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INSURANCE AND FINANCIAL SERVICES

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**STATE OF MAINE
HOUSE OF REPRESENTATIVES
125TH LEGISLATURE
FIRST REGULAR SESSION**

COMMITTEE AMENDMENT “A” to H.P. 979, L.D. 1333, Bill, “An Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services”

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

'PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §1 and affected by §10, is further amended to read:

C. A carrier may vary the premium rate due to ~~smoking status~~ geographic area and family membership. The superintendent may adopt rules setting forth appropriate methodologies regarding ~~rate discounts~~ rating based on ~~smoking status~~ geographic area. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~H-A~~ 2-A.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2007, c. 629, Pt. A, §4, is further amended to read:

D. A carrier may vary the premium rate due to age and ~~geographic area~~ smoking status in accordance with the limitations set out in this paragraph.

(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%.

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1 (3) For all policies, contracts or certificates that are executed, delivered, issued
2 for delivery, continued or renewed in this State between July 15, 1995 and June
3 30, ~~2009~~ 2012, the premium rate may not deviate above or below the community
4 rate filed by the carrier by more than 20%.

5 ~~(4) For all policies, contracts or certificates that are executed, delivered, issued~~
6 ~~for delivery, continued or renewed in this State on or after July 1, 2009, for each~~
7 ~~health benefit plan offered by a carrier, the highest premium rate for each rating~~
8 ~~tier may not exceed 2.5 times the premium rate that could be charged to an~~
9 ~~eligible individual with the lowest premium rate for that rating tier in a given~~
10 ~~rating period. For purposes of this subparagraph, "rating tier" means each~~
11 ~~category of individual or family composition for which a carrier charges separate~~
12 ~~rates.~~

13 ~~(a) In determining the rating factor for geographic area pursuant to this~~
14 ~~subparagraph, the ratio between the highest and lowest rating factor used by a~~
15 ~~carrier for geographic area may not exceed 1.5 and the ratio between highest~~
16 ~~and lowest combined rating factors for age and geographic area may not~~
17 ~~exceed 2.5.~~

18 ~~(b) In determining rating factors for age and geographic area pursuant to this~~
19 ~~subparagraph, no resulting rates, taking into account the savings resulting~~
20 ~~from the reinsurance program created by chapter 54, may exceed the rates~~
21 ~~that would have resulted from using projected claims and expenses and the~~
22 ~~rating factors applicable prior to July 1, 2009, as determined without taking~~
23 ~~into account the savings resulting from the Maine Individual Reinsurance~~
24 ~~Association established in chapter 54.~~

25 ~~(c) The superintendent shall adopt rules setting forth appropriate~~
26 ~~methodologies regarding determination of rating factors pursuant to this~~
27 ~~subparagraph. Rules adopted pursuant to this division are routine technical~~
28 ~~rules as defined in Title 5, chapter 375, subchapter 2-A.~~

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

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

39 (7) For all policies, contracts or certificates that are executed, delivered, issued
40 for delivery, continued or renewed in this State on or after January 1, 2015, the
41 maximum rate differential due to age filed by the carrier as determined by ratio is
42 5 to 1. The limitation does not apply for determining rates for an attained age of
43 less than 19 years of age or more than 65 years of age.

1 (8) For all policies, contracts or certificates that are executed, delivered, issued
2 for delivery, continued or renewed in this State on or after July 1, 2012, the
3 maximum rate differential due to smoking status filed by the carrier as
4 determined by ratio is 1.5 to 1.

5 **Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶H**, as enacted by PL 2007, c. 629, Pt.
6 A, §6, is repealed.

7 **Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶I** is enacted to read:

8 I. A carrier that offered individual health plans prior to July 1, 2012 may close its
9 individual book of business sold prior to July 1, 2012 and may establish a separate
10 community rate for individuals applying for coverage under an individual health plan
11 on or after July 1, 2012. If a carrier closes its individual book of business as
12 permitted under this paragraph, the carrier may vary the premium rate for individuals
13 in that closed book of business only as permitted in this paragraph.

14 (1) For all policies, contracts or certificates that are executed, delivered, issued
15 for delivery, continued or renewed in this State between July 1, 2012 and
16 December 31, 2012, the maximum rate differential due to age filed by the carrier
17 as determined by ratio is 2 to 1. The limitation does not apply for determining
18 rates for an attained age of less than 19 years of age or more than 65 years of age.

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

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

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

34 (5) For all policies, contracts or certificates that are executed, delivered, issued
35 for delivery, continued or renewed in this State on or after January 1, 2016, the
36 maximum rate differential due to age filed by the carrier as determined by ratio is
37 5 to 1. The limitation does not apply for determining rates for an attained age of
38 less than 19 years of age or more than 65 years of age.

39 (6) For all policies, contracts or certificates that are executed, delivered, issued
40 for delivery, continued or renewed in this State on or after July 1, 2012, the
41 maximum rate differential due to smoking status filed by the carrier as
42 determined by ratio is 1.5 to 1.

1 The superintendent shall establish by rule procedures and policies that facilitate the
2 implementation of this paragraph, including, but not limited to, notice requirements
3 for policyholders and experience pooling requirements of individual health products.
4 When establishing rules regarding experience pooling requirements, the
5 superintendent shall ensure, to the greatest extent possible, the availability of
6 affordable options for individuals transitioning from the closed book of business.
7 Rules adopted pursuant to this paragraph are routine technical rules as defined in
8 Title 5, chapter 375, subchapter 2-A. The superintendent shall direct the Consumer
9 Health Care Division, established in section 4321, to work with carriers and health
10 advocacy organizations to provide information about comparable alternative
11 insurance options to individuals in a carrier's closed book of business and upon
12 request to assist individuals to facilitate the transition to an individual health plan in
13 that carrier's or another carrier's open book of business.

14 **Sec. A-5. 24-A MRS §2808-B, sub-§2, ¶C**, as amended by PL 2001, c. 410,
15 Pt. A, §3 and affected by §10, is further amended to read:

16 C. A carrier may vary the premium rate due to occupation and industry, geographic
17 area, family membership, ~~smoking status~~, participation in wellness programs and
18 group size. The superintendent may adopt rules setting forth appropriate
19 methodologies regarding rate discounts for participation in wellness programs and
20 rating for geographic area, family membership and group size pursuant to this
21 paragraph. Rules adopted pursuant to this paragraph are routine technical rules as
22 defined in Title 5, chapter 375, subchapter ~~H-A~~ 2-A.

23 **Sec. A-6. 24-A MRS §2808-B, sub-§2, ¶D**, as amended by PL 2001, c. 410,
24 Pt. A, §4 and affected by §10, is further amended to read:

25 D. A carrier may vary the premium rate due to age, ~~occupation or industry and~~
26 geographic area and smoking status only under the following schedule and within the
27 listed percentage bands.

28 (1) For all policies, contracts or certificates that are executed, delivered, issued
29 for delivery, continued or renewed in this State between July 15, 1993 and July
30 14, 1994, the premium rate may not deviate above or below the community rate
31 filed by the carrier by more than 50%.

32 (2) For all policies, contracts or certificates that are executed, delivered, issued
33 for delivery, continued or renewed in this State between July 15, 1994 and July
34 14, 1995, the premium rate may not deviate above or below the community rate
35 filed by the carrier by more than 33%.

36 (3) For all policies, contracts or certificates that are executed, delivered, issued
37 for delivery, continued or renewed in this State after between July 15, 1995 and
38 September 30, 2011, the premium rate may not deviate above or below the
39 community rate filed by the carrier by more than 20%, ~~except as provided in~~
40 ~~paragraph D-1.~~

41 (4) For all policies, contracts or certificates that are executed, delivered, issued
42 for delivery, continued or renewed in this State between October 1, 2011 and
43 December 31, 2012, the maximum rate differential due to age filed by the carrier

1 as determined by ratio is 2 to 1. The limitation does not apply for determining
2 rates for an attained age of less than 19 years of age or more than 65 years of age.

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

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

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

18 (8) For all policies, contracts or certificates that are executed, delivered, issued
19 for delivery, continued or renewed in this State on or after January 1, 2016, the
20 maximum rate differential due to age filed by the carrier as determined by ratio is
21 5 to 1. The limitation does not apply for determining rates for an attained age of
22 less than 19 years of age or more than 65 years of age.

23 (9) For all policies, contracts or certificates that are executed, delivered, issued
24 for delivery, continued or renewed in this State on or after October 1, 2011, the
25 maximum rate differential due to smoking status filed by the carrier as
26 determined by ratio is 1.5 to 1.

27 **Sec. A-7. 24-A MRSA §2808-B, sub-§2, ¶D-1**, as amended by PL 2001, c. 410,
28 Pt. A, §5 and affected by §10, is repealed.

29 **Sec. A-8. 24-A MRSA §2808-B, sub-§2, ¶H** is enacted to read:

30 H. A carrier that offered small group health plans prior to October 1, 2011 may close
31 its small group book of business sold prior to October 1, 2011 and may establish a
32 separate community rate for eligible groups applying for coverage under a small
33 group health plan on or after October 1, 2011. If a carrier closes its small group book
34 of business as permitted under this paragraph, the carrier may vary the premium rate
35 for that closed book of business only as permitted in this paragraph.

36 (1) For all policies, contracts or certificates that are executed, delivered, issued
37 for delivery, continued or renewed in this State between October 1, 2011 and
38 December 31, 2012, the maximum rate differential due to age filed by the carrier
39 as determined by ratio is 2 to 1. The limitation does not apply for determining
40 rates for an attained age of less than 19 years of age or more than 65 years of age.

41 (2) For all policies, contracts or certificates that are executed, delivered, issued
42 for delivery, continued or renewed in this State between January 1, 2013 and

1 **Sec. B-5. 24-A MRSA §2736-C, sub-§2-A**, as enacted by PL 2007, c. 629, Pt.
2 A, §7, is repealed.

3 **Sec. B-6. 24-A MRSA §2736-C, sub-§3**, as corrected by RR 2001, c. 1, §30, is
4 amended to read:

5 **3. Guaranteed issuance and guaranteed renewal.** Carriers providing individual
6 health plans must meet the following requirements on issuance and renewal.

