An Act To Return Affordable Health Insurance to the State

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

PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§1, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is repealed.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, as amended by PL 2003, c. 469, Pt. E, §12, is repealed.

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 A-3. 24-A MRSA §2736-C, sub-§3, ¶A, as corrected by RR 2001, c. 1, §30, is repealed.

Sec. A-4. 24-A MRSA §2736-C, sub-§3, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is repealed.

Sec. A-5. 24-A MRSA §2736-C, sub-§3, ¶D, as enacted by PL 1999, c. 256, Pt. D, §1, is amended to read:

D. ~~Notwithstanding paragraph A, carriers~~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.

Sec. A-6. 24-A MRSA §2736-C, sub-§6, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is repealed.

Sec. A-7. 24-A MRSA §2736-C, sub-§6, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

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~~.

Sec. A-8. 24-A MRSA §2736-C, sub-§6, ¶D, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is repealed.

Sec. A-9. 24-A MRSA §2736-C, sub-§9, as enacted by PL 1995, c. 570, §7, is amended to read:

9. Exemption for certain associations. The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the requirements of ~~subsection 3, paragraph A;~~ subsection 6, paragraph A~~;~~ and subsection 8 if:

A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents;

B. Rates for the association ~~comply with the premium rate requirements of subsection 2 or~~ are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any;

C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%;

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect;

E. The association's group health plan is not marketed to the general public;

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A;

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and

H. Granting an exemption to the association does not conflict with the purposes of this section.

Sec. A-10. 24-A MRSA §2808-B, sub-§1, ¶B, as enacted by PL 1991, c. 861, §2, is repealed.

Sec. A-11. 24-A MRSA §2808-B, sub-§2, as amended by PL 2003, c. 469, Pt. E, §§14 and 15, is repealed.

Sec. A-12. 24-A MRSA §2808-B, sub-§2-B, ¶D, as enacted by PL 2003, c. 469, Pt. E, §16, is repealed.

Sec. A-13. 24-A MRSA §2808-B, sub-§4, as corrected by RR 2001, c. 1, §32, is amended to read:

4. 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.~~

B. Renewal is guaranteed under section 2850-B.

Sec. A-14. 24-A MRSA §2808-B, sub-§6, ¶B, as enacted by PL 1991, c. 861, §2, is repealed.

Sec. A-15. 24-A MRSA §2808-B, sub-§6, ¶C, as enacted by PL 1991, c. 861, §2, is amended to read:

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~~.

Sec. A-16. 24-A MRSA §2808-B, sub-§6, ¶D, as enacted by PL 1991, c. 861, §2, is repealed.

Sec. A-17. 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) The plan offered by the Comprehensive Health Insurance Risk Pool Association pursuant to chapter 54.

Sec. A-18. 24-A MRSA §2849-B, sub-§2, ¶A, as amended by PL 2001, c. 258, Pt. E, §7, is further amended to read:

A. That person was covered under ~~an individual or~~a group contract or policy issued by any 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 or group policy under which the person is seeking coverage is the "succeeding policy." The group ~~or individual~~ contract or policy, uninsured employee benefit plan or governmental program that previously covered the person is the "prior contract or policy"; and

Sec. A-19. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

§ 3901. Short title

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

§ 3902. Definitions

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

1. Association. "Association" means the Comprehensive Health Insurance Risk Pool Association established in section 3903.

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

3. Covered person. "Covered person" means an individual resident of this State, exclusive of dependents, 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 or resident unmarried child under 19 years of age, a child who is a student under 23 years of age and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

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

6. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. "Insurer" includes an insurance company, nonprofit hospital and medical service organization, fraternal benefit society, health maintenance organization, 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, 3rd-party administrator, multiple-employer welfare arrangement, any other entity providing medical insurance or health benefits subject to state insurance regulation or any reinsurer reissuing health insurance in this State.

7. Medical insurance. "Medical insurance" means a hospital and medical expense-incurred policy, nonprofit hospital and medical service plan, health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; and 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 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. 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 established by the board and subject to the approval of the superintendent and not to exceed one year;

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.

12. 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.

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

§ 3903. Comprehensive Health Insurance Risk Pool Association

1. Risk pool established. The Comprehensive Health Insurance Risk Pool Association is established as a nonprofit legal entity. As a condition of doing business, every insurer that has sold medical insurance within the previous 12 months or is actively marketing a medical insurance policy in this State shall participate in the association.

