129th MAINE LEGISLATURE

SECOND REGULAR SESSION-2020

Legislative Document **No. 2007**

H.P. 1425 House of Representatives, January 8, 2020

An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Speaker GIDEON of Freeport. (GOVERNOR'S BILL)
Cosponsored by President JACKSON of Aroostook.

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 22 MRSA c. 1479 is enacted to read:

CHAPTER 1479

MADE FOR MAINE HEALTH COVERAGE ACT

§5401. Short title

This Act may be known and cited as "the Made for Maine Health Coverage Act."

§5402. Definitions

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

1. Educated health care consumer. "Educated health care consumer" means an individual who is knowledgeable about the health care system, has no financial interest in the delivery of health care services or sale of health insurance and has a background or experience in making informed decisions regarding health, medical or scientific matters.

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

3. Marketplace. "Marketplace" means the Maine Health Insurance Marketplace established by this chapter.

4. Marketplace trust fund. "Marketplace trust fund" means the Maine Health Insurance Marketplace Trust Fund established by this chapter.

5. Superintendent. "Superintendent" means the Superintendent of Insurance.

§5403. Maine Health Insurance Marketplace established

The Maine Health Insurance Marketplace is established to conduct the functions defined in 42 United States Code, Section 18031(d)(4). The purpose of the marketplace is to benefit the State's health insurance market and persons enrolling in health insurance policies, facilitate the purchase of qualified health plans, reduce the number of uninsured individuals, improve transparency and conduct consumer education and outreach.

§5404. Powers and duties of the commissioner

1. Powers. In addition to any other powers specified in this chapter and subject to any limitations contained in this chapter or in any other law, the commissioner:

A. Has and may exercise powers necessary to carry out the purposes for which the marketplace is organized or to further the functions in which the marketplace may lawfully be engaged, including the creation and operation of the marketplace;

B. May charge user fees to health insurance carriers that offer qualified health plans in the marketplace or otherwise secure funding necessary to support the functions of the marketplace subject to the limitations imposed by section 5406;

C. May apply for and receive funds, grants or contracts from public and private sources to be used for marketplace functions;

D. May enter into interagency agreements with state or federal entities as considered necessary to efficiently and effectively perform marketplace functions; and

E. May enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out marketplace functions.

2. Duties. The commissioner shall:

A. Direct the operations of the marketplace as provided in this chapter;

B. Consult with stakeholders regarding the execution of the functions of the marketplace required under this chapter. Stakeholders include, but are not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) Representatives and members of the MaineCare program;

(5) Advocates for enrolling hard-to-reach populations;

(6) Representatives of the Passamaquoddy Tribe, the Penobscot Nation, the Houlton Band of Maliseet Indians and the Aroostook Band of Micmacs, appointed by the tribes' respective chiefs in consultation with their tribal councils;

(7) Representatives of health care providers;

(8) Representatives of insurance carriers;

(9) Representatives of insurance producers; and

(10) Any other groups or representatives required by the federal Affordable Care Act and recommended by the commissioner;

C. Accept recommendations from the superintendent on certification of qualified health plans and shall exercise the discretion to delegate to the superintendent authority and duties as appropriate for effective administration of the marketplace, including but not limited to the responsibility for plan management. Authority delegated pursuant to this paragraph is in addition to any other powers or duties of the superintendent established by statute with respect to the marketplace; and

D. Initially and subsequently as needed assess and report to the Legislature on the feasibility and cost of the State's using the federal platform as described in 45 Code of

Federal Regulations, Section 155.200(f) compared to the State's performing all the functions of a state-based marketplace as described in 45 Code of Federal Regulations, Section 155.200. These reports must consider the availability of federal grants, whether existing user fees are sufficient to create and operate state-run functions and whether use of a state-run platform would improve the accessibility and affordability of health insurance in the State.

§5405. Maine Health Insurance Marketplace Trust Fund

1. Establishment. The Maine Health Insurance Marketplace Trust Fund is established as a special fund within the State Treasury for the deposit of any funds generated by user fees, any funds secured by the commissioner for marketplace functions, federal funds and any funds received from any public or private source. The marketplace trust fund must be administered by the commissioner for the purposes set forth in this chapter, including the deposit of money that may be received pursuant to and disbursements permitted by this chapter.

