

PLEASE NOTE: Legislative Information **cannot** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

Amend the bill by striking out the title and substituting the following:

'An Act To Establish the Maine Health Benefit Marketplace'

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

'**Sec. 1. 2 MRSA §6, sub-§1**, as repealed and replaced by PL 2005, c. 397, Pt. A, §1, is amended to read:

1. Range 91. The salaries of the following state officials and employees are within salary range 91:

Commissioner of Transportation;

Commissioner of Conservation;

Commissioner of Administrative and Financial Services;

Commissioner of Education;

Commissioner of Environmental Protection;

Executive Director of Dirigo Health;

Commissioner of Public Safety;

Commissioner of Professional and Financial Regulation;

Commissioner of Labor;

Commissioner of Agriculture, Food and Rural Resources;

Commissioner of Inland Fisheries and Wildlife;

Commissioner of Marine Resources;

Commissioner of Corrections;

Commissioner of Economic and Community Development;

Commissioner of Defense, Veterans and Emergency Management; and

Executive Director, Workers' Compensation Board; and

Executive Director, Maine Health Benefit Marketplace.

Sec. 2. 5 MRSA §934-C is enacted to read:

§ 934-C. Maine Health Benefit Marketplace

The position of executive director is a major policy-influencing position within the Maine Health Benefit Marketplace established pursuant to Title 24-A, chapter 93. Notwithstanding any other provision of law, this position and any successor position are subject to this chapter.

Sec. 3. 5 MRSA §12004-G, sub-§14-I is enacted to read:

14-I.

Health Care

24-A MRSA §7204

\$100 per diem and
expenses

Board of Directors
of the Maine Health
Benefit Marketplace

Sec. 4. 24-A MRSA c. 93 is enacted to read:

CHAPTER 93

MAINE HEALTH BENEFIT MARKETPLACE ACT

§ 7201. Short title

This chapter may be known and cited as "the Maine Health Benefit Marketplace Act."

§ 7202. Definitions

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

1. Board. "Board" means the Board of Directors of the Maine Health Benefit Marketplace established in section 7204.

2. Educated health care consumer. "Educated health care consumer" means an individual who is knowledgeable about the health care system, who has no financial interest in the delivery of health care services or sale of health insurance and has a background or experience in making informed decisions regarding health, medical or scientific matters.

3. Federal Affordable Care Act. "Federal Affordable Care Act" has the same meaning as in section 14.

4. Federally recognized Indian tribe. "Federally recognized Indian tribe" means the Passamaquoddy Tribe, the Penobscot Nation, the Houlton Band of Maliseet Indians as defined in 25 United States Code, Section 1722(a) and (h), and the Aroostook Band of Micmacs as defined in the federal Aroostook Band of Micmacs Settlement Act, Public Law 102-171, Section 3(1).

5. Health benefit plan. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

A. "Health benefit plan" does not include:

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; or

(8) Insurance coverage similar to any coverage listed in subparagraphs (1) to (7), as specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

B. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited-scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(3) Limited benefits similar to benefits listed in subparagraphs (1) and (2) as specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

C. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

D. "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined under the United States Social Security Act, Section 1882(g)(1);

(2) Coverage supplemental to the coverage provided under 10 United States Code, Chapter 55; or

(3) Supplemental coverage similar to coverage listed in subparagraphs (1) and (2) provided under a group health plan.

6. Health carrier. "Health carrier" or "carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32;

D. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or

E. An employee benefit excess insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance pursuant to section 707, subsection 1, paragraph C-1.

7. Marketplace. "Marketplace" means the Maine Health Benefit Marketplace established in section 7203 pursuant to Section 1311 of the federal Affordable Care Act.

8. Qualified employer. "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans or qualified stand-alone dental benefit plans offered through the SHOP exchange and that:

A. Has its principal place of business in this State and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

B. Elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in this State.

9. Qualified health plan. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the federal Affordable Care Act and this chapter.

10. Qualified individual. "Qualified individual" means an individual, including a minor, who:

A. Is seeking to enroll in a qualified health plan or qualified stand-alone dental benefit plan offered to individuals through the marketplace;

B. Resides in this State within the meaning of the federal Affordable Care Act;

C. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

D. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

11. Qualified stand-alone dental benefit plan. "Qualified stand-alone dental benefit plan" means a stand-alone dental benefit plan that has been certified in accordance with section 7211.

12. Secretary. "Secretary" means the Secretary of the United States Department of Health and Human Services.

13. SHOP exchange. "SHOP exchange" means the Small Business Health Options Program established pursuant to section 7203.

14. Small employer. "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year except that, for plan years beginning before January 1, 2016, "small employer" means an employer that employed an average of not more than 50 employees during the preceding calendar year. For purposes of this subsection:

A. All persons treated as a single employer under 26 United States Code, Section 414(b), (c), (m) or (o) must be treated as a single employer;

B. An employer and a predecessor employer must be treated as a single employer;

C. All employees must be counted, including part-time employees and employees who are not eligible for coverage through the employer;

D. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

E. An employer that makes enrollment in qualified health plans or qualified stand-alone dental benefit plans available to its employees through the SHOP exchange, and would cease to be a small employer by reason of an increase in the number of its employees, must continue to be treated as a small employer for purposes of this chapter as long as the employer continuously makes enrollment through the SHOP exchange available to its employees.

