B

L.D. 1890

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INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

123RD LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "B" to H.P. 1322, L.D. 1890, Bill, "An Act To Make Health Care Affordable, Accessible and Effective for All"

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

'**PART A**

Sec. A-1. 24-A MRSA §2808-B, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §3 and affected by §10, is further amended to read:

C. A carrier may vary the premium rate due to family membership, smoking status, participation in wellness programs in accordance with section 4303, subsection 12 and group size for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts pursuant to this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~II-A~~ 2-A.

Sec. A-2. 24-A MRSA §2839, as amended by PL 2003, c. 428, Pt. E, §2, is further amended by adding at the end a new paragraph to read:

A carrier may vary the premium rate due to participation in wellness programs in accordance with section 4303, subsection 12 for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008.

Sec. A-3. 24-A MRSA §4303, sub-§12 is enacted to read:

12. Wellness program. A carrier offering a health plan in this State shall develop and maintain a wellness program for enrollees in small group and group health plans. A carrier shall offer enrollees that participate in a wellness program a financially tangible benefit, including, but not limited to, a discount in premium pursuant to section 2808-B,

subsection 2, paragraph C. A carrier shall report before January 1st annually to the superintendent, in the manner and format approved by the superintendent, on the wellness program offered by the carrier, the financial benefits provided to enrollees, including premium discounts, and the number of enrollees participating in the wellness program. On or before April 1st annually, the superintendent shall compile the data submitted by carriers as required in this subsection and submit that data in aggregate for all carriers to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the Maine Quality Forum established in section 6951.

PART B

Sec. B-1. 24-A MRSA §2736-C, sub-§8, as amended by PL 1999, c. 256, Pt. D, §2, is further amended to read:

8. Authority of the superintendent. The superintendent ~~may~~ shall by rule define one or more standardized individual health plans that must be offered by all carriers offering individual health plans in the State, other than carriers offering only CHAMPUS supplemental coverage. One of the plans defined by rule under this section must be a plan that includes a $1,000 deductible, a prescription drug benefit not subject to a deductible and the option of no cap on the lifetime maximum benefit.

PART C

Sec. C-1. 24-A MRSA §4303, sub-§1, as amended by PL 2007, c. 199, Pt. B, §5, is further amended to read:

1. Demonstration of adequate access to providers. Except as provided in ~~paragraph A~~ paragraphs A-1 and B, a carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent. These standards must consider the geographical and transportational problems in rural areas. All managed care plans covering residents of this State must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

A. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

(1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;

(2) The health plan is consistent with product design guidelines for Bureau of Insurance Rule Chapter 750;

(3) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;

(4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;

(5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent may consult with other state entities, including the Department of Health and Human Services, Bureau of Health and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph. The superintendent shall provisionally adopt rules by January 1, 2004 regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph and present those rules for legislative review during the Second Regular Session of the 121st Legislature; and

(6) The financial provisions may not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.

This paragraph takes effect January 1, 2004 and is repealed July 1, 2009.

A-1. Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

(1) The entire network meets overall access standards pursuant to Bureau of Insurance Rule Chapter 850;

(2) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined in Bureau of Insurance Rule Chapter 850;

(3) The financial provisions apply to all of the enrollees covered under the carrier's health plan;

(4) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent may consult with other state entities, including the Department of Health and Human Services and the Maine Quality Forum established in section 6951, to determine whether the carrier has met the requirements of this subparagraph; and

(5) The financial provisions do not permit travel at a distance that exceeds the standards established in Bureau of Insurance Rule Chapter 850 for mileage and travel time by 100%.

B. Notwithstanding paragraph A-1, a carrier may develop and file with the superintendent for approval a pilot program that does not adhere to any geographic access requirements set forth in this Title or in rules adopted by the superintendent. Any carrier offering a health plan using this pilot program must collect data on the impact of the pilot program on premiums paid by enrollees, payments made to providers, quality of care received and access to health care services by individuals enrolled in health plans under the pilot program and must submit that data to the superintendent. The superintendent shall report annually beginning January 15, 2009 to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on any approval of a pilot program pursuant to this paragraph.