7 A. Coverage must be guaranteed to all residents of this State other than those eligible
8 without paying a premium for Medicare Part A and may be reinsured through the
9 Maine Guaranteed Access Reinsurance Association established pursuant to chapter
10 54-A. On or after ~~January 1, 1998~~ July 1, 2012, coverage must be guaranteed to all
11 legally domiciled federally eligible individuals, as defined in section 2848, regardless
12 of the length of time they have been legally domiciled in this State. Except for
13 federally eligible individuals, coverage need not be issued to an individual whose
14 coverage was terminated for nonpayment of premiums during the previous 91 days or
15 for fraud or intentional misrepresentation of material fact during the previous 12
16 months. When a managed care plan, as defined by section 4301-A, provides
17 coverage a carrier may:

18 (1) Deny coverage to individuals who neither live nor reside within the approved
19 service area of the plan for at least 6 months of each year; and

20 (2) Deny coverage to individuals if the carrier has demonstrated to the
21 superintendent's satisfaction that:

22 (a) The carrier does not have the capacity to deliver services adequately to
23 additional enrollees within all or a designated part of its service area because
24 of its obligations to existing enrollees; and

25 (b) The carrier is applying this provision uniformly to individuals and groups
26 without regard to any health-related factor.

27 A carrier that denies coverage in accordance with this paragraph may not enroll
28 individuals residing within the area subject to denial of coverage or groups or
29 subgroups within that area for a period of 180 days after the date of the first
30 denial of coverage.

31 B. Renewal is guaranteed, pursuant to section 2850-B.

32 C. A carrier is exempt from the guaranteed issuance requirements of paragraph A
33 provided that the following requirements are met.

34 (1) The carrier does not issue or deliver any new individual health plans on or
35 after the effective date of this section;

36 (2) If any individual health plans that were not issued on a guaranteed renewable
37 basis are renewed on or after December 1, 1993, all such policies must be
38 renewed by the carrier and renewal must be guaranteed after the first such
39 renewal date; and

40 (3) The carrier complies with the rating practices requirements of subsection 2.

1 D. Notwithstanding paragraph A, carriers offering supplemental coverage for the
2 Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are
3 not required to issue this coverage if the applicant for insurance does not have
4 CHAMPUS coverage.

5 E. A carrier may evaluate the health status of an individual for purposes of
6 designating that individual for reinsurance through the Maine Guaranteed Access
7 Reinsurance Association established in chapter 54-A. For individual health plans
8 issued on or after July 1, 2012, the carrier shall use the health statement developed by
9 the Board of Directors of the Maine Guaranteed Access Reinsurance Association
10 pursuant to section 3955, subsection 1, paragraph E to make a designation and may
11 not use any other method to determine the health status of an individual. For purposes
12 of this subsection, "health statement" means any information intended to inform the
13 carrier or an insurance producer acting on behalf of a carrier of the health status of an
14 enrollee or prospective enrollee in an individual health plan.

15 F. An individual may not be denied health insurance due to age or gender. This
16 paragraph may not be construed to require a carrier to actively market health
17 insurance to an individual 65 years of age or older.

18 **Sec. B-7. 24-A MRSA c. 54**, as amended, is repealed.

19 **Sec. B-8. 24-A MRSA c. 54-A** is enacted to read:

20 **CHAPTER 54-A**

21 **MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION ACT**

22 **§3951. Short title**

23 This chapter may be known and cited as "the Maine Guaranteed Access Reinsurance
24 Association Act."

25 **§3952. Definitions**

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

28 **1. Association.** "Association" means the Maine Guaranteed Access Reinsurance
29 Association under section 3953.

30 **2. Board.** "Board" means the Board of Directors of the Maine Guaranteed Access
31 Reinsurance Association under section 3953, subsection 2.

32 **3. Covered person.** "Covered person" means an individual covered as a
33 policyholder, participant or dependent under a plan, policy or contract of medical
34 insurance.

35 **4. Dependent.** "Dependent" means a spouse, a domestic partner as defined in
36 section 2832-A, subsection 1 or a child under 26 years of age.

37 **5. Health maintenance organization.** "Health maintenance organization" means an
38 organization authorized under chapter 56 to operate a health maintenance organization in
39 this State.

1 **6. Insurer.** "Insurer" means an entity that is authorized to write medical insurance
2 or that provides medical insurance in this State. For the purposes of this chapter,
3 "insurer" includes an insurance company, a nonprofit hospital and medical service
4 organization, a fraternal benefit society, a health maintenance organization, a self-insured
5 employer subject to state regulation as described in section 2848-A, a 3rd-party
6 administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health
7 insurance in this State, a captive insurance company established pursuant to chapter 83
8 that insures the health coverage risks of its members, the Dirigo Health Program
9 established in chapter 87 or any other state-sponsored health benefit program whether
10 fully insured or self-funded.

11 **7. Medical insurance.** "Medical insurance" means a hospital and medical expense-
12 incurred policy, nonprofit hospital and medical service plan, health maintenance
13 organization subscriber contract or other health care plan or arrangement that pays for or
14 furnishes medical or health care services whether by insurance or otherwise, whether sold
15 as an individual or group policy. "Medical insurance" does not include accidental injury,
16 specified disease, hospital indemnity, dental, vision, disability income, Medicare
17 supplement, long-term care or other limited benefit health insurance or credit insurance;
18 coverage issued as a supplement to liability insurance; insurance arising out of workers'
19 compensation or similar law; automobile medical payment insurance; or insurance under
20 which benefits are payable with or without regard to fault and that is statutorily required
21 to be contained in any liability insurance policy or equivalent self-insurance.

22 **8. Medicare.** "Medicare" means coverage under both Parts A and B of Title XVIII
23 of the federal Social Security Act, 42 United States Code, Section 1395 et seq., as
24 amended.

25 **9. Member insurer.** "Member insurer" means an insurer that offers individual
26 health plans and is actively marketing individual health plans in this State.

27 **10. Producer.** "Producer" means a person who is licensed to sell health insurance in
28 this State.

29 **11. Reinsurer.** "Reinsurer" means an insurer from whom a person providing health
30 insurance for a resident procures insurance for itself with the insurer with respect to all or
31 part of the medical insurance risk of the person. "Reinsurer" includes an insurer that
32 provides employee benefits excess insurance.

33 **12. Resident.** "Resident" has the same meaning as in section 2736-C, subsection 1,
34 paragraph C-2.

35 **13. Third-party administrator.** "Third-party administrator" means an entity that is
36 paying or processing medical insurance claims for a resident.

37 **§3953. Maine Guaranteed Access Reinsurance Association**

38 **1. Guaranteed access reinsurance mechanism established.** The Maine
39 Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As
40 a condition of doing business in the State, an insurer that has issued or administered
41 medical insurance within the previous 12 months or is actively marketing a medical
42 insurance policy or medical insurance administrative services in this State must

1 participate in the association. The Dirigo Health Program established in chapter 87 and
2 any other state-sponsored health benefit program shall also participate in the association.

3 **2. Board of directors.** The association is governed by the Board of Directors of the
4 Maine Guaranteed Access Reinsurance Association established under Title 5, section
5 12004-G, subsection 14-H.

6 A. The board consists of 11 members appointed as described in this paragraph:

7 (1) Six members appointed by the superintendent: 2 members chosen from the
8 general public and who are not associated with the medical profession, a hospital
9 or an insurer; 2 members who represent medical providers; one member who
10 represents a statewide organization that represents small businesses; and one
11 member who represents producers. A board member appointed by the
12 superintendent may not be removed without cause; and

13 (2) Five members appointed by the member insurers, at least one of whom is a
14 domestic insurer and at least one of whom is a 3rd-party administrator.

15 B. Members of the board serve for 3-year terms. Members of the board may serve
16 up to 3 consecutive terms.

17 C. The board shall elect one of its members as chair.

18 D. Board members may be reimbursed from funds of the association for actual and
19 necessary expenses incurred by them as members but may not otherwise be
20 compensated for their services.

21 **3. Plan of operation; rules.** The board shall adopt a plan of operation in accordance
22 with the requirements of this chapter and submit its articles, bylaws and operating rules to
23 the superintendent for approval. If the board fails to adopt the plan of operation and
24 suitable articles and bylaws within 90 days after the appointment of the board, the
25 superintendent shall adopt rules to effectuate the requirements of this chapter and those
26 rules remain in effect until superseded by a plan of operation and articles and bylaws
27 submitted by the board and approved by the superintendent. Rules adopted by the
28 superintendent pursuant to this subsection are routine technical rules as defined in Title 5,
29 chapter 375, subchapter 2-A.

30 **4. Immunity.** A board member is not liable and is immune from suit at law or
31 equity for any conduct performed in good faith that is within the scope of the board's
32 jurisdiction.

33 **§3954. Liability and indemnification**

34 **1. Liability.** The board and its employees may not be held liable for any obligations
35 of the association. A cause of action may not arise against the association; the board, its
36 agents or its employees; a member insurer or its agents, employees or producers; or the
37 superintendent for any action or omission in the performance of powers and duties
38 pursuant to this chapter.

39 **2. Indemnification.** The board may provide in its bylaws or rules for
40 indemnification of, and legal representation for, its members and employees.