15. Stand-alone dental benefit plan. "Stand-alone dental benefit plan" means a policy, contract, certificate or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of limited-scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the federal Internal Revenue Code of 1986.

§ 7203. Maine Health Benefit Marketplace established; declaration of necessity

1. Marketplace established. The Maine Health Benefit Marketplace is established as an independent executive agency to provide, pursuant to the federal Affordable Care Act, for the establishment of a health benefit exchange to facilitate the purchase and sale of qualified health plans and qualified stand-alone dental benefit plans in the individual market in this State and for the establishment of the Small Business Health Options Program to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans and qualified stand-alone dental benefit plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured individuals, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium tax credits and cost-sharing reductions. The Maine Health Benefit Marketplace is also responsible for monitoring and improving the quality of health care in this State. The exercise by the Maine Health Benefit Marketplace of the powers conferred by this chapter is deemed and held to be the performance of essential governmental functions.

2. Contracting authority. The marketplace may contract with an eligible entity for any of its functions described in this chapter. For the purposes of this subsection, "eligible entity" includes, but is not limited to, the MaineCare program or any entity that has experience in individual and small group health insurance or benefit administration or other experience relevant to the responsibilities to be assumed by the entity, except that a health carrier or an affiliate of a health carrier is not an eligible entity.

3. Information sharing. The marketplace may enter into information-sharing agreements with federal and state agencies and other states' exchanges to carry out its responsibilities under this chapter; such agreements must include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules and regulations.

§ 7204. Board of Directors of Maine Health Benefit Marketplace

The Board of Directors of the Maine Health Benefit Marketplace, as established in Title 5, section 12004-G, subsection 14-I, shall supervise the marketplace.

1. Appointments. The board consists of 9 voting members and 4 ex officio, nonvoting members as follows.

A. The 9 voting members of the board are appointed as follows, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate:

(1) Three members appointed by the Governor;

(2) Two members appointed by the President of the Senate;

(3) Two members appointed by the Speaker of the House;

(4) One member appointed by the President of the Senate upon recommendation from the leader of the minority in the Senate; and

(5) One member appointed by the Speaker of the House upon recommendation from the leader of the minority in the House of Representatives.

B. The 4 ex officio, nonvoting members of the board are:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

(2) The Commissioner of Health and Human Services or the commissioner's designee;

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee; and

(4) The Treasurer of State or the treasurer's designee.

2. Qualifications of voting members. Voting members of the board must be qualified in accordance with this subsection.

A. Five voting members of the board must have knowledge of and experience in at least 2 of the following areas:

(1) Health care purchasing;

(2) Individual health insurance coverage;

(3) Small group health insurance coverage;

(4) The MaineCare program;

(5) Health benefit plan or dental benefit plan administration;

(6) Administering a public or private health care delivery system;

(7) Health care financing; and

(8) Health policy and law.

B. Four voting members of the board must be qualified as follows:

(1) One member who serves as the chair of the Medicaid advisory committee within the Department of Health and Human Services;

(2) One member representing a federally recognized Indian tribe; and

(3) Two members representing consumers, including either one employee who receives health care coverage through a commercially insured product or one representative of organized labor and either one representative of a consumer health advocacy organization or one representative of the uninsured or Medicaid recipients.

C. A member or staff member of the board or an immediate family member of a member or staff member of the board may not be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of a carrier or other insurer, an agent or broker, a health care provider or a health care facility or a health clinic while serving on or employed by the board. A member or staff member of the board or an immediate family member of a member or staff member of the board may not be a member, a board member or an employee of a trade association of carriers, health facilities, health clinics or health care providers while serving on or employed by the board. A member or staff member of the board or an immediate family member of a member or staff member of the board may not be a health care provider unless the member or staff member receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

(1) A member or staff member of the board may not make, participate in making or in any way attempt to use that member's or staff member's official position to influence the making of any decision that the member or staff member knows or has reason to know will have a reasonably

foreseeable material financial effect, distinguishable from its effect on the public generally, on that member or staff member or a member of that member's or staff member's immediate family, or on either of the following:

(a) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status, aggregating \$250 or more in value provided to, received by or promised to the member or staff member within 12 months prior to the time when the decision is made; or

(b) Any business entity in which the member or staff member is a director, officer, partner, trustee or employee or holds any position of management.

(2) If a member or staff member of the board has a conflict of interest in a matter before the board requiring member or staff action, the member or staff member shall recuse that member's or staff member's self from the matter and may not vote on or attempt to influence the outcome of the matter. Whether or not recusal is required under this subparagraph, a member or staff member of the board shall consider recusing that member's or staff member's self from any matter that would give rise to an appearance of a conflict of interest.

D. Notwithstanding any other provision of law, a current or former member of the Board of Trustees of Dirigo Health may also serve as a member of the board.

3. Terms of office. Voting members of the board serve 3-year terms. Voting members may serve up to 2 consecutive terms. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2. A member may serve until a replacement is appointed and qualified.

4. Chair. The Governor shall appoint one of the voting members of the board as the chair of the board.

5. Quorum. Five voting members of the board constitute a quorum.

6. Affirmative vote. An affirmative vote of a majority of the members who have not recused themselves from voting on an action is required for any action taken by the board.