PART D

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

3. Guaranteed issuance and guaranteed renewal. Carriers providing individual health plans must offer all health plans approved by the Maine Individual High-risk Reinsurance Pool Association pursuant to section 3908, subsection 1 beginning on or after January 1, 2009 as a condition of offering individual health plans in this State. Carriers must meet the following requirements on issuance and renewal.

A. Coverage issued through the Maine Individual High-risk Reinsurance Pool Association established pursuant to chapter 54 must be guaranteed to all residents of this State eligible for coverage pursuant to section 3910 other than those eligible without paying a premium for Medicare Part A. On or after January 1, 1998, such 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, such 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 paragraph 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.

B. Renewal is guaranteed for all individual health plans, pursuant to section 2850-B.

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.

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.

E. An individual may not be denied coverage under any individual health plan due to age or gender. This paragraph may not be construed to require a carrier to actively market health insurance to an individual 65 years of age or older.

Sec. D-2. 24-A MRSA c. 54 is enacted to read:

CHAPTER 54

MAINE INDIVIDUAL HIGH-RISK REINSURANCE POOL ASSOCIATION

§3901. Short title

This chapter may be known and cited as "the Maine Individual High-risk Reinsurance Pool Association Act."

§3902. Definitions

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

1. Association. "Association" means the Maine Individual High-risk Reinsurance Pool Association established in section 3903.

2. Board. "Board" means the board of directors of the association.

3. Covered person. "Covered person" means an individual resident of this State, exclusive of dependents, who:

A. Is eligible to receive benefits from an insurer;

B. Is eligible for benefits under the federal Health Insurance Portability and Accountability Act of 1996; or

C. Has been certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002.

4. Dependent. "Dependent" means a resident spouse, a domestic partner as defined in section 2832-A, subsection 1, a resident unmarried child under 19 years of age, a child who is a student under 23 years of age and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

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

6. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. "Insurer" includes an insurance company, nonprofit hospital and medical service organization, fraternal benefit society, health maintenance organization, self-insurance arrangement that provides health care benefits in this State to the extent allowed under the federal Employee Retirement Income Security Act of 1974, 3rd-party administrator, multiple-employer welfare arrangement, any other entity providing medical insurance or health benefits subject to state insurance regulation, any reinsurer reissuing health insurance in this State or the Dirigo Health Program established in chapter 87 or any other state-run or state-sponsored health benefit program, whether fully insured or self-funded.

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

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

9. Producer. "Producer" means a person who is licensed to sell health insurance in this State.

10. Reinsurer. "Reinsurer" means an insurer from whom a person providing health insurance for a resident procures insurance for itself with the insurer with respect to all or

part of the medical insurance risk of the person. "Reinsurer" includes an insurer that provides employee benefits excess insurance.

11. Resident. "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2. "Resident" includes an individual who is legally domiciled in this State on the date of application to the plan and has been certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002.

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

§3903. Maine Individual High-risk Reinsurance Pool Association

1. Risk pool established. The Maine Individual High-risk Reinsurance Pool Association is established as a nonprofit legal entity. As a condition of doing business, every insurer that has sold medical insurance within the previous 12 months or is actively marketing a medical insurance policy in this State shall participate in the association. The Dirigo Health Program established in chapter 87 and any other state-run or state-sponsored health benefit program shall also participate in the association.

2. Board of directors. The association is governed by a board of directors in accordance with this subsection.

A. The board consists of 11 members appointed pursuant to this paragraph:

(1) Six members appointed by the superintendent, of whom:

(a) Two members must be chosen from the general public and may not be associated with the medical profession, a hospital or an insurer;

(b) Two members must represent medical providers;

(c) One member must represent health insurance producers; and

(d) One member must represent a statewide association representing small businesses that receives the majority of its funding from persons and businesses in the State.A board member appointed by the superintendent may be removed at any time without cause; and

(2) Five members appointed by insurers belonging to the association, at least 2 of whom are domestic insurers and at least one of whom is a 3rd-party administrator.

