An Act To Continue Maine's Leadership in Covering the Uninsured

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

PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§10 is enacted to read:

10. Pilot projects; persons under 30 years of age. The superintendent shall authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers individual insurance, is marketing an individual insurance policy in this State and has a medical-loss ratio of at least 70% in the individual market to offer individual medical insurance products to persons under 30 years of age beginning July 1, 2009.

A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements.

B. A pilot project approved by the superintendent pursuant to this subsection must provide coverage for specific health services, specific diseases and certain providers of health care services as required in this Title.

C. A pilot project approved by the superintendent pursuant to this subsection qualifies as creditable coverage under this Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under a pilot project approved under this subsection is not subject to any preexisting conditions exclusion provisions. Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates.

D. Beginning in 2010, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any pilot project approved by the superintendent pursuant to this subsection. The report must include an analysis of the effectiveness of the pilot project in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the pilot project on the broader insurance market, including any impact on premiums and availability of coverage.

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any

requirements for pharmacy benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection.

PART B

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

14-F.

Health Care	Board of Directors of the Maine Reinsurance Association	Expenses Only	24-A §3903

Sec. B-2. 24-A MRSA §423-E is enacted to read:

§ 423-E. Report to Legislature

The superintendent shall report each year by March 1st to the joint standing committee of the Legislature having jurisdiction over insurance matters on the impact of any changes to the rating provisions in section 2736-C, the status of the Maine Individual Reinsurance Association established pursuant to chapter 54 and the impact on rates related to reimbursements paid by the Maine Individual Reinsurance Association, the total number of individuals enrolled in any health insurance product regulated by the bureau and the number of previously uninsured or underinsured individuals 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. Along with the annual report, the superintendant may submit any proposed legislation for consideration by the joint standing committee.

Sec. B-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~~ 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 June 30, 2009, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

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

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

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

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

G. A carrier that adjusts its rate shall account in its experience for the effect of the annual reimbursements paid to the carrier by the Maine Individual Reinsurance Association established in chapter 54.

Sec. B-5. 24-A MRSA §2736-C, sub-§2, ¶H is enacted to read:

H. A carrier that offered individual health plans prior to July 1, 2009 may close its individual book of business sold prior to July 1, 2009 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after July 1, 2009. A carrier must merge the closed book with its open book by the earlier of:

(1) July 1, 2012; and

(2) When the number of subscribers remaining in a carrier's closed individual book of business is less than 25% of the carrier's individual health plan subscriber total as of June 30, 2009. In order to administer this subparagraph, a carrier shall compare the number of current individual health plan subscribers in its closed book of business to its individual health plan subscriber total as of June 30, 2009 on an annual basis.

The superintendent shall establish by rule procedures and policies that facilitate the implementation of this paragraph, including, but not limited to, notice requirements for policyholders and experience pooling requirements of individual health products. When establishing rules regarding experience pooling requirements, the superintendent shall ensure, to the greatest extent possible, the availability of affordable options for individuals transitioning from the closed book of business. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

2-A. Reinsurance requirement. Carriers providing individual health plans are subject to the requirements of chapter 54.

Sec. B-7. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

MAINE INDIVIDUAL REINSURANCE ASSOCIATION

§ 3901. Short title

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

§ 3902. Definitions

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

1. Association. "Association" means the Maine Individual Reinsurance Association established in section 3903.

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

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

4. 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, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insurance arrangement that provides health care benefits in this State to the extent allowed under the federal Employee Retirement Income Security Act of 1974, a 3rd-party administrator, a multiple-employer welfare arrangement, any other entity providing medical insurance or health benefits subject to state insurance regulation, any reinsurer of health insurance in this State, the Dirigo Health Program established in chapter 87 or any other state-run or state-sponsored health benefit program, whether fully insured or self-funded.

5. Medical insurance. "Medical insurance" means a hospital and medical expense-incurred policy, a nonprofit hospital and medical service plan, a 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.

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

7. Member insurer. "Member insurer" means an insurer that offers individual medical insurance, is marketing an individual medical insurance policy in this State and has a medical-loss ratio of at least 70% in the individual insurance market.

