L.D. 1

Date: (Filing No. S-)

HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

Reproduced and distributed under the direction of the Secretary of the Senate.

STATE OF MAINE

SENATE

129TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT " " to S.P. 10, L.D. 1, Bill, "An Act To Protect Health Care Coverage for Maine Families"

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

'PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§2, ¶B, as amended by PL 2007, c. 629, Pt. A, §3, is further amended to read:

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual or any other rating factor not specified in this subsection.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2011, c. 364, §3, is further amended to read:

C. A carrier may vary the premium rate due to family membership ~~to the extent permitted by the federal Affordable Care Act~~. The premium rate for a family must equal the sum of the premiums for each individual in the family, except that it may not be based on more than 3 dependent children who are less than 21 years of age.

Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2011, c. 364, §4, is further amended to read:

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

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between 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 between July 15, 1995 and June 30, 2012, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015, except as provided in subparagraph (9), the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration.

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

Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶F, as amended by PL 2007, c. 629, Pt. M, §4, is repealed.

Sec. A-5. 24-A MRSA §2736-C, sub-§2, ¶I, as amended by PL 2011, c. 364, §5, is repealed.

Sec. A-6. 24-A MRSA §2736-C, sub-§5, as amended by PL 2011, c. 90, Pt. D, §3, is further amended to read:

5. Loss ratios. Except as provided in subsection 2-B, 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 payments paid pursuant to former section 6913 must be treated as incurred claims~~ medical loss ratio calculated under section 4319 will be at least 80%.

Sec. A-7. 24-A MRSA §2736-C, sub-§11, as enacted by PL 2013, c. 271, §1, is amended to read:

11. Open enrollment; rules. Notwithstanding subsection 3, on or after January 1, 2014, a carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods ~~consistent with requirements of the federal Affordable Care Act~~ to the extent not inconsistent with applicable federal law. The superintendent may adopt rules establishing minimum open enrollment dates and minimum criteria for special enrollment periods for all individual health plans offered in this State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-8. 24-A MRSA §2742-B, as amended by PL 2007, c. 514, §§1 to 5, is further amended to read:

§2742-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under an individual health insurance policy ~~when that child:~~.

~~A. Is unmarried;~~

~~B. Has no dependent of the child's own; and~~

~~C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.~~

2. Offer of coverage. Notwithstanding section 2703, subsection 3, an individual health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child ~~is 25~~ attains 26 years

of age. ~~An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.~~

Sec. A-9. 24-A MRSA §2808-B, sub-§2, ¶B, as amended by PL 1993, c. 477, Pt. B, §1 and affected by Pt. F, §1, is further 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 eligible group or members of the group or any other rating factor not specified in this section.

Sec. A-10. 24-A MRSA §2808-B, sub-§2, ¶C, as amended by PL 2011, c. 638, §1, is further amended to read:

C. A carrier may vary the premium rate due to ~~occupation and industry,~~ family membership and participation in wellness programs ~~to the extent permitted by the federal Affordable Care Act~~. The premium rate for a family must equal the sum of the premiums for each individual in the family, except that it may not be based on more than 3 dependent children who are less than 21 years of age. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for participation in wellness programs ~~and rating for occupation and industry pursuant to this paragraph~~. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-11. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 2011, c. 638, §2, is further amended to read:

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

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

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

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and September 30, 2011, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and September 30, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2012 and December 31, 2013, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, except as provided in subparagraph (10), the maximum rate differential due to age and group size filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration.

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

Sec. A-12. 24-A MRSA §2808-B, sub-§2, ¶H, as amended by PL 2011, c. 638, §3, is repealed.

Sec. A-13. 24-A MRSA §2833-B, as amended by PL 2007, c. 514, §§6 to 10, is further amended to read:

§2833-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under a group health insurance policy ~~when that child:~~.

~~A. Is unmarried;~~

~~B. Has no dependent of the child's own; and~~

~~C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.~~

2. Offer of coverage. Notwithstanding section 2822, a group health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the ~~policyholder~~ parent, until the dependent child ~~is 25~~ attains 26 years of age. ~~An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.~~

Sec. A-14. 24-A MRSA §2849, sub-§3-A, as enacted by PL 2009, c. 244, Pt. E, §3, is repealed.

