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

## PART A

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**Sec. A-1. 24-A MRSA §2743-B** is enacted to read:

### § 2743-B. Coverage for tobacco cessation treatment

**1. Required coverage.** All individual health plans as defined in section 2736-C must provide coverage for tobacco cessation treatment in accordance with any rules adopted by the Department of Health and Human Services. Coverage provided under this subsection may not be subject to any deductible, copayment, coinsurance, out-of-pocket maximum or other cost-sharing mechanism except as provided in subsection 2.

**2. Health savings accounts.** Benefits for tobacco cessation treatment under individual health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.

**3. Application.** The requirements of this section apply to all policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after the effective date of this section. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

**Sec. A-2. 24-A MRSA §2808-B, sub-§2, ¶C,** as amended by PL 2001, c. 410, Pt. A, §3 and affected by §10, is further amended to read:

C. A carrier may vary the premium rate due to family membership, smoking status, participation in wellness programs in accordance with section 4303, subsection 12 and group size for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts pursuant to this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~H-A~~2-A.

**Sec. A-3. 24-A MRSA §2839,** as amended by PL 2003, c. 428, Pt. E, §2, is further amended by adding at the end a new paragraph to read:

A carrier may vary the premium rate due to participation in wellness programs in accordance with section 4303, subsection 12 for all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2008.

**Sec. A-4. 24-A MRSA §4303, sub-§12** is enacted to read:

**12. Wellness program.** A carrier offering a health plan in this State shall develop and maintain a wellness program for enrollees in small group and group health plans. A carrier shall offer enrollees that participate in a wellness program a financially tangible benefit, including, but not limited to, a discount in premium pursuant to section 2808-B, subsection 2, paragraph C. A carrier shall report before January 1st annually to the superintendent, in the manner and format approved by the superintendent, on the wellness program offered by the carrier, the financial benefits provided to enrollees, including premium discounts, and the number of enrollees participating in the wellness program. On or before April 1st annually, the superintendent shall compile the data submitted by carriers as required in this subsection and submit that data in aggregate for all carriers to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and to the Maine Quality Forum.

**Sec. A-5. Exemption from review.** Notwithstanding the Maine Revised Statutes, Title 24-A, section 2752, this Part is enacted without review and evaluation by the Department of Professional and Financial Regulation, Bureau of Insurance.

**Sec. A-6. Application.** That section of this Part that enacts the Maine Revised Statutes, Title 24-A, section 2743-B applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2008.

## PART B

**Sec. B-1. 24-A MRSA §2736-C, sub-§8,** as amended by PL 1999, c. 256, Pt. D, §2, is further amended to read:

**8. Authority of the superintendent.** The superintendent ~~may~~shall by rule define one or more standardized individual health plans that must be offered by all carriers offering individual health plans in the State, other than carriers offering only CHAMPUS supplemental coverage. One of the plans defined by rule under this section must be a plan that includes a $1,000 deductible, a prescription drug benefit not subject to a deductible and the option of no cap on the lifetime maximum benefit.

## PART C

**Sec. C-1. Rule Chapter 850 rulemaking; authority to submit legislation.** By January 1, 2008, the Superintendent of Insurance shall report the results of the consensus-based rule-making process undertaken by the superintendent related to the consideration of possible amendments to Bureau of Insurance Rule Chapter 850. The Joint Standing Committee on Insurance and Financial Services may submit a bill to the Second Regular Session of the 123rd Legislature relating to the geographic access standards in the Maine Revised Statutes, Title 24-A, section 4303, subsection 1 and Bureau of Insurance Rule Chapter 850.

## PART D

**Sec. D-1. 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. D-2. 24-A MRSA c. 54** is enacted to read:

## CHAPTER 54

## MAINE INDIVIDUAL REINSURANCE program

### § 3901. Short title

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

### § 3902. Maine Individual Reinsurance Program

**1. Program established.** The Maine Individual Reinsurance Program, referred to in this chapter as "the program," is established within the bureau.

**2. Plan of operation; rules.** The superintendent shall adopt by rule a plan of operation in accordance with the requirements of this chapter within 90 days after the effective date of this chapter. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A. The plan of operation must:

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

B. Establish procedures under which participants in the program may have grievances reviewed and reported to the superintendent;

C. Account for the selection of a program administrator by the superintendent in accordance with section 3903;

D. Establish procedures for the assessment of premiums and the handling and accounting of program assets;

E. Establish procedures for determining reinsurance amounts in accordance with section 3904;

F. Establish procedures for contracting for appropriate legal, actuarial and other consultants as necessary to provide technical assistance and any other functions within the authority of the program;

G. Establish rules, conditions and procedures for reinsuring risks of insurers under the program in accordance with section 3904;

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

I. Establish an advisory council to provide input on the program to the superintendent and program administrator. The advisory council must include representation from participating insurers, policyholders, consumers and other stakeholders; and

J. Permit the program administrator to apply for funds or grants from public or private sources, including federal grants provided to qualified high-risk reinsurance plans.

**3. Review for solvency.** The superintendent shall review the operations of the program after the first year and at least every 3 years thereafter to determine its solvency.

**4. Annual report.** The program shall report annually on the operations of the program to the joint standing committee of the Legislature having jurisdiction over health insurance matters by March 15th. The report must include information on the number and value of claims reinsured by the program, the types and ages of risks reinsured, information derived from tracking enrollment in the fund, the surplus and reserves of carriers reinsured by the program and the financial solvency and the administrative expenses of the program.

**5. Audit.** The program must be audited annually by the State Auditor. The superintendent, at the superintendent's discretion, may arrange for an independent audit to be conducted. A copy of the audit must be provided to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

**6. Enterprise fund.** The Maine Individual Reinsurance Program Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, premiums paid pursuant to section 3904, revenue transferred to the fund pursuant to section 6915 and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

## § 3903. Selection of program administrator

**1. Selection of program administrator.** The superintendent shall select an appropriate entity through a competitive bidding process to administer the program.