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

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

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

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

§ 3903. Maine Individual Reinsurance Association

1. Association established. The Maine Individual Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business, every member insurer must participate in the association. The Dirigo Health Program established in chapter 87 and any other state-run or state-sponsored health benefit program shall also participate in the association.

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

A. The board consists of 11 members appointed pursuant to this paragraph:

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

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

(b) One member must be a representative of a public health plan;

(c) One member must represent health insurance producers; and

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

(2) Six members appointed by insurers licensed to do business in this State, at least one of whom is a 3rd-party administrator other than an insurer.

B. A board member appointed by the superintendent may be removed at any time without cause.

C. A board member may not be a registered lobbyist under Title 3, chapter 15.

D. Members of the board serve terms of 3 years.

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

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

3. Plan of operation; rules. The association shall adopt a plan of operation in accordance with the requirements of this chapter and submit its articles, bylaws and operating rules to the superintendent for approval. If the association fails to adopt the plan of operation and suitable articles and bylaws within 90 days after the appointment of the board, the superintendent shall adopt rules to effectuate the requirements of this chapter, and those rules remain in effect until superseded by a plan of operation and articles and bylaws submitted by the association and approved by the superintendent. Rules adopted pursuant to this subsection by the superintendent are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

4. Immunity. A board member is not liable and is immune from suit at law or equity for any conduct performed in good faith that is within the subject matter over which the board has been given jurisdiction.

§ 3904. Liability and indemnification

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

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

§ 3905. Duties and powers of the association

1. Duties. The association shall:

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

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

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

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

E. Establish an amount to be retained in the Reinsurance Association Reserve in accordance with section 3907.

2. Powers. The association may:

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

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

C. Sue or be sued, including taking any legal actions necessary or proper to recover or collect obligations due the association;

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

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

F. Establish procedures for reinsuring risks of insurers in the association in accordance with section 3908;

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

H. Apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk reinsurance associations.

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

4. Review for solvency. The superintendent shall review the operations of the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to adjust the initial level of claims and the reserve amount to be retained by the association.

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

6. Audit. The association must be audited at least 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 plan administrator

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

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

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

A. Perform all administrative functions relating to the association;

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

C. Following the close of each calendar year, report to the superintendent the amount of revenue received from the Dirigo Health Enterprise Fund pursuant to section 6915, the expenses of administration pertaining to reinsurance operations of the program and the incurred losses of the year; and

D. Pay reinsurance amounts as provided for in the plan of operation.

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

§ 3907. Reinsurance Association Reserve

1. Reserve established. The Reinsurance Association Reserve is established within the Dirigo Health Enterprise Fund as an account for the deposit of funds as required by subsection 2.

2. Funds. The Reinsurance Association Reserve is capitalized by money from the Dirigo Health Enterprise Fund, as established pursuant to section 6915, and any other fund advanced for initial operating expenses, any funds received from any public or private source, legislative appropriations, payments from state departments and agencies and such other means as the Legislature may approve. All money in the Reinsurance Association Reserve may be used only by the association for the purposes of this section. Funds in the reserve do not lapse, but must be carried forward to carry out the purposes of this chapter.

§ 3908. Reinsurance

1. Reinsurance amount. Any member insurer offering an individual health insurance plan pursuant to section 2736-C must be reinsured by the association to the level of coverage provided in this subsection.

A. Beginning July 1, 2009, the association shall reimburse a member insurer with respect to claims of an insured individual at a rate of 50% of the aggregate claims paid between $75,000 and $250,000 for that person for covered benefits in a state fiscal year, to the extent funds are available pursuant to paragraph B.

B. The association shall limit total annual reimbursements to member insurers to the amount of money transferred annually from the Dirigo Health Enterprise Fund. Any money at the end of the fiscal year not used for reimbursements must be transferred to the Reinsurance Association Reserve account under section 3907.

