§2736-C. Individual health plans

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Carrier" means any insurance company, nonprofit hospital and medical service organization or health maintenance organization authorized to issue individual health plans in this State. For the purposes of this section, carriers that are affiliated companies or that are eligible to file consolidated tax returns are treated as one carrier and any restrictions or limitations imposed by this section apply as if all individual health plans delivered or issued for delivery in this State by affiliated carriers were issued by one carrier. For purposes of this section, health maintenance organizations are treated as separate organizations from affiliated insurance companies and nonprofit hospital and medical service organizations. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

B. "Community rate" means the rate charged to all eligible individuals for individual health plans prior to any adjustments pursuant to subsection 2, paragraphs C and D. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

C. "Individual health plan" means any hospital and medical expense-incurred policy or health, hospital or medical service corporation plan contract. It includes both individual contracts and certificates issued under group contracts specified in section 2701, subsection 2, paragraph C. "Individual health plan" does not include the following types of insurance:

(1) Accident;

(2) Credit;

(3) Disability;

(4) Long-term care or nursing home care;

(5) Medicare supplement;

(6) Specified disease;

(7) Dental or vision;

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

(9) Workers' compensation;

(10) Automobile medical payment;

(11) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability insurance policy or equivalent self-insurance; or

(12) Short-term, limited-duration policies, as described in section 2849-B, subsection 1. [PL 2019, c. 330, §1 (AMD); PL 2019, c. 330, §6 (AFF).]

C-1. "Legally domiciled" means a person who lives in this State and who satisfies the criteria contained in 2 of the following subparagraphs.

(1) The person has a motor vehicle operator's license or nondriver identification card from this State.

(2) The person has a valid passport or visa and is lawfully admitted to the United States.

(3) The person is registered to vote in this State.

(4) The person has a permanent dwelling place in this State.

(5) The person submits a written sworn affidavit declaring that person's intent to reside in this State.

(6) The person files an income tax return for this State that declares the person is a Maine resident.

A person may establish that that person is legally domiciled in this State by providing evidence of other relevant criteria associated with residency. A child is legally domiciled in this State if at least one of the child's parents or the child's legal guardian is legally domiciled in this State. A person with a developmental or other disability that prevents that person from obtaining a motor vehicle operator's license, registering to vote or filing an income tax return is legally domiciled in this State by living in this State. [PL 2005, c. 493, §1 (RPR).]

C-2. "Resident" means a person who is legally domiciled in this State and has been for at least the last 60 days. [PL 1997, c. 445, §8 (NEW); PL 1997, c. 445, §32 (AFF).]

D. "Premium rate" means the rate charged to an individual for an individual health plan. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

E. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended. [PL 1997, c. 370, Pt. E, §2 (NEW).]

[PL 2019, c. 330, §1 (AMD); PL 2019, c. 330, §6 (AFF).]

2. Rating practices. The following requirements apply to the rating practices of carriers providing individual health plans.

A. A carrier issuing an individual health plan after December 1, 1993 must file the carrier's community rate and any formulas and factors used to adjust that rate with the superintendent prior to issuance of any individual health plan. [PL 1993, c. 547, §3 (AMD).]

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual or any other rating factor not specified in this subsection. [PL 2019, c. 5, Pt. A, §1 (AMD).]

C. A carrier may vary the premium rate due to family membership. The premium rate for a family must equal the sum of the premiums for each individual in the family, except that it may not be based on more than 3 dependent children who are less than 21 years of age. [PL 2019, c. 5, Pt. A, §2 (AMD).]

C-1. A carrier may vary the premium rate due to geographic area in accordance with the limitation set out in this paragraph. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2023, the rating factor used by a carrier for geographic area may not exceed 1.5. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2024, the rating factor used by a carrier for geographic area may not exceed 1.25. [PL 2021, c. 655, §1 (AMD).]

D. A carrier may vary the premium rate due to age and tobacco use in accordance with the limitations set out in this paragraph. A carrier that varies the premium rate due to age must vary the premium rate according to a uniform age curve. The superintendent shall adopt rules establishing a uniform age curve that is substantially similar to the age curve in effect on January 1, 2019 under the federal Affordable Care Act. Rules adopted under this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

(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%.

