L.D. 1333

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INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

125TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 979, L.D. 1333, Bill, "An Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services"

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 §2736-C, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §1 and affected by §10, is further amended to read:

C. A carrier may vary the premium rate due to ~~smoking status~~ geographic area and family membership. The superintendent may adopt rules setting forth appropriate methodologies regarding ~~rate discounts~~ rating based on ~~smoking status~~ geographic area. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~II-A~~ 2-A.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2007, c. 629, Pt. A, §4, is further amended to read:

D. A carrier may vary the premium rate due to age and ~~geographic area~~ smoking status in accordance with the limitations set out in this paragraph.

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

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

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1995 and June 30, ~~2009~~ 2012, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

~~(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2009, for each health benefit plan offered by a carrier, the highest premium rate for each rating tier may not exceed 2.5 times the premium rate that could be charged to an eligible individual with the lowest premium rate for that rating tier in a given rating period. For purposes of this subparagraph, "rating tier" means each category of individual or family composition for which a carrier charges separate rates.~~

~~(a) In determining the rating factor for geographic area pursuant to this subparagraph, the ratio between the highest and lowest rating factor used by a carrier for geographic area may not exceed 1.5 and the ratio between highest and lowest combined rating factors for age and geographic area may not exceed 2.5.~~

~~(b) In determining rating factors for age and geographic area pursuant to this subparagraph, no resulting rates, taking into account the savings resulting from the reinsurance program created by chapter 54, may exceed the rates that would have resulted from using projected claims and expenses and the rating factors applicable prior to July 1, 2009, as determined without taking into account the savings resulting from the Maine Individual Reinsurance Association established in chapter 54.~~

~~(c) The superintendent shall adopt rules setting forth appropriate methodologies regarding determination of rating factors pursuant to this subparagraph. Rules adopted pursuant to this division are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.~~

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

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

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

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the maximum rate differential due to smoking status filed by the carrier as determined by ratio is 1.5 to 1.

Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶H, as enacted by PL 2007, c. 629, Pt. A, §6, is repealed.

Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶I is enacted to read:

I. A carrier that offered individual health plans prior to July 1, 2012 may close its individual book of business sold prior to July 1, 2012 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after July 1, 2012. If a carrier closes its individual book of business as permitted under this paragraph, the carrier may vary the premium rate for individuals in that closed book of business only as permitted in this paragraph.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 1, 2012 and December 31, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2013 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2012, the maximum rate differential due to smoking status filed by the carrier as determined by ratio is 1.5 to 1.

The superintendent shall establish by rule procedures and policies that facilitate the implementation of this paragraph, including, but not limited to, notice requirements for policyholders and experience pooling requirements of individual health products. When establishing rules regarding experience pooling requirements, the superintendent shall ensure, to the greatest extent possible, the availability of affordable options for individuals transitioning from the closed book of business. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The superintendent shall direct the Consumer Health Care Division, established in section 4321, to work with carriers and health advocacy organizations to provide information about comparable alternative insurance options to individuals in a carrier's closed book of business and upon request to assist individuals to facilitate the transition to an individual health plan in that carrier's or another carrier's open book of business.

Sec. A-5. 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 occupation and industry, geographic area, family membership, ~~smoking status,~~ participation in wellness programs and group size. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for participation in wellness programs and rating for geographic area, family membership and group size 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-6. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §4 and affected by §10, is further amended to read:

D. A carrier may vary the premium rate due to age~~, occupation or industry and geographic area~~ and smoking status only under the following schedule and within the listed percentage bands.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.

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

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after~~ between July 15, 1995 and September 30, 2011, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%~~, except as provided in paragraph D-1~~.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and December 31, 2012, the maximum rate differential due to age filed by the carrier

as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2013 and December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(7) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(8) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(9) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to smoking status filed by the carrier as determined by ratio is 1.5 to 1.

Sec. A-7. 24-A MRSA §2808-B, sub-§2, ¶D-1, as amended by PL 2001, c. 410, Pt. A, §5 and affected by §10, is repealed.

Sec. A-8. 24-A MRSA §2808-B, sub-§2, ¶H is enacted to read:

H. A carrier that offered small group health plans prior to October 1, 2011 may close its small group book of business sold prior to October 1, 2011 and may establish a separate community rate for eligible groups applying for coverage under a small group health plan on or after October 1, 2011. If a carrier closes its small group book of business as permitted under this paragraph, the carrier may vary the premium rate for that closed book of business only as permitted in this paragraph.

(1) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between October 1, 2011 and December 31, 2012, the maximum rate differential due to age filed by the carrier as determined by ratio is 2 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2013 and

December 31, 2013, the maximum rate differential due to age filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2014 and December 31, 2014, the maximum rate differential due to age filed by the carrier as determined by ratio is 3 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State between January 1, 2015 and December 31, 2015, the maximum rate differential due to age filed by the carrier as determined by ratio is 4 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(5) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2016, the maximum rate differential due to age filed by the carrier as determined by ratio is 5 to 1. The limitation does not apply for determining rates for an attained age of less than 19 years of age or more than 65 years of age.

(6) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 2011, the maximum rate differential due to smoking status filed by the carrier as determined by ratio is 1.5 to 1.

PART B

Sec. B-1. 5 MRSA §12004-G, sub-§14-F, as enacted by PL 2007, c. 629, Pt. A, §1, is repealed.

Sec. B-2. 5 MRSA §12004-G, sub-§14-H is enacted to read:

14-H.

Health Care	Board of Directors of the Maine Guaranteed Access Reinsurance Association	Expenses Only	24-A §3953

Sec. B-3. 24-A MRSA §423-E, as enacted by PL 2007, c. 629, Pt. A, §2, is repealed.

Sec. B-4. 24-A MRSA §2736-C, sub-§2, ¶G, as enacted by PL 2007, c. 629, Pt. A, §5, is repealed.

Sec. B-5. 24-A MRSA §2736-C, sub-§2-A, as enacted by PL 2007, c. 629, Pt. A, §7, is repealed.

Sec. B-6. 24-A MRSA §2736-C, sub-§3, as corrected by RR 2001, c. 1, §30, is amended to read:

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

A. Coverage must be guaranteed to all residents of this State other than those eligible without paying a premium for Medicare Part A and may be reinsured through the Maine Guaranteed Access Reinsurance Association established pursuant to chapter 54-A. On or after ~~January 1, 1998~~ July 1, 2012, coverage must be guaranteed to all legally domiciled federally eligible individuals, as defined in section 2848, regardless of the length of time they have been legally domiciled in this State. Except for federally eligible individuals, coverage need not be issued to an individual whose coverage was terminated for nonpayment of premiums during the previous 91 days or for fraud or intentional misrepresentation of material fact during the previous 12 months. When a managed care plan, as defined by section 4301-A, provides coverage a carrier may:

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

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

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

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

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

B. Renewal is guaranteed, pursuant to section 2850-B.

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

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

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

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

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

E. A carrier may evaluate the health status of an individual for purposes of designating that individual for reinsurance through the Maine Guaranteed Access Reinsurance Association established in chapter 54-A. For individual health plans issued on or after July 1, 2012, the carrier shall use the health statement developed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association pursuant to section 3955, subsection 1, paragraph E to make a designation and may not use any other method to determine the health status of an individual. For purposes of this subsection, "health statement" means any information intended to inform the carrier or an insurance producer acting on behalf of a carrier of the health status of an enrollee or prospective enrollee in an individual health plan.

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

Sec. B-7. 24-A MRSA c. 54, as amended, is repealed.

Sec. B-8. 24-A MRSA c. 54-A is enacted to read:

CHAPTER 54-A

MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION ACT

§3951. Short title

This chapter may be known and cited as "the Maine Guaranteed Access Reinsurance Association Act."

§3952. Definitions

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

1. Association. "Association" means the Maine Guaranteed Access Reinsurance Association under section 3953.

2. Board. "Board" means the Board of Directors of the Maine Guaranteed Access Reinsurance Association under section 3953, subsection 2.