§ 3909. Actions against association or members based upon joint or collective actions

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

Sec. B-8. Maine Individual Reinsurance Association; staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 3903, subsection 2, paragraph C, the terms for initial appointments to the board of directors of the Maine Individual Reinsurance Association are as follows. Of those members of the board appointed by insurers, 2 members serve for a term of one year, 2 members for a term of 2 years and 2 members for a term of 3 years. Of those members appointed by the Superintendent of Insurance, one member serves for a term of one year, 2 members serve for a term of 2 years and 2 members serve for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

Sec. B-9. Funding. By January 1, 2012, the Maine Individual Reinsurance Association shall determine whether the amount transferred to the association as provided in the Maine Revised Statutes, Title 24-A, section 6915 is adequate to meet the reinsurance requirements of Title 24-A, chapter 54. The association shall submit a report to the joint standing committee of the Legislature having jurisdiction over insurance matters with its recommendations, if any, for changes to the funding percentage. The committee may submit a bill to the Second Regular Session of the 125th Legislature relating to the funding.

PART C

Sec. C-1. 24-A MRSA §6912, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

PART D

Sec. D-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 the effective date of this section.

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this paragraph, 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 E

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

Sec. E-2. 24-A MRSA §6913-A is enacted to read:

§ 6913-A. Health access surcharge

1. Health access surcharge on paid claims required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators, not including carriers and 3rd-party administrators with respect to accidental injury, specified disease,

hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, shall pay a health access surcharge of 1.8% on all paid claims. The following provisions govern the health access surcharge.

A. A health insurance and employee benefit excess insurance carrier is not required to pay a surcharge on policies or contracts insuring federal employees.

B. The surcharge applies to paid claims beginning July 1, 2008.

C. Surcharge payments must be made monthly to Dirigo Health beginning August 2008 and are due not less than 15 days after the end of the month and must accrue interest at 12% per annum on or after the due date, except that:

(1) Surcharge payments for 3rd-party administrators for groups of 500 or fewer members may be made annually not less than 60 days after the close of the plan year.

D. Surcharge payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Enterprise Fund established in section 6915.

2. Failure to pay health access surcharge payments. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any health insurance carrier or employee benefit excess insurance carrier or the license of any 3rd-party administrator to operate in this State that fails to pay a health access surcharge. In addition, the superintendent may assess civil penalties in accordance with section 12-A against any health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator that fails to pay a health access surcharge, may take any other enforcement action authorized under section 12-A to collect any unpaid health access surcharge payments and may collect the costs of enforcement including attorney's fees from those who fail to pay a health access surcharge.

3. Definitions. As used in this section, the following terms have the following meanings.

A. "Paid claims" means all payments made by health insurance carriers, 3rd-party administrators and employee benefit excess carriers for health and medical services provided under policies issued pursuant to the laws of this State that insure residents of this State or, in the case of 3rd-party administrators, for health care for residents of this State, except that "paid claims" does not include:

(1) Claims-related expenses and general administrative expenses;

(2) Payments made to qualifying providers under a "pay for performance" or other incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals;

(3) Claims paid by carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, except that claims paid for dental services covered under a medical policy are included;

(4) Claims paid for services rendered to nonresidents of this State;

(5) Claims paid under retiree health benefit plans that are separate from and not included within benefit plans for existing employees;

(6) Claims paid by an employee benefit excess carrier that have been counted by a 3rd-party administrator for determining its savings offset payment;

(7) Claims paid for services rendered to persons covered under a benefit plan for federal employees; and

(8) Claims paid for services rendered outside of this State to a person who is a resident of this State.

In those instances in which a health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator is contractually entitled to withhold certain amounts from payments due to providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before application of such withholds must be reflected in the calculation of paid claims.

B. "Claims-related expenses" includes:

(1) Payments for utilization review, care management, disease management, risk assessment and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals, usually either by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping such covered individuals to maintain or improve their health; and

(2) Payments that are made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements, which payments are unrelated to the provision of services to specific covered individuals.

C. "Health and medical services" includes, but is not limited to, any services included in the furnishing of medical care, dental care to the extent covered under a medical insurance policy, pharmaceutical benefits or hospitalization, including but not limited to services provided in a hospital or other medical facility; ancillary services, including but not limited to ambulatory services; physician and other practitioner services, including but not limited to services provided by a physician's assistant, nurse practitioner or midwife; and behavioral health services, including but not limited to mental health and substance abuse services.