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

A. The board consists of 11 members as follows.

(1) Six members appointed by the superintendent:

(a) Two members must be chosen from the general public and may not be associated with the medical profession, a hospital or an insurer;

(b) Two members must represent medical providers;

(c) One member must represent producers; and

(d) One member must represent a statewide association representing small businesses that receives the majority of its funding from persons and businesses in the State.

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.

B. All terms after the initial terms must be for 3 years.

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 association 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 association 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 association and approved by the superintendent. Rules adopted pursuant to this subsection by the superintendent 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 subject matter over which the board has been given jurisdiction.

§ 3904. 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; any 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 in its bylaws or rules may provide for indemnification of, and legal representation for, its members and employees.

§ 3905. 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 3906;

D. Collect assessments as provided in section 3907. The level of payments must be established by the board. Assessments must be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments must be equal in amount for all insurers but may not exceed $500 per insurer for all such assessments. Assessments are due and payable within 30 days of receipt of the assessment notice by the insurer;

E. Require that all policy forms issued by the association conform to standard forms developed by the association. The forms must be approved by the superintendent and must comply with this Title; and

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

2. Powers. The association may:

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

B. Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the superintendent, to enter into contracts with similar organizations in 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, including taking any legal actions necessary or proper to recover or collect assessments due the association;

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

E. Establish a system to modify from time to time as appropriate rates, rate schedules, rate adjustments, expense allowances, producers' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association in accordance with section 3909;

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

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

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

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

J. Prepare and distribute application forms and enrollment instruction forms to producers and to the general public;

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

L. Issue additional types of health insurance policies to provide optional coverage, including Medicare supplement health insurance;

M. Provide for and employ cost-containment measures and requirements, including, but not limited to, preadmission screening, 2nd surgical opinions, concurrent utilization review and individual case management for the purpose of making the plan more cost-effective;

N. Design, use, contract or otherwise arrange for the delivery of high-quality and cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and limited network provider arrangements for the management of chronic diseases and high-risk conditions;

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

P. Develop a subsidy program for low-income individuals who receive coverage under the plan.

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 operations of the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support enrollment of additional persons, the superintendent may order the association to increase its assessments or increase its premium rates. If the superintendent determines that the funds of the association are insufficient to support the enrollment of additional persons and that the cap of assessments in section 3907 is too low to support the enrollment of additional persons, the superintendent may order the association to charge an assessment in excess of the cap for a period not to exceed 12 months.

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

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

§ 3906. Selection of plan administrator

1. Selection of plan administrator. The board shall select an insurer or 3rd-party administrator, through a competitive bidding process, to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, including:

A. The insurer's or the 3rd-party administrator's proven ability to handle large group accident and health insurance;

B. The efficiency of the insurer's or the 3rd-party administrator's claims payment procedures; and

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

2. Contract with plan administrator. The plan administrator selected pursuant to subsection 1 is contracted for a period of 3 years. At least one year prior to the expiration of each 3-year period of service by a plan administrator, 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 selection of the plan administrator for the succeeding period must be made at least 6 months prior to the expiration of the 3-year period.

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

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

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

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

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

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

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

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

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

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

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

4. Payment to plan administrator. The plan administrator selected pursuant to subsection 1 must be paid, as provided in the contract of the association under subsection 2, for the plan administrator's direct and indirect expenses incurred in the performance of the plan administrator's 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 specifications of a bid under subsection 2.

§ 3907. Assessments against insurers

1. Assessments. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess member insurers at such a time and for such amounts as the board finds necessary. Assessments are due no later than 30 days after receipt of written notice by member insurers and accrue interest at 12% per annum on and after the due date.

2. Maximum assessment. The board shall assess each insurer an amount not to exceed $2 per person insured or reinsured by each insurer per month for medical insurance. A member insurer may not be assessed on policies or contracts insuring federal or state employees. This assessment begins January 1, 2008.

3. Determination of assessment. The board shall make reasonable efforts to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all individuals whose coverage is insured, in whole or in part, through excess or stop loss coverage. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this section. The board may verify each insurer's assessment based on annual statements and other reports determined to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

4. 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.

5. Failure to pay assessment. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer that fails to pay an assessment. As an alternative, the superintendent may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the superintendent may use any power granted to the superintendent by this Title to collect any unpaid assessment.