**2. Contract with program administrator.** The program 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 the program administrator, the superintendent shall invite all appropriate entities, including the current program administrator, to submit bids to serve as the program administrator for the succeeding 3-year period. The selection of the program administrator for the succeeding period must be made at least 6 months prior to the expiration of the current 3-year period.

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

A. Perform all administrative functions relating to the program;

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

C. Following the close of each calendar year, determine reinsurance premiums, the amount of revenue transferred to the program pursuant to section 6915, the expenses of administration pertaining to the reinsurance operations of the program and the incurred losses of the year and report this information to the superintendent; and

D. Collect reinsurance premiums and pay reinsurance amounts as provided for in the plan of operation under section 3904, subsection 4.

**4. Payment to program administrator.** The program administrator selected pursuant to subsection 1 must be paid, as provided in the contract of the program under subsection 2, for the program administrator's direct and indirect expenses incurred in the performance of the program 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 program administrator that are approved by the superintendent as allocable to the administration of the program and included in the specifications of a bid under subsection 2.

## § 3904. Reinsurance; premium rates

**1. Carrier participation.** Beginning on January 1, 2009, any carrier offering an individual health plan pursuant to section 2736-C is liable to the program for the reinsurance premium rate established in accordance with subsection 4. The Dirigo Health Program established in chapter 87, whether fully insured or self-funded, is also liable to the program for the reinsurance premium rate established in accordance with subsection 4.

**2. Health plans eligible for reimbursement.** The program must reimburse a carrier for 80% of claims paid by the carrier between $50,000 and $200,000 in a calendar year for any enrollee covered under an individual health plan that meets minimum standards for benefits and cost sharing as determined by the superintendent. The superintendent must consider the benefit plans required by Bureau of Insurance Rule Chapter 750 and by the Board of Directors of Dirigo Health pursuant to section 6910. Once claims paid on behalf of an enrollee reach or exceed $200,000 in a given calendar year, no further claims paid on behalf of that enrollee in that calendar year are eligible for reimbursement. The superintendent shall by rule adopt additional eligibility requirements for the minimum loss ratio that must be achieved by a carrier, consistent with the goals of enhancing competition, decreasing premiums and maximizing the availability of comprehensive benefits. Rules adopted pursuant to this subsection are major substantive rules pursuant to Title 5, chapter 375, subchapter 2-A.

**3. Reinsurance amount.** The total amount of claims projected to be reinsured for all individuals each calendar year and the projected administrative expenses for the program must be equal to the sum of projected revenue from the amounts transferred pursuant to section 6915 plus the reinsurance premiums collected pursuant to subsection 4. The program may not obligate the General Fund beyond that amount allocated by the Legislature pursuant to section 6913-A and Title 36, sections 4365 and 4403-A.

**4. Premium rates.** The superintendent shall, as part of the plan of operation under section 3902, subsection 2, establish a methodology for determining premium rates to be charged insurers offering individual health plans pursuant to section 2736-C. The superintendent shall review at least once every 2 years the methodology established under this subsection and may make changes to the methodology as needed. The superintendent shall consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer.

**Sec. D-3. Contingent effective date; report; certification.** The Maine Individual Reinsurance Program established in the Maine Revised Statutes, Title 24-A, chapter 54 does not take effect unless the percentages certified by the Superintendent of Insurance for all carriers pursuant to subsection 3 is greater than the percentage reported by the superintendent pursuant to subsection 1.

**1. Report by superintendent.** By April 1, 2008, the Superintendent of Insurance shall review the actuarial analysis prepared by consultants to the Department of Professional and Financial Regulation, Bureau of Insurance in May 2007 and report to the Joint Standing Committee on Insurance and Financial Services a range of the percentages by which individual health insurance rates would be less than those that would be applicable in the absence of the reinsurance requirements set forth in this Part, using a model based upon generally accepted actuarial principles.

**2. Filing by carriers.** Each carrier providing individual health plans in the State shall file no later than September 1, 2008 the percentage by which its rates for January 1, 2009 and thereafter will be less than that which would be applicable in the absence of the reinsurance requirements set forth in this Part.

**3. Certification by superintendent.** The Superintendent of Insurance shall review the filings for all carriers submitted pursuant to subsection 2 and shall certify whether the weighted average for all carriers meets the range of percentages described in subsection 1. No later than November 1, 2008, the superintendent shall submit the certification to the Joint Standing Committee on Insurance and Financial Services and shall forward a copy of the certification to the Office of the Revisor of Statutes.

**Sec. D-4. Rulemaking.** The Superintendent of Insurance shall provisionally adopt rules pursuant to the Maine Revised Statutes, Title 24-A, chapter 54 by January 1, 2008 and present those rules for review by the Legislature pursuant to Title 5, chapter 375, subchapter 2-A during the Second Regular Session of the 123rd Legislature.

**Sec. D-5. Review by Legislature.** During the First Regular Session of the 125th Legislature, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall review the operations of the Maine Individual Reinsurance Program established in the Maine Revised Statutes, Title 24-A, chapter 54. The committee shall seek input from the Superintendent of Insurance, health insurance carriers, insurance producers, employers and consumers. The committee may submit a bill to the First Regular Session of the 125th Legislature relating to the operations and effectiveness of the Maine Individual Reinsurance Program.

## PART E

**Sec. E-1. 24-A MRSA §2736-C, sub-§1, ¶B,** as enacted by PL 1993, c. 477, Pt. C, §1 and affected by Pt. F, §1, is amended to read:

B. "Community rate" means the average rate charged to all eligible individuals for individual health plans ~~prior to any adjustments pursuant to subsection 2, paragraphs C and D~~based on the anticipated mix of business by age. The community rate may differ based on family composition.

