L.D. 2007

Date: (Filing No. H-)

HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

Reproduced and distributed under the direction of the Clerk of the House.

STATE OF MAINE

HOUSE OF REPRESENTATIVES

129TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 1425, L.D. 2007, Bill, "An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine"

Amend the bill in Part A in section 1 in §5404 in subsection 2 in paragraph D in the first line (page 2, line 37 in L.D.) by striking out the following: "Legislature" and inserting the following: 'joint standing committee of the Legislature having jurisdiction over health insurance coverage matters'

Amend the bill in Part A in section 1 in §5411 in the first paragraph in the 2nd line (page 4, line 26 in L.D.) by striking out the following: "Legislature" and inserting the following: 'joint standing committee of the Legislature having jurisdiction over health insurance coverage matters'

Amend the bill in Part B in section 2 by inserting after the chapter headnote and before §2791 the following:

'**§2791. Definitions**

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

1. Individual health plan. "Individual health plan" has the same meaning as in section 2736-C, subsection 1, paragraph C.

2. Small group health plan. "Small group health plan" has the same meaning as in section 2808-B, subsection 1, paragraph G.'

Amend the bill in Part B in section 2 in §2791 by striking out all of subsection 1 (page 5, lines 34 to 40 and page 6, lines 1 and 2 in L.D.) and inserting the following:

'**1. Pooled market established.** Subject to the requirements of subsection 5, all individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2022 must be offered through a pooled market. A health insurance carrier offering an individual health plan subject to this section shall make the plan available to all eligible small employers within the plan's approved service area, and a health insurance carrier offering a small group health plan subject to this section shall

make the plan available to all eligible individuals residing within the plan's approved service area. This subsection does not require the Maine Health Insurance Marketplace established in Title 22, chapter 1479 to offer identical choices of health plans to individuals and to small employers under Title 22, chapter 1479.'

Amend the bill in Part B in section 2 in §2791 by striking out all of subsection 3 (page 6, lines 11 to 16 in L.D.) and inserting the following:

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

Amend the bill in Part B in section 2 in §2791 by striking out all of subsection 5 (page 6, lines 20 to 25 in L.D.) and inserting the following:

'**5. Preconditions for pooled market.** This section may not be implemented unless routine technical rules as defined in Title 5, chapter 375, subchapter 2-A are adopted to implement this section and the Federal Government approves a state innovation waiver amendment that extends reinsurance under section 3953 to the pooled market established pursuant to this section based on projections by the superintendent that both average individual premium rates and average small group premium rates would be the same or lower than they would have been absent the provisions of this section. If this section is not implemented, the superintendent shall conduct an analysis of alternative proposals to improve the stability and affordability of the small group market.'

Amend the bill in Part B in section 2 in §2792 in subsection 1 in the 4th line (page 6, line 34 in L.D.) by striking out the following: "2791" and inserting the following: '2792'

Amend the bill in Part B in section 2 in §2792 in subsection 2 by striking out all of the 3rd sentence (page 6, line 41 and page 7, lines 1 and 2 in L.D.) and inserting the following: 'The superintendent shall develop at least one clear choice design for each tier of health insurance plan designated as bronze, silver, gold and platinum in accordance with the federal Affordable Care Act.'

Amend the bill in Part B in section 2 in §2792 by striking out all of subsection 4 (page 7, lines 11 to 17 in L.D.) and inserting the following:

'**4. Alternative plan designs.** In addition to one or more health plans that include cost-sharing parameters consistent with a clear choice design developed pursuant to this section, a carrier may offer up to 3 health plans that modify one or more specific cost-sharing parameters in a clear choice design if the carrier submits an actuarial certification to the satisfaction of the superintendent that the alternative plan design offers significant consumer benefits and does not result in adverse selection. An alternative plan design may be offered only in a service area where the carrier offers at least one clear choice design plan at the same tier.'

Amend the bill in Part B in section 2 in chapter 34-B by renumbering the sections to read consecutively.