B. Members serve terms of 3 years.

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

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

3. Plan of operation; rules. The association shall adopt a plan of operation in accordance with the requirements of this chapter and submit its articles, bylaws and operating rules to the superintendent for approval. If the association fails to adopt the plan

of operation and suitable articles and bylaws within 90 days after the appointment of the board, the superintendent shall adopt rules to effectuate the requirements of this chapter, and those rules remain in effect until superseded by a plan of operation and articles and bylaws submitted by the association and approved by the superintendent. Rules adopted pursuant to this subsection by the superintendent are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

4. Immunity. A board member is not liable and is immune from suit at law or equity for any conduct performed in good faith that is within the subject matter over which the board has been given jurisdiction.

§3904. Liability and indemnification

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

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

§3905. Duties and powers of the association

1. Duties. The association shall:

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

B. Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board;

C. Select a plan administrator in accordance with section 3906;

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

E. Collect assessments as provided in section 3907. The level of payments must be established by the board. Assessments must be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments must be equal in amount for all insurers but may not exceed $500 per insurer for all such assessments. Assessments are due and payable within 30 days of receipt of the assessment notice by the insurer; and

F. Comply with all reserve requirements and solvency requirements applicable to insurers that offer fully insured products in the event that the association offers a self-funded health plan.

2. Powers. The association may:

A. Exercise powers granted to insurers under the laws of this State;

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

C. Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the association;

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

E. Define the health benefit plans for which reinsurance will be provided under this chapter;

F. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy or other contract design and any other function within the authority of the association;

G. Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default must be legal investments for insurers and may be carried as admitted assets;

H. Establish rules, conditions and procedures for reinsuring risks of insurers under the pool in accordance with section 3909;

I. Provide for reinsurance of risks incurred by the association. The provision of reinsurance may not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers; and

J. Apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk reinsurance pools.

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

4. Review for solvency. The superintendent shall review the operations of the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to increase its assessments. If the superintendent determines that the funds of the association are insufficient, the superintendent may order the association to charge an additional assessment.

5. Annual report. The association shall report annually to the joint standing committee of the Legislature having jurisdiction over health insurance matters by March 15th. The report must include information on the benefits and rate structure of coverage offered by the association, the financial solvency of the association and the administrative expenses of the association.

6. Audit. The association must be audited at least every 3 years. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

§3906. Selection of plan administrator

1. Selection of plan administrator. The board shall select an insurer or 3rd-party administrator, through a competitive bidding process, to administer the association.

2. Contract with plan administrator. The plan administrator selected pursuant to subsection 1 is contracted for a period of 3 years. At least one year prior to the expiration of each 3-year period of service by a plan administrator, the board shall invite all insurers, including the current plan administrator, to submit bids to serve as the plan administrator for the succeeding 3-year period. The selection of the plan administrator for the succeeding period must be made at least 6 months prior to the expiration of the 3-year period.

3. Duties of plan administrator. The plan administrator selected pursuant to subsection 1 shall:

A. Perform all administrative functions relating to the association;

B. Pay a producer's referral fee if established by the board to each producer who refers an applicant to the plan, if the applicant's application is accepted. The selling or marketing of policies approved by the association is not limited to the plan administrator or its producers. The plan administrator shall pay the referral fees from funds received as premiums for the plan;

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

D. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expenses of administration pertaining to the reinsurance operations of the association and the incurred losses of the year and report this information to the superintendent; and

E. Pay reinsurance amounts as provided for in the plan of operation.

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

§3907. Assessments against insurers

1. Assessments. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess member insurers at such a time and for such amounts as the board finds necessary. Assessments are due not less

than 30 days after written notice to the member insurers and accrue interest at 12% per annum on and after the due date.

2. Maximum assessment. Each insurer must be assessed by the board an amount not to exceed $2 per covered person insured or reinsured by each insurer per month for medical insurance. An insurer may not be assessed on policies or contracts insuring federal or state employees.

