An Act To Phase Out Dirigo Health and Establish the Maine Health Benefit Exchange for Small Businesses and Individuals

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

PART A

Sec. A-1. 2 MRSA §6, sub-§1, as repealed and replaced by PL 2005, c. 397, Pt. A, §1, is amended to read:

1. Range 91. The salaries of the following state officials and employees are within salary range 91:

Commissioner of Transportation;

Commissioner of Conservation;

Commissioner of Administrative and Financial Services;

Commissioner of Education;

Commissioner of Environmental Protection;

Executive Director of ~~Dirigo~~the Maine Health Benefit Exchange;

Commissioner of Public Safety;

Commissioner of Professional and Financial Regulation;

Commissioner of Labor;

Commissioner of Agriculture, Food and Rural Resources;

Commissioner of Inland Fisheries and Wildlife;

Commissioner of Marine Resources;

Commissioner of Corrections;

Commissioner of Economic and Community Development;

Commissioner of Defense, Veterans and Emergency Management; and

Executive Director, Workers' Compensation Board.

Sec. A-2. 5 MRSA §286-M, sub-§11, as enacted by PL 2005, c. 636, Pt. A, §3, is repealed.

Sec. A-3. 5 MRSA §934-B, as enacted by PL 2003, c. 469, Pt. A, §2, is amended to read:

§ 934-B.Maine Health Benefit Exchange

The position of executive director is a major policy-influencing position within ~~Dirigo~~the Maine Health Benefit Exchange established pursuant to Title 24A, chapter ~~87~~89. Notwithstanding any other provision of law, this position and any successor position are subject to this chapter.

Sec. A-4. 5 MRSA §1667-B, first ¶, as amended by PL 2005, c. 386, Pt. D, §2, is further amended to read:

Allotments in Other Special Revenue funds accounts, internal service fund accounts and enterprise funds, except the State Lottery Fund and the ~~Dirigo~~Maine Health Benefit Exchange Enterprise Fund, may exceed current year allocations and the unused balance of allocations authorized to carry forward by law under the following conditions, except that funds in Other Special Revenue funds accounts, internal service fund accounts and enterprise funds must be expended in accordance with the statutes that establish the accounts and for no other purpose:

Sec. A-5. 5 MRSA §12004-G, sub-§14-D, as amended by PL 2007, c. 447, §1, is repealed.

Sec. A-6. 22 MRSA §2685, sub-§2, ¶C, as enacted by PL 2007, c. 327, §1, is repealed.

Sec. A-7. 22 MRSA §2685, sub-§4, as enacted by PL 2007, c. 327, §1, is amended to read:

4. Program coverage. The program must provide outreach and education to prescribers and dispensers who participate in, contract with or are reimbursed by state-funded health care programs, including but not limited to the MaineCare program, the Maine Rx Plus Program, ~~Dirigo Health insurance~~, the elderly low-cost drug program and the state employee health insurance program. The program may provide outreach and education to carriers, health plans, hospitals, employers and other persons interested in the program on a subscription or fee-paying basis under rules adopted by the department.

Sec. A-8. 22 MRSA §3174-V, sub-§2, as amended by PL 2005, c. 400, Pt. C, §1, is further amended to read:

2. Contracted services. When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a managed care plan ~~or the Dirigo Health Program~~ for the provision of MaineCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan ~~or the Dirigo Health Program~~ and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan ~~or the Dirigo Health Program~~ would make for services provided by an entity not defined as a federally qualified health center.

Sec. A-9. 22 MRSA §3174-DD, as amended by PL 2007, c. 447, §2, is repealed.

Sec. A-10. 22 MRSA §8703, sub-§2, ¶D, as enacted by PL 2009, c. 71, §6, is amended to read:

D. The Executive Director of ~~Dirigo~~the Maine Health Benefit Exchange as appointed under Title 24-A, section 7008, or a designee of the executive director who is an employee of ~~Dirigo~~the Maine Health Benefit Exchange, shall serve as a voting member.

Sec. A-11. 24-A MRSA §1952, as amended by PL 2003, c. 469, Pt. E, §8, is further amended to read:

§ 1952.Licensure

A private purchasing alliance may not market, sell, offer or arrange for a package of one or more health benefit plans underwritten by one or more carriers without first being licensed by the superintendent. The superintendent shall specify by rule standards and procedures for the issuance and renewal of licenses for private purchasing alliances. A rule may require an application fee of not more than $400 and an annual license fee of not more than $100. A license may not be issued until the rulemaking required by this chapter has been undertaken and all required rules are in effect. ~~Dirigo Health, as established in chapter 87, is exempt from the licensure requirements of this section as an independent executive agency of the State.~~

Sec. A-12. 24-A MRSA §2736-A, first ¶, as amended by PL 2009, c. 439, Pt. C, §3, is further amended to read:

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 not in compliance with section 6913~~ or that the filing violates any of the provisions of chapter 23, the superintendent shall cause a hearing to be held. If a filing proposes an increase in rates in an individual health plan as defined in section 2736-C, the superintendent shall cause a hearing to be held at the request of the Attorney General. In any hearing conducted under this section, the insurer has the burden of proving rates are not excessive, inadequate or unfairly discriminatory ~~and in compliance with section 6913~~.

