

MAINE STATE LEGISLATURE

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L.D. 1

Date: 2/27/19

(Filing No. S- 3)

HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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

**STATE OF MAINE
SENATE
129TH LEGISLATURE
FIRST REGULAR SESSION**

COMMITTEE AMENDMENT "A" to S.P. 10, L.D. 1, Bill, "An Act To Protect Health Care Coverage for Maine Families"

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

'PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§2, ¶B, as amended by PL 2007, c. 629, Pt. A, §3, is further amended to read:

B. A carrier may not vary the premium rate due to the gender, health status, occupation or industry, claims experience or policy duration of the individual or any other rating factor not specified in this subsection.

Sec. A-2. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2011, c. 364, §3, 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.~~ The premium rate for a family must equal the sum of the premiums for each individual in the family, except that it may not be based on more than 3 dependent children who are less than 21 years of age.

Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2011, c. 364, §4, is further amended to read:

D. A carrier may vary the premium rate due to age and tobacco use in accordance with the limitations set out in this paragraph. A carrier that varies the premium rate due to age must vary the premium rate according to a uniform age curve. The superintendent shall adopt rules establishing a uniform age curve that is substantially similar to the age curve in effect on January 1, 2019 under the federal Affordable Care Act. Rules adopted under this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

- 1 (1) For all policies, contracts or certificates that are executed, delivered, issued
2 for delivery, continued or renewed in this State between December 1, 1993 and
3 July 14, 1994, the premium rate may not deviate above or below the community
4 rate filed by the carrier by more than 50%.
- 5 (2) For all policies, contracts or certificates that are executed, delivered, issued
6 for delivery, continued or renewed in this State between July 15, 1994 and July
7 14, 1995, the premium rate may not deviate above or below the community rate
8 filed by the carrier by more than 33%.
- 9 (3) For all policies, contracts or certificates that are executed, delivered, issued
10 for delivery, continued or renewed in this State between July 15, 1995 and June
11 30, 2012, the premium rate may not deviate above or below the community rate
12 filed by the carrier by more than 20%.
- 13 (5) For all policies, contracts or certificates that are executed, delivered, issued
14 for delivery, continued or renewed in this State between July 1, 2012 and
15 December 31, 2013, the maximum rate differential due to age filed by the carrier
16 as determined by ratio is 3 to 1. The limitation does not apply for determining
17 rates for an attained age of less than 19 years of age or more than 65 years of age.
- 18 (6) For all policies, contracts or certificates that are executed, delivered, issued
19 for delivery, continued or renewed in this State between January 1, 2014 and
20 December 31, 2014, the maximum rate differential due to age filed by the carrier
21 as determined by ratio is 4 to 1 to the extent permitted by the federal Affordable
22 Care Act. The limitation does not apply for determining rates for an attained age
23 of less than 19 years of age or more than 65 years of age.
- 24 (7) For all policies, contracts or certificates that are executed, delivered, issued
25 for delivery, continued or renewed in this State on or after January 1, 2015,
26 except as provided in subparagraph (9), the maximum rate differential due to age
27 filed by the carrier as determined by ratio is 5 to 1 to the extent permitted by the
28 federal Affordable Care Act. The limitation does not apply for determining rates
29 for an attained age of less than 19 years of age or more than 65 years of age.
- 30 (8) For all policies, contracts or certificates that are executed, delivered, issued
31 for delivery, continued or renewed in this State on or after July 1, 2012, the
32 maximum rate differential due to tobacco use filed by the carrier as determined
33 by ratio is 1.5 to 1, except that the carrier may not apply a rate differential
34 pursuant to this subparagraph when the covered individual is participating in an
35 evidence-based tobacco cessation strategy approved by the United States
36 Department of Health and Human Services, Food and Drug Administration.
- 37 (9) For all policies, contracts or certificates that are executed, delivered, issued
38 for delivery, continued or renewed in this State on or after the effective date of
39 this subparagraph, the maximum rate differential due to age filed by the carrier as
40 determined by ratio is 3 to 1 for individuals 21 years of age and older on the first
41 day of coverage under the policy, contract or certificate. The variation in rate due
42 to age must be actuarially justified for individuals under 21 years of age
43 consistent with the uniform age rating curve adopted under this paragraph.

1 **Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶F**, as amended by PL 2007, c. 629,
2 Pt. M, §4, is repealed.

3 **Sec. A-5. 24-A MRSA §2736-C, sub-§2, ¶I**, as amended by PL 2011, c. 364,
4 §5, is repealed.

5 **Sec. A-6. 24-A MRSA §2736-C, sub-§5**, as amended by PL 2011, c. 90, Pt. D,
6 §3, is further amended to read:

7 **5. Loss ratios.** Except as provided in subsection 2-B, for all policies and certificates
8 issued on or after the effective date of this section, the superintendent shall disapprove
9 any premium rates filed by any carrier, whether initial or revised, for an individual health
10 policy unless it is anticipated that the ~~aggregate benefits estimated to be paid under all the~~
11 ~~individual health policies maintained in force by the carrier for the period for which~~
12 ~~coverage is to be provided will return to policyholders at least 65% of the aggregate~~
13 ~~premiums collected for those policies, as determined in accordance with accepted~~
14 ~~actuarial principles and practices and on the basis of incurred claims experience and~~
15 ~~earned premiums. For the purposes of this calculation, any payments paid pursuant to~~
16 ~~former section 6913 must be treated as incurred claims~~ medical loss ratio calculated
17 under section 4319 will be at least 80%.

18 **Sec. A-7. 24-A MRSA §2736-C, sub-§11**, as enacted by PL 2013, c. 271, §1, is
19 amended to read:

20 **11. Open enrollment; rules.** Notwithstanding subsection 3, on or after January 1,
21 2014, a carrier may restrict enrollment in individual health plans to open enrollment
22 periods and special enrollment periods ~~consistent with requirements of the federal~~
23 ~~Affordable Care Act to the extent not inconsistent with applicable federal law. The~~
24 superintendent may adopt rules establishing minimum open enrollment dates and
25 minimum criteria for special enrollment periods for all individual health plans offered in
26 this State. Rules adopted pursuant to this subsection are routine technical rules as defined
27 in Title 5, chapter 375, subchapter 2-A.