Amend the bill in Part B by striking out all of sections 4 to 6 and inserting the following:

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

B. A filing and all supporting information, except for protected health information required to be kept confidential by state or federal statute and except for descriptions of the amount and terms or conditions or reimbursement in a contract between an insurer and a 3rd party, are public records notwithstanding Title 1, section 402, subsection 3, paragraph B and become part of the official record of any hearing held pursuant to subsection 2-B, paragraph B or ~~F~~ section 2792, subsection 2.

Sec. B-5. 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 2-B and 2-C or section 2792, as applicable, for premium rates effective on or after July 1, 2004, except that the ~~filing of~~ rates for small group health plans are not required to account for any payment or any recovery of that payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005.

Sec. B-6. 24-A MRSA §2808-B, sub-§2-B, as amended by PL 2011, c. 364, §15, is further amended to read:

2-B. Rate review and hearings. Except as provided in subsection 2-C and section 2792, rate filings are subject to this subsection.

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

B. If at any time the superintendent has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. Hearings held under this subsection must conform to the procedural requirements set forth in Title 5, chapter 375, subchapter 4. The superintendent shall issue an order or decision within 30 days after the close of the hearing or of any rehearing or reargument or within such other period as the superintendent for good cause may require, but not to exceed an additional 30 days. In the order or decision, the superintendent shall either approve or disapprove the rate filing. If the superintendent disapproves the rate filing, the superintendent shall establish the date on which the filing is no longer effective, specify the filing the

superintendent would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the carrier to furnish the information upon which it supports the filing.

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

Sec. B-7. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2011, c. 364, §16, is further amended to read:

2-C. Guaranteed loss ratio. Notwithstanding subsection 2-B, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection 2-B, except as otherwise provided in section 2792. Rates filed in accordance with this subsection are filed for informational purposes.

A. A block of small group health plans is considered credible if the anticipated average number of members during the period for which the rates will be in effect meets standards for full or partial credibility pursuant to the federal Affordable Care Act. The rate filing must state the anticipated average number of members during the period for which the rates will be in effect and the basis for the estimate. If the superintendent determines that the number of members is likely to be less than needed to meet the credibility standard, the filing is subject to subsection 2-B.'

Amend the bill in Part B by striking out all of section 11 and inserting the following:

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

1. Guaranteed access reinsurance mechanism established. The Maine Guaranteed Access Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business in the State, an insurer that has issued or administered medical insurance within the previous 12 months or is actively marketing a medical insurance policy or medical insurance administrative services in this State must participate in the association. ~~The Dirigo Health Program established in chapter 87 and any other state-sponsored health benefit program shall also participate in the association. Unless an earlier resumption of operations is ordered by the superintendent in accordance with paragraph A, operations of the association are suspended until December 31, 2023 except to the extent provided in section 3962 and the association may not collect assessments as provided in section 3957, provide reinsurance for member insurers under section 3958 or provide reimbursement for member insurers under section 3961 as of the date on which a transitional reinsurance program established under the authority of Section 1341 of the federal Affordable Care Act commences operations in this State.~~ The association may operate a reinsurance program contingent on the approval of, or continued approval of, a state innovation waiver under Section 1332 of the federal Affordable Care Act submitted by the superintendent as provided for in section 2781.

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

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

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

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

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

Amend the bill in Part B by striking out all of section 17 and inserting the following:

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

§3958. Reinsurance; premium rates

1. Reinsurance amount. A member insurer offering an individual health plan under section 2736-C must be reinsured by the association to the level of coverage provided in this subsection and is liable to the association for ~~the~~ any applicable reinsurance premium at the rate established in accordance with subsection 2. For calendar year 2022 and subsequent calendar years, the association shall also reinsure member insurers for small group health plans issued under section 2808-B, unless otherwise provided in rules adopted by the superintendent pursuant to section 2792, subsection 5.

