LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-THIRD LEGISLATURE

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THE GENERAL EFFECTIVE DATE FOR
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trustee, executor, legal representative or registered agent who alone or jointly and severally with others owns, holds or controls the whole or any part of the freehold or leasehold interest to any property, with or without actual possession.

Sec. B-3. 38 MRSA §1291, sub-§26-A is enacted to read:

26-A. Residential dwelling. "Residential dwelling" means a room or group of rooms that form a single independent habitable unit for permanent occupation by one or more individuals that has facilities with permanent provisions for living, sleeping, eating, cooking and sanitation, including common areas and appurtenant structures. "Residential dwelling" does not include:

A. An area not used for living, sleeping, eating, cooking or sanitation, such as an unfinished basement, that is not readily accessible to children under 6 years of age;

B. A unit within a hotel, motel or seasonal or temporary lodging facility unless the unit is occupied by one or more children under 6 years of age for a period exceeding 30 days;

C. An area that is secured and inaccessible to occupants;

D. Housing for the elderly, or a dwelling unit designated exclusively for adults with disabilities. This exemption does not apply if a child under 6 years of age resides or is expected to reside in the dwelling unit or visit the dwelling unit on a regular basis; or

E. An unoccupied dwelling unit that is to be demolished, as long as the dwelling unit remains unoccupied until demolition.

Sec. B-4. 38 MRSA §1298 is enacted to read:

§1298. Registry of leased lead-safe residential dwellings

1. Registry. The department shall maintain a registry of leased residential dwellings built before 1978 that are lead-safe as designated by the property owners in accordance with subsection 2.

2. Designation as lead-safe. A leased residential dwelling may be designated as lead-safe for the purposes of this section if the property owner has submitted to the department an application for the property to be placed on the registry created under subsection 1. Submission of an application to the registry is voluntary on the part of the property owner.

3. Application. The application under subsection 2 must be submitted together with a report by a lead inspector that indicates that the leased residential dwelling has been tested for the presence of lead-based paint and lead-contaminated dust and that the dwelling meets the requirements for certification as lead-safe in accordance with the standards and procedures established by rules adopted by the commissioner.

PART C

Sec. C-1. Review and report. The Department of Environmental Protection, the Maine State Housing Authority and the Department of Health and Human Services, Maine Center for Disease Control and Prevention, jointly referred to in this section as "the agencies," shall review the following issues related to achieving housing safe from lead hazards and the elimination of childhood lead poisoning. The agencies shall report by January 1, 2009 and may make recommendations regarding achieving lead-safe housing and eliminating lead poisoning with proposed legislation to the joint standing committees of the Legislature having jurisdiction over health and human services matters and natural resources matters.

1. The agencies shall review and make recommendations on resources and incentives to promote housing that is lead-safe, as defined in the Maine Revised Statutes, Title 38, section 1291, subsection 19-A, including the lead poisoning prevention fee established in Title 22, section 1322-F and lead-safe renovation notification and work practice requirements.

2. The agencies shall review and make recommendations concerning the establishment of a requirement to ensure that every leased residential dwelling is maintained as lead-safe, including routine maintenance and owner self-inspection requirements, and the inclusion of such a requirement under a warranty of habitability.

3. The agencies shall review and make recommendations concerning the establishment of a requirement that the owner of a residential property built before 1978 subject the property to a lead inspection and provide a copy of the lead inspection report to any prospective buyer prior to transfer of the property to a new owner and the capacity of qualified lead professionals to perform this work.

4. The agencies shall review ways to fully implement and enforce lead poisoning prevention programs established by statute and make recommendations to eliminate lead paint and lead poisoning risks in the State.

See title page for effective date.

CHAPTER 629

H.P. 1608 - L.D. 2247

An Act To Continue Maine's Leadership in Covering the Uninsured

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

PART A

Sec. A-1. 5 MRSA §12004-G, sub-§14-F is enacted to read:

14-F.

Health Care	Board of Directors of the Maine Reinsurance Association	Expenses Only	24-A §3903

Sec. A-2. 24-A MRSA §423-E is enacted to read:

§423-E. Report to Legislature

The superintendent shall report each year by March 1st to the joint standing committee of the Legislature having jurisdiction over insurance matters on the impact of any changes to the rating provisions in section 2736-C, the status of the Maine Individual Reinsurance Association established pursuant to chapter 54 and the impact on rates related to reimbursements paid by the Maine Individual Reinsurance Association, the total number of individuals enrolled in any health insurance product regulated by the bureau and the number of previously uninsured or underinsured individuals who have enrolled during that year in any health insurance product regulated by the bureau, which information is collected pursuant to rules adopted under this section. Along with the annual report, the superintendant may submit any proposed legislation for consideration by the joint standing committee.

Sec. A-3. 24-A MRSA §2736-C, sub-§2, ¶B, as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is 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.

Sec. A-4. 24-A MRSA §2736-C, sub-§2, ¶D, as amended by PL 2001, c. 410, Pt. A, §2 and affected by §10, is further amended to read:

D. A carrier may vary the premium rate due to age~~, occupation or industry~~ and geographic area ~~only under the following schedule and within the listed percentage bands~~ in accordance with the limitations set out in this paragraph.

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

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

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

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

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

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

(c) The superintendent shall adopt rules setting forth appropriate methodologies regarding determination of rating factors pursuant to this subparagraph. Rules

adopted pursuant to this division are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. A-5. 24-A MRSA §2736-C, sub-§2, ¶G is enacted to read:

G. A carrier that adjusts its rate shall account in its experience for the effect of the annual reimbursements paid to the carrier by the Maine Individual Reinsurance Association established in chapter 54.