Sec. A-13. 24-A MRSA §3902, sub-§4, as enacted by PL 2007, c. 629, Pt. A, §8, is amended to read:

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 3rdparty administrator, a multiple-employer welfare arrangement, any other entity providing medical insurance or health benefits subject to state insurance regulation, any reinsurer of health insurance in this State~~, 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.

Sec. A-14. 24-A MRSA §3903, sub-§1, as enacted by PL 2007, c. 629, Pt. A, §8, is amended to read:

1. Association established. The Maine Individual Reinsurance Association is established as a nonprofit legal entity. As a condition of doing business, every member insurer must 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.~~

Sec. A-15. 24-A MRSA §3905, sub-§1, ¶E, as enacted by PL 2007, c. 629, Pt. A, §8, is amended to read:

E. Establish an amount to be retained in the Reinsurance Association Reserve Enterprise Fund in accordance with section 3907.

Sec. A-16. 24-A MRSA §3906, sub-§3, ¶C, as enacted by PL 2007, c. 629, Pt. A, §8, is amended to read:

C. Following the close of each calendar year, report to the superintendent ~~the amount of revenue received from the Dirigo Health Enterprise Fund pursuant to section 6915,~~ the expenses of administration pertaining to reinsurance operations of the program and the incurred losses of the year; and

Sec. A-17. 24-A MRSA §3907, as enacted by PL 2007, c. 629, Pt. A, §8, is amended to read:

§ 3907.Reinsurance Association Reserve Enterprise Fund

1. Reserve established. The Reinsurance Association Reserve Enterprise Fund is established ~~within the Dirigo Health Enterprise Fund~~ as an account for the deposit of funds as required by subsection 2.

2. Funds. The Reinsurance Association Reserve Enterprise Fund is capitalized by money from ~~the Dirigo Health Enterprise Fund, as established pursuant to section 6915, and~~ any ~~other fund~~funds advanced for initial operating expenses, any funds received from any public or private source, legislative appropriations, payments from state departments and agencies and such other means as the Legislature may approve. All money in the Reinsurance Association Reserve Enterprise Fund may be used only by the association for the purposes of this section. Funds in the reserve do not lapse, but must be carried forward to carry out the purposes of this chapter.

Sec. A-18. 24-A MRSA §3908, sub-§1, ¶B, as enacted by PL 2007, c. 629, Pt. A, §8, is amended to read:

B. ~~The association shall limit total annual reimbursements to member insurers to the amount of money transferred annually from the Dirigo Health Enterprise Fund.~~ Any money at the end of the fiscal year not used for reimbursements must be transferred to the Reinsurance Association Reserve Enterprise Fund account under section 3907.

Sec. A-19. 24-A MRSA §6901, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

Sec. A-20. 24-A MRSA §6902, as enacted by PL 2003, c. 469, Pt. A, §8, is repealed.

Sec. A-21. 24-A MRSA §6903, as amended by PL 2007, c. 447, §3, is repealed.

Sec. A-22. 24-A MRSA §6904, as amended by PL 2007, c. 447, §4, is repealed.

Sec. A-23. 24-A MRSA §6905, as repealed and replaced by PL 2007, c. 447, §5, is repealed.

Sec. A-24. 24-A MRSA §6906, as amended by PL 2005, c. 400, Pt. C, §4, is repealed.

Sec. A-25. 24-A MRSA §6907, as amended by PL 2005, c. 615, §§2 and 3, is repealed.

Sec. A-26. 24-A MRSA §6908, as amended by PL 2009, c. 359, §1 and affected by §8, is repealed.

Sec. A-27. 24-A MRSA §6909, as amended by PL 2007, c. 447, §8, is repealed.

Sec. A-28. 24-A MRSA §6910, as amended by PL 2007, c. 447, §9, is repealed.

Sec. A-29. 24-A MRSA §6911, as amended by PL 2005, c. 400, Pt. A, §6, is repealed.

Sec. A-30. 24-A MRSA §6912, as amended by PL 2007, c. 629, Pt. B, §1, is repealed.

