Amend the bill by striking out all of Parts A to C and inserting the following:

PART A

‘

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

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

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

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

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

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

E. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this subsection, including, but not limited to, a process for submitting a pilot project proposal, minimum requirements for approval of a pilot project and any

requirements for minimum benefits. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than 90 days after the effective date of this subsection.

PART B

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

14-F.

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

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

§ 423-E. Report to Legislature

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

Sec. B-3. 24-A MRSA §606 is enacted to read:

§ 606. Premium assessment; health maintenance organizations

1. Assessment. A health maintenance organization authorized to do business in this State pursuant to chapter 56 shall pay an assessment of 2% per year on all gross direct premiums on all policies, contracts and certificates written on residents in this State. The assessment imposed by this subsection applies to all gross direct premiums collected or contracted for on health maintenance organization policies, contracts and certificates issued or renewed on or after July 1, 2008. Beginning in 2009, each health maintenance organization shall file an annual report on or before August 1st of each year with the superintendent containing a sworn statement of the gross direct premiums and shall pay to the superintendent an amount equal to 2% of those gross premiums.

2. Dedicated account. The assessments paid pursuant to subsection 1 must be deposited in a special dedicated, nonlapsing revenue account administered by the superintendent.

3. Transfer to reinsurance pool association. Beginning October 1, 2009 and annually thereafter, the superintendent shall transfer assessments paid by health maintenance organizations pursuant to subsection 1 from the account established in subsection 2 to the Maine Individual Reinsurance Pool Association established in chapter 54.

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

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

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

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

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

(4) For all policies, contracts or certificates that are executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 2009, for each health benefit plan offered by a carrier, the premium rate may not deviate above or below the community rate filed by the carrier by more than 40%.

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

(b) The superintendent shall adopt rules setting forth appropriate methodologies regarding determination of rating factors pursuant to this subparagraph. Rules adopted pursuant to this division are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

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

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

(1) July 1, 2012; and

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

The superintendent shall establish by rule procedures and policies that facilitate the implementation of this paragraph, including, but not limited to, notice requirements for policyholders and experience pooling requirements of individual health products. When establishing rules regarding experience pooling requirements, the superintendent shall ensure, to the greatest extent possible, the availability of affordable options for individuals transitioning from the closed book of business. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

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

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

CHAPTER 54

MAINE INDIVIDUAL REINSURANCE POOL ASSOCIATION

§ 3901. Short title

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

§ 3902. Definitions

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

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

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

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

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

5. Medical insurance. "Medical insurance" means a hospital and medical expense-incurred policy, a nonprofit hospital and medical service plan, a health maintenance organization subscriber contract or other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise, whether sold as an individual or group policy. "Medical insurance" does not include accidental injury, specified disease, hospital indemnity, dental, vision, disability income, Medicare supplement, long-term care or other limited benefit health insurance or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; or automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

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

§ 3903. Maine Individual Reinsurance Pool Association

1. Reinsurance pool established. The Maine Individual Reinsurance Pool Association is established as a nonprofit legal entity to provide reinsurance for individual health plans in accordance with this chapter. As a condition of doing business, every insurer that has sold medical insurance within the previous 12 months or is actively marketing a medical insurance policy in this State shall participate in the association. The Dirigo Health Program established in chapter 87 and any other state-run or state-sponsored health benefit program shall also participate in the association.

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

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

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

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

(b) Two members must represent medical providers;

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

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

A board member appointed by the superintendent may be removed at any time without cause; and

(2) Five members appointed by insurers belonging to the association, at least 2 of whom are domestic insurers and at least one of whom is a 3rd-party administrator.