3. Determination of assessment. The board shall make reasonable efforts to ensure that each covered person is counted only once with respect to an assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all individuals whose coverage is insured, in whole or in part, through excess or stop loss coverage. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this subsection. The board may verify each insurer's assessment based on annual statements and other reports determined to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

4. Excess funds. If assessments and other receipts by the association, board or plan administrator exceed the actual losses and administrative expenses of the plan, the board shall hold the excess as interest and may use those excess funds to offset future losses or to reduce plan premiums. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

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

6. Net losses; additional assessments. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess member insurers at such a time and for such amounts as the board finds necessary to cover any net loss in accordance with this subsection.

A. Prior to April 1st of each year, the association shall determine and report to the superintendent the association's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses and an estimate of the assessments needed to fund the loss incurred by the association in the previous calendar year.

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

C. The association shall impose a penalty of interest for late payment of assessments.

§3908. Requirements for coverage

1. Approved coverage. The association shall approve a choice of 2 or more coverage options for which reinsurance is available through the association. Policies approved by the association must be available for sale beginning on January 1, 2009. At least one coverage option must be a standardized health plan as defined in Bureau of Insurance Rule Chapter 750. Any person whose medical insurance coverage is involuntarily terminated for any reason other than nonpayment of premiums may apply for coverage under the plan. If such coverage is applied for within 90 days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage is the date of termination of the previous coverage.

2. Rates. Rates for coverage approved by the association must meet the requirements of this subsection.

A. Rates may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

B. Rate schedules must comply with section 2736-C and are subject to approval by the superintendent.

C. Standard risk rates for coverage issued by the association must be established by the association, subject to approval by the superintendent, using reasonable actuarial techniques, and must reflect anticipated experiences and expenses of such coverage for standard risks. The premium for the standard risk rates must range from a minimum of 125% to a maximum of 150% of the weighted average of rates charged by those insurers and health maintenance organizations with individuals enrolled in similar medical insurance plans.

3. Compliance with state law. Products approved by the association must comply with all relevant requirements of this Title applicable to individual health insurance policies, including requirements for mandated coverage for specific health services, for specific diseases and for certain providers of health care services.

§3909. Reinsurance; premium rates

1. Reinsurance amount. Any insurer offering the coverage options approved by the association pursuant to section 3908, subsection 1 must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for the reinsurance premium rate established in accordance with subsection 2.

A. The association may not reimburse a reinsuring insurer with respect to claims of a reinsured person until the insurer has incurred an initial level of claims for that person of $5,000 for covered benefits in a calendar year. In addition, the reinsuring insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The association shall reimburse reinsuring insurers for claims paid in excess of $25,000. The association may annually adjust the initial level of claims and the maximum limit to be retained by the reinsuring insurer to reflect increases in costs and utilization within the standard market for health plans within the State. The adjustments may not be less than the annual change in the medical component of the Consumer Price Index unless the superintendent approves a lower adjustment factor as requested by the association.

B. A reinsuring 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.

2. Premium rates. The association may charge reinsuring insurers premium rates established in accordance with this subsection. The association, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged reinsuring 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. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that reasonably approximate gross premiums charged for individual health plans with similar benefits to the coverage options approved by the association pursuant to section 3908, subsection 1 and that are adjusted to reflect retention levels required under this Title. 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 a reinsuring insurer.

§3910. Eligibility for coverage

1. Eligibility; application for coverage. A resident is eligible for coverage under the plan if evidence is provided of rejection, a requirement of restrictive riders, a rate increase or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one insurer belonging to the association within 6 months of the date of the certificate, or if the resident meets other eligibility requirements adopted by rule by the superintendent that are not inconsistent with this chapter and that indicate that a person is unable to obtain coverage substantially similar to that which may be obtained by a person who is considered a standard risk. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

2. Change of domicile. The board shall develop standards for eligibility for coverage by the association for any natural person who changes that person's domicile to this State and who at the time domicile is established in this State is insured by an organization similar to the association. The eligible maximum lifetime benefits for that covered person may not exceed the lifetime benefits available through the association, less any benefits received from a similar organization in the former domiciliary state.

3. Eligibility without application. The board shall develop a list of medical or health conditions for which a person is eligible for plan coverage without applying for health insurance under subsection 1. A person who can demonstrate the existence or history of a medical or health condition on the list developed by the board may not be required to provide the evidence specified in subsection 1. The board may amend the list from time to time as appropriate.

