Date: 6/6/11

L.D. 1554

(Filing No. H-545)

INSURANCE AND FINANCIAL SERVICES

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

STATE OF MAINE

HOUSE OF REPRESENTATIVES

125TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 1140, L.D. 1554, Bill, "An Act To Implement the Requirements of the Federal Patient Protection and Affordable Care Act"

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

'**Sec. 1. 24-A MRSA §2735-A, sub-§1,** as amended by PL 2009, c. 244, Pt. C, §4, is further amended to read:

1. Notice of rate filing or rate increase on existing policies. An insurer offering individual health plans as defined in section 2736-C must provide written notice by first class mail of a rate filing to all affected policyholders at least 60 days before the effective date of any proposed increase in premium rates or any proposed rating formula, classification of risks or modification of any formula or classification of risks. ~~The~~ Except as otherwise provided in section 2736-C, subsection 2-B, the notice must also inform policyholders of their right to request a hearing pursuant to section 229. The notice must show the proposed rate and, unless otherwise provided in section 2736-C, subsection 2-B, state that the rate is subject to regulatory approval. ~~The~~ Except as otherwise provided in section 2736-C, subsection 2-B, the superintendent may not take final action on a rate filing until 40 days after the date notice is mailed by an insurer. An increase in premium rates may not be implemented until 60 days after the notice is provided or until the effective date under section 2736, whichever is later.

Sec. 2. 24-A MRSA §2736-A, first ¶, as amended by PL 2009, c. 439, Pt. C, §3, is further amended to read:

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate~~,~~ or unfairly discriminatory ~~or not in compliance with section 6913~~ or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory ~~and in compliance with section 6913~~.

Sec. 3. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2011, c. 90, Pt. A, §1, is further amended to read:

C. A carrier may vary the premium rate due to family membership to the extent permitted by the federal Affordable Care Act.

Sec. 4. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2011, c. 90, Pt. A, §3, is further amended to read:

D. A carrier may vary the premium rate due to age and ~~smoking status~~ tobacco use 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, 2012, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.

(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 to the extent permitted by the federal Affordable Care Act. 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 to the extent permitted by the federal Affordable Care Act. 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~~ tobacco use filed by the carrier as determined by ratio is 1.5 to 1.

Sec. 5. 24-A MRSA §2736-C, sub-§2, ¶I, as enacted by PL 2011, c. 90, Pt. A, §5, is amended 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 and paragraphs C and C-1.

(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 to the extent permitted by the federal Affordable Care Act. 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 to the extent permitted by the federal Affordable Care Act. 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~~ tobacco use 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. 6. 24-A MRSA §2736-C, sub-§2, ¶J is enacted to read:

J. Except for enrollees in grandfathered health plans under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all individual health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act.

Sec. 7. 24-A MRSA §2736-C, sub-§2-B, as enacted by PL 2011, c. 90, Pt. D, §2, is amended 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 credible block of 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~~ meets standards ~~adopted by the superintendent by rule~~ for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than ~~1,000 and the carrier does not satisfy any alternative credibility standards adopted by the superintendent by rule~~ needed to meet the credibility standard, the filing is subject to section 2736, 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~~ the calculation of rebates as required pursuant to the federal Affordable Care Act, except that the calculation must be based on a minimum medical loss ratio of 80% if the applicable federal minimum for the individual market in this State is lower. If the calculation indicates that rebates must be paid, the carrier

must pay the rebates in the same manner as is required for rebates pursuant to the federal Affordable Care Act.