7. Compensation. A member of the board is entitled to compensation according to the provisions of Title 5, section 12004-G, subsection 14-I; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

8. Meetings. The board shall meet monthly and may also meet at other times at the call of the chair or the executive director appointed under section 7208. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

§ 7205. Limitation on liability

1. Indemnification of marketplace employees. A board member or employee of the marketplace is not subject to personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. The marketplace shall indemnify a member of the board or an employee of the marketplace against expenses actually and necessarily incurred by that member or employee in connection with the defense of an action or proceeding in which that member or employee is made a party by reason of past or present authority with the marketplace.

2. Limitation on liability of board members. The personal liability of a member of the board is governed by Title 18-B, section 1010.

§ 7206. Prohibited interests of board members and employees

Board members and employees of the marketplace and their spouses and dependent children may not receive any direct personal benefit from the activities of the marketplace in assisting any private entity, except that they may participate in the marketplace on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members are associated by reason of ownership or employment from participating in activities of the marketplace or receiving services offered by the marketplace as long as the ownership or employment is made known to the board and, if applicable, the board members abstain from voting on matters relating to that participation.

§ 7207. Records

Except as provided in subsections 1 and 2, information obtained by the marketplace under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by the marketplace under this chapter is confidential and not open to public inspection.

2. Health information. Health information obtained by the marketplace under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711-C is confidential and not open to public inspection.

§ 7208. Executive director

1. Appointed position. The board shall appoint an executive director, who serves at the pleasure of the board. The position of Executive Director of the Maine Health Benefit Marketplace is a major policy-influencing position as designated in Title 5, section 934-C.

2. Duties of executive director. The executive director appointed under subsection 1 shall:

A. Serve as the liaison between the board and the marketplace and serve as secretary and treasurer to the board;

- B. Manage the marketplace's programs and services;
- C. Employ or contract on behalf of the marketplace for professional and nonprofessional personnel or service. Employees of the marketplace are subject to the Civil Service Law;
- D. Approve all accounts for salaries, per diems, allowable expenses of the marketplace or of any employee or consultant and expenses incidental to the operation of the marketplace; and
- E. Perform other duties prescribed by the board to carry out the functions of this chapter.

§ 7209. Availability of coverage

1. Coverage. The marketplace shall make qualified health plans and qualified stand-alone dental benefit plans available to qualified individuals and qualified employers no later than January 1, 2014. The marketplace may enroll qualified individuals and qualified employers beginning on or after September 1, 2013.

2. Qualified plan required. The marketplace may not make available any health benefit plan that is not a qualified health plan or any stand-alone dental benefit plan that is not a qualified stand-alone dental benefit plan.

3. Dental benefits. The marketplace shall allow a health carrier to offer a qualified stand-alone dental benefit plan through the marketplace, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the federal Affordable Care Act. This subsection does not prohibit a carrier from offering other dental benefit plans consistent with the requirements of section 7211, subsections 5 and 6.

4. No fee or penalty for termination of coverage. The marketplace or a carrier offering qualified health plans or qualified stand-alone dental benefit plans through the marketplace may not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 1401 of the federal Affordable Care Act.

5. Standardized plans. The marketplace may standardize qualified health plans to be offered through the marketplace.

§ 7210. Powers and duties of the Maine Health Benefit Marketplace

1. Powers. Subject to any limitations contained in this chapter or in any other law, the marketplace may:

- A. Take any legal actions that are necessary for the proper administration of the marketplace;
- B. Make and alter bylaws, not inconsistent with this chapter or with the laws of this State, for the administration and regulation of the activities of the marketplace;

C. Have and exercise all powers necessary or convenient to effect the purposes for which the marketplace is organized or to further the activities in which the marketplace may lawfully be engaged, including the establishment of the marketplace;

D. Engage in legislative liaison activities, including gathering information regarding legislation, analyzing the effect of legislation, communicating with Legislators and attending and giving testimony at legislative sessions, public hearings or committee hearings;

E. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter;

F. Apply for and receive funds, grants or contracts from public and private sources; and

G. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more organizations organized, created or operated under the laws of this State.

2. Duties. The marketplace shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the secretary under Section 1311(c) of the federal Affordable Care Act and pursuant to section 7211, of health benefit plans as qualified health plans and of stand-alone dental benefit plans as qualified stand-alone dental benefit plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance except that the hotline may not be automated unless the hotline provides the opportunity for live customer service;

C. Provide for enrollment periods as provided under Section 1311(c)(6) of the federal Affordable Care Act;

D. Maintain a publicly accessible website through which enrollees and prospective enrollees of qualified health plans and qualified stand-alone dental benefit plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the marketplace in accordance with the criteria developed by the secretary under Section 1311(c)(3) of the federal Affordable Care Act and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under Section 1302(d)(2)(A) of the federal Affordable Care Act;

F. Use a standardized format for presenting health and dental benefit options in the marketplace, including the use of the uniform outline of coverage established under the federal Public Health Service Act, 42 United States Code, Section 300gg-15 (2010);

G. In accordance with Section 1413 of the federal Affordable Care Act, inform individuals of eligibility requirements for the Medicaid program under the United States Social Security Act, Title XIX, or the State Children's Health Insurance Program under the United States Social Security Act,

Title XXI, or under any applicable state or local public program and if, through screening of an application by the marketplace, the marketplace determines that an individual is eligible for any such program, enroll the individual in that program;

