L.D. 1179

Date: (Filing No. H-)

INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

125TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 877, L.D. 1179, Bill, "An Act To Require Advance Review and Approval of Certain Small Group Health Insurance Rate Increases and To Implement the Requirements of the Federal Patient Protection and Affordable Care Act"

Amend the bill by striking out the title and substituting the following:

'An Act To Restore Advance Review and Prior Approval for Individual Health Insurance Rates and Extend the Same Process to Small Groups'

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

'PART A

Sec. A-1. 24-A MRSA §2736-C, sub-§2-B, as amended by PL 2011, c. 364, §7, is further amended to read:

2-B. Rate filings; credible health plans. ~~Notwithstanding section 2736, subsection 1 and section 2736-A, at the carrier's option, rate~~ Rate filings for a carrier's credible block of individual health plans ~~may~~ must be filed in accordance with this subsection. ~~Rates filed in accordance with this subsection are filed for informational purposes unless rate review is required pursuant to the federal Affordable Care Act.~~

A. A carrier's individual health plans are 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 section 2736, subsection 1 and section 2736-A.~~

B. On an annual schedule as determined by the superintendent, the carrier shall file a report with the superintendent showing the calculation of rebates as required pursuant to the federal Affordable Care Act, except that the calculation must be based on a minimum medical loss ratio of 80% if the applicable federal minimum for the individual market in this State is lower. If the calculation indicates that rebates must be paid, the carrier must pay the rebates in the same manner as is required for rebates pursuant to the federal Affordable Care Act.

Sec. A-2. 24-A MRSA §2736-C, sub-§5, as amended by PL 2011, c. 90, Pt. D, §3, is further amended to read:

5. Loss ratios. ~~Except as provided in subsection 2-B, for~~ For all policies and certificates issued on or after the effective date of this section, the superintendent shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least 65% 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.

PART B

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

C. Rates for small group health plans must be filed in accordance with this section ~~and subsections 2-B and 2-C for premium rates effective on or after July 1, 2004, except that the filing of rates for small group health plans are not required to account for any payment or any recovery of that payment pursuant to subsection 2-B, paragraph D and former section 6913 for rates effective before July 1, 2005~~.

Sec. B-2. 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, rate~~ Rate filings are subject to this subsection.

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

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

C. When a filing is not accompanied by the information upon which the carrier supports the filing or the superintendent does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, 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-3. 24-A MRSA §2808-B, sub-§2-C, as amended by PL 2011, c. 364, §16, is repealed.

Sec. B-4. Contingent effective date. This Part takes effect on the date on which the United States Supreme Court overturns 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, in whole or in part, or the federal law is repealed, in whole or in part.'

SUMMARY

This amendment replaces the bill and is the minority report of the committee. The amendment restores the statutory process for advance review and prior approval of individual health insurance rates and repeals the changes to the rate review process for individual health insurance made by Public Law 2011, chapter 90.

The amendment also extends the same process for advance review and prior approval for small group health insurance rates, but makes those provisions contingent on the repeal of the federal Patient Protection and Affordable Care Act by Congress or the invalidation of the federal law by the United States Supreme Court, either in whole or in part.