B. Members serve terms of 3 years.

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

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

3. Plan of operation; rules. The association shall adopt a plan of operation in accordance with the requirements of this chapter and submit its articles, bylaws and operating rules to the superintendent for approval. If the association fails to adopt the plan of operation and suitable articles and bylaws within 90 days after the appointment of the board, the superintendent shall adopt rules to effectuate the

requirements of this chapter, and those rules remain in effect until superseded by a plan of operation and articles and bylaws submitted by the association and approved by the superintendent. Rules adopted pursuant to this subsection by the superintendent are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

§ 3904. Liability and indemnification

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

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

§ 3905. Duties and powers of the association

1. Duties. The association shall:

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

B. Select an administrator in accordance with section 3906;

C. Establish procedures for the handling and accounting of funds held by the association, including transfers pursuant to section 606, subsection 3, assessments as provided in section 3907 and premiums as provided in section 3909, subsection 2; and

D. Collect assessments as provided in section 3907.

2. Powers. The association may:

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

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

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

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

E. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance to the association;

F. Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default must be legal investments for insurers and may be carried as admitted assets;

G. Establish rules, conditions and procedures for reinsuring risks of insurers in accordance with section 3909; and

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

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

4. Review for solvency. The superintendent shall review the operations of the association at least every 3 years to determine its solvency. If the superintendent determines that the funds of the association are insufficient to support the need for reinsurance, the superintendent may order the association to increase its assessments. If the superintendent determines that the funds of the association are insufficient, the superintendent may order the association to charge an additional assessment.

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

6. Audit. The association must be audited at least every 3 years. A copy of the audit must be provided to the superintendent and to the joint standing committee of the Legislature having jurisdiction over health insurance matters.

§ 3906. Selection of administrator

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

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

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

A. Perform all administrative functions relating to the association;

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

C. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expenses of administration pertaining to the reinsurance operations of the association and the incurred losses of the year and report this information to the superintendent; and

D. Pay reinsurance and reimbursement amounts as provided for in the plan of operation and sections 3909 and 3911.

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

§ 3907. Assessments against insurers

1. Assessment. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess member insurers at such a time and for such amounts as the board finds necessary to cover any net loss in accordance with this subsection.

A. Prior to April 1st of each year, the association shall determine and report to the superintendent the association's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses and any assessments transferred to the association pursuant to section 606 and an estimate of the assessments needed to fund the loss incurred by the association in the previous calendar year.

B. Individual assessments of each insurer are determined by multiplying net losses, if net earnings are negative, by a fraction, the numerator of which is the insurer's total premiums earned in the preceding calendar year from all health benefit plans, including excess or stop loss coverage, and the denominator of which is the total premiums earned in the preceeding calendar year from all health benefit plans.

C. The association shall impose a penalty of interest for late payment of assessments.

2. Organizational assessment. In addition to the collection of assessments as provided in subsection 1, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses that have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments must be equal in amount for all insurers but may not exceed $500 per insurer for all such assessments. Assessments are due and payable within 30 days of receipt of the assessment notice by the insurer.

3. Deferral of assessment. An insurer may apply to the superintendent for a deferral of all or part of an assessment imposed by the association under this section. The superintendent may defer all or part of the assessment if the superintendent determines that the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.

4. Excess funds. If assessments and other receipts by the association, board or administrator exceed the actual losses and administrative expenses of the association, the board shall hold the excess as interest and may use those excess funds to offset future losses or to reduce reinsurance premiums. As used in this subsection, "future losses" includes reserves for claims incurred but not reported.

5. Failure to pay assessment. The superintendent may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any insurer that fails to pay an assessment. As an alternative, the superintendent may levy a penalty on any insurer that fails to pay an assessment when due. In addition, the superintendent may use any power granted to the superintendent by this Title to collect any unpaid assessment.

§ 3908. Coverage for reinsurance

For individual health plans issued or renewed on or after July 1, 2009 pursuant to section 2736-C, an insurer may designate through the use of individual health statements or other reasonable means a person covered under an individual health plan to be reinsured by the association in accordance with section 3909 and rules adopted by the association.

§ 3909. Reinsurance; premium rates

1. Reinsurance amount. Any insurer must be reinsured by the association to the level of coverage provided in this subsection for individuals designated by the insurer pursuant to section 3908 and is liable to the association for the reinsurance premium rate established in accordance with subsection 2.

