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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 " " to H.P. 1140, L.D. 1554, Bill, "An Act To Implement the Requirements of the Federal Patient Protection and Affordable Care Act"

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

Sec. 1. 24-A MRSA §2735-A, sub-§1, as amended by PL 2009, c. 244, Pt. C, §4, is further amended to read:

1. Notice of rate filing or rate increase on existing policies. An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least 60 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any formula or classification of risks. The Except as otherwise provided in section 2736-C, subsection 2-B, the notice must also inform policyholders of their right to request a hearing pursuant to section 229. The notice must show the proposed rate and, unless otherwise provided in section 2736-C, subsection 2-B, state that the rate is subject to regulatory approval. The Except as otherwise provided in section 2736-C, subsection 2-B, the superintendent may not take final action on a rate filing until 40 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until 60 days after the notice is provided or until the effective date under section 2736, whichever is later.

Sec. 2. 24-A MRSA §2736-A, first ¶, as amended by PL 2009, c. 439, Pt. C, §3, is further amended to read:

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate, or unfairly discriminatory or not in compliance with section 6913 or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory and in compliance with section 6913.

COMMITTEE AMENDMENT

1 **Sec. 3. 24-A MRSA §2736-C, sub-§2, ¶C**, as amended by PL 2011, c. 90, Pt. A,
2 §1, is further amended to read:

3 C. A carrier may vary the premium rate due to family membership to the extent
4 permitted by the federal Affordable Care Act.

5 **Sec. 4. 24-A MRSA §2736-C, sub-§2, ¶D**, as amended by PL 2011, c. 90, Pt. A,
6 §3, is further amended to read:

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

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

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

17 (3) For all policies, contracts or certificates that are executed, delivered, issued
18 for delivery, continued or renewed in this State between July 15, 1995 and June
19 30, 2012, the premium rate may not deviate above or below the community rate
20 filed by the carrier by more than 20%.

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

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

32 (7) For all policies, contracts or certificates that are executed, delivered, issued
33 for delivery, continued or renewed in this State on or after January 1, 2015, the
34 maximum rate differential due to age filed by the carrier as determined by ratio is
35 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation
36 does not apply for determining rates for an attained age of less than 19 years of
37 age or more than 65 years of age.

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

1 **Sec. 5. 24-A MRSA §2736-C, sub-§2, ¶I,** as enacted by PL 2011, c. 90, Pt. A,
2 §5, is amended to read:

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

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

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

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

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

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

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

41 ~~The superintendent shall establish by rule procedures and policies that facilitate the~~
42 ~~implementation of this paragraph, including, but not limited to, notice requirements~~
43 ~~for policyholders and experience pooling requirements of individual health products.~~

1 ~~When establishing rules regarding experience pooling requirements, the~~
2 ~~superintendent shall ensure, to the greatest extent possible, the availability of~~
3 ~~affordable options for individuals transitioning from the closed book of business.~~
4 ~~Rules adopted pursuant to this paragraph are routine technical rules as defined in~~
5 ~~Title 5, chapter 375, subchapter 2-A. The superintendent shall direct the Consumer~~
6 ~~Health Care Division, established in section 4321, to work with carriers and health~~
7 ~~advocacy organizations to provide information about comparable alternative~~
8 ~~insurance options to individuals in a carrier's closed book of business and upon~~
9 ~~request to assist individuals to facilitate the transition to an individual health plan in~~
10 ~~that carrier's or another carrier's open book of business.~~

11 **Sec. 6. 24-A MRSA §2736-C, sub-§2, ¶J** is enacted to read:

12 J. Except for enrollees in grandfathered health plans under the federal Affordable
13 Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all
14 individual health plans offered by the carrier to be members of a single risk pool to
15 the extent required by the federal Affordable Care Act.

16 **Sec. 7. 24-A MRSA §2736-C, sub-§2-B**, as enacted by PL 2011, c. 90, Pt. D,
17 §2, is amended to read:

18 **2-B. Optional guaranteed loss ratio.** Notwithstanding section 2736, subsection 1
19 and section 2736-A, at the carrier's option, rate filings for a carrier's credible block of
20 individual health plans may be filed in accordance with this subsection. Rates filed in
21 accordance with this subsection are filed for informational purposes unless rate review is
22 required pursuant to the federal Affordable Care Act.

23 A. A carrier's individual health plans are considered credible if the anticipated
24 average number of members during the period for which the rates will be in effect ~~is~~
25 ~~at least 1,000 in the aggregate or if the individual health plans in the aggregate meet~~
26 ~~credibility meets standards adopted by the superintendent by rule for full or partial~~
27 ~~credibility pursuant to the federal Affordable Care Act. The rate filing must state the~~
28 ~~anticipated average number of members during the period for which the rates will be~~
29 ~~in effect and the basis for the estimate. If the superintendent determines that the~~
30 ~~number of members is likely to be less than 1,000 and the carrier does not satisfy any~~
31 ~~alternative credibility standards adopted by the superintendent by rule needed to meet~~
32 ~~the credibility standard, the filing is subject to section 2736, subsection 1 and section~~
33 ~~2736-A.~~