§ 3908. Availability of coverage

The association shall offer a choice of 2 or more coverage options through the plan. The requirements of this plan become effective January 1, 2008. Policies offered through the association must be available for sale beginning on July 1, 2008. The association shall directly insure the coverage provided by the plan, and the policies must be issued through the plan administrator. At least one coverage option must be a standardized health plan as defined in Chapter 750 of the rules of the bureau.

§ 3909. Requirements for coverage

1. Coverage offered. The plan must offer in an annually renewable policy the coverage specified in this section for each eligible person. If an eligible person is also eligible for Medicare coverage, the plan may not pay or reimburse any person for expenses paid by Medicare. Any person whose health insurance coverage 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, the effective date of the coverage is the date of termination of the previous coverage.

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

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

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

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

C. 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.

4. 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 care services.

5. Other sources primary. The association must be payer of last resort of benefits whenever any other benefit or source of 3rd-party payment is available. The coverage provided by the association must be considered excess coverage, and benefits otherwise payable under association coverage must be reduced by all amounts paid or payable through any other health insurance and by all hospital and medical expense benefits paid or payable under any short-term, accident, dental-only, vision-only, fixed indemnity, limited benefit or credit insurance; coverage issued as a supplement to liability insurance; workers' compensation coverage; automobile medical payment; or liability insurance whether or not provided on the basis of fault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

6. Recovery of claims paid. An amount paid or payable by Medicare or any other government program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may not be made or recognized as claims under such a policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available. The association has a cause of action against a participant for the recovery of the amount of any benefits paid to the participant that should not have been claimed or recognized as claims because of the provisions of this subsection or because the benefits are otherwise not covered. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this subsection.

§ 3910. Eligibility for coverage

1. Eligibility; application for coverage. A resident is eligible for coverage under the plan if evidence is provided 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 association member 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 indicate 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 any natural person who changes that person's domicile to this State and who at the time domicile is established in this State is insured by an organization similar to the association. The eligible maximum lifetime benefits for that covered person may not exceed the lifetime benefits available through the association, less any benefits received from a similar organization in the former domiciliary state.

3. Eligibility without application. The board shall develop a list of medical or health conditions for which a person is eligible for plan coverage without applying for health insurance under subsection 1. A person who can demonstrate the existence or history of a medical or health condition 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 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 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.

§ 3911. Actions against association or members 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 any member insurer.

§ 3912. Reimbursement of carriers

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

A. The carrier sold an individual health plan to the member between December 1, 1993 and January 1, 2008, and the policy that was sold has been continuously renewed by the member;

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

C. The carrier has closed its book of business for individual health plans sold prior to January 1, 2009.

2. Rules. The superintendent may adopt rules to facilitate payment to a carrier pursuant to this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-20. Comprehensive Health Insurance Risk Pool Association; staggered terms for board of directors. Notwithstanding the Maine Revised Statutes, Title 24-A, section 6903, the terms for initial appointments to the board of directors of the Comprehensive Health Insurance Risk Pool Association are as follows. Of those members of the board 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. Of those members appointed by the member insurers, one member serves for a term of one year, one member serves for a term of 2 years and one member serves for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

Sec. A-21. Application for funds. The Superintendent of Insurance shall apply for all available federal funds for the purpose of operating a high-risk health insurance pool.

Sec. A-22. Subsidy program. No later than January 1, 2009, the Comprehensive Health Insurance Risk Pool Association Board of Directors shall develop a subsidy program for low-income individuals who receive coverage under the plan as authorized under the Maine Revised Statutes, Title 24-A, section 3905, subsection 2, paragraph P. The association shall also determine whether the subsidy program could be expanded within the limitations of available funding to all low-income individuals who would otherwise not be eligible for coverage pursuant to Title 24-A, section 3910. The association shall submit a report on the subsidy program and any recommendations for expanding eligibility to the Joint Standing Committee on Insurance and Financial Services on or before February 15, 2008. The Joint Standing Committee on Insurance and Financial Services may summit any necessary legislation to the Second Regular Session of the 123rd Legislature to implement the subsidy program.

Sec. A-23. Effective date. Those sections of this Part that repeal the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 2; section 2736-C, subsection 3, paragraphs A and C; section 2808-B, subsection 2; and section 2808-B, subsection 4, paragraph A take effect January 1, 2010. Those sections of this Part that amend Title 24-A, section 2848, subsection 1-B, paragraph A and section 2849-B, subsection 2, paragraph A take effect January 1, 2010.