**Sec. E-2. 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.

(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 December 31, 2007, 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 January 1, 2008, the premium rate may not deviate on the basis of age above the community rate filed by the carrier by more than 20% and may not deviate on the basis of age below the community rate by more than 40%. The premium rate may not vary on the basis of geographic area or occupation or industry.

## PART F

**Sec. F-1. Study of merger of individual and small group health insurance markets.** The Superintendent of Insurance shall review the actuarial analysis completed by Gorman Actuarial, LLC in May 2007 regarding the merger of the individual and small group health insurance markets. The superintendent shall evaluate the efficacy of merging these markets, the impact on group size adjustments and the impact on premiums and make recommendations for statutory and regulatory approaches to minimize any adverse premium impact on small groups. The superintendent shall submit the superintendent's review and recommendations to the Joint Standing Committee on Insurance and Financial Services by January 1, 2008. The Joint Standing Committee on Insurance and Financial Services may submit legislation relating to the merger of the individual and small group markets to the Second Regular Session of the 123rd Legislature.

## PART G

**Sec. G-1. 24-A MRSA §2736, sub-§5** is enacted to read:

**5. Standard for approval.** The following standards apply to the making and use of rates pursuant to this section for individual health plans as defined in section 2736-C.

A. Rates are not considered to be reasonable and necessary if the rates are likely to produce a profit from business in this State that is unreasonably high in relation to the benefits provided, the surplus requirements and the surplus available, or if expenses are unreasonably high in relation to the benefits provided.

B. Rates are not considered to be reasonable and necessary if the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums when replenishment is attributable to investment losses.

C. Rates are inadequate if the rates are clearly insufficient, together with investment income attributable to the rates, to sustain projected losses and expenses for the benefits provided.

D. Rates are unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses.

**Sec. G-2. 24-A MRSA §2736, sub-§6** is enacted to read:

**6. Factors to be considered.** In determining whether the standards in subsection 5 have been met, the factors considered by the superintendent may include but are not limited to:

A. The past and prospective net underwriting gains of the insurer from the line of insurance for which the insurer seeks rate approval;

B. The past, current and reasonably expected surplus levels of the carrier anticipated in the filing;

C. Investment income reasonably expected by the carrier from premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves;

D. The degree of competition in the market for which the rate approval is sought and in the overall health insurance market; and

E. The profit and risk charge included in the previous year's rate filing and the profit actually achieved.

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

If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates ~~not~~ be ~~excessive,~~reasonable and necessary, and not inadequate, unfairly discriminatory or not in compliance with former section 6913 and section 6913-A or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held.

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

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

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 and section 6913-A 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 be reasonable and necessary and 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 be reasonable and necessary and not ~~be excessive,~~ inadequate, unfairly discriminatory or not in compliance with former section 6913 and section 6913-A, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

D. A carrier may not increase its rate to account for any payment made pursuant to former section 6913 or section 6913-A. A carrier that otherwise adjusts its rate shall account for the ~~savings offset payment~~payments paid pursuant to former section 6913 or section 6913-A or any recovery of ~~that savings offset payment~~those payments in its experience consistent with this section ~~and~~, former section 6913 and section 6913-A. With regard to accounting for any recovery of the payments paid pursuant to former section 6913 or section 6913-A, a carrier shall provide demonstrable proof to the superintendent and quantify the total amount negotiated and saved by the carrier.

E. Any filing of rates, rating formulas and modifications that satisfies the criteria set forth in this paragraph is subject to the provisions of paragraph F:

(1) The proposed rate for any group or subgroup does not include a unit cost change that exceeds the index of inflation multiplied by 1.5, excluding any approved rate differential based on age. For the purposes of this subparagraph, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the superintendent that includes this State for the most recent 12-month period immediately preceding the date of the filing for which data are available; and

(2) The carrier demonstrates 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 ratio of benefits incurred to premiums earned averages no less than 78% for the previous 36-month period.

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 remains with the carrier.

G. The following standards apply to the making and use of rates pursuant to this section.

(1) Rates are not considered to be reasonable and necessary if the rates are likely to produce a profit from business in this State that is unreasonably high in relation to the benefits provided, the surplus requirements and the surplus available, or if expenses are unreasonably high in relation to the benefits provided.

(2) Rates are not considered to be reasonable and necessary if the rate structure established by a stock insurance company provides for replenishment of surpluses from premiums when replenishment is attributable to investment losses.

(3) Rates are inadequate if the rates are clearly insufficient, together with investment income attributable to the rates, to sustain projected losses and expenses for the benefits provided.

(4) Rates are unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses.

H. In determining whether the standards in paragraph G have been met, the factors considered by the superintendent may include but are not limited to:

(1) The past and prospective net underwriting gains of the insurer from the line of insurance for which the insurer seeks rate approval;

(2) The past, current and reasonably expected surplus levels of the carrier anticipated in the filing;

(3) Investment income reasonably expected by the carrier from premiums anticipated in the filing plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves;

(4) The degree of competition in the market for which the rate approval is sought and in the overall health insurance market; and

(5) The profit and risk charge included in the previous year's rate filing and the profit actually achieved.

## PART H

**Sec. H-1. 24-A MRSA §2736, sub-§2,** as amended by PL 1997, c. 344, §8, is further amended to read:

**2. Filing; information.** When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates be reasonable and necessary and not ~~be excessive,~~ inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. ~~A~~ Notwithstanding the exception set forth in Title 1, section 402, subsection 3, paragraph B, a filing and supporting information, except for descriptions of the amount

and terms or conditions of compensation or reimbursement in a contract between an insurer and a 3rd party, are public records within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to section 2736-A.

