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Legislative Document **No. 1497**

H.P. 1098 House of Representatives, April 20, 2011

An Act To Comply with the Health Insurance Exchange Provision of the Patient Protection and Affordable Care Act

Received by the Clerk of the House on April 15, 2011. Referred to the Committee on Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

HEATHER J.R. PRIEST
Clerk

Presented by Representative McKANE of Newcastle.
Cosponsored by Senator WHITTEMORE of Somerset and
Representatives: FITZPATRICK of Houlton, MORISSETTE of Winslow, PICCHIOTTI of Fairfield, RICHARDSON of Warren, Senator: SNOWE-MELLO of Androscoggin.

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

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

14-H.

Health care	Board of Directors of the Maine Health Benefit Exchange	Expenses Only	24-A MRSA §7004

Sec. 2. 24-A MRSA c. 89 is enacted to read:

CHAPTER 89

MAINE HEALTH BENEFIT EXCHANGE ACT

§7001. Short title

This chapter may be known and cited as "the Maine Health Benefit Exchange Act."

§7002. Definitions

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

1. Board. "Board" means the Board of Directors of the Maine Health Benefit Exchange established in section 7004.

2. Educated health care consumer. "Educated health care consumer" means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical and scientific matters.

3. Exchange. "Exchange" means the Maine Health Benefit Exchange established in section 7003.

4. 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.

5. Health benefit plan. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

A. "Health benefit plan" does not include:

(1) Coverage only for accident or disability income insurance or any combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' compensation or similar insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for on-site medical clinics; or

(8) Insurance coverage similar to any coverage listed in subparagraphs (1) to (7), as specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

B. "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited-scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(3) Limited benefits similar to those listed in subparagraphs (1) and (2), as specified in federal regulations issued pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

C. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) Coverage only for a specified disease or illness; or

(2) Hospital indemnity or other fixed indemnity insurance.

D. "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined under the United States Social Security Act, Section 1882(g)(1) of ;

(2) Coverage supplemental to the coverage provided under 10 United States Code, Chapter 55; or

(3) Supplemental coverage similar to coverage listed in subparagraphs (1) and (2) provided under a group health plan.

6. Health carrier. "Health carrier" or "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 nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or

E. An employee benefit excess insurance company licensed in accordance with this Title to provide property and casualty insurance that provides employee benefit excess insurance pursuant to section 707, subsection 1, paragraph C-1.

7. Qualified dental plan. "Qualified dental plan" means a limited-scope dental plan that has been certified in accordance with this chapter.

8. Qualified employer. "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered through the SHOP exchange and that:

A. Has its principal place of business in this State and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

B. Elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in this State.

9. Qualified health plan. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the Federal Act and this chapter.

10. Qualified individual. "Qualified individual" means an individual, including a minor, who:

A. Is seeking to enroll in a qualified health plan offered to individuals through the exchange;

B. Resides in this State;

C. At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

D. Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

11. Secretary. "Secretary" means the Secretary of the United States Department of Health and Human Services.

12. SHOP exchange. "SHOP exchange" means the Small Business Health Options Program established pursuant to section 7003.

13. Small employer. "Small employer" means an employer that employed an average of not more than 50 employees during the preceding calendar year. For purposes of this subsection:

A. All persons treated as a single employer under 26 United States Code, Section 414(b), (c), (m) or (o) must be treated as a single employer;

B. An employer and a predecessor employer must be treated as a single employer;

C. All employees must be counted, including part-time employees and employees who are not eligible for coverage through the employer;

D. If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

E. An employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange and would cease to be a small employer by reason of an increase in the number of its employees must continue to be treated as a small employer for purposes of this chapter as long as it continuously makes enrollment through the SHOP exchange available to its employees.

§7003. Maine Health Benefit Exchange established; declaration of necessity

1. Exchange established. The Maine Health Benefit Exchange is established as an independent executive agency to provide, pursuant to the Federal Act, for the establishment of a health benefit exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and for the establishment of the Small Business Health Options Program to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured individuals, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

2. Contracting authority. The exchange may contract with an eligible entity for any of its functions described in this chapter. For the purposes of this subsection, "eligible entity" includes, but is not limited to, the MaineCare program or any entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, except that a health carrier or an affiliate of a health carrier is not an eligible entity.