3. Covered person. "Covered person" means an individual covered as a policyholder, participant or dependent under a plan, policy or contract of medical insurance.

4. Dependent. "Dependent" means a spouse, a domestic partner as defined in section 2832-A, subsection 1 or a child under 26 years of age.

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

6. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. For the purposes of this chapter, "insurer" includes an insurance company, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insured employer subject to state regulation as described in section 2848-A, a 3rd-party administrator, a multiple-employer welfare arrangement, a reinsurer that reinsures health insurance in this State, a captive insurance company established pursuant to chapter 83 that insures the health coverage risks of its members, the Dirigo Health Program established in chapter 87 or any other state-sponsored health benefit program whether fully insured or self-funded.

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

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

9. Member insurer. "Member insurer" means an insurer that offers individual health plans and is actively marketing individual health plans in this State.

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

11. Reinsurer. "Reinsurer" means an insurer from whom a person providing health insurance for a resident procures insurance for itself with the insurer with respect to all or part of the medical insurance risk of the person. "Reinsurer" includes an insurer that provides employee benefits excess insurance.

12. Resident. "Resident" has the same meaning as in section 2736-C, subsection 1, paragraph C-2.

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

§3953. Maine Guaranteed Access Reinsurance Association

1. Guaranteed access reinsurance mechanism established. The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business in the State, an insurer that has issued or administered medical insurance within the previous 12 months or is actively marketing a medical insurance policy or medical insurance administrative services in this State must

participate in the association. The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association.

2. Board of directors. The association is governed by the Board of Directors of the Maine Guaranteed Access Reinsurance Association established under Title 5, section 12004-G, subsection 14-H.

A. The board consists of 11 members appointed as described in this paragraph:

(1) Six members appointed by the superintendent: 2 members chosen from the general public and who are not associated with the medical profession, a hospital or an insurer; 2 members who represent medical providers; one member who represents a statewide organization that represents small businesses; and one member who represents producers. A board member appointed by the superintendent may not be removed without cause; and

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

B. Members of the board serve for 3-year terms. Members of the board may serve up to 3 consecutive terms.

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

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

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

4. Immunity. A board member is not liable and is immune from suit at law or equity for any conduct performed in good faith that is within the scope of the board's jurisdiction.

§3954. Liability and indemnification

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

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

§3955. Duties and powers of association

1. Duties. The association shall:

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

B. Select an association administrator in accordance with section 3956;

C. Collect the assessments provided in section 3957. The level of payments must be established by the board. Assessments must be collected pursuant to the plan of operation approved by the board and adopted pursuant to section 3953, subsection 3. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred before receipt of the first calendar year assessments;

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

E. Develop a health statement to be used by a member insurer to designate a resident for reinsurance pursuant to section 3959; and

F. Provide for reinsurance for member insurers pursuant to section 3958.

2. Powers. The association may:

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

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

C. Sue or be sued and may take legal actions necessary or proper to recover or collect assessments provided in section 3957 due the association;

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

E. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance and any other function within the authority of the association;

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

G. Provide for reinsurance of risks incurred by members of the association and purchase reinsurance retroceding those risks to the extent the board determines appropriate. The provision of reinsurance may not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers; and

H. Apply for funds or grants from public or private sources, including federal grants.

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

4. Review for solvency. An annual review of the association for solvency must be performed by an independent certified public accountant using generally accepted accounting principles. The association shall submit the annual review to the superintendent. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to increase its assessments. If the superintendent determines that the funds of the association are insufficient, the superintendent may order the association to charge additional assessments.

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

6. Audit. The association must be audited at least annually by an independent certified public auditor. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

§3956. Selection of administrator

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

2. Contract with administrator. The administrator selected pursuant to subsection 1 serves for a period of 3 years pursuant to a contract with the association. At least one year prior to the expiration of that 3-year period of service, the board shall invite all insurers, including the current administrator, to submit bids to serve as the administrator for the succeeding 3-year period. The board shall select the administrator for the succeeding period at least 6 months prior to the ending of the 3-year period.

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

A. Perform all administrative functions relating to the association;

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

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

D. Pay reinsurance amounts as provided for in the plan of operation under section 3953, subsection 3.

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

§3957. Assessments against insurers

1. Assessments. For the purpose of providing the funds necessary to carry out the powers and duties of the association under section 3955, the board shall assess insurers at such a time and for such amounts as the board finds necessary. Assessments are due not less than 30 days after written notice to the insurers and accrue interest at 12% per annum on and after the due date.

2. Maximum assessment. The board shall assess each insurer an amount not to exceed $4 per month per covered person enrolled in medical insurance insured, reinsured or administered by the insurer. An insurer may not be assessed on policies or contracts insuring federal or state employees.

3. Determination of assessment. The board shall make reasonable efforts to ensure that each covered person is counted only once with respect to an assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all persons whose coverage is insured, in whole or in part, through excess or stop loss coverage. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this subsection. The board may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is not reported.

4. Organizational assessments. The board may assess insurers for the purpose of organizing the association. Organizational assessments must be equal in amount for all insurers but may not exceed $500 per insurer for all such assessments.

5. Assessments to cover net losses. In addition to the assessment described in subsections 1 to 3, the board shall assess insurers at such a time and for such amounts as the board finds necessary to cover any net loss in accordance with this subsection.

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

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

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

6. Deferral of assessment. An insurer may apply to the superintendent for a deferral of all or part of an assessment imposed by the association under this section. The superintendent may defer all or part of the assessment if the superintendent determines that the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.

7. Excess funds. If assessments and other receipts by the association, board or administrator selected pursuant to section 3956 exceed the actual losses and administrative expenses of the association, the board shall hold the excess as interest and shall use those excess funds to offset future losses or to reduce reinsurance premiums. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

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

9. Federal funding; reduction of assessment. The board shall work collaboratively with the Dirigo Health Program established pursuant to chapter 87 to develop a proposal to access unused funds from the State's allocation from the federal preexisting condition insurance plan established pursuant to the federal Affordable Care Act to be used to fund, in part, the operations of the association. Any federal funding obtained by the association must be used to reduce the assessment of member insurers required under this section. In developing the proposal, funds necessary for the federal preexisting condition insurance plan as currently administered by Dirigo Health have priority over any funds transferred to the association.

§3958. Reinsurance; premium rates

1. Reinsurance amount. A member insurer offering an individual health plan must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for the reinsurance premium rate established in accordance with subsection 2.

A. The association may not reimburse a member insurer with respect to claims of a person designated for reinsurance by the member insurer pursuant to section 3959 until the insurer has incurred an initial level of claims for that person of $7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The association shall reimburse insurers for claims paid in excess of $32,500. The association may annually adjust the initial level of claims and the maximum limit to be retained by the insurer to reflect increases in costs and utilization within the standard market for individual health plans within the State. The adjustments may not be less than the annual change in the Consumer Price Index for medical care services unless the superintendent approves a lower adjustment factor as requested by the association.

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

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that reasonably approximate gross premiums charged for individual health plans and that are adjusted to reflect retention levels required under this Title. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by a insurer.

§3959. Designation for reinsurance

1. Designation. The association shall provide reinsurance to a member insurer for persons designated by a member insurer using the health statement developed by the board pursuant to section 3955, subsection 1, paragraph F.

2. Designation without application. The board shall develop a list of medical or health conditions for which a person is automatically designated for reinsurance. A person who demonstrates the existence or history of any medical or health conditions on the list developed by the board may not be required to complete the health statement specified in subsection 1. The board may amend the list from time to time as appropriate.

§3960. Actions against association or insurers based upon joint or collective actions

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

§3961. Reimbursement of member insurer

1. Reimbursement. A member insurer may seek reimbursement from the association and the association shall reimburse the member insurer to the extent claims made by a covered person on a calendar year basis after July 1, 2012 exceed the amounts otherwise eligible for reimbursement pursuant to section 3958, subsection 1, paragraph A, if:

A. The member insurer sold an individual health plan to the covered person between December 1, 1993 and July 1, 2012, the individual health plan that was sold has been continuously renewed by the covered person and the member insurer has closed its book of business for individual health plans sold between December 1, 1993 and July 1, 2012; and

B. The member insurer is able to determine through the use of individual health statements, claims history, risk scores or any reasonable means that, between December 1, 1993 and July 1, 2012, while the person received coverage under an individual health plan issued by the member insurer, the covered person would have been designated by the member insurer pursuant to section 3959, subsection 1.