**Sec. H-2. 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~~payments paid pursuant to former section 6913 or section 6913-A or any recovery ~~in that offset payment~~of those payments in its experience consistent with this section ~~and~~, former section 6913 and section 6913-A, except that a carrier may not increase its rate to account for any payment made pursuant to section 6913-A unless the superintendent certifies that the aggregate incurred claims estimated to be paid under all individual health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 83% of the aggregate earned premiums for those policies as determined in accordance with actuarial principles and practices. With regard to accounting for any recovery of the payments paid pursuant to former section 6913 or section 6913-A, a carrier shall provide demonstrable proof to the superintendent and quantify the total amount negotiated and saved by the carrier. A carrier may not increase its rate to account for any reinsurance premiums paid pursuant to chapter 54.

**Sec. H-3. 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%~~78% 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 and section 6913-A must be treated as incurred claims. If incurred claims were less than 78% of aggregate earned premiums over a continuous 36-month period, the carrier shall refund total excess premiums to current in-force policyholders. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's individual policies during the same 36-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums. The superintendent may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large. The superintendent shall adopt rules setting forth appropriate methodologies for determining incurred claims experience and earned premiums and for calculating refunds pursuant to this subsection. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

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

B. ~~A~~ Notwithstanding the exception set forth in Title 1, section 402, subsection 3, paragraph B, a filing and supporting information, except for descriptions of the amount and terms or conditions of compensation or reimbursement in a contract between an insurer and a 3rd party, are public records ~~except as provided by~~within the meaning of Title 1, section 402, subsection 3 and become part of the official record of any hearing held pursuant to subsection 2-B, ~~paragraphs~~paragraph B ~~or F~~.

**Sec. H-5. Review of Rule 945 filings.** The Superintendent of Insurance shall review the data reported by insurance companies pursuant to Bureau of Insurance Rule Chapter 945 and identify any gaps in the data required to be reported that would improve transparency in the development of premium rates. On or before January 1, 2008, the superintendent shall report the superintendent's findings to the Joint Standing Committee on Insurance and Financial Services. The Joint Standing Committee on Insurance and Financial Services may submit legislation relating to the superintendent's findings to the Second Regular Session of the 123rd Legislature.

## PART I

**Sec. I-1. 24-A MRSA §423-D, sub-§3** is enacted to read:

**3. Report by superintendent.** 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 changes to the rating provisions in section 2736-C and the establishment of the Maine Individual Reinsurance Program pursuant to chapter 54, the premium rate reductions achieved, if any, the impact on a carrier's market share and the number of carriers, the impact on the types of health insurance products offered, 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.

**Sec. I-2. Report on employer and individual shared responsibility requirements.** The Governor's Office of Health Policy and Finance, in conjunction with the Department of Labor, shall review and analyze the impact of a shared responsibility requirement on individuals and employers in this State. In conducting the review and analysis required by this section, the Governor's Office of Health Policy and Finance shall:

1. Review laws enacted in other states, particularly Massachusetts and Vermont, that mandate health insurance coverage for individuals and employers;

2. Analyze the impact of such a requirement on individuals and employers in this State; and

3. Make recommendations for appropriate shared responsibility requirements for individuals and employers.

On or before March 1, 2008, the Governor's Office of Health Policy and Finance shall report its findings to the Joint Standing Committee on Insurance and Financial Services. The Joint Standing Committee on Insurance and Financial Services may submit legislation relating to the office's findings to the Second Regular Session of the 123rd Legislature.

## PART J

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

K. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; ~~and~~

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

L. In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one or more organizations organized, created or operated under the laws of this State~~.~~;

**Sec. J-3. 24-A MRSA §6908, sub-§1, ¶M** is enacted to read:

M. Establish and administer grant, subsidy and facilitation programs designed to assist providers and health care practitioners in the development, enhancement and maintenance of quality improvement infrastructure and processes. Dirigo Health may solicit and collect contributions to fund these programs; and

## PART K

**Sec. K-1. 24-A MRSA §6903, sub-§6,** as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

**6. Eligible employee.** "Eligible employee" means an employee of an eligible business who works at least 20 hours per week for that eligible business, except that an eligible business may elect to treat as eligible an employee who works a normal workweek of at least 10 hours as long as at least one employee works a normal workweek of 30 hours or more. ~~"Eligible employee" does not~~The board may, by rule, permit an eligible business to include an employee who works on a temporary or substitute basis or ~~who does not work more than 26 weeks annually~~seasonal basis.

**Sec. K-2. 24-A MRSA §6908, sub-§1, ¶N** is enacted to read:

N. Provide subsidies in the same manner as subsidies for enrollees pursuant to section 6912, subsection 4 for eligible enrollees covered under health benefit plans approved by the board pursuant to section 6910, subsection 3, paragraph A that are offered by multiple licensed health insurance carriers in the State.

**Sec. K-3. 24-A MRSA §6910, sub-§3,** as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

**3. Carrier participation requirements.** To qualify as a carrier of Dirigo Health Program coverage, a health insurance carrier must:

A. Provide the comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under Title 24 and this Title and any supplemental benefits the board wishes to make available; and

B. Ensure that:

(1) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or 3rd parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance or as provided in section 4204, subsection 6;

(2) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(3) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.

Health insurance carriers that seek to qualify to provide Dirigo Health Program coverage ~~must~~may also qualify as health plans in Medicaid.

**Sec. K-4. 24-A MRSA §6910, sub-§4, ¶B,** as amended by PL 2005, c. 400, Pt. C, §8, is further amended to read:

B. Dirigo Health shall contract with eligible businesses seeking assistance from Dirigo Health in arranging for health benefits coverage by the Dirigo Health Program for their employees and dependents as set out in this paragraph.

(1) Dirigo Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(2) Dirigo Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(a) The Dirigo Health Program for enrolled employees and dependents in contribution amounts determined by the board;

(b) Dirigo Health's quality assurance, disease prevention, disease management and cost-containment programs;

(c) Dirigo Health's administrative services; and

(d) Other health promotion costs.