Sec. A-15. 24-A MRSA §2849-B, sub-§3-B, as enacted by PL 2009, c. 244, Pt. E, §5, is repealed.

Sec. A-16. 24-A MRSA §2850, sub-§2, as amended by PL 2011, c. 364, §18, is further amended to read:

2. Limitation. An individual, group or blanket contract issued by an insurer may not impose a preexisting condition exclusion ~~except as provided in this subsection. A preexisting condition exclusion may not exceed 12 months from the date of enrollment, including the waiting period, if any. For purposes of this subsection, "waiting period" includes any period between the time a substantially complete application for an individual or small group health plan is filed and the time the coverage takes effect. A preexisting condition exclusion may not be more restrictive than as follows~~. This subsection does not limit a carrier's ability to restrict enrollment in an individual contract to open enrollment and special enrollment periods in accordance with section 2736-C, subsection 11.

~~A. In a group contract, a preexisting condition exclusion may relate only to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period ending on the earlier of the date of enrollment in the contract and the date of enrollment in a prior contract covering the same group if there has not been a gap in coverage of greater than 90 days between contracts. An exclusion may not be imposed relating to pregnancy as a preexisting condition.~~

~~B. In an individual contract not subject to paragraph C, or in a blanket policy, a preexisting condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months immediately preceding the date of application or to a pregnancy existing on the effective date of coverage.~~

~~C. An individual policy issued on or after January 1, 1998 to a federally eligible individual as defined in section 2848 may not contain a preexisting condition exclusion.~~

~~D. A routine preventive screening or test yielding only negative results may not be considered to be diagnosis, care or treatment for the purposes of this subsection.~~

~~E. Genetic information may not be used as the basis for imposing a preexisting condition exclusion in the absence of a diagnosis of the condition relating to that information. For the purposes of this paragraph, "genetic information" has the same meaning as set forth in the Code of Federal Regulations.~~

~~F. Except for individual health plans in effect on March 23, 2010 that have grandfathered status under the federal Affordable Care Act, a carrier as defined in section 4301-A, subsection 3 offering a health plan as defined in section 4301-A, subsection 7 may not apply a preexisting condition exclusion to any enrollee under 19 years of age. A preexisting condition exclusion may not be imposed on any enrollee after January 1, 2014 to the extent prohibited by the federal Affordable Care Act.~~

Sec. A-17. 24-A MRSA §2850-B, sub-§3, as amended by PL 2011, c. 90, Pt. F, §3 and c. 238, Pt. F, §1, is further amended to read:

3. Cancellation of coverage; renewal. Coverage may not be rescinded for an individual, a group or eligible members and their dependents in those groups once an individual, a group or eligible members and their dependents in those groups are covered under an individual or group health plan, except that this subsection does not prohibit rescission with respect to a covered individual, a group or eligible members and their dependents in those groups who have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the individual or group health plan to the extent consistent with section 2411. Such coverage may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except:

A. When the policyholder or contract holder fails to pay premiums or contributions in accordance with the terms of the contract or the carrier has not received timely premium payments;

B. For fraud or intentional misrepresentation of material fact by the policyholder or contract holder;

C. With respect to coverage of individuals under a group policy or contract, for fraud or intentional misrepresentation of material fact on the part of the individual or the individual's representative;

D. In the large or small group market, for noncompliance with the carrier's minimum participation requirements, which may not exceed the participation requirement when the policy was issued;

E. With respect to a managed care plan, as defined in section 4301-A, if there is no longer an insured who lives, resides or works in the service area;

F. When the carrier ceases offering large or small group health plans in compliance with subsection 4 and does not renew any existing policies in that market;

F-1. When the carrier ceases offering individual health plans in compliance with section 2736-C, subsection 4 and does not renew any existing policies in that market;

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

(1) In the large group market:

(a) The carrier provides notice to the policyholder and to the certificate holders at least 90 days before termination;

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

(c) In exercising the option to discontinue the product and in offering the option of coverage under division (b), the carrier acts uniformly without regard to the claims experience of the policyholders or the health status of the certificate holders or their dependents or prospective certificate holders or their dependents;

(2) In the small group market:

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

(b) The superintendent finds that the replacement is in the best interests of the policyholders; and

(c) The carrier provides notice of the replacement to the policyholder and to the certificate holders at least 90 days before replacement, including notice of the policyholder's right to purchase any other product currently being offered by that carrier in the small group market pursuant to section 2808-B, subsection 4; or