1 **§3955. Duties and powers of association**

2 **1. Duties.** The association shall:

3 A. Establish administrative and accounting procedures for the operation of the
4 association;

5 B. Select an association administrator in accordance with section 3956;

6 C. Collect the assessments provided in section 3957. The level of payments must be
7 established by the board. Assessments must be collected pursuant to the plan of
8 operation approved by the board and adopted pursuant to section 3953, subsection 3.
9 In addition to the collection of such assessments, the association shall collect an
10 organizational assessment or assessments from all insurers as necessary to provide for
11 expenses that have been incurred or are estimated to be incurred before receipt of the
12 first calendar year assessments;

13 D. Establish procedures for the handling and accounting of association assets;

14 E. Develop a health statement to be used by a member insurer to designate a resident
15 for reinsurance pursuant to section 3959; and

16 F. Provide for reinsurance for member insurers pursuant to section 3958.

17 **2. Powers.** The association may:

18 A. Exercise powers granted to nonprofit corporations under the laws of this State;

19 B. Enter into contracts as necessary or proper to carry out the provisions and
20 purposes of this chapter and may, with the approval of the superintendent, enter into
21 contracts with similar organizations of other states for the joint performance of
22 common administrative functions or with persons or other organizations for the
23 performance of administrative functions;

24 C. Sue or be sued and may take legal actions necessary or proper to recover or
25 collect assessments provided in section 3957 due the association;

26 D. Take legal actions necessary to avoid the payment of improper claims against the
27 association or the coverage provided by or through the association, to recover any
28 amounts erroneously or improperly paid by the association, to recover amounts paid
29 by the association as a result of mistake of fact or law or to recover other amounts
30 due the association;

31 E. Appoint appropriate legal, actuarial and other committees as necessary to provide
32 technical assistance and any other function within the authority of the association;

33 F. Borrow money to effect the purposes of the association. Notes or other evidence
34 of indebtedness of the association not in default must be legal investments for
35 insurers and may be carried as admitted assets;

36 G. Provide for reinsurance of risks incurred by members of the association and
37 purchase reinsurance retroceding those risks to the extent the board determines
38 appropriate. The provision of reinsurance may not subject the association to any of
39 the capital or surplus requirements, if any, otherwise applicable to reinsurers; and

40 H. Apply for funds or grants from public or private sources, including federal grants.

1 **3. Additional duties and powers.** The superintendent may, by rule, establish
2 additional powers and duties of the board and may adopt such rules as are necessary and
3 proper to implement this chapter. Rules adopted pursuant to this subsection are routine
4 technical rules as defined in Title 5, chapter 375, subchapter 2-A.

5 **4. Review for solvency.** An annual review of the association for solvency must be
6 performed by an independent certified public accountant using generally accepted
7 accounting principles. The association shall submit the annual review to the
8 superintendent. If the superintendent determines that the funds of the association are
9 insufficient to support the need for reinsurance, the superintendent may order the
10 association to increase its assessments. If the superintendent determines that the funds of
11 the association are insufficient, the superintendent may order the association to charge
12 additional assessments.

13 **5. Annual report.** The association shall report annually to the joint standing
14 committee of the Legislature having jurisdiction over health insurance matters by March
15 15th. The report must include information on the financial solvency of the association
16 and the administrative expenses of the association.

17 **6. Audit.** The association must be audited at least annually by an independent
18 certified public auditor. A copy of the audit must be provided to the superintendent and
19 to the joint standing committee of the Legislature having jurisdiction over health
20 insurance matters.

21 **§3956. Selection of administrator**

22 **1. Selection of administrator.** The board shall select an insurer or 3rd-party
23 administrator through a competitive bidding process to administer the reinsurance
24 provided by the association.

25 **2. Contract with administrator.** The administrator selected pursuant to subsection
26 1 serves for a period of 3 years pursuant to a contract with the association. At least one
27 year prior to the expiration of that 3-year period of service, the board shall invite all
28 insurers, including the current administrator, to submit bids to serve as the administrator
29 for the succeeding 3-year period. The board shall select the administrator for the
30 succeeding period at least 6 months prior to the ending of the 3-year period.

31 **3. Duties of administrator.** The administrator selected pursuant to subsection 1
32 shall:

33 A. Perform all administrative functions relating to the association;

34 B. Submit regular reports to the board regarding the operation of the association.
35 The frequency, content and form of the reports must be as determined by the board;

36 C. Following the close of each calendar year, determine reinsurance premiums less
37 any administrative expense allowance, the expense of administration pertaining to the
38 reinsurance operations of the association and the incurred losses of the year, and
39 report this information to the superintendent; and

40 D. Pay reinsurance amounts as provided for in the plan of operation under section
41 3953, subsection 3.

1 **4. Payment to administrator.** The administrator selected pursuant to subsection 1
2 must be paid, as provided in the contract of the association under subsection 2, for its
3 direct and indirect expenses incurred in the performance of its services. As used in this
4 subsection, "direct and indirect expenses" includes that portion of the audited
5 administrative costs, printing expenses, claims administration expenses, management
6 expenses, building overhead expenses and other actual operating and administrative
7 expenses of the administrator that are approved by the board as allocable to the
8 administration of the association and included in the bid specifications pursuant to
9 subsection 1.

10 **§3957. Assessments against insurers**

11 **1. Assessments.** For the purpose of providing the funds necessary to carry out the
12 powers and duties of the association under section 3955, the board shall assess insurers at
13 such a time and for such amounts as the board finds necessary. Assessments are due not
14 less than 30 days after written notice to the insurers and accrue interest at 12% per annum
15 on and after the due date.

16 **2. Maximum assessment.** The board shall assess each insurer an amount not to
17 exceed \$4 per month per covered person enrolled in medical insurance insured, reinsured
18 or administered by the insurer. An insurer may not be assessed on policies or contracts
19 insuring federal or state employees.

20 **3. Determination of assessment.** The board shall make reasonable efforts to ensure
21 that each covered person is counted only once with respect to an assessment. For that
22 purpose, the board shall require each insurer that obtains excess or stop loss insurance to
23 include in its count of covered persons all persons whose coverage is insured, in whole or
24 in part, through excess or stop loss coverage. The board shall allow a reinsurer to exclude
25 from its number of covered persons those who have been counted by the primary insurer
26 or by the primary reinsurer or primary excess or stop loss insurer for the purpose of
27 determining its assessment under this subsection. The board may verify the amount of
28 each insurer's assessment based on annual statements and other reports determined to be
29 necessary by the board. The board may use any reasonable method of estimating the
30 number of covered persons of an insurer if the specific number is not reported.

31 **4. Organizational assessments.** The board may assess insurers for the purpose of
32 organizing the association. Organizational assessments must be equal in amount for all
33 insurers but may not exceed \$500 per insurer for all such assessments.

34 **5. Assessments to cover net losses.** In addition to the assessment described in
35 subsections 1 to 3, the board shall assess insurers at such a time and for such amounts as
36 the board finds necessary to cover any net loss in accordance with this subsection.

37 **A.** Before April 1st of each year, the association shall determine and report to the
38 superintendent the association's net losses for the previous calendar year, including
39 administrative expenses and incurred losses for the year, taking into account
40 investment income and other appropriate gains and losses and an estimate of the
41 assessments needed to cover the losses incurred by the association in the previous
42 calendar year.

1 B. Individual assessments of each insurer are determined by multiplying the absolute
2 value of net losses, if net earnings are negative, by a fraction, the numerator of which
3 is the insurer's total premiums earned in the preceding calendar year from all health
4 benefit plans, including excess or stop loss coverage, and the denominator of which is
5 the total premiums earned in the preceding calendar year from all health benefit
6 plans.

7 C. The association shall impose a penalty of interest on insurers for late payment of
8 assessments.

9 **6. Deferral of assessment.** An insurer may apply to the superintendent for a deferral
10 of all or part of an assessment imposed by the association under this section. The
11 superintendent may defer all or part of the assessment if the superintendent determines
12 that the payment of the assessment would place the insurer in a financially impaired
13 condition. If all or part of the assessment is deferred, the amount deferred must be
14 assessed against other insurers in a proportionate manner consistent with this section.
15 The insurer that receives a deferral remains liable to the association for the amount
16 deferred and is prohibited from reinsuring any person through the association until such
17 time as the insurer pays the assessments.

18 **7. Excess funds.** If assessments and other receipts by the association, board or
19 administrator selected pursuant to section 3956 exceed the actual losses and
20 administrative expenses of the association, the board shall hold the excess as interest and
21 shall use those excess funds to offset future losses or to reduce reinsurance premiums. As
22 used in this subsection, "future losses" includes reserves for claims incurred but not
23 reported.

24 **8. Failure to pay assessment.** The superintendent may suspend or revoke, after
25 notice and hearing, the certificate of authority to transact insurance in this State of any
26 member insurer that fails to pay an assessment. As an alternative, the superintendent may
27 levy a penalty on any insurer that fails to pay an assessment when due. In addition, the
28 superintendent may use any power granted to the superintendent by this Title to collect
29 any unpaid assessment.

30 **9. Federal funding; reduction of assessment.** The board shall work collaboratively
31 with the Dirigo Health Program established pursuant to chapter 87 to develop a proposal
32 to access unused funds from the State's allocation from the federal preexisting condition
33 insurance plan established pursuant to the federal Affordable Care Act to be used to fund,
34 in part, the operations of the association. Any federal funding obtained by the association
35 must be used to reduce the assessment of member insurers required under this section. In
36 developing the proposal, funds necessary for the federal preexisting condition insurance
37 plan as currently administered by Dirigo Health have priority over any funds transferred
38 to the association.

39 **§3958. Reinsurance; premium rates**

40 **1. Reinsurance amount.** A member insurer offering an individual health plan must
41 be reinsured by the association to the level of coverage provided in this subsection and is
42 liable to the association for the reinsurance premium rate established in accordance with
43 subsection 2.

1 A. The association may not reimburse a member insurer with respect to claims of a
2 person designated for reinsurance by the member insurer pursuant to section 3959
3 until the insurer has incurred an initial level of claims for that person of \$7,500 for
4 covered benefits in a calendar year. In addition, the insurer is responsible for 10% of
5 the next \$25,000 of claims paid during a calendar year. The association shall
6 reimburse insurers for claims paid in excess of \$32,500. The association may
7 annually adjust the initial level of claims and the maximum limit to be retained by the
8 insurer to reflect increases in costs and utilization within the standard market for
9 individual health plans within the State. The adjustments may not be less than the
10 annual change in the Consumer Price Index for medical care services unless the
11 superintendent approves a lower adjustment factor as requested by the association.

12 B. An insurer shall apply all managed care, utilization review, case management,
13 preferred provider arrangements, claims processing and other methods of operation
14 without regard to whether claims paid for coverage are reinsured under this
15 subsection.