34 B. On an annual schedule as determined by the superintendent, the carrier shall file a
35 report with the superintendent showing ~~aggregate earned premiums and incurred~~
36 ~~claims for the period the rates were in effect. Incurred claims must include claims~~
37 ~~paid to a date after the end of the annual reporting period and an estimate of unpaid~~
38 ~~claims. The report must state how the unpaid claims estimate was determined. The~~
39 ~~superintendent shall determine the reporting period and the paid to date; beginning~~
40 ~~January 1, 2011, both the reporting period and the paid to date must be consistent~~
41 ~~with those for the rebates required pursuant to the federal Affordable Care Act and~~
42 ~~federal regulations adopted the calculation of rebates as required pursuant to the~~
43 ~~federal Affordable Care Act, except that the calculation must be based on a minimum~~
44 ~~medical loss ratio of 80% if the applicable federal minimum for the individual market~~
45 ~~in this State is lower. If the calculation indicates that rebates must be paid, the carrier~~

1 must pay the rebates in the same manner as is required for rebates pursuant to the
2 federal Affordable Care Act.

3 **Sec. 8. 24-A MRSA §2736-C, sub-§9**, as enacted by PL 1995, c. 570, §7, is
4 amended to read:

5 **9. Exemption for certain associations.** The superintendent may exempt a group
6 health insurance policy or group nonprofit hospital or medical service corporation
7 contract issued to an association group, organized pursuant to section 2805-A, from the
8 requirements of subsection 3, paragraph A; subsection 6, paragraph A; and subsection 8
9 if:

10 A. Issuance and renewal of coverage under the policy or contract is guaranteed to all
11 members of the association who are residents of this State and to their dependents;

12 B. Rates for the association comply with the premium rate requirements of
13 subsection 2 or are established on a nationwide basis and substantially comply with
14 the purposes of this section, except that exempted associations may be rated
15 separately from the carrier's other individual health plans, if any;

16 C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%;

17 D. The association's membership criteria do not include age, health status, medical
18 utilization history or any other factor with a similar purpose or effect;

19 E. The association's group health plan is not marketed to the general public;

20 F. The association does not allow insurance agents or brokers to market association
21 memberships, accept applications for memberships or enroll members, except when
22 the association is an association of insurance agents or brokers organized under
23 section 2805-A;

24 G. Insurance is provided as an incidental benefit of association membership and the
25 primary purposes of the association do not include group buying or mass marketing
26 of insurance or other goods and services; and

27 H. Granting an exemption to the association does not conflict with the purposes of
28 this section.

29 Except for individuals with grandfathered health plans under the federal Affordable Care
30 Act, this subsection does not apply to policies, contracts or certificates that are executed,
31 delivered, issued for delivery, continued or renewed in this State on or after January 1,
32 2014.

33 **Sec. 9. 24-A MRSA §2808-B, sub-§1, ¶D**, as repealed and replaced by PL 2003,
34 c. 428, Pt. H, §5, is amended to read:

35 D. "Eligible group" means any person, firm, corporation, partnership, association or
36 subgroup engaged actively in a business that employed an average of 50 or fewer
37 eligible employees during the preceding calendar year.

38 (1) If an employer was not in existence throughout the preceding calendar year,
39 the determination must be based on the average number of employees that the
40 employer is reasonably expected to employ on business days in the current
41 calendar year.

- 1 (2) In determining the number of eligible employees, companies that are
2 affiliated companies or that are eligible to file a combined tax return for purposes
3 of state taxation are considered one employer.
- 4 (3) A group is not an eligible group if there is any one other state where there are
5 more eligible employees than are employed within this State and the group had
6 coverage in that state or is eligible for guaranteed issuance of coverage in that
7 state.
- 8 (4) An employer qualifies as an eligible group for 2-person coverage if the
9 employer provides a carrier with the following information demonstrating that
10 the employer's business and employees meet the minimum qualifications for
11 group coverage in paragraph C:
- 12 (a) A copy of the most recent quarterly combined filing for income tax
13 withholding and unemployment contributions, Form 941/C1-ME;
- 14 (b) For an employee claimed to be an employee eligible for group coverage
15 whose name is not listed on Form 941/C1-ME, a copy of the employer's
16 payroll records for the most recent 3 months showing tax withholding or a
17 wage report from a payroll company showing wages paid to that employee
18 for the most recent quarter with tax withholding;
- 19 (c) If an employer is exempt from filing Form 941/C1-ME for group
20 coverage, documentation of that exemption and a copy of the employer's
21 payroll records for the most recent 3 months showing tax withholding or a
22 wage report from a payroll company showing wages paid to that employee
23 for the most recent quarter with tax withholding; or
- 24 (d) If the name of the business owner or employee does not appear on Form
25 941/C1-ME, a copy of one of the following:
- 26 (i) Federal income tax Form Schedule C or Schedule F;
- 27 (ii) Federal income tax Form 1120S, Schedule K-1;
- 28 (iii) Federal income tax Form 1065, Schedule K-1;
- 29 (iv) A workers' compensation insurance audit or evidence of a waiver of
30 benefits under Title 39-A;
- 31 (v) A description of operations in a commercial general liability
32 insurance policy or equivalent insurance policy providing coverage for
33 the business; or
- 34 (vi) A signature card from a financial institution or credit union
35 authorizing the employee to sign checks on a business checking or share
36 draft account that is at least 6 months old; a notarized affidavit from the
37 employer describing the duties of the employee and the average number
38 of hours worked by the employee and attesting that the employer is not
39 defrauding the carrier and is aware of the consequences of committing
40 fraud or making a material misrepresentation to the carrier, including a

