



132nd MAINE LEGISLATURE

FIRST REGULAR SESSION-2025

Legislative Document

No. 519

H.P. 337

House of Representatives, February 11, 2025

**An Act to Remove the Requirement That Individual and Small
Group Health Plans Be Offered Through a Pooled Market and to
Eliminate the Provision of Law Establishing a Pooled Market for
Those Plans**

Received by the Clerk of the House on February 7, 2025. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

A handwritten signature in cursive script that reads "Robert B. Hunt".

ROBERT B. HUNT
Clerk

Presented by Representative MORRIS of Turner.
Cosponsored by Representatives: CIMINO of Bridgton, FLYNN of Albion, FOLEY of Wells,
OLSEN of Raymond, Senator: HAGGAN of Penobscot.

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

2 **Sec. 1. 24-A MRSA c. 34-B, headnote** is amended by amending the chapter
3 headnote to read:

4 **CHAPTER 34-B**

5 **~~POOLED MARKET AND CLEAR CHOICE DESIGN~~**

6 **Sec. 2. 24-A MRSA §2792**, as amended by PL 2021, c. 361, §§1 and 2, is repealed.

7 **Sec. 3. 24-A MRSA §2793, sub-§1**, as amended by PL 2021, c. 361, §3, is further
8 amended to read:

9 **1. Clear choice design.** For the purposes of this section, "clear choice design" means
10 a set of annual copayments, coinsurance and deductibles for all or a designated subset of
11 the essential health benefits. ~~An individual health plan subject to section 2736-C or a pooled~~
12 ~~market health plan subject to section 2792 must conform to one of the clear choice designs~~
13 ~~developed pursuant to this section unless it is approved as an alternative plan under~~
14 ~~subsection 4.~~

15 **Sec. 4. 24-A MRSA §2793, sub-§2**, as amended by PL 2021, c. 361, §3, is further
16 amended to read:

17 **2. Development of clear choice designs.** The superintendent shall develop clear
18 choice designs in consultation with working groups consisting of consumers, carriers,
19 health policy experts and other interested persons. The superintendent shall adopt rules for
20 clear choice designs, taking into consideration the ability of plans to conform to actuarial
21 value ranges, consumer needs and promotion of benefits with high value and return on
22 investment. The superintendent shall develop at least one clear choice design for each tier
23 of health insurance plan designated as bronze, silver, gold and platinum in accordance with
24 the federal Affordable Care Act. Rules adopted pursuant to this subsection are routine
25 technical rules as defined in Title 5, chapter 375, subchapter 2-A. Clear choice designs
26 apply to all individual health plans offered in this State with effective dates of coverage on
27 or after January 1, 2022 and to all small group health plans ~~offered through the pooled~~
28 ~~market under section 2792.~~

29 **Sec. 5. 24-A MRSA §2808-B, sub-§2-A, ¶B**, as amended by PL 2019, c. 653, Pt.
30 B, §4, is further amended to read:

31 B. A filing and all supporting information, except for protected health information
32 required to be kept confidential by state or federal statute and except for descriptions
33 of the amount and terms or conditions or reimbursement in a contract between an
34 insurer and a 3rd party, are public records notwithstanding Title 1, section 402,
35 subsection 3, paragraph B and become part of the official record of any hearing held
36 pursuant to subsection 2-B, paragraph B ~~or section 2792, subsection 2.~~

37 **Sec. 6. 24-A MRSA §2808-B, sub-§2-A, ¶C**, as amended by PL 2023, c. 59, §5,
38 is further amended to read:

1 C. Rates for small group health plans must be filed in accordance with this section and
2 subsections 2-B and 2-C ~~or section 2792, as applicable~~, for premium rates effective on
3 or after July 1, 2004.

4 **Sec. 7. 24-A MRSA §2808-B, sub-§2-B**, as amended by PL 2023, c. 59, §§6 and
5 7, is further amended to read:

6 **2-B. Rate review and hearings.** Except as provided in subsection 2-C ~~and section~~
7 ~~2792~~, rate filings are subject to this subsection.

