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| **Maine Bureau of Insurance** |
| Form Filing Review Requirements Checklist |
| TOI - H16I |
| **INDIVIDUAL MAJOR MEDICAL PLANS (NON-GRANDFATHERED)****Inside and Outside the Marketplace****For Plans Issued On or After January 1, 2025** |
| Revised – 4/13/2023 |
| Carriers must confirm compliance and IDENTIFY the LOCATION (Form number, Page number, Section, Paragraph, etc.) of the standard in the form in the last column. Any response of N/A requires that a carrier explain why the requirement is not applicable. |
| This checklist is intended to provide a summary of State and Federal requirements for the TOI listed above. Please see the laws/rules referenced in the checklist below for the full requirement. |

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| **REVIEW REQUIREMENTS** | **REFERENCES** |  | **COMPLIANCE** |
| **GENERAL SUBMISSION REQUIREMENTS** |  |  |  |
| Electronic (SERFF) Filing Requirements: | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)(2) [Bulletin 360](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/360_0.pdf) | All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See http://www.serff.com. |  |
| FILING FEES | [Title 24-A § 601](https://legislature.maine.gov/statutes/24-A/title24-Asec601.html) (17) | $20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report. |  |
| Grounds for disapproval | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Seven categories of the grounds for disapproving a filing. |  |
| Readability | [Title 24-A § 2441](https://legislature.maine.gov/statutes/24-A/title24-Asec2441.html) | Minimum of 50.  Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF. |  |
| Variability of Language | [Title 24-A § 2412](https://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)  [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations. |  |
| NQTL's | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-T(3)(D) | I confirm that, on or before 4/30, we submitted the required comparative analyses to the Market Conduct Division demonstrating how we design and apply nonquantitative treatment limitations (NQTLs), both as written and in operation, for mental health and substance use disorder benefits as compared to how we design and apply NQTLs, as written and in operation, for medical and surgical benefits.  |  |
| **GENERAL POLICY PROVISIONS** |  |  |  |
| AIDS | [Title 24-A § 2750](https://legislature.maine.gov/statutes/24-A/title24-Asec2750.html) | May not provide more restrictive benefits for expenses resulting from Acquired Immune Deficiency Syndrome (AIDS) or related illness. |  |
| Classification, Disclosure, and Minimum Standards | [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | Must comply with all applicable provisions of [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) for Major Medical coverage including, but not limited to, Sections 4, 5, 6(A), 6(F), and Sections 7(A), 7(B), and 7(G). |  |
| Continuity of Care | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(7) | If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. |  |
| Coordination of Benefits provisions (requirement applicable only if policy contains a coordination of benefits provision)Coordination of Benefits with Medicare and Medicaid | [Title 24-A § 2723](https://legislature.maine.gov/statutes/24-A/title24-Asec2723-A.html)-A[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(A) [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(D)[Rule 790](https://www.maine.gov/sos/cec/rules/02/031/031c790.doc) | Provisions relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to Bureau of Insurance [Rule 790](https://www.maine.gov/sos/cec/rules/02/031/031c790.doc).The statute also sets forth how coordination with Medicare and Medicaid is governed. |  |
| Death with Dignity | [Title 22 § 2140](https://legislature.maine.gov/statutes/22/title22sec2140.html)(19) | The sale, procurement or issuance of any health or accident insurance or the rate charged for any health or accident policy may not be conditioned upon or affected by the making or rescinding of a request by a qualified patient for medication that the patient may self-administer to end the patient's life in accordance with the Maine Death With Dignity Act. |  |
| Definition of Medically Necessary | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(10-A) | Forms that use the term "medically necessary" or similar terms must include the following definition verbatim: A. Consistent with generally accepted standards of medical practice; B. Clinically appropriate in terms of type, frequency, extent, site and duration; C. Demonstrated through scientific evidence to be effective in improving health outcomes; D. Representative of "best practices" in the medical profession; and E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. |  |
| Designation of Product Category | [Title 24-A § 2694](https://legislature.maine.gov/statutes/24-A/title24-Asec2694.html)[Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) § 6 | Heading of form filer’s cover letter shall designate intended coverage category. |  |
| Examination, autopsy | [Title 24-A § 2714](https://legislature.maine.gov/statutes/24-A/title24-Asec2714.html)[Title 24-A § 2826](https://legislature.maine.gov/statutes/24-A/title24-Asec2826.html) | The following must be included:Physical examination and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. |  |
| Explanations for any Exclusion of Coverage for work related sicknesses or injuries | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(15) | If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws. |  |
| Explanations Regarding DeductiblesHigh Deductible Plans & HSAs | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(15)[45 CFR § 156.130](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1130)[45 CFR § 156.130](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1130) | All policies must include clear explanations of all of the following regarding deductibles:Whether it is a calendar or policy year deductible.Clearly advise whether non-covered expenses apply to the deductible.Clearly advise whether it is a per person or family deductible or both.Cost sharing for non-calendar plans accrues for a 12-month period, and ensuring that an enrollee only has to accumulate cost sharing towards one annual limitation on cost sharing.The annual limitation cost sharing is to apply on an annual basis regardless of whether it is a calendar year or a non-calendar year plan.Family high deductible health plans that count the family’s cost sharing to the deductible limit can continue to be offered under this policy. The only limit will be that the family high deductible health plan cannot require an individual in the family plan to exceed the annual limitation on cost sharing for self-only coverage. |  |
| Format of Policy | [Title 24-A § 2703](https://legislature.maine.gov/statutes/24-A/title24-Asec2703.html) | Time, place, and amount of premium payment required, Effective and Termination Date required, Name of Insured(s) required. Each form, including riders and endorsements, which comprise the contract, shall be identified by a form number in the lower left hand corner of the first page thereof. |  |
| Genetic information (GINA) Protections | PHSA § 2753([74 Fed Reg 51664](https://www.federalregister.gov/documents/2009/10/07/E9-22504/interim-final-rules-prohibiting-discrimination-based-on-genetic-information-in-health-insurance), [45 CFR § 148.180](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1180))[Title 24-A § 2159](https://legislature.maine.gov/statutes/24-A/title24-Asec2159-C.html)-C(2) | An issuer is not allowed to adjust premiums based on genetic information; request/require genetic testing; collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for underwriting purposes. |  |