Sec. 8. 24-A MRSA §2736-C, sub-§9, as enacted by PL 1995, c. 570, §7, is amended to read:

9. Exemption for certain associations. The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the requirements of subsection 3, paragraph A; subsection 6, paragraph A; and subsection 8 if:

A. Issuance and renewal of coverage under the policy or contract is guaranteed to all members of the association who are residents of this State and to their dependents;

B. Rates for the association comply with the premium rate requirements of subsection 2 or are established on a nationwide basis and substantially comply with the purposes of this section, except that exempted associations may be rated separately from the carrier's other individual health plans, if any;

C. The group's anticipated loss ratio, as defined in subsection 5, is at least 75%;

D. The association's membership criteria do not include age, health status, medical utilization history or any other factor with a similar purpose or effect;

E. The association's group health plan is not marketed to the general public;

F. The association does not allow insurance agents or brokers to market association memberships, accept applications for memberships or enroll members, except when the association is an association of insurance agents or brokers organized under section 2805-A;

G. Insurance is provided as an incidental benefit of association membership and the primary purposes of the association do not include group buying or mass marketing of insurance or other goods and services; and

H. Granting an exemption to the association does not conflict with the purposes of this section.

Except for individuals with grandfathered health plans under the federal Affordable Care Act, this subsection does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014.

Sec. 9. 24-A MRSA §2808-B, sub-§1, ¶D, as repealed and replaced by PL 2003, c. 428, Pt. H, §5, is amended to read:

D. "Eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 50 or fewer eligible employees during the preceding calendar year.

(1) If an employer was not in existence throughout the preceding calendar year, the determination must be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(2) In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(3) A group is not an eligible group if there is any one other state where there are more eligible employees than are employed within this State and the group had coverage in that state or is eligible for guaranteed issuance of coverage in that state.

(4) An employer qualifies as an eligible group for 2-person coverage if the employer provides a carrier with the following information demonstrating that the employer's business and employees meet the minimum qualifications for group coverage in paragraph C:

(a) A copy of the most recent quarterly combined filing for income tax withholding and unemployment contributions, Form 941/C1-ME;

(b) For an employee claimed to be an employee eligible for group coverage whose name is not listed on Form 941/C1-ME, a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding;

(c) If an employer is exempt from filing Form 941/C1-ME for group coverage, documentation of that exemption and a copy of the employer's payroll records for the most recent 3 months showing tax withholding or a wage report from a payroll company showing wages paid to that employee for the most recent quarter with tax withholding; or

(d) If the name of the business owner or employee does not appear on Form 941/C1-ME, a copy of one of the following:

(i) Federal income tax Form Schedule C or Schedule F;

(ii) Federal income tax Form 1120S, Schedule K-1;

(iii) Federal income tax Form 1065, Schedule K-1;

(iv) A workers' compensation insurance audit or evidence of a waiver of benefits under Title 39-A;

(v) A description of operations in a commercial general liability insurance policy or equivalent insurance policy providing coverage for the business; or

(vi) A signature card from a financial institution or credit union authorizing the employee to sign checks on a business checking or share draft account that is at least 6 months old; a notarized affidavit from the employer describing the duties of the employee and the average number of hours worked by the employee and attesting that the employer is not defrauding the carrier and is aware of the consequences of committing fraud or making a material misrepresentation to the carrier, including a

loss of coverage and benefits; and, if the group coverage is purchased through a producer, a notarized affidavit from the producer affirming the producer's belief that the employer qualifies as an eligible group for coverage.

In determining if a new business or a business that adds an owner or a new employee to payroll during the course of a year qualifies as an eligible group for 2-person coverage under this subparagraph, the employer must submit an affidavit stating that all employees meet the criteria in this subparagraph and that the documentation and forms required under this subparagraph will be provided to the carrier when payroll records become available, when ownership distribution forms become available or the first renewal date of the coverage, whichever date is earlier. A false affidavit or misrepresentation on an affidavit submitted by an employer may result in the loss of group coverage and repayment of claims paid. This subparagraph may not be construed to prohibit a carrier from recognizing an employer as an eligible group if the employer has not produced the documentation required in this subparagraph.

This subparagraph applies only to an employer applying for group health insurance coverage as a 2-person group ~~on or after~~ from October 1, 2001 to December 31, 2013.

Sec. 10. 24-A MRSA §2808-B, sub-§2, ¶C, as amended by PL 2011, c. 90, Pt. A, §6, is further amended to read:

C. A carrier may vary the premium rate due to occupation and industry, family membership, participation in wellness programs and group size to the extent permitted by the federal Affordable Care Act. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts for participation in wellness programs and rating for occupation and industry 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 2-A.

