AMD). 2009, c. 335, §9 (AMD). 2011, c. 90, Pt. I, §§1, 2 (AMD).

§6703. NAMES OF COMPANIES

A captive insurance company may not adopt a name that is the same as, deceptively similar to or likely to be confused with or mistaken for any other existing business name registered in the State. [1997, c. 435, §1 (NEW).]

SECTION HISTORY
1997, c. 435, §1 (NEW).

§6704. MINIMUM CAPITAL AND SURPLUS

1. **Minimum capital and surplus.** A captive insurance company may not be issued a license unless the company has and maintains unimpaired paid-in capital and surplus of:

A. In the case of a pure captive insurance company, not less than $250,000; [2009, c. 335, §10 (AMD).]

B. In the case of an association captive insurance company, not less than $750,000, except for an association captive insurance company insuring only health risks that elects to secure coverage in accordance with section 6706, subsection 2-A, maintains adequate reserve funds and has reinsurance unless the superintendent waives or modifies the reinsurance requirement. Reserve funds are presumed adequate if the association members have an aggregate net worth of at least $100,000,000 and the superintendent determines that the funds are adequate to cover at least 3 months of claims and expenses; [2011, c. 90, Pt. I, §3 (AMD).]

C. In the case of an industrial insured captive insurance company, not less than $500,000; [2009, c. 335, §10 (AMD).]

D. In the case of a sponsored captive insurance company, not less than $500,000; and [2009, c. 335, §10 (NEW).]

E. In the case of a risk retention group, not less than $1,000,000. [2009, c. 335, §10 (NEW).]

The superintendent may prescribe additional capital based upon the type, volume and nature of insurance business transacted, except for an association captive health insurance company insuring only health risks that elects to secure coverage in accordance with section 6706, subsection 2-A.

[2011, c. 90, Pt. I, §3 (AMD) .]

2. **Letter of credit.** The required capital may be in the form of cash, an irrevocable letter of credit issued by a bank chartered in this State or a member bank of the Federal Reserve System or any other security approved by the superintendent.

[1997, c. 435, §1 (NEW) .]

3. **Dividends.** A captive insurance company may not pay a dividend out of or make any other distribution with respect to capital and surplus in excess of the limitations under section 222 without the prior approval of the superintendent. Approval of an ongoing plan for the payment of dividends or other distributions must be conditioned upon the retention, at the time of each payment, of capital and surplus in excess of amounts specified by, or determined in accordance with formulas approved by, the superintendent. Notwithstanding the provisions of Title 13-B or 13-C, a captive insurance company organized under the provisions of either Title may make such distributions as are in conformity with its purposes with the prior approval of the superintendent.

[2009, c. 335, §10 (AMD) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §10 (AMD). 2011, c. 90, Pt. I, §3 (AMD).

§6705. MINIMUM SURPLUS

(REPEALED)

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §11 (RP).

§6706. FORMATION OF CAPTIVE INSURANCE COMPANIES IN THIS STATE

1. **Pure captive insurance company.** A pure captive insurance company must be:

A. Incorporated as a stock insurer with capital divided into shares and held by the stockholders; [2009, c. 335, §12 (AMD).]

B. Incorporated as a nonprofit corporation whose votes of membership interest are held by a parent organization formed under a nonprofit law or by such nonprofit corporation with one or more members; or [2009, c. 335, §12 (AMD).]

C. Organized as a manager-managed limited liability company. [2009, c. 335, §12 (NEW).]

[2009, c. 335, §12 (AMD) .]

2. **Association captive insurance company.** An association captive insurance company or an industrial insured captive insurance company may be:

A. Incorporated as a stock insurer with its capital divided into shares and held by the stockholders; [2009, c. 1, §17 (COR).]

B. Incorporated as a mutual insurer without capital stock, the governing body of which must be elected by the member organizations of its association; [2009, c. 335, §12 (AMD).]

C. Organized as a reciprocal insurer in accordance with this Title; or [2009, c. 335, §12 (NEW).]

D. Organized as a manager-managed limited liability company. [2009, c. 335, §12 (NEW).]

[2009, c. 1, §17 (COR) .]

2-A. **Association captive insurance company providing health insurance.** An association captive insurance company that provides health insurance may elect to require, in its plan of operation, that all association members who participate in the health insurance be jointly and severally liable for the health insurance obligations of the association captive insurance company and meet the financial criteria and employer required wellness criteria established in the plan of operation. The wellness criteria may not have the effect of making health status a condition of eligibility for any association member. The superintendent may not require joint and several liability as a condition of approval of an application.

[2011, c. 90, Pt. I, §4 (NEW) .]

3. **Incorporators.** A captive insurance company may not have fewer than 3 incorporators or 3 organizers of whom at least one must be a resident of this State. If the captive insurance company is a limited liability company, at least one manager must be a resident of this State.

[2009, c. 335, §12 (AMD) .]

4. **Applicability of chapter 47.** To the extent consistent with this chapter, a captive insurance company is subject to the procedures applicable to domestic insurers pursuant to chapter 47 except that, if the surviving entity after a merger, consolidation, conversion or mutualization is a captive insurance company, a captive insurance company is subject to this chapter. With respect to mergers, consolidations, conversions and mutualizations, the superintendent, in the superintendent's discretion, may:

A. Waive any public hearing requirement; [2009, c. 335, §12 (NEW).]

B. Permit an alien insurer as a party to a merger as long as the requirements for a merger between a captive insurance company and a foreign insurer apply. For the purposes of this paragraph, an alien insurer must be treated as a foreign insurer and the jurisdiction of the alien insurer is considered a state; or [2009, c. 335, §12 (NEW).]

C. Approve the conversion of a captive insurance company organized as a stock insurer to a nonprofit corporation with one or more members or a limited liability company. [2009, c. 335, §12 (NEW).]

[2011, c. 90, Pt. I, §5 (AMD) .]

5. **Issuance of stock.** If the capital stock of a captive insurance company incorporated as a stock insurer is issued at par value, stock may not be issued at less than par value.

[2009, c. 335, §12 (AMD) .]

6. **Board of directors.** If a captive insurance company incorporated in this State is formed as a corporation, then at least one of the members of the board of directors of the company incorporated in this State must be a resident of this State. If the company is formed as a reciprocal insurer, then at least one of the members of the subscribers' advisory committee must be a resident of this State. If the company is organized as a limited liability company, then at least one manager must be a resident of this State.

[2013, c. 588, Pt. A, §30 (AMD) .]

7. **Captive insurance company.** A captive insurance company formed under this chapter, except for a pure nonprofit captive insurance company, has the privileges granted by and is subject to Title 13-C and this chapter. In the event of conflict between Title 13-C and this chapter, this chapter controls.

[2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §45 (COR) .]

8. **Pure nonprofit captive insurance company.** A pure nonprofit captive insurance company formed under this chapter has the privileges granted by and is subject to Title 13-B and this chapter. In the event of conflict between Title 13-B and this chapter, this chapter controls.

[1997, c. 435, §1 (NEW) .]

9. **Quorum.** If formed as a corporation, the articles of incorporation or bylaws of a captive insurance company may authorize a quorum of its board of directors to consist of no fewer than 1/3 of the fixed or prescribed number of directors determined under Title 13-B or 13-C. If formed as a reciprocal insurer, the subscribers' agreement or other organizing document may authorize a quorum of its subscribers' advisory committee to consist of no fewer than 1/3 of the number of its members.

[2009, c. 335, §12 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). RR 2001, c. 2, §B58 (AFF). RR 2001, c. 2, §B45 (COR). RR 2009, c. 1, §17 (COR). 2009, c. 335, §12 (AMD). 2011, c. 90, Pt. I, §§4, 5 (AMD). 2013, c. 588, Pt. A, §30 (AMD).

§6707. FINANCIAL STATEMENTS AND OTHER REPORTS

1. **Financial statement.** A captive insurance company shall submit an annual statement of financial condition written according to generally accepted accounting principles and audited by an independent certified public accountant to the superintendent on or before the last day of the 6th month following the end of the company's fiscal year.

[1997, c. 435, §1 (NEW) .]

2. **Annual report.** An association captive insurance company or industrial insured captive insurance company shall file an annual statement in accordance with statutory accounting practices, which must be a true statement of its financial condition, transactions and affairs as of the immediately preceding December 31st, in general form and context as approved by the National Association of Insurance Commissioners, or other format prescribed by the superintendent, verified by oaths of at least 2 of the insurer's principal officers.

[1997, c. 583, §4 (AMD) .]

3. **Reserves.** The statements required under subsections 1 and 2 must include, but are not limited to, actuarially appropriate reserves for:

A. Known claims and associated expenses; [1997, c. 435, §1 (NEW).]

B. Claims incurred but not reported and associated expenses; [1997, c. 435, §1 (NEW).]

C. Unearned premiums; and [1997, c. 435, §1 (NEW).]

D. Bad debts, reserves for which must be shown as liabilities. [1997, c. 435, §1 (NEW).]

An actuarial opinion regarding reserves for known claims and claims incurred but not reported, and expenses associated with those claims, must be included in the audited statements. The actuarial opinion must be given by a member of the American Academy of Actuaries or other qualified loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners.

[1997, c. 435, §1 (NEW) .]

4. **Other reports.** The superintendent may prescribe the format and frequency of other reports, which may include, but are not limited to, summary loss reports and quarterly financial statements.

[1997, c. 435, §1 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 1997, c. 583, §4 (AMD).

§6708. EXAMINATIONS AND INVESTIGATIONS

1. **Powers, authorities and duties of superintendent.** The powers, authorities and duties relating to examinations and investigations are vested in and imposed upon the superintendent in order for the superintendent to verify that all captive insurance companies operate in accordance with the provisions of this chapter.

[2011, c. 90, Pt. I, §6 (AMD) .]

2. **Confidentiality of examinations documents.** All examination reports, preliminary examination reports or results, working papers, recorded information, documents and copies of any of these produced by, obtained by or disclosed to the superintendent or any other person in the course of an examination made under this section are confidential and are not subject to subpoena and may not be made public by the superintendent or any other person, except to the extent provided in this subsection. The superintendent may grant access to such information to public officers having jurisdiction over the regulation of insurance in any other state or country or to law enforcement officers of this State or any other state or agency of the Federal Government at any time, as long as the officers receiving the information agree in writing to hold it in a manner consistent with this subsection.

[1997, c. 435, §1 (NEW) .]

3. **Examinations.** At least once in 3 years, and whenever the superintendent determines it to be prudent, the superintendent shall personally, or by some competent person appointed by the superintendent, visit each captive insurance company and thoroughly inspect and examine its affairs to ascertain its financial condition, its ability to fulfill its obligations and whether it has complied with the provisions of this chapter. The superintendent may enlarge the 3-year period to 5 years, as long as the captive insurance company is

subject to a comprehensive annual audit during the period of a scope satisfactory to the superintendent by independent auditors approved by the superintendent. The expenses and charges of the examination must be paid to the State by the company or companies examined.

[2009, c. 335, §13 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §13 (AMD). 2011, c. 90, Pt. I, §6 (AMD).

§6709. GROUNDS AND PROCEDURES FOR SUSPENSION AND REVOCATION OF LICENSE

1. **Grounds for suspension or revocation.** The superintendent may suspend or revoke the license of a captive insurance company for any of the following reasons:

A. Insolvency or impairment of capital or surplus; [1997, c. 435, §1 (NEW).]

B. Failure to meet the requirements of section 6704; [2009, c. 335, §14 (AMD).]

C. Refusal or failure to submit an annual report required by section 6707 or any other report or statement required by law or by lawful order of the superintendent; [1997, c. 435, §1 (NEW).]

D. Failure to comply with the provisions of the company's charter or bylaws or other organizational document; [2009, c. 335, §15 (AMD).]

E. Failure to submit to examination or any legal obligation as required by section 6708; [1997, c. 435, §1 (NEW).]

F. Refusal or failure to pay the cost of examination required by sections 228 and 6708; [1997, c. 435, §1 (NEW).]

G. Use of methods that, although not otherwise specifically prohibited by law, nevertheless render the company's operation detrimental or the company's condition unsound with respect to the public or to its policyholders; [1997, c. 435, §1 (NEW).]

H. Failure to maintain actuarially appropriate loss reserves as determined by the superintendent, except that the superintendent shall issue at least one warning to the captive insurance company requiring it to correct the problem prior to suspending or revoking the license; and [1997, c. 435, §1 (NEW).]

I. Failure otherwise to comply with the laws of this State. [1997, c. 435, §1 (NEW).]

[2009, c. 335, §§14, 15 (AMD) .]

2. **Procedure.** Notwithstanding any other law, if the superintendent, upon examination, hearing or other evidence, finds that a captive insurance company has committed any of the acts specified in subsection 1, the superintendent may suspend or revoke the license if the superintendent determines that it is in the best interest of the public and the policyholders of the captive insurance company.

[1997, c. 435, §1 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §§14, 15 (AMD).

§6710. LEGAL INVESTMENTS

A pure captive insurance company is not subject to any restrictions on allowable investments including those provided under chapter 13 and chapter 13-A, except that the superintendent may prohibit or limit any investment that threatens the solvency or liquidity of such insurance company. A pure captive insurance company may not make a loan to or investments in its parent or affiliated companies without the prior written approval of the superintendent. A loan of any minimum capital and surplus funds required by section 6704 is prohibited. Except as otherwise authorized by the superintendent, association captive insurance companies and industrial insured captive insurance companies are subject to the restrictions on allowable investments applicable to admitted insurers transacting the same type of business. With respect to investments of association captive insurance companies, the superintendent may approve the use of alternative methods of valuation and rating. [2009, c. 335, §16 (AMD).]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §16 (AMD).

§6711. REINSURANCE

1. **Reinsurance.** A captive insurance company may provide reinsurance on risks ceded by any other insurer to the extent permitted by section 6702.

[2009, c. 335, §17 (AMD) .]

2. **Credit for reserves.** A captive insurance company may take credit for the reinsurance of risks or portions of risks ceded to a reinsurer in accordance with this Title. A captive insurance company may not cede risks or take credit for the reinsurance of risks or portions of risk without the approval of the superintendent, except for business written outside the United States by an alien captive insurance company.

[2009, c. 335, §18 (AMD) .]

3. **Credit for reserves on risks; adequate security.** In addition to reinsurers complying with chapter 9, subchapter III, a captive insurance company may take credit for reserves on risks or portions of risks ceded to a pool, exchange or association acting as a reinsurer that has been authorized by the superintendent. The superintendent may require any other documents, financial information or other evidence that such a pool, exchange or association is able to provide adequate security for its financial obligations. The superintendent may deny authorization or impose any limitations on the activities of a reinsurance pool, exchange or association that, in the superintendent's judgment are necessary and proper to provide adequate security for the ceding captive insurance company and for the protection and benefit of the public.

[1997, c. 435, §1 (NEW) .]

4. **Reinsurance of workers' compensation risks.** A captive insurance company may, with the approval of the superintendent, reinsure workers' compensation risks of its parent and affiliated companies under a statutory workers' compensation policy issued by a licensed insurer or under a qualified self-insured plan. The superintendent may require that all or part of any assumed self-insured risk be retroceded to an insurance company that meets the standards for acceptance of reinsurance of workers' compensation self-insurance.

[2009, c. 335, §19 (AMD) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §§17-19 (AMD).

§6712. RATING ORGANIZATIONS

A captive insurance company is not required to become a member of a rating organization. [1997, c. 435, §1 (NEW).]

SECTION HISTORY
1997, c. 435, §1 (NEW).

§6713. EXEMPTION FROM COMPULSORY ASSOCIATIONS

A captive insurance company may not join or contribute financially to any plan, pool, association or guaranty or insolvency fund in this State, and a captive insurance company and its insureds, its parent or any affiliated company or member organization of its association may not receive any benefit from the plan, pool, association or guaranty or insolvency fund for claims arising out of the operations of the captive insurance company. [1997, c. 435, §1 (NEW).]

SECTION HISTORY
1997, c. 435, §1 (NEW).

§6714. DELINQUENT CAPTIVE INSURERS

The provisions of chapter 57 apply to captive insurers. [2009, c. 335, §20 (AMD).]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2009, c. 335, §20 (AMD).

§6715. CONFIDENTIAL INFORMATION

All information submitted to the superintendent pursuant to section 6702, subsection 3 is confidential and is not a public record within the meaning of Title 1, chapter 13, subchapter I. Each report or statement filed with the superintendent pursuant to section 6707, except those filed by or with respect to industrial insured groups as defined in section 6701, subsection 8, is confidential and is not a public record within the meaning of Title 1, chapter 13, subchapter I. The confidential nature of this information does not limit the ability of the superintendent, in the superintendent's discretion, to disclose such information to a public official in another state, as long as the public official agrees in writing to maintain the confidentiality of such information and the laws of the state in which the public official serves designate such information as confidential. [1997, c. 583, §5 (AMD).]

SECTION HISTORY
1997, c. 435, §1 (NEW). 1997, c. 583, §5 (AMD).

§6716. REDOMESTICATION; APPROVAL AS A DOMESTIC CAPTIVE INSURER

1. **Procedure.** A foreign or alien captive insurance company may become a domestic captive insurance company by:

A. Complying with all of the requirements relating to the organization and licensing of a domestic captive insurance company of the same type and any requirements that the superintendent may adopt by rule; [1997, c. 435, §1 (NEW).]

B. Amending the articles of incorporation or other organizational document to comply with the laws of this State. The document must be restated in its entirety before its submission to the superintendent. Before the amended and restated articles of incorporation or other organizational document is transmitted to the Secretary of State, the foreign or alien captive insurance company shall petition the superintendent to issue a certificate setting forth the superintendent's finding that the redomestication and

maintenance of the corporation satisfies paragraph A and will promote the general good of the State. The company's petition must be accompanied by a redomestication fee of $500. In arriving at the finding, the superintendent shall consider:

(1) The character, reputation, financial standing and purposes of the foreign or alien captive insurance company;

(2) The character, reputation, financial responsibility, insurance experience and business qualifications of the officers and directors; and

(3) Any other aspects the superintendent determines advisable; [1997, c. 435, §1 (NEW).]

C. Transmitting the following to the Secretary of State for filing:

(1) The articles of redomestication including the filing fee as provided by either Title 13-B, section 1401, subsection 13 or Title 13-C, section 123, subsection 1, paragraph L and this information required by a new domestic or domestic nonprofit corporation on a form prescribed by the Secretary of State;

(2) The certificate of general good issued by the superintendent;

(3) The certificate of good standing duly authenticated by the proper officer of the state or country under the laws of which the foreign or alien captive insurance company is incorporated. The certificate may not be dated earlier than 30 days prior to the filing of the articles of redomestication. If the certificate of good standing is in a foreign language, a translation under oath of the translator must accompany the certificate;

(4) Amendments to the articles of incorporation or other organizational document in compliance with the laws of this State; and

(5) The restatement of the articles of incorporation or other organizational document in its entirety; and [2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §46 (COR).]

D. Stating in the articles of redomestication:

(1) The name of the corporation;

(2) The date of incorporation and state or country of incorporation;

(3) The street address of the principal office in this State;

(4) The names and titles of the officers and directors of the corporation;

(5) A statement that the corporation is moving its domicile from its present state or country to this State;

(6) A statement that redomestication will occur upon filing the articles of redomestication and that the corporation is subject to the laws of this State; and

(7) A statement that copies of the articles of incorporation or other organizational document and any amendments certified by the proper officer of the state or country under the laws of which the corporation is incorporated are attached. If any of these documents are in a foreign language, a translation under oath of the translator must accompany these documents. [1997, c. 435, §1 (NEW).]

[2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §46 (COR) .]

2. **Licensure.** Upon payment to the superintendent of the issuance fee set forth in section 601, subsection 1, the domestic captive insurance company is entitled to the necessary or appropriate certificates and licenses to do business in this State and is subject to the authority and jurisdiction of this State. A captive insurance company redomesticating into this State need not merge, consolidate, transfer assets or otherwise engage in any other reorganization other than as specified in this section.

[1997, c. 435, §1 (NEW) .]

3. **Rights and privileges; liabilities.** Upon redomestication in accordance with this section, the foreign or alien captive insurance company becomes a domestic captive insurance company organized under the laws of this State and has all the rights, privileges, immunities and powers and is subject to all applicable laws, duties and liabilities of a domestic captive insurance company of the same type. The domestic captive insurance company possesses all rights that it had prior to the redomestication to the extent permitted by the laws of this State and is responsible and liable for all the liabilities and obligations that it was subject to prior to the redomestication. All outstanding policies of the captive insurance company remain in full force and effect.

[1997, c. 435, §1 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). RR 2001, c. 2, §B58 (AFF). RR 2001, c. 2, §B46 (COR).

§6717. REDOMESTICATION; CONVERSION TO FOREIGN INSURER

1. **Transfer of domicile.** A domestic captive insurance company, upon approval by the superintendent, may transfer its domicile to any other jurisdiction in accordance with the laws of that jurisdiction.

[1997, c. 435, §1 (NEW) .]

2. **Notice of intent to transfer required.** Before transferring its domicile to any other jurisdiction and before the notice of change in domicile is transmitted to the Secretary of State, the domestic captive insurance company shall deliver to the superintendent a notice of intent to transfer, along with payment of a transfer fee of $500, and shall petition the superintendent to issue a certificate of transfer.

[1997, c. 435, §1 (NEW) .]

3. **Contents of notice.** The notice of change in domicile, the certificate of transfer issued by the superintendent, the proof of redomestication and the filing fee of either $35 in the case of a company governed by Title 13-C or $5 in the case of a company governed by Title 13-B must be transmitted to the Secretary of State. The notice of the change in domicile must contain the following:

A. Name of the corporation; [1997, c. 435, §1 (NEW).]

B. Dates that notice of the corporation's intent to transfer domicile from this State was published, once in each of 4 successive weeks in 4 publications in a newspaper of general circulation published in this State; [1997, c. 435, §1 (NEW).]

C. Date of the transfer of its domicile; and [1997, c. 435, §1 (NEW).]

D. State or country to which its domicile will be transferred. [1997, c. 435, §1 (NEW).]

[2001, c. 2, Pt. B, §58 (AFF); 2001, c. 2, Pt. B, §47 (COR) .]

4. **Effect of transfer.** Upon any transfer authorized pursuant to this section, the captive insurance company ceases to be domiciled in this State, and its corporate or other legal existence in this State ceases upon the filing of the notice under this section by the Secretary of State.

[2009, c. 56, §20 (AMD) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). RR 2001, c. 2, §B58 (AFF). RR 2001, c. 2, §B47 (COR). 2009, c. 56, §20 (AMD).

§6718. RULES

1. **Authority.** The superintendent may adopt rules to implement this chapter. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 238, Pt. E, §5 (NEW) .]

2. **Risk retention groups.** Notwithstanding section 6719, the superintendent shall adopt rules establishing financial standards and corporate governance standards for captive insurance companies that are risk retention groups as defined in section 6093, subsection 13. Such rules may include, but are not limited to, rules making specified provisions of this Title applicable to captive insurance companies that are risk retention groups, subject to any modifications that the superintendent determines to be appropriate to the nature of a risk retention group's business. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2013, c. 238, Pt. E, §5 (NEW) .]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2011, c. 90, Pt. I, §7 (AMD). 2013, c. 238, Pt. E, §5 (RPR).

§6719. LAWS APPLICABLE

An insurance law of this State, other than described or referenced in this chapter, does not apply to a captive insurance company. This exclusion must be strictly construed so as to further the public policy in favor of providing alternative means for providing insurance coverage. [2011, c. 90, Pt. I, §8 (AMD).]

SECTION HISTORY
1997, c. 435, §1 (NEW). 2011, c. 90, Pt. I, §8 (AMD).

§6720. FEES, TAXES AND ASSESSMENTS

Except as otherwise specified in this chapter, all fees, taxes and assessments as set out in sections 237, 601 and 602 apply to captive insurers in the same manner as they apply to other insurers. [1997, c. 435, §1 (NEW).]

SECTION HISTORY
1997, c. 435, §1 (NEW).

§6721. RULES FOR CONTROLLED UNAFFILIATED BUSINESS

The superintendent may adopt rules establishing standards to ensure that a parent or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by a pure captive insurance company. In the absence of any rules, the superintendent may approve

the coverage of such risks by a pure captive insurance company upon request. Any rules adopted by the superintendent pursuant to this section are routine technical rules as described in Title 5, chapter 375, subchapter 2-A. [2009, c. 335, §21 (NEW).]

SECTION HISTORY
2009, c. 335, §21 (NEW).

§6722. CONVERSION TO OR MERGER WITH RECIPROCAL INSURER

1. **Authority for conversion or merger.** A captive insurance company, association captive insurance company or industrial insured captive insurance company formed as a stock or mutual insurer may convert to or merge with a reciprocal insurer with the approval of the superintendent in accordance with a plan of operation and with the requirements of this section. Any plan for conversion or merger must provide a fair and equitable mechanism for purchasing, retiring or otherwise extinguishing the interests of stockholders and policyholders of a stock insurer and the interests of members and policyholders of a mutual insurer, including a fair and equitable provision for the rights and remedies of dissenting stockholders, members or policyholders.

[2009, c. 335, §22 (NEW) .]

2. **Conversion.** The superintendent may not approve a plan of conversion unless the plan:

A. Provides notice of the opportunity to request a hearing to directors, officers, stockholders, members and policyholders of the captive insurance company. If no request for a hearing is received, the superintendent is not required to hold a hearing in the superintendent's discretion; [2009, c. 335, §22 (NEW).]

B. Provides a fair and equitable plan for the conversion of stockholder, member or policyholder interests into subscriber interests in the resulting reciprocal insurer in a substantially proportionate manner to the corresponding interest in the stock or mutual insurer except that the resulting reciprocal insurer is not precluded from applying underwriting criteria that may affect ongoing ownership interests; [2009, c. 335, §22 (NEW).]