Sec. A-6. 24-A MRSA §2736-C, sub-§2, ¶H is enacted to read:

H. A carrier that offered individual health plans prior to July 1, 2009 may close its individual book of business sold prior to July 1, 2009 and may establish a separate community rate for individuals applying for coverage under an individual health plan on or after July 1, 2009. A carrier must merge the closed book with its open book by the earlier of:

(1) July 1, 2012; and

(2) When the number of subscribers remaining in a carrier's closed individual book of business is less than 25% of the carrier's individual health plan subscriber total as of June 30, 2009. In order to administer this subparagraph, a carrier shall compare the number of current individual health plan subscribers in its closed book of business to its individual health plan subscriber total as of June 30, 2009 on an annual basis.

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

Sec. A-7. 24-A MRSA §2736-C, sub-§2-A is enacted to read:

2-A. Reinsurance requirement. Carriers providing individual health plans are subject to the requirements of chapter 54.

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

CHAPTER 54

MAINE INDIVIDUAL REINSURANCE ASSOCIATION

§3901. Short title

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

§3902. Definitions

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

1. Association. "Association" means the Maine Individual Reinsurance Association established in section 3903.

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

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

4. Insurer. "Insurer" means an entity that is authorized to write medical insurance or that provides medical insurance in this State. "Insurer" includes an insurance company, a nonprofit hospital and medical service organization, a fraternal benefit society, a health maintenance organization, a self-insurance arrangement that provides health care benefits in this State to the extent allowed under the federal Employee Retirement Income Security Act of 1974, a 3rd-party administrator, a multiple-employer welfare arrangement, any other entity providing medical insurance or health benefits subject to state insurance regulation, any reinsurer of health insurance in this State, the Dirigo Health Program established in chapter 87 or any other state-run or state-sponsored health benefit program, whether fully insured or self-funded.

5. Medical insurance. "Medical insurance" means a hospital and medical expense-incurred policy, a nonprofit hospital and medical service plan, a health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers'

compensation or similar law; or automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

7. Member insurer. "Member insurer" means an insurer that offers individual medical insurance, is marketing an individual medical insurance policy in this State and has a medical-loss ratio of at least 70% in the individual insurance market.

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

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

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

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

§3903. Maine Individual Reinsurance Association

1. Association established. The Maine Individual Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business, every member insurer must participate in the association. The Dirigo Health Program established in chapter 87 and any other state-run or state-sponsored health benefit program shall also participate in the association.

2. Board of directors. The association is governed by a board of directors in accordance with this subsection.

A. The board consists of 11 members appointed pursuant to this paragraph:

(1) Five members appointed by the superintendent, of whom:

(a) Two members must be chosen from the general public and may not be associated with the medical profession, a hospital or an insurer;

(b) One member must be a representative of a public health plan;

(c) One member must represent health insurance producers; and

(d) One member must represent a statewide association representing small businesses that receives the majority of its funding from persons and businesses in the State; and

(2) Six members appointed by insurers licensed to do business in this State, at least one of whom is a 3rd-party administrator other than an insurer.

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

C. A board member may not be a registered lobbyist under Title 3, chapter 15.

D. Members of the board serve terms of 3 years.

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

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

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

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

§3904. Liability and indemnification

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

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

§3905. Duties and powers of the association

1. Duties. The association shall:

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

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

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

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

E. Establish an amount to be retained in the Reinsurance Association Reserve in accordance with section 3907.

2. Powers. The association may:

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

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

C. Sue or be sued, including taking any legal actions necessary or proper to recover or collect obligations due the association;

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

E. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy or other contract design and any other function within the authority of the association;

F. Establish procedures for reinsuring risks of insurers in the association in accordance with section 3908;

G. Provide for reinsurance of risks incurred by the association. The provision of reinsurance may not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers; and

H. Apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk reinsurance associations.

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

4. Review for solvency. The superintendent shall review the operations of the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to adjust the initial level of claims and the reserve amount to be retained by the association.

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

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

§3906. Selection of plan administrator

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

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

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

A. Perform all administrative functions relating to the association;

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

C. Following the close of each calendar year, report to the superintendent the amount of revenue received from the Dirigo Health Enterprise Fund pursuant to section 6915, the expenses of admini-

stration pertaining to reinsurance operations of the program and the incurred losses of the year; and

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

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

§3907. Reinsurance Association Reserve

1. Reserve established. The Reinsurance Association Reserve is established within the Dirigo Health Enterprise Fund as an account for the deposit of funds as required by subsection 2.

2. Funds. The Reinsurance Association Reserve is capitalized by money from the Dirigo Health Enterprise Fund, as established pursuant to section 6915, and any other fund advanced for initial operating expenses, any funds received from any public or private source, legislative appropriations, payments from state departments and agencies and such other means as the Legislature may approve. All money in the Reinsurance Association Reserve may be used only by the association for the purposes of this section. Funds in the reserve do not lapse, but must be carried forward to carry out the purposes of this chapter.

§3908. Reinsurance

1. Reinsurance amount. Any member insurer offering an individual health insurance plan pursuant to section 2736-C must be reinsured by the association to the level of coverage provided in this subsection.

A. Beginning July 1, 2009, the association shall reimburse a member insurer with respect to claims of an insured individual at a rate of 50% of the aggregate claims paid between $75,000 and $250,000 for that person for covered benefits in a state fiscal year, to the extent funds are available pursuant to paragraph B.