16 **2. Premium rates.** The association, as part of the plan of operation under section
17 3953, subsection 3, shall establish a methodology for determining premium rates to be
18 charged member insurers to reinsure persons eligible for coverage under this chapter.
19 The methodology must include a system for classification of persons eligible for coverage
20 that reflects the types of case characteristics used by insurers for individual health plans
21 pursuant to section 2736-C. The methodology must provide for the development of base
22 reinsurance premium rates, subject to approval of the superintendent, set at levels that
23 reasonably approximate gross premiums charged for individual health plans and that are
24 adjusted to reflect retention levels required under this Title. The association shall
25 periodically review the methodology established under this subsection and may make
26 changes to the methodology as needed with the approval of the superintendent. The
27 association may consider adjustments to the premium rates charged for reinsurance to
28 reflect the use of effective cost containment and managed care arrangements by a insurer.

29 **§3959. Designation for reinsurance**

30 **1. Designation.** The association shall provide reinsurance to a member insurer for
31 persons designated by a member insurer using the health statement developed by the
32 board pursuant to section 3955, subsection 1, paragraph F.

33 **2. Designation without application.** The board shall develop a list of medical or
34 health conditions for which a person is automatically designated for reinsurance. A
35 person who demonstrates the existence or history of any medical or health conditions on
36 the list developed by the board may not be required to complete the health statement
37 specified in subsection 1. The board may amend the list from time to time as appropriate.

38 **§3960. Actions against association or insurers based upon joint or collective actions**

39 Participation in the association, the establishment of reinsurance rates, forms or
40 procedures or any other joint or collective action required by this chapter may not be the
41 basis of any legal action or criminal or civil liability or penalty against the association or
42 an insurer.

1 **§3961. Reimbursement of member insurer**

2 **1. Reimbursement.** A member insurer may seek reimbursement from the
3 association and the association shall reimburse the member insurer to the extent claims
4 made by a covered person on a calendar year basis after July 1, 2012 exceed the amounts
5 otherwise eligible for reimbursement pursuant to section 3958, subsection 1, paragraph A,
6 if:

7 A. The member insurer sold an individual health plan to the covered person between
8 December 1, 1993 and July 1, 2012, the individual health plan that was sold has been
9 continuously renewed by the covered person and the member insurer has closed its
10 book of business for individual health plans sold between December 1, 1993 and July
11 1, 2012; and

12 B. The member insurer is able to determine through the use of individual health
13 statements, claims history, risk scores or any reasonable means that, between
14 December 1, 1993 and July 1, 2012, while the person received coverage under an
15 individual health plan issued by the member insurer, the covered person would have
16 been designated by the member insurer pursuant to section 3959, subsection 1.

17 **2. Rules.** The superintendent may adopt rules to facilitate payment to a member
18 insurer pursuant to this section. Rules adopted pursuant to this subsection are routine
19 technical rules as defined in Title 5, chapter 375, subchapter 2-A.

20 **Sec. B-9. Maine Guaranteed Access Reinsurance Association staggered**
21 **terms.** Notwithstanding the Maine Revised Statutes, Title 24-A, section 3953,
22 subsection 2, of the members of the Board of Directors of the Maine Guaranteed Access
23 Reinsurance Association initially appointed by the Superintendent of Insurance, 2
24 members serve for terms of one year, 2 members for terms of 2 years and 2 members for
25 terms of 3 years and, of those members initially appointed by the member insurers, one
26 member serves for a term of one year, 2 members serve for terms of 2 years and 2
27 members serve for terms of 3 years. The appointing authority shall designate the period
28 of service of each initial appointee at the time of appointment.

29 **Sec. B-10. Effective date.** Those sections of this Part that repeal the Maine
30 Revised Statutes, Title 5, section 12004-G, subsection 14-F, Title 24-A, section 423-E,
31 Title 24-A, section 2736-C, subsection 2, paragraph G, Title 24-A, section 2736-C,
32 subsection 2-A and Title 24-A, chapter 54 and that section of this Part that amends Title
33 24-A, section 2736-C, subsection 3 take effect July 1, 2012.

34 **PART C**

35 **Sec. C-1. 24-A MRSA §405, sub-§6,** as enacted by PL 1969, c. 132, §1, is
36 amended to read:

37 **6.** Any suit or action by the duly constituted receiver, rehabilitator or liquidator of
38 the insurer, or of the insurer's assignee or successor, under laws similar to those contained
39 in chapter 57 (~~delinquency proceedings; rehabilitation and liquidation~~); or

40 **Sec. C-2. 24-A MRSA §405, sub-§7** is enacted to read:

1 7. Transactions pursuant to individual health insurance covering residents of this
2 State written by a regional insurer or health maintenance organization, as defined in
3 section 405-A, duly authorized or qualified to transact individual health insurance in the
4 state or country of its domicile if the superintendent certifies that the regional insurer or
5 health maintenance organization meets the requirements of section 405-A.

6 **Sec. C-3. 24-A MRSA §405-A** is enacted to read:

7 **§405-A. Certification of regional insurers or health maintenance organizations to**
8 **transact individual health insurance**

9 **1. Regional insurer or health maintenance organization defined.** As used in this
10 section, "regional insurer or health maintenance organization" means an insurer or health
11 maintenance organization that holds a valid certificate of authority to transact individual
12 health insurance in Connecticut, Massachusetts, New Hampshire or Rhode Island.

13 **2. Certification of regional insurers or health maintenance organizations.** A
14 regional insurer or health maintenance organization may not transact individual health
15 insurance in this State by mail, the Internet or otherwise unless the superintendent has
16 issued a certification that the regional insurer or health maintenance organization has met
17 the requirements of this subsection. The superintendent shall issue a certification or deny
18 certification within 30 days of a request.

19 A. A policy, contract or certificate of individual health insurance offered for sale in
20 this State by a regional insurer or health maintenance organization must comply with
21 the applicable individual health insurance laws in the state of domicile of that
22 regional insurer and must be actively marketed in that state.

23 B. A regional insurer or health maintenance organization shall meet the requirements
24 of section 4302 for reporting plan information with respect to individual health plans
25 offered for sale in this State and disclose to prospective enrollees how the health
26 plans differ from individual health plans offered by domestic insurers in a format
27 approved by the superintendent. Health plan policies and applications for coverage
28 must contain the following disclosure statement or a substantially similar statement:
29 "This policy is issued by a regional insurer or health maintenance organization and is
30 governed by the laws and rules of (regional insurer's or health maintenance
31 organization's state of domicile). This policy may not be subject to all the insurance
32 laws and rules of the State of Maine, including coverage of certain health care
33 services or benefits mandated by Maine law. Before purchasing this policy, you
34 should carefully review the terms and conditions of coverage under this policy,
35 including any exclusions or limitations of coverage."

36 C. A regional insurer or health maintenance organization shall meet the requirements
37 of section 4303, subsection 4 for grievance procedures with respect to health plans
38 offered for sale in this State.

39 D. A regional insurer or health maintenance organization shall meet the requirements
40 of chapter 56-A for provider network adequacy with respect to health plans offered
41 for sale in this State.

1 E. A regional insurer or health maintenance organization shall meet the requirements
2 of chapter 33 with respect to rates for individual health plans offered for sale in this
3 State.

4 F. A regional insurer or health maintenance organization shall designate an agent for
5 receiving service of legal documents or process in the manner provided in this Title.

6 G. A regional insurer or health maintenance organization shall meet the requirements
7 of this Title with respect to allowing the superintendent access to records of the
8 regional insurer or health maintenance organization.

9 **3. Unfair trade practices.** The provisions of chapter 23 apply to a regional insurer
10 or health maintenance organization permitted to transact individual health insurance
11 under this section or section 405.

12 **4. Taxes; assessments.** A regional insurer or health maintenance organization
13 transacting individual health insurance in this State under this section is subject to
14 applicable taxes or assessments imposed on insurers transacting individual health
15 insurance in this State pursuant to this Title and Title 36.

16 **5. Compliance with court orders.** A regional insurer or health maintenance
17 organization transacting individual health insurance in this State under this section shall
18 comply with lawful orders from courts of competent jurisdiction issued in a voluntary
19 dissolution proceeding or in response to a petition for an injunction by the superintendent
20 asserting that the regional insurer or health maintenance organization is in a hazardous
21 financial condition.

22 **6. Exemption from other requirements.** Except as expressly provided in this
23 section, the requirements of this Title do not apply to a regional insurer or health
24 maintenance organization permitted to transact individual health insurance under this
25 section.

26 **7. Agreement with insurance regulators in other state.** The superintendent shall
27 enter into a memorandum of understanding or other agreement with the insurance
28 department of the state of domicile of a regional insurer or health maintenance
29 organization permitted to transact individual health insurance in this State under this
30 section with respect to enforcement of the provisions of this section.

31 **8. Sale of policies.** An individual health insurance policy, contract or certificate may
32 not be offered for sale in this State pursuant to this section before January 1, 2014.

33 **Sec. C-4. 24-A MRSA §405-B** is enacted to read:

34 **§405-B. Domestic insurers or licensed health maintenance organization; individual**
35 **health insurance approved in other states**

36 Notwithstanding any other provision of this Title, a domestic insurer or licensed
37 health maintenance organization authorized to transact individual health insurance in this
38 State may offer for sale in this State an individual health plan duly authorized for sale in
39 Connecticut, Massachusetts, New Hampshire or Rhode Island by a parent or corporate
40 affiliate of the domestic insurer or licensed health maintenance organization if the
41 following requirements are met.

1 **§14. Affordable Care Act defined**

2 As used in this Title, "federal Affordable Care Act" means the federal Patient
3 Protection and Affordable Care Act, Public Law 111-148, as amended by the federal
4 Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any
5 amendments to or regulations or guidance issued under those acts.