A. The association may not reimburse a reinsuring insurer with respect to claims of a reinsured person until the insurer has incurred an initial level of claims for that person of $5,000 for covered benefits in a calendar year. In addition, the reinsuring insurer is responsible for 10% of the next $25,000 of claims paid during a calendar year. The association shall reimburse reinsuring insurers

for claims paid in excess of $25,000. The association may annually adjust the initial level of claims and the maximum limit to be retained by the reinsuring insurer to reflect increases in costs and utilization within the standard market for health plans within the State. The adjustments may not be less than the annual change in the medical component of the Consumer Price Index unless the superintendent approves a lower adjustment factor as requested by the association.

B. A reinsuring insurer is eligible for reimbursement on claims only for the calendar year in which the claims are paid. Beginning October 1, 2009, a reinsuring insurer may submit a request for reimbursement to the association at any time during the calendar year once the claims of a reinsured person have met the claims levels specified in paragraph A, but all reimbursement requests must be submitted no later than April 1st following the end of the calendar year for which the reimbursement requests are being made. The association may require a reinsuring insurer to submit the reimbursement request and any claims data in connection with the request on forms prescribed by the association.

C. A reinsuring 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.

2. Premium rates. The association may charge reinsuring insurers premium rates established in accordance with this subsection. The association, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged reinsuring 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. The methodology must provide for the development of base reinsurance premium rates, subject to approval of the superintendent, set at levels that reasonably approximate gross premiums charged for individual health plans and that are adjusted to reflect retention levels required under this Title. 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 a reinsuring insurer.

§ 3910. Actions against association or members based upon joint or collective actions

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

§ 3911. Reimbursement of insurers

1. Reimbursement. An insurer may seek reimbursement from the association and the association shall reimburse the insurer to the extent claims paid by the insurer after July 1, 2009 meet the requirements for reinsurance pursuant to section 3909 and the insurer meets the following criteria:

A. The insurer sold an individual health plan between December 1, 1993 and June 30, 2008, and the policy that was sold has been continuously renewed by the insured;

B. The insurer is able to determine through the use of individual health statements, claims history or any reasonable means that at any time while the policy was in effect the insured was diagnosed with one of the following medical conditions: acquired immune deficiency syndrome, angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open-heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia or Wilson's disease; and

C. The insurer has closed its book of business for individual health plans sold prior to July 1, 2009.

2. Rules. The superintendent may adopt rules to facilitate payment to an insurer pursuant to this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

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

PART C

Sec. C-1. 24-A MRSA §6912, sub-§4, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

4. Amount subsidized. Dirigo Health may ~~limit~~vary the amount ~~subsidized of the payment made by individual plan enrollees under section 6910, subsection 4, paragraph C to 40% of the payment to more closely parallel the subsidy received by employees~~of the subsidy granted to eligible individuals from the subsidy received by eligible employees in accordance with the sliding scale established pursuant to this section. ~~In no case may the subsidy granted to eligible individuals in accordance with subsection 2, paragraph A exceed the maximum subsidy level available to other eligible individuals.~~'

Amend the bill by striking out all of Part E and inserting the following:

PART E

'

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

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

§ 6913-A. Health access surcharge

1. Health access surcharge on paid claims required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, employee benefit excess insurance carriers and 3rd-party administrators, not including carriers and 3rd-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance, shall pay a health access surcharge not to exceed 1.7% on all paid claims as determined by the board in accordance with this section. The following provisions govern the health access surcharge.

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

B. The surcharge applies to paid claims as follows:

(1) For paid claims beginning July 1, 2008 and until June 30, 2009, the surcharge is 1.7% of paid claims;

(2) For paid claims beginning July 1, 2009 and until June 30, 2010, the surcharge is 1.6% of paid claims;

(3) For paid claims beginning July 1, 2010 and until June 30, 2011, the surcharge is 1.5% of paid claims;

(4) For paid claims beginning July 1, 2011 and until June 30, 2012, the surcharge is 1.4% of paid claims;

(5) For paid claims beginning July 1, 2012 and until June 30, 2013, the surcharge is 1.3% of paid claims;

(6) For paid claims beginning July 1, 2013 and until June 30, 2014, the surcharge is 1.2% of paid claims;