C. In the case of a stock insurer, has been approved by a majority of voting shares represented in person or by proxy at a duly called regular or special meeting at which a quorum is present; and [2009, c. 335, §22 (NEW).]

D. In the case of a mutual insurer, has been approved by a majority of the voting interests of policyholders represented in person or by proxy at a duly called regular or special meeting at which a quorum is present. [2009, c. 335, §22 (NEW).]

The superintendent shall approve a plan of conversion if the superintendent finds that the conversion will promote the general good of the State in conformity with this chapter. If the superintendent approves the plan, the superintendent shall amend the converting insurer's certificate of authority to reflect conversion to a reciprocal insurer and issue the amended certificate of authority to the converting insurer's designated attorney. The conversion is effective upon the issuance of the amended certificate of authority by the superintendent. Upon the conversion, the corporate existence of the converting insurer ceases and the resulting reciprocal insurer shall notify the Secretary of State of the conversion.

[2009, c. 335, §22 (NEW) .]

3. **Merger.** A plan of merger may not be approved by the superintendent unless the plan of merger satisfies the same requirements in subsection 2, paragraphs A to D. The superintendent may permit the formation, without surplus, of a captive insurance company organized as a reciprocal insurer into which an existing captive insurance company may be merged for the purpose of facilitation of a transaction under this section except that no more than one authorized insurance company may survive the merger. An alien insurer

may be a party to a merger authorized under this section if the requirements of this Title for a merger between a domestic and foreign insurer are met. For the purposes of this section, the alien insurer is treated as a foreign insurer and the jurisdiction of the alien insurer is considered a state.

[2009, c. 335, §22 (NEW) .]

4. **Effect.** A conversion or merger pursuant to this section has all of the effects of a conversion or merger approved pursuant to this Title to the extent that such effects are not inconsistent with the provisions of this chapter.

[2009, c. 335, §22 (NEW) .]

SECTION HISTORY
2009, c. 335, §22 (NEW).

§6724. SPONSORED CAPTIVE INSURANCE COMPANIES

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

A. "Participant" means an entity as described in subsection 6, and any affiliates thereof, that are insured by a sponsored captive insurance company. [2009, c. 335, §23 (NEW).]

B. "Participant contract" means a contract by which a sponsored captive insurance company insures the risks of a participant. [2009, c. 335, §23 (NEW).]

C. "Protected cell" means a separate account established by a sponsored captive insurance company formed or licensed under the provisions of this chapter in which assets are maintained for one or more participants in accordance with the terms of one or more participant contracts to fund the liability of the sponsored captive insurance company assumed on behalf of the participants as set forth in the participant contracts. [2009, c. 335, §23 (NEW).]

D. "Sponsor" means an entity that meets the requirements of subsection 5 and is approved by the superintendent to provide all or part of the capital and surplus required by applicable law and to organize and operate a sponsored captive insurance company. [2009, c. 335, §23 (NEW).]

E. "Sponsored captive insurance company" means a captive insurance company:

(1) In which the minimum capital and surplus required by applicable law is provided by one or more sponsors;

(2) That is formed or licensed under the provisions of this chapter;

(3) That insures the risks only of its participants through separate participant contracts; and

(4) That funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the sponsored captive insurance company's general account. [2009, c. 335, §23 (NEW).]

[2009, c. 335, §23 (NEW) .]

2. **Formation.** One or more sponsors may form a sponsored captive insurance company under this chapter. In addition to the general provisions of this chapter, the provisions of this section apply to sponsored captive insurance companies. A sponsored captive insurance company must be incorporated as a stock insurer with its capital divided into shares and held by the stockholder, as a nonprofit corporation with one or more members or as a manager-managed limited liability company.

[2009, c. 335, §23 (NEW) .]

3. **Supplemental application materials.** In addition to the information required by section 6702, each applicant sponsored captive insurance company shall file with the superintendent the following:

A. Materials demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the superintendent and how it will report the experience to the superintendent; [2009, c. 335, §23 (NEW).]

B. A statement acknowledging that all financial records of the sponsored captive insurance company, including records pertaining to any protected cells, will be made available for inspection or examination by the superintendent or the superintendent's designated agent; [2009, c. 335, §23 (NEW).]

C. All contracts or sample contracts between the sponsored captive insurance company and any participants; and [2009, c. 335, §23 (NEW).]

D. Evidence that expenses will be allocated to each protected cell in a fair and equitable manner. [2009, c. 335, §23 (NEW).]

[2009, c. 335, §23 (NEW) .]

4. **Protected cells.** A sponsored captive insurance company formed or licensed under the provisions of this chapter may establish and maintain one or more protected cells to insure risks of one or more participants, subject to the following conditions:

A. The shareholders of a sponsored captive insurance company must be limited to its participants and sponsors, except that a sponsored captive insurance company may issue nonvoting securities to other persons on terms approved by the superintendent; [2009, c. 335, §23 (NEW).]

B. Each participant contract must specify one or more protected cells as the sole source of the participant's coverage and limit the losses of the participant to its pro rata share of the assets of the protected cell identified in the contract. If the sponsored captive insurance company enters into a contract involving more than one protected cell, the rights and obligations relating to each protected cell must be several rather than joint and the contract must make clear provisions for apportionment of the rights and obligations between protected cells; [2009, c. 335, §23 (NEW).]

C. Each protected cell must be accounted for separately on the books and records of the sponsored captive insurance company to reflect the financial condition and results of operations of each protected cell, net income or loss, dividends or other distributions to participants and such other factors as may be provided in the participant contract or required by the superintendent; [2009, c. 335, §23 (NEW).]

D. The assets of a protected cell may not be chargeable with liabilities arising out of any other insurance business the sponsored captive insurance company may conduct; [2009, c. 335, §23 (NEW).]

E. A sale, exchange or other transfer of assets may not be made by a sponsored captive insurance company between or among any of its protected cells without the consent of the protected cells; [2009, c. 335, §23 (NEW).]

F. A sale, exchange, transfer of assets, dividend or distribution may not be made from a protected cell to a sponsor or participant without the superintendent's approval and in no event may approval be given if the sale, exchange, transfer, dividend or distribution would result in insolvency or impairment with respect to a protected cell; [2009, c. 335, §23 (NEW).]

G. Each sponsored captive insurance company must annually file with the superintendent such financial reports as the superintendent requires, which must include, without limitation, accounting statements detailing the financial experience of each protected cell; [2009, c. 335, §23 (NEW).]

H. Each sponsored captive insurance company must notify the superintendent in writing within 10 business days of any protected cell that is insolvent or otherwise unable to meet its claim or expense obligations; [2009, c. 335, §23 (NEW).]

I. A participant contract may not take effect without the superintendent's prior written approval, and the addition of each new protected cell and withdrawal of any participant or termination of any existing protected cell constitutes a change in the business plan requiring the superintendent's prior written approval; [2009, c. 335, §23 (NEW).]

J. The business written by a sponsored captive insurance company, with respect to each protected cell, must be:

(1) Fronted by a properly licensed insurance company;

(2) Reinsured by a reinsurer authorized or approved by the superintendent; or

(3) Secured by a trust fund in the United States for the benefit of policyholders and claimants or funded by an irrevocable letter of credit or other arrangement that is acceptable to the superintendent. The amount of security provided must be no less than the reserves associated with those liabilities that are neither fronted nor reinsured, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses and unearned premiums for business written through the participant's protected cell. The superintendent may require the sponsored captive insurance company to increase the funding of any security arrangement established under this subparagraph. If the form of security is a letter of credit, the letter of credit must be established, issued or confirmed by a bank chartered in this State or a member of the Federal Reserve System and established in a form and upon such terms approved by the superintendent; [2009, c. 335, §23 (NEW).]

K. In any action or proceeding involving the potential for monetary recovery by or against a sponsored captive insurance company or for nonmonetary relief relating to a particular protected cell or cells, any process, pleading or order must name the specific protected cell or cells affected, including if applicable the general account; and [2009, c. 335, §23 (NEW).]

L. A sponsored captive insurance company shall notify the superintendent in writing within 10 business days after the special purpose reinsurance vehicle or any protected cell becomes impaired or insolvent. [2009, c. 335, §23 (NEW).]

[2009, c. 335, §23 (NEW) .]

5. **Qualification of sponsors.** A sponsor of a sponsored captive insurance company must be an insurer licensed under the laws of any state, a reinsurer authorized or approved under the laws of any state, a captive insurance company formed or licensed under this chapter, a broker-dealer licensed pursuant to the Maine Uniform Securities Act, a financial institution or financial institution holding company authorized under Title 9-B, including any affiliate or subsidiary of such financial institution holding company, or any other person approved by the superintendent in the exercise of the superintendent's discretion after finding that the approval of a person as a sponsor is not inconsistent with the purposes of this chapter. A risk retention group authorized pursuant to chapter 72-A may not be either a sponsor or a participant of a sponsored captive insurance company.

[2009, c. 335, §23 (NEW) .]

6. **Participants in sponsored captive insurance companies.** The following may be participants in a sponsored captive insurance company:

A. Associations, corporations, limited liability companies, partnerships, trusts and other business entities may be participants in any sponsored captive insurance company formed or licensed under this chapter; [2009, c. 335, §23 (NEW).]

B. A sponsor may be a participant in a sponsored captive insurance company; [2009, c. 335, §23 (NEW).]

C. A participant need not be a shareholder of the sponsored captive insurance company or any affiliate thereof; and [2009, c. 335, §23 (NEW).]

D. A participant may insure only its own risks through a sponsored captive insurance company. [2009, c. 335, §23 (NEW).]

[2009, c. 335, §23 (NEW) .]

7. **Investments by sponsored captive insurance companies.** Notwithstanding the provisions of subsection 5, the assets of 2 or more protected cells may be combined for purposes of investment, and such a combination may not be construed as defeating the segregation of assets for accounting or other purposes. Sponsored captive insurance companies shall comply with the investment requirements contained in this Title, as applicable, except that compliance with such investment requirements must be waived for sponsored captive insurance companies to the extent that credit for reinsurance ceded to reinsurers is allowed pursuant to section 6711 or to the extent otherwise considered reasonable and appropriate by the superintendent. Section 6707 applies to sponsored captive insurance companies except to the extent it is inconsistent with approved accounting standards in use by the company. Notwithstanding any other provision of this Title, the superintendent may approve the use of alternative reliable methods of valuation and rating.

[2009, c. 335, §23 (NEW) .]

8. **Delinquency of sponsored captive insurance companies or protected cells.** In the case of a sponsored captive insurance company, the provisions of section 6714 apply, except as otherwise provided in this subsection.

A. The insolvency of one protected cell does not constitute the insolvency of any other protected cell or of the sponsored captive insurance company itself. The insolvency of a sponsored captive insurance company does not constitute the insolvency of any of its solvent protected cells and is not a basis for the receivership of any solvent protected cell capable of independent operation. [2009, c. 335, §23 (NEW).]

B. Notwithstanding the insolvency of the sponsored captive insurance company or of any other protected cell, the obligations attributed to any solvent protected cell must continue to be paid as they become due. [2009, c. 335, §23 (NEW).]

C. The assets attributed to a protected cell may not be applied to the liabilities attributed to another protected cell or to the sponsored captive insurance company generally, except that:

(1) If the insolvency of the sponsored captive insurance company renders a protected cell incapable of being managed independently, a receiver may, after consultation with the creditors of a protected cell, contract for the management of the protected cell and charge to the protected cell a reasonable amount for those services;

(2) A general liability of an insolvent sponsored captive insurance company may be apportioned equitably in whole or in part to one or more of its protected cells if the Superior Court determines that the liability arises out of the operations of the protected cell or cells and that the interests of innocent creditors of the protected cell or cells are not unreasonably impaired; and

(3) If assets or liabilities have been commingled, or have been wrongfully transferred between protected cells or between a protected cell and the general account, the Superior Court shall trace the assets and attribute them to the proper accounts, giving due consideration to the terms of any relevant governing instrument or contract. [2009, c. 335, §23 (NEW).]

D. The plan of rehabilitation or liquidation of any sponsored captive insurance company must make reasonable provision for the continued operation of all solvent protected cells, which may involve the formation of one or more new sponsored captive insurance companies or the transfer of one or more protected cells. [2009, c. 335, §23 (NEW).]

[2009, c. 335, §23 (NEW) .]

SECTION HISTORY

2009, c. 335, §23 (NEW).

§6725. BRANCH CAPTIVE INSURANCE COMPANIES

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

A. "Alien captive insurance company" means an insurance company formed to write insurance business for its parents and affiliates and licensed pursuant to the laws of an alien jurisdiction that imposes statutory or regulatory standards in a form acceptable to the superintendent on companies transacting the business of insurance in the alien jurisdiction. [2009, c. 335, §24 (NEW).]

B. "Branch business" means any insurance business transacted by a branch captive insurance company in this State. [2009, c. 335, §24 (NEW).]

C. "Branch captive insurance company" means any alien captive insurance company licensed by the superintendent to transact the business of insurance in this State through a business unit with a principal place of business in this State. [2009, c. 335, §24 (NEW).]

D. "Branch operations" means any business operations of a branch captive insurance company in this State. [2009, c. 335, §24 (NEW).]

[2009, c. 335, §24 (NEW) .]

2. **Establishment of a branch captive insurance company.** A branch captive insurance company may be established in this State in accordance with the provisions of this chapter to write in this State only insurance or reinsurance of the employee benefit business of its parent and affiliated companies that is subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as amended. In addition to the general provisions of this chapter, the provisions of this section apply to branch captive insurance companies. A branch captive insurance company may not do any insurance business in this State unless it maintains the principal place of business for its branch operations in this State.

[2009, c. 335, §24 (NEW) .]

3. **Security required.** In the case of a branch captive insurance company, as security for the payment of liabilities attributable to the branch operations, the superintendent shall require that either a trust fund funded by assets acceptable to the superintendent or an irrevocable letter of credit be established and maintained in the United States for the benefit of United States policyholders and United States ceding insurers under insurance policies issued or reinsurance contracts issued or assumed by the branch captive insurance company through its branch operations. The amount of the security may be no less than the amount set forth in section 6704, subsection 1, paragraph A and the reserves on the insurance policies or reinsurance contracts, including reserves for losses, allocated loss adjustment expenses, incurred but not reported losses and unearned premiums with regard to business written through the branch operation, except that the superintendent may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account or the amount payable under the irrevocable letter of credit required by this subsection by the same amount as long as the security remains posted with the reinsurer. If the form of security selected is a letter of credit, the letter of credit must be established by, or issued or confirmed by, a bank chartered in this State or a member bank of the Federal Reserve System.

[2009, c. 335, §24 (NEW) .]

4. **Certificate of general good.** In the case of a captive insurance company licensed as a branch captive insurance company, the alien captive insurance company shall petition the superintendent to issue a certificate setting forth the superintendent's finding that, after considering the character, reputation, financial responsibility, insurance experience and business qualifications of the officers and directors of the alien

captive insurance company, the licensing and maintenance of the branch operations will promote the general good of the State. The alien captive insurance company may register to do business in this State after the superintendent's certificate is issued.

[2009, c. 335, §24 (NEW) .]

5. **Reports.** Prior to March 1st of each year, or with the approval of the superintendent within 60 days after its fiscal year-end, a branch captive insurance company shall file with the superintendent a copy of all reports and statements required to be filed under the laws of the jurisdiction in which the alien captive insurance company is formed, verified by oath of 2 of its executive officers. If the superintendent is satisfied that the annual report filed by the alien captive insurance company in its domiciliary jurisdiction provides adequate information concerning the financial condition of the alien captive insurance company, the superintendent may waive the requirement for completion of the captive annual statement for business written in the alien jurisdiction.

[2009, c. 335, §24 (NEW) .]

6. **Examination of branch captive insurance companies.** The examination of a branch captive insurance company pursuant to section 6708 must be of the branch business and branch operations only, as long as the branch captive insurance company provides annually to the superintendent a certificate of compliance, or its equivalent, issued by or filed with the licensing authority of the jurisdiction in which the branch captive insurance company is formed and demonstrates to the superintendent's satisfaction that it is operating in sound financial condition in accordance with all applicable laws and regulations of that jurisdiction. As a condition of licensure, the alien captive insurance company must grant authority to the superintendent for examination of the affairs of the alien captive insurance company in the jurisdiction in which the alien captive insurance company is formed.

[2009, c. 335, §24 (NEW) .]

SECTION HISTORY
2009, c. 335, §24 (NEW).

Chapter 85: VIATICAL AND LIFE SETTLEMENTS ACT

§6801. SHORT TITLE

This chapter may be known and cited as the "Viatical and Life Settlements Act." [2003, c. 636, §3 (AMD).]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §3 (AMD).

§6802. DEFINITIONS

(REPEALED)

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §4 (RP).

§6802-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2003, c. 636, §5 (NEW).]

1. **Advertising.** "Advertising" means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet or a similar communications medium, including film strips, motion pictures and videos, published, disseminated, circulated or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to sell a life insurance policy pursuant to a settlement contract.

[2003, c. 636, §5 (NEW) .]

2. **Business of settlements.** "Business of settlements" means any activity involved in, but not limited to, the offering, solicitation, negotiation, procurement, effectuation, purchasing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, hypothecating or in any other manner engaging in the business of settlement contracts.

[2003, c. 636, §5 (NEW) .]

3. **Chronically ill.** "Chronically ill" means:

A. Being unable to perform at least 2 activities of daily living, including, but not limited to, eating, moving from one place to another, bathing, dressing, voiding the bladder, eliminating the bowel or maintaining continence; [2003, c. 636, §5 (NEW).]

B. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or [2003, c. 636, §5 (NEW).]

C. Having a level of disability similar to that described in paragraph A, as determined by the United States Secretary of Health and Human Services. [2003, c. 636, §5 (NEW).]

[2003, c. 636, §5 (NEW) .]

4. **Financing entity.** "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a settlement provider, credit enhancer or any entity that has a direct ownership in a policy or certificate that is the subject of a settlement contract:

A. Whose principal activity related to the transaction is providing funds to effect the settlement or purchase of one or more purchased policies or to provide credit enhancement; and [2003, c. 636, §5 (NEW).]

B. Who has an agreement in writing with one or more licensed settlement providers to finance the acquisition of settlement contracts or to provide stop loss insurance. [2003, c. 636, §5 (NEW).]

"Financing entity" does not include a nonaccredited investor.

[2003, c. 636, §5 (NEW) .]

5. **Financing transaction.** "Financing transaction" means any transaction in which a licensed settlement provider obtains financing for the purchase, acquisition, transfer or other assignment of one or more settlement contracts or policies acquired pursuant to a settlement contract or interests therein, including, without limitation, any secured or unsecured financing, securitization transaction or securities offering, either registered or exempt from registration under federal and state securities law, or otherwise sells, assigns, transfers, pledges, hypothecates or otherwise disposes of a settlement contract or policy acquired pursuant to a settlement contract or interest therein.

[2003, c. 636, §5 (NEW) .]

6. **Fraudulent viatical or life settlement act.** "Fraudulent viatical or life settlement act" includes:

A. Acts or omissions committed by any person who, knowingly or with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in, acts including:

(1) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by a settlement provider, settlement producer, financing entity, insurer, insurance producer or any other person false material information, or concealing material information, as part of, in support of or concerning a fact material to one or more of the following:

(a) An application for the issuance of a settlement contract or insurance policy;

(b) The underwriting of a settlement contract or insurance policy;

(c) A claim for payment or benefit pursuant to a settlement contract or insurance policy;

(d) Premiums paid on an insurance policy;

(e) Payments and changes in ownership or beneficiary made in accordance with the terms of a settlement contract or insurance policy;

(f) The reinstatement or conversion of an insurance policy;

(g) The solicitation, offer, effectuation or sale of a settlement contract or insurance policy;

(h) The issuance of written evidence of a settlement contract or insurance policy; or

(i) A financing transaction;

(2) Employing any device, scheme or artifice to defraud related to policies acquired pursuant to a settlement contract;

(3) Entering into stranger-originated life insurance; or

(4) Failing to disclose to the insurer when requested by the insurer that the prospective insured has undergone a life expectancy evaluation by any person other than the insurer or its authorized representatives in connection with the issuance of a policy; [2007, c. 543, §1 (AMD).]

B. In the furtherance of a fraud or to prevent the detection of a fraud committing or permitting one's employees or agents to:

(1) Remove, conceal, alter, destroy or sequester from the superintendent the assets or records of a licensee or other person engaged in the business of settlements;

(2) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer or other person;

(3) Transact the business of settlements in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of settlements; or

(4) File with the superintendent or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the superintendent; [2003, c. 636, §5 (NEW).]

C. Embezzlement, theft, misappropriation or conversion of money, funds, premiums, credits or other property of a settlement provider, insurer, insured, viator, insurance policyowner or any other person engaged in the business of settlements or insurance; [2003, c. 636, §5 (NEW).]

D. Recklessly entering into, brokering or otherwise dealing in a settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, when the viator or the viator's agent intended to defraud the policy's issuer. For the purposes of this paragraph, "recklessly" means engaging in conduct in consciously and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks, such disregard involving a gross deviation from acceptable standards of conduct; [2009, c. 376, §1 (AMD).]

E. Attempting to commit; assisting, aiding or abetting in the commission of; or conspiring to commit the acts or omissions specified in this subsection; [2009, c. 376, §1 (AMD).]

F. Engaging in any transaction, practice or course of business by a person who knows or reasonably should have known that the intent was to avoid the notice requirements of this chapter; [2009, c. 376, §1 (NEW).]

G. With respect to a settlement producer, knowingly soliciting an offer from, effectuating a life settlement contract with or making a sale to any settlement provider, financing entity or related provider trust that is controlling, controlled by or under common control with the producer, unless this relationship is disclosed to the viator; [2009, c. 376, §1 (NEW).]

H. With respect to a settlement provider, knowingly entering into a settlement contract if anything of value will be paid to a settlement producer controlling, controlled by or under common control with the provider or the financing entity or related provider trust that is involved in the settlement contract, unless this relationship is disclosed to the viator; and [2009, c. 376, §1 (NEW).]

I. Any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time, unless free coverage is provided in the policy in the manner described. [2009, c. 376, §1 (NEW).]

[2009, c. 376, §1 (AMD) .]

6-A. **Life expectancy evaluation.** "Life expectancy evaluation" means any evaluation of the number of months the insured under the life insurance policy to be settled can be expected to live, or of the probability that the insured will live beyond a specified date, considering medical records and appropriate experiential data.

[2009, c. 376, §2 (AMD) .]

7. **Policy.** "Policy" means an individual or group policy, group certificate, contract or arrangement of life insurance affecting the rights of a resident of this State or bearing a reasonable relation to this State, regardless of whether delivered or issued for delivery in this State.

[2003, c. 636, §5 (NEW) .]

8. **Related provider trust.** "Related provider trust" means a titling trust or other trust established by a licensed settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with the licensed settlement provider under which the licensed settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to settlement transactions available to the superintendent as if those records and files were maintained directly by the licensed settlement provider.

[2003, c. 636, §5 (NEW) .]

9. **Settlement contract.**

[2007, c. 543, §3 (RP) .]

9-A. **Settlement contract.** "Settlement contract" means an agreement between a viator and a settlement provider establishing the terms under which compensation or anything of value will be paid, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance. "Settlement contract" includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of a person residing in this State. "Settlement contract" includes a premium finance loan made for a life insurance policy by a lender to a viator on or before the date of issuance of the policy when the viator or the insured receives on the date of the premium finance loan a guarantee of a future settlement value of the policy or when the viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy. "Settlement contract" does not include:

A. A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms; [2007, c. 543, §4 (NEW).]

B. A collateral assignment of a policy by the owner of the policy, unless the assignee knows or reasonably expects that the owner does not intend to repay the loan; [2009, c. 376, §3 (AMD).]

C. Loan proceeds that are used solely to pay:

(1) Premiums for the policy; and

(2) The costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses and 3rd-party collateral provider fees and expenses, including fees payable to letter of credit issuers; [2007, c. 543, §4 (NEW).]

D. A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, as long as neither the default itself nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter; [2007, c. 543, §4 (NEW).]

E. Unless the premium finance loan otherwise constitutes a settlement contract under this subsection, a loan made by a lender that does not violate Title 9-A, Article 2; [2007, c. 543, §4 (NEW).]

F. An agreement in which all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured or are trusts established primarily for the benefit of such parties; [2007, c. 543, §4 (NEW).]

G. Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or by a trust established by the employer, of life insurance on the life of the employee; [2007, c. 543, §4 (NEW).]

H. A bona fide business succession planning arrangement:

(1) Between shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(2) Between partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(3) Between members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members; [2007, c. 543, §4 (NEW).]

I. An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or [2007, c. 543, §4 (NEW).]

J. Any contract, transaction or arrangement other than those set forth in paragraphs A to I exempted from the definition of "settlement contract" by the superintendent by rule based on a determination that the contract, transaction or arrangement is not of the type intended to be regulated by this chapter. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2007, c. 543, §4 (NEW).]

[2009, c. 376, §3 (AMD) .]

10. **Settlement producer.** "Settlement producer" means any person who has life insurance producer authority, who acts or aids in any manner in the soliciting of a settlement on behalf of a viator and for a fee, commission or other valuable consideration offers or attempts to negotiate settlement contracts between a viator and one or more settlement providers. "Settlement producer" does not include an attorney, accountant, financing entity or person exercising a power of attorney granted by the viator retained to represent the viator and whose compensation is paid solely by the viator without regard to whether the settlement is effected. "Settlement producer" does not include a credit union or an employer or association that makes its employees or members aware of settlement contracts.

[2009, c. 376, §4 (AMD) .]

11. **Settlement provider.** "Settlement provider" means a person other than the viator that enters into or effectuates a settlement contract. "Settlement provider" does not include:

A. A supervised lender, as defined in Title 9-A, section 1-301, subsection 39, that takes an assignment of a life insurance policy as collateral for a loan; [2003, c. 636, §5 (NEW).]

