

**§2808-B. Small group health plans**

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

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue small group health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all small group health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations. [PL 1991, c. 861, §2 (NEW).]

B. "Community rate" means the rate to be charged to all eligible groups for small group health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [PL 1991, c. 861, §2 (NEW).]

C. "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 hours or more. "Eligible employee" includes a sole proprietor, a partner of a partnership or an independent contractor, but does not include employees who work on a temporary or substitute basis. An employer may elect to treat as eligible employees part-time employees who work a normal work week of 10 hours or more as long as at least one employee works a normal work week of 30 hours or more. An employer may elect to treat as eligible employees employees who retire from the employer's employment. [PL 1999, c. 256, Pt. P, §1 (AMD).]

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 50 or fewer eligible employees during the preceding calendar year.

(1) If an employer was not in existence throughout the preceding calendar year, the determination must be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(2) In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(3) A group is not an eligible group if there is any one other state where there are more eligible employees than are employed within this State and the group had coverage in that state or is eligible for guaranteed issuance of coverage in that state.

(4) An employer qualifies as an eligible group for 2-person coverage if the employer provides a carrier with the following information demonstrating that the employer's business and employees meet the minimum qualifications for group coverage in paragraph C:

(a) A copy of the most recent quarterly combined filing for income tax withholding and unemployment contributions, Form 941/C1-ME;

(b) For an employee claimed to be an employee eligible for group coverage whose name is not listed on Form 941/C1-ME, a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding;

(c) If an employer is exempt from filing Form 941/C1-ME for group coverage, documentation of that exemption and a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding; or

(d) If the name of the business owner or employee does not appear on Form 941/C1-ME, a copy of one of the following:

- (i) Federal income tax Form Schedule C or Schedule F;
- (ii) Federal income tax Form 1120S, Schedule K-1;
- (iii) Federal income tax Form 1065, Schedule K-1;
- (iv) A workers' compensation insurance audit or evidence of a waiver of benefits under Title 39-A;
- (v) A description of operations in a commercial general liability insurance policy or equivalent insurance policy providing coverage for the business; or
- (vi) A signature card from a financial institution or credit union authorizing the employee to sign checks on a business checking or share draft account that is at least 6 months old; a notarized affidavit from the employer describing the duties of the employee and the average number of hours worked by the employee and attesting that the employer is not defrauding the carrier and is aware of the consequences of committing fraud or making a material misrepresentation to the carrier, including a loss of coverage and benefits; and, if the group coverage is purchased through a producer, a notarized affidavit from the producer affirming the producer's belief that the employer qualifies as an eligible group for coverage.

In determining if a new business or a business that adds an owner or a new employee to payroll during the course of a year qualifies as an eligible group for 2-person coverage under this subparagraph, the employer must submit an affidavit stating that all employees meet the criteria in this subparagraph and that the documentation and forms required under this subparagraph will be provided to the carrier when payroll records become available, when ownership distribution forms become available or the first renewal date of the coverage, whichever date is earlier. A false affidavit or misrepresentation on an affidavit submitted by an employer may result in the loss of group coverage and repayment of claims paid. This subparagraph may not be construed to prohibit a carrier from recognizing an employer as an eligible group if the employer has not produced the documentation required in this subparagraph.

This subparagraph applies only to an employer applying for group health insurance coverage as a 2-person group from October 1, 2001 to December 31, 2013. [PL 2011, c. 364, §9 (AMD).]

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A, B, C-1 or D. [PL 1997, c. 777, Pt. B, §2 (AMD).]

F. "Premium rate" means the rate charged to an eligible group or eligible individual for a small group health plan. [PL 1991, c. 861, §2 (NEW).]

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

- (1) Accident;
- (2) Credit;
- (3) Disability;

- (4) Long-term care or nursing home care;
- (5) Medicare supplement;
- (6) Specified disease;
- (7) Dental or vision;
- (8) Coverage issued as a supplement to liability insurance;
- (9) Workers' compensation;
- (10) Automobile medical payment; or
- (11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance. [PL 1991, c. 861, §2 (NEW).]

