125th MAINE LEGISLATURE

FIRST REGULAR SESSION-2011

Legislative Document	**No. 1179**
H.P. 877	House of Representatives, March 17, 2011

An Act To Require Advance Review and Approval of Certain Small Group Health Insurance Rate Increases and To Implement the Requirements of the Federal Patient Protection and Affordable Care Act

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

HEATHER J.R. PRIEST
Clerk

Presented by Representative GOODE of Bangor.
Cosponsored by Senator BRANNIGAN of Cumberland and
Representatives: CAIN of Orono, EVES of North Berwick, GRAHAM of North Yarmouth, MORRISON of South Portland, PRIEST of Brunswick, SANBORN of Gorham, STUCKEY of Portland, TREAT of Hallowell.

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

PART A

Sec. A-1. 24-A MRSA §2808-B, sub-§2-A, ¶C, as amended by PL 2007, c. 629, Pt. M, §6, is further amended to read:

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

Sec. A-2. 24-A MRSA §2808-B, sub-§2-B, as amended by PL 2009, c. 244, Pt. C, §§8 and 9 and Pt. G, §2, is further amended to read:

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

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

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. If a filing proposes an increase in rates in a small group health plan, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this paragraph, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

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

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

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

Sec. A-3. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2007, c. 629, Pt. M, §10, is repealed.

PART B

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

B-1. "Federal act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts.

Sec. B-2. 24-A MRSA §2736-C, sub-§2, ¶C, as amended by PL 2001, c. 410, Pt. A, §1 and affected by §10, is further amended to read:

C. ~~A~~ For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State before January 1, 2014, a carrier may vary the premium rate due to smoking status and family membership. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts based on smoking status. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~II-A~~ 2-A.

Sec. B-3. 24-A MRSA §2736-C, sub-§2, ¶C-1 is enacted to read:

C-1. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, a carrier may vary the premium rate due to tobacco use and family membership. Premium rate variations due to tobacco use may not exceed a ratio of 1.5 to 1.

Sec. B-4. 24-A MRSA §2736-C, sub-§2, ¶I is enacted to read:

I. A carrier must consider all enrollees in all individual health plans offered by the carrier, except plans that have grandfathered status under the federal act, to be members of a single risk pool to the extent required by the federal act.

Sec. B-5. 24-A MRSA §2736-C, sub-§9, as enacted by PL 1995, c. 570, §7, is amended to read:

9. Exemption for certain associations. The superintendent may exempt a group health insurance policy or group nonprofit hospital or medical service corporation contract issued to an association group, organized pursuant to section 2805-A, from the

requirements of subsection 3, paragraph A; subsection 6, paragraph A; and subsection 8 if:

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

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

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

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

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

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

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

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

This subsection does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, except with respect to association members whose coverage has grandfathered status under the federal act.

Sec. B-6. 24-A MRSA §2808-B, sub-§1, ¶D, as repealed and replaced by PL 2003, c. 428, Pt. H, §5, is amended to read:

D. Prior to January 1, 2014, "~~Eligible~~ eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 50 or fewer eligible employees during the preceding calendar year. On or after January 1, 2014, "eligible group" means any person, firm, corporation, partnership, association or subgroup engaged actively in a business that employed an average of 100 or fewer employees during the preceding calendar year.

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

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

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

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

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

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

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

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

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

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

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

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

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

(vi) A signature card from a financial institution or credit union authorizing the employee to sign checks on a business checking or share draft account that is at least 6 months old; a notarized affidavit from the employer describing the duties of the employee and the average number of hours worked by the employee and attesting that the employer is not defrauding the carrier and is aware of the consequences of committing fraud or making a material misrepresentation to the carrier, including a loss of coverage and benefits; and, if the group coverage is purchased through a producer, a notarized affidavit from the producer affirming the producer's belief that the employer qualifies as an eligible group for coverage.

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

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

Sec. B-7. 24-A MRSA §2808-B, sub-§1, ¶D-1 is enacted to read:

D-1. "Federal act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts.