| Grace Period | [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707.html) | The policy must include a “Grace period” of not less than 7 days for weekly premium, 10 days for monthly premium, and 31 days for all other policies. |  |
| Guaranteed issue and renewalGuaranteed renewable | [Title 24-A § 2736](https://legislature.maine.gov/statutes/24-A/title24-Asec2736-C.html)-C[Title 24-A § 4319](https://legislature.maine.gov/statutes/24-A/title24-Asec4319-A.html)-A PHSA § 2702 ([45 CFR § 148.122](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1122)) | Requires guaranteed issue and renewal.May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership. |  |
| Health plan accountability | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) | Standards in this rule include, but are not limited to, required provisions for grievance and appeal procedures, emergency services, and utilization review standards. |  |
| Intoxicants and narcotics | [Title 24-A § 2728](https://legislature.maine.gov/statutes/24-A/title24-Asec2728.html)[Title 24-A § 2829](https://legislature.maine.gov/statutes/24-A/title24-Asec2829.html)(3) | Policies cannot contain the following provision: “2728 and narcotics. The insurer is not liable for any loss sustained or contracted in consequence of the insured’s being intoxicated or under the influence of any narcotic or of any hallucinogenic drug, unless administered on the advice of a physician.” |  |
| Legal Actions | [Title 24-A § 2715](https://legislature.maine.gov/statutes/24-A/title24-Asec2715.html) | There shall be a provision as follows:Legal actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished. |  |
| Lifetime Limits and Annual Dollar Limits Prohibited - Lifetime or annual limits on the dollar value of Essential Health Benefits (EHB): \*2023 Plan Year Limits: Use current maximum out-of-pocket limits as prescribed by CMS final rule. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html) PHSA § 2711 ([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual),[45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1126).126) | A carrier offering an individual, small group or large group health plan, may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or annual limits on the dollar value of essential benefits. Plans may not establish lifetime limits on the dollar value of essential health benefits: Ambulatory patient services, Emergency services, Hospitalization Maternity and newborn care, Mental health, and substance use disorder services, including behavioral health treatment, Prescription drugs Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services and chronic disease management, Pediatric services, including oral and vision care Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply. |  |
| Limitations & Exclusions | [45 CFR § 156.115](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1115) [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(N) | Limitations and exclusions must be substantially similar or more favorable to the insured in the Maine EHB benchmark plan. A plan may contain exclusions approved by the Superintendent that are not otherwise prohibited by state or federal law, rule, or regulation. Unless otherwise directed by the Superintendent, HMO plans may contain exclusions similar to exclusions permitted in non-HMO plans that provide Essential Healthcare Benefits in accordance with the Affordable Care Act. |  |
| Notice of Policy Changes and Modifications | [Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850.html)(B)(3)(I)PHSA 2715 ([75 Fed Reg 41760](https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of)) | A carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. Provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits. |  |
| Notice of Rate Increase | [Title 24-A § 2735-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2735-A.html)[Title 24-A § 2839](https://legislature.maine.gov/statutes/24-A/title24-Asec2839-A.html)-A | Requires that insurers provide a minimum of 60 days written notice to policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. See statute for the requirements for the notice. |  |
| Notification prior to cancellation; restrictions on cancellation, termination or lapse due to cognitive impairment or functional incapacity | [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html)-A [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) | An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium. Insurers must provide the following disclosure, notice and reinstatement rights:1. Insured has the right to elect a third party to receive notice and that the insurer will send them a third party notice request form to make that selection.2. Insured and designated individual will receive a 10 day notice of cancellation.3. Insured has the right to reinstatement of the contract if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured’s nonpayment of premium or other lapse or default on the part of the insured.4. Notice that if a request for reinstatement of coverage because of cognitive impairment or functional incapacity is denied, notice of denial shall be provided to the insured and to the person making the request, if different. The notice of denial shall include notification of the 30 day period following receipt of the notice during which a hearing before the Superintendent may be requested. |  |
| Penalty for failure to notify of hospitalization prohibited | [Title 24-A § 2749-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-A.html) | A policy may not include a provision permitting the insurer to impose a penalty for the failure of any person to notify the insurer of an insured person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22 § 1829. |  |
| PPOs – Payment for Non-preferred Providers (as applicable) | [Title 24-A § 2677-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2677-A.html) | There cannot be more than a 20% differential in benefits between preferred and non-preferred providers. Superintendent can grant waiver for the 20%, in particular for designated providers for cost or quality. |  |
| Prohibited practices Rescissions prohibited | [Title 24-A § 2736](https://legislature.maine.gov/statutes/24-A/title24-Asec2736.html)-C(3)(A)[Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850-B.html)-B(3) PHSA § 2712([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1128).128) | An enrollee may not be cancelled or denied renewal except for fraud or material misrepresentation and/or failure to pay premiums for coverage. Coverage may not be rescinded for an individual, a group or eligible members and their dependents in those groups once an individual, a group or eligible members and their dependents in those groups are covered under an individual or group health plan, except for an act or practice that constitutes fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the health plan to the extent consistent with [Title 24-A § 2411](https://legislature.maine.gov/statutes/24-A/title24-Asec2411.html).Rescissions are prohibited except in cases of fraud or intentional misrepresentation of material fact. Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected. |  |
| Prohibition against Absolute Discretion Clauses | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (11) | Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements. |  |
