

PLEASE NOTE: Legislative Information **cannot** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

An Act To Reform Maine's Health Insurance Laws

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

PART A

Sec. A-1. 24-A MRS §2736-C, sub-§2, ¶D, as amended by PL 2007, c. 629, Pt. A, §4, is further amended to read:

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

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between December 1, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and ~~June 30, 2009~~ December 31, 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 on or after July 1, 2009, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2.5 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period. For purposes of this subparagraph, "rating tier" means each category of individual or family composition for which a carrier charges separate rates.~~

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

~~(b) In determining rating factors for age and geographic area pursuant to this subparagraph, no resulting rates, taking into account the savings resulting from the reinsurance program created by chapter 54, may exceed the rates that would have resulted from using projected claims and expenses and the rating factors applicable prior to July 1, 2009, as determined without taking into account the savings resulting from the Maine Individual Reinsurance Association established in chapter 54.~~

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

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2012, the maximum rate differential filed by the carrier as determined by ratio is 4:1. The limitation does not apply for determining rates for an attained age of less than 19 years or more than 65 years.

(6) A variation in rate is not permitted on the basis of changes in health status after a policy, contract or certificate is issued or renewed.

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

Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶I is enacted to read:

I. A carrier that offered individual health plans prior to January 1, 2012 may close its individual book of business sold prior to January 1, 2012 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after January 1, 2012.

Sec. A-4. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §4 and affected by §10, is further amended to read:

D. A carrier may vary the premium rate due to age, health status, occupation or industry and geographic area only under the following schedule and within the listed percentage bands.

(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 ~~after~~between July 15, 1995 and December 31, 2011, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%; ~~except as provided in paragraph D-1.~~

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2012, the maximum rate differential filed by the carrier as determined by ratio is 4:1. The limitation does not apply for determining rates for an attained age of less than 19 years or more than 65 years.

(5) A variation in rate is not permitted on the basis of changes in health status after a policy, contract or certificate is issued or renewed.

Sec. A-5. 24-A MRSA §2808-B, sub-§2, ¶D-1, as amended by PL 2001, c. 410, Pt. A, §5 and affected by §10, is repealed.

Sec. A-6. 24-A MRSA §2808-B, sub-§2, ¶H is enacted to read:

H. A carrier that offered small group health plans prior to January 1, 2012 may close its small group book of business sold prior to January 1, 2012 and may establish a separate community rate for small groups applying for coverage under a small group health plan on or after January 1, 2012.

PART B

Sec. B-1. 5 MRSA §12004-G, sub-§14-F, as enacted by PL 2007, c. 629, Pt. A, §1, is repealed.

Sec. B-2. 24-A MRSA §423-E, as enacted by PL 2007, c. 629, Pt. A, §2, is repealed.

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

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

Sec. B-4. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §1 and affected by §10, is further amended to read:

C. A carrier may vary the premium rate due to ~~smoking status~~ and family membership. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts based on smoking status. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter H-A.

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

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

Sec. B-7. 24-A MRSA §2736-C, sub-§3, as corrected by RR 2001, c. 1, §30, is amended to read:

3. Guaranteed issuance and guaranteed renewal. Carriers providing individual health plans must offer all health plans approved by the Maine High-risk Reinsurance Pool Association pursuant to section 3958, subsection 1 as a condition of offering individual health plans in this State. Carriers must meet the following requirements on issuance and renewal.

A. Coverage issued through the Maine High-risk Reinsurance Pool Association established pursuant to chapter 54-A must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A. On or after January 1, 1998, such coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, such coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

(1) Deny coverage to individuals who neither live nor reside within the approved service area of the plan for at least 6 months of each year; and

(2) Deny coverage to individuals if the carrier has demonstrated to the superintendent's satisfaction that:

(a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and

(b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this paragraph may not enroll individuals residing within the area subject to denial of coverage or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage.

B. Renewal is guaranteed, pursuant to section 2850-B.

C. A carrier is exempt from the guaranteed issuance requirements of paragraph A provided that the following requirements are met.

(1) The carrier does not issue or deliver any new individual health plans on or after the effective date of this section;

(2) If any individual health plans that were not issued on a guaranteed renewable basis are renewed on or after December 1, 1993, all such policies must be renewed by the carrier and renewal must be guaranteed after the first such renewal date; and

(3) The carrier complies with the rating practices requirements of subsection 2.

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage.

E. An individual may not be denied health insurance due to age or gender. This paragraph may not be construed to require a carrier to actively market health insurance to an individual 65 years of age or older.