3. Information sharing. The exchange may enter into information-sharing agreements with federal and state agencies and other states' exchanges to carry out its responsibilities under this chapter; such agreements must include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws, rules and regulations.

§7004. Board of Directors of Maine Health Benefit Exchange

The Board of Directors of the Maine Health Benefit Exchange, as established in Title 5, section 12004-G, subsection 14-H, is established to supervise the exchange.

1. Appointments. The board consists of 10 members appointed by the Governor subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate. The Governor shall appoint the members as follows:

A. Two members representing insurers;

B. Two members representing insurance producers;

C. One member representing hospitals;

D. One member representing physicians;

E. One member representing nurses;

F. One member representing large employers;

G. One member representing small employers; and

H. One member who purchases individual health insurance.

2. Terms of office. Members of the board are appointed to 6-year terms. Members may serve 2 consecutive terms. Any vacancy for an unexpired term must be filled in accordance with subsection 1. A member may serve until a replacement is appointed and qualified.

3. Chair. The Governor shall appoint one of the members as the chair of the board.

4. Quorum. Six members of the board constitute a quorum.

5. Affirmative vote. An affirmative vote of 6 members is required for any action taken by the board.

6. Compensation. Members are entitled to compensation for expenses incurred in the performance of their duties on the board.

7. Meetings. The board shall meet monthly and may also meet at other times at the call of the chair or the executive director selected pursuant to section 7006, subsection 2. All meetings of the board are public proceedings within the meaning of Title 1, chapter 13, subchapter 1.

§7005. Limitation on liability

1. Indemnification of exchange employees and board members. A board member or employee of the exchange is not subject to personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. The exchange shall indemnify a member of the board or an employee of the exchange against expenses actually and necessarily incurred by that member or employee

in connection with the defense of an action or proceeding in which that member or employee is made a party by reason of past or present authority with the exchange.

2. Limitation on liability of board members. The personal liability of a member of the board is governed by Title 18-B, section 1010.

§7006. Duties of board; plan of operation

1. Plan of operation. Within 6 months of appointment, the board shall submit to the superintendent a plan of operation for the exchange that will ensure fair, reasonable and equitable administration of the exchange. The plan of operation takes effect upon the approval of the superintendent.

2. Requirements. In addition to the other requirements of this chapter, the plan of operation submitted under subsection 1 must include procedures for:

A. Operation of the exchange;

B. Selecting and hiring an executive director;

C. Creating a fund, managed by the board, for administrative expenses;

D. Handling, according and auditing of money and other assets of the exchange;

E. Developing and implementing a program to foster public awareness of the exchange and to publicize the eligibility requirements and enrollment procedures for coverage under the exchange and for subsidies offered for individual coverage;

F. Developing and implementing requirements that only producers licensed under chapter 16, subchapter 2-A enroll individuals and small employers in qualified health plans offered through the exchange, including an annual educational certification process for producers who elect to participate in the exchange;

G. Developing and implementing requirements to assist individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans sold through the exchange; and

H. Any matters necessary and proper for the execution of the board's powers, duties and obligations under this chapter.

3. Failure to submit plan of operation. If the board fails to submit a plan of operation as required in subsection 1, the superintendent may, after notice and hearing, determine a plan of operation for the exchange. A plan of operation determined by the superintendent pursuant to this subsection continues in effect until the board submits a plan of operation approved by the superintendent.

§7007. Availability of coverage

1. Coverage. The exchange shall make qualified health plans available to qualified individuals and qualified employers no later than January 1, 2014.

2. Qualified health plan required. The exchange may not make available any health benefit plan that is not a qualified health plan.

3. Dental benefits. The exchange shall allow a health carrier to offer a plan that provides limited-scope dental benefits meeting the requirements of 26 United States Code, Section 9832(c)(2)(A) through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Federal Act.

4. No fee or penalty for termination of coverage. The exchange or a carrier offering qualified health plans through the exchange may not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 1401 of the Federal Act.