| Prohibition on Discrimination | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-L.html)-L 45 CFR § 156.1259(a) | 1. Nondiscrimination. An individual may not, on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability, be excluded from participation in, be denied benefits of or otherwise be subjected to discrimination under any health plan offered in accordance with this Title. A carrier may not in offering, providing or administering a health plan:A. Deny, cancel, limit or refuse to issue or renew a health plan or other health-related coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability;B. Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability in a health plan or other health-related coverage;C. Deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;D. Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; orE. Otherwise deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual. Nothing in this subsection is intended to determine or restrict a carrier from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.2. Meaningful access for individuals with limited English proficiency. A carrier shall take reasonable steps to provide meaningful access to each enrollee or prospective enrollee under a health plan who has limited proficiency in English.3. Effective communication for persons with disabilities. A carrier shall take reasonable steps to ensure that communication with an enrollee or prospective enrollee in a health plan who is an individual with a disability is as effective as communication with other enrollees or prospective enrollees. |  |
| Prohibition on preexisting condition exclusions | [Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850.html)(2) PHSA § 2704PHSA § 1255([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1108).108) | A policy may not impose a preexisting condition exclusion. Prohibits the imposition of a preexisting condition exclusion by all group plans and non-grandfathered individual market plans. |  |
| Rate Filing | [Title 24-A § 2736](https://legislature.maine.gov/statutes/24-A/title24-Asec2736.html) | Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701. If the filing applies to individual health plans as defined in section 2736-C, the insurer shall simultaneously file a copy with the Attorney General. Every such filing must state the effective date of the filing. Every such filing must be made not less than 60 days in advance of the stated effective date, unless the 60-day requirement is waived by the superintendent, and the effective date may be suspended by the superintendent for a period of time not to exceed 30 days. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. PLEASE NOTE: Rates must be filed simultaneously with the forms. Forms submitted in advance of rates, will not be approved until rates have been filed, reviewed and approved. If forms are being revised and there is no effect on current rates, please indicate so in the filing cover letter. |  |
| Rebates | [Title 24-A § 2160](https://legislature.maine.gov/statutes/24-A/title24-Asec2160.html)[Title 24-A § 2163-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2163-A.html)[Bulletin 426](https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/426.pdf)[Bulletin 382](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/382.pdf) | Are there any provisions that give the insured a benefit not associated with indemnification or loss? Yes \_\_\_No \_\_\_ |  |
| Reinstatement | [Title 24-A § 2708](https://legislature.maine.gov/statutes/24-A/title24-Asec2708.html) | There shall be a provision that if any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. |  |
| Renewal provision | [Title 24-A § 2738](https://legislature.maine.gov/statutes/24-A/title24-Asec2738.html)[Title 24-A § 2820](https://legislature.maine.gov/statutes/24-A/title24-Asec2820.html) | Policy must contain the terms under which it can/ cannot be renewed. Must be placed prominently on the first page. |  |
| Required disclosures (Summary of Benefits and Coverage) | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(15)PHSA § 2715 [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1200).200 [45 CFR § 156.420](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1420)(h) | All insurers must provide a Summary of Benefits and Coverage and Uniform Glossary to enrollees. Please see http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html for forms and instructions. For each silver health plan that an issuer offers, or intends to offer in the individual market on the Exchange, the issuer must submit annually to the Exchange for certification prior to each benefit year the standard silver plan and three cost sharing reduction plans. A carrier offering a health plan in this State shall: A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; and B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act. |  |
| Right to Examine and Return Policy ("free look period") | [Title 24-A § 2717](https://legislature.maine.gov/statutes/24-A/title24-Asec2717.html) | The policy, or a separate rider attached thereto when delivered, must include a provision stating that the person being issued the policy must be permitted to return the policy within 10 days of delivery to such person and to have a refund of premium paid if not satisfied with the policy for any reason after examining it. The policy may be returned to the insurer at its home or branch office to the agent through whom it was applied for, and shall be void from the beginning, as if the policy had not been issued. The provision must be under an appropriate caption in the policy, and if it’s not printed on the face page, adequate notice of the provision must be printed or stamped conspicuously on the face page. |  |
| Time Limit on Certain Defenses | [Title 24-A § 2706](https://legislature.maine.gov/statutes/24-A/title24-Asec2706.html)   | After 3 years from the date of issue of policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, commencing after the expiration of such 3-year period. |  |
| UCR Required Disclosure | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (8) | Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment and provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. |  |
| **ELIGIBILITY / ENROLLMENT** |  |  |  |
| Annual Open Enrollment/Special Enrollment Periods – INDIVIDUALAnnual Open Enrollment/Special Enrollment Periods - SHOP | [Title 24-A § 2736](https://legislature.maine.gov/statutes/24-A/title24-Asec2736-C.html)-C(11) [45 CFR § 155.410](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.155&rgn=div5#se45.1.155_1410)[45 CFR § 155.420](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.155&rgn=div5#se45.1.155_1420)[45 CFR § 155.725](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.155&rgn=div5#se45.1.155_1725)[45 CFR § 155.725](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.155&rgn=div5#se45.1.155_1725)(g) | Individual:A carrier may restrict enrollment in individual health plans to open enrollment periods and special enrollment periods to the extent not inconsistent with applicable federal law. Must provide an annual open enrollment period that begins November 1, and extends through December 15, annually.Must also provide a written annual open enrollment notification to each enrollee no earlier than September 1, and no later than September 30.Must provide special enrollment periods consistent with this section, during which qualified individuals may enroll. A qualified individual or enrollee has 60 days for individuals from the date of a triggering event to select a plan.Also applies to off-marketplace plans.Employer:Enrollment periods under SHOP for plan years beginning on or after January 1, 2018.(a) General requirements. The SHOP must ensure that issuers offering QHPs through the SHOP adhere to applicable enrollment periods, including special enrollment periods.