

# MAINE STATE LEGISLATURE

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L.D. 1890

Date: 06-21-07

(Filing No. S-380)

Reproduced and distributed under the direction of the Secretary of the Senate.

STATE OF MAINE  
SENATE  
123RD LEGISLATURE  
FIRST REGULAR SESSION

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

Amend the amendment by striking out everything after the title and before the summary and inserting the following:

'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 H-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

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1 benefit, including, but not limited to, a discount in premium pursuant to section 2808-B,  
2 subsection 2, paragraph C. A carrier shall report before January 1st annually to the  
3 superintendent, in the manner and format approved by the superintendent, on the wellness  
4 program offered by the carrier, the financial benefits provided to enrollees, including  
5 premium discounts, and the number of enrollees participating in the wellness program.  
6 On or before April 1st annually, the superintendent shall compile the data submitted by  
7 carriers as required in this subsection and submit that data in aggregate for all carriers to  
8 the joint standing committee of the Legislature having jurisdiction over insurance and  
9 financial services matters and to the Maine Quality Forum established in section 6951.

10

**PART B**

11 **Sec. B-1. 24-A MRS §2736-C, sub-§8**, as amended by PL 1999, c. 256, Pt. D,  
12 §2, is further amended to read:

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

19

**PART C**

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

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

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

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

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

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

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- 1 (4) The financial provisions may apply to all of the enrollees covered under the
- 2 carrier's health plan;
- 3 (5) The carrier establishes to the satisfaction of the superintendent that the
- 4 financial provisions permit the provision of better quality services and the quality
- 5 improvements either significantly outweigh any detrimental impact to covered
- 6 persons forced to travel longer distances to access services, or the carrier has
- 7 taken steps to effectively mitigate any detrimental impact associated with
- 8 requiring covered persons to travel longer distances to access services. The
- 9 superintendent may consult with other state entities, including the Department of
- 10 Health and Human Services, Bureau of Health and the Maine Quality Forum
- 11 established in section 6951, to determine whether the carrier has met the
- 12 requirements of this subparagraph. The superintendent shall provisionally adopt
- 13 rules by January 1, 2004 regarding the criteria used by the superintendent to
- 14 determine whether the carrier meets the quality requirements of this subparagraph
- 15 and present those rules for legislative review during the Second Regular Session
- 16 of the 121st Legislature; and
- 17 (6) The financial provisions may not permit travel at a distance that exceeds the
- 18 standards established in Bureau of Insurance Rule Chapter 850 for mileage and
- 19 travel time by 100%.

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

21 A-1. Upon approval of the superintendent, a carrier may offer a health plan that

22 includes financial provisions designed to encourage members to use designated

23 providers in a network if:

- 24 (1) The entire network meets overall access standards pursuant to Bureau of
- 25 Insurance Rule Chapter 850;
- 26 (2) The health plan does not include financial provisions designed to encourage
- 27 members to use designated providers of primary, preventive, maternity,
- 28 obstetrical, ancillary or emergency care services, as defined in Bureau of
- 29 Insurance Rule Chapter 850;
- 30 (3) The financial provisions apply to all of the enrollees covered under the
- 31 carrier's health plan;
- 32 (4) The carrier establishes to the satisfaction of the superintendent that the
- 33 financial provisions permit the provision of better quality services and the quality
- 34 improvements either significantly outweigh any detrimental impact to covered
- 35 persons forced to travel longer distances to access services or the carrier has
- 36 taken steps to effectively mitigate any detrimental impact associated with
- 37 requiring covered persons to travel longer distances to access services. The
- 38 superintendent may consult with other state entities, including the Department of
- 39 Health and Human Services and the Maine Quality Forum established in section
- 40 6951, to determine whether the carrier has met the requirements of this
- 41 subparagraph; and

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

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

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

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

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

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

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

17 D. Notwithstanding paragraph A, carriers offering supplemental coverage for the  
18 Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, are  
19 not required to issue this coverage if the applicant for insurance does not have  
20 CHAMPUS coverage.