B. The issuer of a life insurance policy providing accelerated benefits under section 2555 and pursuant to the contract; [2003, c. 636, §5 (NEW).]

C. An authorized or eligible insurer that provides stop-loss coverage to a settlement provider, purchaser, financing entity, special purpose entity or related provider trust; [2003, c. 636, §5 (NEW).]

D. A viator's friend or family member or other natural person who enters into no more than one agreement in a calendar year for the assignment, transfer, sale, devise or bequest of a life insurance policy for any value less than the expected death benefit; [2003, c. 636, §5 (NEW).]

E. A financing entity; [2003, c. 636, §5 (NEW).]

F. A special purpose entity; [2003, c. 636, §5 (NEW).]

G. A related provider trust; or [2003, c. 636, §5 (NEW).]

H. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 and Rule 144A of the Federal Securities Act of 1933, as amended, and who acquires a policy from a settlement provider. [2003, c. 636, §5 (NEW).]

[2003, c. 636, §5 (NEW) .]

12. **Special purpose entity.** "Special purpose entity" means a corporation, partnership, trust, limited liability company or similar entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or licensed settlement provider.

[2003, c. 636, §5 (NEW) .]

12-A. **Stranger-originated life insurance.** "Stranger-originated life insurance" means an act or practice to initiate a life insurance policy for the benefit of a person who, at the time of the origination of the policy, has no insurable interest in the insured. "Stranger-originated life insurance" includes, but is not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person who, at the time of the inception of the policy, could not lawfully initiate the policy and when, at the time of policy inception, there is an arrangement or agreement to directly or indirectly transfer the ownership of the policy or the policy benefits to another person. "Stranger-originated life insurance" also includes the creation of a trust to give the appearance of insurable interest and the use of such a trust in order to initiate policies for investors in circumvention or violation of insurable interest laws and the prohibition against wagering on life.

[2009, c. 597, §1 (AMD) .]

13. **Terminally ill.** "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death within 24 months or less.

[2003, c. 636, §5 (NEW) .]

14. **Viator.** "Viator" means a person who assigns, transfers, sells, devises or bequeaths or seeks to assign, transfer, sell, devise or bequeath a death benefit or ownership of a life insurance policy or certificate under a settlement contract. "Viator" does not include:

A. A settlement provider licensed under this chapter; [2003, c. 636, §5 (NEW).]

B. An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 and Rule 144A of the Federal Securities Act of 1933, as amended; [2003, c. 636, §5 (NEW).]

C. A financing entity; [2003, c. 636, §5 (NEW).]

D. A special purpose entity; or [2003, c. 636, §5 (NEW).]

E. A related provider trust. [2003, c. 636, §5 (NEW).]

[2003, c. 636, §5 (NEW) .]

SECTION HISTORY
2003, c. 636, §5 (NEW). 2007, c. 543, §§1-5 (AMD). 2009, c. 376, §§1-5 (AMD). 2009, c. 597, §1 (AMD).

§6803. SETTLEMENT PROVIDER AND PRODUCER LICENSE; LICENSE REQUIREMENTS

1. **License required.** Licenses are required in accordance with this subsection.

A. A person may not act as a settlement provider without a license from the superintendent issued pursuant to this section and subject to the provisions of this chapter. [2003, c. 636, §6 (AMD).]

B. A person may not perform the functions of, or otherwise act as, a settlement producer without a license from the superintendent as a life insurance producer. [2003, c. 636, §6 (AMD).]

C. [2003, c. 636, §6 (RP).]

C-1. If there is more than one viator on a single policy and the viators are residents of different states, the settlement contract is governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one viator agreed upon in writing by all viators. [2003, c. 636, §6 (NEW).]

D. [2003, c. 636, §6 (RP).]

E. [2003, c. 636, §6 (RP).]

[2003, c. 636, §6 (AMD) .]

2. **Application; fee.** Application for a settlement provider license must be made to the superintendent by the applicant on a form prescribed by the superintendent. The application must be accompanied by a fee not to exceed $400 in accordance with section 601.

[2003, c. 636, §6 (AMD) .]

3. **Renewal.** A license for a settlement provider is continuous as long as the licensee remains qualified. The settlement provider must pay an annual fee not to exceed $400 in accordance with section 601. Failure to pay the fee within the terms prescribed may result in the revocation of the license unless cured within 5 days of written notice of failure to pay to the principal office of the licensee.

[2003, c. 636, §6 (AMD) .]

4. **Information required.** The applicant for a settlement provider license shall provide such information as the superintendent requires and the information must be submitted on forms required by the superintendent. The superintendent may at any time require the applicant to disclose fully the identity of all stockholders except stockholders owning less than 5% of the shares of an applicant whose shares are publicly traded, partners, officers, directors, members and employees and the superintendent may, in the exercise of the superintendent's discretion, refuse to issue a license to an applicant if not satisfied that any stockholder, partner, director, member or employee of the applicant who may materially influence the applicant's conduct meets the criteria set forth in subsection 6. A settlement provider shall provide to the superintendent new or revised information about officers, stockholders controlling 10% or more of stock, partners, directors, members or designated employees within 30 days of the change.

[2003, c. 636, §6 (AMD) .]

5. **Authority under license.** A settlement provider license issued to any person authorizes all officers, partners, directors, members and key management personnel of that person to act on behalf of the settlement provider, unless such activity requires a license under another provision of this Title. All officers, partners, directors, members and key management personnel of the person must be named in the application and any supplements to the application.

[2003, c. 636, §6 (AMD) .]

6. **Investigation.** Upon the filing of an application and the payment of the settlement provider license fee, the superintendent shall make an investigation of the applicant and shall issue a license if the superintendent finds that the applicant:

A. Has provided a detailed plan of operation; [1997, c. 430, §1 (NEW); 1997, c. 430, §2 (AFF).]

B. Is competent and trustworthy and intends to act in good faith in the capacity of a settlement provider; [2003, c. 636, §6 (AMD).]

C. Has a good business reputation and has had experience, training or education so as to be qualified as a settlement provider; [2003, c. 636, §6 (AMD).]

D. If organized under the laws of this State, has provided a certificate of good standing from this State. If the applicant is a foreign entity, it must provide a certificate of good standing from its state of organization and a certificate of good standing from this State; [2003, c. 636, §6 (AMD).]

E. Has no officer, partner, director, member or key management personnel of the applicant that has been found guilty of, or has pleaded guilty or nolo contendere to, any crime involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court; and [2003, c. 636, §6 (AMD).]

F. Has provided an antifraud plan that meets the requirements of section 6818. [2003, c. 636, §6 (NEW).]

[2003, c. 636, §6 (AMD) .]

7. **Financial responsibility.** Evidence of financial responsibility must be provided to the superintendent in accordance with this subsection.

A. A settlement provider shall provide evidence of financial accountability. Such evidence may include, but is not limited to, a binding and committed lending facility of at least $1,000,000 with a term of at least one year or a net worth in excess of $100,000. [2003, c. 636, §6 (AMD).]

[2003, c. 636, §6 (AMD) .]

8. **Nonresidents.** The superintendent may not issue a settlement provider license to a nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the superintendent or the applicant has filed with the superintendent the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the superintendent.

[2003, c. 636, §6 (AMD) .]

9. **List.** The superintendent shall maintain a complete list of all settlement providers licensed or with license pending in this State. The list must be available upon request to the general public.

[2003, c. 636, §6 (AMD) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 1997, c. 592, §§76-80 (AMD). 2003, c. 636, §6 (AMD).

§6803-A. FIDUCIARY OBLIGATION OF SETTLEMENT PRODUCER

Irrespective of the manner in which the settlement producer is compensated, a settlement producer may represent only the interests of the viator and owes a fiduciary duty to the viator. [2009, c. 376, §6 (NEW).]

SECTION HISTORY
2009, c. 376, §6 (NEW).

§6804. LICENSE REVOCATION AND ADMINISTRATIVE ASSESSMENTS

1. **Superintendent's authority.**

[2003, c. 636, §7 (RP) .]

1-A. **Superintendent's authority.** The superintendent may deny, suspend, revoke or refuse to renew the license of a settlement provider if the superintendent finds just cause to do so, which may include, but is not limited to, a finding that:

A. There was any material misrepresentation in the application for the license or other information submitted to the superintendent; [2003, c. 636, §7 (NEW).]

B. The licensee or any officer, partner, director, member or key management personnel of the licensee has been convicted of fraudulent or dishonest practices, is subject to a final administrative action to suspend or revoke a settlement provider license or is otherwise shown to be untrustworthy or incompetent to act as a settlement provider; [2003, c. 636, §7 (NEW).]

C. The licensee as a settlement provider demonstrates an unreasonable pattern of payments to viators; [2003, c. 636, §7 (NEW).]

D. The licensee or any officer, partner, director, member or key management personnel of the licensee has been found guilty of, or has pleaded guilty or nolo contendere to, any crime involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court; [2003, c. 636, §7 (NEW).]

E. The settlement provider has entered into any settlement contract that has not been approved pursuant to this chapter; [2003, c. 636, §7 (NEW).]

F. The settlement provider has failed to honor contractual obligations set out in a settlement contract; [2003, c. 636, §7 (NEW).]

G. The settlement provider no longer meets the requirements for initial licensure; [2003, c. 636, §7 (NEW).]

H. The settlement provider has assigned, transferred or pledged a policy acquired pursuant to a settlement contract to a person other than a settlement provider licensed in this State, an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 and Rule 144A of the Federal Securities Act of 1933, as amended, a financing entity, a special purpose entity or a related provider trust; or [2003, c. 636, §7 (NEW).]

I. The licensee has violated any of the provisions of this chapter or any rules adopted pursuant to this chapter. [2003, c. 636, §7 (NEW).]

[2003, c. 636, §7 (NEW) .]

2. **Hearing.** Before the superintendent may deny a license application or suspend, revoke or refuse to renew the license of a settlement provider, the licensee or applicant has an opportunity for a hearing in accordance with Title 5, chapter 375, subchapter 4.

[2003, c. 636, §7 (AMD) .]

3. **Administrative penalty.** The superintendent may, in addition to denying a license application or suspending or revoking a license, assess an administrative civil forfeiture of $500 for each willful violation of this chapter. This section may not be construed to diminish the penalties available for any violation of chapter 23, in addition to any penalties authorized under section 12-A.

[1997, c. 430, §1 (NEW); 1997, c. 430, §2 (AFF) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 1997, c. 562, §D5 (AMD). 1997, c. 562, §D10 (AFF). 2003, c. 636, §7 (AMD).

§6805. APPROVAL OF SETTLEMENTS CONTRACTS; DISCLOSURE STATEMENTS AND APPLICATIONS

A settlement contract must be in writing and signed by all parties to the contract. A person may not use any contract, disclosure statement or application form with a viator who is a resident of this State unless it has been filed with and approved by the superintendent, pursuant to sections 2412 and 2413. The superintendent shall disapprove a settlement contract form or disclosure statement form if, in the superintendent's opinion, the contract or provisions contained therein are unreasonable, contrary to the interests of the public or otherwise misleading or unfair to the viator. All such forms must be approved or denied by the superintendent within 60 calendar days following receipt of submission by the superintendent. [2009, c. 376, §7 (AMD).]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §8 (AMD). 2009, c. 376, §7 (AMD).

§6806. REPORTING REQUIREMENTS; CONFIDENTIALITY OF INFORMATION

1. **Annual report.** A settlement provider licensee shall file with the superintendent by March 1st of each year an annual statement containing such information as the superintendent prescribes by rule, including information related to settlement transactions on policies settled within 5 years of policy issuance. The superintendent may not adopt any rule that requires the submission of information that permits the identification of a viator or relates to transactions when the viator is not a resident of this State. The superintendent may not request, collect or compile personal information that identifies any viator or insured except in connection with the investigation of a specific complaint and with the prior written permission of the viator or insured or the viator's or insured's estate or representative to collect that information.

[2009, c. 376, §8 (AMD) .]

1-A. **Fee for filing annual report.** The fee for filing the annual report is the same as for an insurer as provided in section 601. On or before July 1st of each year, the superintendent shall forward to each settlement provider an itemized bill for the amount due for the filing of the annual statement and the amount due for the certificate of authority annual fee.

[2003, c. 636, §9 (AMD) .]

2. **Privacy protection.** Except as otherwise required or permitted by law, a settlement provider, settlement producer, insurance company, insurance producer, independent insurance producer, information bureau, rating company or any other person with actual knowledge of the identity of a viator, or of the insured if other than the viator, may not disclose that identity, or the insured's financial or medical information, to any other person unless the disclosure:

A. Is necessary to effectuate a settlement contract between the viator and a settlement provider and the viator and the insured have provided prior written consent to the disclosure; [2003, c. 636, §9 (AMD).]

B. Is provided in response to an investigation or examination by the superintendent or any other government officer or agency pursuant to section 6807; [2003, c. 636, §9 (AMD).]

C. Is necessary to permit a financing entity, related provider trust or special purpose entity to finance the purchase of policies by a settlement provider and the viator and insured have provided prior written consent to the disclosure; [2003, c. 636, §9 (AMD).]

D. Is a term or condition to the transfer of a policy by one settlement provider to another settlement provider; [2003, c. 636, §9 (NEW).]

E. Is necessary to allow the settlement provider or insurance producer or an authorized representative to make contacts for the purpose of determining health status; or [2003, c. 636, §9 (NEW).]

F. Is required to purchase stop-loss coverage. [2003, c. 636, §9 (NEW).]

[2003, c. 636, §9 (AMD) .]

3. **Sale or transfer.**

[2003, c. 636, §9 (RP) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 1997, c. 592, §81 (AMD). 2003, c. 636, §9 (AMD). 2009, c. 376, §8 (AMD).

§6807. EXAMINATIONS AND INVESTIGATIONS

1. **Complaint.**

[2003, c. 636, §10 (RP) .]

1-A. **Examinations.** The superintendent may conduct examinations in accordance with this subsection.

A. The superintendent may conduct an examination under this chapter of a licensee as often as the superintendent in the superintendent's sole discretion considers appropriate. [2003, c. 636, §10 (NEW).]

B. For purposes of completing an examination of a licensee under this chapter, subject to the provisions of section 6806, the superintendent may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the superintendent, considered necessary or material to the examination of the licensee. [2003, c. 636, §10 (NEW).]

C. In lieu of an examination under this chapter of any foreign or alien licensee licensed in this State, the superintendent may, at the superintendent's discretion, accept an examination report on the licensee as prepared by the superintendent of insurance for the licensee's state of domicile or port-of-entry state. [2003, c. 636, §10 (NEW).]

[2003, c. 636, §10 (NEW) .]

2. **Confidential information.**

[2003, c. 636, §10 (RP) .]

3. **Records.** Records of all settlement transactions must be maintained by the settlement provider licensee in accordance with this subsection.

A. A settlement provider required to be licensed by this chapter shall retain for 5 years copies of all:

(1) Proposed, offered or executed settlement contracts, settlement purchase agreements, underwriting documents, policy forms and applications from the date of the proposal, offer or execution of the settlement contract or settlement purchase agreement, whichever is later;

(2) Checks, drafts or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date of the transaction; and

(3) Other records and documents related to the requirements of this chapter. [2003, c. 636, §10 (NEW).]

B. This subsection does not relieve a settlement provider licensee of the obligation to produce these documents to the superintendent after the retention period has expired if the person has retained the documents. [2003, c. 636, §10 (NEW).]

C. Subject to the provisions of section 6806, records required to be retained by this subsection must be legible and complete and may be retained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces or forms a durable medium for the reproduction of a record. [2003, c. 636, §10 (NEW).]

[2003, c. 636, §10 (AMD) .]

4. **Immunity.** A cause of action may not arise against any person for the act of communicating or delivering information or data to the superintendent or the superintendent's authorized representative or examiner pursuant to an examination made under this chapter if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subsection does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by the superintendent, the superintendent's authorized representatives or any examiner appointed by the superintendent.

A. A cause of action may not arise against the superintendent, the superintendent's authorized representatives or any examiner appointed by the superintendent for any statements made or conduct performed in good faith while carrying out the provisions of this chapter. [2003, c. 636, §10 (NEW).]

B. A cause of action may not arise against any person for the act of communicating or delivering information or data to the superintendent or the superintendent's authorized representative or examiner pursuant to an examination made under this chapter if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in paragraph A. [2003, c. 636, §10 (NEW).]

C. A person identified in paragraph A or B is entitled to an award of attorney's fees and costs if that person is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this paragraph, a proceeding is "substantially justified" if the proceeding had a reasonable basis in law or fact at the time that it was initiated. [2003, c. 636, §10 (NEW).]

[2003, c. 636, §10 (AMD) .]

5. **Conduct of examinations.** The following provisions govern the conduct of examinations.

A. Upon determining that an examination should be conducted, the superintendent shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures as the superintendent considers appropriate. [2003, c. 636, §10 (NEW).]

B. Every licensee or person from whom information is sought and its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee or person being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination insofar as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the superintendent is grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the licensee to engage in the business of settlements or other business subject to the superintendent's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority must be conducted pursuant to Title 5, chapter 375, subchapter 4. [2003, c. 636, §10 (NEW).]

C. The superintendent has the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the superintendent may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order is punishable as contempt of court. [2003, c. 636, §10 (NEW).]

D. When making an examination under this chapter, the superintendent may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals or specialists as examiners, the reasonable cost of which must be borne by the licensee that is the subject of the examination. [2003, c. 636, §10 (NEW).]

E. This chapter may not be construed to limit the superintendent's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this State. Findings of fact and conclusions made pursuant to any examination are prima facie evidence in any legal or regulatory action. [2003, c. 636, §10 (NEW).]

F. This chapter may not be construed to limit the superintendent's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the superintendent may, in the superintendent's sole discretion, consider appropriate. [2003, c. 636, §10 (NEW).]

[2003, c. 636, §10 (NEW) .]

6. **Examination reports.** Examination reports may be composed only of facts appearing upon the books, records or other documents of the licensee or its agents or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and of such conclusions and recommendations as the examiners find reasonably warranted from the facts. No later than 60 days following completion of the examination, the examiner in charge shall file under oath with the superintendent a verified written report of examination. Upon receipt of the verified report, the superintendent shall transmit the report to the licensee examined, together with a notice that affords the licensee examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. In the event the superintendent determines that regulatory action is appropriate as a result of an examination, the superintendent may initiate any proceedings or actions provided by law.

[2003, c. 636, §10 (NEW) .]

7. Confidentiality of examination information. The disclosure of information is governed by this subsection.

A. Names and individual identification data for all viators and insured persons are considered private and confidential information and may not be disclosed by the superintendent, unless required by law. [2003, c. 636, §10 (NEW).]

B. Except as otherwise provided in this chapter, all examination reports, workpapers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the superintendent or any other person in the course of an examination made under this chapter, or in the course of analysis or investigation by the superintendent of the financial condition or market conduct of a licensee, are confidential by law and privileged, are not subject to subpoena and are not subject to discovery or admissible in evidence in any private civil action. The superintendent is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the superintendent's official duties.

For the purposes of this paragraph and paragraph C, "chapter" includes the law of another state or jurisdiction that is substantially similar to this chapter. [2003, c. 636, §10 (NEW).]

C. Documents, materials or other information, including, but not limited to, all workpapers and copies thereof, in the possession or control of the National Association of Insurance Commissioners, or its successor organization, and its affiliates and subsidiaries are confidential by law and privileged, are not subject to subpoena and are not subject to discovery or admissible in evidence in any private civil action if they are:

(1) Created, produced or obtained by or disclosed to the National Association of Insurance Commissioners, or its successor organization, and its affiliates and subsidiaries in the course of assisting an examination made under this chapter or assisting a superintendent in the analysis or investigation of the financial condition or market conduct of a licensee; or

(2) Disclosed to the National Association of Insurance Commissioners, or its successor organization, and its affiliates and subsidiaries under paragraph D by a superintendent. [2003, c. 636, §10 (NEW).]

D. The superintendent and any person that receives documents, material or other information while acting under the authority of the superintendent, including the National Association of Insurance Commissioners, or its successor organization, and its affiliates and subsidiaries, may not testify in any private civil action concerning any confidential documents, materials or information subject to paragraph A. [2003, c. 636, §10 (NEW).]

E. In order to assist in the performance of the superintendent's duties, the superintendent:

(1) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph A, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, or its successor organization, and its affiliates and subsidiaries and with state, federal and international law enforcement authorities, as long as the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, communication or other information; and

(2) May receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, or its successor organization, and its affiliates and subsidiaries and from regulatory and law enforcement officials of foreign or other domestic jurisdictions and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information. [2003, c. 636, §10 (NEW).]

F. A waiver of any applicable privilege or claim of confidentiality in the documents, materials or information does not occur as a result of disclosure to the superintendent under this section or as a result of sharing as authorized in paragraph E. [2003, c. 636, §10 (NEW).]

G. A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection is available and enforced in any proceeding in, and in any court of, this State. [2003, c. 636, §10 (NEW).]

H. This chapter may not prevent or be construed as prohibiting the superintendent from disclosing the content of an examination report or preliminary examination report or results, or any matter relating thereto, to the superintendent of insurance of any other state or country or to law enforcement officials of this State or any other state or an agency of the Federal Government at any time or to the National Association of Insurance Commissioners, or its successor organization, as long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this chapter. [2003, c. 636, §10 (NEW).]

[2003, c. 636, §10 (NEW) .]

8. **Conflict of interest.** The following provisions apply.

A. An examiner may not be appointed by the superintendent if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This section may not be construed to automatically preclude an examiner from being:

(1) A viator;

(2) An insured in an insurance policy acquired pursuant to a settlement contract; or

(3) A beneficiary in an insurance policy that is proposed to be acquired pursuant to a settlement contract. [2003, c. 636, §10 (NEW).]

B. Notwithstanding the requirements of this subsection, the superintendent may retain from time to time, on an individual basis, qualified actuaries, certified public accountants or similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter. [2003, c. 636, §10 (NEW).]

[2003, c. 636, §10 (NEW) .]

9. **Investigative authority of superintendent.** In addition to the authority granted pursuant to section 220, the superintendent may investigate persons engaged in the business of settlements and persons suspected of engaging in fraudulent viatical or life settlement acts.

[2003, c. 636, §10 (NEW) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §10 (AMD).

§6808. DISCLOSURE

With each application for a settlement, a settlement provider shall disclose in writing at least the following disclosures to a viator. Disclosure to a viator must include distribution of a brochure, approved by the superintendent, describing the process of settlements. The disclosures must be provided to the viator no later than the time the application for the settlement contract is signed by all parties and must be signed by the viator and the settlement provider and provide the following information: [2003, c. 636, §10 (AMD).]

1. **Alternatives or options.** Possible alternatives to or options that can be used in conjunction with settlement contracts, including, but not limited to, accelerated death benefits or policy loans offered by the issuer of the life insurance policy;

[2003, c. 636, §10 (AMD) .]

2. **Federal tax implications.** The fact that some or all of the proceeds of the settlement contract may be free from federal income tax under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; and that restrictions, qualifications and other tax laws, particularly those of the state in which the viator resides, may apply and assistance should be sought from a professional tax advisor;

[2003, c. 636, §10 (AMD) .]

3. **State tax implications.** The fact that some or all of the proceeds of the settlement may be free from state income tax under section 6809 and that restrictions, qualifications and other tax laws, including those of the state in which the viator resides, may apply and assistance should be sought from a professional tax advisor;

[2003, c. 636, §10 (AMD) .]

4. **Claims of creditors.** The fact that proceeds of the settlement could be subject to the claims of creditors;

[2003, c. 636, §10 (AMD) .]

5. **Effect on government benefits.** The fact that receipt of the proceeds of the settlement may adversely affect the recipient's eligibility for Medicaid or other means-based government programs, benefits or entitlements and that advice should be obtained from the appropriate agencies;

[2003, c. 636, §10 (AMD) .]

6. **Right to rescind.** The fact that the viator has the right to rescind a settlement contract before the earlier of 30 calendar days after the date upon which the settlement contract is executed by all parties or 15 calendar days after the date upon which payment is received by the viator as provided in section 6809. If exercised by the viator, rescission is effective only if both notice of the rescission is given and repayment of all proceeds and any premiums, loans and loan interest to the settlement provider is made within the rescission period. If the insured dies during the rescission period, the settlement contract is deemed to have been rescinded, subject to repayment of all proceeds and any premiums, loans and loan interest to the settlement provider;

[2003, c. 636, §10 (AMD) .]

7. **Potential reduction or loss of benefits to beneficiary.** The fact that entering into a settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator and that assistance should be sought from a financial adviser;

[2003, c. 636, §10 (AMD) .]

7-A. **Potential inability to purchase additional insurance.** The fact that, because of limits insurers may set on the amount of insurance on a single life, a change of ownership could leave the viator without the ability to purchase insurance in the future to replace the transferred policy;

[2009, c. 376, §9 (NEW) .]

8. **Funds.** The fact that funds will be sent to the viator within 3 business days after the settlement provider has received the insurer's or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated; and

[2003, c. 636, §10 (NEW) .]

9. **Privacy disclosure.** A statement containing the following language: "All medical, financial or personal information solicited or obtained by a settlement provider or settlement producer about an insured, including the insured's identity or the identity of family members, a spouse or a significant other, may be disclosed as necessary to effect the settlement contract between the viator and the settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every 2 years."

[2003, c. 636, §10 (NEW) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §10 (AMD). 2009, c. 376, §9 (AMD).

§6808-A. CONTACT WITH INSURED; ADDITIONAL DISCLOSURES

1. **Contact with insured.** The insured may be contacted by either the settlement provider or its authorized representative for the purpose of determining the insured's health status. This contact is limited to once every 3 months if the insured has a life expectancy of more than one year and no more than once per month if the insured has a life expectancy of one year or less.

[2003, c. 636, §11 (NEW) .]