(b) Rolling enrollment in the SHOP. The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage, unless the plan is issued in a State that has elected to merge its individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act, in which case the plan year will end on December 31 of the calendar year in which coverage first became effective.(c) Special enrollment periods. (1) The SHOP must ensure that issuers offering QHPs through the SHOP provide special enrollment periods consistent with the section, during which certain qualified employees or dependents of qualified employees may enroll in QHPs and enrollees may change QHPs.(2) The SHOP must ensure that issuers offering QHPs through a SHOP provide a special enrollment period for a qualified employee or a dependent of a qualified employee who;(i) Experiences an event described in §155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in §155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);(ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act; or(iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).(3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:(i) Thirty (30) days from the date of a triggering event described in paragraph (c)(2)(i) of this section to select a QHP through the SHOP; and(ii) Sixty (60) days from the date of a triggering event described in paragraph (c)(2)(ii) or (iii) of this section to select a QHP through the SHOP;(4) A dependent of a qualified employee is not eligible for a special enrollment period if the employer does not extend the offer of coverage to dependents.(5) The effective dates of coverage for special enrollment periods are determined using the provisions of §155.420(b).(6) Loss of minimum essential coverage is determined using the provisions of §155.420(e).(d) Limitation. Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under §155.706(b)(10).(e) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2018.Must provide notification to a qualified employee of the annual open enrollment period in advance of such period.Also applies to off-marketplace plans. |  |
| Child-Only coverage | ACA 1302(d) PHSA § 2707(c) [45 CFR § 156.200](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1200)(c)(2) | Must provide the same level of coverage, as described in the Affordable Care Act, to individuals who, as of the beginning of the plan year, have not attained the age of 21. The carrier does not need to file a separate child-only plan. The carrier may provide the following notice predominantly displayed on the first page of the policy: "THIS [POLICY OR CERTIFICATE] IS ALSO AVAILABLE AS A CHILD ONLY [POLICY OR CONTRACT]. |  |
| Domestic partner benefits | [Title 24-A § 2741](https://legislature.maine.gov/statutes/24-A/title24-Asec2741-A.html)-A | Contracts must make available to policyholders the option for additional benefits for the domestic partner of a policyholder at appropriate rates and under the same terms and conditions as are provided to spouses of married policyholders. This section provides criteria defining "domestic partner" for purposes of this requirement and what evidence may be required as a condition of eligibility. |  |
| Extension of dependent coverage to age 26 | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-B.html)-BPHSA § 2714([75 Fed Reg 27122](https://www.federalregister.gov/documents/2010/05/13/2010-11391/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-dependent), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1120).120) | A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act. An insurer shall provide notice to policyholders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrolment periods and notice of the insurer’s definition of and benefit limitations for preexisting conditions. Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: financial dependency on primary subscriber, residency, student status, employment, eligibility for other coverage, marital status. Terms of the policy for dependent coverage cannot vary based on the age of a child. |  |
| Ensure Health Insurance for Certain Adults with Disabilities | [Title 24-A § 2742](https://legislature.maine.gov/statutes/24-A/title24-Asec2742-B.html)-B(2)[Title 24-A § 2742](https://legislature.maine.gov/statutes/24-A/title24-Asec2742-C.html)-C[Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833-B.html)-B(2)[Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833-C.html)-C[Title 24-A § 4233-B](https://legislature.maine.gov/statutes/24-A/title24-Asec4233-B.html)(2)[Title 24-A § 4233-C](https://legislature.maine.gov/statutes/24-A/title24-Asec4233-C.html)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-B [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-R-1.html)-R | This act applies to:1. Individual health insurance policies,2. group health insurance policies,3. individual or group health maintenance organization contracts, and4. health insurance plans subject to the requirements of the Federal Affordable Care Act.-The act requires health insurance policies that offer coverage for a dependent child to offer coverage for adults with disabilities who are unable to sustain themselves through employment in the same manner as for a dependent child on a parent’s policy. The law clarifies that an insurer is required to offer coverage for a dependent child with a disability, at the option of the policyholder, regardless of age.A. Definition of "Disability": A disability is a physical, mental, intellectual or developmental disability that renders a person incapable of self-sustaining employment. B. Proof of disability. A policyholder shall furnish proof of a dependent child's disability to the insurer within 31 days of the dependent child's attainment of the limiting age established in the statute and subsequently as may be required by the insurer, but the insurer may not require proof more frequently than annually after the 2-year period following the dependent child's attainment of the limiting age. |  |
| Provide Consistency in the Laws Regarding Domestic Partners | [Title 24-A § 2319-A](https://www.mainelegislature.org/legis/statutes/24/title24sec2319-A.html)(4)[Title 24-A § 2319-A](https://www.mainelegislature.org/legis/statutes/24/title24sec2319-A.html)(6)[Title 24-A § 2741](https://legislature.maine.gov/statutes/24-A/title24-Asec2741.html)-A(4)[Title 24-A § 2741](https://legislature.maine.gov/statutes/24-A/title24-Asec2741-A.html)-A(6)[Title 24-A § 2832](https://legislature.maine.gov/statutes/24-A/title24-Asec2832-A.html)-A(4)[Title 24-A § 2832](https://legislature.maine.gov/statutes/24-A/title24-Asec2832.html)-A(6)[Title 24-A § 4249](https://legislature.maine.gov/statutes/24-A/title24-Asec4249.html)(4)[Title 24-A § 4249](https://legislature.maine.gov/statutes/24-A/title24-Asec4249.html)(6) | Titles 24 and 24-A M.R.S. are amended to reflect the definition of “domestic partner,” as set forth in 1 MRSA §72, sub-§2-C. 1. Definition. "Domestic partner" means one of 2 unmarried adults who are domiciled together under long-term arrangements that evidence a commitment to remain responsible indefinitely for each other's welfare.2. 12-Month Waiting Periods Repealed. There is no longer a 12-month waiting period for a subscriber to enroll a new domestic partner after terminating coverage for a prior domestic partner. |  |
| **CLAIMS** |  |  |  |
| Assignment of benefits | [Title 24-A § 2755](https://legislature.maine.gov/statutes/24-A/title24-Asec2755.html) | All policies providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy. |  |
| Calculation of health benefits based on actual cost | [Title 24-A § 2185](https://legislature.maine.gov/statutes/24-A/title24-Asec2185.html) | If the insurer has negotiated discounts with providers, the insurer must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. |  |