(3) Dirigo Health shall establish the minimum required contribution levels, not to exceed 60%, to be paid by employers toward the aggregate payment in subparagraph (2) and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in MaineCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. Dirigo Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(4) Dirigo Health shall require participating employers to certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health Program and that the employer group otherwise meets the minimum participation requirements specified by section 2808-B, subsection 4, paragraph A.

(5) Dirigo Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 6912 accordingly. Dirigo Health shall return any payments made by plan enrollees also enrolled in MaineCare to those enrollees.

(6) Dirigo Health shall require participating employers to pass on any subsidy in section 6912 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(7) Dirigo Health may establish other criteria for participation.

(8) Dirigo Health may limit the number of participating employers.

(9) Dirigo Health may provide participating employers assistance to adopt and maintain a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 United States Code, Section 125.

# PART L

**Sec. L-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 July 1, 2008.

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this section, 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.

C. If, in any year, a majority of hospitals do not voluntarily restrain cost increases pursuant to this section, the Advisory Council on Health Systems Development established in Title 2, section 104 shall recommend to the Legislature options for achieving the restraints in cost increases in accordance with this section.

## PART M

**Sec. M-1. Dirigo Health Program demonstration project for health coverage of temporary and seasonal workers and direct-care workers providing long-term care.** The Board of Directors of Dirigo Health may establish a demonstration project to design a targeted DirigoChoice health coverage plan to meet the needs of temporary and seasonal workers and long-term care employers and their employees. The health coverage plan designed by the board pursuant to this section must allow temporary and seasonal workers and long-term care employers to offer monthly premium assistance to temporary and seasonal workers and direct-care workers eligible for coverage under DirigoChoice as an individual and accommodate contributions for premium assistance from more than one employer. In designing the plan, the board shall consult with and seek input from temporary and seasonal employers and workers and long-term care employers and direct-care workers. The board may establish a cap on the number of employers and workers that participate in the demonstration project and shall evaluate the demonstration project for its impact on workforce retention. The board shall operate the demonstration project on a cost-neutral basis within the limitation of available resources and shall maximize the use of federal Medicaid funds. In the event the board ends the demonstration project, the board shall ensure that participating employers and employees maintain DirigoChoice health coverage. The board shall submit a report to the joint standing committee of the Legislature having jurisdiction over health insurance and financial services matters on the operation of the demonstration project.

## PART N

**Sec. N-1. 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 or section 6913-A. 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. N-2. 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 provided in section 6913-A due Dirigo Health or that are necessary for the proper administration of Dirigo Health;

**Sec. N-3. 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 or section 6913-A;

**Sec. N-4. 24-A MRSA §6908, sub-§2, ¶F,** as amended by PL 2005, c. 400, Pt. C, §6, is further amended to read:

F. Develop a high-risk pool for plan enrollees in the Dirigo Health Program in accordance with the provisions of section 6971; ~~and~~

**Sec. N-5. 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. N-6. 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 participating in the Dirigo Health Program; and

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

**Sec. N-7. 24-A MRSA §6913,** as amended by PL 2005, c. 683, Pt. A, §§43 and 44, is repealed.

**Sec. N-8. 24-A MRSA §6913-A** is enacted to read:

## § 6913-A. Surcharge

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

A. "Hospital" means an acute care health care facility:

(1) With permanent inpatient beds planned, organized, operated and maintained to offer for a continuing period of time facilities and services for the diagnosis and treatment of illness, injury and deformity;

(2) With a governing board and an organized medical staff offering continuous 24-hour professional nursing care;

(3) With a plan to provide emergency treatment 24 hours a day and including other services as defined in rules of the Department of Health and Human Services relating to licensure of general and specialty hospitals; and

(4) That is licensed under Title 22, chapter 405 as a general hospital, specialty hospital or critical access hospital.

For purposes of this paragraph, "hospital" does not include a nursing home or a publicly owned specialty hospital.

B. "Payments subject to surcharge" means all amounts paid, directly or indirectly, by surcharge payors to hospitals for all hospital-only health services on or after the effective date of this paragraph, except that "payments subject to surcharge" does not include payments with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance. "Payments subject to surcharge" may exclude amounts established in rules adopted by the board for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost-effective. For the purposes of this paragraph, a hospital's hospital-only services include any item that is listed on the hospital's Medicare cost report as a subprovider and submitted to the Maine Health Data Organization pursuant to Title 22, chapter 1683, such as a psychiatric unit or rehabilitation unit, and do 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. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

C. "Publicly owned specialty hospital" means a publicly owned hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and that is licensed as a specialty hospital by the Department of Health and Human Services.

D. "Surcharge payor" means an individual or entity that pays for or arranges for the purchase of health care services provided by hospitals, except that "surcharge payor" does not include:

(1) Any governmental entity that pays for health care services provided under the Medicare program or Medicaid program, or beneficiaries or recipients under those programs except that the Dirigo Health Program is a surcharge payor;

(2) Any federal governmental entity that pays for health care services, or beneficiaries or recipients under those programs;

(3) An insurance company or other entity for health care services provided pursuant to the Maine Workers' Compensation Act of 1992; or

(4) An insurance company subject to chapter 39 for lines of insurance other than health insurance.

**2. Surcharge.** Beginning July 1, 2008, hospitals shall assess a surcharge of 1.8% on all payments subject to surcharge and the total amount of the surcharge may not exceed $29,000,000 except as provided in paragraph B. The surcharge must be paid by all surcharge payors. The surcharge is distinct from any other amount paid by a surcharge payor for the services of the hospital.

A. If, by May 30, 2008, the board determines that the surcharge percentage is not adequate to yield $29,000,000, the board may redetermine the surcharge percentage in order to ensure that the amount collected is not 1% more or less than the surcharge amount by the end of that fiscal year. The board may redetermine the surcharge percentage by January 1st of each subsequent year in order to ensure that the amount collected is not 1% more or less than the surcharge amount by the end of that fiscal year. In each redetermination of the surcharge percentage, the board shall divide the surcharge amount by the projected annual aggregate payments subject to surcharge. The board shall use the most recent net patient service revenue data available from the Maine Health Data Organization to calculate the projected annual aggregate payments subject to surcharge. The board shall incorporate all adjustments by prospective adjustment rather than retrospective payments or assessments.