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

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

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

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015, except as provided in subparagraph (9), the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the federal Affordable Care Act. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2022, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.5 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2023 and December 31, 2023, the maximum rate differential due to tobacco use filed by the carrier as determined by ratio is 1.25 to 1, except that the carrier may not apply a rate differential pursuant to this subparagraph when the covered individual is participating in an evidence-based tobacco cessation strategy approved by the United States Department of Health and Human Services, Food and Drug Administration. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2024, a carrier may not vary the premium rate due to tobacco use.

(9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this subparagraph, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1 for individuals 21 years of age and older on the first day of coverage under the policy, contract or certificate. The variation in rate due to age must be actuarially justified for individuals under 21 years of age consistent with the uniform age rating curve adopted under this paragraph. [PL 2021, c. 344, §1 (AMD).]

E. A separate community rate may be established for individuals eligible for Medicare Part A without paying a premium; however, this rate may not be applied if both the Medicare eligibility date and the issue date are prior to July 1, 2000. [PL 1999, c. 44, §1 (AMD); PL 1999, c. 44, §2 (AFF).]

F. [PL 2019, c. 5, Pt. A, §4 (RP).]

G. [PL 2011, c. 90, Pt. B, §4 (RP); PL 2011, c. 90, Pt. B, §10 (AFF).]

H. [PL 2011, c. 90, Pt. A, §4 (RP).]

I. [PL 2019, c. 5, Pt. A, §5 (RP).]

J. Except for enrollees in grandfathered health plans under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all individual health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act. [PL 2011, c. 364, §6 (NEW).]

[PL 2021, c. 655, §1 (AMD).]

2-A. Reinsurance requirement.

[PL 2011, c. 90, Pt. B, §5 (RP); PL 2011, c. 90, Pt. B, §10 (AFF).]

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

A. A carrier's individual health plans are considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to section 2736, subsection 1 and section 2736-A. [PL 2011, c. 364, §7 (AMD).]

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing the calculation of rebates as required pursuant to the federal Affordable Care Act, except that the calculation must be based on a minimum medical loss ratio of 80% if the applicable federal minimum for the individual market in this State is lower. If the calculation indicates that rebates must be paid, the carrier must pay the rebates in the same manner as is required for rebates pursuant to the federal Affordable Care Act. [PL 2011, c. 364, §7 (AMD).]

[PL 2011, c. 364, §7 (AMD).]

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

A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A. Coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

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

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

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

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

A carrier that denies coverage in accordance with this subparagraph may not enroll individuals residing within the area subject to denial of coverage or groups or subgroups within that area for a period of 180 days after the date of the first denial of coverage. [PL 2011, c. 621, §1 (AMD).]

B. Renewal is guaranteed, pursuant to section 2850-B. [PL 1997, c. 445, §10 (RPR); PL 1997, c. 445, §32 (AFF).]

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

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

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

(3) The carrier complies with the rating practices requirements of subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

D. Notwithstanding paragraph A, carriers offering supplemental coverage for the Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are not required to issue this coverage if the applicant for insurance does not have CHAMPUS coverage. [PL 1999, c. 256, Pt. D, §1 (NEW).]

E. As part of the application process for individual health coverage, a carrier shall require an individual to complete the health statement developed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association pursuant to section 3955, subsection 1, paragraph E. A carrier may not deny coverage or refuse to renew or cancel an individual health plan on the basis of an individual's complete or incomplete health statement, claims history or risk scores or on the basis of any omission of material information from a health statement or misrepresentation of an individual's health status. The rejection of an application for individual health coverage by a carrier because an individual has not submitted a completed health statement is not a denial of coverage for the purposes of this paragraph. [PL 2011, c. 621, §1 (AMD).]

[PL 2011, c. 621, §1 (AMD).]

4. Cessation of business. Carriers that provide individual health plans after the effective date of this section that plan to cease doing business in the individual health plan market must comply with the following requirements.

