An Act To Make Health Care Affordable, Accessible and Effective for All

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

PART A

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

B-1. A carrier may vary the premium rate due to family membership.

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

C. A carrier ~~may~~must vary the premium rate due to smoking status ~~and family membership~~for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. ~~The superintendent may adopt rules setting forth~~Carriers shall develop and submit to the superintendent appropriate methodologies regarding rate discounts based on smoking status. The superintendent shall report annually on the compliance with this paragraph to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~H-A~~2-A.

Sec. A-3. 24-A MRSA §2808-B, sub-§2, ¶B-1 is enacted to read:

B-1. A carrier may vary the premium rate due to family membership and group size.

Sec. A-4. 24-A MRSA §2808-B, sub-§2, ¶B-2 is enacted to read:

B-2. A carrier must vary the premium rate due to smoking status for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. Carriers shall develop and submit to the superintendent appropriate methodologies regarding rate discounts based on smoking status. The superintendent shall report annually on the compliance with this paragraph to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters.

Sec. A-5. 24-A MRSA §2808-B, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §3 and affected by §10, is further amended to read:

C. A carrier ~~may~~must vary the premium rate by January 1, 2008 due to ~~family membership, smoking status,~~ participation in wellness programs ~~and group size~~certified by the Maine Quality Forum established in section 6951 for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. ~~The superintendent~~

~~may adopt rules setting forth appropriate methodologies regarding rate discounts pursuant to this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.~~

Sec. A-6. 24-A MRSA §2839, as amended by PL 2003, c. 428, Pt. E, §2, is further amended to read:

§ 2839. Rates filed

A policy of group health insurance may not be delivered in this State until a copy of the group rates to be used in calculating the premium for these policies has been filed for informational purposes with the superintendent. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care insurance contracts and for certain association groups and other groups specified in section 2701, subsection 2, paragraph C must be filed in accordance with section 2736. Rates for small group health insurance subject to section 2808-B are subject to the additional filing requirements specified in that section.

A carrier must vary the premium rate due to smoking status for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. Carriers shall develop and submit to the superintendent appropriate methodologies regarding rate discounts based on smoking status. The superintendent shall report annually on the compliance with this paragraph to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters.

A carrier must vary the premium rate by January 1, 2008 due to participation in wellness programs certified by the Maine Quality Forum established in section 6951 for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008.

Sec. A-7. 24-A MRSA §6951, first ¶, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded, at least in part, through the ~~savings offset~~ payments made pursuant to former section 6913 and section 6913-A. Except as provided in section 6907, subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

Sec. A-8. 24-A MRSA §6951, sub-§10 is enacted to read:

10. Wellness program certification. The forum shall develop standards and criteria for wellness programs and shall certify such programs eligible for premium rate variances in accordance with section 2808-B, subsection 2, paragraph C and section 2839.

PART B

Sec. B-1. 24-A MRSA §2736, sub-§2, as amended by PL 1997, c. 344, §8, is further amended to read:

2. Filing; information. When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. ~~A~~ Notwithstanding the exception set forth in Title 1, section 402, subsection 3, paragraph B, a filing and supporting information, including all accompanying rates, rating formulas, rating classifications, trend documentation and actuarial information used to support the filing, are public records within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to section 2736-A.

Sec. B-2. 24-A MRSA §2736-C, sub-§2, ¶F, as enacted by PL 2003, c. 469, Pt. E, §12, is amended to read:

F. A carrier that adjusts its rate shall account for the ~~savings offset payment~~payments paid pursuant to former section 6913 or section 6913-A or any recovery ~~in that offset payment~~of those payments in its experience consistent with this section and former section 6913 and section 6913-A. With regard to accounting for any recovery of the payments paid pursuant to former section 6913 or section 6913-A, a carrier shall provide demonstrable proof to the superintendent and quantify the total amount negotiated and saved by the carrier.

Sec. B-3. 24-A MRSA §2808-B, sub-§2-A, ¶B, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

B. ~~A~~ Notwithstanding the exception set forth in Title 1, section 402, subsection 3, paragraph B, a filing and supporting information, including all accompanying rates, rating formulas, rating classifications, trend documentation and actuarial information used to support the filing, are public records ~~except as provided by~~within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to subsection 2-B, ~~paragraphs~~paragraph B or F.

PART C

Sec. C-1. 24-A MRSA §2736-C, sub-§5, as amended by PL 2003, c. 469, Pt. E, §13, is further amended to read:

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least ~~65%~~78% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any

~~savings offset~~ payments paid pursuant to former section 6913 or section 6913-A must be treated as incurred claims. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund total excess premiums to current in-force policyholders. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's individual policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large. The superintendent may adopt rules setting forth appropriate methodologies regarding refunds pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

A. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least ~~75%~~78% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any ~~savings offset~~ payments paid pursuant to former section 6913 or section 6913-A must be treated as incurred claims.

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.

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, unfairly discriminatory or not in compliance with former section 6913 or section 6913-A, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

D. A carrier that adjusts its rate shall account for the ~~savings offset payment~~payments paid pursuant to former section 6913 or section 6913-A or any recovery ~~of that savings offset payment~~of those payments in its experience consistent with this section and former section 6913 and section 6913-A. With regard to accounting for any recovery of the payments paid pursuant to former section 6913 or section 6913-A, a carrier shall provide demonstrable proof to the superintendent and quantify the total amount negotiated and saved by the carrier.

E. Any filing of rates, rating formulas and modifications that satisfies the criteria set forth in this paragraph is subject to the provisions of paragraph F:

(1) The proposed rate for any group or subgroup does not include a unit cost change that exceeds the index of inflation multiplied by 1.5, excluding any approved rate differential based on age. For the purposes of this subparagraph, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes this State for the most recent 12-month period immediately preceding the date of the filing for which data are available; and

(2) The carrier demonstrates in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratio of benefits incurred to premiums earned averages no less than 78% for the previous 36-month period.