(7) For paid claims beginning July 1, 2014 and until June 30, 2015, the surcharge is 1.1% of paid claims; and

(8) For paid claims beginning July 1, 2015 and thereafter, the surcharge is 1.0% of paid claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. "Claims-related expenses" includes:

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

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

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

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

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

§ 6915. Dirigo Health Enterprise Fund

The Dirigo Health Enterprise Fund is created as an enterprise fund for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any ~~savings offset~~ payments made pursuant to former section 6913 and section 6913-A and any funds received from any public or private source. The fund may not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. E-4. Savings offset payments calculated prior to effective date. Notwithstanding that section of this Part that repeals the Maine Revised Statutes, Title 24-A, section 6913, the savings offset payments that have been calculated and required under former Title 24-A, section 6913 for claims paid prior to the effective date of this Part are due and payable in the same manner and subject to the same procedures set forth in former Title 24-A, section 6913 until the first monthly health access surcharge required under Title 24-A, section 6913-A becomes due and payable.

Sec. E-5. Effective date. This Part takes effect July 1, 2008 or on the effective date of this Act, whichever occurs later.

PART F

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

DIRIGO HEALTH

Dirigo Health Fund 0988

Initiative: Allocates Dirigo Health funds from a health access surcharge starting at 1.7% on all paid claims.

DIRIGO HEALTH FUND	2007-08	2008-09
All Other	$0	$31,166,667
DIRIGO HEALTH FUND TOTAL	$0	$31,166,667

Dirigo Health Fund 0988

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

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

DIRIGO HEALTH DEPARTMENT TOTALS	**2007-08**	**2008-09**
DIRIGO HEALTH FUND	**$0**	**($1,733,333)**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**($1,733,333)**

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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.

The amendment modifies the provision in the bill that authorizes the Superintendent of Insurance to approve pilot projects to offer health insurance products for people under the age of 30. The amendment authorizes the superintendent to approve pilot projects that do not comply with statutory and regulatory requirements for certain mandated benefits, geographic access standards and standard plans if determined to be appropriate to establish affordable and attractive products.

The amendment replaces the reinsurance provision in Part B of the bill. The amendment establishes a reinsurance program for the individual health insurance market but makes it clear that individuals will not be placed in a separate risk pool or be covered under different health plans than those available in the individual market. The amendment permits carriers in the individual market to use an individual health assessment to designate persons covered under an individual health plan for inclusion in the reinsurance program at the time a policy is issued. The amendment requires carriers to account for the impact of the reinsurance program in rates for individual health plans filed for approval with the Superintendent of Insurance. The amendment imposes a 2% assessment on direct premium of health maintenance organizations to partially fund the costs of the reinsurance program.

The amendment also modifies the community rating provisions in the individual health insurance market to permit premium rates to vary up to 40% above or below the community rate. The amendment retains the provisions in the bill that allow a carrier to close its individual book of business and establish a separate community rate for those individuals applying for coverage under an individual health plan on or after July 1, 2009. As in the bill, a carrier must merge the closed book with its open book by July 1, 2012 or when the number of subscribers remaining in a carrier's closed individual book of business is less than 25 percent of the carrier's individual health plan subscriber total as of June 30, 2009, whichever is earlier.

The amendment clarifies Part C of the bill by making clear that the Board of Directors of Dirigo Health has authority to vary the amount of the subsidy granted to eligible individuals and eligible employees to ensure affordability.

The amendment makes changes to Part E in the bill related to funding for the Dirigo Health Program. The amendment repeals the savings offset payment and replaces it with a health access surcharge not to exceed 1.7% on paid claims. The amendment requires that the amount of the surcharge be reduced annually by 0.1% until the surcharge amount is 1.0% paid claims. The amendment directs all of the revenue from the health access surcharge to support subsidies for the Dirigo Health Program. The amendment removes the provisions in Part E of the bill that would have increased the tax on cigarettes from $2.00 to $2.50 a pack and equalized the rate of tax on all other tobacco products.

The amendment makes no changes to Parts D, F and G of the bill.

The amendment also adds an appropriations and allocations section to the bill.

FISCAL NOTE REQUIRED
(See attached)