B. The board may adjust the surcharge amount each fiscal year by an amount not to exceed the product of:

(1) The index of inflation multiplied by 1.5; and

(2) The rate of growth in member months in DirigoChoice in the preceding fiscal year.

For the purposes of this paragraph, "index of inflation" means the rate of increase in medical care costs for a section of the United States that includes this State for the most recent 12-month period immediately preceding the date of the adjustment for which data are available, published monthly by the United States Department of Labor, Bureau of Labor Statistics.

**3. Billing.** Beginning July 1, 2008, each hospital shall bill a surcharge payor an amount equal to the surcharge described in subsection 2 as a separate and identifiable amount distinct from any amount billed to or paid by a surcharge payor for hospital services. Each surcharge payor shall pay the surcharge amount to Dirigo Health, which amount must be pooled with other revenues of Dirigo Health in the Dirigo Health Enterprise Fund established in section 6915.

**4. Surcharge payor's liability.** The board shall specify by rule appropriate mechanisms that provide for determination and payment of a surcharge payor's liability, including requirements for data to be submitted by surcharge payors and hospitals. A surcharge payor's liability, in the case of a transfer of ownership, must be assumed by the successor in interest to the surcharge payor.

**5. Failure to pay surcharge payments.** The board shall establish by rule an appropriate mechanism for enforcing a surcharge payor's liability to the Dirigo Health Enterprise Fund in the event that a surcharge payor does not make a scheduled payment under subsection 3, except that the board, for the purpose of administrative simplicity, may establish threshold liability amounts below which enforcement may be modified or waived. Such an enforcement mechanism must include an assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18% and late fees or penalties at a rate not to exceed 5% per month.

**6. Demonstration of recovery of surcharge payments through reduction in bad debt and charity care.** In accordance with the requirements of this subsection, every health insurance carrier and provider shall demonstrate that best efforts have been made to ensure that a carrier has recovered surcharge payments made pursuant to this section through negotiated reimbursement rates that reflect providers' reductions or stabilization in the cost of bad debt and charity care.

A health insurance carrier shall use best efforts to ensure health insurance premiums reflect any such recovery of surcharge payments as those surcharge payments are reflected through incurred claims experience in accordance with subsection 7.

**7. Demonstration of offset.** As provided in sections 2736-C, 2808-B and 2839-B, the claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, any reduction or avoidance of bad debt and charity care costs to providers in this State.

**Sec. N-9. 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, any ~~savings offset~~ payments made pursuant to former section 6913 or section 6913-A, revenues pursuant to Title 36, sections 4385 and 4403-A and any funds received from any public or private source. The fund may be used by Dirigo Health to exercise its powers and duties pursuant to this chapter. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter. Beginning July 1, 2008 and annually thereafter, Dirigo Health shall transfer 24% of the funds credited to the fund from section 6913-A and Title 36, sections 4385 and 4403-A to the Maine Individual Reinsurance Program established in chapter 54.

**Sec. N-10. 36 MRSA §4365,** as amended by PL 2005, c. 457, Pt. AA, §1 and affected by §8, is further amended to read:

## § 4365. Rate of tax

A tax is imposed on all cigarettes imported into this State or held in this State by any person for sale at the rate of ~~100~~137.5 mills for each cigarette. Payment of the tax is evidenced by the affixing of stamps to the packages containing the cigarettes.

**Sec. N-11. 36 MRSA §4365-F,** as enacted by PL 2005, c. 457, Pt. AA, §3 and affected by §8, is repealed.

**Sec. N-12. 36 MRSA §4365-G** is enacted to read:

## § 4365-G. Application of cigarette tax rate increase effective October 1, 2007

The following provisions apply to cigarettes held for resale on October 1, 2007.

**1. Stamped rate.** Cigarettes stamped at the rate of 100 mills per cigarette and held for resale after September 30, 2007 are subject to tax at the rate of 137.5 mills per cigarette.

**2. Liability.** A person possessing cigarettes for resale is liable for the difference between the tax rate of 137.5 mills per cigarette and the tax rate of 100 mills per cigarette in effect before October 1, 2007. Stamps indicating payment of the tax imposed by this section must be affixed to all packages of cigarettes held for resale as of October 1, 2007, except that cigarettes held in vending machines as of that date do not require that stamp.

**3. Vending machines.** Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on October 1, 2007 and that the tax imposed by this section must be reported on that basis. A credit against this inventory tax must be allowed for cigarettes stamped at the rate of 137.5 mills per cigarette placed in vending machines before October 1, 2007.

**4. Payment.** Payment of the tax imposed by this section must be made to the assessor by January 1, 2007, accompanied by forms prescribed by the assessor.

**Sec. N-13. 36 MRSA §4366-A, sub-§2,** as amended by PL 2005, c. 622, §25 and affected by §34, is further amended to read:

**2. Provided to sellers.** The State Tax Assessor shall provide stamps suitable to be affixed to packages of cigarettes as evidence of the payment of the tax imposed by this chapter. The assessor may permit a licensed distributor to pay for the stamps within 30 days after the date of purchase, if a bond satisfactory to the assessor in an amount not less than 50% of the sale price of the stamps has been filed with the assessor conditioned upon payment for the stamps. Such a distributor may continue to purchase stamps on a 30-day deferral basis only if it remains current with its cigarette tax obligations. The assessor may not sell additional stamps to a distributor that has failed to pay in full within 30 days for stamps previously purchased until such time as the overdue payment is received. The assessor shall sell cigarette stamps to licensed distributors at the following discounts from their face value:

A. For stamps at the face value of 37 mills sold through September 30, 2001, 2.5%;

B. For stamps at the face value of 50 mills sold prior to July 1, 2002, 2.16%;

C. For stamps at the face value of 50 mills sold on or after July 1, 2002, 2.03%; ~~and~~

D. For stamps at the face value of 100 mills, 1.15%.~~;~~ and

E. For stamps at the face value of 137.5 mills, 0.88%.

**Sec. N-14. 36 MRSA §4385** is enacted to read:

## § 4385. Applications of revenues

**1. Credited to suspense account.** Revenues derived from the tax equal to 37.5 mills imposed on cigarettes pursuant to section 4365 must be credited to a General Fund suspense account.

