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L.D. 1890

Date: 6/19/07

(Filing No. H-617)

Report C  
INSURANCE AND FINANCIAL SERVICES

Reproduced and distributed under the direction of the Clerk of the House.

STATE OF MAINE  
HOUSE OF REPRESENTATIVES  
123RD LEGISLATURE  
FIRST REGULAR SESSION

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 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 benefit, including, but not limited to, a discount in premium pursuant to section 2808-B,

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

9 **PART B**

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

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

18 **PART C**

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

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

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

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

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

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



1 (b) The carrier is applying this provision uniformly to individuals and  
2 groups 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  
8 2850-B.

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

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

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

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

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

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

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

26 **CHAPTER 54**

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

29 **§3901. Short title**

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

32 **§3902. Definitions**

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

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

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

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

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

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

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

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

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



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

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

10 **§3904. Liability and indemnification**

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

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

18 **§3905. Duties and powers of the association**

19 1. Duties. The association shall:

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

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

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

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

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

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

38 2. Powers. The association may:

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

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

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

4 **§3906. Selection of plan administrator**

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

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

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

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

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

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

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

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

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

38 **§3907. Assessments against insurers**

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

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

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

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

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

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

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

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

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

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

1 **§3908. Requirements for coverage**

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

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

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

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

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

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

28 **§3909. Reinsurance; premium rates**

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

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

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

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

21 **§3910. Eligibility for coverage**

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

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

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

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

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

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

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

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

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

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

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

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

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

22 B. Upon the death of the covered person;

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

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

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

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

35 §3911. Actions against association or members based upon joint or collective  
36 actions

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

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

3 **§3912. Reimbursement of insurers**

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

8 A. The insurer sold an individual health plan to the member between December 1,  
9 1993 and December 31, 2008, and the policy that was sold has been continuously  
10 renewed by the member;

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

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

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

26 **Sec. D-3. Maine Individual High-risk Reinsurance Pool Association;**  
27 **staggered terms.** Notwithstanding the Maine Revised Statutes, Title 24-A, section  
28 3903, subsection 2, paragraph B, the terms for initial appointments to the Maine  
29 Individual High-risk Reinsurance Pool Association are as follows. Of those members of  
30 the board appointed by the superintendent, 2 members serve for a term of one year, 2  
31 members for a term of 2 years and 2 members for a term of 3 years. Of those members  
32 appointed by insurers, one member serves for a term of one year, one member serves for  
33 a term of 2 years and one member serves for a term of 3 years. The appointing authority  
34 shall designate the period of service of each initial appointee at the time of appointment.

35 **PART E**

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

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





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

5 **PART G**

6 **Sec. G-1. 24-A MRSA §6908, sub-§1, ¶K**, as enacted by PL 2003, c. 469, Pt. A,  
7 §8, is amended to read:

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

11 **Sec. G-2. 24-A MRSA §6908, sub-§1, ¶L**, as enacted by PL 2003, c. 469, Pt. A,  
12 §8, is amended to read:

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

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

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

21 **PART H**

22 **Sec. H-1. 24-A MRSA §6903, sub-§6**, as enacted by PL 2003, c. 469, Pt. A, §8,  
23 is amended to read:

24 **6. Eligible employee.** "Eligible employee" means an employee of an eligible  
25 business who works at least 20 hours per week for that eligible business, except that an  
26 eligible business may elect to treat as eligible an employee who works a normal work  
27 week of at least 10 hours as long as at least one employee works a normal work week of  
28 30 hours or more. "Eligible employee" does not The board may, by rule, permit an  
29 eligible business to include an employee who works on a temporary or substitute basis or  
30 who does not work more than 26 weeks annually seasonal basis.

31 **Sec. H-2. 24-A MRSA §6908, sub-§1, ¶N** is enacted to read:

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

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

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

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

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

6 B. Ensure that:

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

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

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

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

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

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

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

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

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

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

36 (c) Dirigo Health's administrative services; and

37 (d) Other health promotion costs.