Sec. A-31. 24-A MRSA §6914, as amended by PL 2005, c. 400, Pt. A, §14, is repealed.

Sec. A-32. 24-A MRSA §6915, as amended by PL 2009, c. 359, §3 and affected by §8, is repealed.

Sec. A-33. 24-A MRSA §6916, as enacted by PL 2007, c. 447, §10, is repealed.

Sec. A-34. 24-A MRSA §6917, first ¶ is enacted to read:

The Maine Health Benefit Exchange established in chapter 89 shall collect access payments to support its operations as provided in this section.

Sec. A-35. 24-A MRSA §6917, sub-§1, as enacted by PL 2009, c. 359, §4 and affected by §8, is amended to read:

1. Access payments required from health insurance carriers, 3rd-party administrators and employee benefit excess insurance carriers. All health insurance carriers, 3rdparty administrators and employee benefit excess insurance carriers shall pay an access payment of 2.14% on all paid claims, except claims under accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement, Medicaid managed care or other limited benefit health insurance. The following provisions govern access payments.

A. A health insurance carrier or employee benefit excess insurance carrier may not be required to pay an access payment on policies or contracts insuring federal employees.

B. Access payments apply to claims paid beginning on or after ~~September 1, 2009~~January 1, 2014.

C. Access payments must be made monthly to ~~Dirigo~~the Maine Health Benefit Exchange and are due 30 days after the end of each month and must accrue interest at 12% per annum on or after the due date, except that access payments for 3rdparty 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. Access payments received by ~~Dirigo~~the Maine Health Benefit Exchange must be pooled with other revenues of the ~~agency~~exchange in the ~~Dirigo~~Maine Health Benefit Exchange Enterprise Fund established in section ~~6915~~7012.

Sec. A-36. 24-A MRSA §6917, sub-§3, ¶¶B-1 and D are enacted to read:

B-1. "Health insurance carrier" means:

(1) An insurance company licensed in accordance with this Title to provide health insurance;

(2) A health maintenance organization licensed pursuant to chapter 56;

(3) A preferred provider arrangement administrator registered pursuant to chapter 32;

(4) A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; or

(5) 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 C1.

D. "Third-party administrator" means any person who, on behalf of any person who establishes a health insurance plan covering residents, receives or collects charges, contributions or premiums for or settles claims on residents in connection with any type of health benefit provided in or as an alternative to insurance as defined by section 704, other than:

(1) Any person listed in section 1901, subsection 1, paragraphs A to C and paragraphs E to O; or

(2) Any person who provides those services in connection with a group health plan sponsored by an agricultural cooperative association located outside of this State that provides heath insurance coverage to members and employees of agricultural cooperative associations located within this State.

Sec. A-37. 24-A MRSA §6917, sub-§5 is enacted to read:

5. Use of access payments. In addition to the support of its administration and operations, the Maine Health Benefit Exchange established in chapter 89 shall use the access payments, to the extent funds are available, to support the following:

A. The Maine Quality Forum established under section 6951;

B. The provision of the consumer assistance program and navigators under the Federal Act as defined in section 7002, subsection 4; and

C. Subsidies to facilitate coverage through the Maine Health Benefit Exchange for sole proprietors and small businesses as determined by the Maine Health Benefit Exchange Board.

If sufficient funds are available to support the administration and operation of the exchange and the purposes described in paragraphs A to C, the Maine Health Benefit Exchange Board may use the funds to provide subsidies for benefits in addition to the minimum essential benefits provided by qualified health plans or to reduce the access payments of health insurance carriers, 3rdparty administrators and employee benefit excess insurance carriers required under subsection 1.

Sec. A-38. 24-A MRSA §6951, first ¶, as amended by PL 2009, c. 359, §5 and affected by §8, is further amended to read:

The Maine Quality Forum, referred to in this subchapter as "the forum," is established within ~~Dirigo Health~~the Maine Health Benefit Exchange established in chapter 89. The forum is governed by the board with advice from the Maine Quality Forum Advisory Council pursuant to section 6952. The forum must be funded, at least in part, through the ~~savings offset payments made pursuant to former section 6913 and the~~ access payment pursuant to section 6917. Except as provided in section ~~6907, subsection 2~~7007, subsection 3, information obtained by the forum is a public record as provided by Title 1, chapter 13, subchapter 1. The forum shall perform the following duties.