§7008. Powers and duties of the Maine Health Benefit Exchange

1. Powers. Subject to any limitations contained in this chapter or in any other law, the exchange may:

A. Take any legal actions that are necessary for the proper administration of the exchange;

B. Make and alter bylaws, not inconsistent with this chapter or with the laws of this State, for the administration and regulation of the activities of the exchange;

C. Have and exercise all powers necessary or convenient to effect the purposes for which the exchange is organized or to further the activities in which the exchange may lawfully be engaged, including the establishment of the exchange;

D. Engage in legislative liaison activities, including gathering information regarding legislation, analyzing the effect of legislation, communicating with Legislators and attending and giving testimony at legislative sessions, public hearings or committee hearings;

E. Enter into contracts with qualified 3rd parties both private and public for any service necessary to carry out the purposes of this chapter;

F. Apply for and receive funds, grants or contracts from public and private sources; and

G. 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.

2. Duties. The exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the secretary under Section 1311(c) of the Federal Act and pursuant to section 7009, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as provided under Section 1311(c)(6) of the Federal Act;

D. Maintain a publicly accessible website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the secretary under Section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under Section 1302(d)(2)(A) of the Federal Act;

F. Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under the federal Public Health Service Act, 42 United States Code, Section 300gg-15 (2010);

G. In accordance with Section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under the United States Social Security Act, Title XIX, the State Children's Health Insurance Program under the United States Social Security Act, Title XXI, or any applicable state or local public program and if, through screening of an application by the exchange, the exchange determines that an individual is eligible for any such program, enroll the individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 1401 of the Federal Act and any cost-sharing reduction under Section 1402 of the Federal Act;

I. Establish the SHOP exchange through which qualified employers may access coverage for their employees, and that enables a qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage;

J. Subject to Section 1411 of the Federal Act, issue a certification attesting that, for purposes of the individual responsibility penalty under 26 United State Code, Section 5000A, an individual is exempt from the individual responsibility requirement or from the penalty because:

(1) There is no affordable qualified health plan available through the exchange or the individual's employer covering the individual; or

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty;

K. Transfer to the United States Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under paragraph J, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 1401 of the Federal Act because:

(a) The employer did not provide the minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under Section 1401 of the Federal Act to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the exchange under Section 1411(b)(4) of the Federal Act that the individual has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in paragraph K, subparagraph (3) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the exchange by the secretary or the United States Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing and individual responsibility requirement exemptions;

N. Select entities qualified to serve as navigators in accordance with Section 1311(i) of the Federal Act and standards developed by the secretary and award grants to enable navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 1401 of the Federal Act and cost-sharing reductions under Section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under 42 United States Code, Section 300gg-93 (2010), or any other appropriate state agency or agencies, for an enrollee with a grievance, complaint or question regarding a health benefit plan or coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

O. Review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with Section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. Consult with stakeholders regarding carrying out the activities required under this chapter, including, but not limited to:

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

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

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

(4) The MaineCare program; and

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

R. Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the secretary, the Governor, the superintendent and the Legislature a report concerning such accountings;

S. Fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the Federal Act and allow the secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(1) Investigate the affairs of the exchange;

(2) Examine the properties and records of the exchange; and

(3) Require periodic reports in relation to the activities undertaken by the exchange; and

T. In carrying out its activities under this chapter, avoid using any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications.

3. Budget. The revenues and expenditures of the exchange are subject to legislative approval in the biennial budget process. At the direction of the board, the executive director selected under section 7006, subsection 2 shall prepare the budget for the administration and operation of the exchange in accordance with the provisions of law that apply to departments of State Government.

4. Audit. The exchange must be audited annually by the State Auditor. The board may, in its discretion, arrange for an independent audit to be conducted. A copy of any audit must be provided to the State Controller, the superintendent, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

5. Rulemaking. The exchange may adopt rules as necessary for the proper administration and enforcement of this chapter pursuant to the Maine Administrative Procedure Act. Unless otherwise specified, rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Rules adopted pursuant to this subsection may not conflict with or prevent the application of regulations promulgated by the secretary under the Federal Act.

6. Annual report. Beginning February 1, 2015, and annually thereafter, the board shall report on the operation of the exchange to the Governor, the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

7. Technical assistance from other state agencies. Other state agencies, including, but not limited to, the bureau; the Department of Health and Human Services; the Department of Administrative and Financial Services, Maine Revenue Services; and the Maine Health Data Organization, shall provide technical assistance and expertise to the exchange upon request.

8. Legal counsel. The Attorney General, when requested, shall furnish any legal assistance, counsel or advice the exchange requires in the discharge of its duties.