4. Exclusions from eligibility. A person is not eligible for coverage under the plan if:

A. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy or would be eligible to have coverage if the person elected to obtain it, except that:

(1) A person may maintain other coverage for the period of time the person is satisfying a preexisting condition waiting period under a plan policy; and

(2) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

B. The person is determined eligible for health care benefits under the MaineCare program pursuant to Title 22;

C. The person previously terminated plan coverage, unless 6 months have elapsed since the person's last termination;

D. The person is an inmate or resident of a public institution; or

E. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

5. Termination of coverage. The coverage of any person ceases:

A. On the date a person is no longer a resident;

B. Upon the death of the covered person;

C. On the date state law requires cancellation of the policy; or

D. At the option of the association, 30 days after the association makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately.

6. Unfair trade practice. It constitutes an unfair trade practice for any insurer, producer, employer or 3rd-party administrator to refer an individual employee or a dependent of an individual employee to the association or to arrange for an individual employee or a dependent of an individual employee to apply to the plan for the purpose of separating such an employee or dependent from a group health benefits plan provided in connection with the employee's employment.

§3911. Actions against association or members based upon joint or collective actions

Participation in the association, the establishment of rates, forms or procedures or any other joint or collective action required by this chapter may not be the basis of any legal

action or criminal or civil liability or penalty against the association or any insurer belonging to the association.

§3912. Reimbursement of insurers

1. Reimbursement. An insurer may seek reimbursement from the association and the association shall reimburse the insurer to the extent claims made by a member after January 1, 2009 exceed premiums paid on a calendar year basis by the member to the insurer for a member who meets the following criteria:

A. The insurer sold an individual health plan to the member between December 1, 1993 and December 31, 2008, and the policy that was sold has been continuously renewed by the member;

B. The insurer is able to determine through the use of individual health statements, claims history or any reasonable means that at any time while the policy was in effect, the member was diagnosed with one of the following medical conditions: acquired immune deficiency syndrome, angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open-heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia or Wilson's disease; and

C. The insurer has closed its book of business for individual health plans sold prior to January 1, 2009.

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

Sec. D-3. Maine Individual High-risk Reinsurance Pool Association; staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 3903, subsection 2, paragraph B, the terms for initial appointments to the Maine Individual High-risk Reinsurance Pool Association are as follows. Of those members of the board appointed by the superintendent, 2 members serve for a term of one year, 2 members for a term of 2 years and 2 members for a term of 3 years. Of those members appointed by insurers, one member serves for a term of one year, one member serves for a term of 2 years and one member serves for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

PART E

Sec. E-1. 24-A MRSA §2736-C, sub-§2, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

B. A carrier may not vary the premium rate due to the gender, ~~health status,~~ claims experience or policy duration of the individual. A carrier may vary the premium rate based on health status, age, occupation or industry and geographic area only as permitted in paragraph D.

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

D. A carrier may vary the premium rate due to age, health status, occupation or industry and geographic area ~~only under the following schedule and within the listed percentage bands~~ in accordance with the limitations set out in this paragraph.

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

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

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

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after January 1, 2008, the maximum rate differential filed by the carrier for age, occupation or industry or geographic area as determined by ratio is 4 to one. The limitation does not apply for determining rates for an attained age of less than 19 or more than 65 years.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after January 1, 2008, the maximum rate differential filed by the carrier for health status as determined by ratio is 1.5 to one.

(6) A variation in rate is not permitted on the basis of changes in health status after a policy, contract or certificate is issued or renewed.

Sec. E-3. 24-A MRSA §2736-C, sub-§2, ¶G is enacted to read:

G. A carrier that offered individual health plans prior to January 1, 2008 may close its individual book of business sold prior to January 1, 2008 and may establish a separate community rate for individuals applying for coverage under an individual health plan after January 1, 2008.

PART F

Sec. F-1. 24-A MRSA §423-D, sub-§3 is enacted to read:

3. Report by superintendent. The superintendent shall report each year by March 1st to the joint standing committee of the Legislature having jurisdiction over insurance matters on the impact of changes to the rating provisions in section 2736-C and the establishment of the Maine Individual High-risk Reinsurance Pool Association pursuant

to chapter 54, the total number of individuals enrolled in any health insurance product regulated by the bureau and the number of previously uninsured individuals who have enrolled during that year in any health insurance product regulated by the bureau, which information is collected pursuant to rules adopted under this section.