38 (3) Dirigo Health shall establish the minimum required contribution levels, not  
39 to exceed 60%, to be paid by employers toward the aggregate payment in

1 subparagraph (2) and establish an equivalent minimum amount to be paid by  
2 employers or plan enrollees and their dependents who are enrolled in MaineCare.  
3 The minimum required contribution level to be paid by employers must be  
4 prorated for employees that work less than the number of hours of a full-time  
5 equivalent employee as determined by the employer. Dirigo Health may  
6 establish a separate minimum contribution level to be paid by employers toward  
7 coverage for dependents of the employers' enrolled employees.

8 (4) Dirigo Health shall require participating employers to certify that at least  
9 75% of their employees that work 30 hours or more per week and who do not  
10 have other creditable coverage are enrolled in the Dirigo Health Program and that  
11 the employer group otherwise meets the minimum participation requirements  
12 specified by section 2808-B, subsection 4, paragraph A.

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

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

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

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

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

25 **Sec. H-5. 24-A MRSA §6912, sub-§4**, as enacted by PL 2003, c. 469, Pt. A, §8,  
26 is repealed.

27 **PART I**

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

29 **§1721. Voluntary restraint**

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

37 **A.** Each hospital may voluntarily hold its consolidated operating margin to no more  
38 than 3%. For purposes of this section, a hospital's consolidated operating margin is

1 calculated by dividing its consolidated operating income by its total consolidated  
2 operating revenue.

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

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

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

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

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

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

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

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

29 **PART J**

30 **Sec. J-1.** 24-A MRSA §2736, sub-§3, as amended by PL 2003, c. 469, Pt. E, §9,  
31 is repealed.

32 **Sec. J-2.** 24-A MRSA §2736, sub-§4, as amended by PL 2003, c. 469, Pt. E,  
33 §10, is repealed.

34 **Sec. J-3.** 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

1 accordance with generally accepted actuarial principles and with the applicable actuarial  
2 standards of practice as promulgated by an actuarial standards board. The filing must  
3 also certify that the carrier has included in its experience any ~~savings-offset~~ payments or  
4 recovery of those ~~savings-offset~~ payments consistent with former section 6913 or section  
5 6913-A. The filing also must state the number of policyholders, certificate holders and  
6 dependents, as of the close of the preceding calendar year, enrolled in large group health  
7 insurance plans offered by the carrier. A filing and supporting information are public  
8 records except as provided by Title 1, section 402, subsection 3.

9 **Sec. J-4. 24-A MRSA §6908, sub-§1, ¶A**, as enacted by PL 2003, c. 469, Pt. A,  
10 §8, is amended to read:

11 A. Take any legal actions necessary or proper to recover or collect ~~savings-offset~~  
12 payments provided in section 6913-A due Dirigo Health or that are necessary for the  
13 proper administration of Dirigo Health;

14 **Sec. J-5. 24-A MRSA §6908, sub-§2, ¶B**, as enacted by PL 2003, c. 469, Pt. A,  
15 §8, is amended to read:

16 B. Collect the ~~savings-offset~~ payments provided in former section 6913 or section  
17 6913-A;

18 **Sec. J-6. 24-A MRSA §6908, sub-§2, ¶F**, as amended by PL 2005, c. 400, Pt. C,  
19 §6, is further amended to read:

20 F. Develop a high-risk pool for plan enrollees in the Dirigo Health Program in  
21 accordance with the provisions of section 6971; ~~and~~

22 **Sec. J-7. 24-A MRSA §6908, sub-§2, ¶G**, as enacted by PL 2003, c. 469, Pt. A,  
23 §8, is amended to read:

24 G. Establish and operate the Maine Quality Forum in accordance with the  
25 provisions of section 6951; and

26 **Sec. J-8. 24-A MRSA §6908, sub-§2, ¶H** is enacted to read:

27 H. On a quarterly basis no less than 60 days from the end of each quarter, collect and  
28 report on:

29 (1) The total enrollment in the Dirigo Health Program, including the number of  
30 enrollees previously underinsured or uninsured, the number of enrollees  
31 previously insured, the number of individual enrollees and the number of  
32 enrollees enrolled through small employers;

33 (2) The number of new participating employers in the Dirigo Health Program;

34 (3) The number of employers ceasing to offer coverage through the Dirigo  
35 Health Program;

36 (4) The duration of employers' participation in the Dirigo Health Program; and

37 (5) A comparison of actual enrollees in the Dirigo Health Program to projected  
38 enrollees.