(3) In the individual market:

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

(b) The superintendent finds that the replacement is in the best interests of the policyholders; and

(c) The carrier provides notice of the replacement to the policyholder and, if a group policy subject to section 2736-C, to a certificate holder at least 90 days before replacement, including notice of the policyholder's or certificate holder's right to purchase any other product currently being offered by that carrier in the individual market pursuant to section 2736-C, subsection 3;

H. In renewing a large group policy in accordance with this section, a carrier may modify the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications are applied uniformly to all policyholders of the same product; or

I. In renewing an individual or small group policy in accordance with this section, a carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Modifications not meeting the requirements in this paragraph are considered a discontinuance of the product pursuant to paragraph G.

(1) A modification pursuant to this paragraph must be approved by the superintendent. The superintendent shall approve the modification if it meets the requirements of this section.

(2) A change in a requirement for eligibility is not a minor modification pursuant to this paragraph if the change results in the exclusion of a class or category of enrollees currently covered.

(3) Benefit modifications required by law are deemed minor modifications for purposes of this paragraph.

(4) Benefit modifications other than modifications required by law are minor modifications only if they meet the requirements of this subparagraph. For purposes of this subparagraph, changes in administrative conditions or requirements specified in the policy, such as preauthorization requirements, are not considered benefit modifications.

(a) The total of any increases in benefits may not increase the actuarial value of the total benefit package by more than 5%.

(b) The total of any decreases in benefits may not decrease the actuarial value of the total benefit package by more than 5%.

(c) For purposes of the calculations in divisions (a) and (b), increases and decreases must be considered separately and may not offset one another.

(5) A carrier must give 60 days' notice of any modification pursuant to this paragraph to all affected policyholders and certificate holders.

Sec. A-18. 24-A MRSA §4233-B, as amended by PL 2007, c. 514, §§11 to 15, is further amended to read:

§4233-B. Mandatory offer to extend coverage for dependent children up to 26 years of age

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under an individual or group health maintenance organization contract ~~when that child:~~.

~~A. Is unmarried;~~

~~B. Has no dependent of the child's own; and~~

~~C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.~~

2. Offer of coverage. An individual or group health maintenance organization contract that offers coverage for a dependent child ~~shall~~ must offer such coverage, at the option of the ~~contract holder~~ parent, until the dependent child ~~is 25~~ attains 26 years of age. ~~An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.~~

Sec. A-19. 24-A MRSA §4302, sub-§1, as amended by PL 2017, c. 232, §§3-5, is further amended to read:

1. Description of plan. A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans and be in a format that is substantially similar to the format required for a carrier pursuant to the federal Affordable Care Act as of January 1, 2019. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. A carrier shall post descriptions of its plans on its publicly accessible website and, in addition to the plan description, include a link to the health plan's certificate of coverage. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type;

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics;

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service;

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria;

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisting conditions and waiting periods;

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums;

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition;

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment;

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary;

I. Information on where and in what manner health care services may be obtained;

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter;

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended;

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating; and

M. If the health plan is subject to the requirements of section 4318-A, a description of the incentives available to an enrollee and how to earn such incentives if enrolled in a health plan offering a comparable health care service incentive program designed pursuant to section 4318-A.

Sec. A-20. 24-A MRSA §4303, sub-§4, ¶E, as enacted by PL 2011, c. 364, §25, is amended to read:

E. Health plans ~~subject to the requirements of the federal Affordable Care Act must comply with federal claims and appeal requirements, including, but not limited to, the requirement that benefits for an ongoing course of treatment~~ may not ~~be reduced or terminated without advance notice and an opportunity for advance review, consistent with the requirements of the federal Affordable Care Act~~ reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with section 4312.

Sec. A-21. 24-A MRSA §4311, sub-§1-A is enacted to read:

1-A. Access to clinically appropriate prescription drugs. For plan years beginning on or after the effective date of this subsection, a carrier must allow an enrollee, the enrollee's designee or the person who has issued a valid prescription for the enrollee to request and gain access to a clinically appropriate drug not otherwise covered by the health plan. The carrier's process must comply with section 4304 and with this subsection. If the carrier approves a request under this subsection for a drug not otherwise covered by the health plan, the carrier must treat the drug as an essential health benefit, including counting any cost sharing toward the plan's annual limit on cost sharing and including it when calculating the plan's actuarial value.