1 loss of coverage and benefits; and, if the group coverage is purchased
2 through a producer, a notarized affidavit from the producer affirming the
3 producer's belief that the employer qualifies as an eligible group for
4 coverage.

5 In determining if a new business or a business that adds an owner or a new
6 employee to payroll during the course of a year qualifies as an eligible group for
7 2-person coverage under this subparagraph, the employer must submit an
8 affidavit stating that all employees meet the criteria in this subparagraph and that
9 the documentation and forms required under this subparagraph will be provided
10 to the carrier when payroll records become available, when ownership
11 distribution forms become available or the first renewal date of the coverage,
12 whichever date is earlier. A false affidavit or misrepresentation on an affidavit
13 submitted by an employer may result in the loss of group coverage and
14 repayment of claims paid. This subparagraph may not be construed to prohibit a
15 carrier from recognizing an employer as an eligible group if the employer has not
16 produced the documentation required in this subparagraph.

17 This subparagraph applies only to an employer applying for group health
18 insurance coverage as a 2-person group ~~on or after~~ from October 1, 2001 to
19 December 31, 2013.

20 **Sec. 10. 24-A MRSA §2808-B, sub-§2, ¶C**, as amended by PL 2011, c. 90, Pt.
21 A, §6, is further amended to read:

22 C. A carrier may vary the premium rate due to occupation and industry, family
23 membership, participation in wellness programs and group size to the extent
24 permitted by the federal Affordable Care Act. The superintendent may adopt rules
25 setting forth appropriate methodologies regarding rate discounts for participation in
26 wellness programs and rating for occupation and industry and group size pursuant to
27 this paragraph. Rules adopted pursuant to this paragraph are routine technical rules
28 as defined in Title 5, chapter 375, subchapter 2-A.

29 **Sec. 11. 24-A MRSA §2808-B, sub-§2, ¶D**, as amended by PL 2011, c. 90, Pt.
30 A, §8, is further amended to read:

31 D. A carrier may vary the premium rate due to age and ~~smoking status~~ tobacco use
32 only under the following schedule and within the listed percentage bands.

33 (1) For all policies, contracts or certificates that are executed, delivered, issued
34 for delivery, continued or renewed in this State between July 15, 1993 and July
35 14, 1994, the premium rate may not deviate above or below the community rate
36 filed by the carrier by more than 50%.

37 (2) For all policies, contracts or certificates that are executed, delivered, issued
38 for delivery, continued or renewed in this State between July 15, 1994 and July
39 14, 1995, the premium rate may not deviate above or below the community rate
40 filed by the carrier by more than 33%.

41 (3) For all policies, contracts or certificates that are executed, delivered, issued
42 for delivery, continued or renewed in this State between July 15, 1995 and

1 September 30, 2011, the premium rate may not deviate above or below the
2 community rate filed by the carrier by more than 20%.

3 (4) For all policies, contracts or certificates that are executed, delivered, issued
4 for delivery, continued or renewed in this State between October 1, 2011 and
5 December 31, 2012, the maximum rate differential due to age filed by the carrier
6 as determined by ratio is 2 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 (5) For all policies, contracts or certificates that are executed, delivered, issued
9 for delivery, continued or renewed in this State between January 1, 2013 and
10 December 31, 2013, the maximum rate differential due to age filed by the carrier
11 as determined by ratio is 2.5 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 (6) For all policies, contracts or certificates that are executed, delivered, issued
14 for delivery, continued or renewed in this State between January 1, 2014 and
15 December 31, 2014, the maximum rate differential due to age filed by the carrier
16 as determined by ratio is 3 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 (7) For all policies, contracts or certificates that are executed, delivered, issued
19 for delivery, continued or renewed in this State between January 1, 2015 and
20 December 31, 2015, the maximum rate differential due to age filed by the carrier
21 as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable
22 Care Act. The limitation does not apply for determining rates for an attained age
23 of less than 19 years of age or more than 65 years of age.

24 (8) For all policies, contracts or certificates that are executed, delivered, issued
25 for delivery, continued or renewed in this State on or after January 1, 2016, the
26 maximum rate differential due to age filed by the carrier as determined by ratio is
27 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation
28 does not apply for determining rates for an attained age of less than 19 years of
29 age or more than 65 years of age.