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

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

25 **CHAPTER 54**

26 **MAINE INDIVIDUAL HIGH-RISK REINSURANCE POOL**  
27 **ASSOCIATION**

28 **§3901. Short title**

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

31 **§3902. Definitions**

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

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

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

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

- 3 A. Is eligible to receive benefits from an insurer;
- 4 B. Is eligible for benefits under the federal Health Insurance Portability and  
5 Accountability Act of 1996; or
- 6 C. Has been certified as eligible for federal trade adjustment assistance or for  
7 pension benefit guarantee corporation assistance, as provided by the federal Trade  
8 Adjustment Assistance Reform Act of 2002.

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

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

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

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

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

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

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

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

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

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

10 **§3903. Maine Individual High-risk Reinsurance Pool Association**

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

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

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

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

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

23 (b) Two members must represent medical providers;

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

25 (d) One member must represent a statewide association representing small  
26 businesses that receives the majority of its funding from persons and  
27 businesses in the State.

28 A board member appointed by the superintendent may be removed at any time  
29 without cause; and

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

33 **B.** Members serve terms of 3 years.

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

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



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1 3. Plan of operation; rules. The association shall adopt a plan of operation in  
2 accordance with the requirements of this chapter and submit its articles, bylaws and  
3 operating rules to the superintendent for approval. If the association fails to adopt the plan  
4 of operation and suitable articles and bylaws within 90 days after the appointment of the  
5 board, the superintendent shall adopt rules to effectuate the requirements of this chapter,  
6 and those rules remain in effect until superseded by a plan of operation and articles and  
7 bylaws submitted by the association and approved by the superintendent. Rules adopted  
8 pursuant to this subsection by the superintendent are routine technical rules as defined in  
9 Title 5, chapter 375, subchapter 2-A.

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

13 **§3904. Liability and indemnification**

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

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

21 **§3905. Duties and powers of the association**

22 1. Duties. The association shall:

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

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

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

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

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

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

41 2. Powers. The association may:

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- 1        A. Exercise powers granted to insurers under the laws of this State;
- 2        B. Enter into contracts as necessary or proper to carry out the provisions and
- 3        purposes of this chapter, including the authority, with the approval of the
- 4        superintendent, to enter into contracts with similar organizations in other states for
- 5        the joint performance of common administrative functions or with persons or other
- 6        organizations for the performance of administrative functions;
- 7        C. Sue or be sued, including taking any legal actions necessary or proper to recover
- 8        or collect assessments due the association;
- 9        D. Take any legal actions necessary to avoid the payment of improper claims against
- 10       the association or the coverage provided by or through the association, to recover any
- 11       amounts erroneously or improperly paid by the association, to recover any amounts
- 12       paid by the association as a result of mistake of fact or law or to recover other
- 13       amounts due the association;
- 14       E. Define the health benefit plans for which reinsurance will be provided under this
- 15       chapter;
- 16       F. Appoint appropriate legal, actuarial and other committees as necessary to provide
- 17       technical assistance in the operation of the plan, policy or other contract design and
- 18       any other function within the authority of the association;
- 19       G. Borrow money to effect the purposes of the association. Any notes or other
- 20       evidence of indebtedness of the association not in default must be legal investments
- 21       for insurers and may be carried as admitted assets;
- 22       H. Establish rules, conditions and procedures for reinsuring risks of insurers under
- 23       the pool in accordance with section 3909;
- 24       I. Provide for reinsurance of risks incurred by the association. The provision of
- 25       reinsurance may not subject the association to any of the capital or surplus
- 26       requirements, if any, otherwise applicable to reinsurers; and
- 27       J. Apply for funds or grants from public or private sources, including federal grants
- 28       provided to qualified high-risk reinsurance pools.
- 29       **3. Additional duties and powers.** The superintendent may, by rule, establish
- 30       additional powers and duties of the association and may adopt such rules as are necessary
- 31       and proper to implement this chapter. Rules adopted pursuant to this subsection are
- 32       routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
- 33       **4. Review for solvency.** The superintendent shall review the operations of the
- 34       association at least every 3 years to determine its solvency. If the superintendent
- 35       determines that the funds of the association are insufficient to support the need for
- 36       reinsurance, the superintendent may order the association to increase its assessments. If
- 37       the superintendent determines that the funds of the association are insufficient, the
- 38       superintendent may order the association to charge an additional assessment.
- 39       **5. Annual report.** The association shall report annually to the joint standing
- 40       committee of the Legislature having jurisdiction over health insurance matters by March
- 41       15th. The report must include information on the benefits and rate structure of coverage

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1 offered by the association, the financial solvency of the association and the administrative  
2 expenses of the association.