A. The carrier must determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has issued the valid prescription for the enrollee of its coverage decision within 2 business days

following receipt of the request. A carrier that grants coverage under this paragraph must provide coverage of the drug for the duration of the prescription, including refills.

B. The carrier must have a process by which an expedited review may be requested in exigent circumstances. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug. When an expedited review has been requested, the carrier must determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has provided a valid prescription for the enrollee of its coverage decision within 24 hours following receipt of the request. A carrier that grants coverage under this paragraph must provide coverage of the drug for the duration of the exigency.

Sec. A-22. 24-A MRSA §4318, as amended by PL 2011, c. 364, §33, is repealed.

Sec. A-23. 24-A MRSA §4319, as enacted by PL 2011, c. 90, Pt. D, §5, is amended to read:

§4319. Rebates

1. Rebates required. Carriers must provide rebates in the large group, small group and individual markets ~~to the extent required by the federal Affordable Care Act and federal regulations adopted pursuant thereto~~ if the medical loss ratio under subsection 2 is less than the minimum medical loss ratio under subsection 3.

2. Medical loss ratio. For purposes of this section, the medical loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively, plus any credibility adjustment. ~~The period for which the medical loss ratio is determined and the meaning of all terms used in this subsection must be in accordance with the federal Affordable Care Act and federal regulations adopted pursuant thereto.~~ For the purposes of this subsection:

A. The numerator is the amount expended on reimbursement for clinical services provided to enrollees and activities that improve health care quality; and

B. The denominator is the total amount of premium revenue excluding federal and state taxes and licensing and regulatory fees paid and after accounting for payments or receipts for risk adjustment, risk corridors and reinsurance pursuant to federal law.

3. Minimum medical loss ratio. The minimum medical loss ratio is:

A. In the large group market, 85%;

B. In the small group market, 80%; and

C. In the individual market, 80% ~~or such lower minimum medical loss ratio as the Secretary of the United States Department of Health and Human Services determines based on a finding, pursuant to the federal Affordable Care Act and federal regulations adopted pursuant thereto, that an 80% minimum medical loss ratio might destabilize the individual market in this State~~.

4. Rules. The superintendent may adopt rules to implement this section in a substantially similar manner as required under the federal Affordable Care Act in effect as of January 1, 2019, including, but not limited to, rules establishing the period for which the medical loss ratio is calculated. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-24. 24-A MRSA §4319-A is enacted to read:

§4319-A. Guaranteed issue

A carrier offering a health plan in this State in the individual, small group or large group market must offer to an individual or group in the State all health plans that are approved for sale in the applicable market and must accept any individual or group that applies for any of those health plans in accordance with the requirements of section 2736-C, subsection 3 and section 2808-B, subsection 4 and section 2850-B.

Sec. A-25. 24-A MRSA §4320, as enacted by PL 2011, c. 364, §34, is amended to read:

§4320. No lifetime or annual limits on health plans

~~Notwithstanding the requirements of section 4318, a~~ A carrier offering a health plan ~~subject to the federal Affordable Care Act~~ in the individual, small group or large group market, as those markets are defined under applicable federal law, may not:

1. Establish lifetime limits. Establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or

2. Establish annual limits. Establish annual limits on the dollar value of essential benefits~~, except that, prior to January 1, 2014, health plans may include restricted annual limits on essential benefits consistent with the requirements of the federal Affordable Care Act and may establish annual limits consistent with waivers granted by the Secretary of the United States Department of Health and Human Services~~.

3. Application. This section applies to health plans offered or renewed in this State in the individual, small group and large group markets, as those markets are defined under applicable federal law. A health plan may contain annual dollar limits to the extent allowed under the federal Affordable Care Act as of January 1, 2019 if the plan has been continuously renewed since that date, but the plan may not impose any new limits or reduce any existing limit in effect as of January 1, 2019.

PART B

Sec. B-1. 24-A MRSA §4320-D, as enacted by PL 2011, c. 364, §34, is amended to read:

§4320-D. Comprehensive health coverage

Notwithstanding any other requirements of this Title, a carrier offering a health plan ~~subject to the requirements of the federal Affordable Care Act~~ in this State shall, at a minimum, provide coverage that incorporates an essential health benefits ~~and cost-~~

~~sharing limitations~~ package consistent with the requirements of ~~the federal Affordable Care Act~~ this section.