PART G

Sec. G-1. 24-A MRSA §6908, sub-§1, ¶K, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

K. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; ~~and~~

Sec. G-2. 24-A MRSA §6908, sub-§1, ¶L, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

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

Sec. G-3. 24-A MRSA §6908, sub-§1, ¶M is enacted to read:

M. Establish and administer grant, subsidy and facilitation programs designed to assist providers and health care practitioners in the development, enhancement and maintenance of quality improvement infrastructure and processes. Dirigo Health may solicit and collect contributions to fund these programs.

PART H

Sec. H-1. 24-A MRSA §6908, sub-§1, ¶N is enacted to read:

N. Provide subsidies for eligible enrollees covered under health benefit plans approved by the board pursuant to section 6910, subsection 3, paragraph A that are offered by multiple licensed health insurance carriers in the State.

Sec. H-2. 24-A MRSA §6910, sub-§3, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

3. Carrier participation requirements. To qualify as a carrier of Dirigo Health Program coverage, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has

contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.

Health insurance carriers that seek to qualify to provide Dirigo Health Program coverage ~~must~~ may also qualify as health plans in Medicaid.

Sec. H-3. 24-A MRSA §6910, sub-§4, ¶B, as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health Program for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) The Dirigo Health Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health Program and that

the employer group otherwise meets the minimum participation requirements specified by section 2808-B, subsection 4, paragraph A.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

(9) Dirigo Health may provide participating employers assistance to adopt and maintain a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 United States Code, Section 125.

Sec. H-4. 24-A MRSA §6912, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

PART I

Sec. I-1. 22 MRSA §1721 is enacted to read:

§1721. Voluntary restraint

1. Voluntary restraint. To control the rate of growth of the costs of hospital services, each hospital licensed under chapter 405 may voluntarily restrain cost increases and consolidated operating margins in accordance with this section. Each hospital shall annually report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding its efforts made pursuant to this section. The targets and methodology apply to each hospital's fiscal year beginning on or after July 1, 2008.

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this section, a hospital's consolidated operating margin is calculated by dividing its consolidated operating income by its total consolidated operating revenue.

B. Each hospital may voluntarily restrain its increase in its expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge to no more than 110% of the forecasted increase in the hospital market basket index for the coming federal fiscal year, as published in the Federal Register, when the federal Centers for Medicare and Medicaid Services publishes the Medicare program's hospital inpatient prospective payment system rates for the coming federal fiscal year. For purposes of this paragraph, the measure of a hospital's expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge is calculated by:

(1) Calculating the hospital's total hospital-only expenses;

(2) Subtracting from the hospital's total hospital-only expenses the amount of the hospital's bad debt;

(3) Subtracting from the amount reached in subparagraph (2) the hospital taxes paid to the State during the hospital's fiscal year; and

(4) Dividing the amount reached in subparagraph (3) by the product of:

(a) The number of inpatient discharges, adjusted by the all payer case mix index for the hospital; and

(b) The ratio of total gross patient service revenue to gross inpatient service revenue.

For the purposes of this paragraph, a hospital's total hospital-only expenses include any item that is listed on the hospital's Medicare cost report as a subprovider, such as a psychiatric unit or rehabilitation unit, and does not include nonhospital cost centers shown on the hospital's Medicare cost report, such as home health agencies, nursing facilities, swing beds, skilled nursing facilities and hospital-owned physician practices. For purposes of this paragraph, a hospital's bad debt is as defined and reported in the hospital's Medicare cost report and as submitted to the Maine Health Data Organization pursuant to Title 22, chapter 1683.