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

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

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

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

G. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund total excess premiums to current in-force policyholders. For the purposes of calculating this loss-ratio percentage, any payments paid pursuant to former section

6913 or section 6913-A must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large. The superintendent may adopt rules setting forth appropriate methodologies regarding refunds pursuant to this subsection. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. C-3. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2005, c. 121, Pt. E, §§1 and 2, is repealed.

PART D

Sec. D-1. 24-A MRSA §4303, sub-§1, as amended by PL 2003, c. 469, Pt. E, §20 and c. 689, Pt. B, §6, is further amended to read:

1. Demonstration of adequate access to providers. Except as provided in ~~paragraph A~~paragraphs A-1 and B, a carrier offering a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent. These standards must consider the geographical and transportational problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

A. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

(1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;

(2) The health plan is consistent with product design guidelines for Bureau of Insurance Rule Chapter 750;

(3) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;

(4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;

(5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent may consult with other state entities, including the Department of Health and Human Services, Bureau of Health and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph. The superintendent shall provisionally adopt rules by January 1, 2004 regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph and present those rules for legislative review during the Second Regular Session of the 121st Legislature; and

(6) The financial provisions may not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.

This paragraph takes effect January 1, 2004 and is repealed July 1, 2007.

A-1. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

(1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;

(2) The health plan is consistent with product design guidelines for Bureau of Insurance Rule Chapter 750;

(3) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;

(4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;

(5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent

may consult with other state entities, including the Department of Health and Human Services and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph; and

(6) The financial provisions may not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.

B. Notwithstanding paragraph A-1, a carrier may develop and file with the superintendent for approval a pilot program that does not adhere to any geographic access requirements set forth in this Title or in rules adopted by the superintendent. Any carrier offering a health plan using this pilot program must collect data on the impact of the pilot program on premiums paid by enrollees, payments made to providers, quality of care received and access to health care services by individuals enrolled in health plans under the pilot program and must submit that data to the superintendent. The superintendent shall report annually beginning January 15, 2009 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on any approval of a pilot program pursuant to this paragraph.

PART E

Sec. E-1. 5 MRSA §12004-G, sub-§14-F is enacted to read:

14-F.

Health Care	Board of Directors of the Maine Individual Reinsurance Program	Not Authorized	24-A MRSA §3903

Sec. E-2. 24-A MRSA §2736-C, sub-§2, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

B. A carrier may not vary the premium rate due to the gender, ~~health status,~~ claims experience or policy duration of the individual. A carrier may vary the premium rate due to health status on that date that reinsurance is available under chapter 54.

Sec. E-3. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §2 and affected by §10, is further amended to read:

D. A carrier may vary the premium rate due to age, ~~occupation or industry~~health status and geographic area ~~only under the following schedule and within the listed percentage bands~~, in accordance with the limitations set out in this paragraph.

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

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

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after~~between July 15, 1995 and December 31, 2007, 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 January 1, 2008 and the date on which reinsurance is available under chapter 54, the maximum premium rate may not deviate above or below the community rate filed by the carrier for age and geographic area by more than 33%. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after the date on which reinsurance is available under chapter 54, the maximum premium rate may not deviate above or below the community rate filed by the carrier for age and geographic area by more than 50%. This limitation does not apply for determining rates for an attained age of less than 19 or more than 65 years.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after the date when reinsurance is available under chapter 54, the maximum premium rate may not deviate for health status by more than 10% above the community rate filed by the carrier and adjusted pursuant to subparagraph (4).

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

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

2-A. Reinsurance requirement. Carriers providing individual health plans must, as a condition of offering health benefit plans in this State to individuals, reinsure, pursuant to chapter 54, all such plans offered.

Sec. E-5. 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~~shall by rule define one or more standardized individual health plans that must be offered by all carriers offering individual health plans in the State, other than carriers offering only CHAMPUS supplemental coverage. One of the plans defined by rule under this section must be a plan that includes a $1,000 deductible, a prescription drug benefit not subject to a deductible and the option of no lifetime benefit maximum.

Sec. E-6. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

MAINE INDIVIDUAL REINSURANCE program

§ 3901. Short title

This chapter may be known and cited as "the Maine Individual Reinsurance Program Act."

§ 3902. Definitions

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

1. Board. "Board" means the board of directors of the program.

2. Dependent. "Dependent" has the same meaning as set forth in section 6903.

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

4. 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 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; or 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.

5. Medicare. "Medicare" means coverage under either Medicare Part A or Medicare Part B pursuant to 42 United States Code, Chapter 7, subchapter XVI.

6. Producer. "Producer" means a person who is licensed to sell medical insurance in this State.

7. Program. "Program" means the Maine Individual Reinsurance Program established in section 3903.

8. Reinsurer. "Reinsurer" means an insurer from whom a person providing medical 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.

9. Resident. "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2.

§ 3903. Maine Individual Reinsurance Program

1. Program established. The Maine Individual Reinsurance Program is established as a nonprofit legal entity.

2. Board of directors. The program is governed by a board of directors in accordance with this subsection.

A. The board consists of 14 members appointed pursuant to this paragraph:

(1) Eight members appointed by the superintendent, of whom:

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

(b) One must represent medical care providers;

(c) One must represent producers;

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

(e) One must represent Dirigo Health;

(2) Three members appointed by insurers belonging to the program, at least 2 of whom are domestic insurers; and

(3) Three ex officio, nonvoting members, 2 of whom are Legislators who serve as the Senate and House chairs of the joint standing committee of the Legislature having jurisdiction over health insurance matters, or the Legislators' designees, and one of whom is the director of the Governor's Office of Health Policy and Finance, or the Governor's designee.