4. Rulemaking. The board may adopt any 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.

Sec. E-3. 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 and section 6913-A, revenues transferred pursuant to Title 36, chapters 703 and 704 and any funds received from any public or private source for the Dirigo Health Program and the Maine Individual Reinsurance Association. An amount equal to 20% of the deposits received by the Dirigo Health Enterprise Fund in the preceding month must be transferred to the Maine Individual Reinsurance Association established by chapter 54 by the first of each month beginning July 1, 2009. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. E-4. 36 MRSA §4361, sub-§1-A, as amended by PL 1997, c. 458, §1, is further amended to read:

1-A. Cigarette. "Cigarette" means ~~a cigarette, as defined in Section 5702 of the Code.~~:

A. Any roll of tobacco that is wrapped in paper or in any substance not containing tobacco; or

B. Any roll of tobacco that is wrapped in a reconstituted tobacco sheet or any other substance, other than leaf tobacco, containing tobacco and that:

(1) Has a typical cigarette size and shape, with a cellulose acetate or other cigarette-type integrated filter;

(2) Is marketed in a traditional cigarette-type package or a package that bears a product designation or tax classification specified in 27 Code of Federal Regulations, Part 40.214(c); or

(3) Has a filler that consists primarily of flue-cured, burley, oriental or unfermented tobaccos or any other material that yields the smoking characteristics of any of those tobaccos.

For purposes of this subsection, a substance other than leaf tobacco contains tobacco only if it consists of at least 2/3 by weight of tobacco leaf or other fibrous material from the plant Nicotiana tabacum or the plant Nicotiana rustica.

Sec. E-5. 36 MRSA §4365, as amended by PL 2005, c. 457, Pt. AA, §1 and affected by §8, is further amended to read:

§ 4365. Rate of tax

A tax is imposed on all cigarettes imported into this State or held in this State by any person for sale at the rate of ~~100~~125 mills for each cigarette. Payment of the tax is evidenced by the affixing of stamps to the packages containing the cigarettes.

Sec. E-6. 36 MRSA §4365-F, as enacted by PL 2005, c. 457, Pt. AA, §3 and affected by §8, is repealed.

Sec. E-7. 36 MRSA §4365-G is enacted to read:

§ 4365-G. Application of cigarette tax rate increase

The following provisions apply to cigarettes held for resale on the effective date of this section.

1. Rate. Cigarettes stamped at the rate of 100 mills per cigarette and held for resale on the effective date of this subsection are subject to tax at the rate of 125 mills per cigarette. Cigarettes not defined as cigarettes prior to the effective date of this section are subject to tax at the rate of 25 mills per cigarette.

2. Liability. A person possessing cigarettes for resale is liable for a tax equal to 25 mills per cigarette. Stamps indicating payment of the tax imposed by this section must be affixed to all packages of cigarettes held for resale as of the effective date of this section, except that cigarettes held in vending machines as of that date do not require that stamp.

3. Vending machines. Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on the effective date of this section, and the tax imposed by this section must be reported on that basis. A credit against this inventory tax must be allowed for cigarettes stamped at the rate of 125 mills per cigarette placed in vending machines before the effective date of this section.

4. Payment. Payment of the tax imposed by this section must be made to the State Tax Assessor accompanied by forms prescribed by the assessor.

Sec. E-8. 36 MRSA §4366-A, sub-§2, ¶D, as amended by PL 2007, c. 438, §93, is further amended to read:

D. For stamps at the face value of 100 mills, the discount rate is 1.15%.; and

Sec. E-9. 36 MRSA §4366-A, sub-§2, ¶E is enacted to read:

E. For stamps at the face value of 125 mills, the discount rate is 0.97%.

Sec. E-10. 36 MRSA §4381 is repealed and the following enacted in its place:

§ 4381. Tax credited to Dirigo Health Enterprise Fund

The State Controller shall transfer by the 15th of each month from General Fund revenues to the Dirigo Health Enterprise Fund established under Title 24-A, section 6915 the amount of tax collected pursuant to this chapter that exceeds the total fiscal year-to-date budget projection for that tax revenue as of the close of the preceding month based on the tax rate for cigarettes that was in effect on July 1, 2008. For purposes of this section, "budget projection" is the amount derived from the March 1, 2008 report of the Revenue Forecasting Committee established under Title 5, section 1710-E regarding the tax that is imposed by this chapter, as determined on a monthly basis by the assessor.