39 **Sec. J-9. 24-A MRSA §6912, sub-§2-A** is enacted to read:

1        **2-A. Employer subsidy.** Notwithstanding subsection 2, Dirigo Health shall  
2 establish subsidies for eligible businesses with excess funds pursuant to section 6913-A,  
3 subsection 6.

4        **Sec. J-10.** **24-A MRSA §6913,** as amended by PL 2007, c. 1, Pt. X, §§1 and 2  
5 and affected by §3, is repealed.

6        **Sec. J-11.** **24-A MRSA §6913-A** is enacted to read:

7        **§6913-A. Assessments**

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

10        A. "Carrier" has the same meaning as in section 4301-A, subsection 3, except that  
11 "carrier" does not include the group health plan provided to state employees and other  
12 eligible persons pursuant to Title 5, section 285.

13        B. "Medical insurance " has the same meaning as in section 3902, subsection 7.

14        **2. Carrier assessment.** Each carrier shall pay an assessment of 1% per year on all  
15 gross direct premiums for medical insurance on all policies, contracts and certificates  
16 written on residents in this State. The assessment imposed by this subsection applies to all  
17 gross direct premiums collected or contracted for on policies, contracts and certificates  
18 issued or renewed on or after January 1, 2008. Each carrier shall file an annual report on  
19 or before February 1st of each year with the board containing a sworn statement of the  
20 gross direct premiums and shall pay to Dirigo Health an amount equal to 1% of those  
21 gross direct premiums. All of the assessments paid by carriers pursuant to this subsection  
22 must be pooled with other revenues of Dirigo Health in the Dirigo Health Enterprise Fund  
23 established in section 6915.

24        **3. Liability.** The board shall specify by rule appropriate mechanisms that provide  
25 for determination and payment of a carrier's liability, including requirements for data to  
26 be submitted by carriers. A carrier's liability, in the case of a transfer of ownership, must  
27 be assumed by the successor in interest to the carrier.

28        **4. Failure to pay surcharge payments.** The board shall establish by rule an  
29 appropriate mechanism for enforcing a carrier's liability to the Dirigo Health Enterprise  
30 Fund in the event that a carrier does not make a scheduled payment under subsection 2,  
31 except that the board, for the purpose of administrative simplicity, may establish  
32 threshold liability amounts below which enforcement may be modified or waived. Such  
33 an enforcement mechanism must include an assessment of interest on the unpaid liability  
34 at a rate not to exceed an annual percentage rate of 18% and late fees or penalties at a rate  
35 not to exceed 5% per month.

36        **5. Excess funds.** If assessments paid pursuant to this section exceed \$50,000,000 in  
37 any calendar year, the board shall use those excess funds to provide subsidies to eligible  
38 businesses pursuant to section 6912, subsection 2-A.

39        **Sec. J-12.** **24-A MRSA §6914-A** is enacted to read:

1 **§6914-A. Intragovernmental transfer related to hospital tax increase**

2 Starting July 1, 2008, Dirigo Health shall transfer funds as necessary to a special  
3 dedicated, nonlapsing Other Special Revenue Funds account administered by the agency  
4 of State Government that administers MaineCare for the purpose of providing the state  
5 match for federal Medicaid dollars for the increased costs to the MaineCare program  
6 resulting from the increase in the hospital tax from 2.23% to 3.23% pursuant to Title 36,  
7 section 2893.

8 **Sec. J-13. 24-A MRSA §6915**, as enacted by PL 2003, c. 469, Pt. A, §8 and as  
9 amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

10 **§6915. Dirigo Health Enterprise Fund**

11 The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of  
12 any funds advanced for initial operating expenses, payments made by employers and  
13 individuals, any ~~savings offset~~ payments made pursuant to former section 6913 or section  
14 6913-A, revenues transferred pursuant to Title 36, section 2893, taxpayer contributions  
15 made pursuant to Title 36, section 5284-B and any funds received from any public or  
16 private source. The fund may be used by Dirigo Health to exercise its powers and duties  
17 pursuant to this chapter. The fund may not lapse, but must be carried forward to carry out  
18 the purposes of this chapter. Beginning July 1, 2008 and annually thereafter, Dirigo  
19 Health shall transfer funds as necessary to that agency of State Government that  
20 administers Title 36, section 5284-B for the costs of administration of that section in an  
21 amount determined by the State Tax Assessor.