B. The association shall limit total annual reimbursements to member insurers to the amount of money transferred annually from the Dirigo Health Enterprise Fund. Any money at the end of the fiscal year not used for reimbursements must be transferred to the Reinsurance Association Reserve account under section 3907.

§3909. Actions against association or members based upon joint or collective actions

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

Sec. A-9. Maine Individual Reinsurance Association; staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 3903, subsection 2, paragraph D, the terms for initial appointments to the board of directors of the Maine Individual Reinsurance Association are as follows. Of those members of the board appointed by insurers, 2 members serve for a term of one year, 2 members for a term of 2 years and 2 members for a term of 3 years. Of those members appointed by the Superintendent of Insurance, one member serves for a term of one year, 2 members serve for a term of 2 years and 2 members serve for a term of 3 years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

Sec. A-10. Funding. By January 1, 2012, the Maine Individual Reinsurance Association shall determine whether the amount transferred to the association as provided in the Maine Revised Statutes, Title 24-A, section 6915 is adequate to meet the reinsurance requirements of Title 24-A, chapter 54. The association shall submit a report to the joint standing committee of the Legislature having jurisdiction over insurance matters with its recommendations, if any, for changes to the funding percentage. The committee may submit a bill to the Second Regular Session of the 125th Legislature relating to the funding.

PART B

Sec. B-1. 24-A MRSA §6912, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

PART C

Sec. C-1. 22 MRSA §1721 is enacted to read:

§1721. Voluntary restraint

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

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this paragraph, a hospital's consolidated operating margin is calculated by dividing its consolidated operating income by its total consolidated operating revenue.

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

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

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

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

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

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

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

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

PART D

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

Sec. D-2. 24-A MRSA §6913-A is enacted to read:

§6913-A. Health access surcharge

1. Health access surcharge on paid claims required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators, not including carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, shall pay a health access surcharge of 1.8% on all paid claims. The following provisions govern the health access surcharge.

A. A health insurance and employee benefit excess insurance carrier is not required to pay a surcharge on policies or contracts insuring federal employees.

B. The surcharge applies to paid claims beginning July 1, 2008.

C. Surcharge payments must be made monthly to Dirigo Health beginning August 2008 and are due not less than 15 days after the end of the month and must accrue interest at 12% per annum on or after the due date, except that:

(1) Surcharge payments for 3rd-party administrators for groups of 500 or fewer members may be made annually not less than 60 days after the close of the plan year.

D. Surcharge payments received by Dirigo Health must be pooled with other revenues of the agency in the Dirigo Health Enterprise Fund established in section 6915.

2. Failure to pay health access surcharge payments. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any health insurance carrier or employee benefit excess insurance carrier or the license of any 3rd-party administrator to operate in this State that fails to pay a health access surcharge. In addition, the superintendent may assess civil penalties in accordance with section 12-A against any health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator that fails to pay a health access surcharge, may take any other enforcement action authorized under section 12-A to collect any unpaid health access surcharge payments and may collect the costs of enforcement including attorney's fees from those who fail to pay a health access surcharge.

3. Definitions. As used in this section, the following terms have the following meanings.

A. "Paid claims" means all payments made by health insurance carriers, 3rd-party administrators and employee benefit excess carriers for health and medical services provided under policies issued pursuant to the laws of this State that insure residents of this State or, in the case of 3rd-party administrators, for health care for residents of this State, except that "paid claims" does not include:

(1) Claims-related expenses and general administrative expenses;

(2) Payments made to qualifying providers under a "pay for performance" or other incentive compensation arrangement if the payments are not reflected in the processing of claims submitted for services rendered to specific covered individuals;

(3) Claims paid by carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, except that claims paid for dental services covered under a medical policy are included;

(4) Claims paid for services rendered to nonresidents of this State;

(5) Claims paid under retiree health benefit plans that are separate from and not included within benefit plans for existing employees;

(6) Claims paid by an employee benefit excess carrier that have been counted by a 3rd-party administrator for determining its savings offset payment;

(7) Claims paid for services rendered to persons covered under a benefit plan for federal employees; and

(8) Claims paid for services rendered outside of this State to a person who is a resident of this State.

In those instances in which a health insurance carrier, employee benefit excess insurance carrier or 3rd-party administrator is contractually entitled to withhold certain amounts from payments due to providers of health and medical services in order to help ensure that the providers can fulfill any financial obligations they may have under a managed care risk arrangement, the full amounts due the providers before application of such withholds must be reflected in the calculation of paid claims.

B. "Claims-related expenses" includes:

(1) Payments for utilization review, care management, disease management, risk assessment and similar administrative services intended to reduce the claims paid for health and medical services rendered to covered individuals, usually either by attempting to ensure that needed services are delivered in the most efficacious manner possible or by helping such covered individuals to maintain or improve their health; and

(2) Payments that are made to or by organized groups of providers of health and medical services in accordance with managed care risk arrangements or network access agreements, which payments are unrelated to the provision of services to specific covered individuals.

C. "Health and medical services" includes, but is not limited to, any services included in the furnishing of medical care, dental care to the extent covered under a medical insurance policy, pharmaceutical benefits or hospitalization, including but not limited to services provided in a hospital or other medical facility; ancillary services, including but not limited to ambulatory services; physician and other practitioner services, including but not limited to services provided by a physician's assistant, nurse practitioner or midwife; and behavioral health services, including but not limited to mental health and substance abuse services.