2. Deposit and use of money. Money deposited into the marketplace trust fund must be held solely for the purposes set forth in this chapter as determined by the commissioner, including but not limited to costs of initial start-up and creation of the marketplace, marketplace operations, outreach, enrollment and other functions supporting the marketplace, including any efforts that may increase market stabilization and that may result in a net benefit to the participants in the marketplace. All interest earned from the investment or deposit of money in the marketplace trust fund must be deposited into the marketplace trust fund. All accrued and future earnings from money held by the marketplace trust fund, including but not limited to money obtained from the Federal Government and fees, must be available to the marketplace. Any unexpended balance in the marketplace trust fund at the end of a year may not lapse and must be carried forward to be available for expenditure by the commissioner in the subsequent year for marketplace functions.

§5406. User fees

The commissioner shall charge a user fee to all carriers that offer qualified health plans in the marketplace. The user fee must be paid monthly by the carrier and deposited into the marketplace trust fund and may be used only for marketplace functions. The user fee must be applied at a rate that is a percentage of the total monthly premium charged by a carrier for each qualified health plan sold in the marketplace and may not exceed the total user fee rate charged by the Federal Government for use of the federally facilitated exchange during plan year 2020. The rate is 0.5% during any period that the State is using the federal platform as described in 45 Code of Federal Regulations, Section 155.200(f) and 3% during any period that the State is performing all the functions of a state-based marketplace as described in 45 Code of Federal Regulations, Section 155.200.

§5407. Rulemaking

The commissioner may adopt rules as necessary for the proper administration and enforcement of this chapter. Rules adopted pursuant to this section are routine technical

rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this section must be consistent with the federal Affordable Care Act and state law.

§5408. Technical assistance from other state agencies

State agencies, including but not limited to the Department of Professional and Financial Regulation, Bureau of Insurance, the Department of Administrative and Financial Services, Bureau of Revenue Services and the Maine Health Data Organization, shall provide technical assistance and expertise to the marketplace upon request.

§5409. Records

Except as provided in this section or by other provision of law, information obtained by the marketplace under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by the marketplace under this chapter is confidential and not open to public inspection pursuant to 26 United States Code, Section 6103 and Title 36, section 191.

2. Health information. Health information obtained by the marketplace under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or information covered by Title 22, section 1711-C is confidential and not open to public inspection.

§5410. Relation to other laws

Nothing in this chapter and no action taken by the marketplace pursuant to this chapter may be construed to preempt or supersede the authority of the superintendent to regulate the business of insurance within this State.

§5411. Reporting

Beginning in 2021 and annually thereafter, the marketplace shall submit a report to the Governor and the Legislature summarizing enrollment, the affordability of health insurance for consumers using the marketplace, marketing activity and operations. This report must be submitted no later than 45 days after the end of the open enrollment period.

PART B

Sec. B-1. 24-A MRSA c. 34-A is enacted to read:

CHAPTER 34-A

STATE-FEDERAL HEALTH COVERAGE PARTNERSHIPS

§2781. State-federal health coverage partnerships

1. Partnerships authorized. The State may enter into state-federal health coverage partnerships that support the availability of affordable health coverage in the State in accordance with this section. As used in this chapter, "state-federal health coverage partnership" means a program established or authorized under federal law that provides or reallocates federal funding or that provides for the waiver or modification of otherwise applicable provisions of federal laws governing health insurance. "State-federal health coverage partnership" includes, but is not limited to, innovation waivers under Section 1332 of the federal Affordable Care Act.

2. Application. Unless the applicable federal laws, regulations or administrative guidelines require a different state official to be the applicant, the superintendent may apply to the appropriate federal agency or agencies to establish or participate in a state-federal health coverage partnership or to modify the terms and conditions of an existing partnership if the superintendent determines that the application, if approved, is likely to improve the affordability, availability or quality of health coverage in this State and the Governor approves the submission of the application.

3. Notice and consultation. The superintendent shall ensure that all federally required notices and opportunities for consultation with respect to a state-federal health coverage partnership or proposed partnership are provided. The superintendent shall take any additional measures that may be necessary to identify persons and constituencies likely to be materially affected by a state-federal health coverage partnership or proposed partnership and to provide such persons and constituencies with reasonable notice and opportunity for input.