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

34 **Sec. 12. 24-A MRSA §2808-B, sub-§2, ¶E**, as amended by PL 2001, c. 258, Pt.
35 E, §4, is further amended to read:

36 E. The superintendent may authorize a carrier to establish a separate community rate
37 for an association group organized pursuant to section 2805-A or a trustee group
38 organized pursuant to section 2806, as long as association group membership or
39 eligibility for participation in the trustee group is not conditional on health status,
40 claims experience or other risk selection criteria and all small group health plans
41 offered by the carrier through that association or trustee group:

- 1 (1) Are otherwise in compliance with the premium rate requirements of this
2 subsection; and
- 3 (2) Are offered on a guaranteed issue basis to all eligible employers that are
4 members of the association or are eligible to participate in the trustee group
5 except that a professional association may require that a minimum percentage of
6 the eligible professionals employed by a subgroup be members of the association
7 in order for the subgroup to be eligible for issuance or renewal of coverage
8 through the association. The minimum percentage must not exceed 90%. For
9 purposes of this subparagraph, "professional association" means an association
10 that:
- 11 (a) Serves a single profession that requires a significant amount of education,
12 training or experience or a license or certificate from a state authority to
13 practice that profession;
- 14 (b) Has been actively in existence for 5 years;
- 15 (c) Has a constitution and bylaws or other analogous governing documents;
- 16 (d) Has been formed and maintained in good faith for purposes other than
17 obtaining insurance;
- 18 (e) Is not owned or controlled by a carrier or affiliated with a carrier;
- 19 (g) Has a least 1,000 members if it is a national association; 200 members if
20 it is a state or local association;
- 21 (h) All members and dependents of members are eligible for coverage
22 regardless of health status or claims experience; and
- 23 (i) Is governed by a board of directors and sponsors annual meetings of its
24 members.

25 Producers may only market association memberships, accept applications for
26 membership or sign up members in the professional association where the individuals
27 are actively engaged in or directly related to the profession represented by the
28 professional association.

29 Except for employers with plans that have grandfathered status under the federal
30 Affordable Care Act, this paragraph does not apply to policies, contracts or
31 certificates that are executed, delivered, issued for delivery, continued or renewed in
32 this State on or after January 1, 2014.

33 **Sec. 13. 24-A MRSA §2808-B, sub-§2, ¶H,** as enacted by PL 2011, c. 90, Pt. A,
34 §10, is amended to read:

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

1 for that closed book of business only as permitted in this paragraph and paragraphs C
2 and C-1.

3 (1) For all policies, contracts or certificates that are executed, delivered, issued
4 for delivery, continued or renewed in this State between October 1, 2011 and
5 December 31, 2012, the maximum rate differential due to age filed by the carrier
6 as determined by ratio is 2 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 (2) For all policies, contracts or certificates that are executed, delivered, issued
9 for delivery, continued or renewed in this State between January 1, 2013 and
10 December 31, 2013, the maximum rate differential due to age filed by the carrier
11 as determined by ratio is 2.5 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 (3) For all policies, contracts or certificates that are executed, delivered, issued
14 for delivery, continued or renewed in this State between January 1, 2014 and
15 December 31, 2014, the maximum rate differential due to age filed by the carrier
16 as determined by ratio is 3 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 (4) For all policies, contracts or certificates that are executed, delivered, issued
19 for delivery, continued or renewed in this State between January 1, 2015 and
20 December 31, 2015, the maximum rate differential due to age filed by the carrier
21 as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable
22 Care Act. The limitation does not apply for determining rates for an attained age
23 of less than 19 years of age or more than 65 years of age.

24 (5) For all policies, contracts or certificates that are executed, delivered, issued
25 for delivery, continued or renewed in this State on or after January 1, 2016, the
26 maximum rate differential due to age filed by the carrier as determined by ratio is
27 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation
28 does not apply for determining rates for an attained age of less than 19 years of
29 age or more than 65 years of age.

30 (6) For all policies, contracts or certificates that are executed, delivered, issued
31 for delivery, continued or renewed in this State on or after October 1, 2011, the
32 maximum rate differential due to ~~smoking status~~ tobacco use filed by the carrier
33 as determined by ratio is 1.5 to 1.

34 **Sec. 14. 24-A MRSA §2808-B, sub-§2, ¶I** is enacted to read:

35 I. Except for plans that have grandfathered status under the federal Affordable Care
36 Act, beginning January 1, 2014, a carrier shall consider all enrollees in all small
37 group health plans offered by the carrier to be members of a single risk pool to the
38 extent required by the federal Affordable Care Act.

39 **Sec. 15. 24-A MRSA §2808-B, sub-§2-B, ¶C**, as enacted by PL 2003, c. 469,
40 Pt. E, §16, is amended to read:

41 C. When a filing is not accompanied by the information upon which the carrier
42 supports the filing or the superintendent does not have sufficient information to

1 determine whether the filing meets the requirements that rates not be excessive,
2 inadequate, or unfairly discriminatory ~~or not in compliance with section 6913~~, the
3 superintendent shall require the carrier to furnish the information upon which it
4 supports the filing.