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

6 **§3906. Selection of plan administrator**

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

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

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

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

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

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

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

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

31 **4. Payment to plan administrator.** The plan administrator selected pursuant to  
32 subsection 1 must be paid, as provided in the contract of the association under subsection  
33 2, for the plan administrator's direct and indirect expenses incurred in the performance of  
34 the plan administrator's services. As used in this subsection, "direct and indirect  
35 expenses" includes that portion of the audited administrative costs, printing expenses,  
36 management expenses, building overhead expenses and other actual operating and  
37 administrative expenses of the plan administrator that are approved by the board as  
38 allocable to the administration of the association and included in the specifications of a  
39 bid under subsection 2.

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1 **§3907. Assessments against insurers**

2 **1. Assessments.** For the purpose of providing the funds necessary to carry out the  
3 powers and duties of the association, the board shall assess member insurers at such a  
4 time and for such amounts as the board finds necessary. Assessments are due not less  
5 than 30 days after written notice to the member insurers and accrue interest at 12% per  
6 annum on and after the due date.

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

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

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

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

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

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

43 **B.** Individual assessments of each insurer are determined by multiplying net losses, if  
44 net earnings are negative, by a fraction, the numerator of which is the insurer's total

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1 premiums earned in the preceding calendar year from all health benefit plans,  
2 including excess or stop loss coverage, and the denominator of which is the total  
3 premiums earned in the preceding calendar year from all health benefit plans.

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

5 **§3908. Requirements for coverage**

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

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

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

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

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

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

32 **§3909. Reinsurance; premium rates**

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

37 A. The association may not reimburse a reinsuring insurer with respect to claims of a  
38 reinsured person until the insurer has incurred an initial level of claims for that person  
39 of \$5,000 for covered benefits in a calendar year. In addition, the reinsuring insurer is  
40 responsible for 10% of the next \$25,000 of claims paid during a calendar year. The  
41 association shall reimburse reinsuring insurers for claims paid in excess of \$25,000.  
42 The association may annually adjust the initial level of claims and the maximum limit

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1 to be retained by the reinsuring insurer to reflect increases in costs and utilization  
2 within the standard market for health plans within the State. The adjustments may not  
3 be less than the annual change in the medical component of the Consumer Price  
4 Index unless the superintendent approves a lower adjustment factor as requested by  
5 the association.

6 B. A reinsuring insurer shall apply all managed care, utilization review, case  
7 management, preferred provider arrangements, claims processing and other methods  
8 of operation without regard to whether claims paid for coverage are reinsured under  
9 this subsection.

10 **2. Premium rates.** The association may charge reinsuring insurers premium rates  
11 established in accordance with this subsection. The association, as part of the plan of  
12 operation, shall establish a methodology for determining premium rates to be charged  
13 reinsuring insurers to reinsure persons eligible for coverage under this chapter. The  
14 methodology must include a system for classification of persons eligible for coverage that  
15 reflects the types of case characteristics used by insurers for individual health plans  
16 pursuant to section 2736-C. The methodology must provide for the development of base  
17 reinsurance premium rates, subject to approval of the superintendent, set at levels that  
18 reasonably approximate gross premiums charged for individual health plans with similar  
19 benefits to the coverage options approved by the association pursuant to section 3908,  
20 subsection 1 and that are adjusted to reflect retention levels required under this Title. The  
21 association shall periodically review the methodology established under this subsection  
22 and may make changes to the methodology as needed with the approval of the  
23 superintendent. The association may consider adjustments to the premium rates charged  
24 for reinsurance to reflect the use of effective cost containment and managed care  
25 arrangements by a reinsuring insurer.

