Amend the amendment by striking out everything after the title and before the summary and inserting the following:

'

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

PART A

'

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 F, §1, is repealed.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶A, as amended by PL 1993, c. 547, §3, is further amended to read:

A. A carrier issuing an individual health plan after December 1, 1993 must file the carrier's ~~community rate~~rates and any formulas and factors used to adjust ~~that rate~~those rates with the superintendent prior to issuance of any individual health plan.

Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and as affected by Pt. F, §1, is repealed.

Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶B-1 is enacted to read:

B-1. A carrier may not vary the premium rate due to the claims experience or policy duration of the individual. A carrier may vary the premium rate based on health status, age, gender and tobacco use. A change in the premium rate is not permitted on the basis of changes in health status after the policy is issued. Renewal of an individual health plan is guaranteed pursuant to section 2850-B.

Sec. A-5. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §2 and as affected by §10, is repealed.

Sec. A-6. 24-A MRSA §2736-C, sub-§2, ¶G is enacted to read:

G. A carrier that offered individual health plans prior to April 1, 2008 may close its individual book of business sold prior to April 1, 2008 and may establish a separate community rate for individuals applying for coverage under an individual health plan after April 1, 2008.

Sec. A-7. 24-A MRSA §2736-C, sub-§3, ¶A, as corrected by RR 2001, c. 1, §30, is repealed.

Sec. A-8. 24-A MRSA §2736-C, sub-§3, ¶C, as enacted by PL 1993, c. 477, Pt. C, §1 and as affected by Pt. F, §1, is repealed.

Sec. A-9. 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-10. 24-A MRSA §2736-C, sub-§6, ¶A, as amended by PL 1995, c. 332, Pt. K, §1, is further amended to read:

A. Each carrier must actively market individual health plan coverage~~, including any standardized plans defined pursuant to subsection 8,~~ to individuals in this State.

Sec. A-11. 24-A MRSA §2736-C, sub-§8, as amended by PL 1999, c. 256, Pt. D, §2, is further amended to read:

8. Authority of the superintendent. The superintendent may by rule define one or more standardized individual health plans that ~~must~~may be offered by ~~all~~ carriers offering individual health plans in the State, other than carriers offering only CHAMPUS supplemental coverage.

Sec. A-12. 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-13. 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 Comprehensive Health Insurance Risk Pool Association pursuant to chapter 54.

Sec. A-14. 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-15. 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 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.

For the purposes of this chapter, "covered person" does not include a dependent of a covered person.

4. Dependent. "Dependent" means a resident spouse, 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, another entity providing medical insurance or health benefits subject to state insurance regulation and a reinsurer that reinsures 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; 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. 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.

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 any entity that is paying or processing medical insurance claims for any 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, 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.

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 appointed as follows:

(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, except that of those members initially appointed by the superintendent, 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, one member serves 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.

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. 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.

§ 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; 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.

§ 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 the assessments 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 and adopted pursuant to section 3903, 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 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 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 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. Establish, and 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 and other contract design and any other function within the authority of the association;

H. 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;

I. 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;

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 opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost-effective;

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

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

P. Develop a plan to subsidize low-income individuals.

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 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 3908 is too low to support the enrollment of additional persons, the superintendent may order the association to charge assessments 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 proven ability to handle large group accident and health insurance;

B. The efficiency of the insurer's claims-paying 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 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 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 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. 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 whether the claim is accepted, rejected or subject to compromise. 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 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

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, 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.

§ 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 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 $2 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 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 subsection. 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 to coverage

The association shall offer a choice of 2 or more coverage options through the plan as set out in section 3909, subsections 1 and 2. The plan becomes effective October 1, 2007. Policies offered through the association must be available for sale April 1, 2008. The association shall directly insure the coverage provided by the plan, and the policies must be issued through the plan administrator.