4. Rulemaking. The board may adopt any rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. D-3. 24-A MRSA §6915, as amended by PL 2005, c. 386, Pt. D, §3, is further amended to read:

§6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, revenues transferred pursuant to Title 28-A, section 1652, subsection 5 and Title 36, section 4853, any ~~savings offset~~ payments made pursuant to former section 6913 and section 6913-A and any funds received from any public or private source for the Dirigo Health Program and the Maine Individual Reinsurance Association established by chapter 54. An amount equal to 18.8% of the deposits received by the Dirigo Health Enterprise Fund from revenues transferred pursuant to Title 28-A, section 1652, subsection 5 and Title 36, section 4853, revenues deposited pursuant to section 6913-A must be transferred to the Maine Individual Reinsurance Association by the first of each month beginning July 1, 2010. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. D-4. 36 MRSA §4404-D is enacted to read:

§4404-D. Tax credited to Dirigo Health Enterprise Fund

The State Controller shall transfer by the 15th of each month from General Fund revenues to the Dirigo Health Enterprise Fund established under Title 24-A, section 6915 the amount of tax collected pursuant to this chapter that exceeds the total fiscal year-to-date budget projection for that tax revenue as of the close of the preceding month based on the tax rate imposed by this chapter that was in effect on July 1, 2008. For purposes of this section, "budget projection" is the amount derived from the March 1, 2008 report of the Revenue Forecasting Committee established under Title 5, section 1710-E regarding the tax that is imposed by this chapter, as determined on a monthly basis by the assessor.

Sec. D-5. Savings offset payments calculated prior to effective date. Notwithstanding that section of this Part that repeals the Maine Revised Statutes, Title 24-A, section 6913, the savings offset payments that have been calculated and required under former Title 24-A, section 6913 for claims paid prior to the effective date of this Part are due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913 until the first monthly health access surcharge required under Title 24-A, section 6913-A becomes due and payable.

Sec. D-6. Transfers to Dirigo Health Enterprise Fund in fiscal year 2008-09. Notwithstanding the Maine Revised Statutes, Title 28-A, section 1652, subsection 5, the total fiscal year-to-date budget projection excludes any period in fiscal year 2008-09 prior to the effective date of this Part.

Sec. D-7. Effective date. This Part takes effect July 1, 2008 or on the effective date of this Act, whichever occurs later.

PART E

Sec. E-1. 28-A MRSA §1652, sub-§1, as repealed and replaced by PL 1987, c. 342, §116, is amended to read:

1. Excise tax on malt liquor. An excise tax is imposed on the privilege of manufacturing and selling malt liquor in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of 25¢ per gallon on all malt liquor sold in the State that is manufactured by a manufacturer that produced a total of less than 100,000 barrels of malt liquor in the previous calendar year and 54¢ per gallon on all other malt liquor sold in the State.

Sec. E-2. 28-A MRSA §1652, sub-§2, as amended by PL 1997, c. 767, §4, is repealed and the following enacted in its place:

2. Excise tax on wine; hard cider. An excise tax is imposed on the privilege of manufacturing and selling wine and hard cider in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of:

B. Thirty cents per gallon on all wine, other than sparkling wine, that is manufactured by a manufacturer that produced a total of less than 20,000 gallons of wine, other than sparkling wine, in the previous calendar year;

C. Sixty-five cents per gallon on all wine, other than sparkling wine and except as provided in paragraph B, manufactured in or imported into the State;

D. One dollar per gallon on all sparkling wine manufactured in or imported into the State; and

E. Twenty-five cents per gallon on all hard cider manufactured in or imported into the State.

Sec. E-3. 28-A MRSA §1652, sub-§5 is enacted to read:

5. Tax credited to Dirigo Health Enterprise Fund. The State Controller shall transfer by the 15th of each month from General Fund revenues to the Dirigo Health Enterprise Fund established under Title 24-A, section 6915 the amount of tax collected pursuant to this section that exceeds the total fiscal year-to-date budget projection for that tax revenue as of the close of the preceding month based on the tax rate for malt liquor and wine, except sparkling wine, that was in effect on July 1, 2008. For purposes of this section, "budget projection" is the amount derived from the March 1, 2008 report of the Revenue Forecasting Committee established under Title 5, section 1710-E regarding the tax that is imposed by this section, as determined on a monthly basis by the State Tax Assessor.

Sec. E-4. Effective date. This Part takes effect August 1, 2008.

PART F

Sec. F-1. 36 MRSA c. 720 is enacted to read:

CHAPTER 720

SOFT DRINK AND SYRUP TAX

§4851. Definitions

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

1. Bottle. "Bottle" means any closed or sealed glass, metal, paper or plastic container or any other type of container regardless of the size or shape of the container.

2. Bottled soft drink. "Bottled soft drink" means any ready-to-consume soft drink contained in a bottle.

3. Distributor, manufacturer or wholesale dealer. "Distributor, manufacturer or wholesale

dealer" means any person who receives, stores, manufactures, bottles or sells bottled soft drinks, syrup, simple syrup or powder or base products for mixing, compounding or making soft drinks for sale to retailers or other manufacturers, wholesale dealers or distributors for resale purposes.

4. Milk. "Milk" means natural liquid milk regardless of animal source or butterfat content; natural milk concentrate, whether or not reconstituted, regardless of animal source or butterfat content; or dehydrated natural milk, whether or not reconstituted.