4. MaineCare program and Maine Health Insurance Marketplace. A state-federal health coverage partnership may coordinate with the MaineCare program or the Maine Health Insurance Marketplace established in Title 22, chapter 1479 and incorporate provisions affecting these programs, including but not limited to a joint Medicaid Section 1115 demonstration waiver and state innovation waiver, with the approval or joint application of the Commissioner of Health and Human Services.

Sec. B-2. 24-A MRSA c. 34-B is enacted to read:

CHAPTER 34-B

POOLED MARKET AND CLEAR CHOICE DESIGN

§2791. Affordable health coverage for individuals, families and small businesses

1. Pooled market established. Subject to the requirements of subsection 5, all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2022 must be offered through a pooled market. Health insurance carriers offering individual health plans subject to this section shall make the same health plans available to eligible small employers, and health insurance carriers offering small group health plans subject to this section shall make the same health plans available to all residents of this State. This subsection does not require the Maine Health

Insurance Marketplace established in Title 22, chapter 1479 to offer identical choices of health plans to individuals and to small employers under Title 22, chapter 1479.

2. Premium rates. Premium rates for a health plan offered in the pooled market described in subsection 1 may not vary based on whether the plan is issued to an individual or to a small employer. Rate filings and review for the pooled market are subject to the provisions of sections 2736 to 2736-C. For health plans that are issued on other than a calendar year basis, rates applicable on and after January 1st of any plan year must be the approved rates for the most similar plan offered during the new calendar year, adjusted by a factor, approved by the superintendent as part of the rating plan, that appropriately accounts for any differences in plan design.

3. Harmonization of mandated benefit laws. A health plan subject to this section must comply with either the applicable mandated benefit provisions in chapter 33 or the corresponding provisions of chapter 35. A health maintenance organization or a nonprofit hospital and medical service organization may offer any health plan approved by the superintendent for sale in the pooled market established pursuant to this section, notwithstanding any provision of chapter 56 or Title 24 to the contrary.

4. Conforming references. All references in this Title to the individual health insurance market, the small group health insurance market or any equivalent terminology refer to the pooled market established pursuant to this section.

5. Preconditions for pooled market. This section may not be implemented unless routine technical rules as defined in Title 5, chapter 375, subchapter 2-A are adopted to implement this section and the Federal Government approves a state innovation waiver amendment that both extends reinsurance under section 3953 to the pooled market established pursuant to this section and projects that average premium rates would be the same or lower than they would have been absent the provisions of this section.

§2792. Clear choice designs

The superintendent shall develop clear choice designs for the individual and small group health insurance markets in order to reduce consumer confusion and provide meaningful choices for consumers by promoting a level playing field on which carriers compete on the basis of price and quality.

1. Clear choice design. For the purposes of this section, "clear choice design" means a set of annual copayments, coinsurance and deductibles for all or a designated subset of the essential health benefits. An individual or small group health plan subject to section 2791 must conform to one of the clear choice designs developed pursuant to this section unless an opt-out request is granted under subsection 4.

2. Development of clear choice designs. The superintendent shall develop clear choice designs in consultation with working groups consisting of consumers, carriers, health policy experts and other interested persons. The superintendent shall adopt rules for clear choice designs, taking into consideration the ability of plans to conform to actuarial value ranges, consumer needs and promotion of benefits with high value and return on investment. There must be at least one clear choice design available at each tier

of health insurance plan designated as bronze, silver, gold and platinum in accordance with the federal Affordable Care Act. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Clear choice designs apply to all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2022.

3. Annual review. The superintendent shall consider annually whether to revise, discontinue or add any clear choice designs for use by carriers in the following calendar year, including but not limited to considering whether deductible and copayment levels should be changed to reflect medical inflation and conform with actuarial value and annual maximum out-of-pocket limits.

4. Opt-out request. A carrier may offer a health plan that modifies one or more specific cost-sharing parameters in a clear choice design developed pursuant to this section if the carrier requests to opt out of the requirement in subsection 1 and demonstrates to the satisfaction of the superintendent that the alternative plan design offers significant consumer benefits and does not result in adverse selection. If the opt-out request is granted, the carrier may also choose to offer another plan conforming to the original unmodified clear choice design.

Sec. B-3. 24-A MRSA §2808-B, sub-§2, ¶E, as amended by PL 2019, c. 96, §1, is repealed and the following enacted in its place:

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 consistent with the provisions of this paragraph and applicable federal law.