Sec. A-39. 24-A MRSA §6951, sub-§4, as amended by PL 2009, c. 350, Pt. A, §2, is further amended to read:

4. Reporting. The forum shall work collaboratively with the Maine Health Data Organization, health care providers, health insurance carriers and others to report in useable formats comparative health care quality information to consumers, purchasers, providers, insurers and policy makers. The forum shall produce annual quality reports in conjunction with the Maine Health Data Organization pursuant to Title 22, section 8712. ~~No later than September 1, 2010, the~~The forum shall make provider-specific information regarding quality of services available on its publicly accessible website.

Sec. A-40. 24-A MRSA §6951, sub-§10, as enacted by PL 2007, c. 594, §1, is amended to read:

10. Health care provider-specific data. The forum shall submit to the Legislature, by January 30th each year ~~beginning in 2009~~, a health care provider-specific performance report. The report must be based on health care quality data, including health care-associated infection quality data, that is submitted by providers to the Maine Health Data Organization pursuant to Title 22, section 8708A. The forum and the Maine Center for Disease Control and Prevention shall make the report available to the citizens of the State through a variety of means, including, but not limited to, the forum's publicly accessible website and the distribution of written reports and publications.

Sec. A-41. 24-A MRSA §6951, sub-§11, as enacted by PL 2007, c. 594, §2, is amended to read:

11. Infection prevention activities. The forum and the Maine Center for Disease Control and Prevention shall, by January 30th of each year ~~beginning in 2009~~, report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on statewide collaborative efforts with health care infection control professionals in the State to control or prevent health care-associated infections.

Sec. A-42. 24-A MRSA §6952, first ¶, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

The Maine Quality Forum Advisory Council, referred to in this subchapter as "the advisory council," is a 17member body established by Title 5, section 12004I, subsection 30A, to advise the forum. Except as provided in section ~~6907~~7007, subsection ~~2~~3, information obtained by the advisory council is a public record as provided by Title 1, chapter 13, subchapter 1.

Sec. A-43. 24-A MRSA §6952, sub-§6, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

6. Meetings. The advisory council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the ~~executive director~~Executive Director of ~~Dirigo Health~~the Maine Health Benefit Exchange appointed under section 7008. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

Sec. A-44. 24-A MRSA §6952, sub-§7, ¶B, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

B. Provide expertise in health care quality to assist the ~~board~~Board of Directors of the Maine Health Benefit Exchange established in chapter 89;

Sec. A-45. 24-A MRSA §6952, sub-§7, ¶C, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

C. Advise and support the forum by:

(1) Establishing and monitoring, with ~~Dirigo Health~~the Maine Health Benefit Exchange established in chapter 89, an annual work plan for the forum;

(2) Providing guidance in the adoption of quality and performance measures;

(3) Serving as a liaison between the provider group established in paragraph A and the forum;

(4) Conducting public hearings and meetings; and

(5) Reviewing consumer education materials developed by the forum;

Sec. A-46. 24-A MRSA c. 87, sub-c. 4, as amended, is repealed.

Sec. A-47. Transfer of funds. All accrued expenditures, assets, liabilities, balances or appropriations, allocations, transfers, revenues or other available funds in the Dirigo Health Enterprise Fund as of January 1, 2014 must be transferred to the Maine Health Benefit Exchange Enterprise Fund established in the Maine Revised Statutes, Title 24A, section 7012 on or before February 1, 2014.

Sec. A-48. Maine Revised Statutes headnote amended; revision clause. In the Maine Revised Statutes, Title 24-A, chapter 87, in the chapter headnote, the words "dirigo health" are amended to read "health access payment; maine quality forum" and the Revisor of Statutes shall implement this revision when updating, publishing or republishing the statutes.

Sec. A-49. Effective date. This Part takes effect January 1, 2014, except that those sections of this Part that repeal the Maine Revised Statutes, Title 24A, sections 6901 to 6916 and Title 24-A, chapter 87, subchapter 4 are repealed as of the date on which the Secretary of the United States Department of Health and Human Services determines that a health insurance exchange established by the State pursuant to the federal Patient Protection and Affordable Care Act, Section 1311 is fully operational and the State has received federal payments under Section 1412(c) or January 1, 2014, whichever is later.

PART B

Sec. B-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	$100 per diem and expenses	24A MRSA §7004

Sec. B-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, who has no financial interest in the delivery of health care services or sale of health insurance and has a background or experience in making informed decisions regarding health, medical or 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 benefits 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);

(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 C1.

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 the employer 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 tax credits and cost-sharing reductions. The Maine Health Benefit Exchange is also responsible for monitoring and improving the quality of health care in this State. The exercise by the Maine Health Benefit Exchange of the powers conferred by this chapter is deemed and held to be the performance of essential governmental functions.

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 or 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 12004G, subsection 14B, shall supervise the exchange.