5 **Sec. 16. 24-A MRSA §2808-B, sub-§2-C**, as amended by PL 2011, c. 90, Pt. D,
6 §4, is further amended to read:

7 **2-C. Guaranteed loss ratio.** Notwithstanding subsection 2-B, ~~at the carrier's option~~,
8 rate filings for a credible block of small group health plans may be filed in accordance
9 with this subsection instead of subsection 2-B. Rates filed in accordance with this
10 subsection are filed for informational purposes.

11 A. A block of small group health plans is considered credible if the anticipated
12 average number of members during the period for which the rates will be in effect ~~is~~
13 ~~at least 1,000 or if it meets credibility standards adopted by the superintendent by rule~~
14 for full or partial credibility pursuant to the federal Affordable Care Act. The rate
15 filing must state the anticipated average number of members during the period for
16 which the rates will be in effect and the basis for the estimate. If the superintendent
17 determines that the number of members is likely to be less than ~~1,000 and the block~~
18 ~~does not satisfy any alternative credibility standards adopted by rule needed to meet~~
19 the credibility standard, the filing is subject to subsection 2-B, ~~except as provided in~~
20 paragraph A-1.

21 ~~A-1. A carrier that elected to file rates in accordance with this subsection prior to~~
22 ~~September 1, 2004 may continue to file rates in accordance with this subsection as~~
23 ~~long as the anticipated number of member months for a 12-month period is at least~~
24 ~~1,000.~~

25 ~~B. On an annual schedule as determined by the superintendent, the carrier shall file a~~
26 ~~report with the superintendent showing aggregate earned premiums and incurred~~
27 ~~claims for the period the rates were in effect. Incurred claims must include claims~~
28 ~~paid to a date after the end of the annual reporting period and an estimate of unpaid~~
29 ~~claims. The report must state how the unpaid claims estimate was determined. The~~
30 ~~superintendent shall determine the reporting period and the paid to date; beginning~~
31 ~~January 1, 2011, both the reporting period and the paid to date must be consistent~~
32 ~~with those for the rebates required pursuant to section 4319 and to the federal~~
33 ~~Affordable Care Act and federal regulations adopted pursuant to the federal~~
34 ~~Affordable Care Act.~~

35 ~~C. If incurred claims were less than 78% of aggregate earned premiums over a~~
36 ~~continuous 36-month period, the carrier shall refund a percentage of the premium to~~
37 ~~the current in force policyholder. For the purposes of calculating this loss ratio~~
38 ~~percentage, any payments paid pursuant to former section 6913 must be treated as~~
39 ~~incurred claims. The excess premium is the amount of premium above that amount~~
40 ~~necessary to achieve a 78% loss ratio for all of the carrier's small group policies~~
41 ~~during the same 36-month period. The refund must be distributed to policyholders in~~
42 ~~an amount reasonably calculated to correspond to the aggregate experience of all~~
43 ~~policyholders holding policies having similar benefits. The total of all refunds must~~
44 ~~equal the excess premiums.~~

1 ~~(1) For determination of loss ratio percentages in 2005, actual aggregate incurred~~
2 ~~claims expenses include expenses incurred in 2005 and projected expenses for~~
3 ~~2006 and 2007. For determination of loss ratio percentages in 2006, actual~~
4 ~~incurred claims expenses include expenses in 2005 and 2006 and projected~~
5 ~~expenses for 2007.~~

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

8 ~~D. The superintendent may require further support for the unpaid claims estimate~~
9 ~~and may require refunds to be recalculated if the estimate is found to be unreasonably~~
10 ~~large.~~

11 ~~E. The superintendent may adopt rules setting forth appropriate methodologies~~
12 ~~regarding reports, refunds and credibility standards pursuant to this subsection. Rules~~
13 ~~adopted pursuant to this subsection are routine technical rules as defined in Title 5,~~
14 ~~chapter 375, subchapter 2-A.~~

15 **Sec. 17. 24-A MRSA §2808-B, sub-§6, ¶I**, as enacted by PL 1993, c. 477, Pt. B,
16 §3 and affected by Pt. F, §1, is amended to read:

17 I. Notwithstanding any other provision of this section, prior to January 1, 2014, a
18 carrier may choose whether it will offer to groups having only one member coverage
19 under the carrier's individual health policies offered to other individuals in this State
20 in accordance with section 2736-C or coverage under a small group health plan in
21 accordance with this section, or both, but the carrier need not offer to groups of one
22 both small group and individual health coverage.

23 **Sec. 18. 24-A MRSA §2850, sub-§2, ¶F** is enacted to read:

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

30 **Sec. 19. 24-A MRSA §4218-A** is enacted to read:

31 **§4218-A. Compliance with the Affordable Care Act**

32 The superintendent may adopt and amend rules, establish standards and enforce
33 federal statutes and regulations in order to carry out the purposes of the federal
34 Affordable Care Act. Rules or amendments to rules adopted pursuant to this section,
35 including amendments to major substantive rules, are routine technical rules as defined in
36 Title 5, chapter 375, subchapter 2-A.