Sec. B-8. 24-A MRS §2808-B, sub-§2, ¶B, as amended by PL 1993, c. 477, Pt. B, §1 and affected by Pt. F, §1, is further amended to read:

B. A carrier may not vary the premium rate due to the gender, ~~health status~~, claims experience or policy duration of the eligible group or members of the group.

Sec. B-9. 24-A MRS §2808-B, sub-§4, ¶A, as corrected by RR 2001, c. 1, §32, is amended to read:

A. Carriers offering small group health plans must offer any health plans issued through the Maine High-risk Reinsurance Pool Association established pursuant to chapter 54-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.

Sec. B-10. 24-A MRSA §2808-B, sub-§9, as enacted by PL 1993, c. 325, §1, is repealed.

Sec. B-11. 24-A MRSA §2848, sub-§1-B, ¶A, as amended by PL 1999, c. 256, Pt. L, §2, is further amended to read:

A. "Federally creditable coverage" means health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonelecting church plan" exceptions, if the plan provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier;

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act or a state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e); or

(11) Insurance coverage offered by the Maine High-risk Reinsurance Pool Association pursuant to chapter 54-A.

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

A. That person was covered under ~~an individual,~~ a group or blanket contract or policy issued by a nonprofit hospital or medical service organization, insurer, or health maintenance organization or was covered under an uninsured employee benefit plan that provides payment for health services received by employees and their dependents or a governmental program, including, but not limited to, those listed in section 2848, subsection 1-B, paragraph A, subparagraphs (3) to ~~(10)~~(11). For purposes of this section, the individual, group or blanket policy under which the person is seeking coverage is the "succeeding policy." The group, or blanket or individual contract or policy, uninsured employee benefit plan or governmental program that previously covered the person is the "prior contract or policy"; and

Sec. B-13. 24-A MRSA c. 54, as amended, is repealed.

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

CHAPTER 54-A

MAINE HIGH-RISK REINSURANCE POOL ASSOCIATION

§ 3951. Short title

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

§ 3952. Definitions

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

1. Association. "Association" means the Maine High-risk Reinsurance Pool Association established in section 3953.

2. Board. "Board" means the board of directors of the association under section 3953, subsection 2.

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

A. Is eligible to receive benefits from an insurer;

B. Is eligible for benefits under the federal Health Insurance Portability and Accountability Act of 1996; or

C. Has been certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002.

4. Dependent. "Dependent" means a resident spouse, a domestic partner as defined in section 2832-A, subsection 1, a resident unmarried child under 19 years of age, a child who is a student under 23 years of age and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

5. Health maintenance organization. "Health maintenance organization" means an organization authorized under chapter 56 to operate a health maintenance organization in this State.

6. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. 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-insurance arrangement that provides health care benefits in this State to the extent allowed under the federal Employee Retirement Income Security Act of 1974, a 3rd-party administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in this State or the Dirigo Health Program established in chapter 87 or any other state-sponsored health benefit program whether fully insured or self-funded.

7. Medical insurance. "Medical insurance" means a hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

11. Reinsurer. "Reinsurer" means an insurer from whom a person providing health insurance for a resident procures insurance for itself with the insurer with respect to all or part of the medical insurance risk of the person. "Reinsurer" includes an insurer that provides employee benefits excess insurance.

12. Resident. "Resident" means an individual who:

A. Is legally located in the United States and has been legally domiciled in this State for a period to be established by the board, not to exceed one year, subject to the approval of the superintendent;

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

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

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

§ 3953. Maine High-risk Reinsurance Pool Association

1. Risk pool established. The Maine High-risk Reinsurance Pool Association is established as a nonprofit legal entity. As a condition of doing business, an insurer that has sold medical insurance within the previous 12 months or is actively marketing a medical insurance policy in this State must participate in the association. The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association.

2. Board of directors. The association is governed by a board of directors.

A. The board consists of 11 members appointed as described in this paragraph:

(1) Six members appointed by the superintendent: 2 members chosen from the general public and who are not associated with the medical profession, a hospital or an insurer; 2 members who represent medical providers; one member who represents a statewide organization that represents small businesses and that receives a majority of its funding from small businesses located in this State; and one member who represents producers. A board member appointed by the superintendent may be removed at any time without cause; and

(2) Five members appointed by the member insurers, at least 2 of whom are domestic insurers and at least one of whom is a 3rd-party administrator.

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

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

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

3. Plan of operation; 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.

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.

§ 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.