26 **§3910. Eligibility for coverage**

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

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

43 **3. Eligibility without application.** The board shall develop a list of medical or  
44 health conditions for which a person is eligible for plan coverage without applying for

**SENATE AMENDMENT**

R. 013

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "C" to H.P. 1322, L.D. 1890

1 health insurance under subsection 1. A person who can demonstrate the existence or  
2 history of a medical or health condition on the list developed by the board may not be  
3 required to provide the evidence specified in subsection 1. The board may amend the list  
4 from time to time as appropriate.

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

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

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

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

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

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

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

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

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

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

26 B. Upon the death of the covered person;

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

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

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

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

10.03

1 **§3911. Actions against association or members based upon joint or collective**  
2 **actions**

3 Participation in the association, the establishment of rates, forms or procedures or any  
4 other joint or collective action required by this chapter may not be the basis of any legal  
5 action or criminal or civil liability or penalty against the association or any insurer  
6 belonging to the association.

7 **Sec. D-3. Maine Individual High-risk Reinsurance Pool Association;**  
8 **staggered terms.** Notwithstanding the Maine Revised Statutes, Title 24-A, section  
9 3903, subsection 2, paragraph B, the terms for initial appointments to the Maine  
10 Individual High-risk Reinsurance Pool Association are as follows. Of those members of  
11 the board appointed by the superintendent, 2 members serve for a term of one year, 2  
12 members for a term of 2 years and 2 members for a term of 3 years. Of those members  
13 appointed by insurers, one member serves for a term of one year, one member serves for  
14 a term of 2 years and one member serves for a term of 3 years. The appointing authority  
15 shall designate the period of service of each initial appointee at the time of appointment.

16 **PART E**

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

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

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

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

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

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

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





R. 018

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

5 **PART H**

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

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

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

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

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

19 B. Ensure that:

20 (1) Providers contracting with a carrier contracted to provide coverage to plan  
21 enrollees do not charge plan enrollees or 3rd parties for covered health care  
22 services in excess of the amount allowed by the carrier the provider has  
23 contracted with, except for applicable copayments, deductibles or coinsurance or  
24 as provided in section 4204, subsection 6;

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

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

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

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

R. of S.

SENATE AMENDMENT " B " to COMMITTEE AMENDMENT "C" to H.P. 1322, L.D. 1890

- 1 B. Dirigo Health shall contract with eligible businesses seeking assistance from  
2 Dirigo Health in arranging for health benefits coverage by the Dirigo Health Program  
3 for their employees and dependents as set out in this paragraph.
- 4 (1) Dirigo Health may establish contract and other reporting forms and  
5 procedures necessary for the efficient administration of contracts.
- 6 (2) Dirigo Health shall collect payments from participating employers and plan  
7 enrollees to cover the cost of:
- 8 (a) The Dirigo Health Program for enrolled employees and dependents in  
9 contribution amounts determined by the board;
- 10 (b) Dirigo Health's quality assurance, disease prevention, disease  
11 management and cost-containment programs;
- 12 (c) Dirigo Health's administrative services; and
- 13 (d) Other health promotion costs.
- 14 (3) Dirigo Health shall establish the minimum required contribution levels, not  
15 to exceed 60%, to be paid by employers toward the aggregate payment in  
16 subparagraph (2) and establish an equivalent minimum amount to be paid by  
17 employers or plan enrollees and their dependents who are enrolled in MaineCare.  
18 The minimum required contribution level to be paid by employers must be  
19 prorated for employees that work less than the number of hours of a full-time  
20 equivalent employee as determined by the employer. Dirigo Health may  
21 establish a separate minimum contribution level to be paid by employers toward  
22 coverage for dependents of the employers' enrolled employees.
- 23 (4) Dirigo Health shall require participating employers to certify that at least  
24 75% of their employees that work 30 hours or more per week and who do not  
25 have other creditable coverage are enrolled in the Dirigo Health Program and that  
26 the employer group otherwise meets the minimum participation requirements  
27 specified by section 2808-B, subsection 4, paragraph A.
- 28 (5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible  
29 for a subsidy under section 6912 accordingly. Dirigo Health shall return any  
30 payments made by plan enrollees also enrolled in MaineCare to those enrollees.
- 31 (6) Dirigo Health shall require participating employers to pass on any subsidy in  
32 section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of  
33 payments made by the plan enrollee.
- 34 (7) Dirigo Health may establish other criteria for participation.
- 35 (8) Dirigo Health may limit the number of participating employers.
- 36 (9) Dirigo Health may provide participating employers assistance to adopt and  
37 maintain a payroll deduction program to facilitate the payment of health benefit  
38 plan premium payments by employees to benefit from deductibility of gross  
39 income under 26 United States Code, Section 125.



