02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 851 CLEAR CHOICE DESIGNS FOR INDIVIDUAL AND SMALL GROUP HEALTH PLANS

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Section 1. Authority and Purpose

This rule is adopted pursuant to 24-A M.R.S. §§ 212 and 2793, to develop health plan cost share designs as set out in 24-A M.R.S. §2793, for individual health plans and, as applicable, for small group health plans.

Section 2. Applicability and Scope

This rule applies to all individual health plans subject to 24-A M.R.S. §2736-C offered in this State with effective dates of coverage on or after January 1, 2022, and to all small group health plans subject to 24-A M.R.S. §2808-B issued or renewed through a pooled health insurance market on or after January 1 of the pooled market implementation year.

Section 3. Definitions

The following definitions apply for purposes of this rule:

1. "Affordable Care Act" or "ACA" has the same meaning as in 24-A M.R.S. §14.

2. "Actuarial value" or "AV" means the anticipated covered medical spending paid by a health plan for a standard population for essential health benefit coverage, as defined in 24-A M.R.S. §4320-D(2), computed in accordance with the plan's cost sharing, and divided by the total anticipated allowed charges for essential health benefit coverage provided to a standard population, using the most recent AV calculator published by CMS and any adjustments made by the carrier.

3. "Carrier" has the same meaning as in 24-A M.R.S. §4301-A(3).

4. "HSA plan" means a health plan that is intended to qualify as a high deductible health plan under the federal *Internal Revenue Code* for purposes of eligibility to maintain a tax-exempt Health Savings Account.

5. "Marketplace" means the Maine Health Insurance Marketplace established pursuant to 22 M.R.S. §5403.

6. "Pooled market implementation year" means the implementation year established by the Superintendent pursuant to Chapter 856 of these rules, "Combination of the Individual and Small Business Health Insurance Risk Pools."

Section 4. General Provisions

1. Each plan subject to this rule must be a Clear Choice Plan approved under Section 5 or an Alternative Plan approved under Section 6.

2. Each plan subject to this rule must comply with all applicable benefit and provider mandates under state law and the ACA, including all essential health benefits specified in accordance with 24-A M.R.S. §4320-D. Behavioral health benefits must comply with all applicable parity requirements.

   A. This rule shall not be construed as creating any new or additional benefit or provider mandates. A plan's failure to provide a particular benefit that is identified in a Clear Choice Design, if otherwise permitted by law, does not prevent that plan from conforming to that Clear Choice Design.

   B. Unless a federal waiver is granted, federal requirements preempt conflicting state requirements. In particular, as long as the applicable federal prohibitions remain in force and have not been waived:

      (1) Catastrophic Plans may not be offered to small employers or ineligible individuals;

      (2) Catastrophic Plans may not exempt any services from the deductible when prohibited by the ACA; and

      (3) HSA Plans may not exempt any services from the deductible that are not approved by the federal Internal Revenue Service for pre-deductible coverage by high deductible health plans.

   C. A plan's inclusion of benefits that are not identified in a Clear Choice Design does not prevent that plan from conforming to that Clear Choice Design.

   D. Clear Choice Designs do not address cost-sharing amounts for any out-of-network services. Plans may include any lawful cost-sharing design for out-of-network services, except when network-level cost sharing is

required by law: for example, emergency services, surprise bills, and cases of network inadequacy or unavailability.

E. Two plans shall be treated as different options within a single Clear Choice Design or within a single Alternative Plan Design if they differ only by characteristics that are not specified in the cost-sharing design, or that are expressly permitted to vary, including but not limited to:

(1) Whether the plan includes or excludes pediatric dental benefits, to the extent permitted by law;

(2) Whether the plan is a Silver plan variant providing cost-sharing reductions as determined by the carrier in accordance with the ACA;

(3) Whether the plan is a preferred provider arrangement, a health maintenance organization plan, or a point-of-service health maintenance organization plan;

(4) Whether the plan uses a tiered network. Tiered network plans may be offered as Clear Choice Plans as long as the specified cost sharing is offered at the broadest network tier;

(5) Whether the plan includes an additional tier for low-cost generic prescription drugs, with a lower copayment than the copayment specified for generic drugs; and

(6) Whether the plan incorporates a site-of-service incentive program. A site-of-service incentive benefit may, for example, apply a copayment in place of a deductible or coinsurance that would otherwise apply.