A. Notice of the decision to cease doing business in the individual health plan market must be provided to the bureau 3 months prior to the cessation unless a shorter notice period is approved by the superintendent. If existing contracts are nonrenewed, notice must be provided to the policyholder or contract holder 6 months prior to nonrenewal. [PL 2001, c. 258, Pt. B, §1 (AMD).]

B. Carriers that cease to write new business in the individual health plan market continue to be governed by this section. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

C. Carriers that cease to write new business in the individual health plan market are prohibited from writing new business in that market for a period of 5 years from the date of notice to the superintendent unless the superintendent waives this requirement for good cause shown. [PL 2001, c. 258, Pt. B, §2 (AMD).]

[PL 2001, c. 258, Pt. B, §§1, 2 (AMD).]

5. Loss ratios. Except as provided in subsection 2-B, for all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the medical loss ratio calculated under section 4319 will be at least 80%.
[PL 2019, c. 5, Pt. A, §6 (AMD).]

6. Fair marketing standards. Carriers providing individual health plans must meet the following standards of fair marketing.

A. Each carrier must actively market individual health plan coverage to individuals in this State. [PL 2023, c. 405, Pt. A, §88 (AMD).]

B. A carrier or representative of the carrier may not directly or indirectly engage in the following activities:

(1) Encouraging or directing individuals to refrain from filing an application for coverage with the carrier because of any of the rating factors listed in subsection 2; or

(2) Encouraging or directing individuals to seek coverage from another carrier because of any of the rating factors listed in subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

C. A carrier may not directly or indirectly enter into any contract, agreement or arrangement with a representative of the carrier that provides for or results in the compensation paid to the representative for the sale of an individual health plan to be varied because of the rating factors listed in subsection 2. A carrier may enter into a compensation arrangement that provides compensation to a representative of the carrier on the basis of percentage of premium, provided that the percentage does not vary because of the rating factors listed in subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

D. A carrier may not terminate, fail to renew or limit its contract or agreement of representation with a representative for any reason related to the rating factors listed in subsection 2. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

E. Denial by a carrier of an application for coverage from an individual must be in writing and must state the reason or reasons for the denial. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

F. The superintendent may establish rules setting forth additional standards to provide for the fair marketing and broad availability of individual health plans in this State. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]

G. A violation of this section by a carrier or a representative of the carrier is an unfair trade practice under chapter 23. If a carrier enters into a contract, agreement or other arrangement with a 3rd-party administrator to provide administrative, marketing or other services related to the offering of individual health plans in this State, the 3rd-party administrator is subject to this section as if it were a carrier. [PL 1993, c. 477, Pt. C, §1 (NEW); PL 1993, c. 477, Pt. F, §1 (AFF).]
[PL 2023, c. 405, Pt. A, §88 (AMD).]

7. Applicability. This section applies to all policies, plans, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after December 1, 1993 with the exception of short-term contracts, as defined in section 2849-B. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.
[PL 1997, c. 445, §11 (AMD); PL 1997, c. 445, §32 (AFF).]

8. Authority of the superintendent.
[PL 2011, c. 90, Pt. F, §1 (RP).]

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

A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents; [PL 1995, c. 570, §7 (NEW).]

B. Rates for the association comply with the premium rate requirements of subsection 2 or are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any; [PL 1995, c. 570, §7 (NEW).]

C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%; [PL 1995, c. 570, §7 (NEW).]

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect; [PL 1995, c. 570, §7 (NEW).]

E. The association's group health plan is not marketed to the general public; [PL 1995, c. 570, §7 (NEW).]

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A; [PL 1995, c. 570, §7 (NEW).]

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and [PL 1995, c. 570, §7 (NEW).]

H. Granting an exemption to the association does not conflict with the purposes of this section. [PL 1995, c. 570, §7 (NEW).]

Except for individuals with grandfathered health plans under the federal Affordable Care Act, this subsection does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014.
[PL 2023, c. 405, Pt. A, §89 (AMD).]

