CHAPTER 34-B

POOLED MARKET AND CLEAR CHOICE DESIGN

§2791. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 2019, c. 653, Pt. B, §2 (NEW).]

1. Individual health plan. "Individual health plan" has the same meaning as in section 2736-C, subsection 1, paragraph C.
[PL 2019, c. 653, Pt. B, §2 (NEW).]

2. Small group health plan. "Small group health plan" has the same meaning as in section 2808-B, subsection 1, paragraph G.
[PL 2019, c. 653, Pt. B, §2 (NEW).]

SECTION HISTORY

PL 2019, c. 653, Pt. B, §2 (NEW).

§2792. Affordable health coverage for individuals, families and small businesses

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

(CONTINGENT IMPLEMENTATION: See Title 24-A, section 2792, subsection 5)

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, 2023 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.
[PL 2021, c. 361, §1 (AMD).]

2. Premium rates. Premium rates for a health plan offered in the pooled market described in subsection 1 may not vary based on whether the plan is issued to an individual or to a small employer. Rate filings and review for the pooled market are subject to the provisions of sections 2736 to 2736-C. For health plans that are issued on other than a calendar year basis, rates applicable on and after January 1st of any plan year must be the approved rates for the most similar plan offered during the new calendar year, adjusted by a factor, approved by the superintendent as part of the rating plan, that appropriately accounts for any differences in plan design.
[PL 2019, c. 653, Pt. B, §2 (NEW).]

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.
[PL 2019, c. 653, Pt. B, §2 (NEW).]

4. Conforming references. All references in this Title to the individual health insurance market, the small group health insurance market or any equivalent terminology refer to the pooled market established pursuant to this section.
[PL 2019, c. 653, Pt. B, §2 (NEW).]

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 and chapter 54-A. 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.
[PL 2021, c. 361, §2 (AMD).]

SECTION HISTORY

PL 2019, c. 653, Pt. B, §2 (NEW). PL 2021, c. 361, §§1, 2 (AMD).

§2793. Clear choice designs

The superintendent shall develop clear choice designs for health plans in order to reduce consumer confusion and provide meaningful choices for consumers by promoting a level playing field on which carriers compete on the basis of price and quality. [PL 2021, c. 361, §3 (AMD).]

1. Clear choice design. For the purposes of this section, "clear choice design" means a set of annual copayments, coinsurance and deductibles for all or a designated subset of the essential health benefits. An individual health plan subject to section 2736-C or a pooled market health plan subject to section 2792 must conform to one of the clear choice designs developed pursuant to this section unless it is approved as an alternative plan under subsection 4.
[PL 2021, c. 361, §3 (AMD).]

2. Development of clear choice designs. The superintendent shall develop clear choice designs in consultation with working groups consisting of consumers, carriers, health policy experts and other interested persons. The superintendent shall adopt rules for clear choice designs, taking into consideration the ability of plans to conform to actuarial value ranges, consumer needs and promotion of benefits with high value and return on investment. 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. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. Clear choice designs apply to all individual health plans offered in this State with effective dates of coverage on or after January 1, 2022 and to all small group health plans offered through the pooled market under section 2792.
[PL 2021, c. 361, §3 (AMD).]

3. Annual review. The superintendent shall consider annually whether to revise, discontinue or add any clear choice designs for use by carriers in the following calendar year, including but not limited to considering whether deductible and copayment levels should be changed to reflect medical inflation and conform with actuarial value and annual maximum out-of-pocket limits.
[PL 2019, c. 653, Pt. B, §2 (NEW).]

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 plan designs 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.
[PL 2021, c. 361, §3 (AMD).]

SECTION HISTORY

PL 2019, c. 653, Pt. B, §2 (NEW). PL 2021, c. 361, §3 (AMD).