(1) Association group membership or eligibility for participation in the trustee group may not be conditioned on health status, claims experience or other risk selection criteria.

(2) All health plans offered by the carrier through that association or trustee group must be made available 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;

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

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

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

(3) The aggregate rate charged by the carrier to the association or trustee group is considered a large group rate, and the terms of coverage are considered a large group health plan. Rates for participating employers within the group may vary only as permitted by paragraphs B to D-2.

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

(5) Carriers may not be reinsured under section 3958 for coverage issued under this paragraph.

(6) 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 until December 31, 2019. To the extent permitted under the federal Affordable Care Act, this paragraph applies to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2020.

Sec. B-4. 24-A MRSA §2808-B, sub-§2-A, as amended by PL 2009, c. 244, Pt. C, §7 and c. 439, Pt. D, §1, is further amended to read:

2-A. Rate filings. A carrier offering small group health plans shall file with the superintendent the community rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

A. Every filing must state the effective date of the filing. Every filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent. The effective date may be suspended by the superintendent for a period of time not to exceed 30 days.

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, paragraph B or ~~F~~ section 2791, subsection 2.

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C or section 2791, as applicable, for premium rates effective on or after July 1, 2004, except that the ~~filing of~~ rates for small group health plans are not required to account for any payment or any recovery of that payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005.

Sec. B-5. 24-A MRSA §2808-B, sub-§2-B, as amended by PL 2011, c. 364, §15, is further amended to read:

2-B. Rate review and hearings. Except as provided in subsection 2-C and section 2791, rate filings are subject to this subsection.

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

B. 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 that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

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, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

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

Sec. B-6. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2011, c. 364, §16, is further amended to read:

2-C. Guaranteed loss ratio. Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B, except as otherwise provided in section 2791. 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 meets standards 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 needed to meet the credibility standard, the filing is subject to subsection 2-B.

Sec. B-7. 24-A MRSA §3952, sub-§4-A is enacted to read:

4-A. Eligible claim. "Eligible claim" means either:

A. For a high-priced item or service, a claim amount that is no greater than 200% of the allowed charge determined for the item or service under the original Medicare fee-for-service program under Part A and Part B of Title XVIII of the Social Security Act for the applicable year; or

B. For all other items or services, a claim paid by the member insurer in accordance with the terms of the policy.

Sec. B-8. 24-A MRSA §3952, sub-§5-A is enacted to read:

5-A. High-priced item or service. "High-priced item or service" means an item or service covered under the original Medicare fee-for-service program under Part A and Part B of Title XVIII of the Social Security Act that the board, in consultation with and based on analysis by the Department of Health and Human Services and Maine Health Data Organization, has identified in advance of a plan year that contributes to association costs and offers an opportunity for savings.

Sec. B-9. 24-A MRSA §3952, sub-§6, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

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

Sec. B-10. 24-A MRSA §3952, sub-§9, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

9. Member insurer. "Member insurer" means an insurer that offers individual health plans and is actively marketing individual health plans in this State. In any calendar year in which the association reinsures small group health plans, "member insurer" also includes an insurer that offers small group health plans and is actively marketing small group health plans in this State.

Sec. B-11. 24-A MRSA §3953, sub-§1, as amended by PL 2017, c. 124, §1, is further amended to read:

1. Guaranteed access reinsurance mechanism established. The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business in the State, an insurer that has issued or administered medical insurance within the previous 12 months or is actively marketing a medical insurance policy or medical insurance administrative services in this State must participate in the association. ~~The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association. Unless an earlier resumption of operations is ordered by the superintendent in accordance with paragraph A, operations of the association are suspended until December 31, 2023 except to the extent provided in section 3962 and the association may not collect assessments as provided in section 3957, provide reinsurance for member insurers under section 3958 or provide reimbursement for member insurers under section 3961 as of the date on which a transitional reinsurance program established under the authority of Section 1341 of the federal Affordable Care Act commences operations in this State.~~

~~A. If the board proposes a revised plan of operation that calls for the resumption of operations earlier than December 31, 2023 and the superintendent determines that the revised plan is likely to provide significant benefit to the State's health insurance market, the superintendent may order the association to resume operations in accordance with the revised plan. This paragraph applies only if:~~