6 **Sec. D-2. 24-A MRSA §2736-C, sub-§2-B** is enacted to read:

7 **2-B. Optional guaranteed loss ratio.** Notwithstanding section 2736, subsection 1
8 and section 2736-A, at the carrier's option, rate filings for a carrier's individual health
9 plans may be filed in accordance with this subsection. Rates filed in accordance with this
10 subsection are filed for informational purposes unless rate review is required pursuant to
11 the federal Affordable Care Act.

12 A. A carrier's individual health plans are considered credible if the anticipated
13 average number of members during the period for which the rates will be in effect is
14 at least 1,000 in the aggregate or if the individual health plans in the aggregate meet
15 credibility standards adopted by the superintendent by rule. The rate filing must state
16 the anticipated average number of members during the period for which the rates will
17 be in effect and the basis for the estimate. If the superintendent determines that the
18 number of members is likely to be less than 1,000 and the carrier does not satisfy any
19 alternative credibility standards adopted by the superintendent by rule, the filing is
20 subject to subsection 1 and section 2736-A.

21 B. On an annual schedule as determined by the superintendent, the carrier shall file a
22 report with the superintendent showing aggregate earned premiums and incurred
23 claims for the period the rates were in effect. Incurred claims must include claims
24 paid to a date after the end of the annual reporting period and an estimate of unpaid
25 claims. The report must state how the unpaid claims estimate was determined. The
26 superintendent shall determine the reporting period and the paid-to date; beginning
27 January 1, 2011, both the reporting period and the paid-to date must be consistent
28 with those for the rebates required pursuant to the federal Affordable Care Act and
29 federal regulations adopted pursuant to the federal Affordable Care Act.

30 **Sec. D-3. 24-A MRSA §2736-C, sub-§5**, as amended by PL 2007, c. 629, Pt. M,
31 §5, is further amended to read:

32 **5. Loss ratios.** ~~For~~ Except as provided in subsection 2-B, for all policies and
33 certificates issued on or after the effective date of this section, the superintendent shall
34 disapprove any premium rates filed by any carrier, whether initial or revised, for an
35 individual health policy unless it is anticipated that the aggregate benefits estimated to be
36 paid under all the individual health policies maintained in force by the carrier for the
37 period for which coverage is to be provided will return to policyholders at least 65% of
38 the aggregate premiums collected for those policies, as determined in accordance with
39 accepted actuarial principles and practices and on the basis of incurred claims experience
40 and earned premiums. For the purposes of this calculation, any payments paid pursuant
41 to former section 6913 must be treated as incurred claims.

42 **Sec. D-4. 24-A MRSA §2808-B, sub-§2-C, ¶B**, as enacted by PL 2003, c. 469,
43 Pt. E, §16, is amended to read:

1 B. On an annual schedule as determined by the superintendent, the carrier shall file
2 a report with the superintendent showing aggregate earned premiums and incurred
3 claims for the period the rates were in effect. Incurred claims must include claims
4 paid to a date ~~6 months~~ after the end of the annual reporting period ~~determined by the~~
5 ~~superintendent~~ and an estimate of unpaid claims. The report must state how the
6 unpaid claims estimate was determined. The superintendent shall determine the
7 reporting period and the paid-to date; beginning January 1, 2011, both the reporting
8 period and the paid-to date must be consistent with those for the rebates required
9 pursuant to section 4319 and to the federal Affordable Care Act and federal
10 regulations adopted pursuant to the federal Affordable Care Act.

11 **Sec. D-5. 24-A MRSA §2808-B, sub-§2-C, ¶C**, as amended by PL 2007, c.
12 629, Pt. M, §10, is further amended to read:

13 C. If incurred claims were less than 78% of aggregate earned premiums over a
14 continuous ~~36-month~~ 12-month period, the carrier shall refund a percentage of the
15 premium ~~to the current in force policyholder. For the purposes of calculating this~~
16 ~~loss ratio percentage, any payments paid pursuant to former section 6913 must be~~
17 ~~treated as incurred claims. The excess premium is the amount of premium above that~~
18 ~~amount necessary to achieve a 78% loss ratio for all of the carrier's small group~~
19 ~~policies during the same 36 month period. The refund must be distributed to~~
20 ~~policyholders in an amount reasonably calculated to correspond to the aggregate~~
21 ~~experience of all policyholders holding policies having similar benefits. The total of~~
22 ~~all refunds must equal the excess premiums.~~The refund must be paid on a basis
23 consistent with requirements for rebates pursuant to section 4319 and to the federal
24 Affordable Care Act and federal regulations adopted pursuant to the federal
25 Affordable Care Act. The superintendent may adopt rules modifying the formula for
26 calculation of refunds attributable to periods that are affected by the transition to
27 calendar year reporting beginning with experience for 2011. Rules adopted pursuant
28 to this paragraph are routine technical rules as defined in Title 5, chapter 375,
29 subchapter 2-A.

30 (1) For determination of loss-ratio percentages in 2005, actual aggregate incurred
31 claims expenses include expenses incurred in 2005 and projected expenses for
32 2006 and 2007. For determination of loss-ratio percentages in 2006, actual
33 incurred claims expenses include expenses in 2005 and 2006 and projected
34 expenses for 2007.

35 (2) ~~The superintendent may waive the requirement for refunds during the first 3~~
36 ~~years after the effective date of this subsection.~~

37 **Sec. D-6. 24-A MRSA §4319** is enacted to read:

38 **§4319. Rebates**

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

1 pending approval at the time of notice, the disclosure must state that the increase is
2 subject to regulatory approval.

3 **Sec. F-3. 24-A MRSA §2850-B, sub-§3, ¶I**, as enacted by PL 2003, c. 428, Pt.
4 A, §2, is amended to read:

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

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

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

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

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

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

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

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

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

33 **Sec. F-4. 24-A MRSA §4202-A, sub-§1**, as amended by PL 2001, c. 218, §1, is
34 further amended to read:

35 **1. Basic health care services.** "Basic health care services" means health care
36 services that an enrolled population might reasonably require in order to be maintained in
37 good health and includes, at a minimum, emergency care, inpatient hospital care,
38 inpatient physician services, outpatient physician services, ancillary services such as x-
39 ray services and laboratory services and all benefits mandated by statute and mandated by
40 rule applicable to health maintenance organizations. The superintendent may adopt rules

1 defining "basic health care services" to be provided by health maintenance organizations.
2 In adopting such rules, the superintendent shall consider the coverages that have
3 traditionally been provided by health maintenance organizations; the need for flexibility
4 in the marketplace; and the importance of providing multiple options to employers and
5 consumers. ~~The superintendent may not require that all health benefit plans offered by~~
6 ~~health maintenance organizations meet or exceed each of the particular requirements of~~
7 ~~standard or basic health plans specified in Bureau of Insurance Rule, Chapter 750. The~~
8 ~~superintendent may select required services from among those set forth in Bureau of~~
9 ~~Insurance Rule, Chapter 750 and shall permit reasonable, but not excessive or unfairly~~
10 ~~discriminatory, variations in the copayment, coinsurance, deductible and other features of~~
11 ~~such coverage, except that these features must meet or exceed those required in benefits~~
12 ~~mandated by statute. The superintendent shall permit deductible, coinsurance and~~
13 ~~copayment levels consistent with the deductible levels permitted for policies issued~~
14 ~~pursuant to chapter 33 or 35. Rules adopted pursuant to this subsection are major~~
15 ~~substantive rules as defined in Title 5, chapter 375, subchapter H-A 2-A.~~

16 **Sec. F-5. 24-A MRSA §4203, sub-§3, ¶S**, as amended by PL 2003, c. 469, Pt. E,
17 §18, is further amended to read:

18 S. A list of the names and addresses of all physicians and facilities with which the
19 health maintenance organization has or will have agreements. If products are offered
20 that pay full benefits only when providers within a subset of the contracted physicians
21 or facilities are utilized, a list of the providers in that limited network must be
22 included, as well as a list of the geographic areas where the products are offered.
23 ~~This paragraph may not be construed to prohibit a health maintenance organization~~
24 ~~from offering a health plan that includes financial provisions designed to encourage~~
25 ~~members to use designated providers in a network in accordance with section 4303,~~
26 ~~subsection 1, paragraph A.~~

27 **Sec. F-6. 24-A MRSA §4204, sub-§2-A, ¶N**, as amended by PL 1995, c. 332,
28 Pt. I, §2, is repealed.

29 **Sec. F-7. 24-A MRSA §4303, sub-§1**, as amended by PL 2009, c. 652, Pt. A,
30 §33, is repealed and the following enacted in its place:

31 **1. Demonstration of adequate access to providers.** A carrier offering or renewing
32 a managed care plan shall provide to its members reasonable access to health care
33 services in accordance with standards developed by rule by the superintendent. These
34 standards may not require access to services based on specific travel times of members
35 enrolled in a managed care plan.

36 **Sec. F-8. 24-A MRSA §6603, sub-§9**, as enacted by PL 2007, c. 278, §1, is
37 repealed.

38 PART G

39 **Sec. G-1. 24-A MRSA §2849-B, sub-§1**, as amended by PL 1999, c. 36, §1, is
40 further amended to read:

41 **1. Policies subject to this section.** This section applies to all individual, group and
42 blanket medical insurance policies except hospital indemnity, specified accident,

1 specified disease, long-term care and short-term policies issued by insurers or health
2 maintenance organizations. For purposes of this section, a short-term policy is an
3 individual, nonrenewable policy issued for a term that ~~does not exceed~~ is less than 12
4 months. This section does not apply to Medicare supplement policies as defined in
5 section 5001, subsection 4.

6 **Sec. G-2. 24-A MRSA §2849-B, sub-§8, ¶B**, as enacted by PL 1995, c. 342, §8,
7 is amended to read:

8 B. An insurer or the insurer's agent or broker may not issue a short-term policy that
9 replaces a prior short-term policy if the combined term of the new policy and all prior
10 successive policies exceed ~~42~~ 24 months. All individuals making an application for
11 coverage under a short-term policy must disclose any prior coverage under a
12 short-term policy and the policy duration.