Sec. 11. 24-A MRSA §2808-B, sub-§2, ¶D, as amended by PL 2011, c. 90, Pt. A, §8, is further amended to read:

D. A carrier may vary the premium rate due to age and ~~smoking status~~ tobacco use 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 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%.

(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 to the extent permitted by the federal Affordable Care Act. 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 to the extent permitted by the federal Affordable Care Act. 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~~ tobacco use filed by the carrier as determined by ratio is 1.5 to 1.

Sec. 12. 24-A MRSA §2808-B, sub-§2, ¶E, as amended by PL 2001, c. 258, Pt. E, §4, is further amended to read:

E. The superintendent may authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group organized pursuant to section 2806, as long as association group membership or eligibility for participation in the trustee group is not conditional on health status, claims experience or other risk selection criteria and all small group health plans offered by the carrier through that association or trustee group:

(1) Are otherwise in compliance with the premium rate requirements of this subsection; and

(2) Are offered on a guaranteed issue basis to all eligible employers that are members of the association or are eligible to participate in the trustee group except that a professional association may require that a minimum percentage of the eligible professionals employed by a subgroup be members of the association in order for the subgroup to be eligible for issuance or renewal of coverage through the association. The minimum percentage must not exceed 90%. For purposes of this subparagraph, "professional association" means an association that:

(a) Serves a single profession that requires a significant amount of education, training or experience or a license or certificate from a state authority to practice that profession;

(b) Has been actively in existence for 5 years;

(c) Has a constitution and bylaws or other analogous governing documents;

(d) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

(g) Has a least 1,000 members if it is a national association; 200 members if it is a state or local association;

(h) All members and dependents of members are eligible for coverage regardless of health status or claims experience; and

(i) Is governed by a board of directors and sponsors annual meetings of its members.

Producers may only market association memberships, accept applications for membership or sign up members in the professional association where the individuals are actively engaged in or directly related to the profession represented by the professional association.

Except for employers with plans that have grandfathered status under the federal Affordable Care Act, this paragraph does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014.

Sec. 13. 24-A MRSA §2808-B, sub-§2, ¶H, as enacted by PL 2011, c. 90, Pt. A, §10, is amended 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 and paragraphs C and C-1.

(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 to the extent permitted by the federal Affordable Care Act. 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 to the extent permitted by the federal Affordable Care Act. 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~~ tobacco use filed by the carrier as determined by ratio is 1.5 to 1.

Sec. 14. 24-A MRSA §2808-B, sub-§2, ¶I is enacted to read:

I. Except for plans that have grandfathered status under the federal Affordable Care Act, beginning January 1, 2014, a carrier shall consider all enrollees in all small group health plans offered by the carrier to be members of a single risk pool to the extent required by the federal Affordable Care Act.

Sec. 15. 24-A MRSA §2808-B, sub-§2-B, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to

determine whether the filing meets the requirements that rates not be excessive, inadequate~~,~~ or unfairly discriminatory ~~or not in compliance with section 6913~~, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

Sec. 16. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2011, c. 90, Pt. D, §4, is further amended to read:

2-C. Guaranteed loss ratio. Notwithstanding subsection 2-B~~, at the carrier's option~~, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is considered credible if the anticipated average number of members during the period for which the rates will be in effect ~~is at least 1,000 or if it~~ meets ~~credibility~~ standards ~~adopted by the superintendent by rule~~ for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than ~~1,000 and the block does not satisfy any alternative credibility standards adopted by rule~~ needed to meet the credibility standard, the filing is subject to subsection 2-B~~, except as provided in paragraph A-1~~.