2. **Additional disclosures.** A settlement provider shall provide the viator with at least the following disclosures no later than the date the settlement contract is signed by all parties. The disclosures must be conspicuously displayed in the settlement contract or in a separate document signed by the viator and the settlement provider or settlement producer and must provide the following information:

A. The affiliation, if any, between the settlement provider and the issuer of the insurance policy to be acquired pursuant to a settlement contract; [2003, c. 636, §11 (NEW).]

B. The name, address and telephone number of the settlement provider; [2003, c. 636, §11 (NEW).]

C. If an insurance policy to be purchased has been issued as a joint policy or involves family riders or any coverage of a life other than the insured's under the policy to be purchased, information regarding the possible loss of coverage on the other lives under the policy and advice to consult with the viator's insurance producer or the insurer issuing the policy for advice on the proposed settlement; [2003, c. 636, §11 (NEW).]

D. The dollar amount of the current death benefit payable to the settlement provider under the policy or certificate. If known, the settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the settlement provider's interest in those benefits; [2009, c. 376, §10 (AMD).]

E. The name, business address and telephone number of the independent 3rd-party escrow agent and the fact that the viator may inspect or receive copies of the relevant escrow or trust agreements or documents; [2009, c. 376, §10 (AMD).]

F. A reconciliation of the settlement provider's gross offer to the net amount to be received by the viator; [2009, c. 376, §10 (NEW).]

G. The identity of all persons compensated directly or indirectly by the settlement provider for the settlement contract, the amount of compensation paid to each and the method of calculating that compensation; [2009, c. 376, §10 (NEW).]

H. Notice that the insured may be contacted as permitted by subsection 1 for the purpose of determining the insured's health; [2009, c. 376, §10 (NEW).]

I. An offer to disclose to the insured all life expectancy estimates obtained by the provider; and [2009, c. 376, §10 (NEW).]

J. Notice that complaints and inquiries may be brought to the attention of the superintendent. [2009, c. 376, §10 (NEW).]

[2009, c. 376, §10 (AMD) .]

2-A. **Disclosure by settlement producers.** A settlement producer shall provide the viator with at least the following disclosures no later than the date the settlement contract is signed by all parties. The disclosures must be conspicuously displayed in the settlement contract or in a separate document signed by the viator and the settlement producer and must provide the following information:

A. Notice that a settlement producer must exclusively represent the viator, not the insurer or the settlement provider, and owes a fiduciary duty to the viator; [2009, c. 376, §11 (NEW).]

B. A description of all offers, counteroffers, acceptances and rejections relating to any proposed settlement of the policy; [2009, c. 376, §11 (NEW).]

C. If any other persons are compensated directly or indirectly by the settlement producer for the settlement contract, their identity, the amount of compensation paid to each and the method of calculating that compensation; and [2009, c. 376, §11 (NEW).]

D. Notice that complaints and inquiries may be brought to the attention of the superintendent. [2009, c. 376, §11 (NEW).]

[2009, c. 376, §11 (NEW) .]

3. **Notice of change in ownership or beneficiary.** If the settlement provider transfers ownership or changes the beneficiary of the insurance policy, the settlement provider shall communicate the change in ownership or beneficiary to the insured within 20 days after the change.

[2003, c. 636, §11 (NEW) .]

4. **Disclosure of policyowner's rights.** The superintendent shall develop an informational brochure to apprise consumers of their rights as owners of life insurance policies. The document must be made available at no cost to all insurance companies and life insurance producers and written in lay terms.

A. The brochure must advise the consumer:

(1) That life insurance is a critical part of a broader financial plan and that the consumer is encouraged, and has a right, to seek additional financial advice and opinions;

(2) That possible alternatives to the lapse of the policy exist; and

(3) Of the definitions of common industry terms. [2009, c. 376, §12 (NEW).]

B. The brochure must contain the following statement in large, bold or otherwise conspicuous typeface calculated to draw the eye: "Life insurance is a critical part of a broader financial plan. There are many options available, and you have the right to shop around and seek advice from different financial advisers in order to find the option best suited to your needs." [2009, c. 376, §12 (NEW).]

C. The brochure may include brief descriptions of common products available from settlement providers. These products must be described in general terms for informative purposes only and not identify any specific settlement provider. [2009, c. 376, §12 (NEW).]

D. If the insured under an individual life insurance policy is 60 years of age or older, or is known by the insurer to be terminally ill or chronically ill, the insurer shall send notice to the policyowner that there may be alternative transactions available, including a copy of the superintendent's brochure, whenever:

(1) The policyowner has requested the surrender of the policy in whole or in part;

(2) The policyowner has requested an accelerated death benefit;

(3) The insurer sends an initial notice that the policy may lapse; or

(4) As the superintendent may require by rule. [2009, c. 376, §12 (NEW).]

[2009, c. 376, §12 (NEW) .]

SECTION HISTORY
2003, c. 636, §11 (NEW). 2009, c. 376, §§10-12 (AMD).

§6809. GENERAL PROVISIONS FOR SETTLEMENT CONTRACTS

1. **Prior conditions.** A settlement provider entering into a settlement contract with a viator shall first obtain:

A. If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a settlement contract; [2003, c. 636, §12 (AMD).]

B. Prior to or at the time of execution of the settlement contract, a witnessed document in which the viator consents to the settlement contract, represents that the viator has a full and complete understanding of the settlement contract and that the viator has a full and complete understanding of the benefits of the life insurance policy, acknowledges that the viator has entered into the settlement contract freely and voluntarily and, for persons who are terminally ill or chronically ill, acknowledges that the insured is terminally ill or chronically ill and that the terminal or chronic illness was diagnosed after the life insurance policy was issued; and [2003, c. 636, §12 (AMD).]

C. Notwithstanding section 2159, subsection 3 or any other provisions of state law, a document in which the insured consents to the release of the insured's medical records to a settlement provider and, if the life insurance policy was issued less than 2 years from the date of application for a settlement contract to the insurance company that issued the life insurance policy covering the life of the insured. [2003, c. 636, §12 (AMD).]

The insurer shall respond to a request for verification of coverage submitted by a settlement provider not later than 30 calendar days from the date the request is received. The request for verification of coverage must be made on a form approved by the superintendent. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation regarding the validity of the insurance contract.

[2003, c. 636, §12 (AMD) .]

2. **Confidentiality of medical information.** All medical information solicited or obtained by any licensee is subject to the applicable provisions of state law relating to confidentiality of medical information.

[1997, c. 430, §1 (NEW); 1997, c. 430, §2 (AFF) .]

3. **Unconditional rescission.** All settlement contracts must contain a provision that the viator has the right to rescind a settlement contract before the earlier of 30 calendar days after the date upon which the settlement contract is executed by all parties or 15 calendar days after the date upon which payment is received by the viator as provided in section 6808. Rescission if exercised by the viator is effective only if both notice of the rescission is given and a full repayment of all proceeds and any premiums, loans and loan interest to the settlement provider is made within the rescission period. If the insured dies during the rescission period, the settlement contract is deemed to have been rescinded, subject to repayment of all proceeds and any premiums, loans and loan interest to the settlement provider.

[2003, c. 636, §12 (AMD) .]

4. **Transfer of insurance policy.** The settlement provider shall designate an independent escrow agent and instruct the viator to send the executed documents required to effect the change in ownership or assignment or change in beneficiary directly to the independent escrow agent. Within 3 business days after the date the escrow agent receives the document, or from the date the settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider, the settlement provider shall pay or transfer the proceeds of the settlement into an escrow or trust account maintained in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation or its successor. Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership or assignment or change in beneficiary forms to the settlement provider or related provider trust. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership or assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

[2009, c. 376, §13 (AMD) .]

5. **Effect of failure to tender consideration.** Failure to tender consideration for the settlement under the terms of the settlement contract renders the contract voidable for lack of consideration until the time consideration is tendered to and accepted by the viator.

[2003, c. 636, §12 (AMD) .]

6. **Unlicensed provider.**

[2003, c. 636, §12 (RP) .]

7. **Income.**

[2003, c. 636, §12 (RP) .]

8. **Advertising standards.**

[2003, c. 636, §12 (RP) .]

9. **Contacts with the insured.** An insured may designate one or more adult individuals in regular contact with the insured as the individual for all inquiries regarding the insured's health status and, if that designation is made, a settlement provider may not make these inquiries to the insured unless the settlement provider is unable, for more than 30 days, to contact the designee after diligent effort. The insured may change this designation at any time upon written notice to the settlement provider. Contacts with the insured for the purpose of determining the health status of the insured after the settlement has occurred are limited to once every 3 months for insureds with an estimated life expectancy of more than one year and once per month for insureds with a life expectancy of one year or less. The settlement provider shall explain to the insured the procedure for these contacts prior to the time the settlement contract is entered into. The limitation

in this rule on contacts does not apply to contacts made for reasons other than determining the insured's health status or necessary to maintain the policy in force. Settlement providers are responsible for the actions of their authorized representatives.

[2003, c. 636, §12 (AMD) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 320, §1 (AMD). 2003, c. 636, §12 (AMD). 2009, c. 376, §13 (AMD).

§6810. RULES

The superintendent may adopt rules implementing this chapter. These rules are routine technical rules under Title 5, chapter 375, subchapter 2-A. Rules may be adopted to: [2003, c. 636, §13 (AMD).]

1. **Standards for evaluating reasonableness of payments.** Establish standards for evaluating the reasonableness of payments to viators under a settlement contract only when the insured in the policy that is the subject of a settlement contract is terminally ill or chronically ill. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy;

[2003, c. 636, §13 (NEW) .]

2. **Licensing requirements and standards.** Establish appropriate licensing requirements and standards for continued licensure for settlement providers;

[2003, c. 636, §13 (NEW) .]

3. **Mechanism for financial accountability.** Require a bond or other mechanism for financial accountability for settlement providers;

[2003, c. 636, §13 (NEW) .]

4. **Govern relationship and responsibilities.** Govern the relationship and responsibilities of both insurers and settlement providers and settlement producers and others in the business of settlement during the period of consideration or effectuation of a settlement contract; and

[2003, c. 636, §13 (NEW) .]

5. **Implement other requirements.** Implement any other requirements of this chapter.

[2003, c. 636, §13 (NEW) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §13 (AMD).

§6811. PROHIBITED PRACTICES AND PROVISIONS UNDER POLICIES

1. **Assignment.** The following provisions govern assignment.

A. A policy of individual or group life insurance that permits assignment issued or delivered in this State may not, in any way, restrict a person from making an absolute assignment of rights for consideration. Prohibited restrictions include, but are not limited to, assignments only as a gift and without consideration, assignments only to a limited class of persons and assignments only to a natural person and not to a legal entity. [2003, c. 636, §13 (AMD).]

B. A life insurance company that acknowledges and records an absolute assignment of life insurance policy or rights under a group life insurance policy may rely solely on the authorization of the assignor to make the assignment and the life insurance company is not obligated to inquire into the validity, sufficiency or terms of the assignment. In acknowledging and recording an assignment, a life insurance company acting in good faith and reliance on the presentation of the absolute assignment, acts in a ministerial capacity and may exhibit no discretion as to whether an assignor may make the assignment or whether the assignment conforms with applicable law. [1997, c. 430, §1 (NEW); 1997, c. 430, §2 (AFF).]

[2003, c. 636, §13 (AMD) .]

2. **Rights under an assignment.** The following provisions apply to an assignment.

A. For life insurance contracts that permit assignment:

(1) A person has the right to assign, transfer, sell or bequeath the ownership of or death benefit payable under a life insurance policy or certificate at any time for any remaining portion of that coverage after exercising any option for accelerated benefits;

(2) A person also has the right to assign, transfer, sell, devise or bequeath the ownership of or death benefit payable under a life insurance policy or certificate if that coverage is on disability waiver of premium at any time; and

(3) The absolute assignee of an individual life insurance policy or of all rights under a group life insurance policy has all rights at law or in equity as the assignor held under that policy, including, but not limited to, the right to convert the coverage to an individual policy, the right to timely notice of the right to that conversion at the time that right accrues, the right to make premium payments or take such other action as may be necessary under the policy in order to preserve the value of the coverage assigned, the right to receive information concerning the coverage, the right to receive notice of a lapse or discontinuation of coverage, the exclusive right to exercise any options concerning the assigned coverage during an open enrollment period and all such other rights and privileges initially granted to a person under the terms of the individual or group life insurance policy. [2003, c. 636, §13 (AMD).]

B. A person has the right to exercise any option for accelerated benefits under the terms of any individual or group life insurance policy at any time for any unassigned portion of that policy or certificate. [2003, c. 636, §13 (AMD).]

[2003, c. 636, §13 (AMD) .]

3. **Failure to give notice under group life insurance policy.** If the rights under a group life insurance policy have been assigned and the administrator of the policy fails to give notice to the assignee that a person is no longer a covered person under the group and of the right to convert the policy to an individual life insurance policy, the period of time during which the assignee must make application for conversion under the terms of the group life insurance policy begins from the date the notice is given to the assignee.

[2003, c. 636, §13 (AMD) .]

4. **Riders and postsettlement increases or additions.** With respect to policies containing a provision for double or additional indemnity for accidental death or any other riders or additional death benefits, including the increase in the death benefit in excess of the amount of the death benefits of the date the settlement contract is effected at the time the policy is assigned, transferred, sold, devised or bequeathed,

unless otherwise mutually agreed to in writing by the viator and the settlement provider, the additional amount remains payable to the beneficiary last named by the viator prior to entering into the settlement contract or to such other beneficiary other than the settlement provider as the viator may thereafter designate or, in the absence of a designation, to the estate of the viator.

[2003, c. 636, §13 (AMD) .]

5. **Prohibition on settlements.** It is a violation of this chapter for any person to enter into a settlement contract at any time prior to, or at the time of the application for, the issuance of a policy or within a 2-year period commencing with the date of issuance of the insurance policy or certificate unless the viator certifies to the settlement provider that one or more of the following conditions have been met within the 2-year period:

A. The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy, as long as the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy must be calculated without regard to any change in insurance carriers, as long as the coverage has been continuous and under the same group sponsorship; and [2003, c. 636, §13 (NEW).]

B. The viator submits independent evidence to the settlement provider that one or more of the following conditions have been met within the 2-year period:

(1) The viator or insured is terminally ill or chronically ill; or

(2) The viator or insured disposes of the viator's entire ownership interest in a closely held corporation pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued. [2003, c. 636, §13 (NEW).]

[2007, c. 543, §6 (AMD) .]

6. **Submission of certification.** If the settlement provider submits to the insurer a copy of the owner's or insured's certification described in subsection 5 when the settlement provider submits a request to the insurer to effect the transfer of the policy or certificate to the settlement provider, the copy is deemed to conclusively establish that the settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

[2003, c. 636, §13 (NEW) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §13 (AMD). 2007, c. 543, §6 (AMD).

§6812. INSURANCE COMPANY PRACTICES

1. **Duty to provide information.** In addition to the provisions in section 6809, an insurance company that is licensed to do business in this State shall promptly respond to reasonable requests for policy information from a settlement provider or settlement producer upon the receipt of the following documents in the office of the insurance company:

A. An authorization signed by the viator to release specified information regarding the policy or certificate to a named licensed settlement provider or settlement producer; and [2003, c. 636, §13 (AMD).]

B. A request in writing from the settlement provider or settlement producer for the specified policy or certificate information. [2003, c. 636, §13 (AMD).]

Requests for the following items related to the policy or certificate that is the subject of a settlement transaction are deemed to be reasonable: ownership of and death benefits under the policy or certificate; premium information on the policy or certificate; liens, assignments and additional benefits; waiver of

premium; and ownership and assignment provisions. The information provided must be the most recent information on file. By rule, the superintendent may specify additional criteria for information requests deemed reasonable under this section by a settlement provider.

[2003, c. 636, §13 (AMD) .]

2. **Conversion of group insurance.** An issuer or 3rd-party administrator of a group life insurance policy shall promptly issue an individual conversion policy if the conversion is being requested for the purpose of entering into a settlement contract. For the purposes of this section, issuance of such a policy is deemed timely if it meets relevant standards for timeliness under chapter 23. This subsection may not be construed to create any new conversion rights not already granted by the policy or certificate being acquired pursuant to a settlement contract.

[2003, c. 636, §13 (AMD) .]

3. **Right to assign rights or benefits.** Subsection 1 or 2 does not prohibit a viator under a group life insurance policy from assigning rights or benefits under the policy to a licensed settlement provider or converting the coverage to an individual life insurance policy.

[2003, c. 636, §13 (AMD) .]

4. **Assignment restrictions prohibited.** A policy of group life insurance issued or in existence in this State that permits any assignment of a viator's rights may not restrict the viator from making assignments other than by gift.

[1997, c. 430, §1 (NEW); 1997, c. 430, §2 (AFF) .]

5. **Purchase of securities.** This chapter does not require notice to the superintendent of, or restrict an insurance company from investing in, or participating in, or purchasing any securities issued in any transaction including without limitation any financing, securitization transaction or securities offering in which the licensed settlement provider sells, assigns, transfers, pledges, hypothecates or otherwise disposes of settlement contracts, policies acquired pursuant to settlement contracts or any interest therein.

[2003, c. 636, §13 (AMD) .]

6. **Protection of policyholder's rights.** An insurer may not engage in a transaction, act, practice or course of business or dealing that restricts, limits or impairs in any way the lawful transfer of ownership, change of beneficiary or assignment of a policy. This subsection does not prohibit a lawful contract provision granting irrevocable rights to a beneficiary or lawfully prohibiting assignment.

[2009, c. 376, §14 (NEW) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §13 (AMD). 2009, c. 376, §14 (AMD).

§6812-A. INQUIRIES AND OPTIONAL DISCLOSURES BY LIFE INSURERS

1. **Permitted inquiries regarding premium financing.** In addition to any other information a life insurer may lawfully request in an application for insurance, the insurer may ask whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing, and if so, whether:

A. The applicant has entered into any agreement or arrangement providing for the future sale of this life insurance policy; [2009, c. 376, §15 (NEW).]

B. The loan arrangement for the policy provides funds sufficient to pay for some or all of the premiums, costs and expenses associated with obtaining and maintaining the applicant's life insurance policy; [2009, c. 376, §15 (NEW).]

C. The applicant has entered into any agreement by which the applicant is to receive consideration in exchange for procuring the policy; and [2009, c. 376, §15 (NEW).]

D. The borrower has an insurable interest in the insured. [2009, c. 376, §15 (NEW).]

[2009, c. 376, §15 (NEW) .]

2. **Prohibited transactions.** If the information obtained by the life insurer demonstrates that the loan provides funds that can be used for a purpose other than paying for the premiums, costs and expenses associated with obtaining and maintaining the life insurance policy and loan or that the transaction otherwise violates this chapter, the insurer shall reject the application.

[2009, c. 376, §15 (NEW) .]

3. **Optional disclosures by the life insurer.** The insurer may make disclosures to the applicant, the insured and other affected persons, either on the application, an amendment to the application or a separate document, in the following form:

"If you have entered into a loan arrangement in which the policy is used as collateral and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

A. A change of ownership could lead to a stranger owning an interest in the insured's life; [2009, c. 376, §15 (NEW).]

B. Your ability to purchase future insurance on the insured’s life could be limited because there is a limit to how much coverage insurers will issue on one life; [2009, c. 376, §15 (NEW).]

C. Should there be a change of ownership and should you wish to obtain more insurance coverage on the insured’s life in the future, the insured’s higher issue age, a change in health status or other factors may reduce the ability to obtain coverage or may result in significantly higher premiums; and [2009, c. 376, §15 (NEW).]

D. You should consult a professional advisor because a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan." [2009, c. 376, §15 (NEW).]

[2009, c. 376, §15 (NEW) .]

SECTION HISTORY
2009, c. 376, §15 (NEW).

§6813. FINANCING

(REPEALED)

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §14 (RP).

§6814. UNFAIR TRADE PRACTICES

A violation of this chapter is an unfair trade practice under Title 5, chapter 10 and subject to the penalties contained in that chapter. [1997, c. 430, §1 (NEW); 1997, c. 430, §2 (AFF).]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF).

§6815. ASSIGNMENT OR RESALE OF POLICIES

1. **Prohibited transfers.** A settlement provider may not sell, assign, transfer or pledge a policy acquired pursuant to a settlement contract except to a licensed settlement provider or a person exempt from licensing under section 6803.

[2003, c. 636, §15 (AMD) .]

2. **Securities registration.** Any sale by a settlement provider of settlement contracts, policies acquired pursuant to settlement contracts or interests therein that constitute a "security" within the meaning of the United States Securities Act of 1933, as amended, or the Maine Uniform Securities Act, as amended, must be registered under those statutes unless there is an available exemption from registration under those statutes.

[2005, c. 65, Pt. C, §14 (AMD) .]

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §15 (AMD). 2005, c. 65, §C14 (AMD).

§6815-A. REGULATORY REQUIREMENTS UNDER MAINE UNIFORM SECURITIES ACT

This chapter does not preempt the regulatory requirements set forth in the Maine Uniform Securities Act, as amended, including but not limited to the regulation of securities transactions in settlement contracts or viatical settlement contracts and the licensing of any person or entity engaged in the sale of securities. [2005, c. 65, Pt. C, §15 (AMD).]

SECTION HISTORY
2003, c. 636, §16 (NEW). 2005, c. 65, §C15 (AMD).

§6816. PERMITTED OPERATIONS BEFORE FORMAL APPROVAL

(REPEALED)

SECTION HISTORY
1997, c. 430, §1 (NEW). 1997, c. 430, §2 (AFF). 2003, c. 636, §17 (RP).

§6817. ADVERTISING OF SETTLEMENTS

1. **Advertising for settlements.** Every settlement provider licensee shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its contracts, products and services. All advertisements, regardless of by whom written, created, designed or presented, are the responsibility of the settlement provider licensee, as well as the individual who created or presented the advertisement. A system of control must include providing regular routine notification, at least once a year, to agents and others authorized by the settlement licensee to disseminate advertisements; the notification must include the requirements and procedures for approval of any advertisements not furnished by the settlement provider licensee prior to the advertisements' use.

[2003, c. 636, §18 (NEW) .]

2. **Form and content.** Advertisements must be truthful and not misleading in fact or by implication. The form and content of an advertisement of a settlement contract must be sufficiently complete and clear so as to avoid deception. It may not have the capacity or tendency to mislead or deceive. Whether an advertisement

has the capacity or tendency to mislead or deceive must be determined by the superintendent from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

[2003, c. 636, §18 (NEW) .]

3. **Standards for disclosure.** An advertisement must comply with standards for disclosure determined by rule by the superintendent.

[2003, c. 636, §18 (NEW) .]

4. **Applicability.** This section applies to any advertisement of settlement contracts or related products or services intended for dissemination in this State, including advertising on the Internet viewed by persons located in this State. If disclosure requirements are established pursuant to federal regulation, this section must be interpreted so as to minimize or eliminate conflict with federal regulation whenever possible.

[2003, c. 636, §18 (NEW) .]

SECTION HISTORY
2003, c. 636, §18 (NEW).

§6818. FRAUD PREVENTION AND CONTROL

1. **Fraudulent viatical or life settlement acts prohibited.** Notwithstanding any other provision of law to the contrary:

A. A person may not commit a fraudulent viatical or life settlement act; [2003, c. 636, §18 (NEW).]

B. A person may not knowingly or intentionally interfere with the enforcement of the provisions of this chapter or investigations of suspected or actual violations of this chapter; and [2003, c. 636, §18 (NEW).]

C. A person in the business of settlements may not knowingly or intentionally permit any person convicted of a crime involving dishonesty or breach of trust to participate in the business of settlements. [2003, c. 636, §18 (NEW).]

[2003, c. 636, §18 (NEW) .]

2. **Fraud warning required.** Settlement contracts and applications for settlements, regardless of the form of transmission, must contain the following statement or a substantially similar statement: "Any person who knowingly presents false information in an application for insurance or a settlement contract is guilty of a crime and may be subject to fines and confinement in prison." The lack of a statement as required in this subsection does not constitute a defense in any prosecution for a fraudulent viatical or life settlement act.

[2003, c. 636, §18 (NEW) .]

3. **Mandatory reporting of fraudulent viatical or life settlement acts.** Any person engaged in the business of settlements having knowledge or a reasonable belief that a fraudulent viatical or life settlement act is being, will be or has been committed shall provide to the superintendent the information required by, and in a manner prescribed by, the superintendent. Any other person having knowledge or a reasonable belief that a fraudulent viatical or life settlement act is being, will be or has been committed may provide to the superintendent the information required by, and in a manner prescribed by, the superintendent.

[2003, c. 636, §18 (NEW) .]

4. **Immunity from liability.** Except as provided in subsection 5, civil liability may not be imposed on and a cause of action may not arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent viatical or life settlement acts or suspected or completed fraudulent insurance acts if the information is provided to or received from:

A. The superintendent or the superintendent's employees, agents or representatives; [2003, c. 636, §18 (NEW).]

B. Federal, state or local law enforcement or regulatory officials or their employees, agents or representatives; [2003, c. 636, §18 (NEW).]

C. The National Association of Insurance Commissioners or its successor organization, National Association of Securities Dealers or its successor organization, the North American Securities Administrators Association or its successor organization, or their employees, agents or representatives of these organizations, or other regulatory body overseeing life insurance, settlements securities or investment fraud; [2003, c. 636, §18 (NEW).]

D. A person involved in the prevention and detection of fraudulent viatical or life settlement acts or that person's agents, employees or representatives; or [2003, c. 636, §18 (NEW).]

E. The life insurer that issued the life insurance policy covering the life of the insured. [2003, c. 636, §18 (NEW).]

[2003, c. 636, §18 (NEW) .]

5. **Exception.** The following provisions apply to the imposition of civil liability arising from information provided to or received from the superintendent or the superintendent's employees, agents or representatives.