A. Beginning July 1, 2012, except as otherwise provided in paragraph A-1, the association shall reimburse a member insurer for claims incurred with respect to a person designated for reinsurance by the member insurer pursuant to section 3959 ~~or 3961~~ after the insurer has incurred an initial level of claims for that person of $7,500 for covered benefits in a calendar year. In addition, the insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The amount of reimbursement is 90% of the amount incurred between $7,500 and $32,500 and 100% of the amount incurred in excess of $32,500 for claims incurred in that calendar year with respect to that person. For calendar year 2012, only claims incurred on or after July 1st are considered in determining the member insurer's reimbursement. ~~The~~ With the approval of the superintendent, the association may annually adjust the initial level of claims and the maximum limit to be retained by the

insurer to reflect ~~increases~~ changes in costs ~~and~~, utilization ~~within the standard market for individual health plans within the State. The adjustments may not be less than the annual change in the Consumer Price Index for medical care services unless the superintendent approves a lower adjustment factor as requested by~~, available funding and any other factors affecting the sustainable operation of the association.

A-1. In any plan year in which a pooled market is operating in accordance with section 2792, the association shall operate a retrospective reinsurance program providing coverage to member insurers for all individual and small group health plans issued in this State in that plan year. For plan years beginning in 2022, if the pooled market has not been implemented pursuant to section 2792, subsection 5, the association may operate a retrospective reinsurance program for individual health plans, subject to the approval of the superintendent.

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

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

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

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

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

2. Premium rates. The association, as part of the plan of operation under section 3953, subsection 3, shall establish a methodology for determining premium rates to be charged member insurers to reinsure persons eligible for coverage under this chapter. The methodology must include a system for classification of persons eligible for coverage that reflects the types of case characteristics used by insurers for individual health plans pursuant to section 2736-C, together with any additional rating factors the association determines to be appropriate. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that, together with other funds available to the association, will be sufficient to meet the

anticipated costs of the association. The association shall periodically review the methodology established under this subsection and may make changes to the methodology as needed with the approval of the superintendent. The association may consider adjustments to the premium rates charged for reinsurance to reflect the use of effective cost containment and managed care arrangements by an insurer. This subsection does not apply to reinsurance with respect to any calendar year for which the association operates a retrospective reinsurance program under subsection 1, paragraph A-1. With the approval of the superintendent, the association's plan of operation for a retrospective reinsurance program may include a provision for charging premium on an equitable basis to all member insurers.'

Amend the bill in Part C in section 1 in §4320-A by striking out all of subsection 3 (page 15, lines 25 to 32 in L.D.) and inserting the following:

'**3. Primary health services.** An individual or small group health plan with an effective date on or after January 1, 2021 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copays for the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year count toward the deductible. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent shall conduct a study analyzing the effects of this subsection on premiums based on experience in plan years 2020 and 2021. The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.'

Amend the bill in Part C in section 2 in the 4th line (page 15, line 36 in L.D.) by striking out the following: "2791" and inserting the following: '2792'

Amend the bill in Part C in section 2 in the next to the last line (page 15, line 38 in L.D.) by striking out the following: "2791" and inserting the following: '2792'

Amend the bill by inserting after Part C the following:

'PART D

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

HEALTH AND HUMAN SERVICES, DEPARTMENT OF

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Executive Director position, beginning July 1, 2020.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$186,547
All Other	$0	$10,804
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$197,351

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Public Service Executive II position to serve as chief technology officer, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$69,306
All Other	$0	$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$74,708

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Public Service Manager III position to handle communications and outreach duties, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$64,455
All Other	$0	$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$69,857

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Public Service Coordinator II position to handle finance and compliance duties, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$56,316
All Other	$0	$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$61,718

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Comprehensive Health Planner II position to serve as a project manager and policy analyst, beginning June 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$7,556
All Other	$0	$901
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$8,457

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for one Secretary Specialist position to serve as administrative assistant, beginning January 1, 2021.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	1.000
Personal Services	$0	$40,878
All Other	$0	$5,402
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$46,280