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

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

29 C. When a filing is not accompanied by the information upon which the carrier
30 supports the filing or the superintendent does not have sufficient information to
31 determine whether the filing meets the requirements that rates not be excessive,
32 inadequate or unfairly discriminatory, the superintendent shall require the carrier to
33 furnish the information upon which it supports the filing.

34 **Sec. 8. 24-A MRSA §2808-B, sub-§2-C**, as amended by PL 2019, c. 653, Pt. B,
35 §7, is further amended to read:

36 **2-C. Guaranteed loss ratio.** Notwithstanding subsection 2-B, rate filings for a
37 credible block of small group health plans may be filed in accordance with this subsection
38 instead of subsection 2-B, ~~except as otherwise provided in section 2792~~. Rates filed in
39 accordance with this subsection are filed for informational purposes.

40 A. A block of small group health plans is considered credible if the anticipated average
41 number of members during the period for which the rates will be in effect meets
42 standards for full or partial credibility pursuant to the federal Affordable Care Act. The
43 rate filing must state the anticipated average number of members during the period for
44 which the rates will be in effect and the basis for the estimate. If the superintendent

1 determines that the number of members is likely to be less than needed to meet the
2 credibility standard, the filing is subject to subsection 2-B.

3 **Sec. 9. 24-A MRSA §3958**, as amended by PL 2021, c. 361, §5, is further amended
4 to read:

5 **§3958. Reinsurance; premium rates**

6 **1. Reinsurance amount.** A member insurer offering an individual health plan under
7 section 2736-C must be reinsured by the association to the level of coverage provided in
8 this subsection and is liable to the association for any applicable reinsurance premium at
9 the rate established in accordance with subsection 2. ~~For calendar year 2023 and~~
10 ~~subsequent calendar years, the association shall also reinsure member insurers for small~~
11 ~~group health plans issued under section 2808-B, unless otherwise provided in rules adopted~~
12 ~~by the superintendent pursuant to section 2792, subsection 5.~~

13 A. Beginning July 1, 2012, ~~except as otherwise provided in paragraph A-1,~~ the
14 association shall reimburse a member insurer for claims incurred with respect to a
15 person designated for reinsurance by the member insurer pursuant to section 3959 after
16 the insurer has incurred an initial level of claims for that person of \$7,500 for covered
17 benefits in a calendar year. In addition, the insurer is responsible for 10% of the next
18 \$25,000 of claims paid during a calendar year. The amount of reimbursement is 90%
19 of the amount incurred between \$7,500 and \$32,500 and 100% of the amount incurred
20 in excess of \$32,500 for claims incurred in that calendar year with respect to that
21 person. For calendar year 2012, only claims incurred on or after July 1st are considered
22 in determining the member insurer's reimbursement. With the approval of the
23 superintendent, the association may annually adjust the initial level of claims and the
24 maximum limit to be retained by the insurer to reflect changes in costs, utilization,
25 available funding and any other factors affecting the sustainable operation of the
26 association.

27 ~~A-1. In any plan year in which a pooled market is operating in accordance with section~~
28 ~~2792, the association shall operate a retrospective reinsurance program providing~~
29 ~~coverage to member insurers for all individual and small group health plans issued in~~
30 ~~this State in that plan year. For plan years beginning in 2022, if the pooled market has~~
31 ~~not been implemented pursuant to section 2792, subsection 5, the association may~~
32 ~~operate a retrospective reinsurance program for individual health plans, subject to the~~
33 ~~approval of the superintendent.~~

34 ~~(1) The association shall reimburse member insurers based on the total eligible~~
35 ~~claims paid during a calendar year for a single individual in excess of the~~
36 ~~attachment point specified by the board. The board may establish multiple layers~~
37 ~~of coverage with different attachment points and different percentages of claims~~
38 ~~payments to be reimbursed by the association.~~

39 ~~(2) Eligible claims by all individuals enrolled in individual or small group health~~
40 ~~plans in this State may not be disqualified for reimbursement on the basis of health~~
41 ~~conditions, predesignation by the member insurer or any other differentiating~~
42 ~~factor.~~