H. "Subgroup" means an employer with 50 or fewer employees within an association, a multiple employer trust, a private purchasing alliance or any similar subdivision of a larger group covered by a single group health policy or contract. For group policies issued to an employee leasing company as defined in Title 32, chapter 125, each client having 50 or fewer employees is considered a separate subgroup. [PL 2009, c. 244, Pt. F, §2 (AMD).]  
[PL 2011, c. 364, §9 (AMD).]

**2. Rating practices.** The following requirements apply to the rating practices of carriers providing small group health plans. This subsection does not apply to policies issued before January 1, 1998 to eligible groups that employed, on average, 25 to 50 eligible employees until their first renewal date on or after January 1, 1998.

A. [PL 2003, c. 469, Pt. E, §14 (RP).]

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group or any other rating factor not specified in this section. [PL 2019, c. 5, Pt. A, §9 (AMD).]

C. A carrier may vary the premium rate due to family membership and participation in wellness programs. The premium rate for a family must equal the sum of the premiums for each individual in the family, except that it may not be based on more than 3 dependent children who are less than 21 years of age. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for participation in wellness programs. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2019, c. 5, Pt. A, §10 (AMD).]

C-1. A carrier may vary the premium rate due to geographic area in accordance with the limitation set out in this paragraph. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and December 31, 2023, the rating factor used by a carrier for geographic area may not exceed 1.5. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2024, the rating factor used by a carrier for geographic area may not exceed 1.25. [PL 2021, c. 655, §2 (AMD).]

D. A carrier may vary the premium rate due to age and tobacco use in accordance with the limitations set out in this paragraph. A carrier that varies the premium rate due to age must vary the premium rate according to a uniform age curve. The superintendent shall adopt rules establishing a uniform age curve that is substantially similar to the age curve in effect on January 1, 2019 under the federal Affordable Care Act. Rules adopted under this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

- (1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.
- (2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1994 and July 14, 1995, the premium rate may not deviate above or below the community rate filed by the carrier by more than 33%.
- (3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and September 30, 2011, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.
- (4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.
- (5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.
- (6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.
- (7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.
- (8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, except as provided in subparagraph (10), the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.
- (9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and December 31, 2022, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2023 and December 31, 2023, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.25 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco

cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2024, a carrier may not vary the premium rate due to tobacco use.

(10) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this Act, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1 for individuals 21 years of age and older on the first day of coverage under the policy, contract or certificate. The variation in rate due to age must be actuarially justified for individuals under 21 years of age consistent with the uniform age rating curve adopted under this paragraph. [PL 2021, c. 344, §2 (AMD).]

D-1. [PL 2011, c. 90, Pt. A, §9 (RP).]

D-2. Notwithstanding the requirements of paragraph D, rates with respect to employees whose work site is not in this State may be based on area adjustment factors appropriate to that location. [RR 1997, c. 1, §22 (RAL).]

E. The superintendent may authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806 consistent with the provisions of this paragraph and applicable federal law.

(1) Association group membership or eligibility for participation in the trustee group may not be conditioned on health status, claims experience or other risk selection criteria.

(2) All health plans offered by the carrier through that association or trustee group must be made available on a guaranteed issue basis to all eligible employers that are members of the association or are eligible to participate in the trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:

- (a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;
- (b) Has been actively in existence for 5 years;
- (c) Has a constitution and bylaws or other analogous governing documents;
- (d) Has been formed and maintained in good faith for purposes other than obtaining insurance;
- (e) Is not owned or controlled by a carrier or affiliated with a carrier;
- (f) Has at least 1,000 members if it is a national association; 200 members if it is a state or local association;
- (g) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and
- (h) Is governed by a board of directors and sponsors annual meetings of its members.

(3) The aggregate rate charged by the carrier to the association or trustee group is considered a large group rate, and the terms of coverage are considered a large group health plan. Rates for participating employers within the group may vary only as permitted by paragraphs B to D-2.

(4) Producers may only market association memberships, accept applications for membership or sign up members in a professional association in which the individuals are actively engaged in or directly related to the profession represented by the professional association.

(5) Carriers may not be reinsured under section 3958 for coverage issued under this paragraph.

(6) Except for employers with plans that have grandfathered status under the federal Affordable Care Act, this paragraph does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014 until December 31, 2019. To the extent permitted under the federal Affordable Care Act, this paragraph applies to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2020. [PL 2019, c. 653, Pt. B, §3 (RPR).]