~~(1) An innovation waiver under Section 1332 of the federal Affordable Care Act as contemplated by paragraphs B and C is granted; or~~

~~(2) The federal Affordable Care Act is repealed or amended in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.~~

~~B. After consulting with the board and receiving public comment, the superintendent may develop a proposal for an innovation waiver under Section 1332 of the federal Affordable Care Act that facilitates the resumption of operations of the association in a manner that prevents or minimizes the loss of federal funding to support the affordability of health insurance in the State.~~

~~C. With the approval of the Governor, the superintendent may submit an application on behalf of the State in accordance with the proposal developed under paragraph B for the purposes of resuming operations of the association to the United States Department of Health and Human Services and to the United States Secretary of the Treasury to waive certain provisions of the federal Affordable Care Act as provided in Section 1332. The superintendent may implement any federally approved waiver.~~

Sec. B-12. 24-A MRSA §3955, sub-§1, ¶D, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

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

Sec. B-13. 24-A MRSA §3955, sub-§1, ¶E, as amended by PL 2011, c. 621, §2, is repealed.

Sec. B-14. 24-A MRSA §3955, sub-§2, ¶H, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

H. ~~Apply for~~ Accept and administer funds or grants from public or private sources, including federal grants, and apply for such funding.

Sec. B-15. 24-A MRSA §3956, sub-§3, ¶C, as enacted by PL 2011, c. 90, Pt. B, §8, is amended to read:

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

Sec. B-16. 24-A MRSA §3957, sub-§9, as enacted by PL 2011, c. 90, Pt. B, §8, is repealed.

Sec. B-17. 24-A MRSA §3958, as amended by PL 2011, c. 621, §§4 and 5, is further amended to read:

§3958. Reinsurance; premium rates

1. Reinsurance amount. A member insurer offering an individual health plan under section 2736-C must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for ~~the~~ any applicable reinsurance premium at the rate established in accordance with subsection 2. For calendar year 2022 and subsequent calendar years, the association shall also reinsure member insurers for small group health plans issued under section 2808-B, unless otherwise provided in rules adopted by the superintendent pursuant to section 2791, subsection 5.

A. Beginning July 1, 2012, except as otherwise provided in paragraph A-1, the association shall reimburse a member insurer for claims incurred with respect to a person designated for reinsurance by the member insurer pursuant to section 3959 ~~or 3961~~ after the insurer has incurred an initial level of claims for that person of $7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The amount of reimbursement is 90% of the amount incurred between $7,500 and $32,500 and 100% of the amount incurred in excess of $32,500 for claims incurred in that calendar year with respect to that person. For calendar year 2012, only claims incurred on or after July 1st are considered in determining the member insurer's reimbursement. ~~The~~ With the approval of the superintendent, the association may annually adjust the initial level of claims and the maximum limit to be retained by the insurer to reflect ~~increases~~ changes in costs ~~and~~, utilization ~~within the standard market for individual health plans within the State. The adjustments may not be less~~

~~than the annual change in the Consumer Price Index for medical care services unless the superintendent approves a lower adjustment factor as requested by~~, available funding and any other factors affecting the sustainable operation of the association.

A-1. Subject to approval by the superintendent, the association shall operate a retrospective reinsurance program providing coverage to member insurers for all individual and small group health plans issued in this State with effective dates on and after January 1, 2022.

(1) The association shall reimburse member insurers based on the total eligible claims paid during a calendar year for a single individual in excess of the attachment point specified by the board. The board may establish multiple layers of coverage with different attachment points and different percentages of claims payments to be reimbursed by the association.

(2) Eligible claims by all individuals enrolled in individual or small group health plans in this State may not be disqualified for reimbursement on the basis of health conditions, predesignation by the member insurer or any other differentiating factor.

(3) The board shall annually review the attachment points and coinsurance percentages and make any adjustments that are necessary to ensure that the retrospective reinsurance program operates on an actuarially sound basis.

(4) The board shall ensure that any surplus in the retrospective reinsurance program at the conclusion of a plan year is used to lower attachment points, increase coinsurance rates or both for that plan year, consistent with its responsibility to ensure that the program operates on an actuarially sound basis.