1. Appointments. The board consists of 9 voting members and 4 ex officio, nonvoting members as follows.

A. The 9 voting members of the board are appointed as follows, subject to review by the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate:

(1) Five members appointed by the Governor;

(2) One member appointed by the President of the Senate;

(3) One member appointed by the Speaker of the House;

(4) One member appointed by the President of the Senate upon recommendation from the leader of the minority in the Senate; and

(5) One member appointed by the Speaker of the House upon recommendation from the leader of the minority in the House.

B. The 4 ex officio, nonvoting members of the board are:

(1) The Commissioner of Professional and Financial Regulation or the commissioner's designee;

(2) The Commissioner of Health and Human Services or the commissioner's designee;

(3) The Commissioner of Administrative and Financial Services or the commissioner's designee; and

(4) The Treasurer of State or the treasurer's designee.

2. Qualifications of voting members. Voting members of the board must be qualified in accordance with this subsection.

A. Six voting members of the board must have knowledge of and experience in at least 2 of the following areas:

(1) Health care purchasing;

(2) Individual health insurance coverage;

(3) Small group health insurance coverage;

(4) The MaineCare program;

(5) Health benefit plan administration;

(6) Administering a public or private health care delivery system;

(7) Health care financing; and

(8) Health policy and law.

B. Three voting members of the board must be qualified as follows:

(1) One member who serves as the chair of the Medicaid advisory committee within the Department of Health and Human Services; and

(2) Two members representing consumers selected from nominations by stakeholders pursuant to section 7010, subsection 2, paragraph W submitted to the appointing authorities by the exchange.

C. A voting member of the board may not be employed by, a consultant to, a member of the board of directors of, affiliated with or otherwise a representative of a carrier or other insurer, an agent or broker, a health care provider or a health care facility or health clinic while serving on the board. A voting member of the board may not be a member, a board member or an employee of a trade association of carriers, health facilities, health clinics or health care providers while serving on the board. A voting member of the board may not be a health care provider unless the member receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

D. Notwithstanding any other provision of law, a current or former member of the Board of Trustees of Dirigo Health may also serve as a member of the board.

3. Terms of office. Voting members of the board serve 3year terms. Voting members may serve up to 2 consecutive terms. Any vacancy for an unexpired term must be filled in accordance with subsections 1 and 2. A member may serve until a replacement is appointed and qualified.

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

5. Quorum. Five voting members of the board constitute a quorum.

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

7. Compensation. A member of the board is entitled to compensation according to the provisions of Title 5, section 12004G, subsection 14H; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

8. Meetings. The board shall meet monthly and may also meet at other times at the call of the chair or the executive director appointed under section 7008. 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. 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 18B, section 1010.

§ 7006. Prohibited interests of board members and employees

Board members and employees of the exchange and their spouses and dependent children may not receive any direct personal benefit from the activities of the exchange in assisting any private entity, except that they may participate in the exchange on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members are associated by reason of ownership or employment from participating in activities of the exchange or receiving services offered by the exchange as long as the ownership or employment is made known to the board and, if applicable, the board members abstain from voting on matters relating to that participation.

§ 7007. Records

Except as provided in subsections 1, 2 and 3, information obtained by the exchange under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by the exchange under this chapter is confidential and not open to public inspection.

2. Health information. Health information obtained by the exchange under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information covered by chapter 24 or Title 22, section 1711C is confidential and not open to public inspection.

3. Practitioner-specific quality data. The confidentiality of practitioner-specific quality data is determined according to this subsection.

A. Practitioner-specific quality data is confidential and may not be disclosed by the Maine Quality Forum established under section 6951 prior to a determination of accuracy and completeness made under paragraph B.

B. Practitioner-specific quality data is not confidential after a determination of its accuracy and completeness is made by the Director of the Maine Quality Forum established under section 6951 or a designee.

For the purposes of this subsection, "practitionerspecific quality data" means material in electronic or paper format that provides information about the professional performance of a health care practitioner licensed to provide health care in the State. "Practitioner-specific quality data" includes, but is not limited to, records, reports, working papers, drafts, analyses, email, interoffice and intraoffice memoranda and other data collected, used, produced or maintained by the Maine Quality Forum, established in section 6951, for the purposes of measuring a health care practitioner's professional performance against consensus best practices and local and national patterns of health care.

§ 7008. Executive director

1. Appointed position. The board shall appoint an executive director, who serves at the pleasure of the board. The position of Executive Director of the Maine Health Benefit Exchange is a major policyinfluencing position as designated in Title 5, section 934B.