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

Sec. B-9. Maine Guaranteed Access Reinsurance Association staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 3953, subsection 2, of the members of the Board of Directors of the Maine Guaranteed Access Reinsurance Association initially appointed by the Superintendent of Insurance, 2 members serve for terms of one year, 2 members for terms of 2 years and 2 members for terms of 3 years and, of those members initially appointed by the member insurers, one member serves for a term of one year, 2 members serve for terms of 2 years and 2 members serve for terms of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

Sec. B-10. Effective date. Those sections of this Part that repeal the Maine Revised Statutes, Title 5, section 12004-G, subsection 14-F, Title 24-A, section 423-E, Title 24-A, section 2736-C, subsection 2, paragraph G, Title 24-A, section 2736-C, subsection 2-A and Title 24-A, chapter 54 and that section of this Part that amends Title 24-A, section 2736-C, subsection 3 take effect July 1, 2012.

PART C

Sec. C-1. 24-A MRSA §405, sub-§6, as enacted by PL 1969, c. 132, §1, is amended to read:

6. Any suit or action by the duly constituted receiver, rehabilitator or liquidator of the insurer, or of the insurer's assignee or successor, under laws similar to those contained in chapter 57 ~~(delinquency proceedings; rehabilitation and liquidation).~~; or

Sec. C-2. 24-A MRSA §405, sub-§7 is enacted to read:

7. Transactions pursuant to individual health insurance covering residents of this State written by a regional insurer or health maintenance organization, as defined in section 405-A, duly authorized or qualified to transact individual health insurance in the state or country of its domicile if the superintendent certifies that the regional insurer or health maintenance organization meets the requirements of section 405-A.

Sec. C-3. 24-A MRSA §405-A is enacted to read:

§405-A. Certification of regional insurers or health maintenance organizations to transact individual health insurance

1. Regional insurer or health maintenance organization defined. As used in this section, "regional insurer or health maintenance organization" means an insurer or health maintenance organization that holds a valid certificate of authority to transact individual health insurance in Connecticut, Massachusetts, New Hampshire or Rhode Island.

2. Certification of regional insurers or health maintenance organizations. A regional insurer or health maintenance organization may not transact individual health insurance in this State by mail, the Internet or otherwise unless the superintendent has issued a certification that the regional insurer or health maintenance organization has met the requirements of this subsection. The superintendent shall issue a certification or deny certification within 30 days of a request.

A. A policy, contract or certificate of individual health insurance offered for sale in this State by a regional insurer or health maintenance organization must comply with the applicable individual health insurance laws in the state of domicile of that regional insurer and must be actively marketed in that state.

B. A regional insurer or health maintenance organization shall meet the requirements of section 4302 for reporting plan information with respect to individual health plans offered for sale in this State and disclose to prospective enrollees how the health plans differ from individual health plans offered by domestic insurers in a format approved by the superintendent. Health plan policies and applications for coverage must contain the following disclosure statement or a substantially similar statement: "This policy is issued by a regional insurer or health maintenance organization and is governed by the laws and rules of (regional insurer's or health maintenance organization's state of domicile). This policy may not be subject to all the insurance laws and rules of the State of Maine, including coverage of certain health care services or benefits mandated by Maine law. Before purchasing this policy, you should carefully review the terms and conditions of coverage under this policy, including any exclusions or limitations of coverage."

C. A regional insurer or health maintenance organization shall meet the requirements of section 4303, subsection 4 for grievance procedures with respect to health plans offered for sale in this State.

D. A regional insurer or health maintenance organization shall meet the requirements of chapter 56-A for provider network adequacy with respect to health plans offered for sale in this State.

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E. A regional insurer or health maintenance organization shall meet the requirements of chapter 33 with respect to rates for individual health plans offered for sale in this State.

F. A regional insurer or health maintenance organization shall designate an agent for receiving service of legal documents or process in the manner provided in this Title.

G. A regional insurer or health maintenance organization shall meet the requirements of this Title with respect to allowing the superintendent access to records of the regional insurer or health maintenance organization.

3. Unfair trade practices. The provisions of chapter 23 apply to a regional insurer or health maintenance organization permitted to transact individual health insurance under this section or section 405.

4. Taxes; assessments. A regional insurer or health maintenance organization transacting individual health insurance in this State under this section is subject to applicable taxes or assessments imposed on insurers transacting individual health insurance in this State pursuant to this Title and Title 36.

5. Compliance with court orders. A regional insurer or health maintenance organization transacting individual health insurance in this State under this section shall comply with lawful orders from courts of competent jurisdiction issued in a voluntary dissolution proceeding or in response to a petition for an injunction by the superintendent asserting that the regional insurer or health maintenance organization is in a hazardous financial condition.

6. Exemption from other requirements. Except as expressly provided in this section, the requirements of this Title do not apply to a regional insurer or health maintenance organization permitted to transact individual health insurance under this section.

7. Agreement with insurance regulators in other state. The superintendent shall enter into a memorandum of understanding or other agreement with the insurance department of the state of domicile of a regional insurer or health maintenance organization permitted to transact individual health insurance in this State under this section with respect to enforcement of the provisions of this section.

8. Sale of policies. An individual health insurance policy, contract or certificate may not be offered for sale in this State pursuant to this section before January 1, 2014.

Sec. C-4. 24-A MRSA §405-B is enacted to read:

§405-B. Domestic insurers or licensed health maintenance organization; individual health insurance approved in other states

Notwithstanding any other provision of this Title, a domestic insurer or licensed health maintenance organization authorized to transact individual health insurance in this State may offer for sale in this State an individual health plan duly authorized for sale in Connecticut, Massachusetts, New Hampshire or Rhode Island by a parent or corporate affiliate of the domestic insurer or licensed health maintenance organization if the following requirements are met.

1. Certificate of authority from state of domicile. The parent or subsidiary of the domestic insurer or licensed health maintenance organization must hold a valid certificate of authority to transact individual health insurance in the state of domicile of the parent or corporate affiliate.

2. Compliance with laws of state of domicile. A policy, contract or certificate of individual health insurance offered for sale in this State by the domestic insurer or licensed health maintenance organization must comply with the applicable individual health insurance laws in the state of domicile of the parent or corporate affiliate and must be actively marketed in that state.

3. Disclosure and reporting. The domestic insurer or licensed health maintenance organization shall meet the requirements of section 4302 for reporting plan information with respect to individual health plans offered for sale in this State and disclose to prospective enrollees how the individual health plans of the parent or subsidiary differ from individual health plans offered by other domestic insurers or licensed health maintenance organizations in a format approved by the superintendent. Health plan policies and applications for coverage must contain the following disclosure statement or a substantially similar statement: "This policy is issued by a domestic insurer or licensed health maintenance organization but is governed by the laws and rules of (state of domicile of parent or corporate affiliate of domestic insurer or licensed health maintenance organization), which is the state of domicile of the parent or corporate affiliate of the domestic insurer or licensed health maintenance organization. This policy may not be subject to all the insurance laws and rules of the State of Maine, including coverage of certain health care services or benefits mandated by Maine law. Before purchasing this policy, you should carefully review the terms and conditions of coverage under this policy, including any exclusions or limitations of coverage."

4. Grievance procedures. The domestic insurer or licensed health maintenance organization shall meet the requirements of section 4303, subsection 4 for grievance procedures with respect to health plans offered for sale in this State.

5. Sale of policies. A domestic insurer or licensed health maintenance organization may not offer an individual health plan for sale in this State pursuant to this section before January 1, 2014.