Sec. B-8. 24-A MRSA §2808-B, sub-§2, as amended by PL 2003, c. 469, Pt. E, §§14 and 15, is further amended to read:

2. Rating practices. The following requirements apply to the rating practices of carriers providing small group health plans. ~~This subsection does not apply to policies issued before January 1, 1998 to eligible groups that employed, on average, 25 to 50 eligible employees until their first renewal date on or after January 1, 1998.~~

B. A carrier may not vary the premium rate due to the gender, health status, claims experience or policy duration of the eligible group or members of the group. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, a carrier may not vary the premium rate due to occupation, industry or group size.

C. ~~A~~ For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State before January 1, 2014, a carrier may vary the premium rate due to family membership, smoking status, participation in wellness programs and group size. The superintendent may adopt rules setting forth appropriate methodologies regarding rate discounts pursuant to this paragraph. The superintendent may adopt rules to phase out group size variations gradually over a period not to exceed 2 years, prior to January 1, 2014. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter ~~II-A~~ 2-A.

C-1. For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, a carrier may

vary the premium rate due to family membership and tobacco use. Premium rate variations due to tobacco use may not exceed a ratio of 1.5 to 1.

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 July 15, 1993 and July 14, 1994, the premium rate may not deviate above or below the community rate filed by the carrier by more than 50%.~~

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

(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State ~~after July 15, 1995~~ before January 1, 2014, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%~~, except as provided in paragraph D-1~~.

(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, 2014, the premium rate may not deviate above or below the community rate filed by the carrier based on age and geographic area by more than 20%.

~~D-1. With respect to eligible groups that employed, on average, 25 to 50 eligible employees in the preceding calendar year, 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 in 1998, the premium rate may not deviate above or below the community rate filed by the carrier by more than 40%.~~

~~(2) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State in 1999, the premium rate may not deviate above or below the community rate filed by the carrier by more than 30%.~~

~~(3) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State after January 1, 2000, the premium rate may not deviate above or below the community rate filed by the carrier by more than 20%.~~

~~D-2. Notwithstanding the requirements of paragraph D, rates with respect to employees whose work site is not in this State may be based on area adjustment factors appropriate to that location.~~

E. The superintendent may authorize a carrier to establish a separate community rate for an association group organized pursuant to section 2805-A or a trustee group

organized pursuant to section 2806, as long as association group membership or eligibility for participation in the trustee group is not conditional on health status, claims experience or other risk selection criteria and all small group health plans offered by the carrier through that association or trustee group:

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

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

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

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

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

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

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

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

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

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

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

This paragraph does not apply to policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2014, except plans that have grandfathered status under the federal act.

F. Premium rates charged to a private purchasing alliance, as defined by chapter 18-A, may be reduced in accordance with rules adopted pursuant to that chapter.

H. A carrier must consider all enrollees in all small group health plans offered by the carrier, except plans that have grandfathered status under the federal act, to be members of a single risk pool to the extent required by the federal act.

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

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing aggregate earned premiums and incurred claims for the period the rates were in effect. Incurred claims must include claims paid to a date ~~6 months~~ after the end of the annual reporting period ~~determined by the superintendent~~ and an estimate of unpaid claims. The report must state how the unpaid claims estimate was determined. The superintendent shall determine the reporting period and the paid-to date, except that beginning January 1, 2011, both the reporting period and the paid-to date must be consistent with those for the rebates required pursuant to the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-10. 24-A MRSA §2808-B, sub-§2-C, ¶C, as amended by PL 2007, c. 629, Pt. M, §10, is further 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~~. The refund must be paid on a basis consistent with requirements for rebates required pursuant to the federal act and federal regulations adopted pursuant to the federal act. For the purposes of calculating this loss-ratio percentage, any payments paid pursuant to former section 6913 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a 78% loss ratio for all of the carrier's small group policies during the same 36-month period. The refund must be distributed ~~to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits~~ in the same manner required for rebates required by the federal act and federal regulations adopted pursuant to the federal act. The total of all refunds must equal the excess premiums. Larger amounts may be required as set forth in section 4320-C.