2. Duties of executive director. The executive director appointed under subsection 1 shall:

A. Serve as the liaison between the board and the exchange and serve as secretary and treasurer to the board;

B. Manage the exchange's programs and services, including the Maine Quality Forum established under section 6951;

C. Employ or contract on behalf of the exchange for professional and nonprofessional personnel or service. Employees of the exchange are subject to the Civil Service Law, except that the position of Director of the Maine Quality Forum is not subject to the Civil Service Law;

D. Approve all accounts for salaries, per diems, allowable expenses of the exchange or of any employee or consultant and expenses incidental to the operation of the exchange; and

E. Perform other duties prescribed by the board to carry out the functions of this chapter.

§ 7009. 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. The exchange may enroll qualified individuals and qualified employers beginning on or after September 1, 2013.

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.

§ 7010. 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;

G. Contract with the Maine Health Data Organization and other organizations with expertise in health care data, including a nonprofit health data processing entity in this State, to assist the Maine Quality Forum established in section 6951 in the performance of its responsibilities;

H. Provide staff support and other assistance to the Maine Quality Forum established in section 6951, including assigning a director and other staff as needed to conduct the work of the Maine Quality Forum; and

I. 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 7011, 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 except that the hotline may not be automated;

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, or the State Children's Health Insurance Program under the United States Social Security Act, Title XXI, or under 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. Determine the criteria and process for eligibility, enrollment and disenrollment of enrollees and potential enrollees in the exchange and coordinate that process with the state and local government entities administering other health care coverage programs, including the MaineCare program and the basic health program, if established, required by paragraph O, in order to ensure consistent

eligibility and enrollment processes and seamless transitions between coverages. To the extent possible, the board shall encourage the use of existing infrastructure and capacity from other state agencies;

I. Determine the minimum requirements a carrier must meet to be considered for participation in the exchange and the standards and criteria for selecting qualified health plans to be offered through the exchange that are in the best interests of qualified individuals and qualified employers. The board shall consistently and uniformly apply these requirements, standards and criteria to all carriers. In the course of selectively contracting for health care coverage offered to qualified individuals and qualified employers through the exchange, the board shall seek to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality and service;

J. Provide, in each region of the State, a choice of qualified health plans at each of the 5 levels of coverage contained in Section 1302(d) and (e) of the Federal Act;

K. Require, as a condition of participation in the exchange, carriers to fairly and affirmatively offer, market and sell in the exchange at least one product within each of the 5 levels of coverage contained in Section 1302(d) and (e) of the Federal Act. The board may require carriers to offer additional products within each of those 5 levels of coverage. This paragraph does not apply to a carrier that solely offers supplemental coverage in the exchange under Section 100504(a)(10) of the Federal Act;

L. Require, as a condition of participation in the exchange, carriers that sell any products outside the exchange to:

(1) Fairly and affirmatively offer, market and sell all products made available to individuals in the exchange to individuals purchasing coverage outside the exchange; and

(2) Fairly and affirmatively offer, market and sell all products made available to small employers in the exchange to small employers purchasing coverage outside the exchange;

M. Establish and make available by electronic means and by a tollfree telephone number 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 costsharing reduction under Section 1402 of the Federal Act;

N. Establish a SHOP exchange through which qualified employers may access coverage for their employees, enabling any qualified employer to specify a level of coverage or amount of contribution toward 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 and provide subsidies to qualified employers to purchase coverage through the SHOP exchange with funding available pursuant to section 6917, subsection 5, paragraph C;

O. Consider establishing a basic health program for eligible individuals in accordance with Section 1331 of the Federal Act in order to ensure continuity of care and that families previously enrolled in Medicaid remain in the same plan;

P. Subject to Section 1411 of the Federal Act, issue a certification attesting that, for purposes of the individual responsibility penalty under 26 United States 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;

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

(1) A list of the individuals who are issued a certification under paragraph P, 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;

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

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

T. 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 federal Public Health Service Act, 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.

An individual licensed as an insurance producer pursuant to chapter 16 may serve as a navigator in the SHOP exchange, in accordance with Section 1311(i) of the Federal Act, but may not qualify as a navigator to qualified individuals in the exchange;

U. 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;

V. 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;

W. 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 selfemployed individuals;

(4) Representatives of the MaineCare program; and

(5) Advocates for enrolling hardtoreach populations;

X. 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;

Y. 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

Z. 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 appointed under section 7008 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 2A. 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.

9. Coordination with federal, state and local health care systems. The exchange shall institute a system to coordinate the activities of the exchange with the health care programs of the Federal Government and state and municipal governments.

10. Advisory committees. The board may appoint advisory committees to advise and assist the board in discharging its responsibilities under this chapter. Members of an advisory committee serve without compensation but may be reimbursed by the exchange for necessary expenses while on official business of the advisory committee.