28 **Sec. A-8. 24-A MRSA §2742-B**, as amended by PL 2007, c. 514, §§1 to 5, is
29 further amended to read:

30 **§2742-B. Mandatory offer to extend coverage for dependent children up to 26 years**
31 **of age**

32 **1. Dependent child; definition.** As used in this section, "dependent child" means
33 the child of a person covered under an individual health insurance policy ~~when that~~
34 ~~child:~~

35 A. ~~Is unmarried;~~

36 B. ~~Has no dependent of the child's own; and~~

37 C. ~~Is a resident of this State or is enrolled as a full-time student at an accredited~~
38 ~~public or private institution of higher education.~~

39 **2. Offer of coverage.** Notwithstanding section 2703, subsection 3, an individual
40 health insurance policy that offers coverage for a dependent child must offer such
41 coverage, at the option of the policyholder, until the dependent child is ~~25~~ attains 26 years

1 of age. ~~An insurer may require, as a condition of eligibility for coverage in accordance~~
2 ~~with this section, that a person seeking coverage for a dependent child provide written~~
3 ~~documentation on an annual basis that the dependent child meets the requirements in~~
4 ~~subsection 1.~~

5 **Sec. A-9. 24-A MRSA §2808-B, sub-§2, ¶B**, as amended by PL 1993, c. 477,
6 Pt. B, §1 and affected by Pt. F, §1, is further amended to read:

7 B. A carrier may not vary the premium rate due to the gender, health status, claims
8 experience or policy duration of the eligible group or members of the group or any
9 other rating factor not specified in this section.

10 **Sec. A-10. 24-A MRSA §2808-B, sub-§2, ¶C**, as amended by PL 2011, c. 638,
11 §1, is further amended to read:

12 C. A carrier may vary the premium rate due to ~~occupation and industry~~, family
13 membership and participation in wellness programs ~~to the extent permitted by the~~
14 ~~federal Affordable Care Act. The premium rate for a family must equal the sum of~~
15 the premiums for each individual in the family, except that it may not be based on
16 more than 3 dependent children who are less than 21 years of age. The
17 superintendent may adopt rules setting forth appropriate methodologies regarding rate
18 discounts for participation in wellness programs ~~and rating for occupation and~~
19 ~~industry pursuant to this paragraph.~~ Rules adopted pursuant to this paragraph are
20 routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

21 **Sec. A-11. 24-A MRSA §2808-B, sub-§2, ¶D**, as amended by PL 2011, c. 638,
22 §2, is further amended to read:

23 D. A carrier may vary the premium rate due to ~~age, group size and tobacco use only~~
24 ~~under the following schedule and within the listed percentage bands in accordance~~
25 ~~with the limitations set out in this paragraph. A carrier that varies the premium rate~~
26 due to age must vary the premium rate according to a uniform age curve. The
27 superintendent shall adopt rules establishing a uniform age curve that is substantially
28 similar to the age curve in effect on January 1, 2019 under the federal Affordable
29 Care Act. Rules adopted under this paragraph are routine technical rules as defined
30 in Title 5, chapter 375, subchapter 2-A.

31 (1) For all policies, contracts or certificates that are executed, delivered, issued
32 for delivery, continued or renewed in this State between July 15, 1993 and July
33 14, 1994, the premium rate may not deviate above or below the community rate
34 filed by the carrier by more than 50%.

35 (2) For all policies, contracts or certificates that are executed, delivered, issued
36 for delivery, continued or renewed in this State between July 15, 1994 and July
37 14, 1995, the premium rate may not deviate above or below the community rate
38 filed by the carrier by more than 33%.

39 (3) For all policies, contracts or certificates that are executed, delivered, issued
40 for delivery, continued or renewed in this State between July 15, 1995 and
41 September 30, 2011, the premium rate may not deviate above or below the
42 community rate filed by the carrier by more than 20%.

- 1 (4) For all policies, contracts or certificates that are executed, delivered, issued
2 for delivery, continued or renewed in this State between October 1, 2011 and
3 September 30, 2012, the maximum rate differential due to age filed by the carrier
4 as determined by ratio is 2 to 1. The limitation does not apply for determining
5 rates for an attained age of less than 19 years of age or more than 65 years of age.
- 6 (5) For all policies, contracts or certificates that are executed, delivered, issued
7 for delivery, continued or renewed in this State between October 1, 2012 and
8 December 31, 2013, the maximum rate differential due to age and group size
9 filed by the carrier as determined by ratio is 2.5 to 1. The limitation does not
10 apply for determining rates for an attained age of less than 19 years of age or
11 more than 65 years of age.
- 12 (6) For all policies, contracts or certificates that are executed, delivered, issued
13 for delivery, continued or renewed in this State between January 1, 2014 and
14 December 31, 2014, the maximum rate differential due to age and group size
15 filed by the carrier as determined by ratio is 3 to 1 to the extent permitted by the
16 federal Affordable Care Act. The limitation does not apply for determining rates
17 for an attained age of less than 19 years of age or more than 65 years of age.
- 18 (7) For all policies, contracts or certificates that are executed, delivered, issued
19 for delivery, continued or renewed in this State between January 1, 2015 and
20 December 31, 2015, the maximum rate differential due to age and group size
21 filed by the carrier as determined by ratio is 4 to 1 to the extent permitted by the
22 federal Affordable Care Act. The limitation does not apply for determining rates
23 for an attained age of less than 19 years of age or more than 65 years of age.
- 24 (8) For all policies, contracts or certificates that are executed, delivered, issued
25 for delivery, continued or renewed in this State on or after January 1, 2016,
26 except as provided in subparagraph (10), the maximum rate differential due to
27 age and group size filed by the carrier as determined by ratio is 5 to 1 to the
28 extent permitted by the federal Affordable Care Act. The limitation does not
29 apply for determining rates for an attained age of less than 19 years of age or
30 more than 65 years of age.
- 31 (9) For all policies, contracts or certificates that are executed, delivered, issued
32 for delivery, continued or renewed in this State on or after October 1, 2011, the
33 maximum rate differential due to tobacco use filed by the carrier as determined
34 by ratio is 1.5 to 1, except that the carrier may not apply a rate differential
35 pursuant to this subparagraph when the covered individual is participating in an
36 evidence-based tobacco cessation strategy approved by the United States
37 Department of Health and Human Services, Food and Drug Administration.
- 38 (10) For all policies, contracts or certificates that are executed, delivered, issued
39 for delivery, continued or renewed in this State on or after the effective date of
40 this Act, the maximum rate differential due to age filed by the carrier as
41 determined by ratio is 3 to 1 for individuals 21 years of age and older on the first
42 day of coverage under the policy, contract or certificate. The variation in rate due
43 to age must be actuarially justified for individuals under 21 years of age
44 consistent with the uniform age rating curve adopted under this paragraph.