PART B

Sec. B-1. 2 MRSA §6, sub-§1, as repealed and replaced by PL 2005, c. 397, Pt. A, §1, is amended to read:

1. Range 91. The salaries of the following state officials and employees are within salary range 91:

Commissioner of Transportation;

Commissioner of Conservation;

Commissioner of Administrative and Financial Services;

Commissioner of Education;

Commissioner of Environmental Protection;

~~Executive Director of Dirigo Health;~~

Commissioner of Public Safety;

Commissioner of Professional and Financial Regulation;

Commissioner of Labor;

Commissioner of Agriculture, Food and Rural Resources;

Commissioner of Inland Fisheries and Wildlife;

Commissioner of Marine Resources;

Commissioner of Corrections;

Commissioner of Economic and Community Development;

Commissioner of Defense, Veterans and Emergency Management; and

Executive Director, Workers' Compensation Board.

Sec. B-2. 2 MRSA §103, sub-§2, as amended by PL 2005, c. 369, §2, is further amended to read:

2. Input. In developing the plan, the Governor shall, at a minimum, review the process for the development of the plan with the joint standing committee of the Legislature having jurisdiction over health and human services matters and seek input from the Advisory Council on Health Systems Development, pursuant to section 104; ~~the Maine Quality Forum and the Maine Quality Forum Advisory Council, pursuant to Title 24-A, chapter 87, subchapter 2;~~ a statewide health performance council; and other agencies and organizations.

Sec. B-3. 5 MRSA §286-M, sub-§11, as enacted by PL 2005, c. 636, Pt. A, §3, is repealed.

Sec. B-4. 5 MRSA §934-B, as enacted by PL 2003, c. 469, Pt. A, §2, is repealed.

Sec. B-5. 5 MRSA §1667-B, first ¶, as amended by PL 2005, c. 386, Pt. D, §2, is further amended to read:

Allotments in Other Special Revenue funds accounts, internal service fund accounts and enterprise funds, except the State Lottery Fund ~~and the Dirigo Health Enterprise Fund~~, may exceed current year allocations and the unused balance of allocations authorized to carry forward by law under the following conditions, except that funds in Other Special Revenue funds accounts, internal service fund accounts and enterprise funds must be expended in accordance with the statutes that establish the accounts and for no other purpose:

Sec. B-6. 5 MRSA §12004-G, sub-§14-D, as enacted by PL 2003, c. 469, Pt. A, §3, is repealed.

Sec. B-7. 5 MRSA §12004-I, sub-§30-A, as enacted by PL 2003, c. 469, Pt. A, §4, is repealed.

Sec. B-8. 22 MRSA §328, sub-§17-A, ¶C, as corrected by RR 2003, c. 1, §15, is amended to read:

C. The addition in the private office of a health care practitioner, as defined in Title 24, section 2502, subsection 1-A, of new technology that costs $1,200,000 or more. ~~The department shall consult with the Maine Quality Forum Advisory Council established pursuant to Title 24-A, section 6952, prior to determining whether a project qualifies as a new technology in the office of a private practitioner.~~ Beginning September 30, 2004 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the Consumer Price Index medical index. With regard to the private office of a health care practitioner, "new health service" does not include the location of a new practitioner in a geographic area.

Sec. B-9. 22 MRSA §335, sub-§1, ¶D, as enacted by PL 2003, c. 469, Pt. C, §8, is amended to read:

D. Does not result in inappropriate increases in service utilization~~, according to the principles of evidence-based medicine adopted by the Maine Quality Forum, as established in Title 24-A, section 6951~~; and

Sec. B-10. 22 MRSA §3174-V, sub-§2, as amended by PL 2005, c. 400, Pt. C, §1, is further amended to read:

2. Contracted services. When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a managed care plan ~~or the Dirigo Health Program~~ for the provision of MaineCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan ~~or the Dirigo Health Program~~ and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan ~~or the Dirigo Health Program~~ would make for services provided by an entity not defined as a federally qualified health center.

Sec. B-11. 22 MRSA §3174-DD, as amended by PL 2005, c. 400, Pt. C, §2, is repealed.