F. Premium rates charged to a private purchasing alliance, as defined by chapter 18-A, may be reduced in accordance with rules adopted pursuant to that chapter. [PL 1995, c. 673, Pt. A, §6 (NEW).]

G. [PL 2003, c. 469, Pt. E, §15 (RP).]

H. [PL 2019, c. 5, Pt. A, §12 (RP).]

I. Except for plans that have grandfathered status under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all small group health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act. [PL 2011, c. 364, §14 (NEW).]

[PL 2021, c. 655, §2 (AMD).]

**2-A. Rate filings.** A carrier offering small group health plans shall file with the superintendent the community rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

A. Every filing must state the effective date of the filing. Every filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days. [PL 2009, c. 244, Pt. C, §7 (AMD).]

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, paragraph B or section 2792, subsection 2. [PL 2019, c. 653, Pt. B, §4 (AMD).]

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C or section 2792, as applicable, for premium rates effective on or after July 1, 2004. [PL 2023, c. 59, §5 (AMD).]

[PL 2023, c. 59, §5 (AMD).]

**2-B. Rate review and hearings.** Except as provided in subsection 2-C and section 2792, rate filings are subject to this subsection.

A. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and

practices and on the basis of incurred claims experience and earned premiums. [PL 2023, c. 59, §6 (AMD).]

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision. [PL 2003, c. 469, Pt. E, §16 (NEW).]

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing. [PL 2011, c. 364, §15 (AMD).]

D. [PL 2023, c. 59, §7 (RP).]

E. [PL 2009, c. 244, Pt. C, §8 (RP).]

F. [PL 2009, c. 244, Pt. C, §9 (RP).]

[PL 2023, c. 59, §§6, 7 (AMD).]

**2-C. Guaranteed loss ratio.** Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B, except as otherwise provided in section 2792. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to subsection 2-B. [PL 2011, c. 364, §16 (AMD).]

A-1. [PL 2011, c. 364, §16 (RP).]

B. [PL 2011, c. 364, §16 (RP).]

C. [PL 2011, c. 364, §16 (RP).]

D. [PL 2011, c. 364, §16 (RP).]

E. [PL 2011, c. 364, §16 (RP).]

[PL 2019, c. 653, Pt. B, §7 (AMD).]

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

[PL 1999, c. 256, Pt. L, §1 (AMD).]

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

A. Any small group health plan offered to any eligible group or subgroup must be offered to all eligible groups that meet the carrier's minimum participation requirements, which may not exceed 75%, to all eligible employees and their dependents in those groups. In determining compliance with minimum participation requirements, eligible employees and their dependents who have existing health care coverage may not be considered in the calculation. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan. A carrier may deny coverage under a managed care plan, as defined by section 4301-A:

- (1) To employers who have no employees who live, reside or work within the approved service area of the plan; and
- (2) To employers if the carrier has demonstrated to the superintendent's satisfaction that:
  - (a) The carrier does not have the capacity to deliver services adequately to additional enrollees within all or a designated part of its service area because of its obligations to existing enrollees; and
  - (b) The carrier is applying this provision uniformly to individuals and groups without regard to any health-related factor.

A carrier that denies coverage in accordance with this subparagraph may not enroll individuals residing within the area subject to denial of coverage, or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage. [RR 2001, c. 1, §32 (COR).]

B. Renewal is guaranteed under section 2850-B. [PL 1997, c. 445, §17 (RPR); PL 1997, c. 445, §32 (AFF).]  
[RR 2001, c. 1, §32 (COR).]

**5. Cessation of business.**  
[PL 1997, c. 445, §18 (RP); PL 1997, c. 445, §32 (AFF).]

**6. Fair marketing standards.** Carriers providing small group health plans must meet the following standards of fair marketing.

A. Each carrier must actively market small group health plan coverage, including any standardized plans required to be offered pursuant to subsection 8-A, to eligible groups in this State. [PL 2009, c. 439, Pt. D, §2 (AMD).]

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

- (1) Encouraging or directing eligible groups to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; and
- (2) Encouraging or directing eligible groups to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [PL 1991, c. 861, §2 (NEW).]