1 **Sec. A-12. 24-A MRSA §2808-B, sub-§2, ¶H**, as amended by PL 2011, c. 638,
2 §3, is repealed.

3 **Sec. A-13. 24-A MRSA §2833-B**, as amended by PL 2007, c. 514, §§6 to 10, is
4 further amended to read:

5 **§2833-B. Mandatory offer to extend coverage for dependent children up to 26 years**
6 **of age**

7 **1. Dependent child; definition.** As used in this section, "dependent child" means
8 the child of a person covered under a group health insurance policy ~~when that child:~~

9 A. ~~Is unmarried;~~

10 B. ~~Has no dependent of the child's own; and~~

11 C. ~~Is a resident of this State or is enrolled as a full-time student at an accredited~~
12 ~~public or private institution of higher education.~~

13 **2. Offer of coverage.** Notwithstanding section 2822, a group health insurance
14 policy that offers coverage for a dependent child must offer such coverage, at the option
15 of the ~~policyholder~~ parent, until the dependent child ~~is 25~~ attains 26 years of age. An
16 insurer may require, as a condition of eligibility for coverage in accordance with this
17 section, that a person seeking coverage for a dependent child provide written
18 documentation on an annual basis that the dependent child meets the requirements in
19 subsection 1.

20 **Sec. A-14. 24-A MRSA §2849, sub-§3-A**, as enacted by PL 2009, c. 244, Pt. E,
21 §3, is repealed.

22 **Sec. A-15. 24-A MRSA §2849-B, sub-§3-B**, as enacted by PL 2009, c. 244, Pt.
23 E, §5, is repealed.

24 **Sec. A-16. 24-A MRSA §2850, sub-§2**, as amended by PL 2011, c. 364, §18, is
25 further amended to read:

26 **2. Limitation.** An individual, group or blanket contract issued by an insurer may not
27 impose a preexisting condition exclusion ~~except as provided in this subsection. A~~
28 ~~preexisting condition exclusion may not exceed 12 months from the date of enrollment,~~
29 ~~including the waiting period, if any. For purposes of this subsection, "waiting period"~~
30 ~~includes any period between the time a substantially complete application for an~~
31 ~~individual or small group health plan is filed and the time the coverage takes effect. A~~
32 ~~preexisting condition exclusion may not be more restrictive than as follows. This~~
33 ~~subsection does not limit a carrier's ability to restrict enrollment in an individual contract~~
34 ~~to open enrollment and special enrollment periods in accordance with section 2736-C,~~
35 ~~subsection 11.~~

36 A. ~~In a group contract, a preexisting condition exclusion may relate only to~~
37 ~~conditions for which medical advice, diagnosis, care or treatment was recommended~~
38 ~~or received during the 6 month period ending on the earlier of the date of enrollment~~
39 ~~in the contract and the date of enrollment in a prior contract covering the same group~~
40 ~~if there has not been a gap in coverage of greater than 90 days between contracts. An~~
41 ~~exclusion may not be imposed relating to pregnancy as a preexisting condition.~~

1 ~~B. In an individual contract not subject to paragraph C, or in a blanket policy, a~~
2 ~~preexisting condition exclusion may relate only to conditions manifesting in~~
3 ~~symptoms that would cause an ordinarily prudent person to seek medical advice,~~
4 ~~diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment~~
5 ~~was recommended or received during the 12 months immediately preceding the date~~
6 ~~of application or to a pregnancy existing on the effective date of coverage.~~

7 ~~C. An individual policy issued on or after January 1, 1998 to a federally eligible~~
8 ~~individual as defined in section 2848 may not contain a preexisting condition~~
9 ~~exclusion.~~

10 ~~D. A routine preventive screening or test yielding only negative results may not be~~
11 ~~considered to be diagnosis, care or treatment for the purposes of this subsection.~~

12 ~~E. Genetic information may not be used as the basis for imposing a preexisting~~
13 ~~condition exclusion in the absence of a diagnosis of the condition relating to that~~
14 ~~information. For the purposes of this paragraph, "genetic information" has the same~~
15 ~~meaning as set forth in the Code of Federal Regulations.~~

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

22 **Sec. A-17. 24-A MRSA §2850-B, sub-§3**, as amended by PL 2011, c. 90, Pt. F,
23 §3 and c. 238, Pt. F, §1, is further amended to read:

24 **3. Cancellation of coverage; renewal.** Coverage may not be rescinded for an
25 individual, a group or eligible members and their dependents in those groups once an
26 individual, a group or eligible members and their dependents in those groups are covered
27 under an individual or group health plan, except that this subsection does not prohibit
28 rescission with respect to a covered individual, a group or eligible members and their
29 dependents in those groups who have performed an act or practice that constitutes fraud
30 or made an intentional misrepresentation of material fact as prohibited by the terms of the
31 individual or group health plan to the extent consistent with section 2411. Such coverage
32 may not be cancelled, and renewal must be guaranteed to all individuals, to all groups and
33 to all eligible members and their dependents in those groups except:

34 A. When the policyholder or contract holder fails to pay premiums or contributions
35 in accordance with the terms of the contract or the carrier has not received timely
36 premium payments;

37 B. For fraud or intentional misrepresentation of material fact by the policyholder or
38 contract holder;

39 C. With respect to coverage of individuals under a group policy or contract, for fraud
40 or intentional misrepresentation of material fact on the part of the individual or the
41 individual's representative;

- 1 D. In the large or small group market, for noncompliance with the carrier's minimum
2 participation requirements, which may not exceed the participation requirement when
3 the policy was issued;
- 4 E. With respect to a managed care plan, as defined in section 4301-A, if there is no
5 longer an insured who lives, resides or works in the service area;
- 6 F. When the carrier ceases offering large or small group health plans in compliance
7 with subsection 4 and does not renew any existing policies in that market;
- 8 F-1. When the carrier ceases offering individual health plans in compliance with
9 section 2736-C, subsection 4 and does not renew any existing policies in that market;
- 10 G. When the carrier ceases offering a product and meets the following requirements:
- 11 (1) In the large group market:
- 12 (a) The carrier provides notice to the policyholder and to the certificate
13 holders at least 90 days before termination;
- 14 (b) The carrier offers to each policyholder the option to purchase any other
15 product currently being offered in the large group market; and
- 16 (c) In exercising the option to discontinue the product and in offering the
17 option of coverage under division (b), the carrier acts uniformly without
18 regard to the claims experience of the policyholders or the health status of the
19 certificate holders or their dependents or prospective certificate holders or
20 their dependents;
- 21 (2) In the small group market:
- 22 (a) The carrier replaces the product with a product that complies with the
23 requirements of this section, including renewability, and with section
24 2808-B;
- 25 (b) The superintendent finds that the replacement is in the best interests of
26 the policyholders; and
- 27 (c) The carrier provides notice of the replacement to the policyholder and to
28 the certificate holders at least 90 days before replacement, including notice of
29 the policyholder's right to purchase any other product currently being offered
30 by that carrier in the small group market pursuant to section 2808-B,
31 subsection 4; or
- 32 (3) In the individual market:
- 33 (a) The carrier replaces the product with a product that complies with the
34 requirements of this section, including renewability, and with section
35 2736-C;
- 36 (b) The superintendent finds that the replacement is in the best interests of
37 the policyholders; and

- 1 (c) The carrier provides notice of the replacement to the policyholder and, if
2 a group policy subject to section 2736-C, to a certificate holder at least 90
3 days before replacement, including notice of the policyholder's or certificate
4 holder's right to purchase any other product currently being offered by that
5 carrier in the individual market pursuant to section 2736-C, subsection 3;
- 6 H. In renewing a large group policy in accordance with this section, a carrier may
7 modify the coverage, terms and conditions of the policy consistent with other
8 applicable provisions of state and federal laws as long as the modifications are
9 applied uniformly to all policyholders of the same product; or
- 10 I. In renewing an individual or small group policy in accordance with this section, a
11 carrier may make minor modifications to the coverage, terms and conditions of the
12 policy consistent with other applicable provisions of state and federal laws as long as
13 the modifications meet the conditions specified in this paragraph and are applied
14 uniformly to all policyholders of the same product. Modifications not meeting the
15 requirements in this paragraph are considered a discontinuance of the product
16 pursuant to paragraph G.
- 17 (1) A modification pursuant to this paragraph must be approved by the
18 superintendent. The superintendent shall approve the modification if it meets the
19 requirements of this section.
- 20 (2) A change in a requirement for eligibility is not a minor modification pursuant
21 to this paragraph if the change results in the exclusion of a class or category of
22 enrollees currently covered.
- 23 (3) Benefit modifications required by law are deemed minor modifications for
24 purposes of this paragraph.
- 25 (4) Benefit modifications other than modifications required by law are minor
26 modifications only if they meet the requirements of this subparagraph. For
27 purposes of this subparagraph, changes in administrative conditions or
28 requirements specified in the policy, such as preauthorization requirements, are
29 not considered benefit modifications.
- 30 (a) The total of any increases in benefits may not increase the actuarial value
31 of the total benefit package by more than 5%.
- 32 (b) The total of any decreases in benefits may not decrease the actuarial
33 value of the total benefit package by more than 5%.
- 34 (c) For purposes of the calculations in divisions (a) and (b), increases and
35 decreases must be considered separately and may not offset one another.
- 36 (5) A carrier must give 60 days' notice of any modification pursuant to this
37 paragraph to all affected policyholders and certificate holders.

38 **Sec. A-18. 24-A MRSA §4233-B**, as amended by PL 2007, c. 514, §§11 to 15, is
39 further amended to read:

1 **§4233-B. Mandatory offer to extend coverage for dependent children up to 26 years**
2 **of age**

3 **1. Dependent child; definition.** As used in this section, "dependent child" means
4 the child of a person covered under an individual or group health maintenance
5 organization contract ~~when that child;~~

6 A. ~~Is unmarried;~~

7 B. ~~Has no dependent of the child's own; and~~

8 C. ~~Is a resident of this State or is enrolled as a full time student at an accredited~~
9 ~~public or private institution of higher education.~~

10 **2. Offer of coverage.** An individual or group health maintenance organization
11 contract that offers coverage for a dependent child shall must offer such coverage, at the
12 option of the ~~contract holder~~ parent, until the dependent child ~~is 25~~ attains 26 years of
13 age. ~~An insurer may require, as a condition of eligibility for coverage in accordance with~~
14 ~~this section, that a person seeking coverage for a dependent child provide written~~
15 ~~documentation on an annual basis that the dependent child meets the requirements in~~
16 ~~subsection 1.~~