Sec. B-12. 22 MRSA §8708-A, as enacted by PL 2003, c. 469, Pt. C, §28, is amended to read:

§ 8708-A. Quality data

The board shall adopt rules regarding the collection of quality data. ~~The board shall work with the Maine Quality Forum and the Maine Quality Forum Advisory Council established in Title 24-A, chapter 87, subchapter 2 to develop the rules. The rules must be based on the quality measures adopted by the Maine Quality Forum pursuant to Title 24-A, section 6951, subsection 2.~~ The rules must specify the content, form, medium and frequency of quality data to be submitted to the organization. In the collection of quality data, the organization must minimize duplication of effort, minimize the burden on those required to provide data and focus on data that may be retrieved in electronic format from within a health care practitioner's office or health care facility. As specified by the rules, health care practitioners and health care facilities shall submit quality data to the organization. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. B-13. 22 MRSA §8712, sub-§1, as enacted by PL 2003, c. 469, Pt. C, §29, is amended to read:

1. Quality. At a minimum, the organization~~, in conjunction with the Maine Quality Forum, established in Title 24-A, section 6951,~~ shall develop and produce annual quality reports.

Sec. B-14. 24-A MRSA §1952, as amended by PL 2003, c. 469, Pt. E, §8, is further amended to read:

§ 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.~~

Sec. B-15. 24-A MRSA §2736, sub-§3, ¶B, as amended by PL 2003, c. 469, Pt. E, §9, is further amended to read:

B. The insurer must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. B-16. 24-A MRSA §2736, sub-§4, ¶C, as amended by PL 2003, c. 469, Pt. E, §10, is further amended to read:

C. In any hearing conducted under this subsection, the Bureau of Insurance and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate,and not unfairly discriminatory ~~and in compliance with the requirements of section 6913~~ remains with the insurer.

Sec. B-17. 24-A MRSA §2736-A, first ¶, as amended by PL 2003, c. 469, Pt. E, §11, is further amended to read:

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 not in compliance with section 6913~~ or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held.

Sec. B-18. 24-A MRSA §2736-C, sub-§5, as amended by PL 2003, c. 469, Pt. E, §13, is further amended to read:

5. Loss ratios. 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 savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. B-19. 24-A MRSA §2808-B, sub-§2-A, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

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 savings offset payment or any recovery of that offset payment pursuant to subsection 2-B, paragraph D ~~and section 6913~~ for rates effective before July 1, 2005.

Sec. B-20. 24-A MRSA §2808-B, sub-§2-B, ¶A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

A. 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 savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. B-21. 24-A MRSA §2808-B, sub-§2-B, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

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~~,~~<u>or</u> unfairly discriminatory ~~or not in compliance with section 6913~~, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

Sec. B-22. 24-A MRSA §2808-B, sub-§2-B, ¶F, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

F. Any rate hearing conducted with respect to filings that meet the criteria in paragraph E is subject to this paragraph.

(1) A person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(2) If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(3) In any hearing conducted under this paragraph, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate~~,~~and not unfairly discriminatory ~~and in compliance with the requirements of section 6913~~ remains with the carrier.

Sec. B-23. 24-A MRSA §2808-B, sub-§2-C, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

C. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. ~~For the purposes of calculating this loss-ratio percentage, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~ The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums.

(1) For determination of loss-ratio percentages in 2005, actual aggregate incurred claims expenses include expenses incurred in 2005 and projected expenses for 2006 and 2007. For determination of loss-ratio percentages in 2006, actual incurred claims expenses include expenses in 2005 and 2006 and projected expenses for 2007.

(2) The superintendent may waive the requirement for refunds during the first 3 years after the effective date of this subsection.

Sec. B-24. 24-A MRSA §2839-B, sub-§2, as enacted by PL 2003, c. 469, Pt. E, §17, is amended to read:

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 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.

Sec. B-25. 24-A MRSA c. 87, as amended, is repealed.

Sec. B-26. Effective date. This Part takes effect January 1, 2009.

SUMMARY

Part A of this bill repeals the guaranteed issue and community rating laws for the individual and small group health insurance markets effective January 1, 2010. The bill enacts the Comprehensive Health Insurance Risk Pool Association Act, which will operate as an alternative to guaranteed issuance laws in the individual health insurance market. The bill requires that the Comprehensive Health Insurance Risk Pool Association begin offering coverage for sale on July 1, 2008. The bill also requires the Department of Professional and Financial Regulation, Bureau of Insurance to apply for federal funds that Congress is offering to states to create high-risk insurance pools.

Part B repeals the Dirigo Health Act effective January 1, 2009. Part B also corrects cross-references.