1. Essential health benefits package; definition. As used in this section, "essential health benefits package" means, with respect to any health plan, coverage that:

A. Provides for the essential health benefits in accordance with subsection 2;

B. Limits cost sharing for coverage in accordance with subsection 3; and

C. Provides for levels of coverage in accordance with subsection 4.

2. Substantially similar to federal Affordable Care Act; required categories. With respect to any individual or small group health plan offered on or after January 1, 2020, a carrier shall provide essential health benefits that are substantially similar to that of the essential health benefits required in this State for a health plan subject to the federal Affordable Care Act as of January 1, 2019. Essential health benefits required for a health plan must include at least the following general categories and the items and services covered within the categories:

A. Ambulatory patient services;

B. Emergency services;

C. Hospitalization;

D. Maternity and newborn care;

E. Mental health and substance use disorder services, including behavioral health treatment;

F. Prescription drugs;

G. Rehabilitative and habilitative services and devices;

H. Laboratory services;

I. Preventive and wellness services and chronic disease management; and

J. Pediatric services, including oral and vision care, to the extent required by the federal Affordable Care Act as of January 1, 2019.

3. Cost-sharing limitations. With respect to any health plan offered on or after the effective date of this subsection, a carrier shall limit cost sharing on an annual basis in a manner that is consistent with the annual limits established for a health plan subject to the federal Affordable Care Act as of January 1, 2019 and as adjusted by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, or, if the Centers for Medicare and Medicaid Services does not establish annual limits on cost sharing, the superintendent shall adopt rules establishing annual limits on cost sharing under this subsection that are calculated in substantially the same manner as the Centers for Medicare and Medicaid Services calculated the annual limit in the most recent year it calculated the annual limit.

4. Levels of coverage. Carriers shall offer coverage at levels that are substantially similar to the levels of coverage required for health plans subject to the federal Affordable Care Act as of January 1, 2019. The superintendent may adopt rules defining

such levels of coverage. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

5. Rule of construction. This section may not be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this section.

PART C

Sec. C-1. 24-A MRSA §2850-C, sub-§3 is enacted to read:

3. Applicability of section 4320-L. In addition to the requirements of this section, a carrier is subject to section 4320-L.

Sec. C-2. 24-A MRSA §4320-L is enacted to read:

§4320-L. Nondiscrimination

1. Nondiscrimination. An individual may not, on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability, be excluded from participation in, be denied benefits of or otherwise be subjected to discrimination under any health plan offered in accordance with this Title. A carrier may not in offering, providing or administering a health plan:

A. Deny, cancel, limit or refuse to issue or renew a health plan or other health-related coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability;

B. Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability in a health plan or other health-related coverage;

C. Deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;

D. Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or

E. Otherwise deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual.

Nothing in this subsection is intended to determine or restrict a carrier from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.

2. Meaningful access for individuals with limited English proficiency. A carrier shall take reasonable steps to provide meaningful access to each enrollee or prospective enrollee under a health plan who has limited proficiency in English.

3. Effective communication for persons with disabilities. A carrier shall take reasonable steps to ensure that communication with an enrollee or prospective enrollee in a health plan who is an individual with a disability is as effective as communication with other enrollees or prospective enrollees.

PART D

Sec. D-1. 24-A MRSA §2749-C, sub-§1, as amended by PL 2003, c. 20, Pt. VV, §8 and affected by §25, is further amended to read:

1. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph ~~A~~ A-1 by all individual policies is subject to this section.

~~A. All individual policies must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:~~

~~(1) Schizophrenia;~~

~~(2) Bipolar disorder;~~

~~(3) Pervasive developmental disorder, or autism;~~

~~(4) Paranoia;~~

~~(5) Panic disorder;~~

~~(6) Obsessive-compulsive disorder; or~~

~~(7) Major depressive disorder.~~

A-1. All individual contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual as defined in section 2843, subsection 3, paragraph A-1, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;

(2) Dissociative disorders;

(3) Mood disorders;

(4) Anxiety disorders;

(5) Personality disorders;

(6) Paraphilias;

(7) Attention deficit and disruptive behavior disorders;

(8) Pervasive developmental disorders;

(9) Tic disorders;

(10) Eating disorders, including bulimia and anorexia; and

(11) Substance use disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State must ~~make available~~ provide coverage providing benefits that meet the requirements of this paragraph.