A.O.S.

1 practices. For purposes of this paragraph, a hospital's bad debt is as defined and  
2 reported in the hospital's Medicare cost report and as submitted to the Maine Health  
3 Data Organization pursuant to Title 22, chapter 1683.

4 **PART J**

5 **Sec. J-1. 24-A MRSA §2736, sub-§3, ¶B**, as amended by PL 2003, c. 469, Pt. E,  
6 §9, is further amended to read:

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

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

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

20 **Sec. J-3. 24-A MRSA §2736-A, first ¶**, as amended by PL 2003, c. 469, Pt. E,  
21 §11, is further amended to read:

22 If at any time the superintendent has reason to believe that a filing does not meet the  
23 requirements that rates not be excessive, inadequate, and unfairly discriminatory ~~or not in~~  
24 ~~compliance with section 6913~~ or that the filing violates any of the provisions of chapter  
25 23, the superintendent shall cause a hearing to be held.

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

28 **Sec. J-5. 24-A MRSA §2736-C, sub-§5**, as amended by PL 2003, c. 469, Pt. E,  
29 §13, is further amended to read:

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

40 **Sec. J-6. 24-A MRSA §2808-B, sub-§2-A, ¶C**, as enacted by PL 2003, c. 469,  
41 Pt. E, §16, is amended to read:

1 C. Rates for small group health plans must be filed in accordance with this section  
2 and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004;  
3 ~~except that the filing of rates for small group health plans are not required to account~~  
4 ~~for any savings offset payment or any recovery of that offset payment pursuant to~~  
5 ~~subsection 2-B, paragraph D and section 6913 for rates effective before July 1, 2005.~~

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

8 A. The superintendent shall disapprove any premium rates filed by any carrier,  
9 whether initial or revised, for a small group health plan unless it is anticipated that the  
10 aggregate benefits estimated to be paid under all the small group health plans  
11 maintained in force by the carrier for the period for which coverage is to be provided  
12 will return to policyholders at least 75% of the aggregate premiums collected for  
13 those policies, as determined in accordance with accepted actuarial principles and  
14 practices and on the basis of incurred claims experience and earned premiums. ~~For~~  
15 ~~the purposes of this calculation, any savings offset payments paid pursuant to section~~  
16 ~~6913 must be treated as incurred claims.~~

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

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

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

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

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

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

34 **Sec. J-10. 24-A MRSA §2839-B, sub-§2**, as enacted by PL 2003, c. 469, Pt. E,  
35 §17, is amended to read:

36 **2. Annual filing.** Every carrier offering group health insurance specified in  
37 subsection 1 shall annually file with the superintendent on or before April 30th a  
38 certification signed by a member in good standing of the American Academy of  
39 Actuaries or a successor organization that the carrier's rating methods and practices are in  
40 accordance with generally accepted actuarial principles and with the applicable actuarial  
41 standards of practice as promulgated by an actuarial standards board. ~~The filing must~~  
42 ~~also certify that the carrier has included in its experience any savings offset payments or~~

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1 ~~recovery of those savings offset payments consistent with section 6913.~~ The filing also  
2 must state the number of policyholders, certificate holders and dependents, as of the close  
3 of the preceding calendar year, enrolled in large group health insurance plans offered by  
4 the carrier. A filing and supporting information are public records except as provided by  
5 Title 1, section 402, subsection 3.

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

8 **Sec. J-12. 24-A MRSA §6913,** as amended by PL 2005, c. 683, Pt. A, §§43 and  
9 44, is repealed.

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

12 **§6915. Dirigo Health Enterprise Fund**

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

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

21 The Maine Quality Forum, referred to in this subchapter as "the forum," is  
22 established within Dirigo Health. The forum is governed by the board with advice from  
23 the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be  
24 funded, ~~at least in part, through the savings offset payments made pursuant to section~~  
25 ~~6913~~ within the limitations of available funds. Except as provided in section 6907,  
26 subsection 2, information obtained by the forum is a public record as provided by Title 1,  
27 chapter 13, subchapter 1. The forum shall perform the following duties.