(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 or for the period between the last reporting period ending before January 1, 2011 and the first reporting period beginning on or after January 1, 2011.

Sec. B-11. 24-A MRSA §2808-B, sub-§6, ¶I, as enacted by PL 1993, c. 477, Pt. B, §3 and affected by Pt. F, §1, is amended to read:

I. Notwithstanding any other provision of this section, prior to January 1, 2014, a carrier may choose whether it will offer to groups having only one member coverage under the carrier's individual health policies offered to other individuals in this State in accordance with section 2736-C or coverage under a small group health plan in

accordance with this section, or both, but the carrier need not offer to groups of one both small group and individual health coverage.

Sec. B-12. 24-A MRSA §2850, sub-§2, ¶F is enacted to read:

F. A carrier as defined in section 4301-A, subsection 3 offering a health plan as defined in section 4301-A, subsection 7 may not apply a preexisting condition exclusion to any enrollee under 19 years of age, except that this prohibition may not apply to individual health plans in effect on March 23, 2010 that have grandfathered status under the federal act. A preexisting condition exclusion may not be imposed on any enrollee after January 1, 2014 to the extent prohibited by the federal act and federal regulations adopted pursuant to the federal act. For the purposes of this paragraph, "federal act" has the same meaning as in section 2808-B, subsection 1, paragraph D-1.

Sec. B-13. 24-A MRSA §4218-A is enacted to read:

§4218-A. Compliance with the federal Patient Protection and Affordable Care Act

The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to or regulations or guidance issued under those acts. Rules or amendments adopted pursuant to this section, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. B-14. 24-A MRSA §4301-A, sub-§1, as amended by PL 2007, c. 199, Pt. B, §1, is further amended to read:

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" also includes rescission determinations and initial coverage eligibility determinations, consistent with the requirements of the federal act.

Sec. B-15. 24-A MRSA §4301-A, sub-§3, as enacted by PL 1999, c. 742, §3, is amended to read:

3. Carrier. "Carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance;

B. A health maintenance organization licensed pursuant to chapter 56;

C. A preferred provider arrangement administrator registered pursuant to chapter 32;

D. A fraternal benefit society, as defined by section 4101;

E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;

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

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

An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier. Notwithstanding any other provision of this Title, any other entity offering coverage in this State that is subject to the requirements of the federal act is considered a carrier.

Sec. B-16. 24-A MRSA §4301-A, sub-§5-A is enacted to read:

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

Sec. B-17. 24-A MRSA §4301-A, sub-§7, as enacted by PL 1999, c. 742, §3, is amended to read:

7. Health plan. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage not subject to the requirements of the federal act. Any plan that is subject to the requirements of the federal act and offered in this State by a carrier, including, but not limited to, any qualified health plan offered through an American Health Benefits Exchange or Small Business Health Options Program Exchange pursuant to the federal act, is considered a health plan for purposes of this chapter.

Sec. B-18. 24-A MRSA §4302, sub-§6 is enacted to read:

6. Reporting required pursuant to the federal Patient Protection and Affordable Care Act. In addition to and notwithstanding any other requirements of this Title, a carrier shall provide to the Secretary of the United States Department of Health and Human Services, and make available to the public when required by federal law, any information required by the federal act and federal regulations adopted pursuant to the federal act. A carrier shall also provide the information to the superintendent upon request.

Sec. B-19. 24-A MRSA §4303, sub-§4, ¶E is enacted to read:

E. A health plan subject to the requirements of the federal act must comply with federal claims and appeal requirements, including but not limited to the requirement that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review, consistent

with the requirements of the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-20. 24-A MRSA §4303, sub-§15 is enacted to read:

15. Uniform explanation of coverage documents and standardized definitions. The following applies with respect to uniform explanation of coverage documents and standardized definitions used by a carrier.