22 **Sec. J-14. 36 MRSA §2892, 2nd ¶**, as amended by PL 2005, c. 12, Pt. ZZ, §2, is  
23 further amended to read:

24 For state fiscal years beginning on or after July 1, 2004, ~~a tax is imposed annually~~  
25 ~~against each hospital in the State.~~ The the tax is equal to 2.23% of the hospital's net  
26 operating revenue as identified in the hospital's audited financial statement for the  
27 hospital's taxable year. For state fiscal years beginning on or after July 1, 2008, the tax is  
28 equal to 3.23% of the hospital's net operating revenue as identified in the hospital's  
29 audited financial statement for the hospital's taxable year. For the state fiscal year  
30 beginning July 1, 2004, the hospital's taxable year is the hospital's fiscal year that ended  
31 during calendar year 2002. For the state fiscal year beginning July 1, 2005, the hospital's  
32 taxable year is the hospital's fiscal year that ended during calendar year 2003. For state  
33 fiscal years beginning on or after July 1, 2006, the hospital's taxable year is the hospital's  
34 fiscal year that ended during calendar year 2004.

35 **Sec. J-15. 36 MRSA §2893, sub-§3**, as enacted by PL 2003, c. 513, Pt. H, §1, is  
36 amended to read:

37 **3. Application of revenues.** All revenues received by the assessor under this  
38 chapter must be credited to a General Fund suspense account. No later than the last day  
39 of each month, the State Controller shall transfer all revenues received by the assessor  
40 during the month under this chapter to the Medical Care - Payments to Providers Other  
41 Special Revenue Funds account in the Department of Health and Human Services. For  
42 state fiscal years beginning on or after July 1, 2008, no later than the last day of each  
43 month, the State Controller shall transfer all revenues attributed to 2.23% of the tax



1 received by the assessor during the month under this chapter to the Medical Care -  
2 Payments to Providers Other Special Revenue Funds account in the Department of Health  
3 and Human Services and shall transfer all revenues attributed to 1.00% of the tax  
4 received by the assessor during the month under this chapter to the Dirigo Health  
5 Enterprise Fund established in Title 24-A, section 6915.

6 **Sec. J-16. 36 MRSA §5284-B** is enacted to read:

7 **§5284-B. Dirigo Health Enterprise Fund; voluntary checkoff**

8 **1. Dirigo Health Enterprise Fund.** A taxpayer who, when filing that taxpayer's  
9 return, is entitled to a refund under this Part may designate that a part of that refund be  
10 paid into the Dirigo Health Enterprise Fund established in Title 24-A, section 6915. A  
11 taxpayer who is not entitled to a refund under this Part may contribute to the Dirigo  
12 Health Enterprise Fund by including with the taxpayer's return sufficient funds to make  
13 the contribution. Each individual income tax return form must contain a designation in  
14 substantially the following form: "Contribution to Dirigo Health Enterprise Fund: ( ) \$25  
15 or ( ) Other \$..."

16 **2. Contributions credited to Dirigo Health Enterprise Fund.** The State Tax  
17 Assessor shall determine annually the total amount contributed pursuant to subsection 1.  
18 Prior to the beginning of the next year, the assessor shall deduct the cost of administering  
19 the Dirigo Health Enterprise Fund checkoff, but not exceeding \$5,000 annually, and  
20 report the remainder to the Treasurer of State, who shall credit the amount to the Dirigo  
21 Health Enterprise Fund, which is established in Title 24-A, section 6915.

22 **3. Effective date.** This section applies to tax years beginning on and after January 1,  
23 2008.

24 **Sec. J-17. Savings offset payments calculated prior to effective date.**  
25 Notwithstanding that section of this Part that repeals the Maine Revised Statutes, Title  
26 24-A, section 6913, any savings offset payment calculated and required under former  
27 Title 24-A, section 6913 prior to the effective date of this Part is due and payable in the  
28 same manner and subject to the same procedures set forth in former Title 24-A, section  
29 6913.

30 **PART K**

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

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

1 days after the date notice is mailed by an insurer. An increase in premium rates may not  
2 be implemented until 60 days after the notice is provided or until the effective date under  
3 section 2736, whichever is later.