~~A-1. A carrier that elected to file rates in accordance with this subsection prior to September 1, 2004 may continue to file rates in accordance with this subsection as long as the anticipated number of member months for a 12-month period is at least 1,000.~~

~~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 section 4319 and to the federal Affordable Care Act and federal regulations adopted pursuant to the federal Affordable Care Act.~~

~~C. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-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.~~

~~(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.~~

~~D. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large.~~

~~E. The superintendent may adopt rules setting forth appropriate methodologies regarding reports, refunds and credibility standards pursuant to this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.~~

Sec. 17. 24-A MRSA §2808-B, sub-§6, ¶I, as enacted by PL 1993, c. 477, Pt. B, §3 and affected by Pt. F, §1, is amended to read:

I. Notwithstanding any other provision of this section, prior to January 1, 2014, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage.

Sec. 18. 24-A MRSA §2850, sub-§2, ¶F is enacted to read:

F. Except for individual health plans in effect on March 23, 2010 that have grandfathered status under the federal Affordable Care Act, a carrier as defined in section 4301-A, subsection 3 offering a health plan as defined in section 4301-A, subsection 7 may not apply a preexisting condition exclusion to any enrollee under 19 years of age. A preexisting condition exclusion may not be imposed on any enrollee after January 1, 2014 to the extent prohibited by the federal Affordable Care Act.

Sec. 19. 24-A MRSA §4218-A is enacted to read:

§4218-A. Compliance with the Affordable Care Act

The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments to rules adopted pursuant to this section, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 20. 24-A MRSA §4301-A, sub-§1, as amended by PL 2007, c. 199, Pt. B, §1, is further amended to read:

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of

otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal Affordable Care Act.

Sec. 21. 24-A MRSA §4301-A, sub-§3, ¶¶F and G, as enacted by PL 1999, c. 742, §3, are further amended to read:

F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; ~~or~~

G. A self-insured employer subject to state regulation as described in section 2848-A.; or

Sec. 22. 24-A MRSA §4301-A, sub-§3, ¶H is enacted to read:

H. Notwithstanding any other provision of this Title, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act.

Sec. 23. 24-A MRSA §4301-A, sub-§7, as enacted by PL 1999, c. 742, §3, is amended to read:

7. Health plan. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage not subject to the requirements of the federal Affordable Care Act. A plan that is subject to the requirements of the federal Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Affordable Care Act, is a health plan for purposes of this chapter.

Sec. 24. 24-A MRSA §4302, sub-§6 is enacted to read:

6. Reporting required pursuant to the Affordable Care Act. Notwithstanding any other requirements of this Title, a carrier shall provide to the Secretary of the United States Department of Health and Human Services, and make available to the public when required by federal law, any information required by the federal Affordable Care Act. Carriers shall provide the information to the superintendent upon request.

Sec. 25. 24-A MRSA §4303, sub-§4, ¶E is enacted to read:

E. Health plans subject to the requirements of the federal Affordable Care Act must comply with federal claims and appeal requirements, including, but not limited to, the requirement that benefits for an ongoing course of treatment may not be reduced or terminated without advance notice and an opportunity for advance review, consistent with the requirements of the federal Affordable Care Act.

Sec. 26. 24-A MRSA §4303, sub-§15 is enacted to read:

15. Uniform explanation of coverage documents and standardized definitions. A carrier offering a health plan in this State shall:

A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits

and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; and

B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act.

Sec. 27. 24-A MRSA §4303, sub-§16 is enacted to read:

16. Language and culture. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act.

Sec. 28. 24-A MRSA §4306, as amended by PL 2007, c. 199, Pt. B, §15, is further amended to read:

§4306. Enrollee choice of primary care provider

A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A, to serve as primary care providers for managed care plans. A carrier is not required to contract with certified nurse practitioners or physicians as primary care providers in any manner that exceeds the access and provider network standards required in this chapter or chapter 56, or any rules adopted pursuant to those chapters. A carrier shall allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides.