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

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

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

3. Plan of operation; rules. The board shall adopt by rule a plan of operation, articles and bylaws in accordance with the requirements of this chapter within 90 days after the initial appointment of members of the board pursuant to subsection 2. Rules adopted 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 in that member's official capacity as a member of the board.

5. Staff assistance. Upon request from the board, the bureau and other appropriate agencies of State Government must provide staff assistance to the board during implementation of the program as necessary and appropriate.

§ 3904. Liability and indemnification

1. Liability. The board and any employees of the program may not be held liable for any obligations of the program. A cause of action may not arise against the program; the board, its agents or its employees; any insurer belonging to the program or its agents, employees or producers; or the superintendent for any action or omission in the performance of powers and duties pursuant to this chapter.

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

§ 3905. Duties and powers of the board

1. Duties. The board shall:

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

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

C. Select a program administrator in accordance with section 3906;

D. Establish procedures for the handling and accounting of program assets; and

E. Establish procedures for determining reinsurance amounts in accordance with section 3907.

2. Powers. The board may:

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

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

C. Sue or be sued;

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

E. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance and any other functions within the authority of the program;

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

G. Establish rules, conditions and procedures for reinsuring risks of insurers under the program in accordance with section 3907;

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

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

J. Establish and adopt such rules as are necessary and proper to implement this chapter. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

4. Review for solvency. The superintendent shall review the operations of the program after the first year and thereafter at least every 3 years to determine its solvency.

5. Annual report. The program 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 number and value of claims reinsured by the program and the financial solvency and the administrative expenses of the program.

6. Audit. The program must be audited every year by an independent auditor. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

§ 3906. Selection of program administrator

1. Selection of program administrator. The board shall select an appropriate entity through a competitive bidding process to administer the program.

2. Contract with program administrator. The program administrator selected pursuant to subsection 1 is contracted for a period of 3 years. At least one year prior to the expiration of each 3-year period of service by the program administrator, the board shall invite all insurers, including the current program administrator, to submit bids to serve as the program administrator for the succeeding 3-year period. The selection of the program administrator for the succeeding period must be made at least 6 months prior to the expiration of the current 3-year period.

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

A. Perform all administrative functions relating to the program;

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

C. Following the close of each calendar year, determine reinsurance premiums, the amount of collections from the premium tax on health maintenance organizations pursuant to Title 36, section 2521-D, the expenses of administration pertaining to the reinsurance operations of the program and the incurred losses of the year and report this information to the superintendent; and

D. Pay reinsurance amounts as provided for in the plan of operation under section 3903, subsection 3.

4. Payment to program administrator. The program administrator selected pursuant to subsection 1 must be paid, as provided in the contract of the program under subsection 2, for the program administrator's direct and indirect expenses incurred in the performance of the program administrator's services. As used in this subsection, "direct and indirect expenses" includes that portion of the audited administrative costs, printing expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the program administrator that are approved by the board as allocable to the administration of the program and included in the specifications of a bid under subsection 2.

§ 3907. Reinsurance; premium rates

1. Reinsurance amount. Any insurer offering an individual health insurance plan pursuant to section 2736-C must be reinsured by the program to the level of coverage provided in this subsection, beginning on January 1, 2009, and is liable to the program for the reinsurance premium rate established in accordance with subsection 2.

A. The program may not reimburse an insurer with respect to claims of an insured individual until the insurer has incurred a certain level of claims for covered benefits in a calendar year for that individual, in an amount and level to be determined by the board by June 1, 2008 and then annually thereafter. The total amount of claims projected to be reinsured for all individuals each calendar year and the projected administrative expenses for the program must be equal to the sum of projected revenue from the premiums tax on health maintenance organizations pursuant to Title 36, section 2521-D plus the reinsurance premiums collected pursuant to subsection 2. The program may annually adjust the initial amount and level of claims to reflect increases in costs and utilization within the standard market for health plans within the State. The adjustments may not be less than the annual change in the medical component of the Consumer Price Index, as reported by the United States Department of Labor, Bureau of Labor Statistics, unless the superintendent approves a lower adjustment factor as requested by the program, and may not be more than the projected revenue from the premiums tax on health maintenance organizations pursuant to Title 36, section 2521-D plus the reinsurance premiums collected pursuant to subsection 2.

2. Premium rates. The program, as part of the plan of operation under section 3903, subsection 3, shall establish a methodology for determining premium rates to be charged insurers offering individual health plans pursuant to section 2736-C. The program shall review at least biannually the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The program shall consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer.

§ 3908. Actions against program or members based upon joint or collective actions

Participation in the program, 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 program or any insurer belonging to the program.

Sec. E-7. 24-A MRSA c. 87, sub-c. 3, as amended, is repealed.

Sec. E-8. 36 MRSA §2513, first ¶, as amended by PL 2005, c. 218, §30, is further amended to read:

Every health maintenance organization that has been issued a certificate of authority under Title 24-A, section 4204 and every insurance company or association that does business or collects premiums or assessments including annuity considerations in the State, including surety companies and companies engaged in the business of credit insurance or title insurance, shall, for the privilege of doing business in this State, and in addition to any other taxes imposed for such privilege pay a tax upon all gross direct

premiums including annuity considerations, whether in cash or otherwise, on contracts written on risks located or resident in the State for insurance of life, annuity, fire, casualty and other risks at the rate of 2% a year. Every surplus lines insurer that does business or collects premiums in the State shall, for the privilege of doing business in this State, and in addition to any other taxes imposed for such privilege, pay a tax upon all gross direct premiums, whether in cash or otherwise, on contracts written on risks located or resident in the State at the rate of 3% a year. The tax must be paid by the insurer's licensed producer with surplus lines authority pursuant to Title 24-A, section 2016. For purposes of this section, the term "annuity considerations" includes amounts paid to an insurance company when received for the purchase of a contract that may result in an annuity, even when the annuitization never occurs or does not occur until some time in the future and the amounts are in the meantime applied to an investment vehicle other than an annuity. This section does not apply to mutual fire insurance companies under section 2517 or to captive insurance companies incorporated under the laws of another state.