PART J

Sec. J-1. 24-A MRSA §2736, sub-§3, ¶B, as amended by PL 2003, c. 469, Pt. E, §9, is further amended to read:

B. The insurer must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. J-2. 24-A MRSA §2736, sub-§4, ¶C, as amended by PL 2003, c. 469, Pt. E, §10, is further amended to read:

C. In any hearing conducted under this subsection, the Bureau of Insurance and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate~~,~~ and not unfairly discriminatory ~~and in compliance with the requirements of section 6913~~ remains with the insurer.

Sec. J-3. 24-A MRSA §2736-A, first ¶, as amended by PL 2003, c. 469, Pt. E, §11, 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~~,~~ and 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.

Sec. J-4. 24-A MRSA §2736-C, sub-§2, ¶F, as enacted by PL 2003, c. 469, Pt. E, §12, is repealed.

Sec. J-5. 24-A MRSA §2736-C, sub-§5, as amended by PL 2003, c. 469, Pt. E, §13, is further amended to read:

5. Loss ratios. 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 aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% 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. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. J-6. 24-A MRSA §2808-B, sub-§2-A, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is 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 for premium rates effective on or after July 1, 2004~~, except that the filing of rates for small group health plans are not required to account for any savings offset payment or any recovery of that offset payment pursuant to subsection 2-B, paragraph D and section 6913 for rates effective before July 1, 2005~~.

Sec. J-7. 24-A MRSA §2808-B, sub-§2-B, ¶A, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

A. 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. ~~For the purposes of this calculation, any savings offset payments paid pursuant to section 6913 must be treated as incurred claims.~~

Sec. J-8. 24-A MRSA §2808-B, sub-§2-B, ¶D, as enacted by PL 2003, c. 469, Pt. E, §16, is repealed.

Sec. J-9. 24-A MRSA §2808-B, sub-§2-B, ¶F, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

F. Any rate hearing conducted with respect to filings that meet the criteria in paragraph E is subject to this paragraph.

(1) A person requesting a hearing shall provide the superintendent with a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(2) If the superintendent decides to hold a hearing, the superintendent shall issue a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in paragraph E.

(3) In any hearing conducted under this paragraph, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate~~,~~ and not unfairly discriminatory ~~and in compliance with the requirements of section 6913~~ remains with the carrier.

Sec. J-10. 24-A MRSA §2839-B, sub-§2, as enacted by PL 2003, c. 469, Pt. E, §17, is amended to read:

2. Annual filing. Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. ~~The filing must also certify that the carrier has included in its experience any savings offset payments or recovery of those savings offset payments consistent with section 6913.~~ The filing also must state the number of policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 1, section 402, subsection 3.

Sec. J-11. 24-A MRSA §6908, sub-§2, ¶B, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

Sec. J-12. 24-A MRSA §6913, as amended by PL 2005, c. 683, Pt. A, §§43 and 44, is repealed.

Sec. J-13. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, ~~any savings offset payments made pursuant to section 6913~~ any funds appropriated from the General Fund and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. J-14. 24-A MRSA §6951, first ¶, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within Dirigo Health. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded~~, at least in part, through the savings offset payments made pursuant to section 6913~~ within the limitations of available funds. Except as provided in section 6907,

subsection 2, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

PART K

Sec. K-1. 24-A MRSA §2735-A, sub-§1, as enacted by PL 2001, c. 432, §4, is 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 notice must also inform policyholders of their right to request a hearing pursuant to section 229 ~~or a special rate hearing pursuant to section 2736, subsection 4 or Title 24, section 2321, subsection 5~~. The notice must show the proposed rate and state that the rate is subject to regulatory approval. 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. K-2. 24-A MRSA §2736, sub-§1, as amended by PL 2003, c. 428, Pt. F, §2, is further amended to read:

1. Filing of rate information. Every insurer shall file with the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. Every such filing must state the effective date of the filing. Every such filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. ~~In the case of a filing that meets the criteria in subsection 3, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the organization satisfactorily responds to any reasonable discovery requests.~~ '

SUMMARY

Part A requires carriers to offer a wellness program in all small group and group health plans. The Part requires that carriers offer enrollees participating in the wellness program a financially tangible benefit, including a premium discount. The Part also requires that carriers report annually to the Superintendent of Insurance about the wellness programs offered to enrollees and that the superintendent report aggregate data from carriers to the Legislature and to the Maine Quality Forum.