A. Subsection 4 does not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical or life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subsection 4 does not apply because the person filing the report or furnishing the information did so with actual malice. [2003, c. 636, §18 (NEW).]

B. Subsection 4 does not apply to a person's furnishing information concerning that person's own suspected, anticipated or completed fraudulent viatical or life settlement acts or suspected or completed fraudulent insurance acts. [2003, c. 636, §18 (NEW).]

C. This subsection does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subsection 4. [2003, c. 636, §18 (NEW).]

[2003, c. 636, §18 (NEW) .]

6. **Confidentiality.** The following provisions apply.

A. The documents and evidence provided pursuant to subsection 4 or obtained by the superintendent in an investigation of suspected or actual fraudulent viatical or life settlement acts is privileged and confidential and is not a public record under Title 1, chapter 13 and is not subject to discovery or subpoena in a civil or criminal action. [2003, c. 636, §18 (NEW).]

B. Paragraph A does not prohibit release by the superintendent of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical or life settlement acts:

(1) In administrative or judicial proceedings to enforce laws administered by the superintendent;

(2) To federal, state or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical or life settlement acts or to the National Association of Insurance Commissioners or its successor organization; or

(3) At the discretion of the superintendent, to a person in the business of settlements that is aggrieved by a fraudulent viatical or life settlement act. [2003, c. 636, §18 (NEW).]

C. Release of documents and evidence under paragraph B does not abrogate or modify the privilege granted in paragraph A. [2003, c. 636, §18 (NEW).]

[2003, c. 636, §18 (NEW) .]

7. **Other law enforcement or regulatory authority.** This section does not:

A. Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law; [2003, c. 636, §18 (NEW).]

B. Prevent or prohibit a person from disclosing voluntarily information concerning viatical or life settlement fraud to a law enforcement or regulatory agency other than the bureau; or [2003, c. 636, §18 (NEW).]

C. Limit the powers granted elsewhere by the laws of this State to the superintendent or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers. [2003, c. 636, §18 (NEW).]

[2003, c. 636, §18 (NEW) .]

8. **Viatical or life settlement antifraud initiatives.** In accordance with this subsection, a settlement provider licensee must have in place antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent viatical or life settlement acts.

A. At the discretion of the superintendent, the superintendent may order, or a licensee may request and the superintendent may grant, such modifications of the required initiatives under paragraph B as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives as long as the modifications may reasonably be expected to accomplish the purpose of this subsection. [2003, c. 636, §18 (NEW).]

B. Antifraud initiatives must include:

(1) Fraud investigators, who may be employees of a settlement provider or independent contractors; and

(2) An antifraud plan, which must be submitted to the superintendent. The antifraud plan must include, but is not limited to:

(a) A description of the procedures for detecting and investigating possible fraudulent viatical or life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(b) A description of the procedures for reporting possible fraudulent viatical or life settlement acts to the superintendent;

(c) A description of the plan for antifraud education and training of underwriters and other personnel; and

(d) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical or life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications. [2003, c. 636, §18 (NEW).]

C. Antifraud plans submitted to the superintendent are privileged and confidential and are not a public record under Title 1, chapter 13 or subject to discovery or subpoena in a civil or criminal action. [2003, c. 636, §18 (NEW).]

[2003, c. 636, §18 (NEW) .]

SECTION HISTORY
2003, c. 636, §18 (NEW).

§6819. CIVIL REMEDIES; INDIVIDUAL REMEDY

1. **Civil remedies and enforcement.** In addition to the penalties available pursuant to section 6814, the superintendent may assess fines or take any other enforcement action permitted under section 12-A against any person who violates any provision of this chapter.

[2003, c. 636, §18 (NEW) .]

2. **Superior Court action.** Any person who is injured by any action of a person in violation of this chapter may bring an action in Superior Court. The requirements for notice and filing of a cause of action under this subsection are governed by the Maine Rules of Civil Procedure. The person may recover damages, together with costs and disbursements.

[2003, c. 636, §18 (NEW) .]

3. **No private right of action.** Except as specifically provided in subsection 2, this chapter provides no express or implied private right of action.

[2003, c. 636, §18 (NEW) .]

SECTION HISTORY
2003, c. 636, §18 (NEW).

Chapter 87: DIRIGO HEALTH

Subchapter 1: GENERAL PROVISIONS
HEADING: PL 2003, C. 469, PT. A, §8 (NEW)

§6901. SHORT TITLE

This chapter may be known and cited as "the Dirigo Health Act." [2003, c. 469, Pt. A, §8 (NEW).]

SECTION HISTORY
2003, c. 469, §A8 (NEW).

§6902. DIRIGO HEALTH ESTABLISHED; DECLARATION OF NECESSITY

Dirigo Health is established as an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis. Dirigo Health is also responsible for monitoring and improving the quality of health care in this State. The exercise by Dirigo Health of the powers conferred by this chapter must be deemed and held to be the performance of essential governmental functions. [2003, c. 469, Pt. A, §8 (NEW).]

SECTION HISTORY
2003, c. 469, §A8 (NEW).

§6903. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2003, c. 469, Pt. A, §8 (NEW).]

1. **Board.** "Board" means the Board of Trustees of Dirigo Health, as established in section 6904.

[2007, c. 447, §3 (AMD) .]

2. **Child.** "Child" means a natural child, stepchild, adopted child or child placed for adoption with a plan enrollee.

[2003, c. 469, Pt. A, §8 (NEW) .]

3. **Dependent.** "Dependent" means a spouse, an unmarried child under 19 years of age, a child who is a student under 23 years of age and is financially dependent upon a plan enrollee or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee. "Dependent" may include a domestic partner consistent with sections 2741-A, 2832-A and 4249 and Title 24, section 2319-A.

[2003, c. 469, Pt. A, §8 (NEW) .]

4. **Dirigo Health Insurance.**

[2005, c. 400, Pt. A, §3 (RP) .]

4-A. **Dirigo Health Program.** "Dirigo Health Program" means the program of services provided by Dirigo Health that includes comprehensive health benefits coverage, subsidies, wellness programs and quality improvement initiatives.

[2005, c. 400, Pt. A, §4 (NEW) .]

5. **Eligible business.** "Eligible business" means a business that employs at least 2 but not more than 50 eligible employees, the majority of whom are employed in the State, including a municipality that has 50 or fewer employees.

After one year of operation of Dirigo Health, the board may, by rule, define "eligible business" to include larger public or private employers.

[2003, c. 469, Pt. A, §8 (NEW) .]

6. **Eligible employee.** "Eligible employee" means an employee of an eligible business who works at least 20 hours per week for that eligible business. "Eligible employee" does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

[2003, c. 469, Pt. A, §8 (NEW) .]

7. **Eligible individual.** "Eligible individual" means:

A. A self-employed individual who:

(1) Works and resides in the State; and

(2) Is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income; [2003, c. 469, Pt. A, §8 (NEW).]

B. An unemployed individual who resides in this State; or [2003, c. 469, Pt. A, §8 (NEW).]

C. An individual employed in an eligible business that does not offer health insurance. [2003, c. 469, Pt. A, §8 (NEW).]

[2003, c. 469, Pt. A, §8 (NEW) .]

8. **Employer.** "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.

[2003, c. 469, Pt. A, §8 (NEW) .]

9. **Executive director.** "Executive director" means the Executive Director of Dirigo Health.

[2003, c. 469, Pt. A, §8 (NEW) .]

10. **Health insurance carrier.** "Health insurance carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance; [2003, c. 469, Pt. A, §8 (NEW).]

B. A health maintenance organization licensed pursuant to chapter 56; [2003, c. 469, Pt. A, §8 (NEW).]

C. A preferred provider arrangement administrator registered pursuant to chapter 32; [2003, c. 469, Pt. A, §8 (NEW).]

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or [2003, c. 469, Pt. A, §8 (NEW).]

E. An employee benefit excess insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance pursuant to section 707, subsection 1, paragraph C-1. [2003, c. 469, Pt. A, §8 (NEW).]

[2003, c. 469, Pt. A, §8 (NEW) .]

11. **Health plan in Medicaid.** "Health plan in Medicaid" means a health insurance carrier that meets the requirements of 42 Code of Federal Regulations, Part 438 (2002) and has a contract with the Department of Health and Human Services to provide MaineCare-covered services to individuals enrolled in MaineCare.

[2003, c. 469, Pt. A, §8 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

12. **Participating employer.** "Participating employer" means an eligible business that contracts with Dirigo Health pursuant to section 6910, subsection 4, paragraph B and that has employees enrolled in the Dirigo Health Program.

[2005, c. 400, Pt. C, §3 (AMD) .]

13. **Plan enrollee.** "Plan enrollee" means an eligible individual or eligible employee who enrolls in the Dirigo Health Program through Dirigo Health. "Plan enrollee" includes an eligible employee who is eligible to enroll in MaineCare.

[2005, c. 400, Pt. C, §3 (AMD) .]

13-A. **Practitioner-specific quality data.** "Practitioner-specific quality data" means material in electronic or paper format that provides information about the professional performance of a health care practitioner licensed to provide health care in the State. "Practitioner-specific quality data" includes, but is not limited to, records, reports, working papers, drafts, analyses, e-mail, interoffice and intraoffice memoranda and other data collected, used, produced or maintained by the Maine Quality Forum, established in section 6951, for the purposes of measuring a health care practitioner's professional performance against consensus best practices and local and national patterns of health care.

[2005, c. 615, §1 (NEW) .]

14. **Provider.** "Provider" means any person, organization, corporation or association that provides health care services and products and is authorized to provide those services and products under the laws of this State.

[2003, c. 469, Pt. A, §8 (NEW) .]

15. **Reinsurance or reinsurer.** "Reinsurance" and "reinsurer" have the same meanings as in section 741.

[2003, c. 469, Pt. A, §8 (NEW) .]

16. **Resident.** "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2.

[2003, c. 469, Pt. A, §8 (NEW) .]

17. **Subsidy.** "Subsidy" means a subsidy as described in section 6912.

[2003, c. 469, Pt. A, §8 (NEW) .]

18. **Third-party administrator.** "Third-party administrator" means any person who, on behalf of any person who establishes a health insurance plan covering residents, receives or collects charges, contributions or premiums for or settles claims on residents in connection with any type of health benefit provided in or as an alternative to insurance as defined by section 704, other than:

A. Any person listed in section 1901, subsection 1, paragraphs A to C and paragraphs E to O; or [2003, c. 469, Pt. A, §8 (NEW).]

B. Any person who provides those services in connection with a group health plan sponsored by an agricultural cooperative association located outside of this State that provides heath insurance coverage to members and employees of agricultural cooperative associations located within this State. [2003, c. 469, Pt. A, §8 (NEW).]

[2003, c. 469, Pt. A, §8 (NEW) .]

19. **Unemployed individual.** "Unemployed individual" means an individual who does not work more than 20 hours a week for any single employer.

[2003, c. 469, Pt. A, §8 (NEW) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2003, c. 689, §B6 (REV). 2005, c. 400, §§A3,4,C3 (AMD). 2005, c. 615, §1 (AMD). 2007, c. 447, §3 (AMD).

§6904. BOARD OF TRUSTEES OF DIRIGO HEALTH

Dirigo Health operates under the supervision of the Board of Trustees of Dirigo Health established in accordance with this section. [2007, c. 447, §4 (AMD).]

1. **Appointments.** The board consists of 9 voting members and 3 ex officio, nonvoting members as follows.

A. The 9 voting members of the board are appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate in accordance with this paragraph.

(1) Five members qualified in accordance with subsection 2-A, paragraph A are appointed by the Governor.

(2) One member qualified in accordance with subsection 2-A, paragraph A is appointed by the Governor and must be selected from candidates nominated by the President of the Senate.

(3) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the Speaker of the House.

(4) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from the candidates nominated by the Senate Minority Leader.

(5) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the House Minority Leader. [2007, c. 447, §4 (AMD).]

B. The 3 ex officio, nonvoting members of the board are:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee; and

(4) The Treasurer of State or the treasurer's designee. [2011, c. 90, Pt. J, §22 (AMD).]

[2011, c. 90, Pt. J, §22 (AMD) .]

2. **Qualifications of voting members.**

[2007, c. 447, §4 (RP) .]

2-A. **Qualifications of voting members.** Voting members of the board must be qualified in accordance with this subsection.

A. Six of the voting members of the board must have knowledge of and experience in one or more of the following areas:

(1) Health care purchasing;

(2) Health insurance;

(3) MaineCare;

(4) Health policy and law;

(5) State management and budgeting;

(6) Health care financing;

(7) Labor or consumer advocacy; and

(8) Marketing. [2007, c. 447, §4 (NEW).]

B. Three of the voting members of the board must have knowledge of and experience in one or more of the following areas:

(1) Accounting;

(2) Banking;

(3) Securities; and

(4) Insurance. [2007, c. 447, §4 (NEW).]

C. Except as provided in this paragraph, a voting member of the board may not be:

(1) A representative or employee of a health insurance carrier authorized to do business in this State;

(2) A representative or employee of a health care provider operating in this State;

(3) Affiliated with a health or health-related organization regulated by State Government; or

(4) A representative or employee of Dirigo Health.

A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health-related organization. [2007, c. 447, §4 (NEW).]

[2007, c. 447, §4 (NEW) .]

3. **Terms of office.** Voting members serve 3-year terms. Voting members may serve up to 2 consecutive terms. Of the initial appointees, one member serves an initial term of one year, 2 members serve initial terms of 2 years and 2 members serve initial terms of 3 years. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2-A. Members reaching the end of their terms may serve until replacements are named.

[2007, c. 447, §4 (AMD) .]

4. **Chair.** The Governor shall appoint one of the voting members as the chair of the board.

[2003, c. 469, Pt. A, §8 (NEW) .]

5. **Quorum.** Five voting members of the board constitute a quorum.

[2007, c. 447, §4 (AMD) .]

6. **Affirmative vote.** An affirmative vote of 5 members is required for any action taken by the board.

[2007, c. 447, §4 (AMD) .]

7. **Compensation.** A member of the board must be compensated according to the provisions of Title 5, section 12004-G, subsection 14-D; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

[2003, c. 469, Pt. A, §8 (NEW) .]

8. **Meetings.** The board shall meet monthly and may also meet at other times at the call of the chair or the executive director. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

[2007, c. 447, §4 (AMD) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2007, c. 447, §4 (AMD). 2011, c. 90, Pt. J, §22 (AMD).

§6905. LIMITATION ON LIABILITY

1. **Indemnification of Dirigo Health employees.** An employee of Dirigo Health is not subject to any personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. Dirigo Health shall indemnify any member of the board and any employee of Dirigo Health against expenses actually and necessarily incurred by that member or employee in connection with the defense of any action or proceeding in which that member or employee is made a party by reason of past or present authority with Dirigo Health.

[2007, c. 447, §5 (NEW) .]

2. **Limitation on liability of board members.** The personal liability of a member of the board is governed by Title 18-B, section 1010.

[2007, c. 447, §5 (NEW) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2007, c. 447, §5 (RPR).

§6906. PROHIBITED INTERESTS OF BOARD MEMBERS AND EMPLOYEES

Board members and employees of Dirigo Health and their spouses and dependent children may not receive any direct personal benefit from the activities of Dirigo Health in assisting any private entity, except that they may participate in the Dirigo Health Program on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members are associated by reason of ownership or employment from participating in activities of Dirigo Health or receiving services offered by Dirigo Health as long as the ownership or employment is made known to the board and, if applicable, the board members abstain from voting on matters relating to that participation. [2005, c. 400, Pt. C, §4 (AMD).]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 400, §C4 (AMD).

§6907. CONFIDENTIAL RECORDS

Except as provided in subsections 1, 2 and 3, information obtained by Dirigo Health under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1. [2005, c. 615, §2 (AMD).]

1. **Financial information.** Any personally identifiable financial information, supporting data or tax return of any person obtained by Dirigo Health under this chapter is confidential and not open to public inspection.

[2003, c. 469, Pt. A, §8 (NEW) .]

2. **Health information.** Health information obtained by Dirigo Health under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.

[2003, c. 469, Pt. A, §8 (NEW) .]

3. **Practitioner-specific quality data.** The confidentiality of practitioner-specific quality data is determined according to this subsection.

A. Practitioner-specific quality data is confidential and may not be disclosed by the Maine Quality Forum prior to a determination of accuracy and completeness made under paragraph B. [2005, c. 615, §3 (NEW).]

B. Practitioner-specific quality data is not confidential after a determination of its accuracy and completeness is made by the Director of the Maine Quality Forum or a designee. [2005, c. 615, §3 (NEW).]

[2005, c. 615, §3 (NEW) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 615, §§2,3 (AMD).

§6908. POWERS AND DUTIES OF DIRIGO HEALTH

1. **Powers.** Subject to any limitations contained in this chapter or in any other law, Dirigo Health may:

A. Take any legal actions necessary or proper to recover or collect payments due Dirigo Health or that are necessary for the proper administration of Dirigo Health; [2007, c. 629, Pt. M, §12 (AMD).]

B. Make and alter bylaws, not inconsistent with this chapter or with the laws of this State, for the administration and regulation of the activities of Dirigo Health; [2003, c. 469, Pt. A, §8 (NEW).]

C. Have and exercise all powers necessary or convenient to effect the purposes for which Dirigo Health is organized or to further the activities in which Dirigo Health may lawfully be engaged, including the establishment of the Dirigo Health Program; [2005, c. 400, Pt. C, §5 (AMD).]

D. Engage in legislative liaison activities, including gathering information regarding legislation, analyzing the effect of legislation, communicating with Legislators and attending and giving testimony at legislative sessions, public hearings or committee hearings; [2003, c. 469, Pt. A, §8 (NEW).]

E. Take any legal actions necessary to avoid the payment of improper claims against Dirigo Health or the coverage provided by or through Dirigo Health, to recover any amounts erroneously or improperly paid by Dirigo Health, to recover any amounts paid by Dirigo Health as a result of mistake of fact or law and to recover other amounts due Dirigo Health; [2003, c. 469, Pt. A, §8 (NEW).]

F. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter; [2003, c. 469, Pt. A, §8 (NEW).]

G. Conduct studies and analyses related to the provision of health care, health care costs and quality; [2003, c. 469, Pt. A, §8 (NEW).]

H. Establish and administer a revolving loan fund to assist health care practitioners and health care providers in the purchase of hardware and software necessary to implement the requirements for electronic submission of claims. Dirigo Health may solicit matching contributions to the fund from each health insurance carrier licensed to do business in this State; [2003, c. 469, Pt. A, §8 (NEW).]

I. Apply for and receive funds, grants or contracts from public and private sources; [2003, c. 469, Pt. A, §8 (NEW).]

J. Contract with the Maine Health Data Organization and other organizations with expertise in health care data, including a nonprofit health data processing entity in this State, to assist the Maine Quality Forum established in section 6951 in the performance of its responsibilities; [2003, c. 469, Pt. A, §8 (NEW).]

K. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; and [2003, c. 469, Pt. A, §8 (NEW).]

L. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more organizations organized, created or operated under the laws of this State. [2003, c. 469, Pt. A, §8 (NEW).]

[2007, c. 629, Pt. M, §12 (AMD) .]

2. **Duties.** Dirigo Health shall:

A. Establish administrative and accounting procedures as recommended by the State Controller for the operation of Dirigo Health in accordance with Title 5; [2003, c. 469, Pt. A, §8 (NEW).]

B. Collect the savings offset payments provided in former section 6913 and the access payment provided in section 6917; [2009, c. 359, §1 (AMD); 2009, c. 359, §8 (AFF).]

C. Determine the comprehensive services and benefits to be included in the Dirigo Health Program and develop the specifications for the Dirigo Health Program in accordance with the provisions in section 6910. Within 30 days of its determination of the benefit package to be offered through the Dirigo Health Program, the board shall report on the benefit package, including the estimated premium and applicable coinsurance, deductibles, copayments and out-of-pocket maximums, to the joint standing committee of

the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters; [2005, c. 400, Pt. C, §6 (AMD).]

D. Develop and implement a program to publicize the existence of Dirigo Health and the Dirigo Health Program and the eligibility requirements and the enrollment procedures for the Dirigo Health Program and to maintain public awareness of Dirigo Health and the Dirigo Health Program; [2005, c. 400, Pt. C, §6 (AMD).]

E. Arrange the provision of Dirigo Health Program benefit coverage to eligible individuals and eligible employees through contracts with one or more qualified bidders in accordance with section 6910 or through the Dirigo Health Self-administered Plan authorized pursuant to section 6981; [2007, c. 447, §6 (AMD).]

F. [2007, c. 629, Pt. L, §2 (RP).]

G. Establish and operate the Maine Quality Forum in accordance with the provisions of section 6951 ; and [2007, c. 629, Pt. L, §3 (AMD).]

H. On a quarterly basis no less than 60 days from the end of each quarter, collect and report on:

(1) The total enrollment in the Dirigo Health Program, including the number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees and the number of enrollees enrolled through small employers;

(2) The number of new participating employers in the Dirigo Health Program;

(3) The number of employers ceasing to offer coverage through the Dirigo Health Program;

(4) The duration of employers' participation in the Dirigo Health Program; and

(5) A comparison of actual enrollees in the Dirigo Health Program to projected enrollees.

Dirigo Health shall submit the quarterly reports required under this subsection to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters. [2007, c. 629, Pt. L, §4 (NEW).]

[2009, c. 359, §1 (AMD); 2009, c. 359, §8 (AFF) .]

3. **Budget.** The revenues and expenditures of Dirigo Health are subject to legislative approval in the biennial budget process. At the direction of the board, the executive director shall prepare the budget for the administration and operation of Dirigo Health in accordance with the provisions of law that apply to departments of State Government.

[2003, c. 469, Pt. A, §8 (NEW) .]

4. **Audit.** Dirigo Health must be audited annually by the State Auditor. The board may, in its discretion, arrange for an independent audit to be conducted. A copy of the audit must be provided to the State Controller, to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

[2003, c. 469, Pt. A, §8 (NEW) .]

5. **Rulemaking.** Dirigo Health may adopt rules as necessary for the proper administration and enforcement of this chapter, pursuant to the Maine Administrative Procedure Act. Unless otherwise specified, rules adopted pursuant to this chapter are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2003, c. 469, Pt. A, §8 (NEW) .]

6. **Annual report.** Beginning September 1, 2004, and annually thereafter, the board shall report on the impact of Dirigo Health on the small group and individual health insurance markets in this State and any reduction in the number of uninsured individuals in the State. The board shall also report on membership in Dirigo Health, the administrative expenses of Dirigo Health, the extent of coverage, the effect on premiums, the number of covered lives, the number of Dirigo Health Program policies issued or renewed and Dirigo Health Program premiums earned and claims incurred by health insurance carriers offering coverage under the Dirigo Health Program. The board shall submit the report to the Governor, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

[2005, c. 400, Pt. C, §7 (AMD) .]

7. **Technical assistance from other state agencies.** Other state agencies, including, but not limited to, the bureau, the Department of Health and Human Services, Maine Revenue Services and the Maine Health Data Organization, shall provide technical assistance and expertise to Dirigo Health upon request.

[2003, c. 469, Pt. A, §8 (NEW); 2003, c. 689, Pt. B, §6 (REV) .]

8. **Legal counsel.** The Attorney General, when requested, shall furnish any legal assistance, counsel or advice Dirigo Health requires in the discharge of its duties.

[2003, c. 469, Pt. A, §8 (NEW) .]

9. **Coordination with federal, state and local health care systems.** Dirigo Health shall institute a system to coordinate the activities of Dirigo Health with the health care programs of the Federal Government and state and municipal governments.

[2003, c. 469, Pt. A, §8 (NEW) .]

10. **Initial staffing.** Upon request from the board, the Governor shall provide staffing assistance to Dirigo Health in the initial phases of its operation.

[2003, c. 469, Pt. A, §8 (NEW) .]

11. **Advisory committees.** Dirigo Health may appoint advisory committees to advise and assist Dirigo Health. Members of an advisory committee serve without compensation but may be reimbursed by Dirigo Health for necessary expenses while on official business of the advisory committee.

[2003, c. 469, Pt. A, §8 (NEW) .]

12. **Legislative jurisdiction.** Notwithstanding any provision of law to the contrary, legislative jurisdiction for oversight of Dirigo Health is governed by the Joint Rules of the Legislature. In adopting the joint rules, the Legislature shall give consideration to ensuring that legislative oversight of Dirigo Health is thorough and ongoing, that normal budgetary procedures and controls are exercised and that committee jurisdiction is consistent with the subject matter jurisdiction of the joint standing committees.

[2005, c. 394, §3 (NEW) .]

12. (TEXT REALLOCATED TO T. 24-A, §6908, sub-§13) **Report; jurisdiction.**

[2005, c. 400, Pt. A, §5 (NEW); 2005, c. 683, Pt. B, §20 (RAL) .]

13. (TEXT REALLOCATED FROM T. 24-A, §6908, sub-§12) **Report; jurisdiction.** Dirigo Health shall report twice annually, once in January and once during the last month of the regular legislative session, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the Dirigo Health Program and budget. Minutes of meetings of the Board of Trustees of Dirigo Health must be provided to each member of the joint standing committees of the Legislature having jurisdiction over insurance and financial services matters, health and human services matters and appropriations and financial affairs.

[2007, c. 447, §7 (AMD) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2003, c. 689, §B6 (REV). 2005, c. 394, §3 (AMD). 2005, c. 400, §§A5,C5-7 (AMD). 2005, c. 683, §B20 (AMD). 2007, c. 447, §§6, 7 (AMD). 2007, c. 629, Pt. L, §§1-4 (AMD). 2007, c. 629, Pt. M, §12 (AMD). 2009, c. 359, §1 (AMD). 2009, c. 359, §8 (AFF).

§6909. EXECUTIVE DIRECTOR

1. **Appointed position.** The executive director is appointed by the board and serves at the pleasure of the board. The position of executive director is a major policy-influencing position as designated in Title 5, section 934-B.