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

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

17 **Sec. K-3. 24-A MRSA §2736, sub-§4, ¶C**, as amended by PL 2003, c. 469, Pt.  
18 E, §10, is further amended to read:

19 C. In any hearing conducted under this subsection, the Bureau of Insurance and any  
20 party asserting that the rates are excessive have the burden of establishing that the  
21 rates are excessive. The burden of proving that rates are adequate, not unfairly  
22 discriminatory and in compliance with the requirements of former section 6913 or  
23 section 6913-A remains with the insurer.

24 **Sec. K-4. 24-A MRSA §2736-A**, as amended by PL 2003, c. 469, Pt. E, §11, is  
25 further amended to read:

26 **§2736-A. Hearing**

27 If at any time the superintendent has reason to believe that a filing does not meet the  
28 requirements that rates not be excessive, inadequate, unfairly discriminatory or not in  
29 compliance with former section 6913 or section 6913-A or that the filing violates any of  
30 the provisions of chapter 23, the superintendent shall cause a hearing to be held.

31 Hearings held under this section must conform to the procedural requirements set  
32 forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4.

33 **Sec. K-5. 24-A MRSA §2736-C, sub-§2, ¶F**, as enacted by PL 2003, c. 469, Pt.  
34 E, §12, is amended to read:

35 F. A carrier that adjusts its rate shall account for the savings offset payment or any  
36 recovery in that offset payment in its experience consistent with this section and  
37 former section 6913 or section 6913-A.

38 **Sec. K-6. 24-A MRSA §2736-C, sub-§5**, as amended by PL 2003, c. 469, Pt. E,  
39 §13, is further amended to read:

40 **5. Loss ratios.** For all policies and certificates issued on or after the effective date of  
41 this section, the superintendent shall disapprove any premium rates filed by any carrier,

COMMITTEE AMENDMENT “**C**” to H.P. 1322, L.D. 1890

1 whether initial or revised, for an individual health policy unless it is anticipated that the  
2 aggregate benefits estimated to be paid under all the individual health policies maintained  
3 in force by the carrier for the period for which coverage is to be provided will return to  
4 policyholders at least 65% of the aggregate premiums collected for those policies, as  
5 determined in accordance with accepted actuarial principles and practices and on the  
6 basis of incurred claims experience and earned premiums. For the purposes of this  
7 calculation, any savings offset payments paid pursuant to former section 6913 or section  
8 6913-A must be treated as incurred claims.

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

11 C. Rates for small group health plans must be filed in accordance with this section  
12 and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004,  
13 except that the filing of rates for small group health plans are not required to account  
14 for any savings offset payment or any recovery of that offset payment pursuant to  
15 subsection 2-B, paragraph D and former section 6913 ~~for rates effective before July~~  
16 ~~1, 2005~~ or section 6913-A.

17 **Sec. K-8. 24-A MRSA §2808-B, sub-§2-B, ¶A**, as enacted by PL 2003, c. 469,  
18 Pt. E, §16, is amended to read:

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

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

30 D. A carrier that adjusts its rate shall account for the savings offset payment or any  
31 recovery of that savings offset payment in its experience consistent with this section  
32 and former section 6913 or section 6913-A.

33 **Sec. K-10. 24-A MRSA §2808-B, sub-§2-B, ¶F**, as enacted by PL 2003, c. 469,  
34 Pt. E, §16, is amended to read:

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

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

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

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

6 **Sec. K-11. 24-A MRSA §6951, first ¶**, as enacted by PL 2003, c. 469, Pt. A, §8,  
 7 is amended to read:

8 The Maine Quality Forum, referred to in this subchapter as "the forum," is  
 9 established within Dirigo Health. The forum is governed by the board with advice from  
 10 the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be  
 11 funded, at least in part, through the savings offset payments made pursuant to former  
 12 section 6913 or section 6913-A. Except as provided in section 6907, subsection 2,  
 13 information obtained by the forum is a public record as provided by Title 1, chapter 13,  
 14 subchapter 1. The forum shall perform the following duties.

15 **PART L**

16 **Sec. L-1. Appropriations and allocations.** The following appropriations and  
 17 allocations are made.

18 **ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF**

19 **Revenue Services - Bureau of 0002**

20 Initiative: Allocates Other Special Revenue Funds for Maine Revenue Services'  
 21 administrative costs associated with the Dirigo Health Enterprise Fund income tax  
 22 checkoff.