Sec. 29. 24-A MRSA §4306-A is enacted to read:

§4306-A. Patient access to obstetrical and gynecological care

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State subject to the requirements of the federal Affordable Care Act:

1. Authorization or referral not required. May not require authorization or referral by the carrier or any other person, including a primary care provider, in the case of a female enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology. The health care professional shall agree to otherwise adhere to the health plan's or carrier's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier; and

2. Treated as primary care. Shall treat the provision of obstetrical and gynecological care by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology, pursuant to subsection 1, as authorized by the primary care provider and the authorization of related obstetrical and gynecological items and services by that professional as the authorization of the primary care provider.

Sec. 30. 24-A MRSA §4309-A is enacted to read:

§4309-A. Compliance with the Affordable Care Act

1. Carriers. A carrier shall comply with all applicable requirements of the federal Affordable Care Act.

2. Superintendent. The superintendent may enforce and administer this section through all powers provided under this Title and Title 24. The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments adopted pursuant to this subsection, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 31. 24-A MRSA §4312, sub-§1, as enacted by PL 1999, c. 742, §19, is amended to read:

1. Request for external review. An enrollee or the enrollee's authorized representative shall make a written request for external review of an adverse health care treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not make a request for external review under a group plan until the enrollee has exhausted all levels of a carrier's internal grievance procedure and may not make a request for external review under an individual plan until the enrollee has exhausted one level of a carrier's internal grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under a carrier's internal grievance procedure. An enrollee may not be required to pay any filing fee as a condition of processing a request for external review.

Sec. 32. 24-A MRSA §4312, sub-§2, as enacted by PL 1999, c. 742, §19, is amended to read:

2. Expedited request for external review. An enrollee or an enrollee's authorized representative is not required to exhaust ~~all levels of~~ a carrier's internal grievance procedure in accordance with subsection 1 before filing a request for external review if:

A. The carrier has failed to make a decision on an internal grievance within the time period required or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal;

B. The carrier and the enrollee mutually agree to bypass the internal grievance procedure;

C. The life or health of the enrollee is in serious jeopardy; ~~or~~

D. The enrollee has died~~.~~; or

E. The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

Sec. 33. 24-A MRSA §4318, sub-§4, as reallocated by RR 2009, c. 2, §70, is amended to read:

4. Disclosure. A health plan issued after the effective date of this section that includes an annual or lifetime maximum aggregate benefit limit as permitted under subsection 3 and under section 4320 must include a disclosure of the applicable limit on the face page of the individual policy or group certificate. The disclosure must be printed in a font that is larger or bolder than the font used in the body of the face page.

Sec. 34. 24-A MRSA §§4320 to 4320-G are enacted to read:

§4320. No lifetime or annual limits on health plans subject to the Affordable Care Act

Notwithstanding the requirements of section 4318, a carrier offering a health plan subject to the federal Affordable Care Act may not:

1. Establish lifetime limits. Establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or

2. Establish annual limits. Establish annual limits on the dollar value of essential benefits, except that, prior to January 1, 2014, health plans may include restricted annual limits on essential benefits consistent with the requirements of the federal Affordable Care Act and may establish annual limits consistent with waivers granted by the Secretary of the United States Department of Health and Human Services.

§4320-A. Coverage of preventive health services

Notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the federal Affordable Care Act shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive services as required by the federal Affordable Care Act.

§4320-B. Extension of dependent coverage

A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act.

§4320-C. Emergency services

If a carrier offering a health plan subject to the requirements of the federal Affordable Care Act provides or covers any benefits with respect to services in an emergency department of a hospital, the plan must cover emergency services in accordance with the requirements of the federal Affordable Care Act, including requirements that emergency services be covered without prior authorization and that cost-sharing requirements,

expressed as a copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network.

§4320-D. Comprehensive health coverage

Notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the requirements of the federal Affordable Care Act shall, at a minimum, provide coverage that incorporates essential benefits and cost-sharing limitations consistent with the requirements of the federal Affordable Care Act.

§4320-E. Reinsurance, risk corridors and risk adjustment

1. Transitional reinsurance program. The superintendent shall establish a transitional reinsurance program for calendar years 2014, 2015 and 2016 as required by Section 1341 of the federal Affordable Care Act.