Part B requires that all insurers in the individual market offer a plan that includes a $1,000 deductible, a prescription drug benefit not subject to a deductible and the option of no cap on the lifetime maximum benefit.

Part C extends the provision allowing carriers to lower premium costs by including financial incentives to members to use designated providers and gives the Superintendent of Insurance the authority to develop a financial incentive pilot program that allows companies to offer products in which consumers can choose to travel further for cost savings and better quality.

Part D establishes a reinsurance pool for the individual health insurance market and is modeled on a similar reinsurance pool in Idaho. The Part requires insurers that provide medical insurance as defined in the bill to pay an assessment of up to $2 per covered person per month to partially support the costs of the reinsurance pool. The Part requires all individual carriers to guarantee issue of all health plans approved by the high-risk reinsurance pool as a condition of offering individual health plans in this State.

Part E allows a maximum rate differential for individual health plans on the basis of age, occupation or industry and geographic area of 4:1 and a maximum rate differential on the basis of health status and tobacco use of 1.5:1.

Part F requires the Superintendent of Insurance to report yearly to the Legislature the impact of changes to the rating provisions in Title 24-A, section 2736-C and the establishment of the Maine Individual High-risk Reinsurance Pool pursuant to Title 24-A, chapter 54, the total number of individuals enrolled in any health insurance product regulated by the Bureau of Insurance and the numbers of previously uninsured individuals who have enrolled in any health insurance product regulated by the Bureau of Insurance.

Part G allows Dirigo Health to administer grants and other subsidies to strengthen the State's health care quality improvement infrastructure.

Part H allows Dirigo Health to subsidize approved plans provided by multiple carriers. This Part allows Dirigo Health to assist employers in establishing payroll deduction systems that would help employees purchase health coverage with pre-tax dollars.

Part I makes permanent, beginning on or after July 1, 2008, the temporary voluntary cost containment targets on hospital consolidated operating margins and cost increases, which were initiated in Public Law 2003, chapter 469, Part F, section 1 and which otherwise would expire.

Part J repeals the savings offset payment as a source of funding for Dirigo Health.

Part K corrects cross-references.

FISCAL NOTE REQUIRED
(See attached)

Revised: 06/18/07 mac

123rd MAINE LEGISLATURE

LD 1890 **LR 2620(03)**

An Act To Make Health Care Affordable, Accessible and Effective for All

Fiscal Note for Bill as Amended by Committee Amendment " B "
Committee: Insurance and Financial Services
Fiscal Note Required: Yes

Fiscal Note

Potential current biennium cost increase - General Fund
Minor cost increase - Other Funds

	2007-08	2008-09	Projections 2009-10	Projections 2010-11
Revenue				
Dirigo Health Fund	$0	($13,720,000)	($34,300,000)	($34,300,000)

Fiscal Detail and Notes

The fiscal note assumes the bill would eliminate the Saving Offset Payment (SOP), one of the funding sources for the Dirigo Health Program, beginning with the assessment effective July 1, 2008. For the purposes of this fiscal note, the baseline assumption for future year SOP's is the $34.3 million SOP assessed for the year beginning July 1, 2007. For the first year of the SOP elimination, fiscal year 2008-09, only 40% of the new SOP is assumed to be collected,and therefore lost, in that year. The Dirigo Health Program does have existing authority to keep program spending within exiting resources but what actions would be taken cannot be determined at this time.

The bill would authorize the Dirigo Health Enterprise Funds to accept funds appropriated from the General Fund. When combined with the elimination of the savings offset payment, this creates the potential for a cost to the General Fund although no funds are actually appropriated or transferred for this purpose.

The additional costs to the Bureau of Insurance in the Department of Professional and Financial Regulation can be absorbed by the bureau utilizing existing budget resources. Additional costs to the Dirigo Health Program can be absorbed by the program utilizing existing budget resources and existing authority to modify its program structure. The fiscal note assumes the Maine Individual High-Risk Reinsurance Pool Association is created in the bill as a nonprofit, non-governmental legal entity so that the costs and assessment created to fund the association do not have a state fiscal impact.