| Claim Forms | [Title 24-A § 2710](https://legislature.maine.gov/statutes/24-A/title24-Asec2710.html) | The policy must include the “Claim forms” provision set forth in Section 2710. |  |
| Claims for Office Visits that include Preventive Health Services | [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1130).130 (a)(1) [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(15) | Policies and certificates must include clear explanations regarding how claims will be paid for office visits that include preventive health services, and the policyholder’s cost sharing may not be greater than the following:If an item or service described in 45 CFR §147.130 (a)(1):1. Is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. 2. Is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.Services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan. |  |
| Credit toward Deductible | [Title 24-A § 2723](https://legislature.maine.gov/statutes/24-A/title24-Asec2723.html)-A(3) | When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan. |  |
| Explanation and notice to parent | [Title 24-A § 2713](https://legislature.maine.gov/statutes/24-A/title24-Asec2713-A.html)-A | If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent; An explanation of any proposed change in the terms and conditions of the policy; Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified. In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy. |  |
| Limitations on Cost Sharing | [45 CFR § 156.130](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1130) | The annual limitation on cost sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only. In both of these cases, an individual’s cost sharing for EHB may never exceed the self-only annual limitation on cost sharing. |  |
| Limits on priority liens/subrogation | [Title 24-A § 2729](https://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html)-A | No policy shall provide for priority over the insured member of payment for any hospital, nursing, medical or surgical services, or of any expenses paid or reimbursed under the policy, in the event the insured member is entitled to receive payment reimbursement from any other person as a result of legal action or claim, except as provided in this section. A policy may contain a provision that allows such payments, if that provision is approved by the superintendent, and if that provision requires the prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. A just and equitable basis shall mean that any factors that diminish the potential value of the insured's claim shall likewise reduce the share in the claim for those claiming payment for services or reimbursement. |  |
| Maximum Allowable Charges | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(8) | If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must: (1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and (2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. Must clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment and provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred. |  |
| Notice of claim | [Title 24-A § 2709](https://legislature.maine.gov/statutes/24-A/title24-Asec2709.html) | There shall be a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.In a policy providing a loss-of-time benefit which may be payable for at least 2 years, an insurer may, at its option, add additional language to the required “Notice of claim” provision, as provided in Section 2709. |  |
| Penalty for noncompliance with utilization review | [Title 24-A § 2749-B](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-B.html) | A health insurance policy issued or renewed in this State after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than $500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary. |  |
| Primary health services | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A | Applicable to an individual or small group health plan:The plan must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year.The plan may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copays for the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year count toward the deductible.Exception: this requirement does not apply to a plan offered for use with a health savings account (HSA) unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). |  |
| Protection from Balance Billing | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (8-A) | If the carrier has a provider network, an enrollee's responsibility for payment under a managed care plan when covered health care is rendered by participating providers must be limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance. If the enrollee has paid their share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. |  |
| Protection from Surprise Bills | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-C.html)-C[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-E.html)-E[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-F.html)-FRule 365 | With respect to a “surprise bill” (defined below) or a bill for covered emergency services rendered by an out-of-network provider:1. A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider. The carrier shall calculate any coinsurance amount based on the median network rate for that service per paragraph B. 2. If a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent.3. Until December 31, 2023, unless the carrier and out-of-network provider agree otherwise, a carrier shall reimburse an out-of-network provider for ambulance services that are covered emergency services at the rate required by section 4303-F. |  |
| Referrals by Direct Primary Care Providers | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(22) [Bulletin 434](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/434.pdf) | A plan requiring a referral from a participating primary care provider to receive a health care service covered under a health plan must provide that a referral made by a direct primary care provider (defined below) who has a direct primary care service agreement (defined below) with an enrollee will be honored on the same terms as a referral made by a participating primary care provider. A carrier may not deny payment for any covered health care service solely on the basis that the enrollee's referral was made by a direct primary care provider who is not a member of the carrier's provider network. |  |
| Timely Payment of Undisputed Insurance Claims | [Title 24-A § 2436](https://legislature.maine.gov/statutes/24-A/title24-Asec2436.html)[Title 24-A § 4207](https://legislature.maine.gov/statutes/24-A/title24-Asec4207.html)[Title 24-A § 4222-B](https://legislature.maine.gov/statutes/24-A/title24-Asec4222-B.html)(13)[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx)(9)(C)(4) | An undisputed claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer An ”undisputed claim” means a manually or electronically submitted claim from a health care provider or health care facility that:A. Contains all the required data elements necessary for accurate adjudication without the need for additional information;B. Is not materially deficient or improper, including lacking substantiating documentation required by the carrier; andC. Has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the carrier. |  |