[2003, c. 469, Pt. A, §8 (NEW) .]

2. **Duties of executive director.** The executive director shall:

A. Serve as the liaison between the board and Dirigo Health and serve as secretary and treasurer to the board; [2007, c. 447, §8 (AMD).]

B. Manage Dirigo Health's programs and services, including the Maine Quality Forum established under section 6951; [2003, c. 469, Pt. A, §8 (NEW).]

C. Employ or contract on behalf of Dirigo Health for professional and nonprofessional personnel or service. Employees of Dirigo Health are subject to the Civil Service Law, except that the position of Director of the Maine Quality Forum is not subject to the Civil Service Law; [2003, c. 469, Pt. A, §8 (NEW).]

D. Approve all accounts for salaries, per diems, allowable expenses of Dirigo Health or of any employee or consultant and expenses incidental to the operation of Dirigo Health; and [2003, c. 469, Pt. A, §8 (NEW).]

E. Perform other duties prescribed by the board to carry out the functions of this chapter. [2003, c. 469, Pt. A, §8 (NEW).]

[2007, c. 447, §8 (AMD) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2007, c. 447, §8 (AMD).

§6910. DIRIGO HEALTH PROGRAM

1. **Dirigo Health Program.** Dirigo Health shall arrange for the provision of health benefits coverage through the Dirigo Health Program not later than October 1, 2004. The Dirigo Health Program must comply with all relevant requirements of this Title. Dirigo Health Program coverage may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board or may be provided through the Dirigo Health Self-administered Plan pursuant to section 6981.

[2007, c. 447, §9 (AMD) .]

2. **Legislative approval of nonprofit health care plan or expansion of public plan.** If health insurance carriers do not apply to offer and deliver Dirigo Health Program coverage, the board may have Dirigo Health provide access to health insurance by proposing the establishment of a nonprofit health care plan organized under Title 13-B and authorized pursuant to Title 24, chapter 19 or by proposing the expansion of an existing public plan. If the board proposes the establishment of a nonprofit health care plan or the expansion of an existing public plan, the board shall submit its proposal, including, but not limited to, a funding mechanism to capitalize a nonprofit health care plan and any recommended legislation to the joint standing committee of the Legislature having jurisdiction over health insurance matters. Dirigo Health may not provide access to health insurance by establishing a nonprofit health care plan or through an existing public plan without specific legislative approval.

[2005, c. 400, Pt. C, §8 (AMD) .]

3. **Carrier participation requirements.** To qualify as a carrier of Dirigo Health Program coverage, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and [2003, c. 469, Pt. A, §8 (NEW).]

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network. [2003, c. 1, §22 (COR).]

Health insurance carriers that seek to qualify to provide Dirigo Health Program coverage must also qualify as health plans in Medicaid.

[2005, c. 400, Pt. C, §8 (AMD) .]

4. **Contracting authority.** Dirigo Health has contracting authority and powers to administer Dirigo Health Insurance as set out in this subsection.

A. Dirigo Health may contract with health insurance carriers licensed to sell health insurance in this State or other private or public third-party administrators to provide Dirigo Health Program coverage. In addition:

(1) Dirigo Health shall issue requests for proposals from health insurance carriers;

(2) Dirigo Health may include quality improvement, disease prevention, disease management and cost-containment provisions in the contracts with participating health insurance carriers or may arrange for the provision of such services through contracts with other entities;

(3) Dirigo Health shall require participating health insurance carriers to offer a benefit plan identical to the Dirigo Health Program, for which no Dirigo Health subsidies are available, in the general small group market;

(4) Dirigo Health shall make payments to participating health insurance carriers under a Dirigo Health Program contract to provide Dirigo Health Program benefits to plan enrollees not enrolled in MaineCare;

(5) Dirigo Health may set allowable rates for administration and underwriting gains for the Dirigo Health Program;

(6) Dirigo Health may administer continuation benefits for eligible individuals from employers with 20 or more employees who have purchased health insurance coverage through Dirigo Health for the duration of their eligibility periods for continuation benefits pursuant to the federal Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003; and

(7) Dirigo Health may administer or contract to administer the United States Internal Revenue Code of 1986, Section 125 plans for employers and employees participating in Dirigo Health, including medical expense reimbursement accounts and dependent care reimbursement accounts. [2005, c. 400, Pt. C, §8 (AMD).]

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health Program for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) The Dirigo Health Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health Program and that the employer group otherwise meets the minimum participation requirements specified by section 2808-B, subsection 4, paragraph A.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers. [2005, c. 400, Pt. C, §8 (AMD).]

C. Dirigo Health may permit eligible individuals to purchase Dirigo Health Program coverage for themselves and their dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health may collect payments from eligible individuals participating in the Dirigo Health Program to cover the cost of:

(a) Enrollment in the Dirigo Health Program for eligible individuals and dependents;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall reduce the payment amounts for individuals eligible for a subsidy under section 6912 accordingly.

(4) Dirigo Health may require that eligible individuals certify that all their dependents are enrolled in the Dirigo Health Program or are covered by another creditable plan.

(5) Dirigo Health may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the 12-month period immediately preceding the eligible individual's application.

(6) Dirigo Health may limit the number of plan enrollees.

(7) Dirigo Health may establish other criteria for participation. [2005, c. 400, Pt. C, §8 (AMD).]

[2005, c. 400, Pt. C, §8 (AMD) .]

5. Enrollment in Dirigo Health Program. Dirigo Health shall perform, at a minimum, the following functions to facilitate enrollment in the Dirigo Health Program.

A. Dirigo Health shall publicize the availability of the Dirigo Health Program to businesses, self-employed individuals and others eligible to enroll in the Dirigo Health Program. [2005, c. 400, Pt. C, §8 (AMD).]

B. Dirigo Health shall screen all eligible individuals and employees for eligibility for subsidies under section 6912 and eligibility for MaineCare. To facilitate the screening and referral process, Dirigo Health shall provide a single application form for Dirigo Health and MaineCare. The application materials must inform applicants of subsidies available through Dirigo Health and of the additional coverage available

through MaineCare. It must allow an applicant to choose on the application form to apply or not to apply for MaineCare or for a subsidy. It must allow an applicant to provide household financial information necessary to determine eligibility for MaineCare or a subsidy. Except when the applicant has declined to apply for MaineCare or a subsidy, an application must be treated as an application for Dirigo Health, for a subsidy and for MaineCare. MaineCare must make the final determination of eligibility for MaineCare. [2003, c. 469, Pt. A, §8 (NEW).]

C. Except as provided in this paragraph, the effective date of coverage for a new enrollee in the Dirigo Health Program is the first day of the month following receipt of the fully completed application for that enrollee by the carrier contracting with Dirigo Health or the first day of the next month if the fully completed application is received by the carrier within 10 calendar days of the end of the month. If a new enrollee in the Dirigo Health Program had prior coverage through an individual or small group policy, coverage under the Dirigo Health Program must take effect the day following termination of that enrollee's prior coverage. [2005, c. 400, Pt. C, §8 (AMD).]

[2005, c. 400, Pt. C, §8 (AMD) .]

6. **Quality improvement, disease management and cost containment.** Dirigo Health shall promote quality improvement, disease prevention, disease management and cost-containment programs as part of its administration of the Dirigo Health Program.

[2005, c. 400, Pt. C, §8 (AMD) .]

SECTION HISTORY
RR 2003, c. 1, §22 (COR). 2003, c. 469, §A8 (NEW). 2005, c. 400, §C8 (AMD). 2007, c. 447, §9 (AMD).

§6911. COORDINATION WITH MAINECARE

The Department of Health and Human Services is the state agency responsible for the financing and administration of MaineCare. It shall pay for MaineCare benefits for MaineCare-eligible individuals, including those enrolled in health plans in MaineCare that are providing coverage under the Dirigo Health Program. An individual participating in the Dirigo Health Program who applies for and is determined eligible for MaineCare is enrolled directly in MaineCare. [2005, c. 400, Pt. A, §6 (AMD).]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2003, c. 689, §B6 (REV). 2005, c. 400, §A6 (AMD).

§6912. SUBSIDIES

Dirigo Health may establish sliding-scale subsidies for the purchase of Dirigo Health Program coverage paid by eligible individuals or employees whose income is under 300% of the federal poverty level. Dirigo Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees, whose income is under 300% of the federal poverty level. [2005, c. 400, Pt. A, §7 (AMD).]

1. **Administration.** Dirigo Health shall, by rule, establish procedures to administer this section.

[2003, c. 469, Pt. A, §8 (NEW) .]

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

A. Be enrolled in the Dirigo Health Program, have an income under 300% of the federal poverty level and be a resident of the State; or [2005, c. 400, Pt. A, §8 (AMD).]

B. Be enrolled in a health plan of an employer with more than 50 employees and have an income under 300% of the federal poverty level. The health plan must meet any criteria established by Dirigo Health. The individual must meet other eligibility criteria established by Dirigo Health. [2005, c. 400, Pt. A, §8 (AMD).]

[2005, c. 400, Pt. A, §8 (AMD) .]

3. **Limitation of subsidies.** Dirigo Health shall limit the availability of subsidies to reflect limitations of available funds.

[2003, c. 469, Pt. A, §8 (NEW) .]

4. **Limitation on amount subsidized.**

[2007, c. 629, Pt. B, §1 (RP) .]

5. **Notification of subsidy.** Dirigo Health shall notify applicants and their employers in writing of their eligibility and approved level of subsidy.

[2003, c. 469, Pt. A, §8 (NEW) .]

6. **Report.** Within 30 days after any subsidies are established pursuant to this section, the board shall report on the amount of the subsidies, the funding required for the subsidies and the estimated number of Dirigo Health Program enrollees eligible for the subsidies and submit the report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

[2005, c. 400, Pt. A, §9 (AMD) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 400, §§A7-9 (AMD). 2007, c. 629, Pt. B, §1 (AMD).

§6913. SAVINGS OFFSET PAYMENTS AGAINST HEALTH INSURANCE CARRIERS, EMPLOYEE BENEFIT EXCESS INSURANCE CARRIERS AND THIRD-PARTY ADMINISTRATORS

(REPEALED)

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 400, §§A10-13,C9 (AMD). 2005, c. 683, §§A43,44 (AMD). 2007, c. 1, Pt. X, §§1, 2 (AMD). 2007, c. 1, Pt. X, §3 (AFF). 2009, c. 359, §8 (AFF). 2009, c. 359, §2 (RP).

§6914. INTRAGOVERNMENTAL TRANSFER

Starting July 1, 2004, and ending September 30, 2012, Dirigo Health shall transfer funds, as necessary, to a special dedicated, nonlapsing revenue account administered by the agency of State Government that administers MaineCare for the purpose of providing a state match for federal Medicaid services provided to individuals eligible pursuant to Title 22, section 3174-G, subsection 1, paragraph E whose nonfarm income is greater than 150% of the nonfarm income official poverty line and is below or equal to 200% of the nonfarm income official poverty line. Dirigo Health shall annually set the amount of contribution. [2011, c. 477, Pt. Y, §1 (AMD).]

Beginning January 1, 2012, and ending September 30, 2012, Dirigo Health shall transfer funds as necessary to a special dedicated, nonlapsing revenue account administered by the agency of State Government that administers MaineCare for the purpose of providing a state match for federal Medicaid services provided to individuals eligible pursuant to Title 22, section 3174-G, subsection 1, paragraph E whose nonfarm income is greater than 133% of the nonfarm income official poverty line and is below or equal to 150% of the nonfarm income official poverty line. Dirigo Health shall annually set the amount of contribution. [2011, c. 477, Pt. Y, §1 (AMD).]

Beginning September 1, 2012, but not later than June 30, 2013, Dirigo Health shall transfer $7,210,000 from the Dirigo Health Enterprise Fund to the Medical Care - Payments to Providers, Other Special Revenue Funds account in the Department of Health and Human Services for the purpose of providing a state match for federal Medicaid services. [2013, c. 1, Pt. X, §1 (AMD).]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 400, §A14 (AMD). 2011, c. 380, Pt. BBB, §1 (AMD). 2011, c. 477, Pt. Y, §1 (AMD). 2013, c. 1, Pt. X, §1 (AMD).

§6915. DIRIGO HEALTH ENTERPRISE FUND

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any savings offset payments made pursuant to former section 6913, any access payments made pursuant to section 6917 and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter. [2009, c. 359, §3 (AMD); 2009, c. 359, §8 (AFF).]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 386, §D3 (AMD). 2009, c. 359, §3 (AMD). 2009, c. 359, §8 (AFF).

§6916. MARKETING AND SALE OF DIRIGO HEALTH PROGRAM; QUALIFICATIONS OF INSURANCE PRODUCERS

1. **Qualifications of insurance producers.** An insurance producer licensed pursuant to chapter 16 may solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program if the following conditions are met prior to any such solicitation, negotiation or sale:

A. The producer is authorized by the superintendent to solicit, negotiate and sell insurance products for the health line of business; [2007, c. 447, §10 (NEW).]

B. The producer has successfully completed all training offered and required by the Dirigo Health Program for the solicitation, negotiation and sale of Dirigo Health Program insurance products, including any continuing training offered and required by the Dirigo Health Program; [2007, c. 447, §10 (NEW).]

C. The producer provides the carrier or carriers with which the Dirigo Health Program has contracted to underwrite and provide Dirigo Health Program coverage a current certificate from the Dirigo Health Program certifying the successful completion of all training offered and required by the Dirigo Health Program; and [2007, c. 447, §10 (NEW).]

D. The producer successfully completes all training specific to the sale of Dirigo Health Program insurance products offered and required by the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage, including any continuing training offered and required by such carrier or carriers. [2007, c. 447, §10 (NEW).]

[2007, c. 447, §10 (NEW) .]

2. **Annual certification required.** Training pursuant to subsection 1 must be completed annually, and any certificate establishing successful completion of training is valid for one year from the date of issuance. If a producer fails to obtain certification following the expiration of the prior year's certification, the producer may not continue to solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program.

[2007, c. 447, §10 (NEW) .]

3. **Carrier appointment not required.** Notwithstanding any other provision of law, an insurance producer licensed pursuant to chapter 16 who complies with this section may solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program without being appointed by the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage. A producer may not solicit, negotiate or sell insurance products offered by or through the Dirigo Health Program if the producer is not in compliance with this subsection. Notwithstanding section 1445, the carrier or carriers contracting with the Dirigo Health Program to underwrite and provide Dirigo Health Program coverage are not liable for the actions of an insurance producer who has not been appointed to solicit, negotiate and sell insurance products offered by or through the Dirigo Health Program.

[2007, c. 447, §10 (NEW) .]

SECTION HISTORY
2007, c. 447, §10 (NEW).

§6917. ACCESS PAYMENT

1. **Access payments required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers.** All health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers shall pay an access payment on all paid claims, except claims under accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance. The amount of the access payment is 2.14% on claims for services provided through June 30, 2011, 1.87% on claims for services provided from July 1, 2011 to June 30, 2012, 1.64% on claims for services provided from July 1, 2012 to June 30, 2013 and 1.14% on claims for services provided from July 1, 2013 to December 31, 2013. No access payment may be charged for any claims for services provided on January 1, 2014 or thereafter. The following provisions govern access payments.

A. A health insurance carrier or employee benefit excess insurance carrier may not be required to pay an access payment on policies or contracts insuring federal employees. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

B. Access payments apply to claims paid beginning on or after September 1, 2009. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

C. Access payments must be made monthly to Dirigo Health and are due 30 days after the end of each month and must accrue interest at 12% per annum on or after the due date, except that access payments for 3rd-party administrators for groups of 500 or fewer members may be made annually not less than 60 days after the close of the plan year. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

D. Access payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Enterprise Fund established in section 6915. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

[2011, c. 380, Pt. BBB, §2 (AMD) .]

2. **Failure to pay access payments.** The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any health insurance carrier or employee benefit excess insurance carrier or the license of any 3rd-party administrator to operate in this State that fails to pay an access payment. In addition, the superintendent may assess civil penalties in accordance with section 12-A against any health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator that fails to pay an access payment or may take any other enforcement action authorized under section 12-A to collect any unpaid access payments and may collect the cost of enforcement including attorney's fees from those who fail to pay an access payment.

[2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF) .]

3. **Definitions.** As used in this section, the following terms have the following meanings.

A. "Claims-related expenses" includes:

(1) Payments for utilization review, care management, disease management, risk assessment and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals, usually either by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping such covered individuals to maintain or improve their health; and

(2) Payments that are made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements and that are unrelated to the provision of services to specific covered individuals. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

B. "Health and medical services" includes, but is not limited to, any services included in the furnishing of medical care, dental care to the extent covered under a medical insurance policy, pharmaceutical benefits or hospitalization, including but not limited to services provided in a hospital or other medical facility; ancillary services, including but not limited to ambulatory services; physician and other practitioner services, including but not limited to services provided by a physician's assistant, nurse practitioner or midwife; and behavioral health services, including but not limited to mental health and substance abuse services. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

C. "Paid claims" means all payments made by health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers for health and medical services provided under policies that insure residents of this State or, in the case of 3rd-party administrators, for health care for residents of this State, except that "paid claims" does not include:

(1) Claims-related expenses and general administrative expenses;

(2) Payments made to qualifying providers under a "pay for performance" or other incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals;

(3) Claims paid by carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, except that claims paid for dental services covered under a medical policy are included;

(4) Claims paid for services rendered to nonresidents of this State;

(5) Claims paid under retiree health benefit plans that are separate from and not included within benefit plans for existing employees;

(6) Claims paid by an employee benefit excess insurance carrier that have been counted by a 3rd-party administrator for determining its access payment;

(7) Claims paid for services rendered to persons covered under a benefit plan for federal employees; and

(8) Claims paid for services rendered outside of this State to a person who is a resident of this State.

In those instances in which a health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator is contractually entitled to withhold certain amounts from payments due to providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before application of such withholds must be reflected in the calculation of paid claims. [2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF).]

[2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF) .]

4. **Rulemaking.** The board may adopt any rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 359, §4 (NEW); 2009, c. 359, §8 (AFF) .]

SECTION HISTORY
2009, c. 359, §4 (NEW). 2009, c. 359, §8 (AFF). 2011, c. 380, Pt. BBB, §2 (AMD).

Subchapter 2: HEALTH CARE QUALITY
HEADING: PL 2003, C. 469, PT. A, §8 (NEW)

§6951. MAINE QUALITY FORUM

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded, at least in part, through the savings offset payments made pursuant to former section 6913 and the access payment pursuant to section 6917. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties. [2009, c. 359, §5 (AMD); 2009, c. 359, §8 (AFF).]

1. **Research dissemination.** The forum shall collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best practices.

[2003, c. 469, Pt. A, §8 (NEW) .]

2. **Quality and performance measures.** The forum shall adopt a set of measures to evaluate and compare health care quality and provider performance. The measures must be adopted with guidance from the advisory council pursuant to section 6952. The quality measures adopted by the forum must be the basis for the rules for the collection of quality data adopted by the Maine Health Data Organization pursuant to Title 22, section 8708-A.

[2003, c. 469, Pt. A, §8 (NEW) .]

3. **Data coordination.** The forum shall coordinate the collection of health care quality data in the State. The forum shall work with the Maine Health Data Organization and other entities that collect health care data to minimize duplication and to minimize the burden on providers of data.

[2003, c. 469, Pt. A, §8 (NEW) .]

4. **Reporting.** The forum shall work collaboratively with the Maine Health Data Organization, health care providers, health insurance carriers and others to report in useable formats comparative health care quality information to consumers, purchasers, providers, insurers and policy makers. The forum shall produce

annual quality reports in conjunction with the Maine Health Data Organization pursuant to Title 22, section 8712. No later than September 1, 2010, the forum shall make provider-specific information regarding quality of services available on its publicly accessible website.

[2009, c. 350, Pt. A, §2 (AMD) .]

5. **Consumer education.** The forum shall conduct education campaigns to help health care consumers make informed decisions and engage in healthy lifestyles.

[2003, c. 469, Pt. A, §8 (NEW) .]

6. **Technology assessment.** The forum shall conduct technology assessment reviews to guide the use and distribution of new technologies in this State. The forum shall make recommendations to the certificate of need program under Title 22, chapter 103-A.

[2003, c. 469, Pt. A, §8 (NEW) .]

7. **Electronic data.** The forum shall encourage the adoption of electronic technology and assist health care practitioners to implement electronic systems for medical records and submission of claims. The assistance may include, but is not limited to, practitioner education, identification or establishment of low-interest financing options for hardware and software and system implementation support.

[2003, c. 469, Pt. A, §8 (NEW) .]

8. **State health plan.**

[2011, c. 90, Pt. J, §23 (RP) .]

9. **Annual report.** The forum shall make an annual report to the public. The forum shall provide the report to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs, health and human services matters and insurance and financial services matters.

[2003, c. 469, Pt. A, §8 (NEW) .]

10. **Health care provider-specific data.** The forum shall submit to the Legislature, by January 30th each year beginning in 2009, a health care provider-specific performance report. The report must be based on health care quality data, including health care-associated infection quality data, that is submitted by providers to the Maine Health Data Organization pursuant to Title 22, section 8708-A. The forum and the Maine Center for Disease Control and Prevention shall make the report available to the citizens of the State through a variety of means, including, but not limited to, the forum's publicly accessible website and the distribution of written reports and publications.

[2007, c. 594, §1 (NEW) .]

11. **Infection prevention activities.** The forum and the Maine Center for Disease Control and Prevention shall, by January 30th of each year beginning in 2009, report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on statewide collaborative efforts with health care infection control professionals in the State to control or prevent health care-associated infections.

[2007, c. 594, §2 (NEW) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2007, c. 594, §§1, 2 (AMD). 2007, c. 629, Pt. L, §5 (AMD). 2009, c. 350, Pt. A, §2 (AMD). 2009, c. 359, §5 (AMD). 2009, c. 359, §8 (AFF). 2011, c. 90, Pt. J, §23 (AMD).

§6952. MAINE QUALITY FORUM ADVISORY COUNCIL

The Maine Quality Forum Advisory Council, referred to in this subchapter as "the advisory council," is a 17-member body established by Title 5, section 12004-I, subsection 30-A, to advise the forum. Except as provided in section 6907, subsection 2, information obtained by the advisory council is a public record as provided by Title 1, chapter 13, subchapter 1. [2003, c. 469, Pt. A, §8 (NEW).]

1. **Appointment; composition.** The Governor shall appoint the following members with the approval of the joint standing committee of the Legislature having jurisdiction over health and human services matters:

A. Seven members representing providers, including 3 physicians, one registered nurse, one representative of hospitals, one mental health provider and one health care practitioner who is not a physician. The 3 physician members must represent allopathic physicians, osteopathic physicians, primary care physicians and specialist physicians; [2003, c. 469, Pt. A, §8 (NEW).]

B. Four members representing consumers, including one employee who receives health care through a commercially insured product, one representative of organized labor, one representative of a consumer health advocacy group and one representative of the uninsured or MaineCare recipients; [2003, c. 469, Pt. A, §8 (NEW).]

C. Four members representing employers, including one member of the State Employee Health Commission, one representative of a private employer with more than 1,000 full-time equivalent employees, one representative of a private employer with 50 to 1,000 full-time employees and one representative of a private employer with fewer than 50 employees; [2003, c. 469, Pt. A, §8 (NEW).]

D. One representative of a private health plan; and [2003, c. 469, Pt. A, §8 (NEW).]

E. One representative of the MaineCare program. [2003, c. 469, Pt. A, §8 (NEW).]

Prior to making appointments to the advisory council, the Governor shall seek nominations from the public and from a statewide allopathic association, a statewide osteopathic association, a statewide hospital association, a statewide nurses association, a statewide health purchasing collaborative, a statewide health management coalition, organized labor, a statewide organization representing consumers advocating for affordable health care, a statewide association representing consumers of mental health services, a national association of retired persons, a statewide citizen action organization, a statewide organization advocating equal justice, a statewide organization representing local chambers of commerce, a statewide organization representing businesses for social responsibility, a statewide small business alliance, a national federation of independent businesses, a statewide association of health plans and other entities as appropriate.

[2003, c. 469, Pt. A, §8 (NEW) .]

2. **Terms.** Members of the advisory council serve 5-year terms except for initial appointments. Initial appointments must include 5 members appointed to 3-year terms, 6 members appointed to 4-year terms and 6 members appointed to 5-year terms. A member may not serve more than 2 consecutive terms.

[2003, c. 469, Pt. A, §8 (NEW) .]

3. **Compensation.** Members of the advisory council are eligible for compensation according to the provisions of Title 5, chapter 379.

[2003, c. 469, Pt. A, §8 (NEW) .]

4. **Quorum.** A quorum is a majority of the members of the advisory council.

[2003, c. 469, Pt. A, §8 (NEW) .]

5. **Chair and officers.** The advisory council shall annually choose one of its members to serve as chair for a one-year term. The advisory council may select other officers and designate their duties.

[2003, c. 469, Pt. A, §8 (NEW) .]

6. **Meetings.** The advisory council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the executive director of Dirigo Health. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

[2003, c. 469, Pt. A, §8 (NEW) .]

7. **Duties.** The advisory council shall:

A. Convene a group of health care providers to provide input and advice to the council. The council shall invite members broadly representing health care practitioners as defined in Title 24, section 2502, subsection 1-A, health care providers as defined in Title 24, section 2502, subsection 2, federally qualified health centers and pharmacists. Members serve as volunteers and without compensation or reimbursement for expenses; [2003, c. 469, Pt. A, §8 (NEW).]

B. Provide expertise in health care quality to assist the board; [2003, c. 469, Pt. A, §8 (NEW).]

C. Advise and support the forum by:

(1) Establishing and monitoring, with Dirigo Health, an annual work plan for the forum;

(2) Providing guidance in the adoption of quality and performance measures;

(3) Serving as a liaison between the provider group established in paragraph A and the forum;

(4) Conducting public hearings and meetings; and

(5) Reviewing consumer education materials developed by the forum; [2003, c. 469, Pt. A, §8 (NEW).]