A. A carrier offering a health plan in this State shall provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. Any summary of benefits and coverage explanation must conform with the requirements of the federal act and federal regulations adopted pursuant to the federal act.

B. A carrier offering a health plan in this State shall use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-21. 24-A MRSA §4303, sub-§16 is enacted to read:

16. Language and culture. All notices to enrollees subject to the requirements of the federal act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-22. 24-A MRSA §4306, as amended by PL 2007, c. 199, Pt. B, §15, is further amended to read:

§4306. Enrollee choice of primary care provider

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

Sec. B-23. 24-A MRSA §4306-A is enacted to read:

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

In addition to and notwithstanding any other requirements of this Title, a carrier offering a health plan in this State subject to the requirements of the federal act:

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

2. Authorization of treatment. Shall consider the provision of obstetrical and gynecological care and the ordering of related obstetrical and gynecological items and services by a participating provider who specializes in obstetrics or gynecology, pursuant to the direct access described in subsection 1, as authorized by the primary care provider.

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

§4309-A. Compliance with the federal act

1. Enforcement. Carriers must comply with all applicable requirements of the federal act and federal regulations adopted pursuant to the federal act. The superintendent may enforce and administer this section through all powers provided under Title 24 and this Title.

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

Sec. B-25. 24-A MRSA §4312, sub-§1, as enacted by PL 1999, c. 742, §19, is amended to read:

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

Sec. B-26. 24-A MRSA §4312, sub-§2, as enacted by PL 1999, c. 742, §19, is amended to read:

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

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

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

C. The life or health of the enrollee is in serious jeopardy, or the decision concerns an admission, availability of care, continued stay or health care services for which the enrollee received emergency services, but has not been discharged from a facility; or

D. The enrollee has died.

Sec. B-27. 24-A MRSA §4317-A is enacted to read:

§4317-A. No lifetime or annual limits on health plans subject to the federal act

In addition to and notwithstanding the requirements of section 4318, a carrier offering a health plan subject to the federal act may not:

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

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

Sec. B-28. 24-A MRSA §4318, sub-§4, as reallocated by RR 2009, c. 2, §70, is amended to read:

4. Disclosure. A health plan issued after the effective date of this section that includes an annual or lifetime maximum aggregate benefit limit as permitted under section 4317-A and subsection 3 must include a disclosure of the applicable limit on the face page of the individual policy or group certificate. The disclosure must be printed in a font that is larger or bolder than the font used in the body of the face page.

Sec. B-29. 24-A MRSA §4319 is enacted to read:

§4319. Coverage of preventive health services

In addition to and notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the federal act shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive services as required by the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-30. 24-A MRSA §4320 is enacted to read:

§4320. Extension of dependent coverage

A carrier offering a health plan subject to the requirements of the federal act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child attains 26 years of age, consistent with the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-31. 24-A MRSA §4320-A is enacted to read:

§4320-A. Emergency services

If a carrier offering a health plan subject to the requirements of the federal act provides or covers any benefits with respect to services in an emergency department of a hospital, the plan must cover emergency services in accordance with the requirements of the federal act and federal regulations adopted pursuant to the federal act, including requirements that emergency services be covered without prior authorization and that cost-sharing requirements expressed as a copayment amount or coinsurance rate for out-of-network services are the same as would apply if such services were provided in-network.

Sec. B-32. 24-A MRSA §4320-B is enacted to read:

§4320-B. Comprehensive health coverage

In addition to and notwithstanding any other requirements of this Title, a carrier offering a health plan subject to the requirements of the federal act shall, at a minimum, provide coverage that incorporates the essential benefits and cost-sharing limitations consistent with the requirements of the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-33. 24-A MRSA §4320-C is enacted to read:

§4320-C. Rebates

1. Rebates required. Carriers must provide rebates in the large group, small group and individual markets, to the extent required by the federal act and federal regulations adopted pursuant to the federal act, if the medical loss ratio defined in subsection 2 is less than the minimum medical loss ratio required by subsection 3. In the small group market, carriers must pay the larger of any rebate required by this section and any refund required by section 2808-B, subsection 2-C.