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of a small group health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2. [PL 1991, c. 861, §2 (NEW).]



D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2. [PL 1991, c. 861, §2 (NEW).]

E. A carrier or representative of the carrier may not induce or otherwise encourage an eligible group to separate or otherwise exclude an employee from small group health plan coverage or benefits. [PL 1991, c. 861, §2 (NEW).]

F. Denial by a carrier of an application for coverage from an eligible group must be in writing and must state the reason or reasons for the denial. [PL 1991, c. 861, §2 (NEW).]

G. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of small group health plans in this State. [PL 1991, c. 861, §2 (NEW).]

H. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of small group health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [PL 1991, c. 861, §2 (NEW).]

I. Notwithstanding any other provision of this section, prior to January 1, 2014, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage. [PL 2011, c. 364, §17 (AMD).]

[PL 2011, c. 364, §17 (AMD).]

**7. Applicability.** This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 15, 1993. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary date of the policy, plan, contract or certificate.

[PL 1995, c. 332, Pt. D, §4 (AMD).]

#### **8. Standardized plans.**

[PL 2001, c. 410, Pt. A, §7 (RP).]

**8-A. Authority of the superintendent.** The superintendent may by rule define one or more standardized small group health plans that must be offered by all carriers offering small group health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2009, c. 439, Pt. D, §3 (NEW).]

**9. Reinsurance mechanism.** Small group carriers, except nonprofit hospital and medical service organizations, may form a reinsurance pool for the purpose of reinsuring small group risks. This pool may not become operative until the superintendent has approved a plan of operation. The superintendent may approve a plan only after the superintendent determines that the plan is in the public interest and is consistent with this section. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool. That guarantee constitutes a permanent financial obligation of each participant on a pro rata basis.

[PL 1993, c. 325, §1 (NEW).]

#### SECTION HISTORY

PL 1991, c. 861, §2 (NEW). PL 1993, c. 325, §1 (AMD). PL 1993, c. 477, §§B1-3 (AMD). PL 1993, c. 477, §F1 (AFF). PL 1993, c. 546, §2 (AMD). PL 1993, c. 588, §§1,2 (AMD). PL 1993,

c. 645, §A4 (AMD). PL 1995, c. 177, §2 (AMD). PL 1995, c. 332, §§D1-4,K2 (AMD). PL 1995, c. 673, §§A5,6 (AMD). RR 1997, c. 1, §22 (COR). PL 1997, c. 370, §E6 (AMD). PL 1997, c. 445, §§12-18 (AMD). PL 1997, c. 445, §32 (AFF). PL 1997, c. 777, §B2 (AMD). PL 1999, c. 256, §§E1,2,L1,P1 (AMD). RR 2001, c. 1, §32 (COR). PL 2001, c. 258, §§D1,E3,4 (AMD). PL 2001, c. 400, §1 (AMD). PL 2001, c. 400, §2 (AFF). PL 2001, c. 410, §§A3-7 (AMD). PL 2001, c. 410, §A10 (AFF). PL 2003, c. 313, §§1,2 (AMD). PL 2003, c. 428, §H5 (AMD). PL 2003, c. 469, §§E14-16 (AMD). PL 2005, c. 121, §§E1,2 (AMD). PL 2007, c. 629, Pt. M, §§6-10 (AMD). PL 2009, c. 244, Pt. C, §§7-9 (AMD). PL 2009, c. 244, Pt. F, §2 (AMD). PL 2009, c. 244, Pt. G, §2 (AMD). PL 2009, c. 439, Pt. D, §§1-3 (AMD). RR 2011, c. 1, §40 (COR). PL 2011, c. 90, Pt. A, §§6-10 (AMD). PL 2011, c. 90, Pt. D, §4 (AMD). PL 2011, c. 364, §§9-17 (AMD). PL 2011, c. 638, §§1-3 (AMD). PL 2019, c. 5, Pt. A, §§9-12 (AMD). PL 2019, c. 96, §1 (AMD). PL 2019, c. 653, Pt. B, §§3-7 (AMD). PL 2021, c. 344, §2 (AMD). PL 2021, c. 655, §2 (AMD). PL 2023, c. 59, §§5-7 (AMD).

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