**2. Transfers in 2008 and thereafter.** Except as provided in subsection 3, on or before the last day of each month of calendar year 2008 and each calendar year thereafter, the State Controller shall transfer the revenues credited to the suspense account under subsection 1 during the month to the Dirigo Health Enterprise Fund established by Title 24-A, section 6915.

**3. Transfer to General Fund.** The State Controller shall transfer into the General Fund the revenues necessary to maintain the level of cigarette tax revenue at the level that was budgeted for the General Fund in fiscal year 2006-07. Beginning in fiscal year 2007-08, the State Controller shall transfer to the General Fund the revenues necessary to maintain the level of cigarette tax revenue in the previous year less 3%. The Treasurer of State shall annually review the recommendations of the Revenue Forecasting Committee to determine whether any change in the reduction rate is required and, if so, shall change the rate accordingly.

**Sec. N-15. 36 MRSA §4403, sub-§2,** as amended by PL 2005, c. 627, §8, is further amended to read:

**2. Other tobacco.** A tax is imposed on cigars, pipe tobacco and other tobacco intended for smoking at the rate of ~~20~~%78% of the wholesale sales price beginning October 1, ~~2005~~2007.

**Sec. N-16. 36 MRSA §4403-A** is enacted to read:

**§ 4403-A. Applications of revenues**

**1. Credited to suspense account.** Revenues derived from the tax equal to 58% of the wholesale sales price of tobacco products pursuant to section 4403, subsection 2 must be credited to a General Fund suspense account.

**2. Transfers in 2008 and thereafter.** On or before the last day of each month of calendar year 2008 and each calendar year thereafter, the State Controller shall transfer 100% of the revenues credited to the suspense account under subsection 1 during the month to the Dirigo Health Enterprise Fund established by Title 24-A, section 6915.

**Sec. N-17. 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, any savings offset payment calculated and required under former Title 24-A, section 6913 prior to the effective date of this Part is due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913.

## PART O

**Sec. O-1. 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~~not reasonable and necessary have the burden of establishing that the rates are ~~excessive~~not reasonable and necessary. The burden of proving that rates are adequate, not unfairly discriminatory and in compliance with the requirements of former section 6913 and section 6913-A remains with the insurer.

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

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. ~~In the case of a filing that meets the criteria in subsection 2-B, paragraph E, the superintendent may suspend the effective date for a longer period not to exceed 30 days from the date the carrier satisfactorily responds to any reasonable discovery requests.~~

**Sec. O-3. 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 and section 6913-A for rates effective before July 1, 2005.

**Sec. O-4. 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 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.

## PART P

**Sec. P-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 Maine Revenue Services administrative costs associated with the cigarette and other tobacco products tax increase.

| **GENERAL FUND** | **2007-08** | **2008-09** |
|---|---|---|
| All Other | $88,000 | $0 |
| GENERAL FUND TOTAL | $88,000 | $0 |

| **ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF DEPARTMENT TOTALS** | **2007-08** | **2008-09** |
|---|---|---|
| **GENERAL FUND** | **$88,000** | **$0** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$88,000** | **$0** |

**DIRIGO HEALTH**

**Dirigo Health Fund 0988**

Initiative: Allocates funds for Dirigo Health costs to be funded by a hospital surcharge with a share of the revenue resulting from the surcharge also to be transferred to help fund the Maine Individual Reinsurance Program.

| **DIRIGO HEALTH FUND** | **2007-08** | **2008-09** |
|---|---|---|
| All Other | $0 | $22,040,000 |
| DIRIGO HEALTH FUND TOTAL | $0 | $22,040,000 |

**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 | ($13,720,000) |
| DIRIGO HEALTH FUND TOTAL | $0 | ($13,720,000) |

**Dirigo Health Fund 0988**

Initiative: Allocates funds for Dirigo Health costs to be funded by a cigarette and other tobacco products tax increase with a share of the revenue resulting from the cigarette tax increase also to be transferred to help fund the Maine Individual Reinsurance Program.

| **DIRIGO HEALTH FUND** | **2007-08** | **2008-09** |
|---|---|---|
| All Other | $35,649,622 | $36,491,247 |
| DIRIGO HEALTH FUND TOTAL | $35,649,622 | $36,491,247 |

| **DIRIGO HEALTH DEPARTMENT TOTALS** | **2007-08** | **2008-09** |
|---|---|---|
| **DIRIGO HEALTH FUND** | **$35,649,622** | **$44,811,247** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$35,649,622** | **$44,811,247** |

## PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

### Insurance - Bureau of 0092

Initiative: Allocates funds for one Managing Insurance Examiner position, one Insurance Actuarial Assistant position and related costs related to implementation and management of the Maine Individual Reinsurance Program and other requirements of the Act.

| OTHER SPECIAL REVENUE FUNDS | 2007-08 | 2008-09 |
|---|---|---|
| POSITIONS - LEGISLATIVE COUNT | 2.000 | 2.000 |
| Personal Services | $120,757 | $165,657 |
| All Other | $28,102 | $17,622 |
| OTHER SPECIAL REVENUE FUNDS TOTAL | $148,859 | $183,279 |

### Insurance - Bureau of 0092

Initiative: Allocates funds for consulting services needed on a one-time basis to implement provisions of this Act.