H. Determine the criteria and process for eligibility, enrollment and disenrollment of enrollees and potential enrollees in the marketplace and coordinate that process with the state and local government entities administering other health care coverage programs, including the MaineCare program and the basic health program, if established, required by paragraph O, in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverages. To the extent possible, the board shall encourage the use of existing infrastructure and capacity from other state agencies;

I. Determine the minimum requirements a carrier must meet to be considered for participation in the marketplace and the standards and criteria for selecting qualified health plans to be offered through the marketplace that are in the best interests of qualified individuals and qualified employers. The board shall consistently and uniformly apply these requirements, standards and criteria to all carriers offering qualified health plans through the marketplace and, if relevant, shall apply those requirements, standards and criteria to carriers offering qualified stand-alone dental benefit plans or other dental benefit plans through the marketplace. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified employers through the marketplace, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality and service. In its evaluation of the quality of health care coverage offered by a carrier, the board shall consider comparative health care quality information and assessments developed by the Maine Quality Forum, as established in section 6951;

J. Provide, in each region of the State, a choice of qualified health plans at each of the 5 levels of coverage contained in Section 1302(d) and (e) of the federal Affordable Care Act;

K. Require, as a condition of participation in the marketplace, carriers to fairly and affirmatively offer, market and sell in the marketplace at least one product within each of the 5 levels of coverage contained in Section 1302(d) and (e) of the federal Affordable Care Act. The board may require carriers to offer additional products within each of those 5 levels of coverage. This paragraph does not apply to a carrier that solely offers supplemental coverage in the marketplace under Section 100504(a)(10) of the federal Affordable Care Act or that solely offers a qualified stand-alone dental benefit plan;

L. Require, as a condition of participation in the marketplace, carriers that sell any products outside the marketplace to:

(1) Fairly and affirmatively offer, market and sell all products made available to individuals in the marketplace to individuals purchasing coverage outside the marketplace; and

(2) Fairly and affirmatively offer, market and sell all products made available to small employers in the marketplace to small employers purchasing coverage outside the marketplace;

M. Establish and make available by electronic means and by a toll-free telephone number a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 1401 of the federal Affordable Care Act and any cost-sharing reduction under Section 1402 of the federal Affordable Care Act;

N. Establish a SHOP exchange through which qualified employers may access coverage for their employees, enabling any qualified employer to specify a level of coverage or amount of contribution toward coverage so that any of its employees may enroll in any qualified health plan or qualified stand-alone dental benefit plan offered through the SHOP exchange at the specified level of coverage;

O. Consider, in consultation with the Department of Health and Human Services and the MaineCare Advisory Committee, establishing a basic health program for eligible individuals in accordance with Section 1331 of the federal Affordable Care Act in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan. On or before April 1, 2013, the board shall submit its recommendation on whether to establish a basic health plan in accordance with this paragraph for review by the joint standing committee of the Legislature having jurisdiction over insurance matters;

P. Subject to Section 1411 of the federal Affordable Care Act, issue a certification attesting that, for purposes of the individual responsibility penalty under 26 United States Code, Section 5000A, an individual is exempt from the individual responsibility requirement or from the penalty because:

(1) There is no affordable qualified health plan available through the marketplace, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

Q. Transfer to the United States Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under paragraph P, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 1401 of the federal Affordable Care Act because:

(a) The employer did not provide the minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under Section 1401 of the federal Affordable Care Act to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the marketplace under Section 1411(b)(4) of the federal Affordable Care Act that the individual has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

R. Provide to each employer the name of each employee of the employer described in paragraph Q, subparagraph (3) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

S. Perform duties required of the marketplace by the secretary and the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing or individual responsibility requirement exemptions;

T. Select entities qualified to serve as navigators in accordance with section 7212, Section 1311(i) of the federal Affordable Care Act and standards developed by the secretary and award grants to enable navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans and qualified stand-alone dental benefit plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans and qualified stand-alone dental benefit plans and the availability of premium tax credits under Section 1401 of the federal Affordable Care Act and cost-sharing reductions under Section 1402 of the federal Affordable Care Act;

(3) Facilitate enrollment in qualified health plans and qualified stand-alone dental benefit plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the federal Public Health Service Act, 42 United States Code, Section 300gg-93 (2010), or any other appropriate state agency or agencies, for an enrollee with a grievance, complaint or question regarding a health benefit plan or stand-alone dental benefit plan or coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the marketplace.

An individual licensed as an insurance producer pursuant to chapter 16 may serve as a navigator to qualified individuals in the marketplace and in the SHOP exchange in accordance with Section 1311(i) of the federal Affordable Care Act;

U. Review the rate of premium growth within the marketplace and outside the marketplace and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

V. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with Section 10108 of the federal Affordable Care Act, and collect the amount credited from the offering employer;

W. Consult with stakeholders regarding carrying out the activities required under this chapter, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans and qualified stand-alone dental benefit plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans and qualified stand-alone dental benefit plans;

(3) Representatives of small businesses and self-employed individuals;

(4) Representatives of the MaineCare program; and

(5) Advocates for enrolling hard-to-reach populations;

X. Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the secretary, the Governor, the superintendent and the Legislature a report concerning such accountings;

Y. Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the federal Affordable Care Act and allow the secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(1) Investigate the affairs of the marketplace;

(2) Examine the properties and records of the marketplace; and

(3) Require periodic reports in relation to the activities undertaken by the marketplace; and

Z. In carrying out its activities under this chapter, avoid using any funds intended for the administrative and operational expenses of the marketplace for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications.