| Utilization Review & Notice Requirements for Health Benefit Determinations | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(16)[Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)[Bulletin 397](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/397.pdf) | Initial determinations: Prior authorization of nonemergency services: Except for a request in exigent circumstances, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with the following: Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. If the carrier responds to a request with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information. If the carrier responds that outside consultation is necessary before making a decision, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier’s initial response. The prior authorization standards used by a carrier must be clear and readily available. A provider must make best efforts to provide all information necessary to evaluate a request, and the carrier must make best efforts to limit requests for additional information. If a carrier does not grant or deny a request for prior authorization within these timeframes, the request is granted. Urgent care determinations: Expedited review in exigent circumstances When exigent circumstances exist, a carrier must answer a prior authorization request no more than 24 hours after receiving the request. [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html)(1-A)(B) (enacted by P.L. 2019, ch.5).Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug. The carrier must notify the enrollee, the enrollee’s designee if applicable, and the provider of its coverage decision. Concurrent review determinations: Determination shall be within 1 working day after obtaining all necessary information. Certification of Extended stay or additional services: Shall notify the covered person and the provider rendering the service within 1 working day. Written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services. Adverse benefit determination of concurrent review the carrier shall: Notify the covered person and the provider rendering the service within 1 working day. Continue the service without liability to the covered person until the covered person has been notified of the determination Utilization Review Disclosure Requirements The carrier shall include a clear and reasonably comprehensive description of its utilization review procedures, including: Procedures for obtaining review of adverse benefit determinations; A Statement of rights and responsibilities of covered persons with respect to those procedures in the certificate of coverage or member handbook; The statement of rights shall disclose the member’s right to request in writing and receive copies of any clinical review criteria utilized in arriving at any adverse health care treatment decision. Carrier shall include a summary of its utilization review procedures in materials intended for prospective covered persons; Carriers requiring enrollees to initiate utilization review provide on its membership cards a toll-free telephone number to call for utilization review decisions. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act. Notices advising enrollees that services have been determined to be medically necessary must also advise whether the service is covered. Once a service has been approved, the approval cannot be withdrawn retrospectively unless fraudulent or materially incorrect information was provided at the time prior approval was granted. Also, if benefits are denied and the enrollee appeals, the carrier cannot deny the appeal without a written explanation addressing the issues that were raised by the enrollee. |  |
| Enhance Access to a Second Opinion for Health Care Services or Treatment | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(25) | An enrollee in a health plan may not be required to obtain a 2nd opinion from a provider that practices in the same office location as the enrollee's provider, even if that office is the only in-network provider for the service. A carrier may not apply a greater deductible, coinsurance or copayment for the 2nd opinion than if they received the 2nd opinion in-network.  |  |
| Expedite the Health Insurance Referral Process for Specialists by Allowing Referrals During Urgent Care Visits | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301.html)-A(2-A)[Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(21)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(22-A) | A carrier may not deny payment for any covered behavioral health care service or physical therapy service solely on the basis that the referral was made during an urgent care visit. A carrier may not apply greater cost sharing for an urgent care referral than a primary care referral. |  |
| Prior Authorization Requirements for Physical and Occupational Therapy Services | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(1)[Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)-A | A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care. This does not limit the right of a carrier to deny a claim when an appropriate review concludes that the services or treatment were not medically necessary. |  |
| **GRIEVANCES & APPEALS** |  |  |  |
| Clinical peer definition | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301.html)-A(4)[Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(7) | An appeal of a carrier’s adverse health care treatment decision must be conducted by a clinical peer.  The clinical peer may not have been involved in making the initial adverse health care treatment decision unless information not previously considered during the initial review is provided on appeal.  An adverse health care treatment decision does not include a carrier’s rescission determination or initial coverage eligibility determination. “Clinical peer” means a physician or other licensed health care practitioner who holds a nonrestricted license in a state in the U.S., is board certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of the carrier. |  |
| External review requests | [Title 24-A § 4312](https://legislature.maine.gov/statutes/24-A/title24-Asec4312.html)[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx)PHSA § 2719([75 Fed Reg 43330](https://www.federalregister.gov/documents/2010/07/23/2010-18043/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-internal-claims), [76 Fed Reg 37208](https://www.federalregister.gov/documents/2011/06/24/2011-15890/group-health-plans-and-health-insurance-issuers-rules-relating-to-internal-claims-and-appeals-and), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1136).136) | An enrollee is not required to exhaust all levels of a carrier's internal grievance procedure before filing a request for external review if the carrier has failed to make a decision on an internal grievance within the time period required, or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law, or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal. Claimant must have at least 1 year to file for external review after receipt of the notice of adverse benefit determination. External review of an adverse benefit determination for: medical necessity; appropriateness; health care setting; level of care; effectiveness of a covered benefit; and rescission. External review of adverse benefit determinations for experimental or investigational treatments or services. Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. |  |
| Grievance and Appeal Procedures | [Title 24-A § 2747](https://legislature.maine.gov/statutes/24-A/title24-Asec2747.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(4)[Title 24-A § 4312](https://legislature.maine.gov/statutes/24-A/title24-Asec4312.html)[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 8 [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 9 | All policies must specify all grievance and appeals procedures contained in [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx), including 1) procedures for review decisions; 2) requests for reconsideration; 3) the first and second level appeals of adverse health care treatment decisions, including expedited first level appeals; 4) the first and second level appeals of adverse benefit determinations not involving heath care treatment decisions, 5) the right to external review, and 6) the right to file a grievance regarding policy provisions or denial of benefits. PLEASE REFER TO [RULE 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) FOR FULL COMPLIANCE CRITERIA. |  |