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

§ 3955. Duties and powers of association

1. Duties. The association shall:

A. Establish administrative and accounting procedures for the operation of the association;

B. Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board;

C. Select a plan administrator in accordance with section 3956;

D. 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. Organizational assessments must be equal in amount for all insurers but may not exceed \$500 per insurer for all such assessments. Assessments are due and payable within 30 days of receipt of the assessment notice by the insurer;

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

F. Comply with all reserve requirements and solvency requirements applicable to insurers that offer fully insured products in the event that the association offers a self-funded health plan; and

G. Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan and the procedures for enrollment in the plan and to maintain public awareness of the plan.

2. Powers. The association may:

A. Exercise powers granted to insurers under the laws of this State;

B. Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter and may, with the approval of the superintendent, enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

C. Sue or be sued and may take legal actions necessary or proper to recover or collect assessments provided in section 3957 due the association;

D. Take legal actions necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association, to recover any amounts erroneously or improperly paid by the association, to recover amounts paid by the association as a result of mistake of fact or law or to recover other amounts due the association;

E. Define the health benefit plans for which reinsurance will be provided under this chapter;

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

G. Borrow money to effect the purposes of the association. Notes or other evidence of indebtedness of the association not in default must be legal investments for insurers and may be carried as admitted assets;

H. Establish rules, conditions and procedures for reinsuring risks of member insurers desiring to issue in their own names plan coverage to individuals otherwise eligible for plan coverage;

I. Provide for reinsurance of risks incurred by the association. The provision of reinsurance may not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers; and

J. Apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk pools.

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

4. Review for solvency. The superintendent shall review the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to increase its assessments. If the superintendent determines that the funds of the association are insufficient, the superintendent may order the association to charge additional assessments.

5. Annual report. The association shall report annually to the joint standing committee of the Legislature having jurisdiction over health insurance matters by March 15th. The report must include information on the benefits and rate structure of coverage offered by the association, the solvency of the association and the administrative expenses of the plan.

6. Audit. The association must be audited at least every 3 years. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

§ 3956. Selection of plan administrator

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

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

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

A. Perform all administrative functions relating to the plan;

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

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

D. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the 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

E. Pay reinsurance amounts as provided for in the plan of operation under section 3953, subsection 3.

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

§ 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 member insurers at such a time and for such amounts as the board finds necessary. Assessments are due not less than 30 days after written notice to the member insurers and accrue interest at 12% per annum on and after the due date.

2. Maximum assessment. Each insurer must be assessed by the board an amount not to exceed \$4 per covered person insured or reinsured by each insurer per month for medical insurance. An insurer may not be assessed on policies or contracts insuring federal or state employees.

3. Determination of assessment. The board shall make reasonable efforts to ensure that each covered person is counted only once with respect to an assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all 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.

4. Assessments to cover net losses. The board shall assess member insurers at such a time and for such amounts as the board finds necessary to cover any net loss in accordance with this subsection.

A. 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.

B. Individual assessments of each insurer are determined by multiplying the absolute value of net losses, if net earnings are negative, by a fraction, the numerator of which is the insurer's total premiums earned in the preceding calendar year from all health benefit plans, including excess or stop loss coverage, and the denominator of which is the total premiums earned in the preceding calendar year from all health benefit plans.

C. The association shall impose a penalty of interest for late payment of assessments.

5. 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.

6. Excess funds. If assessments and other receipts by the association, board or plan administrator exceed the actual losses and administrative expenses of the plan, the board shall hold the excess as interest and may use those excess funds to offset future losses or to reduce plan premiums. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

7. 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.

§ 3958. Requirements for coverage

1. Approved coverage. The association shall approve a choice of 2 or more coverage options for which reinsurance is available through the plan. The requirements of this plan become effective January 1, 2012. Policies approved by the association must be available for sale beginning July 1, 2012. At least one coverage option must be a standardized health plan as defined in Bureau of Insurance Rule Chapter 750. Any person whose medical insurance coverage under an individual or small group health plan is involuntarily terminated for any reason other than nonpayment of premiums may apply for coverage under the plan. If such coverage is applied for within 90 days after the involuntary termination and if premiums are paid for the entire period of coverage under the plan, the effective date of the coverage is the date of termination of the previous coverage.

2. Rates. Rates for coverage under the plan issued by the association must meet the requirements of this subsection.

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

B. Rate schedules must comply with section 2736-C and section 2808-B and are subject to approval by the superintendent.

C. Standard risk rates for coverage issued by the association must be established by the association, subject to approval by the superintendent, using reasonable actuarial techniques and must reflect anticipated experiences and expenses of such coverage for standard risks. The premium for the standard risk rates must range from a minimum of 125% to a maximum of 150% of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in similar medical insurance plans.