B. ~~An~~ A member insurer shall apply all managed care, utilization review, case management, preferred provider arrangements, claims processing and other methods of operation without regard to whether claims paid for coverage are reinsured under this subsection. A member insurer shall report for each plan year the name of each high-priced item or service for which its payment exceeded the amount allowed for eligible claims and the name of the provider that received this payment. The association shall annually compile and publish a list of all reported names.

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C, together with any additional rating factors the association determines to be appropriate. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that, together with other funds available to the association, will be sufficient to meet the anticipated costs of the association. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer. This

subsection does not apply to reinsurance with respect to any calendar year for which the association operates a retrospective reinsurance program under subsection 1, paragraph A-1.

Sec. B-18. 24-A MRSA §3959, sub-§1, ¶A, as enacted by PL 2011, c. 621, §6, is amended to read:

A. By using ~~the health statement developed by the board pursuant to section 3955, subsection 1, paragraph E or by using~~ the person's claims history or risk scores or any other reasonable means;

Sec. B-19. 24-A MRSA §3959, sub-§5 is enacted to read:

5. Inapplicability. This section does not apply to reinsurance with respect to any calendar year for which the association operates a retrospective reinsurance program under section 3958, subsection 1, paragraph A-1.

Sec. B-20. 24-A MRSA §3961, as amended by PL 2011, c. 621, §§7 and 8, is repealed.

Sec. B-21. 24-A MRSA §3962, as amended by PL 2015, c. 404, §§2 and 3, is repealed.

Sec. B-22. 24-A MRSA §3963 is enacted to read:

§3963. State-federal health coverage partnerships involving the association

1. Consultation with board. The superintendent shall consult with the board before developing any proposal to apply for a state-federal health coverage partnership as defined in section 2781, subsection 1 or to modify the terms of an existing state-federal health coverage partnership involving federal funding for the association or otherwise significantly affecting the operations of the association. The superintendent shall give prompt notice to the board if the superintendent becomes aware of a new federal program or material changes to an existing program with the potential for a significant effect on the operations of the association.

PART C

Sec. C-1. 24-A MRSA §4320-A, as amended by PL 2017, c. 343, §1, is further amended to read:

§4320-A. Coverage of preventive and primary health services

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive and primary health services as required by this section.

1. Preventive services. A health plan must, at a minimum, provide coverage for:

A. The evidence-based items or services that have a rating of A or B in the recommendations of the United States Preventive Services Task Force or equivalent rating from a successor organization;

B. With respect to the individual insured, immunizations that have a recommendation from the federal Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices and that are consistent with the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians or the American College of Obstetricians and Gynecologists or a successor organization;

C. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration that are consistent with the recommendations of the American Academy of Pediatrics or a successor organization; and

D. With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration women's preventive services guidelines that are consistent with the recommendations of the American College of Obstetricians and Gynecologists women's preventive services initiative.

2. Change in recommendations. If a recommendation described in subsection 1 is changed during a health plan year, a carrier is not required to make changes to that health plan during the plan year.

3. Primary health services. A health plan with an effective date on or after January 1, 2021 must provide coverage without cost sharing for the first primary care and behavioral health visits in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and behavioral health visits in a plan year. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2).

Sec. C-2. Notification regarding fulfillment of contingency. Upon adoption of routine technical rules and notification from the Federal Government of its approval of a state innovation waiver amendment in accordance with the Maine Revised Statutes, Title 24-A, section 2791, subsection 5, the Superintendent of Insurance shall notify the Secretary of State, the Secretary of the Senate, the Clerk of the House of Representatives and the Revisor of Statutes that the contingencies set forth in section 2791, subsection 5 have been met.

Sec. C-3. Revisor's review; cross-references. The Revisor of Statutes shall review the Maine Revised Statutes and include in the errors and inconsistencies bill submitted to the First Regular Session of the 130th Legislature pursuant to Title 1, section

94 any sections necessary to correct and update any cross-references in the statutes to provisions of law repealed in this Act.

SUMMARY

This bill:

1. Establishes the Made for Maine Health Coverage Act;

2. Establishes the Maine Health Insurance Marketplace Trust Fund;

3. Authorizes the State to enter into state-federal health coverage partnerships that support the availability of affordable health coverage;

4. Establishes a pooled market for individual health plans and small group health plans and changes reinsurance to be retrospective and applied to the pooled market; and

5. Creates clear choice design for cost sharing and requires coverage of certain primary care and behavioral health visits without the application of any deductible.