Sec. E-9. 36 MRSA §2513, as amended by PL 2005, c. 218, §30, is further amended by adding at the end a new paragraph to read:

Notwithstanding any other provision of law, a health maintenance organization is not eligible for any credit against the tax imposed by this section other than the credit allowed by section 2530.

Sec. E-10. 36 MRSA §2518, as amended by PL 1997, c. 435, §4, is further amended to read:

§ 2518. Neglect to make return; assessment; failure to pay

If any insurance company, health maintenance organization, captive insurance company or association fails to pay on demand a tax assessed under section 141, subsection 2, paragraph C, the State Tax Assessor shall certify that failure to the Superintendent of Insurance who shall give notice to the company or association that it may not do any more business in the State. Whoever, after such notice, does business for such company or association is guilty of a Class E crime.

Sec. E-11. 36 MRSA §2521-A, first ¶, as amended by PL 2005, c. 218, §31, is further amended to read:

Every insurance company, health maintenance organization, captive insurance company, association, producer or attorney-in-fact of a reciprocal insurer subject to the tax ~~as~~ imposed by this chapter shall on or before the last day of each April, the 25th day of each June and the last day of each October file with the State Tax Assessor on forms prescribed by the ~~State Tax Assessor~~assessor a return for the quarter ending the last day of the preceding month, except for the month of June, which is for the quarter ending June 30th. These returns may be on an estimated basis, as long as each April and June installment equals at least 35% of the total tax paid for the preceding calendar year or 35% of the total tax to be paid for the current calendar year. The remaining installments must equal 15% of the total tax to be paid for the preceding calendar year or 15% of the total tax to be paid for the current year. An authorized company official shall affirm which elective is selected. Such elective can not be changed during the current calendar year. The final return must be filed on or before March 15th covering the prior calendar year. Notwithstanding this paragraph, a health maintenance organization, with regard to the tax imposed by this chapter on premiums received during the last quarter of calendar year 2007 must report and pay 100% of the tax by March 15, 2008. All subsequent reports and payments by a health maintenance organization must be based on the estimated basis determined in accordance with this section except that

for 2008 the estimated reports and payments must be based on the tax that would have applied to the total premiums received by the taxpayer in calendar year 2007 had it been subject for the entire year to the tax imposed by this chapter.

Sec. E-12. 36 MRSA §2521-D is enacted to read:

§ 2521-D. Applications of revenues

1. Credited to suspense account. Revenues derived from the tax imposed by this chapter on health maintenance organizations must be credited to a General Fund suspense account.

2. Transfers in 2008. On or before the last day of each month of calendar year 2008, the State Controller shall transfer 85% of the revenues credited to the suspense account under subsection 1 during the month to the Dirigo Health Enterprise Fund established by Title 24-A, section 6915 and 15% of the revenues credited to the suspense account to the General Fund. When the General Fund has received $1,250,000 for the fiscal year ending June 30, 2008, all subsequent suspense fund revenues must be credited to the Dirigo Health Enterprise Fund, but only up to and including the transfer due by June 30, 2008.

3. Transfers in 2009 and thereafter. On or before the last day of each month of calendar year 2009 and of each calendar year thereafter, the State Controller shall transfer 85% of the revenues credited to the suspense account under subsection 1 during the month to the individual reinsurance plan established by Title 24-A, chapter 54 and 15% of the revenues credited to the suspense account to the General Fund. When the General Fund has received $1,500,000 for the fiscal year ending June 30, 2009 and for each fiscal year thereafter, all subsequent suspense fund revenues must be credited to the individual reinsurance plan, but only up to and including the transfer due by June 30th of each fiscal year.

Sec. E-13. 36 MRSA §5102, sub-§6, as amended by PL 2001, c. 439, Pt. D, §1 and affected by §9, is further amended to read:

6. Corporation. "Corporation" means any business entity subject to income taxation as a corporation under the laws of the United States, except the following:

A. A corporation that is subject to tax under chapter 357 or that would be subject to tax under chapter 357 if the insurance business conducted by such corporation were conducted in this State;

B. A corporation subject to tax under section 5206; or

C. A business entity referred to in Title 24-A, section 1157, subsection 5, paragraph B, subparagraph (1).

~~For purposes of this subsection, a corporation described in paragraph A is an "insurance company," and a health maintenance organization to the extent operated under authority of a certificate issued by the Superintendent of Insurance pursuant to Title 24-A, section 4204 is a "Maine health maintenance organization." Notwithstanding paragraph A, an insurance company is subject to the tax imposed by this Part with respect to income it receives from a Maine health maintenance organization, except where~~

~~the Maine health maintenance organization is separately organized and subject to income taxation. The provisions of this Part pertaining to the taxation and reporting obligations of a unitary business, including section 5200, section 5220, subsection 5 and section 5244, apply to the income, factors and affiliations of an insurance company arising from a Maine health maintenance organization as though the Maine health maintenance organization were a separate corporation, but do not otherwise apply to such insurance company.~~

Sec. E-14. 36 MRSA §5256, sub-§1, as amended by PL 1995, c. 281, §32 and affected by §43, is further amended to read:

1. General. For purposes of the tax imposed by this Part, a taxpayer's taxable year is the same as the taxpayer's taxable year for federal income tax purposes. Notwithstanding this subsection, the taxable year of a health maintenance organization that has a taxable year for federal income tax purposes that begins on or before September 30, 2007 and ends after September 30, 2007 ends for purposes of the tax imposed by this Part on September 30, 2007, and the health maintenance organization shall compute the tax for the resulting short taxable year in accordance with subsection 2. For purposes of this subsection, "health maintenance organization" means a health maintenance organization that has been issued a certificate of authority under Title 24-A, section 4204.