Sec. C-5. 24-A MRSA §405-C is enacted to read:

§405-C. Domestic insurers or licensed health maintenance organizations; parity with regional insurers

Notwithstanding any other provision of this Title, a domestic insurer or licensed health maintenance organization authorized to transact individual health insurance in this State may offer for sale in this State an individual health plan equivalent to any plan offered for sale in this State by a regional insurer or health maintenance organization pursuant to section 405-A. An individual health plan may not be offered for sale pursuant to this section before January 1, 2014.

PART D

Sec. D-1. 24-A MRSA §14 is enacted to read:

§14. Affordable Care Act defined

As used in this Title, "federal Affordable Care Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts.

Sec. D-2. 24-A MRSA §2736-C, sub-§2-B is enacted to read:

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

A. A carrier's individual health plans are considered credible if the anticipated average number of members during the period for which the rates will be in effect is at least 1,000 in the aggregate or if the individual health plans in the aggregate meet credibility standards adopted by the superintendent by rule. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than 1,000 and the carrier does not satisfy any alternative credibility standards adopted by the superintendent by rule, the filing is subject to subsection 1 and section 2736-A.

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing aggregate earned premiums and incurred claims for the period the rates were in effect. Incurred claims must include claims paid to a date after the end of the annual reporting period and an estimate of unpaid claims. The report must state how the unpaid claims estimate was determined. The superintendent shall determine the reporting period and the paid-to date; beginning January 1, 2011, both the reporting period and the paid-to date must be consistent with those for the rebates required pursuant to the federal Affordable Care Act and federal regulations adopted pursuant to the federal Affordable Care Act.

Sec. D-3. 24-A MRSA §2736-C, sub-§5, as amended by PL 2007, c. 629, Pt. M, §5, is further amended to read:

5. Loss ratios. ~~For~~ Except as provided in subsection 2-B, for all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any payments paid pursuant to former section 6913 must be treated as incurred claims.

Sec. D-4. 24-A MRSA §2808-B, sub-§2-C, ¶B, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing aggregate earned premiums and incurred claims for the period the rates were in effect. Incurred claims must include claims paid to a date ~~6 months~~ after the end of the annual reporting period ~~determined by the superintendent~~ and an estimate of unpaid claims. The report must state how the unpaid claims estimate was determined. The superintendent shall determine the reporting period and the paid-to date; beginning January 1, 2011, both the reporting period and the paid-to date must be consistent with those for the rebates required pursuant to section 4319 and to the federal Affordable Care Act and federal regulations adopted pursuant to the federal Affordable Care Act.

Sec. D-5. 24-A MRSA §2808-B, sub-§2-C, ¶C, as amended by PL 2007, c. 629, Pt. M, §10, is further amended to read:

C. If incurred claims were less than 78% of aggregate earned premiums over a continuous ~~36-month~~ 12-month period, the carrier shall refund a percentage of the premium ~~to the current in-force policyholder~~. ~~For the purposes of calculating this loss-ratio percentage, any payments paid pursuant to former section 6913 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums.~~The refund must be paid on a basis consistent with requirements for rebates pursuant to section 4319 and to the federal Affordable Care Act and federal regulations adopted pursuant to the federal Affordable Care Act. The superintendent may adopt rules modifying the formula for calculation of refunds attributable to periods that are affected by the transition to calendar year reporting beginning with experience for 2011. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

(1) For determination of loss-ratio percentages in 2005, actual aggregate incurred claims expenses include expenses incurred in 2005 and projected expenses for 2006 and 2007. For determination of loss-ratio percentages in 2006, actual incurred claims expenses include expenses in 2005 and 2006 and projected expenses for 2007.

~~(2) The superintendent may waive the requirement for refunds during the first 3 years after the effective date of this subsection.~~

Sec. D-6. 24-A MRSA §4319 is enacted to read:

§4319. Rebates

1. Rebates required. Carriers must provide rebates in the large group, small group and individual markets to the extent required by the federal Affordable Care Act and federal regulations adopted pursuant thereto if the medical loss ratio under subsection 2 is less than the minimum medical loss ratio under subsection 3.

2. Medical loss ratio. For purposes of this section, the medical loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively, plus any credibility adjustment. The period for which the medical loss ratio is determined and the meaning of all terms used in this subsection must be in accordance with the federal Affordable Care Act and federal regulations adopted pursuant thereto. For the purposes of this subsection:

A. The numerator is the amount expended on reimbursement for clinical services provided to enrollees and activities that improve health care quality; and

B. The denominator is the total amount of premium revenue excluding federal and state taxes and licensing and regulatory fees paid and after accounting for payments or receipts for risk adjustment, risk corridors and reinsurance pursuant to federal law.

3. Minimum medical loss ratio. The minimum medical loss ratio is:

A. In the large group market, 85%;

B. In the small group market, 80%; and

C. In the individual market, 80% or such lower minimum medical loss ratio as the Secretary of the United States Department of Health and Human Services determines based on a finding, pursuant to the federal Affordable Care Act and federal regulations adopted pursuant thereto, that an 80% minimum medical loss ratio might destabilize the individual market in this State.

PART E

Sec. E-1. 2 MRSA §101, as amended by PL 2005, c. 369, §1 and amended by c. 397, Pt. C, §1 and affected by §2, is repealed.

Sec. E-2. 2 MRSA §103, as amended by PL 2009, c. 355, §§1 to 3, is repealed.

Sec. E-3. 2 MRSA §104, as amended by PL 2009, c. 609, §§1 to 3, is repealed.

PART F

Sec. F-1. 24-A MRSA §2736-C, sub-§8, as amended by PL 1999, c. 256, Pt. D, §2, is repealed.

Sec. F-2. 24-A MRSA §2839-A, sub-§1, as amended by PL 2005, c. 121, Pt. F, §1, is further amended to read:

1. Notice of rate increase on existing policies. An insurer offering group health insurance, except for accidental injury, specified disease, hospital indemnity, disability income, Medicare supplement, long-term care or other limited benefit group health insurance, must provide written notice by ~~first-class~~ mail or electronically of a rate increase to all affected policyholders or others who are directly billed for group coverage at least 60 days before the effective date of any increase in premium rates. An increase in premium rates may not be implemented until 60 days after the notice is provided. For small group health plan rates subject to section 2808-B, subsection 2-B, if the increase is

pending approval at the time of notice, the disclosure must state that the increase is subject to regulatory approval.

Sec. F-3. 24-A MRSA §2850-B, sub-§3, ¶I, as enacted by PL 2003, c. 428, Pt. A, §2, is amended to read:

I. In renewing an individual or small group policy in accordance with this section, a carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Modifications not meeting the requirements in this paragraph are considered a discontinuance of the product pursuant to paragraph G.

(1) A modification pursuant to this paragraph must be approved by the superintendent. The superintendent shall approve the modification if it meets the requirements of this section.

(2) A change in a requirement for eligibility is not a minor modification pursuant to this paragraph if the change results in the exclusion of a class or category of enrollees currently covered.

(3) Benefit modifications required by law are deemed minor modifications for purposes of this paragraph.

(4) Benefit modifications other than modifications required by law are minor modifications only if they meet the requirements of this subparagraph. For purposes of this subparagraph, changes in administrative conditions or requirements specified in the policy, such as preauthorization requirements, are not considered benefit modifications.

(a) The total of any increases in benefits may not increase the actuarial value of the total benefit package by more than 5%.

(b) The total of any decreases in benefits may not decrease the actuarial value of the total benefit package by more than 5%.

(c) For purposes of the calculations in divisions (a) and (b), increases and decreases must be considered separately and may not offset one another.

(5) A carrier must give 60 days' notice of any modification pursuant to this paragraph to all affected policyholders and certificate holders.