17 **Sec. A-19. 24-A MRSA §4302, sub-§1,** as amended by PL 2017, c. 232, §§3-5,
18 is further amended to read:

19 **1. Description of plan.** A carrier shall provide to prospective enrollees and
20 participating providers, and to members of the public and nonparticipating providers upon
21 request, information on the terms and conditions of the plan to enable those persons to
22 make informed decisions regarding their choice of plan. A carrier shall provide this
23 information annually to current enrollees, participating providers and the superintendent.
24 This information must be presented in a standardized format acceptable to the
25 superintendent. In adopting rules or developing standardized reporting formats, the
26 superintendent shall consider the nature of the health plan and the extent to which rules or
27 standardized formats are appropriate to the plan. All written and oral descriptions of the
28 health plan must be truthful and must use appropriate and objective terms that are easy to
29 understand. These descriptions must be consistent with standards developed for
30 supplemental insurance coverage under the United States Social Security Act, Title
31 XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under
32 this subsection must be standardized so that enrollees may compare the attributes of the
33 plans and be in a format that is substantially similar to the format required for a carrier
34 pursuant to the federal Affordable Care Act as of January 1, 2019. After a carrier has
35 provided the required information, the annual information requirement under this
36 subsection may be satisfied by the provision of any amendments to the materials on an
37 annual basis. A carrier shall post descriptions of its plans on its publicly accessible
38 website and, in addition to the plan description, include a link to the health plan's
39 certificate of coverage. Specific items that must be included in a description are as
40 follows:

41 A. Coverage provisions, benefits and any exclusions by category of service, type of
42 provider and, if applicable, by specific service, including but not limited to the
43 following types of exclusions and limitations:

- 1 (1) Health care services excluded from coverage;
- 2 (2) Health care services requiring copayments or deductibles paid by enrollees;
- 3 (3) Restrictions on access to a particular provider type;
- 4 (4) Health care services that are or may be provided only by referral; and
- 5 (5) Childhood immunizations as recommended by the United States Department
- 6 of Health and Human Services, Centers for Disease Control and Prevention and
- 7 the American Academy of Pediatrics;
- 8 B. Any prior authorization or other review requirements, including preauthorization
- 9 review, concurrent review, postservice review, postpayment review and any
- 10 procedures that may result in the enrollee being denied coverage or not being
- 11 provided a particular service;
- 12 C. A general description of the methods used to compensate providers, including
- 13 capitation and methods in which providers receive compensation based upon
- 14 referrals, utilization or cost criteria;
- 15 D. An explanation of how health plan limitations affect enrollees, including
- 16 information on enrollee financial responsibilities for payment of coinsurance or other
- 17 noncovered or out-of-plan services and limits on preexisting conditions and waiting
- 18 periods;
- 19 E. The terms under which the health plan may be renewed by the plan members or
- 20 enrollees, including any reservation by the health plan of any right to increase
- 21 premiums;
- 22 F. A statement as to when benefits cease in the event of nonpayment of the prepaid
- 23 or periodic premium and the effect of nonpayment upon the enrollees who are
- 24 hospitalized or undergoing treatment for an ongoing condition;
- 25 G. A description of the manner in which the plan addresses the following: the
- 26 provision of appropriate and accessible care in a timely fashion; an effective and
- 27 timely grievance process and the circumstances in which an enrollee may obtain a
- 28 2nd opinion; timely determinations of coverage issues; confidentiality of medical
- 29 records; and written copies of coverage decisions that are not explicit in the health
- 30 plan agreement. The description must also include a statement explaining the
- 31 circumstances under which health status may be considered in making coverage
- 32 decisions in accordance with state and federal laws and that enrollees may refuse
- 33 particular treatments without jeopardizing future treatment;
- 34 H. Procedures an enrollee must follow to obtain drugs and medicines that are subject
- 35 to a plan list or plan formulary, if any; a description of the formulary; and a
- 36 description of the extent to which an enrollee will be reimbursed for the cost of a
- 37 drug that is not on a plan list or plan formulary. Enrollees may request additional
- 38 information related to specific drugs that are not on the drug formulary;
- 39 I. Information on where and in what manner health care services may be obtained;

1 J. A description of the independent external review procedures and the circumstances
2 under which an enrollee is entitled to independent external review as required by this
3 chapter;

4 K. A description of the requirements for enrollees to obtain coverage of routine costs
5 of clinical trials and information on the manner in which enrollees not eligible to
6 participate in clinical trials may qualify for the compassionate use program of the
7 federal Food and Drug Administration for use of investigational drugs pursuant to 21
8 Code of Federal Regulations, Section 312.34, as amended;

9 L. A description of a provider profiling program that may be a part of the health
10 plan, including the location of provider performance ratings in the plan materials or
11 on a publicly accessible website, information explaining the provider rating system
12 and the basis upon which provider performance is measured, the limitations of the
13 data used to measure provider performance, the process for selecting providers and a
14 conspicuous written disclaimer explaining the provider performance ratings should
15 only be used as a guide for choosing a provider and that enrollees should consult their
16 current provider before making a decision about their health care based on a provider
17 rating; and

18 M. If the health plan is subject to the requirements of section 4318-A, a description
19 of the incentives available to an enrollee and how to earn such incentives if enrolled
20 in a health plan offering a comparable health care service incentive program designed
21 pursuant to section 4318-A.

22 **Sec. A-20. 24-A MRSA §4303, sub-§4, ¶E**, as enacted by PL 2011, c. 364, §25,
23 is amended to read:

24 ~~E. Health plans subject to the requirements of the federal Affordable Care Act must~~
25 ~~comply with federal claims and appeal requirements, including, but not limited to, the~~
26 ~~requirement that benefits for an ongoing course of treatment may not be reduced or~~
27 ~~terminated without advance notice and an opportunity for advance review, consistent~~
28 ~~with the requirements of the federal Affordable Care Act~~ reduce or terminate benefits
29 for an ongoing course of treatment, including coverage of a prescription drug, during
30 the course of an appeal pursuant to the grievance procedure used by the carrier or any
31 independent external review in accordance with section 4312.