3. Budget. The revenues and expenditures of the marketplace are subject to legislative approval in the biennial budget process. At the direction of the board, the executive director appointed under section 7208 shall prepare the budget for the administration and operation of the marketplace in accordance with the provisions of law that apply to departments of State Government.

4. Audit. The marketplace must be audited annually by the State Auditor. The board may, in its discretion, arrange for an independent audit to be conducted. A copy of any audit must be provided to the State Controller, the superintendent, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

5. Rulemaking. The marketplace may adopt rules as necessary for the proper administration and enforcement of this chapter pursuant to the Maine Administrative Procedure Act. Unless otherwise specified, rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this subsection may not conflict with or prevent the application of regulations promulgated by the secretary under the federal Affordable Care Act.

6. Annual report. Beginning February 1, 2015, and annually thereafter, the board shall report on the operation of the marketplace to the Governor, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

7. Technical assistance from other state agencies. Other state agencies, including, but not limited to, the bureau; the Department of Health and Human Services; the Department of Administrative and Financial Services, Maine Revenue Services; and the Maine Health Data Organization, shall provide technical assistance and expertise to the marketplace upon request.

8. Legal counsel. The Attorney General, when requested, shall furnish any legal assistance, counsel or advice the marketplace requires in the discharge of its duties.

9. Coordination with federal, state and local health care systems. The marketplace shall institute a system to coordinate the activities of the marketplace with the health care programs of the Federal Government and state and municipal governments.

10. Advisory committees. The board may appoint advisory committees to advise and assist the board in discharging its responsibilities under this chapter. Members of an advisory committee serve without compensation but may be reimbursed by the marketplace for necessary expenses while on official business of the advisory committee.

11. Publication of costs. The marketplace shall publish the average costs of licensing, regulatory fees and any other payments required by the marketplace, and the administrative costs of the marketplace, on a publicly accessible website to educate consumers on such costs. This information must include information on money lost to waste, fraud and abuse.

§ 7211. Health benefit plan certification

1. Certification. The marketplace may certify a health benefit plan as a qualified health plan if:

A. The health benefit plan provides the essential health benefits package described in Section 1302(a) of the federal Affordable Care Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified stand-alone dental benefit plans, as provided in subsection 5, if:

(1) The marketplace has determined that at least one qualified stand-alone dental benefit plan is available to supplement the plan's coverage; and

(2) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the marketplace, that the plan does not provide the full range of essential pediatric dental benefits and that qualified stand-alone dental benefit plans providing those benefits and other dental benefits not covered by the plan are offered through the marketplace;

B. The premium rates and contract language have been approved by the superintendent;

C. The health benefit plan provides at least a bronze level of coverage, as determined pursuant to Section 1302(d)(1)(A) of the federal Affordable Care Act for catastrophic plans, and will be offered only to individuals eligible for catastrophic coverage;

D. The health benefit plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the federal Affordable Care Act and, if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the federal Affordable Care Act;

E. The health carrier offering the health benefit plan:

(1) Is licensed and in good standing to offer health insurance coverage in this State;

(2) Offers at least one qualified health plan in the silver level and at least one plan in the gold level as described in Section 1302(d)(1)(B) and (d)(1)(C) of the federal Affordable Care Act through each component of the marketplace in which the carrier participates. As used in this subparagraph, "component" means the SHOP exchange and the marketplace;

(3) Offers at least one qualified health plan that provides the essential health benefits package described in Section 1302(a) of the federal Affordable Care Act without benefits that duplicate the minimum dental benefits of stand-alone dental benefit plans, if the marketplace has determined that at least one qualified stand-alone dental benefit plan is available through the marketplace to supplement the qualified health plan's coverage;

(4) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the marketplace and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

(5) Does not charge any fees or penalties for termination of coverage in violation of section 7209, subsection 4; and

(6) Complies with the regulations developed by the secretary under Section 1311(c) of the federal Affordable Care Act and such other requirements as the marketplace may establish;

F. The health benefit plan meets the requirements of certification as adopted by rules pursuant to section 7210, subsection 5 and by regulation promulgated by the secretary under Section 1311(c) of the federal Affordable Care Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

G. The marketplace determines that making the health benefit plan available through the marketplace is in the interest of qualified individuals and qualified employers in this State.

2. Authority to exclude health benefit plans. The marketplace may not exclude a health benefit plan:

A. On the basis that the health benefit plan is a fee-for-service plan;

B. Through the imposition of premium price controls by the marketplace; or

C. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances in which the marketplace determines the treatments are inappropriate or too costly.

3. Carrier requirements. The marketplace shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to:

A. Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its publicly accessible website. The marketplace shall take this information, along with the information and the recommendations provided to the marketplace by the superintendent under the federal Public Health Service Act, 42 United States Code, Section 300gg-94 (2010), into consideration when determining whether to allow the carrier to make plans available through the marketplace;

B. Make available to the public and submit to the marketplace, the secretary and the superintendent accurate, transparent and timely disclosure of the following:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost sharing and payments with respect to any out-of-network coverage;

(8) Information on enrollee and participant rights under Title I of the federal Affordable Care Act; and

(9) Other information as determined appropriate by the secretary.

