APPROVED
JUNE 23, 2021
BY GOVERNOR

CHAPTER
361
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-ONE

S.P. 570 - L.D. 1725

An Act To Clarify the Deferral of the Pooled Market and Link Small Employer Clear Choice to Pooling in the Made for Maine Health Coverage Act

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

Sec. 1. 24-A MRSA §2792, sub-§1, as enacted by PL 2019, c. 653, Pt. B, §2, is amended to read:

1. Pooled market established. Subject to the requirements of subsection 5, all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, ~~2022~~ 2023 must be offered through a pooled market. A health insurance carrier offering an individual health plan subject to this section shall make the plan available to all eligible small employers within the plan's approved service area, and a health insurance carrier offering a small group health plan subject to this section shall make the plan available to all eligible individuals residing within the plan's approved service area. This subsection does not require the Maine Health Insurance Marketplace established in Title 22, chapter 1479 to offer identical choices of health plans to individuals and to small employers under Title 22, chapter 1479.

Sec. 2. 24-A MRSA §2792, sub-§5, as enacted by PL 2019, c. 653, Pt. B, §2, is amended to read:

5. Preconditions for pooled market. This section may not be implemented unless routine technical rules as defined in Title 5, chapter 375, subchapter 2-A are adopted to implement this section and the Federal Government approves a state innovation waiver amendment that extends reinsurance under section 3953 to the pooled market established pursuant to this section based on projections by the superintendent that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent the provisions of this section and chapter 54-A. If this section is not implemented, the superintendent shall conduct an analysis of alternative proposals to improve the stability and affordability of the small group market.

Sec. 3. 24-A MRSA §2793, as enacted by PL 2019, c. 653, Pt. B, §2, is amended to read:

§2793. Clear choice designs

The superintendent shall develop clear choice designs for ~~the individual and small group health insurance markets~~ health plans in order to reduce consumer confusion and provide meaningful choices for consumers by promoting a level playing field on which carriers compete on the basis of price and quality.

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

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

3. Annual review. The superintendent shall consider annually whether to revise, discontinue or add any clear choice designs for use by carriers in the following calendar year, including but not limited to considering whether deductible and copayment levels should be changed to reflect medical inflation and conform with actuarial value and annual maximum out-of-pocket limits.

4. Alternative plan designs. In addition to one or more health plans that include cost-sharing parameters consistent with a clear choice design developed pursuant to this section, a carrier may offer up to 3 health ~~plans~~ plan designs that modify one or more specific cost-sharing parameters in a clear choice design if the carrier submits an actuarial certification to the satisfaction of the superintendent that the alternative plan design offers significant consumer benefits and does not result in adverse selection. An alternative plan design may be offered only in a service area where the carrier offers at least one clear choice design plan at the same tier.

Sec. 4. 24-A MRSA §3957, sub-§7, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

7. Excess funds. If assessments and other receipts by the association, board or administrator selected pursuant to section 3956 exceed the actual losses and administrative expenses of the association, the board shall hold the excess ~~as~~ at interest and shall use those excess funds to offset future losses or to ~~reduce reinsurance premiums~~ make adjustments to a reinsurance program operated pursuant to section 3953. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

Sec. 5. 24-A MRSA §3958, sub-§1, as amended by PL 2019, c. 653, Pt. B, §18, is further amended to read:

1. Reinsurance amount. A member insurer offering an individual health plan under section 2736-C must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for any applicable reinsurance premium at the rate established in accordance with subsection 2. For calendar year ~~2022~~ 2023 and subsequent calendar years, the association shall also reinsure member insurers for small group health plans issued under section 2808-B, unless otherwise provided in rules adopted by the superintendent pursuant to section 2792, subsection 5.

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

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

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

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

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

(4) The board shall ensure that any surplus in the retrospective reinsurance program at the conclusion of a plan year is used to lower attachment points,

increase coinsurance rates or both for that plan year, consistent with its responsibility to ensure that the program operates on an actuarially sound basis.

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