| Right to waive the right to a second level appeal/grievance | [Title 24-A § 4312](https://legislature.maine.gov/statutes/24-A/title24-Asec4312.html) | Enrollees have the right to waive the right to a second level appeal/grievance and request an external review after the first level appeal decision. |  |
| Termination of ongoing course of treatment | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(4)(E) | Health plans may not reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with section 4312. |  |
| Timeline for second level grievance review decisions | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(4) | Decisions for second level grievance reviews must be issued within 30 calendar days if the insured has not requested to appear in person before authorized representatives of the health carrier. |  |
| **PROVIDERS / NETWORKS** |  |  |  |
| Acupuncture Services | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-B.html)-B | Policies that provide coverage for acupuncture must cover those services when performed by an acupuncturist licensed in Maine under the same conditions that apply to the services when performed by a licensed physician. |  |
| Certified nurse practitioners, certified midwives, and certified nurse (aka: Advanced midwives Practice Registered Nurse) | [Title 24-A § 2757](https://legislature.maine.gov/statutes/24-A/title24-Asec2757.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(5) | Coverage for services provided by nurse practitioners, certified midwives, and certified nurse midwives and allows nurse practitioners to serve as primary care providers. |  |
| Coverage for Services Provided by Certified Registered Nurse Anesthetists | [Title 24-A § 4320](https://legislature.maine.gov/legis/statutes/24-A/title24-Asec4320-Q.html)-Q | Coverage for services provided by certified registered nurse anesthetists (CRNA) is required. |  |
| Coverage for services provided by registered nurse first assistants | [Title 24-A § 2758](https://legislature.maine.gov/statutes/24-A/title24-Asec2758.html) | Benefits must be provided for coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. |  |
| Dental hygiene therapist | [Title 24-A § 2765](https://legislature.maine.gov/statutes/24-A/title24-Asec2765-A.html)-A[Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-U.html)-U | 1. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental hygiene therapist licensed under Title 32, chapter 16, subchapter 3-C when those services are covered services under the contract and when they are within the lawful scope of practice of the dental hygiene therapist.2.  Limits; coinsurance; deductibles.   A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section. 3.  Coordination of benefits with dental insurance.   If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer. 4.  Application.   The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2015 in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. |  |
| Dentists | [Title 24-A § 2437](https://legislature.maine.gov/statutes/24-A/title24-Asec2437.html) | Must include benefits for dentists’ services to the extent that the same services would be covered if performed by a physician. |  |
| Enrollee choice of PCP | [Title 24-A § 4306](https://legislature.maine.gov/statutes/24-A/title24-Asec4306.html) | A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A to serve as primary care providers for managed care plans. |  |
| Essential Health Care Providers (Rural health clinics)Essential Community Providers | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 745 CFR § 156.235 | Benefits must be made available for outpatient health care services of certified rural health clinics. A QHP must have a sufficient number of essential community providers, where available. |  |
| Inadequate Network | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 7(B)(5) | If the carrier has an insufficient number or type of participating providers to provide a covered benefit, the carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers. |  |
| Independent Practice Dental Hygienists | [Title 24-A § 2765](https://legislature.maine.gov/statutes/24-A/title24-Asec2765.html)[Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-Q.html)-Q | Coverage must be provided for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist. |  |
| Naturopathic doctor | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-K.html)-K | Must provide coverage for health care services performed by a naturopathic doctor licensed in this State when those services are covered services under the plan when performed by any other health care provider and those services are within the lawful scope of practice of the naturopathic doctor. Any deductible, copayment or coinsurance cannot exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers. |  |
| Network adequacy | [Title 24-A § 2673-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2673-A.html)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(1)[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx)(7)[Rule 360](https://www.maine.gov/sos/cec/rules/02/031/031c360.doc) | All managed care arrangements except MEWA’s must be filed for adequacy and compliance with [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) and [Rule 360](https://www.maine.gov/sos/cec/rules/02/031/031c360.doc) access standards. If the policy uses a network, the network(s) need to have been approved by the Bureau for adequacy and access standards (i.e. physician, hospital, and ancillary service networks).Must provide a copy of network approval. |  |
| Pharmacy Providers – “Any Willing Pharmacy” | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317.html) | A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers. |  |
| Physician assistants | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-O.html)-O | Must provide coverage for health care services performed by a physician assistant licensed in this State when those services are covered services under the plan when performed by any other health care provider and those services are within the lawful scope of practice of the physician assistant. |  |
| Provider directories | [45 CFR § 156.230](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1230)[Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-D.html)-D | A QHP must submit its provider directory to the Exchange electronically and make a printed version available to potential enrollees upon request. The directory must identify providers that are not accepting new patients, update directory monthly, post electronically accurate current directory for each network plan, provide a print copy upon request, etc. |  |
| **GENERAL HEALTH CARE TREATMENT / COVERAGE** |  |  |  |
| Abortion services | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-M-1.html)-M | A health plan that provides coverage for maternity services must provide coverage for abortion services in accordance with the following:no deductible, copayment, coinsurance or other cost-sharing requirement for the costs of abortion services allowed. However, the plan may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements of this law. Reasonable limitations include where an insured knowingly goes to an out-of-network provider when an in-network provider was available. |  |
| Anesthesia for Dentistry | [Title 24-A § 2760](https://legislature.maine.gov/statutes/24-A/title24-Asec2760.html) | Anesthesia & associated facility charges for dental procedures are mandated benefits for certain vulnerable persons. |  |