5. Natural fruit juice. "Natural fruit juice" means the original liquid resulting from the pressing of fruit, the liquid resulting from the reconstitution of fruit juice concentrate or the liquid resulting from the restoration of water to dehydrated fruit juice.

6. Natural vegetable juice. "Natural vegetable juice" means the original liquid resulting from the pressing of vegetables, the liquid resulting from the reconstitution of vegetable juice concentrate or the liquid resulting from the restoration of water to dehydrated vegetable juice.

7. Nonalcoholic beverage. "Nonalcoholic beverage" means any beverage not subject to tax under Title 28-A, Part 4.

8. Place of business. "Place of business" means any place where soft drinks, syrups, simple syrups or powder or base products are manufactured or any place where bottled soft drinks, syrup, simple syrup, powder or base product or any other item taxed under this chapter is received.

9. Powder or base product. "Powder or base product" means a solid mixture of basic ingredients used in making, mixing or compounding soft drinks by mixing the powder or other base with water, ice, syrup, simple syrup, fruits, vegetables, fruit juice, vegetable juice or any other product suitable to make a soft drink.

10. Retailer. "Retailer" means any person, other than a distributor, manufacturer or wholesale dealer, who receives, stores, mixes, compounds or manufactures any soft drink and sells or otherwise dispenses the soft drink to the ultimate consumer.

11. Sale. "Sale" means the transfer of title or possession for a valuable consideration of tangible personal property regardless of the manner by which the transfer is accomplished.

12. Simple syrup. "Simple syrup" means a mixture of sugar and water.

13. Soft drink. "Soft drink" means any nonalcoholic beverage, whether naturally or artificially flavored, whether carbonated or noncarbonated, sold for human consumption, including, but not limited to, soda water, cola and other flavored drinks, any fruit or vegetable drink containing 10% or less of natural fruit juice or natural vegetable juice and all other drinks and beverages commonly referred to as soft drinks, but not including coffee or tea unless the coffee or tea is bottled as a liquid for sale.

14. Syrup. "Syrup" means the liquid mixture of basic ingredients used in making, mixing or compounding soft drinks by mixing the syrup with water, simple syrup, ice, fruits, vegetables, fruit juice, vegetable juice or any other product suitable to make a soft drink.

§4852. Tax rate

1. Tax imposed. There is imposed a tax on every distributor, manufacturer or wholesale dealer to be calculated as follows:

A. Four dollars per gallon of syrup or simple syrup sold or offered for sale;

B. Forty-two cents per gallon of bottled soft drinks sold or offered for sale; and

C. When a package or container of powder or base product is sold or offered for sale in the State, the tax on the sale of each package or container is equal to 42¢ for each gallon of soft drink that may be produced from each package or container by following the manufacturer's instructions. This tax applies when the powder or base product is sold to a retailer for sale to the ultimate consumer after the soft drink is produced by the retailer.

2. Purchase from unlicensed seller. A retailer who purchases bottled soft drinks, syrup, simple syrup or powder or base product from an unlicensed distributor, manufacturer or wholesale dealer is liable for the tax imposed in subsection 1.

§4853. Tax credited to Dirigo Health Enterprise Fund

The State Controller shall transfer by the 15th of each month from General Fund revenues to the Dirigo Health Enterprise Fund established under Title 24-A, section 6915 the amount of tax collected pursuant to this chapter.

§4854. Exemptions

The following are exempt from the tax imposed by section 4852:

1. Sales to Federal Government. Syrups, simple syrups, powder or base products or soft drinks sold to the Federal Government;

2. Products exported from State. Syrups, simple syrups, powder or base products or soft drinks exported from the State by a distributor, manufacturer or wholesale dealer;

3. Coffee or tea base. Any powder or base product used in preparing coffee or tea;

4. Juice or vegetable concentrate. Any frozen, freeze-dried or other concentrate to which only water is added to produce a nonalcoholic beverage containing more than 10% natural fruit juice or natural vegetable juice;

5. Fruit or vegetable juice. Any nonalcoholic beverage containing more than 10% natural fruit juice or natural vegetable juice;

6. Sales to another distributor, manufacturer or wholesale dealer. Syrups, simple syrups, powders or base products or soft drinks sold by a distributor, manufacturer or wholesale dealer to a distributor, manufacturer or wholesale dealer who holds a license under section 4856 if the license number of the distributor, manufacturer or wholesale dealer to whom the syrups, simple syrups, powder or base products or soft drinks are sold is clearly shown on the invoice for the sale that is claimed to be exempt. This exemption does not apply to any sale to a retailer;

7. Infant formula. Any product, whether sold in liquid or powder form, that is intended by its manufacturer for consumption by infants and that is commonly referred to as infant formula;

8. Water. Water to which no flavoring, whether artificial or natural, has been added and that has not been artificially carbonated;

9. Dietary aids. Any product, whether sold in liquid or powder form, that is intended by its manufacturer for use as a dietary supplement or for weight reduction;

10. Consumer mix. Any powder or base product that is intended by its manufacturer to be sold and used for the purpose of domestically mixing soft drinks by the ultimate consumer; and

11. Milk products. Any product containing milk or milk products.

§4855. Reports

A distributor, manufacturer or wholesale dealer and any retailer subject to the tax imposed by this chapter shall file a monthly return with the assessor and pay the tax on or before the 15th day of the month following the month in which the sale or purchase was made. The return must be made on a form prescribed by the assessor. The return must contain any information the assessor requires for the proper administration of this chapter. When a retailer is also acting as a distributor, manufacturer or wholesale dealer, the duty to report and pay the tax imposed by this chapter arises when the property is transferred to a retail store for sale to the ultimate consumer, as reflected by the records of the taxpayer.