Sec. E-15. Application. Those sections of this Part that amend the Maine Revised Statutes, Title 36, sections 2513, 2518 and 2521-A and enact Title 36, section 2521-D apply to premiums collected on or after October 1, 2007. That section of this Part that amends Title 36, section 5102, subsection 6 applies to tax years beginning on or after October 1, 2007.

Sec. E-16. Staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 3903, of those original members of the board of directors of the Maine Individual Reinsurance Program appointed by the Superintendent of Insurance, 3 members serve for a term of one year, 3 members for a term of 2 years and 2 members for a term of 3 years. Of those original members appointed by insurers, one member serves for a term of one year, one member serves for a term of 2 years and one member serves for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

Sec. E-17. Contingent repeal; report; certification. The Maine Revised Statutes, Title 24-A, chapter 54 is repealed if the percentage certified by the Superintendent of Insurance for any carrier pursuant to subsection 3 is greater than the percentage reported by the superintendent pursuant to subsection 1.

1. Report by superintendent. By October 1, 2007, the Superintendent of Insurance shall report to the Joint Standing Committee on Insurance and Financial Services the percentage by which individual health insurance rates would be less than those that would be applicable in the absence of the reinsurance requirements set forth in this Part, using a model based upon generally accepted actuarial principles.

2. Filing by carriers. Each carrier providing individual health plans in the State must file no later than September 1, 2008 the percentage by which its rates for January 1, 2009 and thereafter will be less than that which would be applicable in the absence of the reinsurance requirements set forth in this Part.

3. Certification by superintendent. The Superintendent of Insurance shall review the filings for all carriers submitted pursuant to subsection 2 and shall certify whether for each carrier the percentage is at least equal to that reported in accordance with subsection 1 by the superintendent on October 1, 2007. No later than November 1, 2008, the superintendent shall submit the certification to the Joint Standing Committee on Insurance and Financial Services and shall forward a copy of the certification to the Office of the Revisor of Statutes.

PART F

Sec. F-1. 22 MRSA §1721 is enacted to read:

§ 1721. Voluntary restraint

1. Voluntary restraint. To control the rate of growth of the costs of hospital services, each hospital licensed under chapter 405 may voluntarily restrain cost increases and consolidated operating margins in accordance with this section. Each hospital shall annually report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding its efforts made pursuant to this section. The targets and methodology apply to each hospital's fiscal year beginning on or after July 1, 2008.

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this section, a hospital's consolidated operating margin is calculated by dividing its consolidated operating income by its total consolidated operating revenue.

B. Each hospital may voluntarily restrain its increase in its expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge to no more than 110% of the forecasted increase in the hospital market basket index for the coming federal fiscal year, as published in the Federal Register, when the federal Centers for Medicare and Medicaid Services publishes the Medicare program's hospital inpatient prospective payment system rates for the coming federal fiscal year. For purposes of this paragraph, the measure of a hospital's expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge is calculated by:

(1) Calculating the hospital's total hospital-only expenses;

(2) Subtracting from the hospital's total hospital-only expenses the amount of the hospital's bad debt;

(3) Subtracting from the amount reached in subparagraph (2) the hospital taxes paid to the State during the hospital's fiscal year; and

(4) Dividing the amount reached in subparagraph (3) by the product of:

(a) The number of inpatient discharges, adjusted by the all payer case mix index for the hospital; and

(b) The ratio of total gross patient service revenue to gross inpatient service revenue.

For the purposes of this paragraph, a hospital's total hospital-only expenses include any item that is listed on the hospital's Medicare cost report as a subprovider, such as a psychiatric unit or rehabilitation unit, and does not include nonhospital cost centers shown on the hospital's Medicare cost report, such as home health agencies, nursing facilities, swing beds, skilled nursing facilities and hospital-owned physician practices. For purposes of this paragraph, a hospital's bad debt is as defined and reported in the hospital's Medicare cost report and as submitted to the Maine Health Data Organization pursuant to Title 22, chapter 1683.

PART G

Sec. G-1. 24-A MRSA §6908, sub-§1, ¶K, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

K. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; ~~and~~

Sec. G-2. 24-A MRSA §6908, sub-§1, ¶L, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

L. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more organizations organized, created or operated under the laws of this State~~.~~;

Sec. G-3. 24-A MRSA §6908, sub-§1, ¶M is enacted to read:

M. Establish and administer grant, subsidy and facilitation programs designed to assist providers and health care practitioners in the development, enhancement and maintenance of quality improvement infrastructure and processes. Dirigo Health may solicit and collect contributions to fund these programs; and

PART H

Sec. H-1. 24-A MRSA §2808-B, sub-§1, ¶E, as amended by PL 1997, c. 777, Pt. B, §2, is further amended to read:

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 or E.

Sec. H-2. 24-A MRSA §2849-B, sub-§3, ¶C-1, as amended by PL 2005, c. 683, Pt. A, §42, is further amended to read:

C-1. That person was covered by the Cub Care program under Title 22, section 3174-T, and the request for replacement coverage is made while coverage is in effect or within 30 days from the termination of coverage; ~~or~~

Sec. H-3. 24-A MRSA §2849-B, sub-§3, ¶D, as enacted by PL 1995, c. 332, Pt. F, §5, is amended to read:

D. That person was previously ineligible for coverage and the request for enrollment is made within 30 days of the date the person becomes eligible~~.~~; or

Sec. H-4. 24-A MRSA §2849-B, sub-§3, ¶E is enacted to read:

E. That person is eligible for MaineCare under Title 22, section 3174 and is eligible for a premium payment by MaineCare for a group health plan pursuant to rules adopted by the Department of Health and Human Services.