Sec. F-4. 24-A MRSA §4202-A, sub-§1, as amended by PL 2001, c. 218, §1, is further amended to read:

1. Basic health care services. "Basic health care services" means health care services that an enrolled population might reasonably require in order to be maintained in good health and includes, at a minimum, emergency care, inpatient hospital care, inpatient physician services, outpatient physician services, ancillary services such as x-ray services and laboratory services and all benefits mandated by statute and mandated by rule applicable to health maintenance organizations. The superintendent may adopt rules

defining "basic health care services" to be provided by health maintenance organizations. In adopting such rules, the superintendent shall consider the coverages that have traditionally been provided by health maintenance organizations; the need for flexibility in the marketplace; and the importance of providing multiple options to employers and consumers. ~~The superintendent may not require that all health benefit plans offered by health maintenance organizations meet or exceed each of the particular requirements of standard or basic health plans specified in Bureau of Insurance Rule, Chapter 750.~~ The superintendent ~~may select required services from among those set forth in Bureau of Insurance Rule, Chapter 750 and~~ shall permit reasonable, but not excessive or unfairly discriminatory, variations in the copayment, coinsurance, deductible and other features of ~~such~~ coverage, except that these features must meet or exceed those required in benefits mandated by statute. The superintendent shall permit deductible, coinsurance and copayment levels consistent with the deductible levels permitted for policies issued pursuant to chapter 33 or 35. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter ~~II-A~~ 2-A.

Sec. F-5. 24-A MRSA §4203, sub-§3, ¶S, as amended by PL 2003, c. 469, Pt. E, §18, is further amended to read:

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered. ~~This paragraph may not be construed to prohibit a health maintenance organization from offering a health plan that includes financial provisions designed to encourage members to use designated providers in a network in accordance with section 4303, subsection 1, paragraph A.~~

Sec. F-6. 24-A MRSA §4204, sub-§2-A, ¶N, as amended by PL 1995, c. 332, Pt. I, §2, is repealed.

Sec. F-7. 24-A MRSA §4303, sub-§1, as amended by PL 2009, c. 652, Pt. A, §33, is repealed and the following enacted in its place:

1. Demonstration of adequate access to providers. A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the superintendent. These standards may not require access to services based on specific travel times of members enrolled in a managed care plan.

Sec. F-8. 24-A MRSA §6603, sub-§9, as enacted by PL 2007, c. 278, §1, is repealed.

PART G

Sec. G-1. 24-A MRSA §2849-B, sub-§1, as amended by PL 1999, c. 36, §1, is further amended to read:

1. Policies subject to this section. This section applies to all individual, group and blanket medical insurance policies except hospital indemnity, specified accident,

specified disease, long-term care and short-term policies issued by insurers or health maintenance organizations. For purposes of this section, a short-term policy is an individual, nonrenewable policy issued for a term that ~~does not exceed~~ is less than 12 months. This section does not apply to Medicare supplement policies as defined in section 5001, subsection 4.

Sec. G-2. 24-A MRSA §2849-B, sub-§8, ¶B, as enacted by PL 1995, c. 342, §8, is amended to read:

B. An insurer or the insurer's agent or broker may not issue a short-term policy that replaces a prior short-term policy if the combined term of the new policy and all prior successive policies exceed ~~12~~ 24 months. All individuals making an application for coverage under a short-term policy must disclose any prior coverage under a short-term policy and the policy duration.

PART H

Sec. H-1. 36 MRSA §5122, sub-§1, ¶CC, as enacted by PL 2009, c. 213, Pt. BBBB, §5, is amended to read:

CC. For tax years beginning on or after January 1, 2009 but before January 1, 2011, an amount equal to the gross income during the taxable year from the discharge of indebtedness deferred under the Code, Section 108(i); ~~and~~

Sec. H-2. 36 MRSA §5122, sub-§1, ¶DD, as enacted by PL 2009, c. 213, Pt. ZZZ, §1, is amended to read:

DD. For any taxable year beginning in 2009, 2010 or 2011, an amount equal to the absolute value of any net operating loss carry-forward claimed for purposes of the federal income tax~~.~~; and

Sec. H-3. 36 MRSA §5122, sub-§1, ¶EE is enacted to read:

EE. The amount claimed as a deduction in determining federal adjusted gross income that is included in the credit for wellness programs under section 5219-FF.

Sec. H-4. 36 MRSA §5200-A, sub-§1, ¶V, as amended by PL 2009, c. 652, Pt. A, §54, is further amended to read:

V. For any taxable year beginning in 2009, 2010 or 2011, an amount equal to the absolute value of any net operating loss carry-forward claimed for purposes of the federal income tax; ~~and~~

Sec. H-5. 36 MRSA §5200-A, sub-§1, ¶W, as reallocated by PL 2009, c. 652, Pt. A, §55, is amended to read:

W. For tax years beginning on or after January 1, 2009 but before January 1, 2011, an amount equal to the gross income during the taxable year from the discharge of indebtedness deferred under the Code, Section 108(i)~~.~~; and

Sec. H-6. 36 MRSA §5200-A, sub-§1, ¶X is enacted to read:

X. The amount claimed as a deduction in determining federal taxable income that is included in the credit for wellness programs under section 5219-FF.

Sec. H-7. 36 MRSA §5219-FF is enacted to read:

§5219-FF. Credit for wellness programs

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

A. "Employee" means an individual who performs services for an employing unit.

B. "Employing unit" has the same meaning as in Title 26, section 1043, subsection 10.

C. "Qualified wellness program expenditure" means an expenditure made by an employing unit to develop, institute and maintain a wellness program.

D. "Wellness program" means a program instituted by an employing unit that improves employee health, morale and productivity, including, without limitation:

(1) Health education programs;

(2) Behavioral change programs, such as counseling or seminars or classes on nutrition, stress management or smoking cessation; and

(3) Incentive awards to employees who engage in regular physical activity.

2. Credit allowed. A taxpayer constituting an employing unit with 20 or fewer employees, on an average monthly basis during the taxable year, is allowed a credit against the tax imposed by this Part for each taxable year beginning on or after January 1, 2014 for a qualified wellness program expenditure made during the taxable year.

3. Record keeping. An employing unit seeking a credit under subsection 2 is responsible for recording the amount of time employees engage in wellness programs for which the employing unit is claiming an expense.

4. Limit; carry-over. The total credit for each taxpayer under this section is limited to $100 per employee or $2,000, whichever is less, per tax year. The credit may not reduce the tax otherwise due under this Part to less than zero. A taxpayer entitled to a credit under this section for any taxable year may carry over the portion, as reduced from year to year, of any unused credit and apply it to the tax liability for any one or more of the next succeeding 5 taxable years.

Sec. H-8. Application. This Part applies to tax years beginning on or after January 1, 2014.

PART I

Sec. I-1. 24-A MRSA §6702, sub-§4, as amended by PL 2009, c. 335, §9, is further amended to read:

4. License. If the superintendent is satisfied that the documents and statements filed by the captive insurance company under subsections 2 and 3 comply with this chapter, the superintendent may grant a license authorizing it to do insurance business in accordance with this subsection. ~~A captive insurance company shall comply with all~~

~~applicable federal and state laws relating to the risks insured pursuant to the license granted by the superintendent.~~

A. A captive insurance company shall comply with all applicable federal laws. A captive insurance company, other than an association captive insurance company preliminarily conditionally approved for a license before January 1, 2012 and that elects to secure coverage in accordance with section 6706, subsection 2-A, shall comply with state and federal laws relating to the risks insured pursuant to the license granted by the superintendent to the extent provided in rules adopted pursuant to this chapter.

B. An association captive insurance company insuring the health coverage risks of its members shall comply with the requirements for community rating and guaranteed issuance and renewal for association members pursuant to section 2808-B and any requirements for mandated benefits that apply to small group health plans.

C. The superintendent shall grant a license to an association captive insurance company that files an application in accordance with this section and satisfies the following requirements:

(1) The association captive insurance company insures only health risks and requires participating association members to be jointly and severally liable in accordance with section 6706, subsection 2-A;

(2) The association captive insurance company's plan of operation is fiscally sound and establishes dispute resolution mechanisms acceptable to the superintendent in accordance with this section and designates a 3rd-party administrator approved by the superintendent; and

(3) The superintendent determines that the association members have an aggregate net worth of at least $100,000,000.