13 **PART H**

14 **Sec. H-1. 36 MRSA §5122, sub-§1, ¶CC**, as enacted by PL 2009, c. 213, Pt.
15 BBBB, §5, is amended to read:

16 CC. For tax years beginning on or after January 1, 2009 but before January 1, 2011,
17 an amount equal to the gross income during the taxable year from the discharge of
18 indebtedness deferred under the Code, Section 108(i); ~~and~~

19 **Sec. H-2. 36 MRSA §5122, sub-§1, ¶DD**, as enacted by PL 2009, c. 213, Pt.
20 ZZZ, §1, is amended to read:

21 DD. For any taxable year beginning in 2009, 2010 or 2011, an amount equal to the
22 absolute value of any net operating loss carry-forward claimed for purposes of the
23 federal income tax; ~~and~~

24 **Sec. H-3. 36 MRSA §5122, sub-§1, ¶EE** is enacted to read:

25 EE. The amount claimed as a deduction in determining federal adjusted gross
26 income that is included in the credit for wellness programs under section 5219-FF.

27 **Sec. H-4. 36 MRSA §5200-A, sub-§1, ¶V**, as amended by PL 2009, c. 652, Pt.
28 A, §54, is further amended to read:

29 V. For any taxable year beginning in 2009, 2010 or 2011, an amount equal to the
30 absolute value of any net operating loss carry-forward claimed for purposes of the
31 federal income tax; ~~and~~

32 **Sec. H-5. 36 MRSA §5200-A, sub-§1, ¶W**, as reallocated by PL 2009, c. 652,
33 Pt. A, §55, is amended to read:

34 W. For tax years beginning on or after January 1, 2009 but before January 1, 2011,
35 an amount equal to the gross income during the taxable year from the discharge of
36 indebtedness deferred under the Code, Section 108(i); ~~and~~

37 **Sec. H-6. 36 MRSA §5200-A, sub-§1, ¶X** is enacted to read:

38 X. The amount claimed as a deduction in determining federal taxable income that is
39 included in the credit for wellness programs under section 5219-FF.

1 ~~applicable federal and state laws relating to the risks insured pursuant to the license~~
2 ~~granted by the superintendent.~~

3 A. A captive insurance company shall comply with all applicable federal laws. A
4 captive insurance company, other than an association captive insurance company
5 preliminarily conditionally approved for a license before January 1, 2012 and that
6 elects to secure coverage in accordance with section 6706, subsection 2-A, shall
7 comply with state and federal laws relating to the risks insured pursuant to the license
8 granted by the superintendent to the extent provided in rules adopted pursuant to this
9 chapter.

10 B. An association captive insurance company insuring the health coverage risks of
11 its members shall comply with the requirements for community rating and guaranteed
12 issuance and renewal for association members pursuant to section 2808-B and any
13 requirements for mandated benefits that apply to small group health plans.

14 C. The superintendent shall grant a license to an association captive insurance
15 company that files an application in accordance with this section and satisfies the
16 following requirements:

17 (1) The association captive insurance company insures only health risks and
18 requires participating association members to be jointly and severally liable in
19 accordance with section 6706, subsection 2-A;

20 (2) The association captive insurance company's plan of operation is fiscally
21 sound and establishes dispute resolution mechanisms acceptable to the
22 superintendent in accordance with this section and designates a 3rd-party
23 administrator approved by the superintendent; and

24 (3) The superintendent determines that the association members have an
25 aggregate net worth of at least \$100,000,000.

26 **Sec. I-2. 24-A MRSA §6702, sub-§7, ¶D,** as amended by PL 2009, c. 335, §9, is
27 further amended to read:

28 D. A captive insurance company may not provide personal motor vehicle or
29 homeowner's insurance coverage or individual health insurance coverage or any
30 component thereof;

31 **Sec. I-3. 24-A MRSA §6704, sub-§1,** as amended by PL 2009, c. 335, §10, is
32 further amended to read:

33 **1. Minimum capital and surplus.** A captive insurance company may not be issued
34 a license unless the company has and maintains unimpaired paid-in capital and surplus of:

35 A. In the case of a pure captive insurance company, not less than \$250,000;

36 B. In the case of an association captive insurance company, not less than \$750,000,
37 except for an association captive insurance company insuring only health risks that
38 elects to secure coverage in accordance with section 6706, subsection 2-A, maintains
39 adequate reserve funds and has reinsurance unless the superintendent waives or
40 modifies the reinsurance requirement. Reserve funds are presumed adequate if the
41 association members have an aggregate net worth of at least \$100,000,000 and the

1 superintendent determines that the funds are adequate to cover at least 3 months of
2 claims and expenses;

3 C. In the case of an industrial insured captive insurance company, not less than
4 \$500,000;

5 D. In the case of a sponsored captive insurance company, not less than \$500,000;
6 and

7 E. In the case of a risk retention group, not less than \$1,000,000.

8 The superintendent may prescribe additional capital based upon the type, volume and
9 nature of insurance business transacted, except for an association captive health insurance
10 company insuring only health risks that elects to secure coverage in accordance with
11 section 6706, subsection 2-A.

12 **Sec. I-4. 24-A MRS §6706, sub-§2-A** is enacted to read:

13 **2-A. Association captive insurance company providing health insurance.** An
14 association captive insurance company that provides health insurance may elect to
15 require, in its plan of operation, that all association members who participate in the health
16 insurance be jointly and severally liable for the health insurance obligations of the
17 association captive insurance company and meet the financial criteria and employer
18 required wellness criteria established in the plan of operation. The wellness criteria may
19 not have the effect of making health status a condition of eligibility for any association
20 member. The superintendent may not require joint and several liability as a condition of
21 approval of an application.

22 **Sec. I-5. 24-A MRS §6706, sub-§4,** as amended by PL 2009, c. 335, §12, is
23 further amended to read:

24 **4. Applicability of chapter 47.** To the extent ~~not inconsistent~~ consistent with this
25 chapter, a captive insurance company is subject to the procedures applicable to domestic
26 insurers pursuant to chapter 47 except that, if the surviving entity after a merger,
27 consolidation, conversion or mutualization is a captive insurance company, a captive
28 insurance company is subject to this chapter. With respect to mergers, consolidations,
29 conversions and mutualizations, the superintendent, in the superintendent's discretion,
30 may:

31 A. Waive any public hearing requirement;

32 B. Permit an alien insurer as a party to a merger as long as the requirements for a
33 merger between a captive insurance company and a foreign insurer apply. For the
34 purposes of this paragraph, an alien insurer must be treated as a foreign insurer and
35 the jurisdiction of the alien insurer is considered a state; or

36 C. Approve the conversion of a captive insurance company organized as a stock
37 insurer to a nonprofit corporation with one or more members or a limited liability
38 company.

39 **Sec. I-6. 24-A MRS §6708, sub-§1,** as enacted by PL 1997, c. 435, §1, is
40 amended to read:

1 (3) To address other patient safety requirements and standards, ~~consistent with~~
2 ~~the priorities set forth in the current State Health Plan~~; or

3 (4) To address other necessary and time-sensitive patient safety or compliance
4 issues.

5 **Sec. J-5. 22 MRSA §335, sub-§1, ¶B**, as amended by PL 2005, c. 369, §7, is
6 repealed.

7 **Sec. J-6. 22 MRSA §335, sub-§7**, as amended by PL 2005, c. 369, §8, is further
8 amended to read:

9 **7. Review; approval.** Except as provided in section 336, the commissioner shall
10 issue a certificate of need if the commissioner determines and makes specific written
11 findings regarding that determination that:

12 A. The applicant is fit, willing and able to provide the proposed services at the
13 proper standard of care as demonstrated by, among other factors, whether the quality
14 of any health care provided in the past by the applicant or a related party under the
15 applicant's control meets industry standards;

16 B. The economic feasibility of the proposed services is demonstrated in terms of the:

17 (1) Capacity of the applicant to support the project financially over its useful life,
18 in light of the rates the applicant expects to be able to charge for the services to
19 be provided by the project; and

20 (2) Applicant's ability to establish and operate the project in accordance with
21 existing and reasonably anticipated future changes in federal, state and local
22 licensure and other applicable or potentially applicable rules;

23 C. There is a public need for the proposed services as demonstrated by certain
24 factors, including, but not limited to:

25 (1) Whether, and the extent to which, the project will substantially address
26 specific health problems as measured by health needs in the area to be served by
27 the project;

28 (2) Whether the project will have a positive impact on the health status indicators
29 of the population to be served;

30 (3) Whether the services affected by the project will be accessible to all residents
31 of the area proposed to be served; and

32 (4) Whether the project will provide demonstrable improvements in quality and
33 outcome measures applicable to the services proposed in the project;

34 D. The proposed services are consistent with the orderly and economic development
35 of health facilities and health resources for the State as demonstrated by:

36 (1) The impact of the project on total health care expenditures after taking into
37 account, to the extent practical, both the costs and benefits of the project and the
38 competing demands in the local service area and statewide for available resources
39 for health care;

1 (2) The availability of state funds to cover any increase in state costs associated
2 with utilization of the project's services; and

3 (3) The likelihood that more effective, more accessible or less costly alternative
4 technologies or methods of service delivery may become available; and

5 E. The project meets the criteria set forth in subsection 1.

6 In making a determination under this subsection, the commissioner shall use data
7 ~~available in the State Health Plan under Title 2, section 103, including demographic,~~
8 ~~health care service and health care cost data, data~~ from the Maine Health Data
9 Organization established in chapter 1683 and other information available to the
10 commissioner. Particular weight must be given to information that indicates that the
11 proposed health services are innovations in high-quality health care delivery, that the
12 proposed health services are not reasonably available in the proposed area and that the
13 facility proposing the new health services is designed to provide excellent quality health
14 care.