37 **Sec. 20. 24-A MRSA §4301-A, sub-§1**, as amended by PL 2007, c. 199, Pt. B,
38 §1, is further amended to read:

39 **1. Adverse health care treatment decision.** "Adverse health care treatment
40 decision" means a health care treatment decision made by or on behalf of a carrier
41 offering or renewing a health plan denying in whole or in part payment for or provision of

1 otherwise covered services requested by or on behalf of an enrollee. "Adverse health care
2 treatment decision" includes a rescission determination and an initial coverage eligibility
3 determination, consistent with the requirements of the federal Affordable Care Act.

4 **Sec. 21. 24-A MRSA §4301-A, sub-§3, ¶¶F and G,** as enacted by PL 1999, c.
5 742, §3, are further amended to read:

6 F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; ~~or~~

7 G. A self-insured employer subject to state regulation as described in section
8 2848-A; or

9 **Sec. 22. 24-A MRSA §4301-A, sub-§3, ¶H** is enacted to read:

10 H. Notwithstanding any other provision of this Title, an entity offering coverage in
11 this State that is subject to the requirements of the federal Affordable Care Act.

12 **Sec. 23. 24-A MRSA §4301-A, sub-§7,** as enacted by PL 1999, c. 742, §3, is
13 amended to read:

14 **7. Health plan.** "Health plan" means a plan offered or administered by a carrier that
15 provides for the financing or delivery of health care services to persons enrolled in the
16 plan, other than a plan that provides only accidental injury, specified disease, hospital
17 indemnity, Medicare supplement, disability income, long-term care or other limited
18 benefit coverage not subject to the requirements of the federal Affordable Care Act. A
19 plan that is subject to the requirements of the federal Affordable Care Act and offered in
20 this State by a carrier, including, but not limited to, a qualified health plan offered on an
21 American Health Benefit Exchange or a SHOP Exchange established pursuant to the
22 federal Affordable Care Act, is a health plan for purposes of this chapter.

23 **Sec. 24. 24-A MRSA §4302, sub-§6** is enacted to read:

24 **6. Reporting required pursuant to the Affordable Care Act.** Notwithstanding
25 any other requirements of this Title, a carrier shall provide to the Secretary of the United
26 States Department of Health and Human Services, and make available to the public when
27 required by federal law, any information required by the federal Affordable Care Act.
28 Carriers shall provide the information to the superintendent upon request.

29 **Sec. 25. 24-A MRSA §4303, sub-§4, ¶E** is enacted to read:

30 E. Health plans subject to the requirements of the federal Affordable Care Act must
31 comply with federal claims and appeal requirements, including, but not limited to, the
32 requirement that benefits for an ongoing course of treatment may not be reduced or
33 terminated without advance notice and an opportunity for advance review, consistent
34 with the requirements of the federal Affordable Care Act.

35 **Sec. 26. 24-A MRSA §4303, sub-§15** is enacted to read:

36 **15. Uniform explanation of coverage documents and standardized definitions.**
37 A carrier offering a health plan in this State shall:

38 A. Provide to applicants, enrollees and policyholders or certificate holders a
39 summary of benefits and an explanation of coverage that accurately describe the
40 benefits and coverage under the applicable plan or coverage. A summary of benefits

1 and an explanation of coverage must conform with the requirements of the federal
2 Affordable Care Act; and

3 B. Use standard definitions of insurance-related and medical-related terms in
4 connection with health insurance coverage as required by the federal Affordable Care
5 Act.

6 **Sec. 27. 24-A MRSA §4303, sub-§16** is enacted to read:

7 **16. Language and culture.** All notices to applicants, enrollees and policyholders or
8 certificate holders subject to the requirements of the federal Affordable Care Act must be
9 provided in a culturally and linguistically appropriate manner consistent with the
10 requirements of the federal Affordable Care Act.

11 **Sec. 28. 24-A MRSA §4306**, as amended by PL 2007, c. 199, Pt. B, §15, is
12 further amended to read:

13 **§4306. Enrollee choice of primary care provider**

14 A carrier offering or renewing a managed care plan shall allow enrollees to choose
15 their own primary care providers, as allowed under the managed care plan's rules, from
16 among the panel of participating providers made available to enrollees under the managed
17 care plan's rules. A carrier shall allow physicians, including, but not limited to,
18 pediatricians and physicians who specialize in obstetrics and gynecology, and certified
19 nurse practitioners who have been approved by the State Board of Nursing to practice
20 advanced practice registered nursing without the supervision of a physician pursuant to
21 Title 32, section 2102, subsection 2-A, to serve as primary care providers for managed
22 care plans. A carrier is not required to contract with certified nurse practitioners or
23 physicians as primary care providers in any manner that exceeds the access and provider
24 network standards required in this chapter or chapter 56, or any rules adopted pursuant to
25 those chapters. A carrier shall allow enrollees in a managed care plan to change primary
26 care providers without good cause at least once annually and to change with good cause
27 as necessary. When an enrollee fails to choose a primary care provider, the carrier may
28 assign the enrollee a primary care provider located in the same geographic area in which
29 the enrollee resides.