§4856. Licenses

1. Distributor, manufacturer or wholesale dealer. Any distributor, manufacturer or wholesale dealer who sells or offers for sale to retailers within the State syrups, simple syrups, powder or base products or soft drinks shall obtain from the bureau a license for the privilege of conducting such business within the State.

2. Retailer. Any retailer who purchases syrups, simple syrups, powder or base products or soft drinks from a distributor, manufacturer or wholesale dealer not licensed under subsection 1 shall obtain a license from the bureau for the privilege of conducting such business.

3. Location; display. Any person required to obtain a license under this section shall obtain a license for each place of business owned or operated by that person. The license must be conspicuously displayed at the place of business for which it was issued.

§4857. Penalties

1. Failure to file, pay. A person required to file a return and pay tax under this chapter is subject to the same penalties as for failure to file and pay sales tax under Part 3.

2. Failure to obtain license. A person required to obtain a license under section 4856 who fails to do so is subject to the same penalties as for failure to register as a retailer under section 1754-B.

§4858. Rules

The assessor may adopt rules under the Maine Administrative Procedure Act to provide for the administration of this chapter. These rules may provide for a fee to cover the cost of issuing licenses required under section 4856. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. F-2. Effective date. This Part takes effect August 1, 2008.

PART G

Sec. G-1. Distribution of Fund for a Healthy Maine deallocation; report required. The State Budget Officer shall review the programs receiving funds from the Fund for a Healthy Maine and shall make adjustments to each account receiving funding in the All Other line category pursuant to the deallocation in the Department of Administrative and Financial Services included in section 4. The State Budget Officer shall first apply any unexpended balance in the Fund for a Healthy Maine on June 30, 2008 before making any adjustments. These adjustments must be calculated in proportion to each account's allocation in the All Other line category in relation to the total All Other allocation for Fund for a Healthy Maine programs. Notwithstanding any other provision

of law, the State Budget Officer shall transfer the identified amounts by financial order upon approval of the Governor. These transfers are considered adjustments to allocations in fiscal year 2008-09. The State Budget Officer shall report on the distribution of savings to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 1, 2009.

Sec. G-2. Working capital advance. For fiscal year 2008-09, the State Controller is authorized to provide an advance up to $3,600,000 from the General Fund to the Dirigo Health Enterprise Fund established in the Maine Revised Statutes, Title 24-A, section 6915 to provide funds for allocations from the Dirigo Health Enterprise Fund. These funds must be returned to the General Fund from the Dirigo Health Enterprise Fund no later than June 30, 2009.

Sec. G-3. Transfer from unappropriated surplus at close of fiscal year 2008-09 to the Dirigo Health Enterprise Fund. Notwithstanding any other provision of law, at the close of fiscal year 2008-09, the State Controller shall transfer up to $3,600,000 from the unappropriated surplus of the General Fund to the Dirigo Health Enterprise Fund established in the Maine Revised Statutes, Title 24-A, section 6915 after all required deductions of appropriations, budgeted financial commitments and adjustments considered necessary by the State Controller have been made and as the first priority after the transfers required pursuant to Title 5, sections 1507 and 1511 and before the transfers required pursuant to Title 5, section 1536.

Sec. G-4. Appropriations and allocations. The following appropriations and allocations are made.

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF

Fund for a Healthy Maine 0921

Initiative: Reduces funding to allow for the allocation of funds for the Dirigo Health Program. The State Budget Officer shall calculate the amount of the reduction to be achieved from existing balances in the Fund for a Healthy Maine and by deallocations from existing programs, and shall calculate the reductions to the individual Fund for a Healthy Maine program accounts and transfer those amounts by financial order.

FUND FOR A HEALTHY MAINE	2007-08	2008-09
All Other	$0	($5,000,000)
FUND FOR A HEALTHY MAINE TOTAL	$0	($5,000,000)

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF DEPARTMENT TOTALS	2007-08	2008-09
FUND FOR A HEALTHY MAINE	$0	($5,000,000)
DEPARTMENT TOTAL - ALL FUNDS	$0	($5,000,000)

DIRIGO HEALTH

FHM-Dirigo Health N050

Initiative: Allocates funds for the purposes of the Dirigo Health Program.

FUND FOR A HEALTHY MAINE	2007-08	2008-09
All Other	$0	$5,000,000
FUND FOR A HEALTHY MAINE TOTAL	$0	$5,000,000

DIRIGO HEALTH DEPARTMENT TOTALS	2007-08	2008-09
FUND FOR A HEALTHY MAINE	$0	$5,000,000
DEPARTMENT TOTAL - ALL FUNDS	$0	$5,000,000

SECTION TOTALS	2007-08	2008-09
FUND FOR A HEALTHY MAINE	$0	$0
SECTION TOTAL - ALL FUNDS	$0	$0

PART H

Sec. H-1. Report regarding Fund for a Healthy Maine. The Joint Standing Committee on Health and Human Services shall meet to consider the structure, accountability and appropriate level of legislative and independent oversight of the Fund for a Healthy Maine, established in the Maine Revised Statutes, Title 22, section 1511. The committee shall report back to the Joint Standing Committee on Appropriations and Financial Affairs by October 1, 2008 with recommendations, including necessary implementing legislation, for the structure, accountability

and appropriate level and type of oversight of the Fund for a Healthy Maine.