§ 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 a covered person is also eligible for Medicare coverage, the plan may not pay or reimburse any person for expenses paid by Medicare. A person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium 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 covered person who is not eligible for Medicare. The board shall establish the coverage to be issued by the plan, its schedule of benefits and exclusions and other limitations, which the board may amend 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 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. Subject to approval by the superintendent, standard risk rates for coverage issued by the association must be established by the association 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, including requirements for mandated coverage for specific health care services and 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 governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may not be made or recognized as a claim under such a policy or be recognized as or towards satisfaction of an applicable deductible or out-of-pocket maximum or to reduce the limits of benefits available under the plan. The association has a cause of action against a covered person for the recovery of the amount of any benefits paid to the covered person 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 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 natural 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 applicaton. 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 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.

§ 3911. 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.

§ 3912. 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, 2008 exceed premiums paid on a calendar-year basis by the covered person to the member insurer for a covered person who meets the following criteria:

A. The member insurer sold an individual health plan to the covered person between December 1, 1993 and April 1, 2008 and the policy that was sold has been continuously renewed by the covered person and the carrier has closed its book of business for individual health plans sold between December 1, 1993 and April 1, 2008; and

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, 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 causing open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia or Wilson's disease.

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.

3. Repeal. This section is repealed April 1, 2012.

Sec. A-16. Application for federal grant. Within 30 days of the effective date of this Act, the Superintendent of Insurance shall submit an application to the federal Department of Health and Human Services, Health Resources and Services Administration for a federal seed grant to support the creation and initial operation of the Comprehensive Health Insurance Risk Pool Association established in the Maine Revised Statutes, Title 24-A, chapter 54.

Sec. A-17. Comprehensive Health Insurance Risk Pool Association subsidy program. The board of directors of the Comprehensive Health Insurance Risk Pool Association shall develop a plan to subsidize low-income individuals as authorized under the Maine Revised Statutes, Title 24-A, section 3905, subsection 2, paragraph P. The board shall submit that plan to the Joint Standing Committee on Insurance and Financial Services no later than February 1, 2008. The Joint Standing Committee on Insurance and Financial Services may submit legislation to the Second Regular Session of the 123rd Legislature to implement the plan submitted by the association.

Sec. A-18. Effective date. That section of this Part that repeals the Maine Revised Statutes, Title 24-A, section 2736-C, subsection 3, paragraph C takes effect January 1, 2008. Those sections of this Part that repeal Title 24-A, section 2736-C, subsection 1, paragraph B; section 2736-C, subsection 2, paragraphs B and D; and section 2736-C, subsection 3, paragraph A take effect April 1, 2008. Those sections of this Part that amend section 2736-C, subsection 3, paragraph D and subsection 9 take effect April 1, 2008.

PART B

Sec. B-1. 22 MRSA §3161, sub-§5, ¶A, as enacted by PL 2001, c. 677, §1, is repealed and the following enacted in its place:

A. Works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees who retire from the employer's employment;

Sec. B-2. 24 MRSA §2317-B, sub-§14-A is enacted to read:

14-A. Title 24-A, section 2808-C. Small group health plans, Title 24-A, section 2808-C;

Sec. B-3. 24 MRSA §2317-B, sub-§15, as enacted by PL 1999, c. 256, Pt. M, §10, is repealed.

Sec. B-4. 24 MRSA §2327, as amended by PL 2003, c. 469, Pt. E, §1, is further amended to read:

§ 2327. Group rates

A group health care contract may not be issued by a nonprofit hospital or medical service organization in this State until a copy of the group rates to be used in calculating the premium for these contracts has been filed for informational purposes with the superintendent. The filing must include the

base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care contracts and for certain group contracts included within the definition of "individual health plan" in Title 24-A, section 2736-C, subsection 1, paragraph C must be filed in accordance with section 2321 and rates for small group health plans as defined by Title 24-A, section ~~2808-B~~2808-C must be filed in accordance with that section.

Sec. B-5. 24-A MRSA §2803-A, sub-§4, as amended by PL 2001, c. 410, Pt. B, §2, is further amended to read:

4. Exception. An insurer is not required to provide the loss information described in this section for a group that is eligible for small group coverage pursuant to section ~~2808-B~~2808-C.