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides a one-time allocation for a website development contract.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$15,000
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$15,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for an annual contract for navigator grants.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$150,000
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$150,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for a contract for an annual audit.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$65,000
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$65,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides a one-time allocation for an independent verification and validation vendor contract.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$200,000
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$200,000

Maine Health Insurance Marketplace Trust Fund N343

Initiative: Provides allocation for the STA-CAP plan.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$19,751
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$19,751

HEALTH AND HUMAN SERVICES, DEPARTMENT OF DEPARTMENT TOTALS	2019-20	2020-21
OTHER SPECIAL REVENUE FUNDS	**$0**	**$908,122**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**$908,122**

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Administrative Services - Professional and Financial Regulation 0094

Initiative: Provides allocation to establish one part-time Insurance Actuarial Assistant position and All Other costs.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$2,340
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$2,340

Insurance - Bureau of 0092

Initiative: Provides allocation to establish one part-time Insurance Actuarial Assistant position and All Other costs.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	0.500
Personal Services	$0	$39,605
All Other	$0	$7,691
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$47,296

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF DEPARTMENT TOTALS	2019-20	2020-21
OTHER SPECIAL REVENUE FUNDS	**$0**	**$49,636**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**$49,636**

SECTION TOTALS	2019-20	2020-21
OTHER SPECIAL REVENUE FUNDS	**$0**	**$957,758**
SECTION TOTAL - ALL FUNDS	**$0**	**$957,758**

'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment makes the following changes to the bill.

1. It specifies that the reporting to the Legislature on the operations of the Maine Health Insurance Marketplace is to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters.

2. It adds cross-references to the definitions of "individual health plan" and "small group health plan" to clarify that the requirements for the pooled market do not extend to certain limited benefit insurance plans.

3. It clarifies the intent that a health plan in the pooled market must comply with the requirements of the Maine Revised Statutes, Title 24-A, chapter 56-A.

4. It clarifies that the pooled market does not change current law allowing carriers to limit their operations to a designated service area or to offer different plans within different service areas.

5. It clarifies that the "average premium" trigger is not intended to allow the pooled market to go forward merely on a finding that average premiums for the pooled group will be lower, if savings for nongroup policyholders come at the expense of increased costs for small business. It also adds language requiring the Superintendent of Insurance

to conduct an analysis of alternative proposals to stabilize the small group market, should the pooled market not be implemented.

6. It clarifies that the Superintendent of Insurance is required to develop at least one clear choice design plan for each tier and allows carriers to offer up to 3 alternative plans subject to submission of a satisfactory actuarial certification to the Superintendent of Insurance.

7. It allows the Maine Guaranteed Access Reinsurance Association the option to continue to charge a ceding premium even after converting to a retrospective program.

8. It clarifies that the Maine Guaranteed Access Reinsurance Association is not required to transition to a retrospective reinsurance model in 2022 if the pooled market is not in effect. It does provide the option that the association may elect to move to a retrospective model regardless of the pooled market, subject to approval by the Superintendent of Insurance.

9. It affirms that the reinsurance program is contingent on federal approval, which is an important technical distinction, in order for the program to generate pass-through funding.

10. It limits the scope of the primary care and behavioral health benefit to the individual, small group and future pooled markets and corrects an error that inadvertently made it applicable to large group plans. It clarifies the intent of the bill to apply the primary health services requirement to a total of 6 visits, 3 primary care visits and 3 behavioral health visits, and further requires that copays for the 2nd and 3rd primary care and behavioral health visits must count toward the enrollee's deductible. It adds the word "office" after "behavioral health" for clarity. It requires the Superintendent of Insurance to analyze the effects of the primary health services requirement on premiums following implementation and authorizes the superintendent to adopt rules to address the coordination of the requirements for coverage without cost sharing for the first primary care visit and the requirements with respect to coverage of an annual well visit.

11. It adds an appropriations and allocations section.

FISCAL NOTE REQUIRED

(See attached)