



131st MAINE LEGISLATURE

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Legislative Document

No. 1253

H.P. 801

House of Representatives, March 21, 2023

**An Act to Maintain the Integrity of the Individual and Small Group
Health Insurance Markets**

Reference to the Committee on Health Coverage, Insurance and Financial Services
suggested and ordered printed.

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

ROBERT B. HUNT
Clerk

Presented by Representative MORRIS of Turner.

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

2 **Sec. 1. 24-A MRSA §2792**, as amended by PL 2021, c. 361, §§1 and 2, is repealed.

3 **Sec. 2. 24-A MRSA §2793, sub-§1**, as amended by PL 2021, c. 361, §3, is further
4 amended to read:

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

11 **Sec. 3. 24-A MRSA §2808-B, sub-§2-A, ¶B**, as amended by PL 2019, c. 653, Pt.
12 B, §4, is further amended to read:

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

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

21 C. Rates for small group health plans must be filed in accordance with this section and
22 subsections 2-B and 2-C ~~or section 2792, as applicable~~, for premium rates effective on
23 or after July 1, 2004, except that the rates for small group health plans are not required
24 to account for any payment or any recovery of that payment pursuant to subsection
25 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005.

26 **Sec. 5. 24-A MRSA §2808-B, sub-§2-B**, as amended by PL 2019, c. 653, Pt. B,
27 §6, is further amended to read:

28 **2-B. Rate review and hearings.** Except as provided in subsection 2-C ~~and section~~
29 ~~2792~~, rate filings are subject to this subsection.

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

40 B. If at any time the superintendent has reason to believe that a filing does not meet
41 the requirements that rates not be excessive, inadequate or unfairly discriminatory or
42 that the filing violates any of the provisions of chapter 23, the superintendent shall

1 cause a hearing to be held. Hearings held under this subsection must conform to the
2 procedural requirements set forth in Title 5, chapter 375, subchapter 4. The
3 superintendent shall issue an order or decision within 30 days after the close of the
4 hearing or of any rehearing or reargument or within such other period as the
5 superintendent for good cause may require, but not to exceed an additional 30 days. In
6 the order or decision, the superintendent shall either approve or disapprove the rate
7 filing. If the superintendent disapproves the rate filing, the superintendent shall
8 establish the date on which the filing is no longer effective, specify the filing the
9 superintendent would approve and authorize the insurer to submit a new filing in
10 accordance with the terms of the order or decision.

11 C. When a filing is not accompanied by the information upon which the carrier
12 supports the filing or the superintendent does not have sufficient information to
13 determine whether the filing meets the requirements that rates not be excessive,
14 inadequate or unfairly discriminatory, the superintendent shall require the carrier to
15 furnish the information upon which it supports the filing.

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

19 **Sec. 6. 24-A MRSA §2808-B, sub-§2-C**, as amended by PL 2019, c. 653, Pt. B,
20 §7, is further amended to read:

21 **2-C. Guaranteed loss ratio.** Notwithstanding subsection 2-B, rate filings for a
22 credible block of small group health plans may be filed in accordance with this subsection
23 instead of subsection 2-B, ~~except as otherwise provided in section 2792.~~ Rates filed in
24 accordance with this subsection are filed for informational purposes.

25 A. A block of small group health plans is considered credible if the anticipated average
26 number of members during the period for which the rates will be in effect meets
27 standards for full or partial credibility pursuant to the federal Affordable Care Act. The
28 rate filing must state the anticipated average number of members during the period for
29 which the rates will be in effect and the basis for the estimate. If the superintendent
30 determines that the number of members is likely to be less than needed to meet the
31 credibility standard, the filing is subject to subsection 2-B.

32 **Sec. 7. 24-A MRSA §3958, sub-§1**, as amended by PL 2021, c. 361, §5, is further
33 amended to read:

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

41 A. Beginning July 1, 2012, ~~except as otherwise provided in paragraph A-1,~~ the
42 association shall reimburse a member insurer for claims incurred with respect to a
43 person designated for reinsurance by the member insurer pursuant to section 3959 after
44 the insurer has incurred an initial level of claims for that person of \$7,500 for covered

1 benefits in a calendar year. In addition, the insurer is responsible for 10% of the next
2 \$25,000 of claims paid during a calendar year. The amount of reimbursement is 90%
3 of the amount incurred between \$7,500 and \$32,500 and 100% of the amount incurred
4 in excess of \$32,500 for claims incurred in that calendar year with respect to that
5 person. For calendar year 2012, only claims incurred on or after July 1st are considered
6 in determining the member insurer's reimbursement. With the approval of the
7 superintendent, the association may annually adjust the initial level of claims and the
8 maximum limit to be retained by the insurer to reflect changes in costs, utilization,
9 available funding and any other factors affecting the sustainable operation of the
10 association.

11 ~~A-1. In any plan year in which a pooled market is operating in accordance with section~~
12 ~~2792, the association shall operate a retrospective reinsurance program providing~~
13 ~~coverage to member insurers for all individual and small group health plans issued in~~
14 ~~this State in that plan year. For plan years beginning in 2022, if the pooled market has~~
15 ~~not been implemented pursuant to section 2792, subsection 5, the association may~~
16 ~~operate a retrospective reinsurance program for individual health plans, subject to the~~
17 ~~approval of the superintendent.~~

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

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

27 ~~(3) The board shall annually review the attachment points and coinsurance~~
28 ~~percentages and make any adjustments that are necessary to ensure that the~~
29 ~~retrospective reinsurance program operates on an actuarially sound basis.~~

30 ~~(4) The board shall ensure that any surplus in the retrospective reinsurance~~
31 ~~program at the conclusion of a plan year is used to lower attachment points,~~
32 ~~increase coinsurance rates or both for that plan year, consistent with its~~
33 ~~responsibility to ensure that the program operates on an actuarially sound basis.~~

34 B. A member insurer shall apply all managed care, utilization review, case
35 management, preferred provider arrangements, claims processing and other methods
36 of operation without regard to whether claims paid for coverage are reinsured under
37 this subsection. A member insurer shall report for each plan year the name of each
38 high-priced item or service for which its payment exceeded the amount allowed for
39 eligible claims and the name of the provider that received this payment. The
40 association shall annually compile and publish a list of all reported names.

41 **SUMMARY**

42 This bill removes the requirement that individual and small group health plans must be
43 offered through a pooled market.