Sec. B-6. 24-A MRSA §2804, sub-§3, as amended by PL 1999, c. 256, Pt. G, §1, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. B-7. 24-A MRSA §2805, sub-§3, as amended by PL 1999, c. 256, Pt. G, §2, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. B-8. 24-A MRSA §2805-A, sub-§4, as amended by PL 1999, c. 256, Pt. G, §3, is further amended to read:

4. Except as provided in section 2736-C, section ~~2808-B~~2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. B-9. 24-A MRSA §2806, sub-§3, as amended by PL 1999, c. 256, Pt. G, §4, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. B-10. 24-A MRSA §2807-A, sub-§3, as amended by PL 1999, c. 256, Pt. G, §5, is further amended to read:

3. Except as provided in section 2736-C, section ~~2808-B~~2808-C and chapter 36, an insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. B-11. 24-A MRSA §2808, sub-§4, as amended by PL 1999, c. 256, Pt. G, §6, is further amended to read:

4. Except as provided in section 2736-C, section ~~2808-B~~2808-C and chapter 36, an insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

Sec. B-12. 24-A MRSA §2808-B, as amended by PL 2005, c. 121, Pt. E, §§1 and 2, is repealed.

Sec. B-13. 24-A MRSA §2808-C is enacted to read:

§ 2808-C. Small group health plans

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

A. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that a carrier offering small group health plans is in compliance with the provisions of subsection 3 based on the person's examination and review of the carrier's appropriate records and the actuarial assumptions and methods used by the carrier to establish premium rates for its small group health plans.

B. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by a small group carrier to small employers with similar case characteristics for health plans with the same or similar coverage.

C. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue small group health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all small group health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations.

D. "Case characteristics" means demographic or other relevant characteristics of a small employer as determined by a carrier that are considered by the carrier in the determination of the premium rates for the small employer. "Case characteristics" does not include claims experience, health status or duration of coverage.

E. "Class of business" means all or a distinct grouping of small employers in accordance with this paragraph to whom the carrier provides coverage as demonstrated by the carrier's records.

(1) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(a) Are marketed and sold through individuals and organizations that are not participating in the marketing or sale of other distinct groupings of small employers for the carrier;

(b) Have been acquired from another carrier as a distinct grouping of plans;

(c) Are provided through an association with membership of not less than 50 small employers that has been formed for purposes other than obtaining insurance; or

(d) Are in a class of business that meets the requirements for exception to the restrictions related to premium rates provided in subsection 3.

(2) A carrier may establish no more than 2 additional groupings under subparagraph (1) on the basis of underwriting criteria that are expected to produce substantial variation in the health care costs.

(3) The superintendent may approve the establishment of additional distinct groupings upon application to the superintendent and a finding by the superintendent that such action would enhance the efficiency and fairness of the small group health plan market.

F. "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

G. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A, B, C-1 or D.

H. "New business premium rate" means, for each class of business as to a rating period, the premium rate charged or offered by the carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

I. "Rating period" means the calendar period for which the premium rates established by a carrier are assumed to be in effect as determined by the carrier.

J. "Small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50% of its working days during the preceding year, employed no more than 50 eligible employees and at least 2 eligible employees. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation must be considered one employer.

K. "Small group health plan" means any hospital and medical expense-incurred policy; health, hospital or medical service corporation plan contract; or health maintenance organization subscriber contract covering an eligible group. "Small group health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

(8) Coverage issued as a supplement to liability insurance;

(9) Workers' compensation;

(10) Automobile medical payment; or

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance.

2. Small group health plans subject to this section. The following small group health plans are subject to this section.

A. Except as provided in paragraph B, this section applies to any small group health plan that provides coverage to one or more employees of a small employer.