3. Compliance with state law. Products offered by the association must comply with all relevant requirements of this Title applicable to individual health insurance policies, including requirements for mandated coverage for specific health services, for specific diseases and for certain providers of health services.

§ 3959. Reinsurance; premium rates

1. Reinsurance amount. Any insurer offering the coverage options approved by the association pursuant to section 3958, subsection 1 must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for the reinsurance premium rate established in accordance with subsection 2.

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

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

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged reinsuring insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a

system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that reasonably approximate gross premiums charged for individual health plans with similar benefits to the coverage options approved by the association pursuant to section 3958, subsection 1 and that are adjusted to reflect retention levels required under this Title. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by a reinsuring insurer.

§ 3960. Eligibility for coverage

1. Eligibility; application for coverage. A resident is eligible for coverage under the plan if the resident provides evidence of rejection, a requirement of restrictive riders, a rate increase or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member insurer within 6 months of the date of the certificate, or if the resident meets other eligibility requirements adopted by rule by the superintendent that are not inconsistent with this chapter and that evidence that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

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

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

(1) A covered person may maintain other coverage for the period of time the person is satisfying a preexisting condition waiting period under a plan policy; and

(2) A covered person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

B. The person is determined eligible for health care benefits under the MaineCare program pursuant to Title 22;

C. The person previously terminated plan coverage, unless 12 months have elapsed since the person's last termination;

D. The person has met the lifetime maximum benefit amount under the plan of \$3,000,000;

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

F. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

5. Termination of coverage. The coverage of any person ceases:

A. On the date a person is no longer a resident;

B. Upon the death of the covered person;

C. On the date state law requires cancellation of the policy; or

D. At the option of the association, 30 days after the association makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately.

6. Unfair trade practice. It constitutes an unfair trade practice for any insurer, producer, employer or 3rd-party administrator to refer an individual employee or a dependent of an individual employee to the association or to arrange for an individual employee or a dependent of an individual employee to apply to the plan for the purpose of separating such an employee or dependent from a group health benefits plan provided in connection with the employee's employment.

§ 3961. Actions against association or member insurers based upon joint or collective actions

Participation in the association, the establishment of rates, forms or procedures or any other joint or collective action required by this chapter may not be the basis of any legal action or criminal or civil liability or penalty against the association or a member insurer.

§ 3962. Reimbursement of member insurer

1. Reimbursement. A member insurer may seek reimbursement from the association and the association shall reimburse the member insurer to the extent claims made by a covered person after April 1, 2012 exceed premiums paid on a calendar year basis by the covered person to the member insurer for a covered person who meets the criteria in this subsection.

A. The member insurer sold an individual health plan to the covered person between December 1, 1993 and April 1, 2012, the individual health plan that was sold has been continuously renewed by the covered person and the member insurer has closed its book of business for individual health plans sold between December 1, 1993 and April 1, 2012.

B. The member insurer is able to determine through the use of individual health statements, claims history or any reasonable means that at the time the person applied for insurance coverage with the member insurer, the covered person was diagnosed with one of the following medical conditions: acquired immune deficiency syndrome, angina pectoris, ascites, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease causing open heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia or Wilson's disease.

2. Rules. The superintendent may adopt rules to facilitate payment to a 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.

Sec. B-15. Maine High-risk Reinsurance Pool Association staggered terms. Pursuant to the Maine Revised Statutes, Title 24-A, section 3953, of the members of the board of directors of the Maine High-risk Reinsurance Pool Association initially appointed by the Superintendent of Insurance, 2 members serve for a term of one year, 2 members for a term of 2 years and 2 members for a term of 3 years and of those members initially appointed by the member insurers, one member serves for a term of one year, 2 members serve for a term of 2 years and 2 members serve for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

SUMMARY

Part A of this bill makes the following changes to the community rating laws for individual and small group health insurance:

1. It changes the maximum rate differential for individual health plans on the basis of age, health status and geographic area from 1.5:1 to 4:1; and
2. It changes the maximum rate differential for small group health plans on the basis of age, health status, occupation or industry and geographic area from 1.5:1 to 4:1.

Part B of the bill amends the laws relating to guaranteed issuance and renewal.

Part B also creates the Maine High-risk Reinsurance Pool Association. The purpose of the association is to provide reinsurance to spread the cost of high-risk individuals and small groups among all health insurers. The bill funds the high-risk reinsurance pool through an assessment on insurers.