PART I

Sec. I-1. 24-A MRSA c. 87, sub-c. 4 is enacted to read:

SUBCHAPTER 4

MAINE HEALTH CARE SHARED RESPONSIBILITY

§ 6991. Contribution requirement established

For the purpose of increasing access to health care and more equitably distributing the rising costs of health care provided to uninsured residents of this State, an employer and individual health care shared responsibility contribution requirement is established under this subchapter to provide a fair and reasonable method for sharing health care costs with employers who do not offer their employees health care coverage and with individuals who do not have health care coverage.

§ 6992. Employers' health care shared responsibility contribution

1. Assessment. Beginning July 1, 2008, the Board of Directors of Dirigo Health shall assess, and certain employers shall pay, an employer health care shared responsibility contribution for each full-time equivalent uncovered employee.

2. Rulemaking. The board, in consultation with representatives from the business, labor, economic development, taxation, consumer, insurance and health care communities along with other interested stakeholders, shall develop rules and definitions necessary to implement this section. Rules adopted pursuant to this subsection must include, but are not limited to, rules establishing:

A. The parameters of the employer health care shared responsibility requirements;

B. The size and number of employers affected;

C. The amount of contributions owed by employers who do not provide coverage to their employees. Contributions pursuant to this paragraph may be established using a sliding scale;

D. The method of collecting assessments; and

E. The definition of "uncovered employee."

In developing rules under this subsection, the board shall consider equity among employers and the impact on the business climate in this State. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

3. Funds deposited. Contributions collected under this section must be deposited into the Dirigo Health Enterprise Fund established under section 6915.

§ 6993. Individual health care shared responsibility contribution

1. Assessment. Beginning January 1, 2009, the board shall assess an individual health care shared responsibility contribution on certain residents of the State, 18 years of age and older, who meet the income financial eligibility threshold established by the board and who do not obtain and maintain minimum acceptable health care coverage.

2. Rulemaking. The board, in consultation with representatives from the business, labor, economic development, taxation, consumer, insurance and health care communities along with other interested stakeholders, shall develop rules and definitions necessary to implement this section. Rules adopted pursuant to this subsection must include, but are not limited to, rules establishing:

A. The parameters of the individual health care shared responsibility requirement;

B. The individual income financial threshold;

C. The amount of contributions owed by uncovered individuals;

D. The method of collecting assessments; and

E. The definition of "minimum acceptable health care coverage."

Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

3. Funds deposited. Contributions collected under this section must be deposited into the Dirigo Health Enterprise Fund established under section 6915.

§ 6994. Rulemaking

In addition to the rules adopted pursuant to sections 6992, subsection 2 and section 6993, subsection 2, the board shall adopt any other necessary rules to implement this subchapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

PART J

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

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~~of 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~~. MaineCare is not considered existing health care coverage for the purposes of this paragraph. If an employee declines coverage because the employee has other coverage, any dependents of that employee who are not eligible under the employee's other coverage are eligible for coverage under the small group health plan. A carrier may deny coverage under a managed care plan, as defined by section 4301-A:

(1) To employers who have no employees who live, reside or work within the approved service area of the plan; and

(2) To employers if the carrier has demonstrated to the superintendent's satisfaction that:

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

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

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

Sec. J-2. 24-A MRSA §6903, sub-§6, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

6. Eligible employee. "Eligible employee" means an employee of an eligible business who works at least ~~2~~0<u>10</u> hours per week for that eligible business. "Eligible employee" does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

Sec. J-3. 24-A MRSA §6908, sub-§1, ¶N is enacted to read:

<u>N. Provide subsidies for eligible enrollees for health benefit products it approves that are offered by multiple licensed health insurance carriers in the State.</u>

Sec. J-4. 24-A MRSA §6910, sub-§3, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

3. Carrier participation requirements. To qualify as a carrier of Dirigo Health Program coverage, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.

Health insurance carriers that seek to qualify to provide Dirigo Health Program coverage ~~must~~<u>may</u> also qualify as health plans in Medicaid.

Sec. J-5. 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 eligible employees ~~that work 30 hours or more per week and~~ who do not have other creditable coverage, not including MaineCare enrollees, 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.

(9) Dirigo Health may provide participating employers assistance to adopt and maintain a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 United States Code, Section 125.

Sec. J-6. 24-A MRSA §6912, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

PART K

Sec. K-1. 24-A MRSA §423-D, sub-§3 is enacted to read:

3. Report by superintendent. The superintendent shall report each year to the joint standing committee of the Legislature having jurisdiction over insurance matters on the number of previously uninsured individuals in this State who have enrolled during that year in any health insurance product regulated by the bureau, which information is collected pursuant to rules adopted under this section.

PART L

Sec. L-1. 24-A MRSA §2736, sub-§3, ¶B, as amended by PL 2003, c. 469, Pt. E, §9, is repealed.

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

2. Annual filing. Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. The filing must also certify that the carrier has included in its experience any ~~savings offset~~ payments or recovery of those ~~savings offset~~ payments consistent with former section 6913 or section 6913-A. The filing also must state the number of policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

Sec. L-3. 24-A MRSA §6908, sub-§1, ¶A, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

A. Take any legal actions necessary or proper to recover or collect ~~savings offset~~ payments provided in section 6913-A due Dirigo Health or that are necessary for the proper administration of Dirigo Health;

Sec. L-4. 24-A MRSA §6908, sub-§2, ¶B, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

B. Collect the ~~savings offset~~ payments provided in former section 6913 or section 6913-A;

Sec. L-5. 24-A MRSA §6913, as amended by PL 2007, c. 1, Pt. X, §§1 and 2 and affected by §3, is repealed.