Sec. I-2. 24-A MRSA §6702, sub-§7, ¶D, as amended by PL 2009, c. 335, §9, is further amended to read:

D. A captive insurance company may not provide personal motor vehicle or homeowner's insurance coverage or individual health insurance coverage or any component thereof;

Sec. I-3. 24-A MRSA §6704, sub-§1, as amended by PL 2009, c. 335, §10, is further amended to read:

1. Minimum capital and surplus. A captive insurance company may not be issued a license unless the company has and maintains unimpaired paid-in capital and surplus of:

A. In the case of a pure captive insurance company, not less than $250,000;

B. In the case of an association captive insurance company, not less than $750,000, except for an association captive insurance company insuring only health risks that elects to secure coverage in accordance with section 6706, subsection 2-A, maintains adequate reserve funds and has reinsurance unless the superintendent waives or modifies the reinsurance requirement. Reserve funds are presumed adequate if the association members have an aggregate net worth of at least $100,000,000 and the

superintendent determines that the funds are adequate to cover at least 3 months of claims and expenses;

C. In the case of an industrial insured captive insurance company, not less than $500,000;

D. In the case of a sponsored captive insurance company, not less than $500,000; and

E. In the case of a risk retention group, not less than $1,000,000.

The superintendent may prescribe additional capital based upon the type, volume and nature of insurance business transacted, except for an association captive health insurance company insuring only health risks that elects to secure coverage in accordance with section 6706, subsection 2-A.

Sec. I-4. 24-A MRSA §6706, sub-§2-A is enacted to read:

2-A. Association captive insurance company providing health insurance. An association captive insurance company that provides health insurance may elect to require, in its plan of operation, that all association members who participate in the health insurance be jointly and severally liable for the health insurance obligations of the association captive insurance company and meet the financial criteria and employer required wellness criteria established in the plan of operation. The wellness criteria may not have the effect of making health status a condition of eligibility for any association member. The superintendent may not require joint and several liability as a condition of approval of an application.

Sec. I-5. 24-A MRSA §6706, sub-§4, as amended by PL 2009, c. 335, §12, is further amended to read:

4. Applicability of chapter 47. To the extent ~~not inconsistent~~ consistent with this chapter, a captive insurance company is subject to the procedures applicable to domestic insurers pursuant to chapter 47 except that, if the surviving entity after a merger, consolidation, conversion or mutualization is a captive insurance company, a captive insurance company is subject to this chapter. With respect to mergers, consolidations, conversions and mutualizations, the superintendent, in the superintendent's discretion, may:

A. Waive any public hearing requirement;

B. Permit an alien insurer as a party to a merger as long as the requirements for a merger between a captive insurance company and a foreign insurer apply. For the purposes of this paragraph, an alien insurer must be treated as a foreign insurer and the jurisdiction of the alien insurer is considered a state; or

C. Approve the conversion of a captive insurance company organized as a stock insurer to a nonprofit corporation with one or more members or a limited liability company.

Sec. I-6. 24-A MRSA §6708, sub-§1, as enacted by PL 1997, c. 435, §1, is amended to read:

1. Powers, authorities and duties of superintendent. The powers, authorities and duties relating to examinations and investigations are vested in and imposed upon the superintendent ~~pursuant to chapter 3 are extended to and imposed upon the superintendent in respect to examinations of captive insurance companies to the same extent they would otherwise be applicable with respect to domestic insurers~~ in order for the superintendent to verify that all captive insurance companies operate in accordance with the provisions of this chapter.

Sec. I-7. 24-A MRSA §6718, as enacted by PL 1997, c. 435, §1, is amended to read:

§6718. Rules

The superintendent may adopt rules to implement this chapter. Rules adopted pursuant to this ~~chapter~~ section are ~~routine technical~~ major substantive rules as defined in Title 5, chapter 375, subchapter ~~II-A~~ 2-A.

Sec. I-8. 24-A MRSA §6719, as enacted by PL 1997, c. 435, §1, is amended to read:

§6719. Laws applicable

An insurance law of this State, other than described or referenced in this chapter, does not apply to a captive insurance company. This exclusion must be strictly construed so as to further the public policy in favor of providing alternative means for providing insurance coverage.

PART J

Sec. J-1. 5 MRSA §12004-I, sub-§31-A, as enacted by PL 2003, c. 469, Pt. B, §2, is repealed.

Sec. J-2. 22 MRSA §328, sub-§3-A, as enacted by PL 2003, c. 469, Pt. C, §2, is amended to read:

3-A. Capital investment fund. "Capital investment fund" means that fund ~~established by the Governor pursuant to~~ described in Title 2, section ~~101, subsection 1, paragraph D~~ 102.

Sec. J-3. 22 MRSA §328, sub-§27, as enacted by PL 2003, c. 469, Pt. C, §6, is repealed.

Sec. J-4. 22 MRSA §333-A, sub-§3, ¶A, as enacted by PL 2007, c. 681, §5, is amended to read:

A. The department may approve a nursing facility certificate of need application when the applicant proposes capital expenditures for renovations and improvements that are necessary:

(1) To achieve compliance with code and related regulatory requirements;

(2) To comply with the federal Health Insurance Portability and Accountability Act of 1996 and related patient privacy standards;

(3) To address other patient safety requirements and standards~~, consistent with the priorities set forth in the current State Health Plan~~; or

(4) To address other necessary and time-sensitive patient safety or compliance issues.

Sec. J-5. 22 MRSA §335, sub-§1, ¶B, as amended by PL 2005, c. 369, §7, is repealed.

Sec. J-6. 22 MRSA §335, sub-§7, as amended by PL 2005, c. 369, §8, is further amended to read:

7. Review; approval. Except as provided in section 336, the commissioner shall issue a certificate of need if the commissioner determines and makes specific written findings regarding that determination that:

A. The applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards;

B. The economic feasibility of the proposed services is demonstrated in terms of the:

(1) Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and

(2) Applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules;

C. There is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

(1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

(2) Whether the project will have a positive impact on the health status indicators of the population to be served;

(3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and

(4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

(1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

(2) The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and

(3) The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available; and

E. The project meets the criteria set forth in subsection 1.

In making a determination under this subsection, the commissioner shall use data ~~available in the State Health Plan under Title 2, section 103, including demographic, health care service and health care cost data, data~~ from the Maine Health Data Organization established in chapter 1683 and other information available to the commissioner. Particular weight must be given to information that indicates that the proposed health services are innovations in high-quality health care delivery, that the proposed health services are not reasonably available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.

~~In making all determinations under this subsection, the commissioner must be guided by the State Health Plan as described in Title 2, section 103.~~

Sec. J-7. 22 MRSA §412, sub-§4, ¶A, as enacted by PL 2009, c. 355, §5, is amended to read:

A. A district coordinating council for public health shall:

(1) Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and

~~(2) Provide a mechanism for districtwide input to the state health plan under Title 2, section 103;~~

~~(3) Ensure that the goals and strategies of the state health plan are addressed in the district; and~~

(4) Ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible.

Sec. J-8. 22 MRSA §412, sub-§6, ¶¶A and B, as enacted by PL 2009, c. 355, §5, are amended to read:

A. The Statewide Coordinating Council for Public Health shall:

(1) Participate as appropriate to help ensure the state public health system is ready and maintained for accreditation; and

~~(2) Provide a mechanism for the Advisory Council on Health Systems Development under Title 2, section 104 to obtain statewide input for the state health plan under Title 2, section 103;~~

~~(3) Provide a mechanism for disseminating and implementing the state health plan; and~~

(4) Assist the Maine Center for Disease Control and Prevention in planning for the essential public health services and resources to be provided in each district and across the State in the most efficient, effective and evidence-based manner possible.

The Maine Center for Disease Control and Prevention shall provide staff support to the Statewide Coordinating Council for Public Health as resources permit. Other agencies of State Government as necessary and appropriate shall provide additional staff support or assistance to the Statewide Coordinating Council for Public Health as resources permit.

B. Members of the Statewide Coordinating Council for Public Health are appointed as follows.

(1) Each district coordinating council for public health shall appoint one member.

(2) The Director of the Maine Center for Disease Control and Prevention or the director's designee shall serve as a member.