28 **PART K**

29 **Sec. K-1. 24-A MRSA §2735-A, sub-§1,** as enacted by PL 2001, c. 432, §4, is  
30 amended to read:

31 **1. Notice of rate filing or rate increase on existing policies.** An insurer offering  
32 individual health plans as defined in section 2736-C must provide written notice by first  
33 class mail of a rate filing to all affected policyholders at least 60 days before the effective  
34 date of any proposed increase in premium rates or any proposed rating formula,  
35 classification of risks or modification of any formula or classification of risks. The notice  
36 must also inform policyholders of their right to request a hearing pursuant to section 229  
37 ~~or a special rate hearing pursuant to section 2736, subsection 4 or Title 24, section 2321,~~  
38 ~~subsection 5.~~ The notice must show the proposed rate and state that the rate is subject to  
39 regulatory approval. The superintendent may not take final action on a rate filing until 40  
40 days after the date notice is mailed by an insurer. An increase in premium rates may not

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1 be implemented until 60 days after the notice is provided or until the effective date under  
2 section 2736, whichever is later.

3 **Sec. K-2. 24-A MRSA §2736, sub-§1**, as amended by PL 2003, c. 428, Pt. F, §2,  
4 is further amended to read:

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

16 **SUMMARY**

17 This amendment strikes all of the committee amendment and replaces it with the  
18 following.

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

25 Part B requires that all insurers in the individual market offer a plan that includes a  
26 \$1,000 deductible, a prescription drug benefit not subject to a deductible and the option of  
27 no cap on the lifetime maximum benefit.

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

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

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

**SENATE AMENDMENT**



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SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "C" to H.P. 1322, L.D. 1890

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

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

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

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

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

19 Part K corrects cross-references.

20 FISCAL NOTE REQUIRED

21 (See attached)

22 SPONSORED BY: *James A. Snowe Mello*

23 (Senator SNOWE-MELLO)

24 COUNTY: Androscoggin



# 123rd MAINE LEGISLATURE

LD 1890

LR 2620(06)

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

Fiscal Note for Senate Amendment " B " to Committee Amendment "C"

Sponsor: Sen. Snowe-Mello of Androscoggin

Fiscal Note Required: Yes

## Fiscal Note

	2007-08	2008-09	Projections 2009-10	Projections 2010-11
<b>Appropriations/Allocations</b>				
Federal Expenditures Fund	\$0	(\$2,595,710)	(\$2,595,710)	(\$2,595,710)
Other Special Revenue Funds	\$0	(\$1,520,444)	(\$1,509,702)	(\$1,509,702)
Dirigo Health Fund	\$0	(\$27,386,556)	(\$6,817,298)	(\$6,817,298)
<b>Revenue</b>				
Dirigo Health Fund	\$0	(\$42,627,000)	(\$42,627,000)	(\$42,627,000)
<b>Transfers</b>				
Other Special Revenue Funds	\$0	(\$1,520,444)	(\$1,509,702)	(\$1,509,702)
Dirigo Health Fund	\$0	\$1,520,444	\$1,509,702	\$1,509,702

### Fiscal Detail and Notes

This amendment retains the repeal of the Saving Offset Payment but eliminates the 1% increase in the hospital assessment and a 1% health insurance carriers assessment.

The amendment does not require a transfer from Dirigo to the MaineCare program and the increased MaineCare allocations because the elimination of the increase in the hospital assessment would not produce the increase in MaineCare cost.

The amendment does not include the checkoff provision and therefore does not require an Other Special Revenue Funds allocation of \$16,154 in fiscal year 2008-09 for Maine Revenue Services' administrative costs associated with the Dirigo Health Enterprise Fund income tax check off.

The remaining fiscal impact of the bill as amended is as follows:

Dirigo Health Fund Summary	2007-08	2008-09	Projections 2009-10	Projections 2010-11

Revenue Changes:

Elimination of the Savings Offset Payment	\$0	(\$13,720,000)	(\$34,300,000)	(\$34,300,000)
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