2. Medical loss ratio. For purposes of this section, the medical loss ratio is expressed as a percentage, the numerator of which is described in paragraph A and the denominator of which is described in paragraph B, plus any credibility adjustment. The time period over which the medical loss ratio is determined and the meaning of all terms used in this subsection are in accordance with the federal act and federal regulations adopted pursuant to the federal act.

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

B. The denominator is the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors and reinsurance under section 4320-D.

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

A. In the large group market, 85%;

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

C. In the individual market, 80%, or lower if the Secretary of the United States Department of Health and Human Services determines based on a finding, pursuant to the federal act and federal regulations adopted pursuant to the federal act, that the 80% minimum medical loss ratio may destabilize the individual market in this State.

Sec. B-34. 24-A MRSA §4320-D is enacted to read:

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

1. Transitional reinsurance program. The superintendent shall establish a transitional reinsurance program for calendar years 2014, 2015 and 2016 as required by Section 1341 of the federal act and federal regulations adopted pursuant to the federal act.

2. Risk corridors. Carriers shall make any payments required under the risk corridors program established by the Secretary of the United States Department of Health and Human Services for calendar years 2014, 2015 and 2016 as required by Section 1342 of the federal act and federal regulations adopted pursuant to the federal act.

3. Risk adjustment. The superintendent shall establish a risk adjustment program as required by Section 1343 of the federal act and federal regulations adopted pursuant to the federal act.

Sec. B-35. 24-A MRSA §4320-E is enacted to read:

§4320-E. Oversight of plans offered through an exchange established in state law pursuant to the federal act

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

A. Certification of a health plan as a qualified health plan, or any other determination made by an exchange pursuant to the federal act; or

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

2. Coordination with exchanges. The superintendent has all additional powers and duties conferred upon a state insurance regulator with respect to American Health Benefit Exchanges and Small Business Health Option Program Exchanges by the federal act and regulations adopted pursuant to the federal act. The superintendent may enter into agreements with an exchange established under state law relating to coordination of responsibilities and such agreements may provide for the superintendent to assume additional authority relating to the certification of qualified health plans or the authorization of a carrier to participate in any exchange.

Sec. B-36. 24-A MRSA §4320-F is enacted to read:

§4320-F. Applicability to health plans grandfathered under the federal act

A health plan that is exempt from certain requirements of the federal act because the health plan has grandfathered status is also exempt, to the same extent, from the substantially similar provisions in Title 24 and this Title.

Sec. B-37. 24-A MRSA §6451, sub-§6-B is enacted to read:

6-B. Qualified nonprofit health insurance issuer. "Qualified nonprofit health insurance issuer" has the same meaning as in Section 1322 of the federal Patient Protection and Affordable Care Act, Public Law 111-148. A qualified nonprofit health insurance issuer is considered a health organization for purposes of this chapter.

SUMMARY

Part A of the bill makes the rate review process for small group health insurance rates the same as the process for individual health insurance. Part A requires that, if a filing proposes an increase in rates in a small group health plan, the Superintendent of Insurance shall hold a hearing on the proposed rate increase at the request of the Attorney General. Part A makes it clear that in any hearings the burden of proving proposed rates are not excessive, inadequate or unfairly discriminatory is on the insurer. Part A also repeals the optional rate review process that permits small group health insurers that meet a minimum 78% medical loss ratio to file rates with the Department of Professional and Financial Regulations, Bureau of Insurance for informational purposes.

Part B of the bill amends the Maine Insurance Code to conform to the requirements of the federal Patient Protection and Affordable Care Act, Public Law 111-148. Part B also authorizes the Superintendent of Insurance to amend rules for consistency with the requirements of the federal law and any regulations adopted pursuant to that law.