30 **Sec. 29. 24-A MRSA §4306-A** is enacted to read:

31 **§4306-A. Patient access to obstetrical and gynecological care**

32 Notwithstanding any other requirements of this Title, a carrier offering a health plan
33 in this State subject to the requirements of the federal Affordable Care Act:

34 **1. Authorization or referral not required.** May not require authorization or
35 referral by the carrier or any other person, including a primary care provider, in the case
36 of a female enrollee who seeks coverage for obstetrical or gynecological care provided by
37 a participating health care professional as described in the federal Affordable Care Act
38 who specializes in obstetrics or gynecology. The health care professional shall agree to
39 otherwise adhere to the health plan's or carrier's policies and procedures, including
40 procedures regarding referrals and obtaining prior authorization and providing services
41 pursuant to a treatment plan, if any, approved by the carrier; and

1 **2. Treated as primary care.** Shall treat the provision of obstetrical and
2 gynecological care by a participating health care professional as described in the federal
3 Affordable Care Act who specializes in obstetrics or gynecology, pursuant to subsection
4 1, as authorized by the primary care provider and the authorization of related obstetrical
5 and gynecological items and services by that professional as the authorization of the
6 primary care provider.

7 **Sec. 30. 24-A MRSA §4309-A** is enacted to read:

8 **§4309-A. Compliance with the Affordable Care Act**

9 **1. Carriers.** A carrier shall comply with all applicable requirements of the federal
10 Affordable Care Act.

11 **2. Superintendent.** The superintendent may enforce and administer this section
12 through all powers provided under this Title and Title 24. The superintendent may adopt
13 and amend rules, establish standards and enforce federal statutes and regulations in order
14 to carry out the purposes of the federal Affordable Care Act. Rules or amendments
15 adopted pursuant to this subsection, including amendments to major substantive rules, are
16 routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

17 **Sec. 31. 24-A MRSA §4312, sub-§1,** as enacted by PL 1999, c. 742, §19, is
18 amended to read:

19 **1. Request for external review.** An enrollee or the enrollee's authorized
20 representative shall make a written request for external review of an adverse health care
21 treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not
22 make a request for external review under a group plan until the enrollee has exhausted all
23 levels of a carrier's internal grievance procedure and may not make a request for external
24 review under an individual plan until the enrollee has exhausted one level of a carrier's
25 internal grievance procedure. A request for external review must be made within 12
26 months of the date an enrollee has received a final adverse health care treatment decision
27 under a carrier's internal grievance procedure. An enrollee may not be required to pay
28 any filing fee as a condition of processing a request for external review.

29 **Sec. 32. 24-A MRSA §4312, sub-§2,** as enacted by PL 1999, c. 742, §19, is
30 amended to read:

31 **2. Expedited request for external review.** An enrollee or an enrollee's authorized
32 representative is not required to exhaust ~~all levels of~~ a carrier's internal grievance
33 procedure in accordance with subsection 1 before filing a request for external review if:

34 A. The carrier has failed to make a decision on an internal grievance within the time
35 period required or has otherwise failed to adhere to all the requirements applicable to
36 the appeal pursuant to state and federal law or the enrollee has applied for expedited
37 external review at the same time as applying for an expedited internal appeal;

38 B. The carrier and the enrollee mutually agree to bypass the internal grievance
39 procedure;

40 C. The life or health of the enrollee is in serious jeopardy; ~~or~~

41 D. The enrollee has died; or

1 E. The adverse health care treatment decision to be reviewed concerns an admission,
2 availability of care, a continued stay or health care services when the claimant has
3 received emergency services but has not been discharged from the facility that
4 provided the emergency services.

5 **Sec. 33. 24-A MRSA §4318, sub-§4**, as reallocated by RR 2009, c. 2, §70, is
6 amended to read:

7 **4. Disclosure.** A health plan issued after the effective date of this section that
8 includes an annual or lifetime maximum aggregate benefit limit as permitted under
9 subsection 3 and under section 4320 must include a disclosure of the applicable limit on
10 the face page of the individual policy or group certificate. The disclosure must be printed
11 in a font that is larger or bolder than the font used in the body of the face page.

12 **Sec. 34. 24-A MRSA §§4320 to 4320-G** are enacted to read:

13 **§4320. No lifetime or annual limits on health plans subject to the Affordable Care**
14 **Act**

15 Notwithstanding the requirements of section 4318, a carrier offering a health plan
16 subject to the federal Affordable Care Act may not:

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

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

24 **§4320-A. Coverage of preventive health services**

25 Notwithstanding any other requirements of this Title, a carrier offering a health plan
26 subject to the federal Affordable Care Act shall, at a minimum, provide coverage for and
27 may not impose cost-sharing requirements for preventive services as required by the
28 federal Affordable Care Act.

29 **§4320-B. Extension of dependent coverage**

30 A carrier offering a health plan subject to the requirements of the federal Affordable
31 Care Act that provides dependent coverage of children shall continue to make such
32 coverage available for an adult child until the child turns 26 years of age, consistent with
33 the federal Affordable Care Act.