32 **Sec. A-21. 24-A MRSA §4311, sub-§1-A** is enacted to read:

33 1-A. Access to clinically appropriate prescription drugs. For plan years
34 beginning on or after the effective date of this subsection, a carrier must allow an
35 enrollee, the enrollee's designee or the person who has issued a valid prescription for the
36 enrollee to request and gain access to a clinically appropriate drug not otherwise covered
37 by the health plan. The carrier's process must comply with section 4304 and with this
38 subsection. If the carrier approves a request under this subsection for a drug not
39 otherwise covered by the health plan, the carrier must treat the drug as an essential health
40 benefit, including counting any cost sharing toward the plan's annual limit on cost sharing
41 and including it when calculating the plan's actuarial value.

42 A. The carrier must determine whether it will cover the drug requested and notify the
43 enrollee, the enrollee's designee, if applicable, and the person who has issued the
44 valid prescription for the enrollee of its coverage decision within 2 business days

1 following receipt of the request. A carrier that grants coverage under this paragraph
2 must provide coverage of the drug for the duration of the prescription, including
3 refills.

4 B. The carrier must have a process by which an expedited review may be requested
5 in exigent circumstances. Exigent circumstances exist when an enrollee is suffering
6 from a health condition that may seriously jeopardize the enrollee's life, health or
7 ability to regain maximum function or when an enrollee is undergoing a current
8 course of treatment using a nonformulary drug. When an expedited review has been
9 requested, the carrier must determine whether it will cover the drug requested and
10 notify the enrollee, the enrollee's designee, if applicable, and the person who has
11 provided a valid prescription for the enrollee of its coverage decision within 24 hours
12 following receipt of the request. A carrier that grants coverage under this paragraph
13 must provide coverage of the drug for the duration of the exigency.

14 **Sec. A-22. 24-A MRS §4318**, as amended by PL 2011, c. 364, §33, is repealed.

15 **Sec. A-23. 24-A MRS §4319**, as enacted by PL 2011, c. 90, Pt. D, §5, is
16 amended to read:

17 **§4319. Rebates**

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

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

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

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

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

34 A. In the large group market, 85%;

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

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

1 4. Rules. The superintendent may adopt rules to implement this section in a
2 substantially similar manner as required under the federal Affordable Care Act in effect
3 as of January 1, 2019, including, but not limited to, rules establishing the period for
4 which the medical loss ratio is calculated. Rules adopted pursuant to this subsection are
5 routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

7 **§4319-A. Guaranteed issue**

8 A carrier offering a health plan in this State in the individual, small group or large
9 group market must offer to an individual or group in the State all health plans that are
10 approved for sale in the applicable market and must accept any individual or group that
11 applies for any of those health plans in accordance with the requirements of section
12 2736-C, subsection 3 and section 2808-B, subsection 4 and section 2850-B.

13 **Sec. A-25. 24-A MRSA §4320**, as enacted by PL 2011, c. 364, §34, is amended
14 to read:

15 **§4320. No lifetime or annual limits on health plans**

16 ~~Notwithstanding the requirements of section 4318, a~~ A carrier offering a health plan
17 subject to the federal Affordable Care Act in the individual, small group or large group
18 market, as those markets are defined under applicable federal law, may not:

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

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

26 **3. Application.** This section applies to health plans offered or renewed in this State
27 in the individual, small group and large group markets, as those markets are defined
28 under applicable federal law. A health plan may contain annual dollar limits to the extent
29 allowed under the federal Affordable Care Act as of January 1, 2019 if the plan has been
30 continuously renewed since that date, but the plan may not impose any new limits or
31 reduce any existing limit in effect as of January 1, 2019.

32 **PART B**

33 **Sec. B-1. 24-A MRSA §4320-D**, as enacted by PL 2011, c. 364, §34, is amended
34 to read:

35 **§4320-D. Comprehensive health coverage**

36 ~~Notwithstanding any other requirements of this Title, a carrier offering a health plan~~
37 ~~subject to the requirements of the federal Affordable Care Act in this State shall, at a~~
38 ~~minimum, provide coverage that incorporates an essential health benefits and cost-~~

1 ~~sharing limitations package~~ consistent with the requirements of the federal Affordable
2 ~~Care Act this section.~~

3 **1. Essential health benefits package; definition.** As used in this section, "essential
4 health benefits package" means, with respect to any health plan, coverage that:

5 A. Provides for the essential health benefits in accordance with subsection 2;

6 B. Limits cost sharing for coverage in accordance with subsection 3; and

7 C. Provides for levels of coverage in accordance with subsection 4.

8 **2. Substantially similar to federal Affordable Care Act; required categories.**

9 With respect to any individual or small group health plan offered on or after January 1,
10 2020, a carrier shall provide essential health benefits that are substantially similar to that
11 of the essential health benefits required in this State for a health plan subject to the federal
12 Affordable Care Act as of January 1, 2019. Essential health benefits required for a health
13 plan must include at least the following general categories and the items and services
14 covered within the categories:

15 A. Ambulatory patient services;

16 B. Emergency services;

17 C. Hospitalization;

18 D. Maternity and newborn care;

19 E. Mental health and substance use disorder services, including behavioral health
20 treatment;

21 F. Prescription drugs;

22 G. Rehabilitative and habilitative services and devices;

23 H. Laboratory services;

24 I. Preventive and wellness services and chronic disease management; and

25 J. Pediatric services, including oral and vision care, to the extent required by the
26 federal Affordable Care Act as of January 1, 2019.

