132nd MAINE LEGISLATURE

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Legislative Document	**No. 519**
H.P. 337	House of Representatives, February 11, 2025

An Act to Remove the Requirement That Individual and Small Group Health Plans Be Offered Through a Pooled Market and to Eliminate the Provision of Law Establishing a Pooled Market for Those Plans

Received by the Clerk of the House on February 7, 2025. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT
Clerk

Presented by Representative MORRIS of Turner.
Cosponsored by Representatives: CIMINO of Bridgton, FLYNN of Albion, FOLEY of Wells, OLSEN of Raymond, Senator: HAGGAN of Penobscot.

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

Sec. 1. 24-A MRSA c. 34-B, headnote is amended by amending the chapter headnote to read:

CHAPTER 34-B

~~POOLED MARKET AND~~ CLEAR CHOICE DESIGN

Sec. 2. 24-A MRSA §2792, as amended by PL 2021, c. 361, §§1 and 2, is repealed.

Sec. 3. 24-A MRSA §2793, sub-§1, as amended by PL 2021, c. 361, §3, is further amended to read:

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

Sec. 4. 24-A MRSA §2793, sub-§2, as amended by PL 2021, c. 361, §3, is further amended to read:

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

Sec. 5. 24-A MRSA §2808-B, sub-§2-A, ¶B, as amended by PL 2019, c. 653, Pt. B, §4, is further amended to read:

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, paragraph B ~~or section 2792, subsection 2~~.

Sec. 6. 24-A MRSA §2808-B, sub-§2-A, ¶C, as amended by PL 2023, c. 59, §5, is further amended to read:

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C ~~or section 2792, as applicable,~~ for premium rates effective on or after July 1, 2004.

Sec. 7. 24-A MRSA §2808-B, sub-§2-B, as amended by PL 2023, c. 59, §§6 and 7, is further amended to read:

2-B. Rate review and hearings. Except as provided in subsection 2-C ~~and section 2792~~, rate filings are subject to this subsection.

A. Rates subject to this subsection must be filed for approval by the superintendent. The superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 75% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums.

B. 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 that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

Sec. 8. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2019, c. 653, Pt. B, §7, is further amended to read:

2-C. Guaranteed loss ratio. Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B~~, except as otherwise provided in section 2792~~. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is 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 subsection 2-B.

Sec. 9. 24-A MRSA §3958, as amended by PL 2021, c. 361, §5, is further amended to read:

§3958. Reinsurance; premium rates

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

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

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

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

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

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

~~(4) The board shall ensure that any surplus in the retrospective reinsurance program at the conclusion of a plan year is used to lower attachment points, increase coinsurance rates or both for that plan year, consistent with its responsibility to ensure that the program operates on an actuarially sound basis.~~

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

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C, together with any additional rating factors the association determines to be appropriate. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that, together with other funds available to the association, will be sufficient to meet the anticipated costs of the association. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer. ~~This subsection does not apply to reinsurance with respect to any calendar year for which the association operates a retrospective reinsurance program under subsection 1, paragraph A-1. With the approval of the superintendent, the association's plan of operation for a retrospective reinsurance program may include a provision for charging premium on an equitable basis to all member insurers.~~

Sec. 10. 24-A MRSA §3959, sub-§5, as enacted by PL 2019, c. 653, Pt. B, §20, is repealed.

SUMMARY

This bill repeals the provisions of the Maine Insurance Code that establish a pooled market for individual and small group health plans, removing the requirement that those types of plans must be offered through a pooled market. The bill also eliminates related provisions that require the Maine Guaranteed Access Reinsurance Association to operate a retrospective reinsurance program providing coverage to member insurers for all individual and small group health plans issued in any plan year in which a pooled market is operating.