10. Pilot projects; persons under 30 years of age. The superintendent shall authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers individual insurance, is marketing an individual insurance policy in this State and has a medical-loss ratio of at least 70% in the individual market to offer individual medical insurance products to persons under 30 years of age beginning July 1, 2009.

A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements. [PL 2007, c. 629, Pt. I, §1 (NEW).]

B. Notwithstanding any requirements in this Title for specific health services, specific diseases and certain providers of health care services, the superintendent may adopt minimum benefit requirements that exclude certain benefits if determined by the superintendent to provide affordable and attractive individual health plans for persons under 30 years of age. [PL 2007, c. 629, Pt. I, §1 (NEW).]

C. A pilot project approved by the superintendent pursuant to this subsection qualifies as creditable coverage under this Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under a pilot project approved under this subsection is not subject to any preexisting conditions exclusion provisions. Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates. [PL 2007, c. 629, Pt. I, §1 (NEW).]

D. Beginning in 2010, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any pilot project approved by the superintendent pursuant to this subsection. The report must include an analysis of the effectiveness of the pilot project in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the pilot project on the broader insurance market, including any impact on premiums and availability of coverage. [PL 2007, c. 629, Pt. I, §1 (NEW).]

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection. [PL 2007, c. 629, Pt. I, §1 (NEW).]

[PL 2007, c. 629, Pt. I, §1 (NEW).]

11. Open enrollment; rules. Notwithstanding subsection 3, on or after January 1, 2014, a carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods to the extent not inconsistent with applicable federal law. The superintendent may adopt rules establishing minimum open enrollment dates and minimum criteria for special enrollment periods for all individual health plans offered in this State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2019, c. 5, Pt. A, §7 (AMD).]

SECTION HISTORY

PL 1993, c. 477, Pt. C, §1 (NEW). PL 1993, c. 477, Pt. F, §1 (AFF). PL 1993, c. 546, §1 (AMD). PL 1993, c. 547, §3 (AMD). PL 1993, c. 645, §§A3, B2 (AMD). PL 1995, c. 177, §1 (AMD). PL 1995, c. 332, §§J2, K1 (AMD). PL 1995, c. 342, §§4, 5 (AMD). PL 1995, c. 570, §7 (AMD). PL 1997, c. 370, Pt. E, §§2-4 (AMD). PL 1997, c. 445, §§8-11 (AMD). PL 1997, c. 445, §32 (AFF). PL 1999, c. 44, §1 (AMD). PL 1999, c. 44, §2 (AFF). PL 1999, c. 256, §§C1, D1, 2 (AMD). RR 2001, c. 1, §30 (COR). PL 2001, c. 258, §§B1, 2, E2 (AMD). PL 2001, c. 410, Pt. A, §§1, 2 (AMD). PL 2001, c. 410, Pt. A, §10 (AFF). PL 2003, c. 428, Pt. H, §3 (AMD). PL 2003, c. 469, Pt. E, §§12, 13 (AMD). PL 2005, c. 493, §1 (AMD). PL 2007, c. 629, Pt. A, §§3-7 (AMD). PL 2007, c. 629, Pt. I, §1 (AMD). PL 2007, c. 629, Pt. M, §§4, 5 (AMD). PL 2011, c. 90, Pt. A, §§1-5 (AMD). PL 2011, c. 90, Pt. B, §§4-6 (AMD). PL 2011, c. 90, Pt. B, §10 (AFF). PL 2011, c. 90, Pt. D, §§2, 3 (AMD). PL 2011, c. 90, Pt. F, §1 (AMD). PL 2011, c. 238, Pt. D, §1 (AMD). PL 2011, c. 364, §§3-8 (AMD). PL 2011, c. 621, §1 (AMD). PL 2013, c. 271, §1 (AMD). PL 2019, c. 5, Pt. A, §§1-7 (AMD). PL 2019, c. 330, §1 (AMD). PL 2019, c. 330, §6 (AFF). PL 2021, c. 344, §1 (AMD). PL 2021, c. 655, §1 (AMD). PL 2023, c. 405, Pt. A, §§88, 89 (AMD).

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