PART I

Sec. I-1. 24-A MRSA §2736-C, sub-§10 is enacted to read:

10. Pilot projects; persons under 30 years of age. The superintendent shall authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers individual insurance, is marketing an individual insurance policy in this State and has a medical-loss ratio of at least 70% in the individual market to offer individual medical insurance products to persons under 30 years of age beginning July 1, 2009.

A. The superintendent shall review pilot project proposals submitted in accordance with rules adopted pursuant to paragraph E. The superintendent shall approve a pilot project proposal if it meets the minimum benefit requirements set forth in rules adopted pursuant to paragraph E and may not approve a proposal that does not provide such minimum benefit requirements.

B. Notwithstanding any requirements in this Title for specific health services, specific diseases and certain providers of health care services, the superintendent may adopt minimum benefit requirements that exclude certain benefits if determined by the superintendent to provide affordable and attractive individual health plans for persons under 30 years of age.

C. A pilot project approved by the superintendent pursuant to this subsection qualifies as creditable coverage under this Title. Notwithstanding section 2849-B, subsection 4, a policy that replaces coverage issued under a pilot project approved under this subsection is not subject to any preexisting conditions exclusion provisions. Each carrier that offers an individual product pursuant to a pilot project approved under this subsection must combine the experience for that product with other individual products offered by that carrier as filed with the bureau when determining premium rates. The experience of a carrier's closed pool may not be taken into account in determining pilot project premium rates.

D. Beginning in 2010, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance matters on the status of any pilot project approved by the superintendent pursuant to this subsection. The report must include an analysis of the effectiveness of the pilot project in encouraging persons under 30 years of age to purchase insurance and an analysis of the impact of the pilot project on the broader insurance market, including any impact on premiums and availability of coverage.

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection.

PART J

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

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF

Revenue Services - Bureau of 0002

Initiative: Provides funds for the administrative costs associated with establishing a soft drink tax, including funds for one Accounting Associate II position and related costs.

GENERAL FUND	2007-08	2008-09
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$54,443
All Other	$0	$140,558
GENERAL FUND TOTAL	$0	$195,001

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF DEPARTMENT TOTALS	2007-08	2008-09
GENERAL FUND	$0	$195,001
DEPARTMENT TOTAL - ALL FUNDS	$0	$195,001

DIRIGO HEALTH

Dirigo Health Fund 0988

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

DIRIGO HEALTH FUND	2007-08	2008-09
All Other	$0	($32,900,000)

DIRIGO HEALTH FUND TOTAL	$0	($32,900,000)

Dirigo Health Fund 0988

Initiative: Allocates Dirigo Health funds from a health access surcharge of 1.8% on all paid claims.

DIRIGO HEALTH FUND	**2007-08**	**2008-09**
All Other	$0	$33,000,000
DIRIGO HEALTH FUND TOTAL	$0	$33,000,000

Dirigo Health Fund 0988

Initiative: Allocates funds from revenue generated from the new tax on soft drinks.

DIRIGO HEALTH FUND	**2007-08**	**2008-09**
All Other	$0	$9,200,000
DIRIGO HEALTH FUND TOTAL	$0	$9,200,000

Dirigo Health Fund 0988

Initiative: Allocates funds from the revenue generated from the increased excise tax on malt beverages and wine.

DIRIGO HEALTH FUND	**2007-08**	**2008-09**
All Other	$0	$7,499,937
DIRIGO HEALTH FUND TOTAL	$0	$7,499,937

DIRIGO HEALTH DEPARTMENT TOTALS	**2007-08**	**2008-09**
DIRIGO HEALTH FUND	**$0**	**$16,799,937**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**$16,799,937**

SECTION TOTALS	**2007-08**	**2008-09**
GENERAL FUND	**$0**	**$195,001**
DIRIGO HEALTH FUND	**$0**	**$16,799,937**
SECTION TOTAL - ALL FUNDS	**$0**	**$16,994,938**

PART K

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

DIRIGO HEALTH

Dirigo Health Fund 0988

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

DIRIGO HEALTH FUND	**2007-08**	**2008-09**
All Other	$0	($32,900,000)
DIRIGO HEALTH FUND TOTAL	$0	($32,900,000)

Dirigo Health Fund 0988

Initiative: Allocates Dirigo Health funds from a health access surcharge of 1.8% on all paid claims.

DIRIGO HEALTH FUND	**2007-08**	**2008-09**
All Other	$0	$33,000,000
DIRIGO HEALTH FUND TOTAL	$0	$33,000,000

DIRIGO HEALTH DEPARTMENT TOTALS	**2007-08**	**2008-09**
DIRIGO HEALTH FUND	**$0**	**$100,000**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**$100,000**

PART L

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

B. Collect the savings offset payments provided in former section 6913 and the health access surcharge provided in section 6913-A;

Sec. L-2. 24-A MRSA §6908, sub-§2, ¶F, as amended by PL 2005, c. 400, Pt. C, §6, is repealed.

Sec. L-3. 24-A MRSA §6908, sub-§2, ¶G, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

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

Sec. L-4. 24-A MRSA §6908, sub-§2, ¶H is enacted to read:

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

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

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

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

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

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

Dirigo Health shall submit the quarterly reports required under this subsection to the superintendent, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

Sec. L-5. 24-A MRSA §6951, first ¶, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

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

Sec. L-6. 24-A MRSA c. 87, sub-c. 3, as amended, is repealed.