(1) The ~~offer of~~ coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy.

Sec. D-2. 24-A MRSA §2843, sub-§5-A, as amended by PL 1989, c. 490, §4, is repealed.

Sec. D-3. 24-A MRSA §4234-A, sub-§6, as amended by PL 2017, c. 407, Pt. A, §98, is further amended to read:

6. Coverage for treatment of certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A-1. All individual and group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those designated as "V" codes in the Diagnostic and Statistical Manual:

(1) Psychotic disorders, including schizophrenia;

(2) Dissociative disorders;

(3) Mood disorders;

(4) Anxiety disorders;

(5) Personality disorders;

(6) Paraphilias;

(7) Attention deficit and disruptive behavior disorders;

(8) Pervasive developmental disorders;

(9) Tic disorders;

(10) Eating disorders, including bulimia and anorexia; and

(11) Substance use disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must provide benefits that meet the requirements of this paragraph.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

(3) If benefits and coverage for the treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.

(4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.

(5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.

(6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.

(7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.

~~This subsection does not apply to policies, contracts or certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.~~

Sec. D-4. 24-A MRSA §4234-A, sub-§7, as amended by PL 2003, c. 20, Pt. VV, §21 and affected by §25, is repealed.'

SUMMARY

This amendment replaces the bill and is the majority report of the committee. The purpose of this amendment is to ensure that consumer protections related to health insurance coverage included in the federal Patient Protection and Affordable Care Act are codified in state law.

In Part A, the amendment does the following.

1. It makes clear that carriers in the individual, small group and large group markets must meet guaranteed issue requirements similar to those required by federal law.

2. It makes clear that individual and group health plans may not impose any preexisting condition exclusion on an enrollee. The amendment does permit a carrier to restrict enrollment in individual health plans to open enrollment and special enrollment periods established in rule.

3. It clarifies that carriers offering individual or group health plans may not establish lifetime or annual limits on the dollar value of benefits unless the plan is grandfathered under the federal Affordable Care Act as of January 1, 2019 and does not impose new limits or reduce existing limits. The amendment specifies that the provision prohibiting annual limits on the dollar value of benefits applies to the dollar value of essential health benefits.

4. It allows children, until they attain 26 years of age, to remain on their parents' health insurance policy.

5. It changes the maximum rate differential due to age that may be filed by the carrier to 3 to 1 and requires that rates that vary based on age do so according to a uniform age rating curve.

6. It provides that if a carrier varies premium rates based on family membership, the premium rate must equal the sum of the premiums for each individual in the family.

7. It prohibits a carrier from varying premium rates based on tobacco use for individuals who are enrolled in an evidence-based tobacco cessation program approved by the United States Department of Health and Human Services, Food and Drug Administration.

8. It makes clear that the minimum medical loss ratio in the individual market is 80% without exception.

9. It adds language to prohibit rescissions of coverage consistent with requirements under federal law.

10. It makes changes to the timelines and requirements for determinations by a carrier of coverage for prescription drugs consistent with federal law.

11. It requires carriers to provide information about the health plans offered by the carrier in a standardized manner that is substantially similar to the manner required for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019.

12. It removes a provision of the bill that would have repealed the authority for certain individuals to purchase coverage under an individual, nonrenewable short-term policy.

13. It prohibits a health plan from reducing or terminating benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal of a determination of coverage.

Part B requires that, at a minimum, individual and small group health plans cover essential health benefits that are substantially similar to those benefits required for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019. The amendment also requires that health plans meet annual limits on cost sharing that are substantially similar to those benefits required for health plans subject to the federal Patient Protection and Affordable Care Act as of January 1, 2019. The amendment removes provisions of the bill that authorized the Superintendent of Insurance to make changes to essential health benefits and cost sharing limits in rule. The amendment clarifies that pediatric dental benefits may not be required of all individual and small group plans if dental coverage is available in accordance with the federal Affordable Care Act as in effect as of January 1, 2019.

Part C adopts nondiscrimination provisions consistent with similar requirements in federal law and rule.

Part D makes changes to current requirements in state law related to mental health parity consistent with similar requirements in federal law and regulations.