15 ~~In making all determinations under this subsection, the commissioner must be guided by~~
16 ~~the State Health Plan as described in Title 2, section 103.~~

17 **Sec. J-7. 22 MRSA §412, sub-§4, ¶A**, as enacted by PL 2009, c. 355, §5, is
18 amended to read:

19 A. A district coordinating council for public health shall:

20 (1) Participate as appropriate in district-level activities to help ensure the state
21 public health system in each district is ready and maintained for accreditation;
22 and

23 ~~(2) Provide a mechanism for districtwide input to the state health plan under~~
24 ~~Title 2, section 103;~~

25 ~~(3) Ensure that the goals and strategies of the state health plan are addressed in~~
26 ~~the district; and~~

27 (4) Ensure that the essential public health services and resources are provided for
28 in each district in the most efficient, effective and evidence-based manner
29 possible.

30 **Sec. J-8. 22 MRSA §412, sub-§6, ¶¶A and B**, as enacted by PL 2009, c. 355,
31 §5, are amended to read:

32 A. The Statewide Coordinating Council for Public Health shall:

33 (1) Participate as appropriate to help ensure the state public health system is
34 ready and maintained for accreditation; and

35 ~~(2) Provide a mechanism for the Advisory Council on Health Systems~~
36 ~~Development under Title 2, section 104 to obtain statewide input for the state~~
37 ~~health plan under Title 2, section 103;~~

38 ~~(3) Provide a mechanism for disseminating and implementing the state health~~
39 ~~plan; and~~

1 (4) Assist the Maine Center for Disease Control and Prevention in planning for
2 the essential public health services and resources to be provided in each district
3 and across the State in the most efficient, effective and evidence-based manner
4 possible.

5 The Maine Center for Disease Control and Prevention shall provide staff support to
6 the Statewide Coordinating Council for Public Health as resources permit. Other
7 agencies of State Government as necessary and appropriate shall provide additional
8 staff support or assistance to the Statewide Coordinating Council for Public Health as
9 resources permit.

10 B. Members of the Statewide Coordinating Council for Public Health are appointed
11 as follows.

12 (1) Each district coordinating council for public health shall appoint one
13 member.

14 (2) The Director of the Maine Center for Disease Control and Prevention or the
15 director's designee shall serve as a member.

16 (3) The commissioner shall appoint an expert in behavioral health from the
17 department to serve as a member.

18 (4) The Commissioner of Education shall appoint a health expert from the
19 Department of Education to serve as a member.

20 (5) The Commissioner of Environmental Protection shall appoint an
21 environmental health expert from the Department of Environmental Protection to
22 serve as a member.

23 (6) The Director of the Maine Center for Disease Control and Prevention, in
24 collaboration with the cochairs of the Statewide Coordinating Council for Public
25 Health, shall convene a membership committee. After evaluation of the
26 appointments to the Statewide Coordinating Council for Public Health, the
27 membership committee shall appoint no more than 10 additional members and
28 ensure that the total membership has at least one member who is a recognized
29 content expert in each of the essential public health services; and has
30 representation from populations in the State facing health disparities ~~and has at~~
31 ~~least 2 members from the Advisory Council on Health Systems Development~~
32 ~~under Title 2, section 104.~~ The membership committee shall also strive to ensure
33 diverse representation on the Statewide Coordinating Council for Public Health
34 from county governments, municipal governments, tribal governments, city
35 health departments, local health officers, hospitals, health systems, emergency
36 management agencies, emergency medical services, Healthy Maine Partnerships,
37 school districts, institutions of higher education, physicians and other health care
38 providers, clinics and community health centers, voluntary health organizations,
39 family planning organizations, area agencies on aging, mental health services,
40 substance abuse services, organizations seeking to improve environmental health
41 and other community-based organizations.

1 **Sec. J-9. 22 MRSA §412, sub-§6, ¶F**, as enacted by PL 2009, c. 355, §5, is
2 repealed and the following enacted in its place:

3 F. The Statewide Coordinating Council for Public Health shall report annually to the
4 joint standing committee of the Legislature having jurisdiction over health and human
5 services matters and the Governor's office on progress made toward achieving and
6 maintaining accreditation of the state public health system and on districtwide and
7 statewide streamlining and other strategies leading to improved efficiencies and
8 effectiveness in the delivery of essential public health services.

9 **Sec. J-10. 22 MRSA §1711-E, sub-§5**, as enacted by PL 2007, c. 460, §1, is
10 amended to read:

11 **5. Rules.** The department, ~~after consultation with the Governor's Office of Health~~
12 ~~Policy and Finance~~, shall adopt rules to implement this section. Rules adopted pursuant
13 to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter
14 2-A.

15 **Sec. J-11. 22 MRSA §1844, sub-§2, ¶A**, as enacted by PL 2005, c. 670, §1 and
16 affected by §4, is amended to read:

17 A. At least 45 days prior to filing an application for a certificate of public advantage
18 for a merger, the parties to a merger agreement shall file a letter of intent with the
19 department describing the proposed merger. Copies of the letter of intent and all
20 accompanying materials must be submitted to the Attorney General ~~and to the~~
21 ~~Governor's Office of Health Policy and Finance~~ at the time the letter of intent is filed
22 with the department.

23 **Sec. J-12. 22 MRSA §1844, sub-§2, ¶D**, as enacted by PL 2005, c. 670, §1 and
24 affected by §4, is amended to read:

25 D. The parties to a cooperative agreement shall submit copies of the application and
26 all the accompanying materials to the Attorney General ~~and the Governor's Office of~~
27 ~~Health Policy and Finance~~ at the time they file the application with the department.

28 **Sec. J-13. 22 MRSA §1844, sub-§4, ¶C**, as enacted by PL 2005, c. 670, §1 and
29 affected by §4, is amended to read:

30 C. The department shall provide the Attorney General ~~and the Governor's Office of~~
31 ~~Health Policy and Finance~~ with copies of all comments from persons submitted under
32 paragraph B.

33 **Sec. J-14. 22 MRSA §1844, sub-§4, ¶F**, as enacted by PL 2005, c. 670, §1 and
34 affected by §4, is amended to read:

35 F. The department shall issue a final decision to grant or deny an application for a
36 certificate of public advantage under this section no less than 40 days and no more
37 than 90 days after the filing of the application. The department shall issue a
38 preliminary decision at least 5 days prior to issuing the final decision. The
39 preliminary and final decisions must be in writing and set forth the basis for the
40 decisions. The department shall provide copies of the preliminary and final decisions
41 to the applicants, the Office of the Attorney General, ~~the Governor's Office of Health~~

1 ~~Policy and Finance~~ and all persons who requested notification from the department
2 under subsection 3, paragraph B.

3 **Sec. J-15. 22 MRSA §1844, sub-§6**, as enacted by PL 2005, c. 670, §1 and
4 affected by §4, is amended to read:

5 **6. Intervention.** The Attorney General ~~and the Governor's Office of Health Policy~~
6 ~~and Finance~~ may intervene as a right in any proceeding under this chapter before the
7 department. Except as provided in this subsection, intervention is governed by the
8 provisions of Title 5, section 9054.

9 **Sec. J-16. 22 MRSA §1845, sub-§1**, as enacted by PL 2005, c. 670, §1 and
10 affected by §4, is amended to read:

11 **1. Periodic report and supervisory review.** With regard to a certificate of public
12 advantage approved under this chapter, the certificate holder shall report periodically to
13 the department on the extent of the benefits realized and compliance with other terms and
14 conditions of the certificate. The certificate holder shall submit copies of the report to the
15 Attorney General ~~and to the Governor's Office of Health Policy and Finance~~ at the time
16 the report is filed with the department. The Attorney General ~~and the Governor's Office~~
17 ~~of Health Policy and Finance~~ may submit to the department comments on the report filed
18 under this subsection. The department shall consider any comments on the report from
19 the Attorney General ~~and the Governor's Office of Health Policy and Finance~~ in the
20 course of its evaluation of the certificate holder's report. Within 60 days of receipt of the
21 certificate holder's report, the department shall make findings regarding the report,
22 including responses to any comments from the Attorney General ~~and the Governor's~~
23 ~~Office of Health Policy and Finance~~, determine whether to institute additional
24 supervisory activities under this section and notify the certificate holder.

25 **Sec. J-17. 22 MRSA §1845, sub-§2, ¶¶A and B**, as enacted by PL 2005, c.
26 670, §1 and affected by §4, are amended to read:

27 A. The department shall conduct additional supervisory activities whenever
28 requested by the Attorney General ~~or the Governor's Office of Health Policy and~~
29 ~~Finance~~, or whenever the department, in its discretion, determines those activities
30 appropriate, and:

31 (1) For certificates of public advantage not involving mergers, at least once in the
32 first 18 months after the transaction described in the cooperative agreement has
33 closed; and

34 (2) For certificates of public advantage involving mergers, at least once between
35 12 and 30 months after the transaction described in the cooperative agreement
36 has closed.

37 B. In its discretion, the department may conduct additional supervisory activities by:

38 (1) Soliciting and reviewing written submissions from the certificate holders, the
39 Attorney General, ~~the Governor's Office of Health Policy and Finance~~ or the
40 public;

41 (2) Conducting a hearing in accordance with Title 5, chapter 375, subchapter 4
42 and the department's administrative hearings rules; or

1 (3) Using any alternative procedures appropriate under the circumstances.

2 **Sec. J-18. 22 MRSA §1849, sub-§5**, as enacted by PL 2005, c. 670, §1 and
3 affected by §4, is amended to read:

4 **5. Termination; surrender.** This chapter does not prohibit certificate holders from
5 terminating their cooperative agreement by mutual agreement, consent decree or court
6 determination or by surrendering their certificate of public advantage to the department.
7 Any certificate holder that terminates the agreement shall file a notice of termination with
8 the department within 30 days after termination, surrender the certificate of public
9 advantage and submit copies to the Attorney General ~~and the Governor's Office of Health~~
10 ~~Policy and Finance~~ at the time the notice of termination is submitted to the department.

11 **Sec. J-19. 22 MRSA §2061, sub-§2**, as corrected by RR 2003, c. 2, §71, is
12 amended to read:

13 **2. Review.** Each project for a health care facility has been reviewed and approved to
14 the extent required by the agency of the State that serves as the designated planning
15 agency of the State or by the Department of Health and Human Services in accordance
16 with the provisions of the Maine Certificate of Need Act of 2002, as amended, ~~and is~~
17 ~~consistent with the cost containment provisions for health care and health coverage of the~~
18 ~~State Health Plan adopted pursuant to Title 2, section 101, subsection 1, paragraph A;~~

19 **Sec. J-20. 24-A MRSA §2694-A, sub-§3**, as enacted by PL 2009, c. 350, Pt. B,
20 §1, is repealed.