The information required in this paragraph must be provided in plain language, as that term is defined in Section 1311(e)(3)(B) of the federal Affordable Care Act;

C. Permit an individual to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information must be made available to the individual through a publicly accessible website and through other means for an individual without access to the Internet; and

D. Make a separate disclosure of the price of pediatric dental benefits if the plan provides a comprehensive essential health benefits package described in Section 1302(a) of the federal Affordable Care Act, as long as the carrier is not required to offer the pediatric dental benefit for sale on the marketplace on a stand-alone basis.

4. No exemption from licensing or solvency requirements. The marketplace may not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures fairness between or among health carriers participating in the marketplace.

5. Application to qualified stand-alone dental benefit plans. The provisions of this chapter that are applicable to qualified health plans also apply to the extent relevant to qualified stand-alone dental benefit plans except as modified in this subsection or by rules adopted by the marketplace.

A. The marketplace may certify a stand-alone dental benefit plan as a qualified stand-alone dental benefit plan if the carrier offering the plan:

(1) Is licensed and in good standing to offer dental coverage in this State. The carrier need not be licensed to offer other health benefits;

(2) Offers at least one stand-alone dental benefit plan that includes only the essential pediatric dental benefit requirement of Section 1302(b)(1)(J) of the federal Affordable Care Act, as long as this requirement does not limit a carrier from providing other stand-alone dental benefit plans that are certified by the marketplace;

(3) Charges the same premium rate for each stand-alone dental benefit plan without regard to whether the plan is offered through the marketplace and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

(4) Submits the premium rates and contract language to the superintendent for approval;

(5) Does not charge any fees or penalties for termination of coverage in violation of section 7209, subsection 4; and

(6) Complies with any regulations adopted by the secretary under Section 1311(d) of the federal Affordable Care Act and any rules adopted by the marketplace pursuant to this chapter.

B. The qualified stand-alone dental benefit plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and must meet the requirements for essential pediatric dental benefits prescribed by the secretary pursuant to Section 1302(b)(1)(J) of the federal Affordable Care Act and such other dental benefits as the marketplace or the secretary may specify by rule or regulation.

C. Carriers may jointly offer a comprehensive plan through the marketplace in which the dental benefits are provided by a carrier through a qualified stand-alone dental benefit plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also made available for purchase separately at the same prices.

D. The marketplace may not exclude a stand-alone dental benefit plan on the basis that the plan is a fee-for-service plan or through the imposition of premium price controls by the marketplace.

E. The marketplace may adopt rules as necessary to carry out the requirements of this subsection, including but not limited to rules to enhance transparency and choice for consumers in the purchase of qualified health plans, qualified stand-alone dental benefit plans or other dental benefit plans offered through the marketplace and rules relating to consumer protections relevant to qualified stand-alone dental benefit plans or other dental benefit plans offered through the marketplace. Rules adopted in accordance with this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

6. Other dental benefit plans. In addition to the certification of a qualified stand-alone dental benefit plan pursuant to this section, the marketplace may certify other dental benefit plans, either as part of a qualified health plan or separately, in accordance with this section and any rules adopted by the marketplace.

§ 7212. Navigators

1. Navigator grant program. The marketplace shall establish a navigator grant program to award grants to entities qualified to serve as navigators, in accordance with this section, Section 1311(i) of the federal Affordable Care Act and standards developed by the secretary, to enable navigators to perform the activities described in section 7210, subsection 2, paragraph T.

2. Selection of navigators. The board shall, in the board's sole discretion, award grants to an eligible entity described in subsection 3 that demonstrates to the satisfaction of the board that it has the capacity and experience to effectively reach out to individuals, including uninsured individuals, underinsured individuals, low-income individuals and self-employed individuals, and small employers and their employees likely to be qualified to enroll in a qualified health plan or qualified stand-alone dental benefit plan. In awarding grants to eligible entities, the board shall ensure that an entity is able to address the needs of individuals and small employers and their employees in all geographic regions of the State in a manner that is culturally and linguistically appropriate to the needs of the population being served.

3. Eligible entities. The board may award navigator grants in accordance with subsection 1 to any of the following eligible entities:

- A. A trade, industry or professional association;
- B. A community-focused and consumer-focused nonprofit group;
- C. A chamber of commerce;
- D. A labor union;
- E. A small business development center; or
- F. An insurance producer or broker licensed in this State.

A navigator may not be an insurer or receive any consideration directly or indirectly from any insurer in connection with the enrollment of any qualified individual or employees of a qualified employer in a qualified health plan.

4. Compliance. A navigator shall comply with all applicable provisions of the federal Affordable Care Act, regulations adopted thereunder and federal guidance issued pursuant to the federal Affordable Care Act.

5. Information standards. The marketplace shall collaborate with the secretary to develop standards to ensure that the information distributed and provided by navigators is fair and accurate.

6. Performance standards; accountability. The marketplace shall establish performance standards, accountability requirements and maximum grant amounts for navigators.

7. Antisteering provisions; participation of insurance producers. The marketplace shall prohibit an insurance producer, as a condition of that insurance producer's participation as a navigator, from steering, directly or indirectly, a qualified individual or an employee of a qualified employer to any particular qualified health plan.