Sec. E-11. 36 MRSA §4401, sub-§1-A is enacted to read:

1-A. Cigar. "Cigar" means a tobacco product that:

A. Consists of a roll of tobacco wrapped in leaf tobacco; or

B. Consists of a roll of tobacco wrapped in a substance other than leaf tobacco and is not defined as a cigarette under section 4361, subsection 1-A.

Sec. E-12. 36 MRSA §4403, sub-§1, as amended by PL 2005, c. 627, §8, is further amended to read:

1. Smokeless tobacco. A tax is imposed on all smokeless tobacco, including chewing tobacco and snuff, at the rate of 78% of the wholesale sales price ~~beginning October 1, 2005~~.

Sec. E-13. 36 MRSA §4403, sub-§2, as amended by PL 2005, c. 627, §8, is further amended to read:

2. Other tobacco. A tax is imposed on cigars, pipe tobacco and other tobacco intended for smoking at the rate of ~~20%~~78% of the wholesale sales price ~~beginning October 1, 2005~~.

Sec. E-14. 36 MRSA §4404-D is enacted to read:

§ 4404-D. Tax credited to Dirigo Health Enterprise Fund

The State Controller shall transfer by the 15th of each month from General Fund revenues to the Dirigo Health Enterprise Fund established under Title 24-A, section 6915 the amount of tax collected pursuant to this chapter that exceeds the total fiscal year-to-date budget projection for that tax revenue as of the close of the preceding month based on the tax rate imposed by this chapter that was in effect on July 1, 2008. For purposes of this section, "budget projection" is the amount derived from the March 1, 2008 report of the Revenue Forecasting Committee established under Title 5, section 1710-E regarding the tax that is imposed by this chapter, as determined on a monthly basis by the assessor.

Sec. E-15. 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, the savings offset payments that have been calculated and required under former Title 24-A, section

6913 for claims paid prior to the effective date of this Part are due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913 until the first monthly health access surcharge required under Title 24-A, section 6913-A becomes due and payable.

Sec. E-16. Transfers to Dirigo Health Enterprise Fund in fiscal year 2008-09. Notwithstanding the Maine Revised Statutes, Title 36, sections 4381 and 4404-D, for fiscal year 2008-09, the total fiscal year-to-date budget projection excludes any period in fiscal year 2008-09 prior to the effective date of this Part.

Sec. E-17. Effective date. This Part takes effect July 1, 2008 or on the effective date of this Act, whichever occurs later.

PART F

Sec. F-1. 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 and the health access surcharge provided in section 6913-A;

Sec. F-2. 24-A MRSA §6908, sub-§2, ¶F, as amended by PL 2005, c. 400, Pt. C, §6, is repealed.

Sec. F-3. 24-A MRSA §6908, sub-§2, ¶G, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

G. Establish and operate the Maine Quality Forum in accordance with the provisions of section 6951.; and

Sec. F-4. 24-A MRSA §6908, sub-§2, ¶H is enacted to read:

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

(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' participation in the Dirigo Health Program; and

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

Dirigo Health shall submit the quarterly reports required under this subsection to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

Sec. F-5. 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 the health access surcharge pursuant to 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. F-6. 24-A MRSA c. 87, sub-c. 3, as amended, is repealed.

PART G

Sec. G-1. 24-A MRSA §2736, sub-§3, ¶B, as amended by PL 2003, c. 469, Pt. E, §9, is further amended to read:

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

Sec. G-2. 24-A MRSA §2736, sub-§4, ¶C, as amended by PL 2003, c. 469, Pt. E, §10, is further amended to read:

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

Sec. G-3. 24-A MRSA §2736-A, as amended by PL 2003, c. 469, Pt. E, §11, is further amended to read:

§ 2736-A. Hearing

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate, unfairly discriminatory or not in compliance with former section 6913 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 section must conform to the procedural requirements set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4.