D. Make recommendations regarding quality assurance and quality improvement priorities; and [2011, c. 90, Pt. J, §24 (AMD).]

E. Serve as a liaison between the forum and other organizations working in the field of health care quality. [2003, c. 469, Pt. A, §8 (NEW).]

[2011, c. 90, Pt. J, §24 (AMD) .]

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2011, c. 90, Pt. J, §24 (AMD).

Subchapter 3: DIRIGO HEALTH HIGH-RISK POOL (HEADING: PL 2003, C. 469, PT. A, §8 (NEW); PL 2007, C. 629, PT. L, §6 (RP))

§6971. DIRIGO HEALTH HIGH-RISK POOL

(REPEALED)

SECTION HISTORY
2003, c. 469, §A8 (NEW). 2005, c. 400, §C10 (AMD). 2007, c. 629, Pt. L, §6 (RP).

Subchapter 4: DIRIGO HEALTH SELF-ADMINISTERED PLAN

§6981. DIRIGO HEALTH SELF-ADMINISTERED PLAN

Notwithstanding section 6910, subsection 2, Dirigo Health may provide access to health benefits coverage by establishing the Dirigo Health Self-administered Plan, referred to in this subchapter as "the self-administered plan," pursuant to this section. [2007, c. 447, §11 (NEW).]

1. **Establishment.** Dirigo Health may provide access to health benefits coverage through the self-administered plan subject to the requirements of this section. The board may make a determination that Dirigo Health will provide access to health benefits coverage through the self-administered plan after the board evaluates competitive bids for health benefits coverage for self-administered and fully underwritten health benefits coverage. If the board determines that Dirigo Health will provide access to health coverage through the self-administered plan as authorized under this section, the board shall submit a report explaining the reasons for the decision to the joint standing committee of the Legislature having jurisdiction over health insurance matters within 30 days of the decision. Upon receipt of a report from the board, the chairs of the joint standing committee of the Legislature having jurisdiction over health insurance matters may call a meeting of the committee. Following receipt of such a report, the joint standing committee of the Legislature having jurisdiction over health insurance matters may report out legislation to the next regular or special session of the Legislature relating to the establishment of the self-administered plan.

[2007, c. 447, §11 (NEW) .]

2. **Cooperative agreements.** Dirigo Health may enter into voluntary cooperative agreements with a public purchaser for purchasing purposes and administrative functions. If a cooperative agreement is entered into pursuant to this subsection, the self-administered plan and any public purchaser shall maintain separate and distinct risk pools and reserves and may not commingle risk pools or reserve funds under any circumstances. For the purposes of this subsection, "public purchaser" means an entity that purchases health coverage in whole or in part with public funds, including, but not limited to, the state employee health insurance program, the University of Maine System, the Maine Community College System, the Maine Education Association benefits trust, the Maine School Management Association benefits trust and municipal and county governments. For the purposes of this subsection, "public purchaser" does not mean the Department of Health and Human Services, Office of MaineCare Services.

[2009, c. 369, Pt. A, §33 (AMD) .]

3. **Additional responsibilities of board.** In addition to the duties and responsibilities set out in sections 6908 and 6910, the board is authorized to:

A. Operate the self-administered plan pursuant to a trust instrument in accordance with Title 18-B; [2007, c. 447, §11 (NEW).]

B. Develop, maintain and modify a business plan for the self-administered plan as appropriate in consultation with the executive director; [2007, c. 447, §11 (NEW).]

C. Establish an operating budget for the self-administered plan subject to legislative approval in the biennial budget process in accordance with section 6908, subsection 3; [2007, c. 447, §11 (NEW).]

D. Ensure the ongoing fiscal integrity and stability of the self-administered plan in accordance with subsections 5 and 11 and monitor statistics provided by the executive director relating to the number of plan enrollees, working rates, utilization of benefits, operating costs and reimbursement for losses related to excess or stop loss coverage; [2007, c. 447, §11 (NEW).]

E. Establish administrative and accounting procedures in accordance with section 6908, subsection 2, paragraph A and develop financial statements that are consistent with generally accepted accounting principles; [2007, c. 447, §11 (NEW).]

F. Obtain necessary contracts for services, including, but not limited to, actuarial services, accounting services, auditing services, investment advice and counsel and custodial services for financial assets in accordance with subsection 4; [2007, c. 447, §11 (NEW).]

G. Take any actions necessary to comply with federal and state Medicaid rules regarding Dirigo Health plan members eligible for MaineCare; [2007, c. 447, §11 (NEW).]

H. Take any actions necessary to comply with federal Medicaid managed care organization contract requirements as provided in 42 Code of Federal Regulations, Part 438 (2002); and [2007, c. 447, §11 (NEW).]

I. Have and exercise all powers necessary and appropriate to carry out the purposes of this section. [2007, c. 447, §11 (NEW).]

[2007, c. 447, §11 (NEW) .]

4. **Services.** If the board determines that Dirigo Health will provide access to health coverage through the self-administered plan pursuant to subsection 2, the board shall contract for the following services through a competitive bidding process unless the requirement for competitive bidding is waived pursuant to Title 5, section 1825-B, subsection 2 or a carrier contracted by Dirigo Health to fully underwrite health benefits coverage terminates that contract.

A. The board shall secure the services of an actuary for technical advice on matters regarding the operation of the self-administered plan in accordance with this paragraph. The board shall contract for actuarial services after a competitive bidding process at least every 3 years and may award a bid only to an actuary who is a member in good standing of the American Academy of Actuaries or a successor organization. The contract must require the actuary to:

(1) Act as a technical advisor to the board on matters regarding the operation of the self-administered plan in accordance with this paragraph;

(2) Certify the amounts of the benefits paid and payable under this section;

(3) Analyze the year's operations and results and the experience of the self-administered plan;

(4) Determine appropriate actuarial assumptions for recommendation to the board; and

(5) Determine the appropriate level of reserves needed to sustain the self-administered plan and pay benefits. [2007, c. 447, §11 (NEW).]

B. The board shall secure the services of one or more fiduciaries or registered investment advisors through negotiated contractual arrangements. The contract must require the fiduciary or registered investment advisor to:

(1) Invest and reinvest the funds in accordance with appropriate financial and trust standards;

(2) Advise the board as to reasonable investment philosophy; and

(3) Submit regular reports of investments and changes to the board. [2007, c. 447, §11 (NEW).]

C. The board shall contract with an appropriate financial institution for custodial services for the securities and other investment assets of the self-administered plan. The contract must require the custodian to meet financial safeguards and other qualifications determined by the board, including restrictions on the manner in which deposits and withdrawals of funds are completed. [2007, c. 447, §11 (NEW).]

D. When the self-administered plan is established, the board shall purchase, through contracts from one or more 3rd-party administrators or any organization necessary to administer and provide a health plan, a policy or policies or a contract to provide the benefits specified by this section. The purchase of policies by the board must be accomplished by use of a written contract for a term determined by the board. [2007, c. 447, §11 (NEW).]

The board may contract for any other applicable services necessary to comply with federal law.

[2007, c. 447, §11 (NEW) .]

5. **Administration.** The following provisions govern the administration of the self-administered plan.

A. The assets and liabilities of the self-administered plan are solely the assets and liabilities of Dirigo Health. [2007, c. 447, §11 (NEW).]

B. The actuary under contract with the board pursuant to subsection 4 shall determine:

(1) The appropriate level of reserves estimated to be sufficient to pay claims and administrative costs according to subsection 11, paragraph B;

(2) Whether the program is operating on an actuarially sound basis and any recommendations based on that determination;

(3) A rate structure for the self-administered plan, including working rates actuarially sufficient to pay anticipated claims for the current claims year as well as to provide sufficient reserves for incurred but not reported claims;

(4) Recommendations as to the purchase of excess or stop loss insurance including suggested attachment levels and limits; and

(5) Recommendations as to the need for a security deposit or surety bond to protect against insolvency.

The actuary shall annually present information to the board on the determinations made pursuant to this paragraph as well as the method of distribution of any accumulations above the reserves including use of excess reserves to moderate the working rates. [2007, c. 447, §11 (NEW).]

C. The superintendent shall complete a detailed review of the financial and actuarial aspects of the self-administered plan, including, but not limited to, the presentation and recommendations of the actuary and the audited financial statements of the self-administered plan. The superintendent shall report the superintendent's findings and any recommendations to the board and at a public meeting of the joint standing committee of the Legislature having jurisdiction over insurance matters on or before March 1st of each year. [2007, c. 447, §11 (NEW).]

D. The self-administered plan may not obligate the General Fund beyond that amount appropriated by the Legislature. [2007, c. 447, §11 (NEW).]

[2007, c. 447, §11 (NEW) .]

6. **Audits; financial statements.** The board shall arrange for an annual audit of its financial statements by an independent certified public accounting firm. Within 30 days of the completion of the audit, a copy of the audited financial statements must be distributed to the Legislature in the same manner as required by section 6908, subsection 4. A copy of the audited financial statements must also be made available for public inspection.

[2007, c. 447, §11 (NEW) .]

7. **Public entity.** The self-administered plan is a public entity for the purposes of 42 Code of Federal Regulations, Section 438.116.

[2007, c. 447, §11 (NEW) .]

8. **Health benefit coverage.** Health benefits coverage provided under the self-administered plan in accordance with this subchapter must be comprehensive and include a low deductible plan option for enrollees in the Dirigo Health Program.

[2007, c. 447, §11 (NEW) .]

9. **Application of certain insurance provisions.** The self-administered plan must meet or exceed the following requirements in the same manner as when health benefits coverage is provided by a health insurance carrier:

A. The requirements for rating practices pursuant to section 2736-C, subsection 2 and section 2808-B, subsection 2; [2007, c. 447, §11 (NEW).]

B. The requirements for guaranteed issuance pursuant to section 2736-C, subsection 3 and section 2808-B, subsection 4; [2007, c. 447, §11 (NEW).]

C. The requirements for guaranteed renewal pursuant to section 2736-C, subsection 3 and section 2808-B, subsection 4 subject to the limitations of available funds maintained by the self-administered plan in accordance with subsection 11; [2007, c. 447, §11 (NEW).]

D. The requirements for continuity of coverage, coverage of late enrollees and preexisting condition exclusions pursuant to chapter 36; [2007, c. 447, §11 (NEW).]

E. The requirements for mandated coverage of specific health care services and for specific diseases and for certain providers of health care services pursuant to Title 24 and this Title; [2007, c. 447, §11 (NEW).]

F. The requirements for the benefits, rights and protections for individuals enrolled in health plans pursuant to chapter 56-A and Bureau of Insurance Rule Chapter 850. Notwithstanding any statute or common law to the contrary, an individual enrolled in the self-administered plan may maintain a cause of action against the self-administered plan subject to the requirements of section 4313. This paragraph is a waiver of the State's defense of immunity under Title 14, chapter 741; [2007, c. 447, §11 (NEW).]

G. The requirements of the Insurance Information and Privacy Protection Act pursuant to chapter 24; and [2007, c. 447, §11 (NEW).]

H. The provisions of sections 2159-B and 2159-C relating to discrimination against victims of domestic abuse and discrimination on the basis of genetic information or testing. [2007, c. 447, §11 (NEW).]

The self-administered plan may not enter into any contract with a 3rd-party administrator, carrier or other organization to administer and provide health coverage that has not demonstrated compliance with all applicable state laws.

[2007, c. 447, §11 (NEW) .]

10. **Self-administered plan not an insurer.** The self-administered plan is not an insurer, reciprocal insurer or joint underwriting association under the laws of the State. The administration of the self-administered plan by the board does not constitute doing the business of insurance.

[2007, c. 447, §11 (NEW) .]

11. **Reserves.** This subsection applies to reserves of the self-administered plan.

A. The Dirigo Health Reserve is created as an account within the Dirigo Health Enterprise Fund, as established pursuant to section 6915, for the deposit of reserves as required by paragraph B. [2007, c. 447, §11 (NEW).]

B. The self-administered plan shall maintain a reserve at least equal to the sum of:

(1) An amount estimated by a qualified actuary under subsection 5 to be necessary to pay claims and administrative costs for the assumed risk for 2 1/2 months; and

(2) The amount determined annually by a qualified actuary under subsection 5 to be necessary to fund the unpaid portion of ultimate expected losses, including incurred but not reported claims, and related expenses incurred in the provision of benefits for eligible participants, less any credit, as determined by a qualified actuary, for excess or stop loss insurance. [2007, c. 447, §11 (NEW).]

C. The Dirigo Health Reserve must be adjusted on a quarterly basis in order to maintain a reserve at least equal to the amount determined in paragraph B. [2007, c. 447, §11 (NEW).]

D. The Dirigo Health Reserve is capitalized by money from the Dirigo Health Enterprise Fund, as established pursuant to section 6915, and any other fund advanced for initial operating expenses, monthly enrollee payments, any funds received from any public or private source, legislative appropriations, payments from state departments and agencies and such other means as the Legislature may approve. All money in the Dirigo Health Reserve is deemed to be the commingled assets of all covered enrollees and may be used only for the purposes of this section. [2007, c. 447, §11 (NEW).]

[2007, c. 447, §11 (NEW) .]

12. **Stop loss insurance.** The board may purchase excess or stop loss insurance for the self-administered plan, with attachment levels and limits as recommended by a qualified actuary pursuant to subsection 5. If the board is unable to purchase excess or stop loss insurance at the recommended attachment levels and limits, the board does not have the authority to establish a self-administered plan as provided in this section.

[2007, c. 447, §11 (NEW) .]

13. **Marketing and distribution.** The board may contract for the marketing and distribution of the self-administered plan in accordance with the requirements of this subsection. Any entity or individual that contracts with the self-administered plan shall successfully complete all training offered by Dirigo Health for the solicitation, negotiation and sale of health benefits coverage. Training must be completed annually, and any certificate establishing successful completion of training is valid for one year from the date of issuance. If an entity or individual fails to obtain certification following the expiration of the prior year's certification, the entity or individual may not continue to solicit, negotiate and sell health benefits coverage under the self-administered plan.

[2007, c. 447, §11 (NEW) .]

14. **Provider reimbursement.** In any contract with a 3rd-party administrator, carrier or other organization to administer and provide health coverage to enrollees of the self-administered plan, the board shall ensure that:

A. Providers contracting to provide health coverage to plan enrollees are reimbursed at a rate comparable to current market reimbursement rates among commercial carriers in the State; [2007, c. 447, §11 (NEW).]

B. Providers contracting to provide health coverage to plan enrollees are paid in a timely manner in accordance with the same requirements that would be required under state law for health insurance carriers pursuant to section 2436; and [2007, c. 447, §11 (NEW).]

C. If the self-administered plan fails to pay for health care services as set forth in the contract, providers are governed by the standards required pursuant to section 4204, subsection 6. This paragraph does not prohibit a provider from collecting or attempting to collect from a plan enrollee any amount for services not normally payable to the self-administered plan, including any applicable copayments and deductibles. [2007, c. 447, §11 (NEW).]

[2007, c. 447, §11 (NEW) .]

15. **No liability for plan enrollees.** This section does not create any liability on the part of eligible employers, eligible employees or eligible individuals enrolled in Dirigo Health in the event that the self-administered plan becomes insolvent or fails to pay claims.

[2007, c. 447, §11 (NEW) .]

SECTION HISTORY
2007, c. 447, §11 (NEW). 2009, c. 369, Pt. A, §33 (AMD).

Chapter 89: PORTABLE ELECTRONIC DEVICE INSURANCE

§7001. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2011, c. 297, §5 (NEW).]

1. **Customer.** "Customer" means a person who purchases a portable electronic device or service.

[2011, c. 297, §5 (NEW) .]

2. **Enrolled customer.** "Enrolled customer" means a customer who elects coverage under a portable electronic device insurance policy issued to a vendor.

[2011, c. 297, §5 (NEW) .]

3. **Limited lines license.** "Limited lines license" means a license to sell or offer a policy for portable electronic device insurance.

[2011, c. 297, §5 (NEW) .]

4. **Location.** "Location" means any physical location in the State or any publicly accessible website, call center or similar operation directed to residents of the State.

[2011, c. 297, §5 (NEW) .]

5. **Portable electronic device.** "Portable electronic device" means an electronic device that is portable in nature, its accessories and services related to the use of the device.

[2011, c. 297, §5 (NEW) .]

6. **Portable electronic device insurance.** "Portable electronic device insurance" means insurance authorized under section 705 providing coverage for the repair or replacement of a portable electronic device that may cover a portable electronic device against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss. "Portable electronic device insurance" does not include:

A. A service contract or extended warranty providing coverage limited to the repair, replacement or maintenance of property for the operational or structural failure of property due to a defect in materials, workmanship, accidental damage from handling or normal wear and tear; [2011, c. 297, §5 (NEW).]

B. A policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or [2011, c. 297, §5 (NEW).]

C. Homeowner's or renter's insurance, private passenger automobile insurance, commercial multiple peril insurance or any similar policy. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

7. **Portable electronic device transaction.** "Portable electronic device transaction" means:

A. The sale or lease of a portable electronic device by a vendor to a customer; or [2011, c. 297, §5 (NEW).]

B. The sale of a service related to the use of a portable electronic device by a vendor to a customer. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

8. **Supervising entity.** "Supervising entity" means a business entity that is a licensed insurance producer or insurer.

[2011, c. 297, §5 (NEW) .]

9. **Vendor.** "Vendor" means a person in the business of engaging in portable electronic device transactions directly or indirectly.

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

§7002. LICENSURE OF VENDORS

1. **License required.** A vendor is required to hold a limited lines license under this chapter to sell or offer coverage under a policy of portable electronic device insurance.

[2011, c. 297, §5 (NEW) .]

2. **Authority provided by license.** A limited lines license issued under this chapter authorizes any employee or authorized representative of a vendor to sell or offer coverage under a policy of portable electronic device insurance to a customer at each location at which the vendor engages in portable electronic device transactions.

[2011, c. 297, §5 (NEW) .]

3. **List of locations.** In connection with a vendor's application for licensure and upon request by the superintendent, the vendor shall provide a list to the superintendent of all locations in this State at which the vendor offers coverage.

[2011, c. 297, §5 (NEW) .]

4. **Activities authorized by license.** Notwithstanding any other provision of law, a license issued pursuant to this chapter authorizes the licensee and its employees or authorized representatives to engage only in those activities that are expressly permitted in this chapter.

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

§7003. REQUIREMENTS FOR SALE OF PORTABLE ELECTRONIC DEVICE INSURANCE

1. **Brochures.** At every location where portable electronic device insurance is offered to customers, brochures or other written materials must be made available to a prospective customer that:

A. Disclose that portable electronic device insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of coverage; [2011, c. 297, §5 (NEW).]

B. State that the enrollment by the customer in a portable electronic device insurance policy is not required in order to purchase or lease a portable electronic device or service; [2011, c. 297, §5 (NEW).]

C. Summarize the material terms of the insurance coverage, including:

(1) The identity of the insurer;

(2) The identity of the supervising entity;

(3) The amount of any applicable deductible and how it is to be paid;

(4) Benefits of the coverage; and

(5) Key terms and conditions of coverage such as whether the portable electronic device may be replaced with a similar make and model or repaired using reconditioned or nonoriginal manufacturer parts or equipment; [2011, c. 297, §5 (NEW).]

D. Summarize the process for filing a claim, including a description of any requirements to return the portable electronic device and the maximum fee applicable if the customer fails to comply with any equipment return requirements; and [2011, c. 297, §5 (NEW).]

E. State that the customer may cancel enrollment for coverage under a portable electronic device insurance policy at any time and the person paying the premium must receive a refund of any applicable unearned premium. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

2. **Periodic basis of coverage.** Portable electronic device insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor under which individual customers may elect to enroll for coverage.

[2011, c. 297, §5 (NEW) .]

3. **Eligibility and underwriting standards.** Eligibility and underwriting standards for customers electing to enroll in coverage must be established by an insurer for each portable electronic device insurance program.

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

§7004. AUTHORITY OF VENDORS

1. **Requirements for employees and authorized representatives of vendors.** An employee or authorized representative of a vendor may sell or offer portable electronic device insurance to a customer and is not subject to licensure as an insurance producer under this chapter if:

A. The vendor obtains a limited lines license to authorize its employees or authorized representatives to sell or offer portable electronic device insurance pursuant to this section; [2011, c. 297, §5 (NEW).]

B. The insurer issuing the portable electronic device insurance either directly supervises or appoints a supervising entity to supervise the administration of the sale of insurance, including development of a training program for employees and authorized representatives of the vendors. The training required by this paragraph must comply with the following:

(1) The training must be delivered to all employees and authorized representatives of the vendor who are directly engaged in the activity of selling or offering portable electronic device insurance. The training may be provided in electronic form. If conducted in electronic form the supervising entity shall implement a supplemental education program that is conducted and overseen by licensed employees of the supervising entity to supplement the electronic training; and

(2) Each employee and authorized representative must receive basic instruction about the portable electronic device insurance offered to customers and the disclosures required under section 7003, subsection 1; and [2011, c. 297, §5 (NEW).]

C. The employee or authorized representative of the vendor does not advertise, represent or otherwise hold that employee or authorized representative out as a nonlimited lines licensed insurance producer. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

2. **Charges.** The charges for portable electronic device insurance coverage may be billed and collected by the vendor. Any charge to the customer for coverage that is not included in the cost associated with the purchase or lease of a portable electronic device or related services must be separately itemized on the customer's bill. If the portable electronic device insurance coverage is included with the purchase or lease of a portable electronic device or related services, the vendor shall clearly and conspicuously disclose to the customer that the portable electronic device insurance coverage is included with the portable electronic device or related services. A vendor billing and collecting charges for coverage is not required to maintain those funds in a segregated account as long as the vendor is authorized by the insurer to hold such funds in an alternative manner and remits the funds to the supervising entity within 60 days of receipt. All funds received by a vendor from a customer for the sale of portable electronic device insurance are considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. A vendor may receive compensation for billing and collection services.

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

§7005. VIOLATIONS

1. **Penalties.** If a vendor or its employee or authorized representative violates any provision of this chapter, the superintendent may enforce this chapter in accordance with section 12-A except the superintendent may not impose a fine exceeding $15,000 for aggregate conduct in violation of this chapter.

[2011, c. 297, §5 (NEW) .]

2. **Suspension or revocation.** In addition to any other penalties authorized by law, the superintendent may:

A. Suspend the authority of a vendor to transact portable electronic device insurance; [2011, c. 297, §5 (NEW).]

B. Suspend the authority of a vendor to transact portable electronic device insurance pursuant to this chapter at specific business locations where violations have occurred; and [2011, c. 297, §5 (NEW).]

C. Suspend or revoke the authority of an individual employee or authorized representative of a vendor to act under a limited lines license under section 7002, subsection 2. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

§7006. TERMINATION OF PORTABLE ELECTRONIC DEVICE INSURANCE

1. **Notice.** Notwithstanding any other provision of law, an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronic device insurance only upon providing the vendor policyholder and enrolled customers with at least 30 days' notice.

[2011, c. 297, §5 (NEW) .]

2. **Revised documents.** Notwithstanding any other provision of law, if the insurer changes the terms and conditions of a policy of portable electronic device insurance, the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate or endorsement, an updated brochure or other evidence indicating that a change in the terms and conditions has occurred and a summary of material changes.

[2011, c. 297, §5 (NEW) .]

3. **Notice in case of fraud or material misrepresentation.** Notwithstanding subsection 1 or any other provision of law, an insurer may upon 15 days' notice terminate an enrolled customer's enrollment under a portable electronic device insurance policy for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

[2011, c. 297, §5 (NEW) .]

4. **Immediate termination of enrollment allowed.** Notwithstanding subsection 1 or any other provision of law, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronic device insurance policy:

A. For nonpayment of premium; [2011, c. 297, §5 (NEW).]

B. If the enrolled customer ceases to have an active service with the vendor; or [2011, c. 297, §5 (NEW).]

C. If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronic device insurance policy and the insurer sends notice of termination to the customer within 30 calendar days after exhaustion of the limit. If this notice is not timely sent, enrollment must continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

5. **Policy terminated by vendor policyholder.** Notwithstanding any other provision of law, when a portable electronic device insurance policy is terminated by a vendor policyholder, the vendor policyholder shall mail or deliver written notice to each enrolled customer advising the customer of the termination of the policy and the effective date of termination. The written notice must be mailed or delivered to the customer at least 30 days prior to the termination.

[2011, c. 297, §5 (NEW) .]

6. **Method of notice.** Notwithstanding any other provision of law, whenever notice is required pursuant to this section, it must be in writing and may be mailed or delivered to the vendor at the vendor's mailing address and to the vendor's affected enrolled customers at the last known mailing addresses on file with the insurer. If notice is mailed, the insurer or vendor, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. Alternatively, an insurer or vendor policyholder may comply with any notice required by this section by providing notice to a vendor or its affected enrolled customers, as the case may be, by electronic means. If notice is accomplished through electronic means, the insurer or vendor, as the case may be, shall maintain proof that the notice was sent.

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

§7007. APPLICATION FOR LICENSE AND FEES

1. **Application for license to be filed with superintendent.** A sworn application for a license under this chapter must be made to and filed with the superintendent on forms prescribed and furnished by the superintendent.

[2011, c. 297, §5 (NEW) .]

2. **Contents of application.** In addition to other information required by the superintendent, the application must:

A. Provide the name, residence address and other information required by the superintendent for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter. If the vendor derives more than 50% of its revenue from the sale of portable electronic device insurance, the information specified in this paragraph must be provided for all officers, directors and shareholders of record having beneficial ownership of 10% or more of any class of securities registered under the federal securities laws; [2011, c. 297, §5 (NEW).]