23	<b>OTHER SPECIAL REVENUE FUNDS</b>	<b>2007-08</b>	<b>2008-09</b>
24	All Other	\$0	\$16,154
25			
26	<b>OTHER SPECIAL REVENUE FUNDS TOTAL</b>	<b>\$0</b>	<b>\$16,154</b>

27 **ADMINISTRATIVE AND FINANCIAL**  
 28 **SERVICES, DEPARTMENT OF**

29	<b>DEPARTMENT TOTALS</b>	<b>2007-08</b>	<b>2008-09</b>
30			
31	<b>OTHER SPECIAL REVENUE FUNDS</b>	<b>\$0</b>	<b>\$16,154</b>
32			
33	<b>DEPARTMENT TOTAL - ALL FUNDS</b>	<b>\$0</b>	<b>\$16,154</b>

34 **DIRIGO HEALTH**

35 **Dirigo Health Fund 0988**

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1 Initiative: Allocates funds for Dirigo Health costs to be funded by an increase in the  
 2 hospital assessment. Part of the revenue resulting from the increased assessment is to be  
 3 transferred to the MaineCare program for the state seed of increased MaineCare costs  
 4 resulting from the increased assessment.

5	<b>DIRIGO HEALTH FUND</b>	<b>2007-08</b>	<b>2008-09</b>
6	All Other	\$0	\$25,401,710
7			
8	<b>DIRIGO HEALTH FUND TOTAL</b>	<b>\$0</b>	<b>\$25,401,710</b>

9 **Dirigo Health Fund 0988**

10 Initiative: Deallocates funds for Dirigo Health costs that were funded by the savings  
 11 offset payment.

12	<b>DIRIGO HEALTH FUND</b>	<b>2007-08</b>	<b>2008-09</b>
13	All Other	\$0	(\$13,720,000)
14			
15	<b>DIRIGO HEALTH FUND TOTAL</b>	<b>\$0</b>	<b>(\$13,720,000)</b>

16 **Dirigo Health Fund 0988**

17 Initiative: Allocates funds for Dirigo Health costs to be funded by a health insurance  
 18 carrier assessment.

19	<b>DIRIGO HEALTH FUND</b>	<b>2007-08</b>	<b>2008-09</b>
20	All Other	\$0	\$15,721,000
21			
22	<b>DIRIGO HEALTH FUND TOTAL</b>	<b>\$0</b>	<b>\$15,721,000</b>

23 **Dirigo Health Fund 0988**

24 Initiative: Deallocates and transfers funds to offset the costs of administering the Dirigo  
 25 Health checkoff program.

26	<b>DIRIGO HEALTH FUND</b>	<b>2007-08</b>	<b>2008-09</b>
27	All Other	\$0	(\$16,154)
28			
29	<b>DIRIGO HEALTH FUND TOTAL</b>	<b>\$0</b>	<b>(\$16,154)</b>