§ 7213. Carrier participation

1. Required levels of coverage. Beginning January 1, 2014, a carrier shall, with respect to health benefit plans, fairly and affirmatively offer, market and sell only the 5 levels of coverage contained in Section 1302(d) and (e) of the federal Affordable Care Act, except that a carrier that does not participate in the marketplace shall, with respect to health benefit plans, fairly and affirmatively offer, market and sell only the 4 levels of coverage contained in Section 1302(d) of the federal Affordable Care Act.

2. Standardized products. Beginning January 1, 2014, a carrier that does not participate in the marketplace shall, with respect to health benefit plans, fairly and affirmatively offer at least one standardized health benefit plan that has been designated by the marketplace in each of the 4 levels of

coverage contained in Section 1302(d) of the federal Affordable Care Act. This subsection applies only if the board exercises its authority under section 7209, subsection 5. This subsection may not be construed to:

- A. Require a carrier that does not participate in the marketplace to offer standardized health benefit plans in the small employer market if the carrier sells health benefit plans only in the individual market;
- B. Require a carrier that does not participate in the marketplace to offer standardized health benefit plans in the individual market if the carrier sells health benefit plans only in the small employer market; or
- C. Prohibit a carrier from offering other health benefit plans as long as the carrier complies with the required levels of coverage described in subsection 1.

§ 7214. The Maine Health Benefit Marketplace Enterprise Fund

The Maine Health Benefit Marketplace 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, federal funds and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

§ 7215. Maine Health Benefit Marketplace Business Advisory Council

The Maine Health Benefit Marketplace Business Advisory Council, referred to in this chapter as "the advisory council," is established to advise the marketplace. Except as provided in section 7207, subsection 2, information obtained by the advisory council is a public record as provided by Title 1, chapter 13, subchapter 1.

1. Appointment; composition. The Governor shall appoint the following members of the advisory council with the approval of the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters:

- A. Three members representing providers, including one physician, one representative of hospitals and one health care practitioner who is not a physician;
- B. One member representing consumers;
- C. One member representing large employers;
- D. One member representing small employers;
- E. One representative of health insurance or dental insurance carriers; and
- F. One representative of health insurance producers.

Prior to making appointments to the advisory council, the Governor shall seek nominations from the public statewide associations representing the interests under paragraphs A to F and other entities as appropriate.

2. Terms. Members of the advisory council serve 5-year terms. A member may not serve more than 2 consecutive terms.

3. No compensation. Members of the advisory council serve as volunteers and without compensation or reimbursement for expenses.

4. Quorum. A quorum is a majority of the members of the advisory council.

5. Chair and officers. The advisory council shall annually choose one of its members to serve as chair for a one-year term. The advisory council may select other officers and designate their duties.

6. Meetings. The advisory council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the executive director appointed under section 7208. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

7. Duties. The advisory council shall:

A. Advise and support the marketplace on matters referred to it by the board or the executive director appointed under section 7208; and

B. Serve as a liaison between the marketplace and individuals and small businesses enrolled in the marketplace.

§ 7216. Relation to other laws

This chapter, and any action taken by the marketplace pursuant to this chapter, may not be construed to preempt or supersede the authority of the superintendent to regulate the business of insurance within this State. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans or qualified stand-alone dental benefit plans in this State shall comply fully with all applicable health insurance laws of this State and rules adopted and orders issued by the superintendent.

Sec. 5. Staggered terms; Board of Directors of the Maine Health Benefit Marketplace. Notwithstanding the Maine Revised Statutes, Title 24-A, section 7204, subsection 3, of the initial voting members appointed to the Board of Directors of the Maine Health Benefit Marketplace, 2 members must be appointed to serve initial terms of one year, 3 members must be appointed to serve initial terms of 2 years and 4 members must be appointed to serve initial terms of 3 years.

Sec. 6. Staggered terms; Maine Health Benefit Marketplace Business Advisory Council. Notwithstanding the Maine Revised Statutes, Title 24-A, section 7215, subsection 2, of the initial members appointed to the Maine Health Benefit Marketplace Business Advisory Council, 3 members must be appointed to serve initial terms of 3 years, 3 members must be appointed to serve initial terms of 4 years and 2 members must be appointed to serve initial terms of 5 years.

Sec. 7. Transition. The following provisions apply to the establishment of the Maine Health Benefit Marketplace pursuant to the Maine Revised Statutes, Title 24-A, chapter 93.

1. Board appointed. Within 30 days of the effective date of this Act, the Governor shall post nominations for the appointment of the members of the Board of Directors of the Maine Health Benefit Marketplace. As soon as practicable after Senate confirmation of board members, the board shall appoint the Executive Director of the Maine Health Benefit Marketplace pursuant to Title 24-A, section 7208.

2. Initial staffing; Dirigo Health. Upon request from the Board of Directors of the Maine Health Benefit Marketplace, the Executive Director of Dirigo Health shall provide initial staffing assistance to the marketplace in the initial phases of its operations until the appointment of the Executive Director of the Maine Health Benefit Marketplace. The Executive Director of the Maine Health Benefit Marketplace shall hire staff and contract for services to implement this Act. In hiring and contracting, the Executive Director of the Maine Health Benefit Marketplace may give preference to state employees and contractors who are employed by Dirigo Health.