11. 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. 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 be offered only 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 (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 7009, 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 rules pursuant to section 7010, 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 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.

§ 7012. The Maine Health Benefit Exchange Enterprise Fund

The Maine Health Benefit Exchange 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 access payments made pursuant to section 6917, federal funds 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.

§ 7013. Maine Health Benefit Exchange Business Advisory Council

The Maine Health Benefit Exchange Business Advisory Council, referred to in this chapter as "the advisory council," is established to advise the exchange. Except as provided in section 7007, subsection 2, information obtained by the advisory council is a public record as provided by Title 1, chapter 13, subchapter 1.

1. Appointment; composition. The Governor shall appoint the following members with the approval of the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters:

A. Three members representing providers, including one physician, one representative of hospitals and one health care practitioner who is not a physician;

B. One member representing consumers;

C. One member representing large employers;

D. One member representing small employers;

E. One representative of health insurance carriers; and

F. One representative of health insurance producers.

Prior to making appointments to the advisory council, the Governor shall seek nominations from the public statewide associations representing the interests under subsection 1, paragraphs A to F and other entities as appropriate.

2. Terms. Members of the advisory council serve 5year terms. A member may not serve more than 2 consecutive terms.

3. No compensation. Members serve as volunteers and without compensation or reimbursement for expenses.

4. Quorum. A quorum is a majority of the members of the advisory council.

5. Chair and officers. The advisory council shall annually choose one of its members to serve as chair for a oneyear term. The advisory council may select other officers and designate their duties.

6. Meetings. The advisory council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the executive director appointed under section 7008. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

7. Duties. The advisory council shall:

A. Advise and support the exchange on matters referred to it by the board or the executive director appointed under section 7008; and

B. Serve as a liaison between the exchange and individuals and small businesses enrolled in the exchange.

§ 7014. 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.

Sec. B-3. Staggered terms; Board of Directors of the Maine Health Benefit Exchange. Notwithstanding the Maine Revised Statutes, Title 24A, section 7004, subsection 3, of the initial voting members appointed to the Board of Directors of the Maine Health Benefit Exchange, 2 members must be appointed to serve initial terms of one year, 3 members must be appointed to serve initial terms of 2 years and 4 members must be appointed to serve initial terms of 3 years.

Sec. B-4. Staggered terms; Maine Health Benefit Exchange Business Advisory Council. Notwithstanding the Maine Revised Statutes, Title 24A, section 7013, subsection 2, of the initial members appointed to the Maine Health Benefit Exchange Business Advisory Council, 3 members must be appointed to serve initial terms of 3 years, 3 members must be appointed to serve initial terms of 4 years and 2 members must be appointed to serve initial terms of 5 years.

Sec. B-5. Transition. The following provisions apply to the establishment of the Maine Health Benefit Exchange pursuant to the Maine Revised Statutes, Title 24A, chapter 89.

1. Board appointed. Within 30 days of the effective date of this Act, the Governor shall post nominations for the appointment of the members of the Board of Directors of the Maine Health Benefit Exchange. As soon as practicable after Senate confirmation of board members, the board shall appoint the Executive Director of the Maine Health Benefit Exchange pursuant to Title 24-A, section 7008.

2. Initial staffing; Dirigo Health. Upon request from the Board of Directors of the Maine Health Benefit Exchange, the Executive Director of Dirigo Health shall provide initial staffing assistance to the exchange in the initial phases of its operations until the appointment of the Executive Director of the Maine Health Benefit Exchange. The Executive Director of the Maine Health Benefit Exchange shall hire staff and contract for services to implement this Part. In hiring and contracting, the Executive Director of the Maine Health Benefit Exchange may give preference to state employees and contractors who are employed by Dirigo Health.

3. Grant funding. As soon as practicable after Senate confirmation of board members, the Board of Directors of the Maine Health Benefit Exchange shall submit an application to the Secretary of the United States Department of Health and Human Services for any grant funding made available to states for exchange planning and implementation pursuant to 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.

4. Report. Beginning 90 days after the effective date of this Part and until June 30, 2014, the Executive Director of the Maine Health Benefit Exchange shall report on a quarterly basis to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters on the actions taken by the Board of Directors of the Maine Health Benefit Exchange and the initial operations of the Maine Health Benefit Exchange.

PART C

Sec. C-1. 24-A MRSA §4218-A is enacted to read:

§ 4218-A. Compliance with the federal Patient Protection and Affordable Care Act

The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of 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. Rules or amendments adopted pursuant to this section, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2A.