2. Risk corridors. A carrier shall make any payments required under the risk corridors program established by the Secretary of the United States Department of Health and Human Services for calendar years 2014, 2015 and 2016 as required by Section 1342 of the federal Affordable Care Act.

3. Risk adjustment. The superintendent shall establish a risk adjustment program as required by Section 1343 of the federal Affordable Care Act.

§4320-F. Oversight of plans offered on the American Health Benefit Exchange and the SHOP Exchange

1. Superintendent's authority preserved. Except as otherwise expressly provided by applicable law, the requirements established by this Title, Title 24 and rules adopted by the superintendent continue to apply to carriers and health plans and are not extinguished or modified in any way by:

A. Certification of a health plan as a qualified health plan or any other determination made by the American Health Benefit Exchange or the SHOP Exchange pursuant to the federal Affordable Care Act; or

B. Recognition by the applicable federal agency of a carrier as a qualified nonprofit health insurance issuer or as an issuer of multistate qualified health plans, or of a health plan as a multistate qualified health plan, pursuant to the federal Affordable Care Act.

2. Coordination with exchanges. The superintendent has all additional powers and duties conferred upon a state insurance regulator with respect to the American Health Benefit Exchange and the SHOP Exchange by the federal Affordable Care Act. The superintendent may enter into agreements with the American Health Benefit Exchange and the SHOP Exchange relating to coordination of responsibilities, and such agreements may provide for the superintendent to assume additional authority relating to the certification of qualified health plans or the authorization of a carrier to participate in the American Health Benefit Exchange or the SHOP Exchange.

§4320-G. Applicability to health plans grandfathered under the Affordable Care Act

A health plan that is exempt from certain requirements of the federal Affordable Care Act because it has grandfathered status is also exempt, to the same extent, from substantially similar provisions in this Title and Title 24 enacted after January 1, 2011, except to the extent that those provisions state that they apply to grandfathered health plans.

Sec. 35. 24-A MRSA §6451-A, sub-§3-A is enacted to read:

3-A. Qualified nonprofit health insurance issuers. Qualified nonprofit health insurance issuers as defined in Section 1322 of the federal Affordable Care Act are considered health organizations for purposes of this chapter.

Sec. 36. Review of transitional reinsurance, risk corridors and risk adjustment programs. No later than January 1, 2013, the Department of Professional and Financial Regulation, Bureau of Insurance shall submit the bureau's proposed transitional reinsurance program and risk adjustment program established pursuant to the Maine Revised Statutes, Title 24-A, section 4320-E and any information related to the risk corridors program established pursuant to Section 1342 of the federal Affordable Care Act for review by the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters. The joint standing committee may report out a bill to the First Regular Session of the 126th Legislature based on the bureau's proposed transitional reinsurance program or risk adjustment program.'

SUMMARY

This amendment replaces the bill and does the following.

1. It retains provisions in the bill that amend the health insurance laws to incorporate changes to implement the requirements of the federal Patient Protection and Affordable Care Act.

2. It removes the provisions in the bill that are inconsistent with changes made in Public Law 2011, chapter 90 related to rating for individual and small group health plans.

3. It removes the provisions in the bill that define "Affordable Care Act" and conform state law to federal law relating to minimum medical loss ratios as these provisions are included in Public Law 2011, chapter 90.

4. It makes technical changes and adds cross-references.

5. It requires the Department of Professional and Financial Regulation, Bureau of Insurance to submit its proposed transitional reinsurance program and risk adjustment program and information related to the federal risk corridors program to the Legislature for review no later than January 1, 2013.

FISCAL NOTE REQUIRED
(See Attached)

Approved: 06/03/11 mac

125th MAINE LEGISLATURE

LD 1554 **LR 443(02)**

An Act To Implement the Requirements of the Federal Patient Protection and Affordable Care Act

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

Fiscal Note

Minor cost increase - Other Special Revenue Funds

Fiscal Detail and Notes

Additional costs to the Department of Professional and Financial Regulation can be absorbed utilizing existing budgeted resources.