27 **3. Cost-sharing limitations.** With respect to any health plan offered on or after the
28 effective date of this subsection, a carrier shall limit cost sharing on an annual basis in a
29 manner that is consistent with the annual limits established for a health plan subject to the
30 federal Affordable Care Act as of January 1, 2019 and as adjusted by the United States
31 Department of Health and Human Services, Centers for Medicare and Medicaid Services,
32 or, if the Centers for Medicare and Medicaid Services does not establish annual limits on
33 cost sharing, the superintendent shall adopt rules establishing annual limits on cost
34 sharing under this subsection that are calculated in substantially the same manner as the
35 Centers for Medicare and Medicaid Services calculated the annual limit in the most
36 recent year it calculated the annual limit.

37 **4. Levels of coverage.** Carriers shall offer coverage at levels that are substantially
38 similar to the levels of coverage required for health plans subject to the federal
39 Affordable Care Act as of January 1, 2019. The superintendent may adopt rules defining

1 such levels of coverage. Rules adopted pursuant to this subsection are routine technical
2 rules as defined in Title 5, chapter 375, subchapter 2-A.

3 5. Rule of construction. This section may not be construed to prohibit a health plan
4 from providing benefits in excess of the essential health benefits described in this section.

5 **PART C**

6 **Sec. C-1. 24-A MRSA §2850-C, sub-§3** is enacted to read:

7 3. Applicability of section 4320-L. In addition to the requirements of this section, a
8 carrier is subject to section 4320-L.

9 **Sec. C-2. 24-A MRSA §4320-L** is enacted to read:

10 **§4320-L. Nondiscrimination**

11 1. Nondiscrimination. An individual may not, on the basis of race, color, national
12 origin, sex, sexual orientation, gender identity, age or disability, be excluded from
13 participation in, be denied benefits of or otherwise be subjected to discrimination under
14 any health plan offered in accordance with this Title. A carrier may not in offering,
15 providing or administering a health plan:

16 A. Deny, cancel, limit or refuse to issue or renew a health plan or other health-related
17 coverage, deny or limit coverage of a claim or impose additional cost sharing or other
18 limitations or restrictions on coverage on the basis of race, color, national origin, sex,
19 sexual orientation, gender identity, age or disability;

20 B. Have or implement marketing practices or benefit designs that discriminate on the
21 basis of race, color, national origin, sex, sexual orientation, gender identity, age or
22 disability in a health plan or other health-related coverage;

23 C. Deny or limit coverage, deny or limit coverage of a claim or impose additional
24 cost sharing or other limitations or restrictions on coverage for any health services
25 that are ordinarily or exclusively available to individuals of one sex to a transgender
26 individual based on the fact that the individual's sex assigned at birth, gender identity
27 or gender otherwise recorded is different from the one to which such health services
28 are ordinarily or exclusively available;

29 D. Have or implement a categorical coverage exclusion or limitation for all health
30 services related to gender transition; or

31 E. Otherwise deny or limit coverage, deny or limit coverage of a claim or impose
32 additional cost sharing or other limitations or restrictions on coverage for specific
33 health services related to gender transition if such denial, limitation or restriction
34 results in discrimination against a transgender individual.

35 Nothing in this subsection is intended to determine or restrict a carrier from determining
36 whether a particular health service is medically necessary or otherwise meets applicable
37 coverage requirements in any individual case.

- 1 (6) Paraphilias;
- 2 (7) Attention deficit and disruptive behavior disorders;
- 3 (8) Pervasive developmental disorders;
- 4 (9) Tic disorders;
- 5 (10) Eating disorders, including bulimia and anorexia; and
- 6 (11) Substance use disorders.

7 For the purposes of this paragraph, the mental illness must be diagnosed by a licensed
8 allopathic or osteopathic physician or a licensed psychologist who is trained and has
9 received a doctorate in psychology specializing in the evaluation and treatment of
10 mental illness.

11 B. All individual policies and contracts executed, delivered, issued for delivery,
12 continued or renewed in this State must ~~make available~~ provide coverage providing
13 benefits that meet the requirements of this paragraph.

14 (1) The ~~offer of~~ coverage must provide benefits for the treatment and diagnosis
15 of mental illnesses under terms and conditions that are no less extensive than the
16 benefits provided for medical treatment for physical illnesses.

17 (2) At the request of a reimbursing insurer, a provider of medical treatment for
18 mental illness shall furnish data substantiating that initial or continued treatment
19 is medically necessary health care. When making the determination of whether
20 treatment is medically necessary health care, the provider shall use the same
21 criteria for medical treatment for mental illness as for medical treatment for
22 physical illness under the individual policy.

23 **Sec. D-2. 24-A MRSA §2843, sub-§5-A**, as amended by PL 1989, c. 490, §4, is
24 repealed.

25 **Sec. D-3. 24-A MRSA §4234-A, sub-§6**, as amended by PL 2017, c. 407, Pt. A,
26 §98, is further amended to read:

27 **6. Coverage for treatment of certain mental illnesses.** Coverage for medical
28 treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

29 A-1. All individual and group contracts must provide, at a minimum, benefits
30 according to paragraph B, subparagraph (1) for a person receiving medical treatment
31 for any of the following categories of mental illness as defined in the Diagnostic and
32 Statistical Manual, except for those designated as "V" codes in the Diagnostic and
33 Statistical Manual:

- 34 (1) Psychotic disorders, including schizophrenia;
- 35 (2) Dissociative disorders;
- 36 (3) Mood disorders;
- 37 (4) Anxiety disorders;

- 1 (5) Personality disorders;
- 2 (6) Paraphilias;
- 3 (7) Attention deficit and disruptive behavior disorders;
- 4 (8) Pervasive developmental disorders;
- 5 (9) Tic disorders;
- 6 (10) Eating disorders, including bulimia and anorexia; and
- 7 (11) Substance use disorders.

8 For the purposes of this paragraph, the mental illness must be diagnosed by a licensed
9 allopathic or osteopathic physician or a licensed psychologist who is trained and has
10 received a doctorate in psychology specializing in the evaluation and treatment of
11 mental illness.