B. This section does not apply to individual health plans that are subject to section 2736-C.

3. Premium rates. Premium rates for small group health plans are subject to the following provisions.

A. The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%. This paragraph does not apply to a class of business if any of the following apply:

(1) The class of business is one for which the carrier does not reject, and never has rejected, small employers included within the carrier's definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience or health status;

(2) The carrier does not involuntarily transfer, and never has involuntarily transferred, a health benefit plan into or out of the class of business; and

(3) The class of business is available for purchase.

B. For a class of business, the premium rate charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, may not vary from the index rate by more than 25% of the index rate.

C. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small group carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(2) An adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than one year, due to the claims experience, health status or duration of coverage or the employees or dependents of the small employer as determined from the carrier's rate manual for the class of business; and

(3) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

D. In the case of health benefit plans issued prior to the effective date of this section, a premium rate for a rating period may exceed the ranges described in paragraphs A and B for a period of 5 years following the effective date of this section. In that case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(1) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small group carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(2) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

E. This section is not intended to affect the use by a small group carrier of legitimate rating factors other than claims experience, health status or duration of coverage in the determination of premium rates. A small group carrier shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

F. A small group carrier may not transfer a small employer involuntarily into or out of a class of business. A small group carrier may not transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to any changes in case characteristics, claims experience, health status or duration of coverage since the first date of coverage.

4. Coverage for late enrollees. In providing coverage to late enrollees, small group health plan carriers are allowed to exclude or limit coverage for a late enrollee subject to the limitations set forth in section 2849-B, subsection 3.

5. Guaranteed issuance and guaranteed renewal. Carriers providing small group health plans must meet the following requirements on issuance and renewal.

A. Any small group health plan offered to any eligible group or subgroup must be offered to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. In determining compliance with minimum participation requirements, eligible employees and their dependents that 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.

B. 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 service 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.

6. Disclosure of rating practices and renewability provisions. Each small group carrier shall disclose the following in the sales and marketing materials provided to small employers:

A. The extent to which premium rates for a specific small employer are established or adjusted due to the claims experience, health status or duration of coverage of the employees and dependents of the small employer;

B. The ability of the carrier to change premium rates and rating factors, including case characteristics, that may affect changes in premium rates;

C. A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans; and

D. The small employer's rights regarding renewal of the small group health plan.

7. Maintenance of records. A small group carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles. On or before March 1st annually, a carrier shall file with the superintendent an actuarial certification that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. A copy of the certification must be retained by the carrier at its principal place of business. A carrier shall also make the information and documentation required in this subsection available to the superintendent upon request. The information provided to the superintendent pursuant to this subsection is proprietary and must be kept confidential by the superintendent. The information may not be disclosed except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

8. Discretion of superintendent. The superintendent may suspend all or any part of subsection 3 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small group carrier and a finding by the superintendent that either the suspension is reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small group health plans.

9. Applicability. This section applies to all small group health plan policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2009. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. B-14. 24-A MRSA §2850-B, sub-§2, ¶C, as enacted by PL 1997, c. 445, §30 and as affected by §32, is amended to read:

C. "Large group market" means groups not subject to section 2736-C or ~~2808-B~~2808-C.

Sec. B-15. 24-A MRSA §2850-B, sub-§2, ¶D, as enacted by PL 1997, c. 445, §30 and as affected by §32, is amended to read:

D. "Small group market" means groups subject to section ~~2808-B~~2808-C.

Sec. B-16. 24-A MRSA §2850-B, sub-§3, ¶G, as amended by PL 2003, c. 428, Pt. A, §1, is further amended to read:

G. When the carrier ceases offering a product and meets the following requirements:

(1) In the large group market:

(a) The carrier must provide notice to the policyholder and to the insureds at least 90 days before termination;

(b) The carrier must offer to each policyholder the option to purchase any other product currently being offered in the large group market; and

(c) In exercising the option to discontinue the product and in offering the option of coverage under division (b), the carrier must act uniformly without regard to the claims experience of the policyholders or the health status of the insureds or prospective insureds;

(2) In the small group market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section ~~2808-B~~2808-C;

(b) The superintendent ~~shall~~must find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and to the insureds at least 90 days before replacement; or

(3) In the individual market:

(a) The carrier shall replace the product with a product that complies with the requirements of this section, including renewability, and with section 2736-C;

(b) The superintendent ~~shall~~must find that the replacement is in the best interests of the policyholders; and

(c) The carrier shall provide notice to the policyholder and, if a group policy, to the insureds at least 90 days before replacement;

Sec. B-17. 24-A MRSA §2850-B, sub-§4, ¶B, as amended by PL 2001, c. 258, Pt. E, §11, is further amended to read:

B. Carriers that cease to write new small group business continue to be governed by section ~~2808-B~~2808-C with respect to small group contracts in force and their renewal or replacement contracts.

Sec. B-18. 24-A MRSA §4202-A, sub-§10, ¶B, as amended by PL 1993, c. 645, Pt. A, §5, is further amended to read:

B. Is compensated, except for reasonable copayments, for basic health care services to enrolled participants solely on a predetermined periodic rate basis, except that the organization is not prohibited from having a provision in a group contract allowing an adjustment of premiums based upon the actual health services utilization of the enrollees covered under the contract, and except that such a contract may not be sold to an eligible group subject to the ~~community~~ rating requirements of section ~~2808-B~~2808-C;

Sec. B-19. 24-A MRSA §4207, sub-§5, as amended by PL 2003, c. 469, Pt. E, §19, is further amended to read:

5. A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with section 2736, ~~2808-B~~2808-C or 2839, whichever is applicable.

Sec. B-20. 24-A MRSA §4210, sub-§1, as amended by PL 1995, c. 332, Pt. O, §4, is further amended to read:

1. After a health maintenance organization has been in operation 24 months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. To the extent not inconsistent with the requirements of chapter 36 and sections 2736-C and ~~2808-B~~2808-C as qualified by section 4222-B, subsection 3, a health maintenance organization may apply to the superintendent for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective

enrollees or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The superintendent shall approve or deny the application within 10 days of the receipt of that application from the health maintenance organization.

Sec. B-21. 24-A MRSA §4212, sub-§2, ¶C, as enacted by PL 1995, c. 332, Pt. O, §6, is amended to read:

C. When the provisions of the State's ~~community~~ rating law are applicable, as provided by section 2736-C, subsection 3, paragraph B ~~and section 2808-B, subsection 4, paragraph B~~; or

Sec. B-22. 24-A MRSA §4222-B, sub-§3, as enacted by PL 1995, c. 332, Pt. O, §8, is amended to read:

3. The requirements of sections 2736-C and ~~2808-B, community rating law,~~2808-C apply to health maintenance organizations, except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group or individual located outside the health maintenance organization's approved service area.

Sec. B-23. 24-A MRSA §4346, sub-§1, ¶D, as enacted by PL 2001, c. 708, §3, is amended to read:

D. "Eligible employee" or "employee" means an individual who:

(1) ~~Meets the definition of "eligible employee" set forth in section 2808-B, subsection 1, paragraph C~~Works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees employees who retire from the employer's employment;

(2) Is a self-employed individual who:

(a) Works and resides in the State; and

(b) Is organized as a sole proprietorship or in any other legally recognized manner that a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income, and who has filed the appropriate United States Internal Revenue Service form for the previous taxable year, and for whom a copy of the appropriate United States Internal Revenue Service form or forms and schedule has been filed with the plan or its administrator; or

(3) Is a sole employee of a nonprofit organization that has been determined by the Internal Revenue Service to be exempt from taxation under the United States Internal Revenue Code, Section 501(c)(3),(4) or (6) and who has a normal work week of at least 20 hours and is not covered under a public or private plan for health insurance or other health benefit arrangement.

Sec. B-24. 24-A MRSA §4346, sub-§1, ¶G, as enacted by PL 2001, c. 708, §3, is amended to read:

G. "Small employer" ~~means an eligible group as defined~~has the same meaning as in section ~~2808-B~~2808-C, subsection 1, paragraph ~~D~~J.