B. Appoint the superintendent as the applicant's attorney to receive service of all legal process issued against it in any civil action or proceeding in this State and agree that process so served is valid and binding against the applicant. The appointment is irrevocable, binds the company and any successor in interest as well as the assets or liabilities of the applicant and must remain in effect as long as the applicant's license remains in force in this State; and [2011, c. 297, §5 (NEW).]

C. Provide the location of the applicant's home office. [2011, c. 297, §5 (NEW).]

[2011, c. 297, §5 (NEW) .]

3. **Time of application.** An application for licensure under this chapter must be made within 90 days of the application being made available by the superintendent.

[2011, c. 297, §5 (NEW) .]

4. **Initial license valid for 24 months.** An initial license issued pursuant to this chapter is valid for 24 months and expires on the last day of the 24th month.

[2011, c. 297, §5 (NEW) .]

5. **Fee.** Each vendor licensed under this chapter shall pay to the superintendent a fee as prescribed by section 601, subsection 29.

[2011, c. 297, §5 (NEW) .]

SECTION HISTORY
2011, c. 297, §5 (NEW).

Chapter 91: SERVICE CONTRACTS

§7101. SHORT TITLE; PURPOSE; SCOPE

1. **Short title.** This chapter may be known and cited as "the Service Contracts Act."

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Purpose.** The purpose of this chapter is to create a legal framework within which service contracts may be sold in this State.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

3. **Exclusions.** The following types of service contracts are exempt from the provisions of this Title, including the other provisions of this chapter:

A. Warranties; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. Maintenance agreements; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

C. Warranties, service contracts or maintenance agreements offered by public utilities on their transmission devices to the extent they are regulated by the Public Utilities Commission; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

D. Service contracts sold or offered for sale to persons other than consumers; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

E. Service contracts on tangible personal property when the tangible personal property for which the service contract is sold has a purchase price of $100 or less, exclusive of sales tax; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

F. Road or tourist service contracts under section 3, subsection 2; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

G. Home service contracts under section 3, subsection 3; and [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

H. Warranties, service contracts and maintenance agreements that are conditioned upon or otherwise associated with the sale or supply of heating fuel. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

4. **Limited exclusions.** The application of this chapter to the following is limited as follows.

A. Service contracts under which a motor vehicle dealer licensed pursuant to Title 29-A, chapter 9 is obligated to perform and that are sold in connection with the sale or service of a motor vehicle as defined in Title 29-A, section 101, subsection 42 are exempt from the requirements of section 7103, subsection 5 but must comply with all other requirements of this chapter. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. A motor vehicle manufacturer's service contracts on the motor vehicle manufacturer's products must comply only with section 7103, subsection 7; section 7105, subsection 1 and subsections 4 to 13; section 7109; and section 7110, as applicable. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

The types of agreements referred to in subsections 3 and 4 and service contracts governed by this chapter are not insurance and are not required to comply with any provision of the insurance laws of this State other than as expressly made applicable in this chapter as long as the service contract provider and administrator have registered with the superintendent as required by section 7103, subsection 4.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7102. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

1. **Administrator.** "Administrator" means the person who is responsible for the administration of a service contract program or who is responsible for any submission required by this chapter.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Consumer.** "Consumer" means an individual who buys other than for purposes of resale any tangible personal property that is distributed in commerce and that is normally used for personal, family or household purposes and not for business or research purposes.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

3. **Maintenance agreement.** "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance only and does not include repair or replacement.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

4. **Motor vehicle manufacturer.** "Motor vehicle manufacturer" means a person that:

A. Manufactures or produces motor vehicles and sells motor vehicles under its own name or label; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. Is a wholly owned subsidiary of a person that manufactures or produces motor vehicles; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

C. Is a corporation that owns 100% of a person that manufactures or produces motor vehicles; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

D. Sells motor vehicles under the trade name or label of another person that manufactures or produces motor vehicles; or [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

E. Does not manufacture or produce motor vehicles but, pursuant to a written contract, licenses the use of its trade name or label to another person that manufactures or produces motor vehicles and that sells motor vehicles under the licensor's trade name or label. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

5. **Nonoriginal manufacturer's parts.** "Nonoriginal manufacturer's parts" means replacement parts not made for or by the original manufacturer of the property, commonly referred to as "aftermarket parts."

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

6. **Person.** "Person" means an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, reciprocal, syndicate or any similar entity or combination of entities acting in concert.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

7. **Premium.** "Premium" means the consideration paid to an insurer for a reimbursement insurance policy.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

8. **Provider.** "Provider" means a person who is contractually obligated to a service contract holder under the terms of a service contract.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

9. **Provider fee.** "Provider fee" means the consideration paid for a service contract.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

10. **Reimbursement insurance policy.** "Reimbursement insurance policy" means a policy of insurance, issued to a provider, that provides reimbursement to the provider under the terms of the insured service contracts issued or sold by the provider or, in the event of the provider's nonperformance, pays to service contract holders on behalf of the provider all covered contractual obligations incurred by the provider under the terms of the insured service contracts issued or sold by the provider.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

11. **Service contract.** "Service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement or maintenance of property or to indemnify for the repair, replacement or maintenance for an operational or structural failure of any motor vehicle or other property due to a defect in materials or workmanship or normal wear and tear, with or without additional provisions for incidental payment of indemnity under limited circumstances, including, but not limited to, towing, rental and emergency road service and road hazard protection. Coverage issued by an authorized insurance company pursuant to a personal automobile insurance policy for payment of towing, rental, emergency road service or automobile mechanical breakdown is not a service contract. Service contracts may provide for the repair, replacement or maintenance of property for damage resulting from power surges or interruption. "Service contract" includes a contract or agreement sold for a separately stated consideration for a specific duration that provides for any of the following:

A. The repair or replacement or indemnification for the repair or replacement of a motor vehicle for the operational or structural failure of one or more parts or systems of the motor vehicle brought about by the failure of an additive product to perform as represented; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. The repair or replacement of tires or wheels on a motor vehicle damaged as a result of coming into contact with road hazards, including, but not limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs or composite scraps; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

C. The removal of dents, dings or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding or painting; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

D. The repair of small motor vehicle windshield chips or cracks but not the replacement of the entire windshield; or [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

E. The repair of damage to the interior components of a motor vehicle caused by wear and tear but that expressly excludes the replacement of any part or component of a motor vehicle's interior. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

Notwithstanding any other provision of law, service contracts are not insurance in this State and may not be regulated as insurance except for a contract or agreement providing indemnification for a loss caused by misplacement, theft, collision, fire or other peril typically covered in the comprehensive section of an automobile insurance policy or by a homeowner's policy or a marine or inland marine policy.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

12. **Service contract holder.** "Service contract holder" means a person who is the purchaser or holder of a service contract.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

13. **Superintendent.** "Superintendent" means the Superintendent of Insurance.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

14. **Tangible net worth.** "Tangible net worth" means equity less assets that have no physical existence and depend on expected future benefits for their ascribed value.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

15. **Warranty.** "Warranty" means a warranty made solely by the manufacturer, importer or seller of property or services without consideration that is not negotiated or separated from the sale of the product and is incidental to the sale of the product and that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor or other remedial measures, such as repair or replacement of the property or repetition of services.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7103. REQUIREMENTS FOR DOING BUSINESS

1. **Administrator.** A provider may, but is not required to, appoint an administrator or other designee to be responsible for any or all of the administration of the provider's service contracts and compliance with this chapter. All administrators of service contracts sold in this State shall register with the superintendent as provided in this section.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Provision of receipt and copy of contract.** A service contract may not be issued, sold or offered for sale in this State unless the provider has:

A. Registered with the superintendent pursuant to this section; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. Provided a receipt for, or other written evidence of, the purchase of the service contract to the service contract holder; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

C. Provided a copy of the service contract to the service contract holder within a reasonable period of time from the date of purchase; and [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

D. Complied with the provisions of this chapter. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

3. **Sample copy before sale.** A provider shall make a complete sample copy of the service contract terms and conditions available for inspection by a consumer prior to the time of sale.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

4. **Registration.** A provider or administrator of service contracts issued, sold or offered for sale in this State shall apply for registration with the superintendent on a form prescribed by the superintendent, providing the registrant's name, full business address, telephone number and contact person and designating an agent in this State for service of process. The registration must be updated by written notification to the superintendent if changes occur in the registration on file.

A. The registrant shall pay to the superintendent a fee as set forth in section 601, subsection 30 upon initial registration and every year thereafter. [2011, c. 1, §44 (COR).]

B. A registrant whose registration has terminated shall send notice within 15 days as follows:

(1) To all in-force service contract holders, if the registrant is a provider. Such registrant shall also cease issuing new service contracts in this State and may not renew existing service contracts unless authorized by the terms of a run-off plan approved by the superintendent; and

(2) To all providers for which it acts as an administrator, and to all in-force service contract holders of those providers, if the registrant is an administrator. Such registrant shall also cease acting as an administrator as to all service contract programs that it has contracted for in this State. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

This section may not be construed to require a provider or administrator to apply for and obtain a license under chapter 16, subchapter 2-A.

[2011, c. 1, §44 (COR) .]

5. **Provider's obligations.** To ensure the performance of the provider's obligations to its service contract holders, the provider shall either:

A. Insure all service contracts under a reimbursement insurance policy filed with the superintendent and issued by an insurer authorized to transact casualty insurance in this State, purchased through a risk retention group registered with the superintendent, or issued pursuant to chapter 19 by an eligible surplus lines insurer that agrees in writing to comply with the terms of this chapter and to submit to the jurisdiction of the superintendent for purposes of enforcing this chapter, as long as such insurer or risk retention group either:

(1) At the time the policy is filed with the superintendent and continuously thereafter:

(a) Maintains surplus as to policyholders and paid-in capital of at least $15,000,000; and

(b) Files annually copies of the insurer's or risk retention group's as audited financial statements, its annual statement under section 423 and the actuarial certification required by and filed in the insurer's state of domicile; or

(2) At the time the policy is filed with the superintendent and continuously thereafter:

(a) Maintains surplus as to policyholders and paid-in capital of at least $10,000,000;

(b) Demonstrates to the satisfaction of the superintendent that the insurer maintains a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than 3 to 1; and

(c) Files annually copies of the insurer's audited financial statements, its annual statement under section 423 and the actuarial certification required by and filed in the insurer's state of domicile; or [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. Maintains, or together with its parent company maintains, a tangible net worth of at least $100,000,000 and upon request provides the superintendent with a copy of the provider's or, if the provider's financial statements are consolidated with those of its parent company, the provider's parent company's most recent Form 10-K or Form 20-F annual report filed with the United States Securities and Exchange Commission within the last calendar year or, if the company does not file with the United States Securities and Exchange Commission, a copy of the company's audited financial statements that shows a tangible net worth of the provider or its parent company of at least $100,000,000. If the provider's parent company's Form 10-K or Form 20-F annual report or financial statements are filed to meet the provider's financial stability requirement, the parent company shall agree, on a form approved by the superintendent, to guarantee the obligations of the provider relating to service contracts sold by the provider in this State. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

6. **Other financial security requirements.** Except for the requirements specified in subsections 4 and 5, other financial security requirements may not be required by the superintendent for providers.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

7. **Return of service contract.** A service contract must require the provider to permit the service contract holder to return the service contract subject to the following conditions.

A. A service contract holder may return a service contract within 20 days of the date the service contract was mailed to the service contract holder or within 10 days of delivery if the service contract is delivered to the service contract holder at the time of sale or within a longer time period permitted under the service contract. Upon return of the service contract to the provider within the applicable time period, if no claim has been made under the service contract prior to its return to the provider, the service contract is void and the provider shall refund to the service contract holder or lienholder if the service contract holder has financed the purchase of the service contract the full provider fee and any sales tax refund required pursuant to state law. The right to void the service contract provided in this subsection is not transferable and applies only to the original service contract purchaser and only if no claim has been made prior to its return to the provider. A monthly penalty equal to 10% of the provider fee outstanding must be added to a refund that is not paid or credited within 45 days after return of the service contract to the provider. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. After the time period specified in paragraph A for returning a service contract or if a claim has been made under the service contract within that time period, a service contract holder may cancel the service contract and the provider shall refund to the service contract holder 100% of the unearned pro rata provider fee, less any claims paid. An administrative fee not to exceed 10% of the provider fee paid by the service contract holder may be charged by the provider. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

8. **Premium taxes.** Insurance premium taxes under Title 36, chapter 357 apply as follows.

A. Provider fees collected on service contracts are not subject to premium taxes. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. Premiums for reimbursement insurance policies are subject to premium taxes. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

9. **Licensing exemption.** Except for the registration requirements in subsection 4, a license or registration is not required under this Title to provide, administer, market, sell or offer to sell service contracts in this State.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

10. **Insurance laws exemption.** The marketing, sale, offering for sale, issuance, making, proposing to make and administration of service contracts by providers and related service contract sellers, administrators and other persons are exempt from all provisions of the State's insurance laws, except as specified in this chapter, as long as a service contract provider or administrator has registered with the superintendent as required by subsection 4. Reimbursement insurance policies are subject to all relevant provisions of this Title to the full extent consistent with this chapter.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
RR 2011, c. 1, §44 (COR). 2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7104. REIMBURSEMENT INSURANCE POLICY

1. **Scope of policy.** A reimbursement insurance policy insuring service contracts issued, sold or offered for sale in this State must unconditionally obligate the insurer that issued the reimbursement insurance policy to reimburse or pay on behalf of the provider any sums, including the refund of unearned provider fees, the provider is legally obligated to pay directly to the service contract holder or, in the event of the provider's nonperformance, to provide the service that the provider is legally obligated to perform according to the provider's contractual obligations under the service contracts issued or sold by the provider.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Application to insurer.** A reimbursement insurance policy must provide that if a covered service is not provided by the provider within 60 days of proof of loss by a service contract holder, or unearned provider fees are not returned within 60 days of a valid refund request, the service contract holder may apply directly to the reimbursement insurance company for reimbursement or performance.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7105. REQUIRED PROVISIONS; SERVICE CONTRACTS

1. **Form; language.** A service contract marketed, sold, offered for sale, issued, made, proposed to be made or administered in this State must be written, printed or typed in clear and understandable language that is in a font size that is easily readable by a person with average eyesight and must conspicuously disclose the requirements set forth in this section, as applicable. A provider may comply with the font size requirement of this subsection by directing the consumer to a publicly accessible website containing a complete sample of terms and conditions of the service contract.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Notice of reimbursement insurance policy.** A service contract insured under a reimbursement insurance policy pursuant to section 7103 must contain a statement in substantially the following form: "Obligations of the provider under this service contract are insured under a service contract reimbursement

insurance policy. If the provider fails to pay or provide service on a claim, including any claim for the return of the unearned portion of the provider fee, within 60 days after proof of loss has been filed, the contract holder is entitled to make a claim directly against the insurance company." The service contract must also state the name and address of the insurer.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

3. **Notice when no reimbursement insurance policy.** A service contract not insured under a reimbursement insurance policy pursuant to section 7103 must contain a statement in substantially the following form: "Obligations of the provider under this service contract are backed by the full faith and credit of the provider and are not guaranteed under a service contract reimbursement insurance policy."

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

4. **Contact information.** A service contract must state the name and address of the provider, the service contract seller and the administrator if different than the provider. A service contract must state the service contract holder's name and address to the extent furnished by the service contract holder. The identities of the service contract seller and service contract holder, to the extent furnished by the service contract holder, are not required to be preprinted on the service contract but may be added to the service contract at the time of sale.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

5. **Purchase price and terms.** A service contract must state the total purchase price of the service contract and the terms under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale with the service contract holder.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

6. **Prior approval.** A service contract must conspicuously state the procedure for obtaining prior approval for repair work when prior approval is required and for making a claim, including a toll-free telephone number for claim service and a procedure for obtaining emergency repairs performed outside of normal business hours.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

7. **Deductible amount.** A service contract must conspicuously state the existence of any deductible amount, if applicable.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

8. **Merchandise and services to be provided.** A service contract must specify the merchandise and services to be provided and any limitations, exceptions or exclusions.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

9. **Nonoriginal manufacturer's parts.** A service contract covering a motor vehicle must state whether the use of nonoriginal manufacturer's parts is allowed.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

10. **Transferability.** A service contract must state any restrictions governing the transferability of the service contract, if applicable.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

11. **Cancellation.** A service contract must state the terms, restrictions or conditions governing cancellation of the service contract prior to the termination or expiration date of the service contract by either the provider or the service contract holder. The provider of the service contract shall mail a written notice to the service contract holder at the last known address of the service contract holder contained in the records of the provider at least 15 days prior to cancellation by the provider. The notice must state the effective date of the cancellation and the reason for the cancellation. If a service contract is cancelled by the provider for a reason other than nonpayment of the provider fee, the provider shall refund to the service contract holder 100% of the unearned pro rata provider fee, less any claims paid. An administrative fee not to exceed 10% of the provider fee paid by the service contract holder may be charged by the provider.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

12. **Obligations and duties.** A service contract must set forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage and any requirement to follow instructions in the owner's manual.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

13. **Consequential damages.** A service contract must state whether the service contract provides for or excludes consequential damages or preexisting conditions, if applicable. A service contract may, but is not required to, cover damage resulting from rust, corrosion or damage caused by a noncovered part or system.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7106. RECORD-KEEPING REQUIREMENTS

1. **Provider records.** A provider shall keep accurate accounts, books and records concerning transactions regulated under this chapter. The provider's accounts, books and records must include the following:

A. Copies of each type of service contract sold; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. The name and address of each service contract holder to the extent furnished by the service contract holder; [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

C. A list of the locations where service contracts are marketed, sold or offered for sale by the provider; and [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

D. Written claims files, which must contain at least the dates and descriptions of claims related to the provider's service contracts. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Retention period.** Except as provided in subsection 4, a provider shall retain all records required to be maintained by this section for at least 3 years after the specified period of coverage has expired.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

3. **Form of records.** The records required under this chapter may be, but are not required to be, maintained on a computer disk or other record-keeping medium. If the records are maintained in other than hard copy, the records must be capable of transfer to legible hard copy at the request of the superintendent.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

4. **Discontinuation of business.** A provider discontinuing business in this State shall maintain its records until it furnishes to the superintendent satisfactory proof that it has discharged all obligations to service contract holders in this State.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7107. CANCELLATION OF REIMBURSEMENT INSURANCE POLICY

An insurer that issued a reimbursement insurance policy may not cancel or nonrenew the policy for any reason, including at the request of the policyholder, until the insurer has delivered a notice of such action to the superintendent at least 45 days before such action. The cancellation or nonrenewal of a reimbursement insurance policy does not reduce the insurer's obligations as to service contracts issued by providers prior to the date of cancellation or nonrenewal. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7108. OBLIGATION OF REIMBURSEMENT INSURANCE POLICY INSURERS

1. **Receipt of premium; agency.** A provider is the agent of the insurer that issued the reimbursement insurance policy for purposes of obligating the insurer to service contract holders in accordance with the service contract and this chapter. When a provider is acting as an administrator and enlists other providers, the provider acting as the administrator shall notify the insurer of the existence and identities of the other providers. An insurer issuing a reimbursement insurance policy to a provider is deemed to have received the premiums for such insurance upon the payment of provider fees by consumers for service contracts issued by the insured provider.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Indemnification or subrogation.** This chapter does not prevent or limit the right of an insurer that issued a reimbursement insurance policy to seek indemnification or subrogation against a provider if the insurer pays or is obligated to pay the service contract holder sums that the provider was obligated to pay pursuant to the provisions of the service contract.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7109. ENFORCEMENT PROVISIONS

1. **Investigation and examination by superintendent.** The superintendent may conduct investigations and examinations of providers, administrators, insurers or other persons to enforce the provisions of this chapter and protect service contract holders. Upon request of the superintendent, a person subject to this chapter shall make available to the superintendent all accounts, books and records concerning service contracts sold by the provider that are necessary to enable the superintendent to determine compliance or noncompliance with this chapter.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Enforcement actions.** The superintendent may assess civil penalties or take any other action permitted under section 12-A against any person who violates any provision of this chapter or the superintendent's rules and orders, and nothing in this section may be construed as limiting the superintendent's authority to take enforcement action under section 12-A in connection with violations of applicable provisions of this Title.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

3. **Refusal of registration, suspension or revocation.** The superintendent may suspend, revoke or refuse to accept the registration of a provider under this chapter as set out in this section.

A. The superintendent shall deny an application for registration if the registrant has not demonstrated that it is qualified to do business in accordance with this chapter or for any reason that would be a ground for suspension or revocation of registration. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. If, upon investigation or examination, the superintendent finds that a person registered under this chapter in this State has exceeded its powers, has failed to comply with any of the provisions of this chapter, is not fulfilling its service contracts in good faith or is conducting its business fraudulently or in a manner injurious to its contract holders or the public, the superintendent shall notify the person of the deficiency or deficiencies and state in writing the reasons that warrant suspension, revocation or refusal of the person's registration. The notice must require that the deficiency or deficiencies be corrected.

After receipt of the notice, the person has 30 days to comply with the superintendent's request for correction, and if the person fails to comply the superintendent shall notify the person of the findings of noncompliance and require the person to show cause, on a date set by the superintendent, why its registration should not be suspended, revoked or refused. If on that date the person does not present good and sufficient reason why its authority to do business in this State should not be suspended, revoked or refused, the superintendent may suspend or refuse the registration of the person to do business in this State until satisfactory evidence is furnished to the superintendent that the suspension or refusal should be withdrawn or the superintendent may revoke the authority of the person to do business in this State. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

4. **Service of process.** A provider and administrator registered under this chapter shall appoint in writing an agent located in the State in the same manner as insurers are required to appoint agents under section 421.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

5. **Administrative procedures.** Any person aggrieved by an order of the superintendent under this chapter may submit an application for a hearing as provided in section 229, upon which the procedures set forth in section 229 apply.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

6. **Construction; existing contracts.** This section may not be construed as preventing any provider from continuing in good faith all service contracts made in this State during the time the provider was legally authorized to transact business in this State.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7110. UNFAIR METHODS OF COMPETITION; UNFAIR AND DECEPTIVE ACTS AND PRACTICES

1. **Prohibited acts and practices.** A person may not engage in this State in any act or practice determined by the superintendent to be unfair or deceptive or in any of the following acts or practices in connection with the marketing, sale, offering for sale, issuance, making, proposing to make or administration or solicitation of a service contract.

A. A person may not make, issue, circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any service contract issued or to be issued or the benefits or advantages promised thereby or make any misleading representation or any misrepresentation as to the financial condition of any provider. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

B. A person may not make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication or on a business card, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of service contracts or with respect to any person in the conduct of that person's service contract business in a manner that is untrue, deceptive or misleading. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

C. A person may not file with any supervisory or other public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, delivered to any person or placed before the public, any false statement of financial condition of a provider with intent to deceive. A person may not make any false entry in any book, report or statement of any provider with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such person is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omit to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such provider. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

D. A person may not engage in any of the following service contract claims practices in conscious disregard of this section and any rules adopted under this section or with such frequency as to indicate a general business practice of the person to engage in such conduct:

(1) Knowingly misrepresenting to service contract holders relevant facts or service contract provisions related to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent written communications with respect to claims arising under its service contracts;

(3) Failing to develop and maintain documented claim files supporting decisions made regarding liability;

(4) Refusing to pay claims without conducting a reasonable investigation;

(5) Failing, in the case of claims denials, to provide an accurate explanation of the basis for those actions; or

(6) Failing to adopt and implement reasonable standards to ensure that the repairs of a repairer owned by or required to be used by the provider are performed in a competent and professional manner. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

E. A provider may not use in its name the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or use a name deceptively similar to the name or description of any insurance or surety corporation or to the name of any other provider. The word "guaranty" or a similar word may be used by a provider. This section does not apply to a

provider that was using any of the prohibited language in its name prior to January 1, 2012; however, such provider must include in its service contracts a statement in substantially the following form: "This agreement is not subject to regulation as an insurance contract." [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

F. A person, including but not limited to a bank, savings and loan association, lending institution, manufacturer or seller of any product may not require the purchase of a service contract as a condition of a loan or a condition for the sale of any property. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

G. A provider of a service contract on a motor vehicle or its representative may not, directly or indirectly, represent in any manner, whether by written solicitation or telemarketing, a false, deceptive or misleading statement with respect to:

(1) The provider's affiliation with a motor vehicle manufacturer;

(2) The provider's possession of information regarding a motor vehicle owner's current motor vehicle manufacturer's original equipment warranty;

(3) The expiration of a motor vehicle owner's current motor vehicle manufacturer's original equipment warranty; or

(4) A requirement that a motor vehicle owner register for a new motor vehicle service contract with the provider in order to maintain coverage under the motor vehicle owner's current motor vehicle service contract or manufacturer's original equipment warranty. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

2. **Cease and desist order.** The superintendent may issue a cease and desist order pursuant to section 12-A, subsection 2 if, after a hearing, the superintendent finds that any person in the State has engaged or is engaging, or that a resident of the State has engaged or is engaging in another state, in an unfair or deceptive practice not described in this chapter or in rules adopted pursuant to this chapter. For any practice not described in this chapter or in rules adopted pursuant to this chapter, the civil penalties set forth in section 12-A, subsection 1 may not be imposed for practice engaged in prior to the issuance and service of a valid cease and desist order.

[2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF) .]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7111. RULE-MAKING AUTHORITY

The superintendent may adopt rules necessary to implement this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

§7112. TRANSITION

The exemptions in section 7101, subsection 3 are effective immediately upon the effective date of this chapter and extend to contracts that are already in force. All other service contracts entered into, renewed or offered for sale in this State on or after January 1, 2012 must comply with this chapter. The exemptions in section 7101, subsection 4 apply to all service contracts entered into, renewed or offered for sale on or after the provider's registration date. [2011, c. 345, §4 (NEW); 2011, c. 345, §7 (AFF).]

SECTION HISTORY
2011, c. 345, §4 (NEW). 2011, c. 345, §7 (AFF).

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