12 B. All policies, contracts and certificates executed, delivered, issued for delivery,
13 continued or renewed in this State must provide benefits that meet the requirements
14 of this paragraph.

15 (1) The contracts must provide benefits for the treatment and diagnosis of mental
16 illnesses under terms and conditions that are no less extensive than the benefits
17 provided for medical treatment for physical illnesses.

18 (2) At the request of a reimbursing health maintenance organization, a provider
19 of medical treatment for mental illness shall furnish data substantiating that initial
20 or continued treatment is medically necessary health care. When making the
21 determination of whether treatment is medically necessary health care, the
22 provider shall use the same criteria for medical treatment for mental illness as for
23 medical treatment for physical illness under the group contract.

24 (3) If benefits and coverage for the treatment of physical illness are provided on
25 an expense-incurred basis, the benefits and coverage required under this
26 subsection may be delivered separately under a managed care system.

27 (4) A policy or contract may not have separate maximums for physical illness
28 and mental illness, separate deductibles and coinsurance amounts for physical
29 illness and mental illness, separate out-of-pocket limits in a benefit period of not
30 more than 12 months for physical illness and mental illness or separate office
31 visit limits for physical illness and mental illness.

32 (5) A health benefit plan may not impose a limitation on coverage or benefits for
33 mental illness unless that same limitation is also imposed on the coverage and
34 benefits for physical illness covered under the policy or contract.

35 (6) Copayments required under a policy or contract for benefits and coverage for
36 mental illness must be actuarially equivalent to any coinsurance requirements or,
37 if there are no coinsurance requirements, may not be greater than any copayment
38 or coinsurance required under the policy or contract for a benefit or coverage for
39 a physical illness.

1 (7) For the purposes of this section, a medication management visit associated
2 with a mental illness must be covered in the same manner as a medication
3 management visit for the treatment of a physical illness and may not be counted
4 in the calculation of any maximum outpatient treatment visit limits.

5 ~~This subsection does not apply to policies, contracts or certificates covering employees of~~
6 ~~employers with 20 or fewer employees, whether the group policy is issued to the~~
7 ~~employer, to an association, to a multiple employer trust or to another entity.~~

8 **Sec. D-4. 24-A MRSA §4234-A, sub-§7**, as amended by PL 2003, c. 20, Pt. VV,
9 §21 and affected by §25, is repealed.'

10

SUMMARY

11 This amendment replaces the bill and is the majority report of the committee. The
12 purpose of this amendment is to ensure that consumer protections related to health
13 insurance coverage included in the federal Patient Protection and Affordable Care Act are
14 codified in state law.

15 In Part A, the amendment does the following.

16 1. It makes clear that carriers in the individual, small group and large group markets
17 must meet guaranteed issue requirements similar to those required by federal law.

18 2. It makes clear that individual and group health plans may not impose any
19 preexisting condition exclusion on an enrollee. The amendment does permit a carrier to
20 restrict enrollment in individual health plans to open enrollment and special enrollment
21 periods established in rule.

22 3. It clarifies that carriers offering individual or group health plans may not establish
23 lifetime or annual limits on the dollar value of benefits unless the plan is grandfathered
24 under the federal Affordable Care Act as of January 1, 2019 and does not impose new
25 limits or reduce existing limits. The amendment specifies that the provision prohibiting
26 annual limits on the dollar value of benefits applies to the dollar value of essential health
27 benefits.

28 4. It allows children, until they attain 26 years of age, to remain on their parents'
29 health insurance policy.

30 5. It changes the maximum rate differential due to age that may be filed by the
31 carrier to 3 to 1 and requires that rates that vary based on age do so according to a
32 uniform age rating curve.

33 6. It provides that if a carrier varies premium rates based on family membership, the
34 premium rate must equal the sum of the premiums for each individual in the family.

35 7. It prohibits a carrier from varying premium rates based on tobacco use for
36 individuals who are enrolled in an evidence-based tobacco cessation program approved
37 by the United States Department of Health and Human Services, Food and Drug
38 Administration.

39 8. It makes clear that the minimum medical loss ratio in the individual market is 80%
40 without exception.

1 9. It adds language to prohibit rescissions of coverage consistent with requirements
2 under federal law.

3 10. It makes changes to the timelines and requirements for determinations by a
4 carrier of coverage for prescription drugs consistent with federal law.

5 11. It requires carriers to provide information about the health plans offered by the
6 carrier in a standardized manner that is substantially similar to the manner required for
7 health plans subject to the federal Patient Protection and Affordable Care Act as of
8 January 1, 2019.

9 12. It removes a provision of the bill that would have repealed the authority for
10 certain individuals to purchase coverage under an individual, nonrenewable short-term
11 policy.

12 13. It prohibits a health plan from reducing or terminating benefits for an ongoing
13 course of treatment, including coverage of a prescription drug, during the course of an
14 appeal of a determination of coverage.

15 Part B requires that, at a minimum, individual and small group health plans cover
16 essential health benefits that are substantially similar to those benefits required for health
17 plans subject to the federal Patient Protection and Affordable Care Act as of January 1,
18 2019. The amendment also requires that health plans meet annual limits on cost sharing
19 that are substantially similar to those benefits required for health plans subject to the
20 federal Patient Protection and Affordable Care Act as of January 1, 2019. The
21 amendment removes provisions of the bill that authorized the Superintendent of
22 Insurance to make changes to essential health benefits and cost sharing limits in rule. The
23 amendment clarifies that pediatric dental benefits may not be required of all individual
24 and small group plans if dental coverage is available in accordance with the federal
25 Affordable Care Act as in effect as of January 1, 2019.

26 Part C adopts nondiscrimination provisions consistent with similar requirements in
27 federal law and rule.

28 Part D makes changes to current requirements in state law related to mental health
29 parity consistent with similar requirements in federal law and regulations.