30 **DIRIGO HEALTH**

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

1	<b>DEPARTMENT TOTALS</b>	<b>2007-08</b>	<b>2008-09</b>
2			
3	<b>DIRIGO HEALTH FUND</b>	<b>\$0</b>	<b>\$27,386,556</b>
4			
5	<b>DEPARTMENT TOTAL - ALL FUNDS</b>	<b>\$0</b>	<b>\$27,386,556</b>
6	<b>HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS)</b>		
7	<b>Medical Care - Payments to Providers 0147</b>		
8	Initiative: Allocates funds for additional costs to the MaineCare program resulting from		
9	an increase in the hospital tax.		
10	<b>FEDERAL EXPENDITURES FUND</b>	<b>2007-08</b>	<b>2008-09</b>
11	All Other	\$0	\$2,595,710
12			
13	<b>FEDERAL EXPENDITURES FUND TOTAL</b>	<b>\$0</b>	<b>\$2,595,710</b>
14	<b>OTHER SPECIAL REVENUE FUNDS</b>	<b>2007-08</b>	<b>2008-09</b>
15	All Other	\$0	\$1,504,290
16			
17	<b>OTHER SPECIAL REVENUE FUNDS TOTAL</b>	<b>\$0</b>	<b>\$1,504,290</b>
18	<b>HEALTH AND HUMAN SERVICES,</b>		
19	<b>DEPARTMENT OF (FORMERLY DHS)</b>		
20	<b>DEPARTMENT TOTALS</b>	<b>2007-08</b>	<b>2008-09</b>
21			
22	<b>FEDERAL EXPENDITURES FUND</b>	<b>\$0</b>	<b>\$2,595,710</b>
23	<b>OTHER SPECIAL REVENUE FUNDS</b>	<b>\$0</b>	<b>\$1,504,290</b>
24			
25	<b>DEPARTMENT TOTAL - ALL FUNDS</b>	<b>\$0</b>	<b>\$4,100,000</b>
26	<b>SECTION TOTALS</b>	<b>2007-08</b>	<b>2008-09</b>
27			
28	<b>FEDERAL EXPENDITURES FUND</b>	<b>\$0</b>	<b>\$2,595,710</b>
29	<b>OTHER SPECIAL REVENUE FUNDS</b>	<b>\$0</b>	<b>\$1,520,444</b>
30	<b>DIRIGO HEALTH FUND</b>	<b>\$0</b>	<b>\$27,386,556</b>
31			
32	<b>SECTION TOTAL - ALL FUNDS</b>	<b>\$0</b>	<b>\$31,502,710</b>

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**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 also permits eligible businesses to elect to treat employees who work at least 10 hours per week as eligible for coverage under their employer's DirigoChoice plan. 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,

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

1 which were initiated in Public Law 2003, chapter 469, Part F, section 1 and which  
2 otherwise would expire.

3 Part J makes changes to the funding for subsidies for the Dirigo Health Program. The  
4 Part repeals the savings offset payment and puts in its place an assessment on carriers and  
5 hospitals. The Part requires carriers to pay an assessment equal to 1% of gross direct  
6 premiums for health insurance. The Part also increases the tax payable by hospitals by  
7 1% of net operating revenue. The assessments and hospital revenues must be pooled  
8 with other revenues of the Dirigo Health Program in the Dirigo Health Enterprise Fund. If  
9 the assessments paid in any year exceed \$50,000,000, the Part requires Dirigo Health to  
10 use those excess funds to provide subsidies to eligible businesses. The Part also  
11 establishes a voluntary checkoff on individual income tax returns for contributions to the  
12 Dirigo Health Enterprise Fund to support the costs of health insurance coverage for the  
13 uninsured and underinsured.

14 Part K corrects cross-references.

15 Part L adds an appropriations and allocations section.

16 **FISCAL NOTE REQUIRED**  
17 **(See attached)**





# 123rd MAINE LEGISLATURE

LD 1890

LR 2620(04)

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

Fiscal Note for Bill as Amended by Committee Amendment "C"

Committee: Insurance and Financial Services

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	\$28,907,000	\$8,327,000	\$8,327,000
<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 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, and replace this revenue with a 1% increase in the hospital assessment and a 1% health insurance carrier assessment. For the purposes of this fiscal note, the baseline assumption for future year SOPs 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 increase in the hospital assessment will result in an increase in MaineCare cost -- the tax is a reimbursable cost for some hospitals and services - that is funded by a transfer from Dirigo to the MaineCare program.

This bill includes 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. Any 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.

<b>Dirigo Health Fund Summary</b>	<b>2007-08</b>	<b>2008-09</b>	<b>Projections 2009-10</b>	<b>Projections 2010-11</b>
<b>Revenue Changes:</b>				
Elimination of the Savings Offset Payment	\$0	(\$13,720,000)	(\$34,300,000)	(\$34,300,000)
Increased Hospital Assessment (1%)	\$0	\$26,906,000	\$26,906,000	\$26,906,000
Health Insurance Carrier Assessment (1%)	\$0	\$15,721,000	\$15,721,000	\$15,721,000
Subtotal Revenue Changes	\$0	\$28,907,000	\$8,327,000	\$8,327,000
<b>Transfers:</b>				
To MaineCare for hospital assessment costs	\$0	(\$1,504,290)	(\$1,504,290)	(\$1,504,290)
To Maine Revenue Services for check off	\$0	(\$16,142)	(\$5,412)	(\$5,412)
Net Change in Dirigo Allocation		\$27,386,568	\$6,817,298	\$6,817,298