3. Carriers shall discontinue all non-grandfathered small group health plans offered in the year preceding the pooled market implementation year. No such plans may be issued or renewed during the pooled market implementation year, with the exception of any existing plan that the carrier chooses to offer as an Alternative Plan pursuant to Section 6. On renewal, the carrier shall map each policyholder with a discontinued plan to its most similar plan offered in the pooled market in the pooled market implementation year.

A. Except as provided in Paragraph B, the replacement shall be considered a benefit modification required by law in accordance with 24-A M.R.S. §2850-B(3)(I)(3).

B. The carrier must demonstrate, in accordance with 24-A M.R.S. §2850-B(3)(G)(2) or (I)(4), that the discontinuance and replacement is a minor modification or is otherwise in the best interest of policyholders if:

(1) The carrier chooses not to offer a Clear Choice design that is more similar to a discontinued plan than the carrier's designated replacement;

(2) The carrier chooses to map a non-HMO policyholder into an HMO plan, or to map an HMO enrollee that has a point-of-service benefit into an HMO plan without a point-of-service benefit; or

(3) The carrier chooses to map an HMO enrollee into non-HMO coverage.

C. The requirement to discontinue small group plans and replace them with plans approved under this rule does not apply to plans issued to small employers through an association or trustee group that is excluded from the pooled market pursuant to 24-A M.R.S. §2808-B(2)(E)(2) and applicable provisions of the ACA.

4. The discontinuance or modification of a health plan is also considered a benefit modification required by law in accordance with 24 A M.R.S. §2850-B(3)(I)(3) if:

A. The Superintendent discontinues or materially modifies a Clear Choice design and the carrier maps enrollees to a new Clear Choice plan designated by the Superintendent as an appropriate replacement; or

B. The carrier offers new Alternative Plans in the pooled market implementation year that are specifically designed to be marketed to small employers, must discontinue or materially modify one or more existing Alternative Plans in order to do so, and maps those policyholders to new plans in a manner that does not exceed the restrictions set forth in Subsection 3, Paragraph B.

Section 5. Clear Choice Plans

1. The Superintendent shall develop and publish a series of Clear Choice Designs, including at least one at each metal level. A health plan may only be approved as a Clear Choice Plan if the Superintendent determines that it conforms to one of the Clear Choice Designs.

A. The Superintendent shall annually review market experience with the Clear Choice designs, and shall solicit stakeholder input on changes that might be desirable, including potential amendments to this rule. The Superintendent shall consider AV requirements, stakeholder input, value-based plan design, and the need for meaningful differences between plans offered by the same carrier in a given service area. For years in which the individual and small group health markets are pooled, the Superintendent shall ensure the availability of a range of designs intended to meet the needs of individuals and small employers. The Superintendent shall expose any proposed revisions to the Clear Choice designs for public comment, and shall publish the final version in time for carriers to use it in their rate and form filings.

B. If changes to the actuarial value calculator, maximum permissible out-of-pocket expenses, or other federal or state requirements require adjustments to one or more Clear Choice Designs after they have been finalized, and a waiver of the new requirements is not granted, the Superintendent shall make adjustments as necessary to remain in compliance.

C. To facilitate comparison between plans, each Clear Choice Design shall be designated by its metal level, or the term "Catastrophic," and a short descriptive term, except for levels with only one Clear Choice Design.

(1) The descriptive name of any HSA plan design shall include "HSA" and the descriptive name of any Off-Marketplace plan design shall include "Off-Marketplace."

(2) The Superintendent shall develop a comparative table of Clear Choice Plans approved to be offered in Maine, grouped by their respective Clear Choice Designs. The table of plans for the upcoming year shall be published on the Bureau of Insurance website after rates are approved and shall be furnished to the Marketplace.

(3) Carriers may use their own branding for Clear Choice Plans as long as they also identify the applicable Clear Choice Design.

2. Except as otherwise provided in this subsection, any Clear Choice Design or approved Alternative Plan Design may be incorporated into a Qualified Health Plan offered by a carrier on the Marketplace.

A. If a carrier participates in the individual Marketplace, its lowest-price Marketplace Silver plan in any service area must be a Clear Choice Plan.

B. The Superintendent shall develop at least one Silver Clear Choice Design which shall be designated as an Off-Marketplace Plan and which may not be offered on the Marketplace by any carrier. Off-Marketplace Clear Choice Designs shall be developed to provide affordable options for Silver-level coverage for non-subsidized individuals, and, if applicable, for small employers. An Off-Marketplace Clear Choice Design, and any other Silver Clear Choice Design that a carrier chooses not to offer on the Marketplace, shall not be subject to "silver-loading" to reflect the anticipated cost of unreimbursed cost-sharing reductions.