21 **Sec. J-21. 24-A MRSA §2752, sub-§3, ¶A**, as amended by PL 1997, c. 616, §5,
22 is further amended to read:

23 A. The social impact of mandating the benefit, including:

24 (1) The extent to which the treatment or service is utilized by a significant
25 portion of the population;

26 (2) The extent to which the treatment or service is available to the population;

27 (3) The extent to which insurance coverage for this treatment or service is
28 already available;

29 (4) If coverage is not generally available, the extent to which the lack of
30 coverage results in persons being unable to obtain necessary health care
31 treatment;

32 (5) If the coverage is not generally available, the extent to which the lack of
33 coverage results in unreasonable financial hardship on those persons needing
34 treatment;

35 (6) The level of public demand and the level of demand from providers for the
36 treatment or service;

37 (7) The level of public demand and the level of demand from the providers for
38 individual or group insurance coverage of the treatment or service;

- 1 (8) The level of interest in and the extent to which collective bargaining
2 organizations are negotiating privately for inclusion of this coverage in group
3 contracts;
- 4 (9) The likelihood of achieving the objectives of meeting a consumer need as
5 evidenced by the experience of other states;
- 6 (10) The relevant findings of ~~the state health planning agency~~ or the appropriate
7 health system agency relating to the social impact of the mandated benefit;
- 8 (11) The alternatives to meeting the identified need;
- 9 (12) Whether the benefit is a medical or a broader social need and whether it is
10 consistent with the role of health insurance and the concept of managed care;
- 11 (13) The impact of any social stigma attached to the benefit upon the market;
- 12 (14) The impact of this benefit on the availability of other benefits currently
13 being offered;
- 14 (15) The impact of the benefit as it relates to employers shifting to self-insured
15 plans and the extent to which the benefit is currently being offered by employers
16 with self-insured plans; and
- 17 (16) The impact of making the benefit applicable to the state employee health
18 insurance program;

19 **Sec. J-22. 24-A MRSA §6904, sub-§1**, as amended by PL 2007, c. 447, §4, is
20 further amended to read:

21 **1. Appointments.** The board consists of 9 voting members and 4 3 ex officio,
22 nonvoting members as follows.

23 A. The 9 voting members of the board are appointed by the Governor, subject to
24 review by the joint standing committee of the Legislature having jurisdiction over
25 health insurance matters and confirmation by the Senate in accordance with this
26 paragraph.

27 (1) Five members qualified in accordance with subsection 2-A, paragraph A are
28 appointed by the Governor.

29 (2) One member qualified in accordance with subsection 2-A, paragraph A is
30 appointed by the Governor and must be selected from candidates nominated by
31 the President of the Senate.

32 (3) One member qualified in accordance with subsection 2-A, paragraph B is
33 appointed by the Governor and must be selected from candidates nominated by
34 the Speaker of the House.

35 (4) One member qualified in accordance with subsection 2-A, paragraph B is
36 appointed by the Governor and must be selected from the candidates nominated
37 by the Senate Minority Leader.

1 (5) One member qualified in accordance with subsection 2-A, paragraph B is
2 appointed by the Governor and must be selected from candidates nominated by
3 the House Minority Leader.

4 B. The 4 ~~3~~ ex officio, nonvoting members of the board are:

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

7 ~~(2) The director of the Governor's Office of Health Policy and Finance or the~~
8 ~~director of a successor agency;~~

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

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

12 **Sec. J-23. 24-A MRSA §6951, sub-§8,** as enacted by PL 2003, c. 469, Pt. A, §8,
13 is repealed.

14 **Sec. J-24. 24-A MRSA §6952, sub-§7, ¶D,** as enacted by PL 2003, c. 469, Pt.
15 A, §8, is amended to read:

16 D. Make recommendations regarding quality assurance and quality improvement
17 priorities ~~for inclusion in the State Health Plan described in Title 2, chapter 5;~~ and

18 **PART K**

19 **Sec. K-1. Appropriations and allocations.** The following appropriations and
20 allocations are made.

21 **PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF**

22 **Insurance - Bureau of 0092**

23 Initiative: Allocates funds for a part-time (0.5) Actuary position and a part-time (0.5)
24 Actuary Assistant position and related costs for the Bureau of Insurance to analyze an
25 expected increase in insurance rate filings as a result of changes that will affect health
26 care premiums.

27	OTHER SPECIAL REVENUE FUNDS	2011-12	2012-13
28	POSITIONS - FTE COUNT	1.000	1.000
29	Personal Services	\$68,607	\$93,191
30	All Other	\$17,933	\$11,249
31			
32	OTHER SPECIAL REVENUE FUNDS TOTAL	<u>\$86,540</u>	<u>\$104,440</u>
33			

34 **SUMMARY**

35 This amendment is the majority report of the committee and replaces the bill.

1 Part A makes the following changes to the community rating laws for individual and
2 small group health insurance:

3 1. It changes the maximum rate differential for individual health plans on the basis of
4 age from 1.5:1 to 5:1. The changes in rating for individual health plans are phased in
5 over a period of 4 years;

6 2. It changes the maximum rate differential for small group health plans on the basis
7 of age from 1.5:1 to 5:1. The changes in rating for small group health plans are phased in
8 over a period of 4 years;

9 3. It authorizes a maximum rate differential on the basis of smoking status from
10 1.5:1; and

11 4. It allows rating on the basis of geographic area outside of the rating bands for age.

12 Part B modifies the laws relating to guaranteed issuance in the individual health
13 insurance market to permit carriers to reinsure coverage offered to certain individuals
14 identified using a health statement. Carriers are prohibited from using health status for
15 any other purpose. Part B also creates the Maine Guaranteed Access Reinsurance
16 Association. The purpose of the association is to provide reinsurance to spread the cost
17 of certain individuals among all health insurers. The amendment funds the guaranteed
18 access reinsurance through an assessment on insurers.

19 Part C permits insurers authorized to transact individual health insurance in
20 Connecticut, Massachusetts, New Hampshire or Rhode Island to offer their individual
21 health plans for sale in this State if certain requirements of Maine law are met, including
22 minimum capital and surplus and reserve requirements, disclosure and reporting
23 requirements and grievance procedures. If out-of-state health plans are offered for sale in
24 this State, the amendment requires that prospective enrollees be provided adequate
25 disclosure in a format approved by the Superintendent of Insurance of how the plans
26 differ from Maine health plans. Part C also permits domestic insurers or licensed health
27 maintenance organizations to offer individual health plans of a parent or corporate
28 affiliate licensed to transact individual health insurance in Connecticut, Massachusetts,
29 New Hampshire or Rhode Island if similar requirements are met. It also permits
30 domestic insurers and licensed health maintenance organizations to offer plans equivalent
31 to any plans offered by a regional insurer. Individual health insurance policies, contracts
32 and certificates may not be offered for sale in this State pursuant to these provisions
33 before January 1, 2014.

34 Part D adopts the definition of medical loss ratio in federal law and the minimum
35 medical loss ratio requirements of federal law. Part D also allows individual health
36 insurance rates to be filed for informational purposes without prior approval by the
37 Department of Professional and Financial Regulation, Bureau of Insurance if the insurer
38 maintains a minimum 80% medical loss ratio.

39 Part E repeals the State Health Plan and the Advisory Council on Health Systems
40 Development.

41 Part F repeals the geographic access standards. Part F repeals the authorization for
42 the Superintendent of Insurance to establish standardized individual health plans by rule.
43 Part F also permits insurers offering group health insurance to notify affected

1 policyholders of a rate increase electronically as well as by mail. Part F clarifies that
2 preauthorizations are not benefit modifications requiring prior approval of the Bureau of
3 Insurance and authorizes health maintenance organizations to offer deductibles in excess
4 of \$1,000. Part F also clarifies that participation in the individual market is voluntary by
5 removing the requirement that health maintenance organizations offering group coverage
6 also offer individual coverage.

7 Part G authorizes the renewal of short-term health insurance policies for a period not
8 to exceed 24 months instead of the current 12 months.

9 Part H provides a tax credit to employers of 20 or fewer employees for the expense of
10 developing, instituting and maintaining wellness programs for their employees in the
11 amount of \$100 per employee, up to a maximum of \$2,000. A wellness program includes
12 programs for behavior modification, such as smoking cessation programs, equipping and
13 maintaining an exercise facility and providing incentive awards to employees who
14 exercise regularly.

15 Part I amends the chapter of the Maine Insurance Code governing captive insurance
16 companies. The amendment clarifies that, in the event of any conflict between the
17 provisions of other state insurance laws and the provisions of the laws governing captive
18 insurance companies, the provisions of the captive insurance company laws control,
19 except that a captive insurance company insuring health risks may not provide individual
20 health insurance and, if it insures health risks of employers, a captive insurance company
21 must comply with the same requirements of community rating, guaranteed issuance and
22 renewal and mandated benefit laws applicable to small group health insurers. Part I
23 permits an association captive insurance company to require its members to be jointly and
24 severally liable for its health insurance obligations and to meet financial obligations and
25 wellness criteria established in a plan of operation and provides solvency standards
26 applicable to such captives. The amendment would require the Superintendent of
27 Insurance to issue a license to an association captive insuring health risks for an
28 association captive insurance company that requires its members to be jointly and
29 severally liable and has an aggregate net worth of more than \$100,000,000 and meets the
30 requirements of the captive insurance law. Part I also specifies that rules related to
31 captive insurance companies are major substantive rules.

32 Part J corrects cross-references and deletes references in statute to the Governor's
33 Office of Health Policy and Finance, originally established in 2003 by executive order.

34 Part K adds an appropriations and allocations section.

35 **FISCAL NOTE REQUIRED**

36 **(See attached)**