3. Grant funding. As soon as practicable after Senate confirmation of board members, the Board of Directors of the Maine Health Benefit Marketplace shall submit an application to the Secretary of the United States Department of Health and Human Services for any grant funding made available to states for exchange planning and implementation pursuant to the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

4. Report. Beginning 90 days after the effective date of this Act and until June 30, 2014, the Executive Director of the Maine Health Benefit Marketplace shall report on a quarterly basis to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the actions taken by the Board of Directors of the Maine Health Benefit Marketplace and the initial operations of the Maine Health Benefit Marketplace.

Sec. 8. Maine Health Benefit Marketplace funding mechanism; report. The Board of Directors of the Maine Health Benefit Marketplace shall consider how to ensure that the marketplace is financially sustainable by 2015 as required by federal law, including, but not limited to:

1. A recommended plan for the budget of the marketplace; and
2. The funding mechanism recommended by the marketplace to fund its operations. Any funding mechanism recommended by the marketplace must be broad-based, may not disadvantage health benefit plans offered inside the marketplace and must minimize adverse selection.

On or before February 1, 2014, the Board of Directors of the Maine Health Benefit Marketplace shall submit a report, including suggested legislation, with its recommended funding mechanism to the joint standing committee of the Legislature having jurisdiction over insurance matters. The joint standing committee of the Legislature having jurisdiction over insurance matters may submit a bill based on the report to the Second Regular Session of the 126th Legislature.

Sec. 9. Impact of adverse selection on the Maine Health Benefit Marketplace; report. The Board of Directors of the Maine Health Benefit Marketplace, in consultation with any advisory committees established pursuant to the Maine Revised Statutes, Title 24-A, chapter 93 and with

other stakeholders, shall study and make recommendations regarding the rules under which health benefit plans should be offered inside and outside the marketplace in order to mitigate adverse selection and encourage enrollment in the marketplace, including:

1. Whether any benefits should be required of qualified health plans beyond those mandated by the federal Affordable Care Act, as defined in the Maine Revised Statutes, Title 24-A, section 14, and whether any such additional benefits should be required of health benefit plans offered outside the marketplace; and

2. Whether carriers offering health benefit plans outside the marketplace should be required to offer either all the same health benefit plans inside the marketplace or, alternatively, at least one health benefit plan inside the marketplace.

On or before April 1, 2013, the Board of Directors of the Maine Health Benefit Marketplace shall submit a report, including any suggested legislation, with its recommendations to the joint standing committee of the Legislature having jurisdiction over insurance matters. The joint standing committee of the Legislature having jurisdiction over insurance matters may submit a bill based on the report to the First Regular Session of the 126th Legislature.

Sec. 10. Appropriations and allocations. The following appropriations and allocations are made.

HEALTH BENEFIT MARKETPLACE

Maine Health Benefit Marketplace Fund N136

Initiative: Allocates funds for the salary, benefits and related costs of the Executive Director, Maine Health Benefit Marketplace position.

MAINE HEALTH BENEFIT MARKETPLACE ENTERPRISE FUND	2011-12	2012-13
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	\$0	\$158,003
All Other	\$0	\$5,000
	<hr/>	
MAINE HEALTH BENEFIT MARKETPLACE ENTERPRISE FUND TOTAL	\$0	\$163,003

SUMMARY

This amendment reflects the recommendations of the minority of the committee. The amendment makes the following changes to the bill.

1. It designates the position of Executive Director of the Maine Health Benefit Marketplace as a major policy-influencing position under state law and establishes the salary range for the position.

2. It makes changes to strengthen the conflict of interest provisions related to members and staff of the Board of Directors of the Maine Health Benefit Marketplace.

3. It authorizes the marketplace to offer qualified stand-alone dental benefit plans and other dental benefit plans.

4. It authorizes the board to standardize health plan coverage to be offered through the marketplace and also requires carriers to offer certain levels of coverage both through the marketplace and outside of the marketplace.

5. It requires the board to consult with the Department of Health and Human Services and the MaineCare Advisory Committee when considering whether to establish a basic health program and requires the board to submit its recommendation to the Legislature by April 1, 2013.

6. It establishes standards for the participation of navigators through the marketplace and authorizes insurance producers to act as navigators with respect to both individuals and small employers.

7. It removes the provisions in the bill that eliminate the Dirigo Health program effective January 1, 2014 and transfer the health access payment from Dirigo Health, since the health access payment is eliminated as of January 1, 2014 pursuant to Public Law 2011, chapter 380, Part BBB. The amendment requires the board to report to the Legislature and the Governor with recommendations for how the marketplace can be self-sustaining by 2015 and also requires the board to study the effect of adverse selection on the marketplace.

8. It removes the provisions in the bill making changes to the Maine Insurance Code that preserve the authority of the Superintendent of Insurance to enforce the federal Patient Protection and Affordable Care Act since substantially similar provisions were enacted by Public Law 2011, chapter 364.

9. It removes the provision in the bill requiring the Department of Professional and Financial Regulation, Bureau of Insurance to review the minimum essential benefits package to be determined by the Secretary of the United States Department of Health and Human Services in comparison with existing state mandated health insurance benefit laws.

10. It allocates funds for the Executive Director of the Maine Health Benefit Marketplace.

FISCAL NOTE REQUIRED

(See attached)