Sec. G-4. 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 or any recovery in that offset payment in its experience consistent with this section and former section 6913.

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

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any ~~savings offset~~ payments paid pursuant to former section 6913 must be treated as incurred claims.

Sec. G-6. 24-A MRSA §2808-B, sub-§2-A, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004, except that the filing of rates for small group health plans are not required to account for any ~~savings offset~~ payment or any recovery of that ~~offset~~ payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005.

Sec. G-7. 24-A MRSA §2808-B, sub-§2-B, ¶A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

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

Sec. G-8. 24-A MRSA §2808-B, sub-§2-B, ¶D, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

D. A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and former section 6913.

Sec. G-9. 24-A MRSA §2808-B, sub-§2-B, ¶F, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

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

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

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

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

Sec. G-10. 24-A MRSA §2808-B, sub-§2-C, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

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

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

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

Sec. G-11. 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. 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. G-12. 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 due Dirigo Health or that are necessary for the proper administration of Dirigo Health;

SUMMARY

Part A authorizes the Superintendent of Insurance to approve a pilot project to authorize health insurance carriers to offer individual health insurance products for young people under the age of 30.

Part B establishes a reinsurance association for the individual health insurance market, without placing individuals in a separate risk association or providing coverage under different health plans than those available in the individual market. The Part also requires individual premium rates charged by a carrier during a rating period to not exceed 2.5 times the lowest individual rate charged by the carrier. This will lower rates for the younger demographic and limit rate increases on the older demographic.

Part B also requires the Superintendent of Insurance to report yearly to the Legislature the impact of changes to the rating provisions in the Maine Revised Statutes, Title 24-A, section 2736-C and the establishment of the Maine Individual Reinsurance Association pursuant to Title 24-A, chapter 54, the total number of individuals enrolled in any health insurance product regulated by the Department of Professional and Financial Regulation, Bureau of Insurance and the numbers of previously uninsured individuals who have enrolled in any health insurance product regulated by the Bureau of Insurance.

Part B also allows a carrier that offered individual health plans prior to July 1, 2009 to close its book of business and establish a separate community rate for those individuals applying for coverage under an individual health plan on or after July 1, 2009. A carrier must merge the closed book with its open book by July 1, 2012 or when the number of subscribers remaining in a carrier’s closed individual book of business is less than 25 percent of the carrier’s individual health plan subscriber total as of June 30, 2009, whichever is earlier. The Superintendent of Insurance shall develop rules regarding notice requirements and experience pooling in a carrier’s open book of business to ensure the availability of affordable options for individuals transitioning from the closed book of business.

Part C removes limitations on the ability of Dirigo Health to adjust the subsidy to individuals to ensure affordability.

Part D makes permanent 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 were reauthorized in Public Law 2005, chapter 394, section 4.

Part E makes changes to the funding for the Dirigo Health Program. The Part repeals the savings offset payment and replaces it with a health access surcharge of 1.8% on paid claims. Part E also increases the tax on cigarettes from $2.00 to $2.50 a pack and equalizes the rate of tax on all other tobacco products by a change in the taxation of "little cigars" from the tobacco products tax to the cigarette tax and an increase in the tobacco products tax from 20% to 78% of the wholesale price on cigars, pipe tobacco and other smoking tobacco.

Part E also requires that all of the revenues from the surcharge and the cigarette tax increases be credited to the Dirigo Health Enterprise Fund to support both the Dirigo Health Program and the Maine Individual Reinsurance Association. Twenty percent of monthly deposits received by the Dirigo Health Enterprise Fund will be transferred to the association.

Part F requires that Dirigo Health submit quarterly reports on information regarding enrollment in the Dirigo Health Program. This Part also repeals the Dirigo Health Risk Pool.

Part G corrects cross-references to reflect the changes made in the bill.