§7009. Health benefit plan certification

1. Certification. The exchange may certify a health benefit plan as a qualified health plan if:

A. The health benefit plan provides the essential health benefits package described in Section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection 5, if:

(1) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(2) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric dental benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

B. The premium rates and contract language have been approved by the superintendent;

C. The health benefit plan provides at least a bronze level of coverage, as determined pursuant to Section 1302(d)(1)(A) of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

D. The health benefit plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the Federal Act, and, if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the Federal Act;

E. The health carrier offering the health benefit plan:

(1) Is licensed and in good standing to offer health insurance coverage in this State;

(2) Offers at least one qualified health plan in the silver level and at least one plan in the gold level as described in Section 1302(d)(1)(B) and Section 1302(d)(1)(C) of the Federal Act through each component of the exchange in which the carrier participates. As used in this subparagraph, "component" means the SHOP exchange and the exchange;

(3) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

(4) Does not charge any cancellation fees or penalties in violation of section 7007, subsection 4; and

(5) Complies with the regulations developed by the secretary under Section 1311(c) of the Federal Act and such other requirements as the exchange may establish;

F. The health benefit plan meets the requirements of certification as adopted by rule pursuant to section 7008, subsection 5 and by regulation promulgated by the secretary under Section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

G. The exchange determines that making the health benefit plan available through the exchange is in the interest of qualified individuals and qualified employers in this State.

2. Authority to exclude health benefit plans. The exchange may not exclude a health benefit plan:

A. On the basis that the health benefit plan is a fee-for-service plan;

B. Through the imposition of premium price controls by the exchange; or

C. On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances in which the exchange determines the treatments are inappropriate or too costly.

3. Carrier requirements. The exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to:

A. Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its publicly accessible website. The exchange shall take this information, along with the information and the recommendations provided to the exchange by the superintendent under the federal Public Health Service Act, 42 United States Code, Section 300gg-94 (2010), into consideration when determining whether to allow the carrier to make plans available through the exchange;

B. Make available to the public and submit to the exchange, the secretary and the superintendent accurate and timely disclosure of the following:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost sharing and payments with respect to any out-of-network coverage;

(8) Information on enrollee and participant rights under Title I of the Federal Act; and

(9) Other information as determined appropriate by the secretary.

The information required in this paragraph must be provided in plain language, as that term is defined in Section 1311(e)(3)(B) of the Federal Act; and

C. Permit an individual to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments and coinsurance, under the individual's health benefit plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information must be made available to the individual through a publicly accessible website and through other means for an individual without access to the Internet.

4. No exemption from licensing or solvency requirements. The exchange may not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that ensures fairness between or among health carriers participating in the exchange.

5. Application to qualified dental plans. The provisions of this chapter that are applicable to qualified health plans also apply to the extent relevant to qualified dental plans except as modified in this subsection or by rules adopted by the exchange.

A. The carrier must be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

B. The qualified dental plan must be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and must include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to Section 1302(b)(1)(J) of the Federal Act and such other dental benefits as the exchange or the secretary may specify by rule or regulation.

C. Carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, if the plans are priced separately and are also made available for purchase separately at the same prices.

§7010. Funding; publication of costs

1. Assessment. The exchange may charge an assessment or user fee to a health carrier or otherwise may generate funding necessary to support its operations as provided in this chapter.

2. Publication of costs. The exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange on a publicly accessible website to educate consumers on such costs. This information must include information on money lost to waste, fraud and abuse.

§7011. Relation to other laws

This chapter, and any action taken by the exchange pursuant to this chapter, may not be construed to preempt or supersede the authority of the superintendent to regulate the business of insurance within this State. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and rules adopted and orders issued by the superintendent.

§7012. Licensing of navigators

A navigator for the exchange, as selected pursuant to section 7008, subsection 2, paragraph N, must be licensed as a producer pursuant to chapter 16.

Sec. 3. Staggered terms. Notwithstanding the Maine Revised Statutes, Title 24-A, section 7004, subsection 2, of the initial members appointed to the Board of Directors of the Maine Health Benefit Exchange, 2 members serve an initial term of 4 years, 4 members serve an initial term of 5 years and 4 members serve an initial term of 6 years.

SUMMARY

This bill establishes the Maine Health Benefit Exchange pursuant to the federal Patient Protection and Affordable Care Act. The exchange is established as authorized by federal law to facilitate the purchase of health care coverage by individuals and small businesses. The bill requires coverage to be available through the exchange no later than January 1, 2014. The bill authorizes the use of an assessment or user fee on health insurance carriers to support the operations of the exchange.