Sec. L-6. 24-A MRSA §6913-A is enacted to read:

§ 6913-A. Surcharge

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

A. "Hospital" means an acute care health care facility:

(1) With permanent inpatient beds planned, organized, operated and maintained to offer for a continuing period of time facilities and services for the diagnosis and treatment of illness, injury and deformity;

(2) With a governing board and an organized medical staff offering continuous 24-hour professional nursing care;

(3) With a plan to provide emergency treatment 24 hours a day and including other services as defined in rules of the Department of Health and Human Services relating to licensure of general and specialty hospitals; and

(4) That is licensed under Title 22, chapter 405 as a general hospital, specialty hospital or critical access hospital.

For purposes of this paragraph, "hospital" does not include a nursing home or a publicly owned specialty hospital.

B. "Payments subject to surcharge" means all amounts paid, directly or indirectly, by surcharge payors to hospitals for all hospital-only health services on or after the effective date of this paragraph, except that "payments subject to surcharge" does not include payments with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance. "Payments subject to surcharge" may exclude amounts established in rules adopted by the board for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost-effective. For the purposes of this paragraph, a hospital's hospital-only services include any item that is listed on the hospital's Medicare cost report as a subprovider and submitted to Maine Health Data Organization pursuant to Title 22, chapter 1683, such as a psychiatric unit or rehabilitation unit, and do not include nonhospital cost centers shown on the hospital's Medicare cost report, such as home health agencies, nursing facilities, swing beds, skilled nursing facilities and hospital-owned physician practices.

C. "Publicly owned specialty hospital" means a publicly owned hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and that is licensed as a specialty hospital by the Department of Health and Human Services.

D. "Surcharge payor" means an individual or entity that pays for or arranges for the purchase of health care services provided by hospitals, except that "surcharge payor" does not include:

(1) Any governmental entity that pays for health care services provided under the Medicare program or Medicaid program, or beneficiaries or recipients under those programs;

(2) Any federal governmental entity that pays for health care services, or beneficiaries or recipients under those programs; or

(3) An insurance company or other entity for health care services provided pursuant to the Maine Workers' Compensation Act of 1992.

2. Surcharge. Hospitals shall assess a surcharge on all payments subject to surcharge. The surcharge is distinct from any other amount paid by a surcharge payor for the services of the hospital. The surcharge amount equals the product of the surcharge percentage and amounts paid for those services by a surcharge payor. The board shall determine not later than April 1, 2008 and then annually by April 1st thereafter the surcharge percentage through the following methodology:

A. The board shall determine the actual total payments subject to surcharge in the preceding calendar year by all surcharge payors to all hospitals;

B. The board shall determine the actual total incurred claims in the previous calendar year by the uninsured and the previously underinsured enrollees in the benefits plan offered by the Dirigo Health Program and MaineCare enrollees due to an expansion in MaineCare eligibility occurring after June 30, 2004, minus the portion of those claims that would have been paid prior to enrollment in the Dirigo Health Program or Mainecare; and

C. The board shall determine the surcharge percentage by dividing the total in paragraph B by the total in paragraph A.

The board may adopt any rules necessary to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

3. Billing. Beginning July 1, 2008, each hospital shall bill a surcharge payor an amount equal to the surcharge described in subsection 2 as a separate and identifiable amount distinct from any amount billed to or paid by a surcharge payor for hospital services. Each surcharge payor shall pay the surcharge amount to Dirigo Health, which amount must be pooled with other revenues of Dirigo Health in the Dirigo Health Enterprise Fund established in section 6915.

4. Surcharge payor's liability. The board shall specify by rule appropriate mechanisms that provide for determination and payment of a surcharge payor's liability, including requirements for data to be submitted by surcharge payors and hospitals. A surcharge payor's liability, in the case of a transfer of ownership, must be assumed by the successor in interest to the surcharge payor.

5. Failure to pay surcharge payments. The board shall establish by rule an appropriate mechanism for enforcing a surcharge payor's liability to the Dirigo Health Enterprise Fund in the event that a surcharge payor does not make a scheduled payment under subsection 3, except that the board, for the purpose of administrative simplicity, may establish threshold liability amounts below which enforcement may be modified or waived. Such an enforcement mechanism must include an assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18% and late fees or penalties at a rate not to exceed 5% per month.

6. Demonstration of recovery of surcharge payments through reduction in bad debt and charity care. In accordance with the requirements of this subsection, every health insurance carrier and provider shall demonstrate that best efforts have been made to ensure that a carrier has recovered surcharge payments made pursuant to this section through negotiated reimbursement rates that reflect providers' reductions or stabilization in the cost of bad debt and charity care, as determined in subsection 2.

A health insurance carrier shall use best efforts to ensure health insurance premiums reflect any such recovery of surcharge payments as those surcharge payments are reflected through incurred claims experience in accordance with subsection 7.

7. Demonstration of offset. As provided in sections 2736-C, 2808-B and 2839-B, the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, any reduction or avoidance of bad debt and charity care costs to providers in this State, as determined in subsection 2.

8. Definition of "actual total incurred claims," "uninsured" and "underinsured"; rulemaking. The board shall adopt rules establishing the definitions of the terms "actual total incurred claims," "uninsured" and "underinsured" for the purposes of calculating the surcharge percentage under subsection 2.

The board shall adopt other rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

9. Reports. The following reports are required in accordance with this subchapter.

A. On a quarterly basis no less than 60 days from the end of each quarter, the board shall collect and report on the following:

(1) The total enrollment in the Dirigo Health Program, including the number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees and the number of enrollees enrolled through small employers;

(2) The number of new participating employers in the Dirigo Health Program;

(3) The number of employers ceasing to offer coverage through the Dirigo Health Program;

(4) The duration of employers participating in the Dirigo Health Program; and

(5) A comparison of actual enrollees in the Dirigo Health Program to the projected enrollees.