Sec. C-2. 24-A MRSA §4309-A is enacted to read:

§ 4309-A. Compliance with the federal Patient Protection and Affordable Care Act

1. Enforcement. Carriers must comply with all applicable requirements of 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. The superintendent may enforce and administer this section through all powers provided under this Title and Title 24.

2. Rules. The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of 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. Rules or amendments adopted pursuant to this subsection, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2A.

Sec. C-3. 24-A MRSA §4319 is enacted to read:

§ 4319. Oversight of plans offered through the Maine Health Benefit Exchange established pursuant to the federal Patient Protection and Affordable Care Act

1. Superintendent's authority preserved. Except as otherwise expressly provided by applicable law, all requirements established by this Title, Title 24 and rules adopted by the superintendent continue to apply to carriers and health plans and are not extinguished or modified in any way by:

A. Certification of a health plan as a qualified health plan or any other determination made by the Maine Health Benefit Exchange established in chapter 89 pursuant to the Federal Act; or

B. Recognition by the applicable federal agency of a carrier as a qualified nonprofit health insurance issuer or as an issuer of qualified multistate health plans, or of a health plan as a qualified multistate health plan, pursuant to the Federal Act.

2. Coordination with the Maine Health Benefit Exchange. The superintendent has all additional powers and duties conferred upon a state insurance regulator with respect to the Maine Health Benefit Exchange established in chapter 89 by the Federal Act. The superintendent may enter into agreements with an exchange established under state law relating to coordination of responsibilities, and such agreements may provide for the superintendent to assume additional authority relating to the certification of qualified health plans or the authorization of a carrier to participate in the Maine Health Benefit Exchange.

For purposes of this section, "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.

Sec. C-4. Bureau of Insurance review of federal law. The Department of Professional and Financial Regulation, Bureau of Insurance shall review 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 comparison to the Maine Revised Statutes, Title 24A. The bureau shall prepare proposed legislation to make any necessary statutory changes to conform Title 24A to the federal law and submit that proposed legislation to the Joint Standing Committee on Insurance and Financial Services on or before January 1, 2012. The Joint Standing Committee on Insurance and Financial Services may report out a bill based on the proposed legislation to the Second Regular Session of the 125th Legislature.

PART D

Sec. D-1. Bureau of Insurance report. The Department of Professional and Financial Regulation, Bureau of Insurance shall review and evaluate the minimum essential benefits package determined by the Secretary of the United States Department of Health and Human Services pursuant to 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 comparison to any laws in the Maine Revised Statutes, Title 24 and Title 24A that mandate medical benefits or coverage in individual or group health insurance policies. The Bureau of Insurance shall evaluate those mandated

benefits required by State law and determine the financial impact, social impact and medical efficacy of each mandated health insurance benefit in a retrospective and prospective manner and the cumulative financial impact of the mandated health insurance benefits on health insurance premiums. The bureau shall also determine the projected cost impact on the State of maintaining the mandated benefit as a supplement to the minimum essential benefits package in qualified health plans to be made available through the Maine Health Benefit Exchange established in Title 24A, chapter 89. Prior to submitting its report, the bureau shall hold at least one public hearing on a draft report to gather input on whether to continue any mandated health benefits not included in the essential benefits package. The bureau shall submit a report, including any recommendations for legislation, to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters no later than 3 months following the adoption of minimum essential benefits by the Secretary of the United States Department of Health and Human Services. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out a bill based on the report to the First Regular Session of the 126th Legislature.

SUMMARY

This bill repeals Dirigo Health effective January 1, 2014 and, in its place, establishes the Maine Health Benefit Exchange. 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. Coverage of individuals and small businesses under the current Dirigo Health program will end on January 1, 2014 as coverage will transition to the exchange. The bill retains the Maine Quality Forum established within the Dirigo Health program and transfers its oversight to the exchange. The bill requires health insurance carriers and 3rd-party administrators to pay an access payment on paid claims to support the operations of the exchange.

The bill makes changes to the Maine Insurance Code to preserve the authority of the Superintendent of Insurance to enforce the federal Patient Protection and Affordable Care Act. The bill also clarifies that the Superintendent of Insurance has oversight over health insurance plans offered through the Maine Health Benefit Exchange.

The bill also requires the Department of Professional and Financial Regulation, Bureau of Insurance to evaluate the minimum essential benefits package to be determined by the Secretary of the United States Department of Health and Human Services in comparison to existing mandated health insurance benefits required by state law. The bill directs the Bureau of Insurance to determine the projected cost impact of maintaining mandated benefits not included in the essential benefits package in qualified health plans made available through the exchange. The bureau must submit its report within 3 months of the adoption of the minimum essential benefits package.