3. A carrier submitting a plan for approval as a Clear Choice Plan shall identify the applicable Clear Choice Design and describe all cost-sharing features not fully specified in that Clear Choice design. The carrier shall provide its AV snapshot calculations as part of the filing submission to demonstrate compliance with the ACA and any necessary adjustments for unique plan design.

4. No new individual or pooled market health plans may be introduced after the deadline announced by the Superintendent for rate and form filings.

5. Clear Choice Plans shall be subject to the following terms and conditions:

A. The specified primary care office visit copayment may be separate from any related laboratory charge from the visit.

B. The plan's deductible shall be applicable to all benefits except as otherwise specified in this rule.

(1) A plan providing family or dependent coverage must provide that if actual charges paid toward the deductible during the year for the entire family meet a family deductible equal to two times the individual deductible, the deductible will be considered satisfied for all family members. The out-of-pocket maximum will work in a similar manner.

(2) Primary care and behavioral health office visits shall be exempt from the deductible to the extent provided in 24-A M.R.S. §4320-A(3), unless an exception is required by Section 4(2)(B).

(3) For all services with a copayment that are not subject to the deductible, the copayment shall accumulate toward the plan's maximum out-of-pocket expense, but not toward the deductible except as required by 24-A M.R.S. §4320-A(3) for primary care and behavioral health office visits.

(4) For services that are subject to both a deductible and a copayment, the full amount of out-of-pocket spending shall accrue toward the deductible until the deductible is satisfied. The copayment shall apply only to services provided after the deductible has been satisfied, or in cases where the amount remaining on the deductible is less than the copayment.

C. Preventive care services shall be covered without copayment, coinsurance, or deductible as required under the ACA. In Clear Choice Designs for HSA plans, if a carrier elects to provide pre-deductible coverage for preventive services beyond the applicable requirements of 24-A M.R.S. §4320-A, it shall include all covered services that the federal Internal Revenue Service has determined to qualify as preventive care for tax purposes, including prescription drugs for certain chronic conditions classified as preventive care for someone with that chronic condition.

D. Office visits for the treatment of mental health, behavioral health, or substance use disorder conditions shall be categorized as Behavioral Health Outpatient Services, regardless of provider type. Outpatient services may be subclassified into office visits and all other outpatient items and services.

E. For prescription drugs in any tier, the cost-share defined is for a standard 30-day supply. Other options for mail order or network pharmacies are

acceptable as long as the basic coverage in the Clear Choice plan is offered.

F. Unless otherwise noted, carriers are permitted to assign a service not specified in the rule to the appropriate benefit category if permissible under state and federal law.

Section 6. Alternative Plan Designs

1. A carrier may request approval, in accordance with this section, to offer up to three Alternative Plan Designs in any plan year.

2. The carrier's application shall be submitted no later than the deadline announced by the Superintendent for rate and form filings, and shall include:

   A. An actuarial certification, including an explanation why the Alternative Plan Design is not expected to promote adverse selection, a description of the significant consumer benefits that are anticipated, and an explanation why those benefits are not available from any Clear Choice Design or from any of the carrier's other Alternative Plan Designs;

   B. Copies of all policy forms the carrier proposes to use in conformance with the Alternative Plan Design, and if there are multiple forms, optional endorsements, or variable language, an explanation why the variations should not be considered distinct plan designs for purposes of this rule; and

   C. If the carrier is proposing to modify or discontinue an Alternative Plan Design already in use, an explanation why the modification or discontinuance is permitted under 24-A M.R.S. §2850-B(3)(G) or (I), including a proposed mapping for existing policyholders.

3. If an Alternative Plan Design is approved, the carrier may only offer it in service areas where the carrier offers at least one Clear Choice Plan in the same metal tier.

Section 7. Severability

If any section, term, or provision of this rule shall be deemed invalid for any reason, any remaining section, provision, or definition shall remain in full force and effect.

Section 8. Effective date

This rule is effective June 8, 2021. The 2022 amendments are effective December 4, 2022.

STATUTORY AUTHORITY:
24-A MRS §§ 212, 2793

AMENDED (EFFECTIVE DATE):
June 8, 2021 – filing 2021-124
December 4, 2022 – filing 2022-232