PART M

Sec. M-1. 24-A MRSA §2736, sub-§3, ¶B, as amended by PL 2003, c. 469, Pt. E, §9, is further amended to read:

B. The insurer must demonstrate in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than 210 days prior to the filing, the ratios of benefits incurred to premiums earned for those products average no less than 80% for the previous 12-month period. For the purposes of this calculation, any savings offset payments paid pursuant to former section 6913 must be treated as incurred claims.

Sec. M-2. 24-A MRSA §2736, sub-§4, ¶C, as amended by PL 2003, c. 469, Pt. E, §10, is further amended to read:

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

Sec. M-3. 24-A MRSA §2736-A, as amended by PL 2003, c. 469, Pt. E, §11, is further amended to read:

§2736-A. Hearing

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate, unfairly discriminatory or not in compliance with former section 6913 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 section must conform to the procedural requirements set forth in the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter 4.

Sec. M-4. 24-A MRSA §2736-C, sub-§2, ¶F, as enacted by PL 2003, c. 469, Pt. E, §12, is amended to read:

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

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

5. Loss ratios. For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% of the

aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any ~~savings offset~~ payments paid pursuant to former section 6913 must be treated as incurred claims.

Sec. M-6. 24-A MRSA §2808-B, sub-§2-A, ¶C, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

C. Rates for small group health plans must be filed in accordance with this section and subsections 2-B and 2-C 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 ~~savings offset~~ payment or any recovery of that ~~offset~~ payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005.

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

A. 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 ~~savings offset~~ payments paid pursuant to former section 6913 must be treated as incurred claims.

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

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. M-9. 24-A MRSA §2808-B, sub-§2-B, ¶F, as enacted by PL 2003, c. 469, Pt. E, §16, is amended to read:

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

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

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

(3) In any hearing conducted under this paragraph, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate, not unfairly discriminatory and in compliance with the requirements of ~~section 6913~~ this Title remains with the carrier.

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

C. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. For the purposes of calculating this loss-ratio percentage, any ~~savings offset~~ payments paid pursuant to former section 6913 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums.

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

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

Sec. M-11. 24-A MRSA §2839-B, sub-§2, as enacted by PL 2003, c. 469, Pt. E, §17, is amended to read:

2. Annual filing. Every carrier offering group health insurance specified in subsection 1 shall annually file with the superintendent on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an

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

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

A. Take any legal actions necessary or proper to recover or collect ~~savings offset~~ payments due Dirigo Health or that are necessary for the proper administration of Dirigo Health;

See title page for effective date, unless otherwise indicated.

CHAPTER 630

H.P. 1452 - L.D. 2068

An Act To Amend the Laws Governing Lobbyist Disclosure

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

Sec. 1. 3 MRSA §312-A, sub-§4-A is enacted to read:

4-A. Covered official. "Covered official" means an official in the executive branch, an official in the legislative branch, a constitutional officer, the Governor and the Governor's cabinet and staff.

Sec. 2. 3 MRSA §312-A, sub-§4-B is enacted to read:

4-B. Domestic partner. "Domestic partner" means the partner of an individual who:

A. Is a mentally competent adult as is the individual;

B. Has been legally domiciled with the individual for at least 12 months;

C. Is not legally married to or legally separated from another individual;

D. Is the sole partner of the individual and expects to remain so; and

E. Is jointly responsible with the individual for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property.

Sec. 3. 3 MRSA §312-A, sub-§7, as amended by PL 1993, c. 691, §4, is further amended to read:

7. Expenditure. "Expenditure" means anything of value or any contract, promise or agreement to transfer anything of value, whether or not legally enforceable. ~~Expenditure includes:~~

~~B. A payment of compensation to a lobbyist by a person employing, retaining or contracting for the services of the lobbyist separately or jointly with other persons;~~

~~C. A payment for or in connection with soliciting or urging other persons to enter into direct communication with a public official.~~

Sec. 4. 3 MRSA §312-A, sub-§7-A, as enacted by PL 1993, c. 446, Pt. A, §10 and affected by §20, is amended to read:

7-A. Immediate family. "Immediate family" means a person's spouse or domestic partner and dependent children.

Sec. 5. 3 MRSA §312-A, sub-§8-A is enacted to read:

8-A. Legislative designee. "Legislative designee" means any employee of a state department or agency who is directed by the head of the department or agency to lobby or monitor legislation on behalf of the department or agency. "Legislative designee" includes an employee who is reasonably expected to lobby or monitor legislation on behalf of the department or agency for more than 20 hours during the session. For the purposes of this subsection, "monitoring legislation" means attending legislative hearings and sessions regarding a legislative action.

Sec. 6. 3 MRSA §312-A, sub-§9, as amended by PL 2007, c. 373, §1, is further amended to read:

9. Lobbying. "Lobbying" means to communicate directly with any official in the legislative branch or any official in the executive branch or with a constitutional officer for the purpose of influencing any legislative action or with the Governor or the Governor's cabinet and staff for the purpose of influencing the approval or veto of a legislative action when reimbursement for expenditures or compensation is made for those activities. "Lobbying" includes the time spent to prepare and submit to the Governor, an official in the legislative branch, an official in the executive branch, a constitutional officer or a legislative committee oral and written proposals for, or testimony or analyses concerning, a legislative action. "Lobbying" does not include time spent by any person providing information to or participating in a subcommittee, stakeholder group, task force or other work group regarding a legislative action by the appointment or at the request of the Governor, a Legislator or legislative committee, a constitutional officer, a state agency commissioner or the chair of a state board or commis-