Sec. L-7. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§ 6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any ~~savings offset~~ payments made pursuant to former section 6913 or section 6913-A and any funds received from any public or private source. The fund may be used by Dirigo Health to exercise its powers and duties pursuant to this chapter. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. L-8. Savings offset payments calculated prior to effective date. Notwithstanding that section of this Part that repeals the Maine Revised Statutes, Title 24-A, section 6913, any savings offset payment calculated and required under former Title 24-A, section 6913 prior to the effective date of this Part is due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913.

Sec. L-9. Revisor's review; cross-references. The Revisor of Statutes shall review the Maine Revised Statutes and include in the errors and inconsistencies bill submitted to the Second Regular Session of the 123rd Legislature pursuant to Title 1, section 94 any sections necessary to correct and update any cross-references in the statutes to provisions of law repealed in this Act.

SUMMARY

This bill accomplishes the following.

Part A requires all insurance carriers to offer a discount on premiums for nonsmokers and requires insurance carriers in the small and large group markets to offer a discount on premiums for participants in workplace wellness programs. This Part directs Dirigo Health's Maine Quality Forum to develop certification standards for eligible workplace wellness programs.

Part B clarifies that all rate filings, as well as information and documentation used to support the filings, are public records. It also requires that carriers provide demonstrable proof and quantify the amount of any recovery of the savings offset payment until repealed or the surcharge through negotiations with health care providers as part of the filing.

Part C requires a medical loss ratio of 78% in the individual market and requires approval from the Department of Professional and Financial Regulation, Bureau of Insurance for all rate filings in the small group market. This Part also requires carriers to refund the amount of the premium above the amount necessary to achieve a 78% loss ratio to policyholders in both the individual and small group markets.

Part D extends the provision allowing carriers to lower premium costs by including financial incentives to members to use designated providers and gives the Superintendent of Insurance the authority to develop a financial incentive pilot program that allows companies to offer products in which consumers can choose to travel further for cost savings and better quality.

Part E establishes a reinsurance plan for the individual health insurance market, effective January 2009. It preserves guaranteed issue, keeps all people in the same pool and provides reinsurance for all claims above a certain limit, reducing the community rate in the individual insurance market. It requires that all insurers in the individual market offer a plan that includes a $1,000 deductible, a prescription drug benefit not subject to a deductible and the option of no lifetime benefit maximum. It expands individual insurance market community rating bands for age and geography to plus or minus 33% in 2008; in 2009, when the reinsurance program becomes effective, the bands may be adjusted to plus or minus 50% and by an additional 10% upward for variation in health status. If individual insurance market savings are not achieved in the rate-filings submitted by insurers to the Bureau of Insurance by September 1, 2008, the 2009 rating expansions and the law establishing the individual reinsurance plan will not go into effect.

Part E also provides that health maintenance organizations are subject to the tax imposed on insurance premiums beginning October 1, 2007, with 85% of the resulting revenue dedicated to the Dirigo Health Program for one year and then to the individual reinsurance plan in the Maine Revised Statutes, Title 24-A, chapter 54. The reinsurance program is also financed in part by reinsurance premiums paid by insurers in the individual market. Beginning October 1, 2007, health maintenance organizations will not be subject to the corporate income tax. This Part also amends the Maine corporate income tax law to provide that income received by an insurance company from a health maintenance organization that is not separately organized is also not subject to the corporate income tax.

Part F makes permanent, beginning on or after July 1, 2008, the temporary voluntary cost containment targets on hospital consolidated operating margins and cost increases, which were initiated in Public Law 2003, chapter 469, Part F, section 1 and which otherwise would expire.

Part G allows Dirigo Health to administer grants and other subsidies to strengthen the State's health care quality improvement infrastructure.

Part H allows persons who become eligible for premium assistance through MaineCare to enroll in their employer’s group health care plan outside of the annual open enrollment period in order to allow MaineCare to pay eligible employees' premiums.

Part I establishes a health care shared responsibility program to require certain employers and individuals who do not offer or take up health insurance to pay a fee toward coverage of the uninsured. This Part directs Dirigo Health, in consultation with representatives from the business, labor, economic development, taxation, consumer, insurance and health care communities along with other interested stakeholders, to adopt major substantive rules to implement this program and to address the concerns for affordability and fairness and the impact on the business climate.

Part J disallows employers from counting MaineCare enrollees for purposes of determining the 75% of workforce eligibility for small group health plans, including DirigoChoice. This Part allows Dirigo Health to reduce the amount employers must contribute toward coverage to join DirigoChoice and also allows Dirigo Health, once the health care shared responsibility contribution requirement is implemented, to subsidize approved plans provided by multiple carriers. This Part also reduces from 20 to 10 the number of hours employees must work before being eligible for coverage under their employer’s DirigoChoice plan. This Part allows Dirigo Health to assist employers in establishing payroll deduction systems that would help employees purchase health coverage with pre-tax dollars.

Part K requires the Superintendent of Insurance to report yearly to the Legislature the numbers of previously uninsured individuals who have enrolled in any health insurance product regulated by the Bureau of Insurance.

Part L replaces the savings offset payment with a surcharge. The surcharge is added to certain payments made to hospitals and is paid to Dirigo Health by an expanded group of payors, some of whom are now exempt from payment. The intent of this provision is to reduce the amount paid by each payor by sharing responsibility among a larger group of payors. The amount of the surcharge cannot exceed the actual total incurred claims paid in the preceding year for previously underinsured and uninsured individuals now covered through the program. The Board of Directors of Dirigo Health has the authority to exclude amounts established by rule for which the costs and efficiency of billing or enforcing collection from an individual would not be cost-effective.