(3) The commissioner shall appoint an expert in behavioral health from the department to serve as a member.

(4) The Commissioner of Education shall appoint a health expert from the Department of Education to serve as a member.

(5) The Commissioner of Environmental Protection shall appoint an environmental health expert from the Department of Environmental Protection to serve as a member.

(6) The Director of the Maine Center for Disease Control and Prevention, in collaboration with the cochairs of the Statewide Coordinating Council for Public Health, shall convene a membership committee. After evaluation of the appointments to the Statewide Coordinating Council for Public Health, the membership committee shall appoint no more than 10 additional members and ensure that the total membership has at least one member who is a recognized content expert in each of the essential public health services~~,~~ and has representation from populations in the State facing health disparities ~~and has at least 2 members from the Advisory Council on Health Systems Development under Title 2, section 104~~. The membership committee shall also strive to ensure diverse representation on the Statewide Coordinating Council for Public Health from county governments, municipal governments, tribal governments, city health departments, local health officers, hospitals, health systems, emergency management agencies, emergency medical services, Healthy Maine Partnerships, school districts, institutions of higher education, physicians and other health care providers, clinics and community health centers, voluntary health organizations, family planning organizations, area agencies on aging, mental health services, substance abuse services, organizations seeking to improve environmental health and other community-based organizations.

Sec. J-9. 22 MRSA §412, sub-§6, ¶F, as enacted by PL 2009, c. 355, §5, is repealed and the following enacted in its place:

F. The Statewide Coordinating Council for Public Health shall report annually to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the Governor's office on progress made toward achieving and maintaining accreditation of the state public health system and on districtwide and statewide streamlining and other strategies leading to improved efficiencies and effectiveness in the delivery of essential public health services.

Sec. J-10. 22 MRSA §1711-E, sub-§5, as enacted by PL 2007, c. 460, §1, is amended to read:

5. Rules. The department~~, after consultation with the Governor's Office of Health Policy and Finance,~~ shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.

Sec. J-11. 22 MRSA §1844, sub-§2, ¶A, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

A. At least 45 days prior to filing an application for a certificate of public advantage for a merger, the parties to a merger agreement shall file a letter of intent with the department describing the proposed merger. Copies of the letter of intent and all accompanying materials must be submitted to the Attorney General ~~and to the Governor's Office of Health Policy and Finance~~ at the time the letter of intent is filed with the department.

Sec. J-12. 22 MRSA §1844, sub-§2, ¶D, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

D. The parties to a cooperative agreement shall submit copies of the application and all the accompanying materials to the Attorney General ~~and the Governor's Office of Health Policy and Finance~~ at the time they file the application with the department.

Sec. J-13. 22 MRSA §1844, sub-§4, ¶C, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

C. The department shall provide the Attorney General ~~and the Governor's Office of Health Policy and Finance~~ with copies of all comments from persons submitted under paragraph B.

Sec. J-14. 22 MRSA §1844, sub-§4, ¶F, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

F. The department shall issue a final decision to grant or deny an application for a certificate of public advantage under this section no less than 40 days and no more than 90 days after the filing of the application. The department shall issue a preliminary decision at least 5 days prior to issuing the final decision. The preliminary and final decisions must be in writing and set forth the basis for the decisions. The department shall provide copies of the preliminary and final decisions to the applicants, the Office of the Attorney General~~, the Governor's Office of Health~~

~~Policy and Finance~~ and all persons who requested notification from the department under subsection 3, paragraph B.

Sec. J-15. 22 MRSA §1844, sub-§6, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

6. Intervention. The Attorney General ~~and the Governor's Office of Health Policy and Finance~~ may intervene as a right in any proceeding under this chapter before the department. Except as provided in this subsection, intervention is governed by the provisions of Title 5, section 9054.

Sec. J-16. 22 MRSA §1845, sub-§1, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

1. Periodic report and supervisory review. With regard to a certificate of public advantage approved under this chapter, the certificate holder shall report periodically to the department on the extent of the benefits realized and compliance with other terms and conditions of the certificate. The certificate holder shall submit copies of the report to the Attorney General ~~and to the Governor's Office of Health Policy and Finance~~ at the time the report is filed with the department. The Attorney General ~~and the Governor's Office of Health Policy and Finance~~ may submit to the department comments on the report filed under this subsection. The department shall consider any comments on the report from the Attorney General ~~and the Governor's Office of Health Policy and Finance~~ in the course of its evaluation of the certificate holder's report. Within 60 days of receipt of the certificate holder's report, the department shall make findings regarding the report, including responses to any comments from the Attorney General ~~and the Governor's Office of Health Policy and Finance~~, determine whether to institute additional supervisory activities under this section and notify the certificate holder.

Sec. J-17. 22 MRSA §1845, sub-§2, ¶¶A and B, as enacted by PL 2005, c. 670, §1 and affected by §4, are amended to read:

A. The department shall conduct additional supervisory activities whenever requested by the Attorney General ~~or the Governor's Office of Health Policy and Finance,~~ or whenever the department, in its discretion, determines those activities appropriate, and:

(1) For certificates of public advantage not involving mergers, at least once in the first 18 months after the transaction described in the cooperative agreement has closed; and

(2) For certificates of public advantage involving mergers, at least once between 12 and 30 months after the transaction described in the cooperative agreement has closed.

B. In its discretion, the department may conduct additional supervisory activities by:

(1) Soliciting and reviewing written submissions from the certificate holders, the Attorney General~~, the Governor's Office of Health Policy and Finance~~ or the public;

(2) Conducting a hearing in accordance with Title 5, chapter 375, subchapter 4 and the department's administrative hearings rules; or

(3) Using any alternative procedures appropriate under the circumstances.

Sec. J-18. 22 MRSA §1849, sub-§5, as enacted by PL 2005, c. 670, §1 and affected by §4, is amended to read:

5. Termination; surrender. This chapter does not prohibit certificate holders from terminating their cooperative agreement by mutual agreement, consent decree or court determination or by surrendering their certificate of public advantage to the department. Any certificate holder that terminates the agreement shall file a notice of termination with the department within 30 days after termination, surrender the certificate of public advantage and submit copies to the Attorney General ~~and the Governor's Office of Health Policy and Finance~~ at the time the notice of termination is submitted to the department.

Sec. J-19. 22 MRSA §2061, sub-§2, as corrected by RR 2003, c. 2, §71, is amended to read:

2. Review. Each project for a health care facility has been reviewed and approved to the extent required by the agency of the State that serves as the designated planning agency of the State or by the Department of Health and Human Services in accordance with the provisions of the Maine Certificate of Need Act of 2002, as amended~~, and is consistent with the cost containment provisions for health care and health coverage of the State Health Plan adopted pursuant to Title 2, section 101, subsection 1, paragraph A~~;

Sec. J-20. 24-A MRSA §2694-A, sub-§3, as enacted by PL 2009, c. 350, Pt. B, §1, is repealed.

Sec. J-21. 24-A MRSA §2752, sub-§3, ¶A, as amended by PL 1997, c. 616, §5, is further amended to read:

A. The social impact of mandating the benefit, including:

(1) The extent to which the treatment or service is utilized by a significant portion of the population;

(2) The extent to which the treatment or service is available to the population;

(3) The extent to which insurance coverage for this treatment or service is already available;

(4) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(5) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(6) The level of public demand and the level of demand from providers for the treatment or service;

(7) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(8) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(9) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(10) The relevant findings of ~~the state health planning agency or~~ the appropriate health system agency relating to the social impact of the mandated benefit;

(11) The alternatives to meeting the identified need;

(12) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(13) The impact of any social stigma attached to the benefit upon the market;

(14) The impact of this benefit on the availability of other benefits currently being offered;

(15) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(16) The impact of making the benefit applicable to the state employee health insurance program;

Sec. J-22. 24-A MRSA §6904, sub-§1, as amended by PL 2007, c. 447, §4, is further amended to read:

1. Appointments. The board consists of 9 voting members and 4 3 ex officio, nonvoting members as follows.

A. The 9 voting members of the board are appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate in accordance with this paragraph.