34 **§4320-C. Emergency services**

35 If a carrier offering a health plan subject to the requirements of the federal Affordable
36 Care Act provides or covers any benefits with respect to services in an emergency
37 department of a hospital, the plan must cover emergency services in accordance with the
38 requirements of the federal Affordable Care Act, including requirements that emergency
39 services be covered without prior authorization and that cost-sharing requirements,

1 expressed as a copayment amount or coinsurance rate, for out-of-network services are the
2 same as requirements that would apply if such services were provided in network.

3 **§4320-D. Comprehensive health coverage**

4 Notwithstanding any other requirements of this Title, a carrier offering a health plan
5 subject to the requirements of the federal Affordable Care Act shall, at a minimum,
6 provide coverage that incorporates essential benefits and cost-sharing limitations
7 consistent with the requirements of the federal Affordable Care Act.

8 **§4320-E. Reinsurance, risk corridors and risk adjustment**

9 **1. Transitional reinsurance program.** The superintendent shall establish a
10 transitional reinsurance program for calendar years 2014, 2015 and 2016 as required by
11 Section 1341 of the federal Affordable Care Act.

12 **2. Risk corridors.** A carrier shall make any payments required under the risk
13 corridors program established by the Secretary of the United States Department of Health
14 and Human Services for calendar years 2014, 2015 and 2016 as required by Section 1342
15 of the federal Affordable Care Act.

16 **3. Risk adjustment.** The superintendent shall establish a risk adjustment program as
17 required by Section 1343 of the federal Affordable Care Act.

18 **§4320-F. Oversight of plans offered on the American Health Benefit Exchange and**
19 **the SHOP Exchange**

20 **1. Superintendent's authority preserved.** Except as otherwise expressly provided
21 by applicable law, the requirements established by this Title, Title 24 and rules adopted
22 by the superintendent continue to apply to carriers and health plans and are not
23 extinguished or modified in any way by:

24 A. Certification of a health plan as a qualified health plan or any other determination
25 made by the American Health Benefit Exchange or the SHOP Exchange pursuant to
26 the federal Affordable Care Act; or

27 B. Recognition by the applicable federal agency of a carrier as a qualified nonprofit
28 health insurance issuer or as an issuer of multistate qualified health plans, or of a
29 health plan as a multistate qualified health plan, pursuant to the federal Affordable
30 Care Act.

31 **2. Coordination with exchanges.** The superintendent has all additional powers and
32 duties conferred upon a state insurance regulator with respect to the American Health
33 Benefit Exchange and the SHOP Exchange by the federal Affordable Care Act. The
34 superintendent may enter into agreements with the American Health Benefit Exchange
35 and the SHOP Exchange relating to coordination of responsibilities, and such agreements
36 may provide for the superintendent to assume additional authority relating to the
37 certification of qualified health plans or the authorization of a carrier to participate in the
38 American Health Benefit Exchange or the SHOP Exchange.

1 **§4320-G. Applicability to health plans grandfathered under the Affordable Care**
2 **Act**

3 A health plan that is exempt from certain requirements of the federal Affordable Care
4 Act because it has grandfathered status is also exempt, to the same extent, from
5 substantially similar provisions in this Title and Title 24 enacted after January 1, 2011,
6 except to the extent that those provisions state that they apply to grandfathered health
7 plans.

8 **Sec. 35. 24-A MRSA §6451-A, sub-§3-A** is enacted to read:

9 **3-A. Qualified nonprofit health insurance issuers.** Qualified nonprofit health
10 insurance issuers as defined in Section 1322 of the federal Affordable Care Act are
11 considered health organizations for purposes of this chapter.

12 **Sec. 36. Review of transitional reinsurance, risk corridors and risk**
13 **adjustment programs.** No later than January 1, 2013, the Department of Professional
14 and Financial Regulation, Bureau of Insurance shall submit the bureau's proposed
15 transitional reinsurance program and risk adjustment program established pursuant to the
16 Maine Revised Statutes, Title 24-A, section 4320-E and any information related to the
17 risk corridors program established pursuant to Section 1342 of the federal Affordable
18 Care Act for review by the joint standing committee of the Legislature having jurisdiction
19 over insurance and financial services matters. The joint standing committee may report
20 out a bill to the First Regular Session of the 126th Legislature based on the bureau's
21 proposed transitional reinsurance program or risk adjustment program.'

22 **SUMMARY**

23 This amendment replaces the bill and does the following.

24 1. It retains provisions in the bill that amend the health insurance laws to incorporate
25 changes to implement the requirements of the federal Patient Protection and Affordable
26 Care Act.

27 2. It removes the provisions in the bill that are inconsistent with changes made in
28 Public Law 2011, chapter 90 related to rating for individual and small group health plans.

29 3. It removes the provisions in the bill that define "Affordable Care Act" and
30 conform state law to federal law relating to minimum medical loss ratios as these
31 provisions are included in Public Law 2011, chapter 90.

32 4. It makes technical changes and adds cross-references.

33 5. It requires the Department of Professional and Financial Regulation, Bureau of
34 Insurance to submit its proposed transitional reinsurance program and risk adjustment
35 program and information related to the federal risk corridors program to the Legislature
36 for review no later than January 1, 2013.