| OTHER SPECIAL REVENUE FUNDS | 2007-08 | 2008-09 |
|---|---|---|
| All Other | $125,000 | $0 |
| OTHER SPECIAL REVENUE FUNDS TOTAL | $125,000 | $0 |

### Maine Individual Reinsurance Program Z055

Initiative: Allocates funds for the costs of the Maine Individual Reinsurance Program.

| MAINE INDIVIDUAL REINSURANCE PROGRAM FUND | 2007-08 | 2008-09 |
|---|---|---|
| All Other | $0 | $18,483,552 |
| MAINE INDIVIDUAL REINSURANCE PROGRAM FUND TOTAL | $0 | $18,483,552 |

| PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF DEPARTMENT TOTALS | 2007-08 | 2008-09 |
|---|---|---|

| | | |
|---|---|---|
| **OTHER SPECIAL REVENUE FUNDS** | **$273,859** | **$183,279** |
| **MAINE INDIVIDUAL REINSURANCE PROGRAM FUND** | **$0** | **$18,483,552** |
| **DEPARTMENT TOTAL - ALL FUNDS** | **$273,859** | **$18,666,831** |

| **SECTION TOTALS** | **2007-08** | **2008-09** |
|---|---|---|
| **GENERAL FUND** | **$88,000** | **$0** |
| **OTHER SPECIAL REVENUE FUNDS** | **$273,859** | **$183,279** |
| **DIRIGO HEALTH FUND** | **$35,649,622** | **$44,811,247** |
| **MAINE INDIVIDUAL REINSURANCE PROGRAM FUND** | **$0** | **$18,483,552** |
| **SECTION TOTAL - ALL FUNDS** | **$36,011,481** | **$63,478,078** |

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## SUMMARY

This amendment replaces the bill.

Part A requires carriers to offer a wellness program in all small group and group health plans. The Part requires that carriers offer enrollees participating in the wellness program a financially tangible benefit, including a premium discount. The Part also requires that carriers report annually to the Superintendent of Insurance about the wellness programs offered to enrollees and that the superintendent report aggregate data from carriers to the Legislature and to the Maine Quality Forum. Part A also requires all individual health plans to provide coverage for tobacco cessation treatment.

Part B requires that all insurers in the individual market offer a plan that includes a $1,000 deductible, a prescription drug benefit not subject to a deductible and the option of no cap on the lifetime maximum benefit.

Part C directs the Superintendent of Insurance to report the results of the consensus-based rule-making process related to possible amendments to Bureau of Insurance Rule Chapter 850. The Part also permits the Joint Standing Committee on Insurance and Financial Services to submit legislation to the Second Regular Session of the 123rd Legislature.

Part D establishes a reinsurance mechanism for the individual health insurance market. The Part provides reimbursement to carriers offering individual health plans for 80% of claims incurred between $50,000 and $200,000 for health plans as determined by the superintendent.

Part E modifies the community rating band in the individual market to permit the variation of rates below the community rate by 40% on the basis of age. This Part prohibits rating variations on the basis

of geographic area and occupation or industry. Rates may not vary above the community rate by more than 20%.

Part F requires the Superintendent of Insurance to study the impact of merging the individual and small group markets.

Part G makes changes to the standards for the review of individual and small group health insurance rate filings. This Part also prohibits carriers from increasing rates to account for the hospital surcharge paid to support Dirigo Health unless the carrier has a loss ratio of 83% or higher for its individual health plans. Small group carriers are prohibited from increasing their rates.

Part H clarifies that rate filings and supporting information are public records subject to disclosure and requires the Superintendent of Insurance to review Bureau of Insurance Rule Chapter 945 to identify any gaps in data filed by insurance companies to improve transparency in developing premium rates. Part H also requires carriers in the individual market to have a loss ratio of 78% and to refund the excess amount to policy holders.

Part I requires the Superintendent of Insurance to report yearly to the Legislature the impact of changes to the rating provisions in the Maine Revised Statutes, Title 24-A, section 2736-C and the establishment of the Maine Individual Reinsurance Program pursuant to Title 24-A, chapter 54 on the overall health insurance market, including the number of carriers, the types of products offered and the number of individuals enrolled in health plans. This Part also requires the Governor's Office of Health Policy and Finance to study the impact of an individual and employer mandate in conjunction with the Department of Labor.

Part J allows Dirigo Health to administer grants and other subsidies to strengthen the State's health care quality improvement infrastructure.

Part K allows Dirigo Health to subsidize approved plans provided by multiple carriers. This Part also permits eligible businesses to elect to treat as eligible employees who work at least 10 hours per week for coverage under their employer's DirigoChoice plan. This Part allows Dirigo Health to assist employers in establishing payroll deduction systems that would help employees purchase health coverage with pre-tax dollars.

Part L makes permanent, beginning on or after July 1, 2008, the temporary voluntary cost containment targets on hospital consolidated operating margins and cost increases, which were initiated in Public Law 2003, chapter 469, Part F, section 1 and which otherwise would expire.

Part M authorizes the Board of Directors of Dirigo Health to develop a demonstration project to provide a targeted DirigoChoice health coverage plan to meet the needs of temporary and seasonal workers and long-term care employers and their employees and that allows multiple employers to contribute monthly premium assistance to temporary and seasonal workers and direct-care employees eligible to enroll in DirigoChoice as an individual.

Part N repeals the savings offset payment. The Part establishes a 1.8% surcharge on hospital bills. The Part increases the tax on cigarettes by 75 cents per pack and equalizes the rate of tax imposed on all tobacco products. The Part requires that these revenues be credited to the Dirigo Health Enterprise Fund to support the Dirigo Health Program except that 24% of the revenues must be transferred to the Maine Individual Reinsurance Program.

Part O changes cross-references.

Part P adds an appropriations and allocations section to the bill.

**FISCAL NOTE REQUIRED**
**(See attached)**