(1) Five members qualified in accordance with subsection 2-A, paragraph A are appointed by the Governor.

(2) One member qualified in accordance with subsection 2-A, paragraph A is appointed by the Governor and must be selected from candidates nominated by the President of the Senate.

(3) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the Speaker of the House.

(4) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from the candidates nominated by the Senate Minority Leader.

(5) One member qualified in accordance with subsection 2-A, paragraph B is appointed by the Governor and must be selected from candidates nominated by the House Minority Leader.

B. The 4 3 ex officio, nonvoting members of the board are:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

~~(2) The director of the Governor's Office of Health Policy and Finance or the director of a successor agency;~~

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee; and

(4) The Treasurer of State or the treasurer's designee.

Sec. J-23. 24-A MRSA §6951, sub-§8, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

Sec. J-24. 24-A MRSA §6952, sub-§7, ¶D, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

D. Make recommendations regarding quality assurance and quality improvement priorities ~~for inclusion in the State Health Plan described in Title 2, chapter 5~~; and

PART K

Sec. K-1. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of 0092

Initiative: Allocates funds for a part-time (0.5) Actuary position and a part-time (0.5) Actuary Assistant position and related costs for the Bureau of Insurance to analyze an expected increase in insurance rate filings as a result of changes that will affect health care premiums.

OTHER SPECIAL REVENUE FUNDS	**2011-12**	**2012-13**
POSITIONS - FTE COUNT	1.000	1.000
Personal Services	$68,607	$93,191
All Other	$17,933	$11,249
OTHER SPECIAL REVENUE FUNDS TOTAL	$86,540	$104,440

SUMMARY

This amendment is the majority report of the committee and replaces the bill.

Part A makes the following changes to the community rating laws for individual and small group health insurance:

1. It changes the maximum rate differential for individual health plans on the basis of age from 1.5:1 to 5:1. The changes in rating for individual health plans are phased in over a period of 4 years;

2. It changes the maximum rate differential for small group health plans on the basis of age from 1.5:1 to 5:1. The changes in rating for small group health plans are phased in over a period of 4 years;

3. It authorizes a maximum rate differential on the basis of smoking status from 1.5:1; and

4. It allows rating on the basis of geographic area outside of the rating bands for age.

Part B modifies the laws relating to guaranteed issuance in the individual health insurance market to permit carriers to reinsure coverage offered to certain individuals identified using a health statement. Carriers are prohibited from using health status for any other purpose. Part B also creates the Maine Guaranteed Access Reinsurance Association. The purpose of the association is to provide reinsurance to spread the cost of certain individuals among all health insurers. The amendment funds the guaranteed access reinsurance through an assessment on insurers.

Part C permits insurers authorized to transact individual health insurance in Connecticut, Massachusetts, New Hampshire or Rhode Island to offer their individual health plans for sale in this State if certain requirements of Maine law are met, including minimum capital and surplus and reserve requirements, disclosure and reporting requirements and grievance procedures. If out-of-state health plans are offered for sale in this State, the amendment requires that prospective enrollees be provided adequate disclosure in a format approved by the Superintendent of Insurance of how the plans differ from Maine health plans. Part C also permits domestic insurers or licensed health maintenance organizations to offer individual health plans of a parent or corporate affiliate licensed to transact individual health insurance in Connecticut, Massachusetts, New Hampshire or Rhode Island if similar requirements are met. It also permits domestic insurers and licensed health maintenance organizations to offer plans equivalent to any plans offered by a regional insurer. Individual health insurance policies, contracts and certificates may not be offered for sale in this State pursuant to these provisions before January 1, 2014.

Part D adopts the definition of medical loss ratio in federal law and the minimum medical loss ratio requirements of federal law. Part D also allows individual health insurance rates to be filed for informational purposes without prior approval by the Department of Professional and Financial Regulation, Bureau of Insurance if the insurer maintains a minimum 80% medical loss ratio.

Part E repeals the State Health Plan and the Advisory Council on Health Systems Development.

Part F repeals the geographic access standards. Part F repeals the authorization for the Superintendent of Insurance to establish standardized individual health plans by rule. Part F also permits insurers offering group health insurance to notify affected

policyholders of a rate increase electronically as well as by mail. Part F clarifies that preauthorizations are not benefit modifications requiring prior approval of the Bureau of Insurance and authorizes health maintenance organizations to offer deductibles in excess of $1,000. Part F also clarifies that participation in the individual market is voluntary by removing the requirement that health maintenance organizations offering group coverage also offer individual coverage.

Part G authorizes the renewal of short-term health insurance policies for a period not to exceed 24 months instead of the current 12 months.

Part H provides a tax credit to employers of 20 or fewer employees for the expense of developing, instituting and maintaining wellness programs for their employees in the amount of $100 per employee, up to a maximum of $2,000. A wellness program includes programs for behavior modification, such as smoking cessation programs, equipping and maintaining an exercise facility and providing incentive awards to employees who exercise regularly.

Part I amends the chapter of the Maine Insurance Code governing captive insurance companies. The amendment clarifies that, in the event of any conflict between the provisions of other state insurance laws and the provisions of the laws governing captive insurance companies, the provisions of the captive insurance company laws control, except that a captive insurance company insuring health risks may not provide individual health insurance and, if it insures health risks of employers, a captive insurance company must comply with the same requirements of community rating, guaranteed issuance and renewal and mandated benefit laws applicable to small group health insurers. Part I permits an association captive insurance company to require its members to be jointly and severally liable for its health insurance obligations and to meet financial obligations and wellness criteria established in a plan of operation and provides solvency standards applicable to such captives. The amendment would require the Superintendent of Insurance to issue a license to an association captive insuring health risks for an association captive insurance company that requires its members to be jointly and severally liable and has an aggregate net worth of more than $100,000,000 and meets the requirements of the captive insurance law. Part I also specifies that rules related to captive insurance companies are major substantive rules.

Part J corrects cross-references and deletes references in statute to the Governor's Office of Health Policy and Finance, originally established in 2003 by executive order.

Part K adds an appropriations and allocations section.

FISCAL NOTE REQUIRED

(See attached)

Revised: 05/04/11 mac

125th MAINE LEGISLATURE

LD 1333 **LR 1371(02)**

An Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services

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

Fiscal Note

	FY 2011-12	FY 2012-13	Projections FY 2013-14	Projections FY 2014-15
Net Cost (Savings)				
General Fund	$0	$0	$75,148	$302,686
Appropriations/Allocations				
Other Special Revenue Funds	$86,540	$104,440	$110,071	$116,040
Revenue				
General Fund	$0	$0	($75,148)	($302,686)
Other Special Revenue Funds	$0	$0	($3,955)	($15,931)

Fiscal Detail and Notes

Providing an income tax credit in the amount of $100 per employee up to a total maximum credit of $2,000 per employer for tax years beginning on or after January 1, 2014 to employers of 20 or fewer employees for wellness programs such as smoking cessation programs, exercise facilities and incentives to exercise regularly will reduce General Fund revenue and reduce revenue sharing starting in fiscal year 2013-14.

Provides an Other Special Revenue Funds allocation of $86,540 in 2011-12 and $104,440 in 2012-13 for a part-time Actuary position and a part-time Actuary Assistant position and related costs for the Bureau of Insurance to analyze an expected increase in insurance rate filings as a result of changes that will affect health care premiums. The Bureau believes it can fund these positions within existing budgetary resources but should this not be the case, the Bureau has assessment authority under existing law to support the costs of the Bureau.

The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity and would therefore have no direct fiscal impact on State agencies or programs. Also assumes any Association assessment on member insurers would have no direct fiscal impact on State agencies or programs.

Assumes a number of provisions in the bill could have a fiscal impact on the Dirigo Health program. The net fiscal impact of these provisions on the Dirigo Health program can not be determined at this time.

Assumes eliminating the Governor's Office of Health Policy and Finance will not have a fiscal impact on the Office of the Governor. That Office no longer exists and the positions have already been assigned to other duties.