Sec. B-25. 24-A MRSA §6603, sub-§1, ¶H, as amended by PL 2001, c. 410, Pt. A, §9, is further amended to read:

H. May issue only health care benefit plans that comply with the requirements of section ~~2808-B~~2808-C with regard to rating practices, coverage for late enrollees and guaranteed renewal. An arrangement may not provide health care benefits that do not meet or exceed the requirements for mandated benefits applicable to comparable insured plans.

Sec. B-26. 24-A MRSA §6910, sub-§4, ¶B, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health Program for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) The Dirigo Health Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health Program and that the employer group otherwise meets the minimum participation requirements ~~specified by section 2808-B, subsection 4, paragraph A~~.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

Sec. B-27. 24-A MRSA §6913, sub-§9, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

9. Demonstration of offset. As provided in sections 2736-C, ~~2808-B~~2808-C and 2839-B, the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, known changes and offsets in payments by the carrier to health care providers in this State, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004 as determined by the board consistent with subsection 1.

Sec. B-28. Effective date. This Part takes effect January 1, 2009.

PART C

Sec. C-1. 24-A MRSA §4205, sub-§1, ¶C, as enacted by PL 1975, c. 503, is amended to read:

C. The furnishing of health care services through providers ~~which~~that are under contract with or employed by the health maintenance organization. A health maintenance organization may offer health plans that exceed the geographic accessibility guidelines imposed by the superintendent by Bureau of Insurance Rule Chapter 850 for specialty care and hospital services, except for emergency hospital and hospital maternity care, if the health maintenance organization offers and actively markets health plans that otherwise meet the standard geographic accessibility guidelines contained in Bureau of Insurance Rule Chapter 850;

PART D

Sec. D-1. Department of Professional and Financial Regulation, Bureau of Insurance review of health insurance rate and form filing requirements. The Department of Professional and Financial Regulation, Bureau of Insurance shall review the State's health insurance rate and form filing requirements and make recommendations for changes in the requirements to reduce the costs and resources for insurers seeking regulatory approval of new health insurance products. In its review, the bureau shall identify the typical costs and resources for insurers seeking regulatory approval for new health insurance products in this State and, to the extent possible, compare those to the costs and resources for the regulatory approval of new health insurance products in other states. The bureau shall submit a report with its review and recommendations to the Joint Standing Committee on Insurance and Financial Services by January 16, 2008. The Joint Standing Committee on Insurance and Financial Services shall submit a bill to the Second Regular Session of the 123rd Legislature based on the recommendations from the bureau's report.

SUMMARY

This amendment strikes out all of the committee amendment and instead does the following in order to increase the affordability and accessibility of health care.

Part A repeals the guaranteed issuance and community rating law for individual health plans effective April 1, 2008 and allows carriers to treat their pre-April 1, 2008 book of business separately from their post-April 1, 2008 book of business. It makes changes to the continuity of coverage laws to allow underwriting when someone switches carriers in the individual market.

Part A creates the Comprehensive Health Insurance Risk Pool Association. The purpose of the association is to spread the cost of high-risk individuals among all health insurers. The bill funds the high-risk pool through an assessment on insurers. An individual insured through the high-risk pool may be charged a premium up to 150% of the average premium rates charged by carriers for similar health insurance plans. The bill requires the State to submit an application to the Federal Government for federal assistance to create a high-risk pool.

Part A also removes the requirement that carriers offer standardized plans as defined in Bureau of Insurance Rule Chapter 750 in the individual market.

Part B repeals the community rating law for small group health plans effective January 1, 2009 and enacts in its place provisions governing the rating of small group health plans based on a model act from the National Association of Insurance Commissioners.

Part C allows a health maintenance organization to offer health plans that do not comply with geographic access standards if the health maintenance organization also offers health plans that comply with those access standards or offers a fee-for-service health plan.

Part D requires the Department of Professional and Financial Regulation, Bureau of Insurance to conduct a study of the State's rate and form filing laws and make recommendations for changes to reduce the costs and resources expended by health insurance carriers seeking regulatory approval of new health insurance products.