| Breast reduction and symptomatic varicose vein surgery | [Title 24-A § 2761](https://legislature.maine.gov/statutes/24-A/title24-Asec2761.html) | Coverage must be offered for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary |  |
| Chiropractic Services/Manipulative Therapy | [Title 24-A § 2748](https://legislature.maine.gov/statutes/24-A/title24-Asec2748.html) | Must provide benefits for care by chiropractors at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. Therapeutic, adjustive and manipulative services must be covered if performed by an allopathic, osteopathic or chiropractic doctor. |  |
| Clinical Trials | [Title 24-A § 4310](https://legislature.maine.gov/statutes/24-A/title24-Asec4310.html)PHSA § 2709 | A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. A non-grandfathered health plan may not discriminate on the basis of participation in a clinical trial and must cover routine patient costs of individuals in clinical trials for treatment of cancer or other life-threatening conditions. |  |
| Colorectal Cancer Screening | [Title 24-A § 2763](https://legislature.maine.gov/statutes/24-A/title24-Asec2763.html) | Coverage must be provided for colorectal cancer screening for asymptomatic individuals who are: At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society; or At high risk for colorectal cancer. “Colorectal cancer screening” means all colorectal cancer examinations and laboratory tests recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society. If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure. |  |
| Comprehensive Health Coverage; Essential Health Benefits | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-D.html)-DACA 1302(b) | A carrier offering a health plan in this State shall, at a minimum, provide coverage that incorporates an essential health benefits package consistent with the requirements of this section. All non-grandfathered individual and small group plans must provide essential health benefits. SEE SEPARATE CHECKLIST FOR SPECIFIC BENEFITS. |  |
| Dental benefit waiting period | [Title 24-A § 2766](https://legislature.maine.gov/statutes/24-A/title24-Asec2766-A.html)-A[Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-W.html)-W | Coverage for dental services may not impose a waiting period for any dental or oral health service or treatment, except for orthodontic treatment, for an enrollee if the enrollee is under 19 years of age.For purposes of this statute, “waiting period” means a period of time after the date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.  24-A M.R.S. § 2848(5). |  |
| Emergency Services, definitions of “Emergency Services” and “Emergency Medical Condition” – Must be Verbatim | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(4-A) & (4-B) [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(5) [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-C.html)-C[Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) Sec 5PHSA §2719A([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual),45 CFR §147.138)SSA §1395dd | The plan must cover emergency services without prior authorization.  Cost-sharing requirements, such as a deductible, copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network , and any payment made by an enrollee pursuant to this section must be applied to the enrollee's in-network cost-sharing limit. The enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)-C (as amended by PL 2019, Ch. 668) or, if there is a dispute, in accordance with [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)-E (as enacted by PL 2019, Ch. 668).“Emergency service” means a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe: A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:(1) Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;(2) Serious impairment of a bodily function; or(3) Serious dysfunction of any organ or body part; or B. With respect to a pregnant woman who is having contractions, that there is:(1) Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or(2) A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital. Before a carrier denies benefits or reduces payment for an emergency service based on a determination of the absence of an emergency medical condition or a determination that a lower level of care was needed, the carrier shall conduct a utilization review done by a board certified emergency physician who is licensed in this State, including a review of the enrollee's medical record related to the emergency medical condition subject to dispute. If a carrier requests records related to a potential denial of or payment reduction for an enrollee's benefits when emergency services were furnished to an enrollee, a provider has an affirmative duty to respond to the carrier in a timely manner. This does not apply when a reduction in payment is made by a carrier based on a contractually agreed upon adjustment for healthcare service. |  |
| Eye Care Services | [Title 24-A § 4314](https://legislature.maine.gov/statutes/24-A/title24-Asec4314.html) | Patient access to eye care providers when the plan provides eye care services. |  |
| Habilitative Services & Devices | [45 CFR § 156.115](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1115)(a)(5)(i) | Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services.Definitions:Habilitation Services Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.Rehabilitation Services Health care services and devices that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. |  |
| Health care services for COVID-19 | [Title 24-A § 4320](https://legislature.maine.gov/legis/statutes/24-A/title24-Asec4320-P-1.html)-P | Notwithstanding any requirements of this Title to the contrary, a carrier offering a health plan in this State shall provide, at a minimum, coverage as required by this section for screening, testing and immunization for COVID-19. 1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings. A. "COVID-19" means the coronavirus disease 2019 resulting from SARS-CoV-2, severe acute respiratory syndrome coronavirus 2, and any virus mutating from that virus. B. "Surveillance testing program" means a structured program of asymptomatic testing at a community or population level to understand the incidence or prevalence of COVID-19 in a group. "Surveillance testing program" does not include a program of testing that occurs less often than once per month per individual. 2. Testing. A carrier shall provide coverage for screening and testing for COVID-19 as follows. A. A carrier shall provide coverage for screening and testing for COVID-19, except when such screening and testing is part of a surveillance testing program. B. A carrier may not impose any deductible, copayment, coinsurance or other cost sharing requirement for the costs of COVID-19 screening and testing, including all associated costs of administration. C. A carrier may not make coverage without cost sharing as required by paragraph B dependent on any prior authorization requirement. D. A carrier may not make coverage without cost sharing as required by paragraph B dependent on the use of a provider in a carrier's network unless an enrollee is offered screening and testing by a network provider without additional delay and the enrollee chooses instead to obtain screening from an out-of-network provider or to be tested by an out-of-network laboratory. E. For the purposes of this subsection, with respect to COVID-19 screening and testing rendered by an out-of-network provider, a carrier shall reimburse the out-of-network provider in accordance with section 4303-C, subsection 2, paragraph B. 3. Immunization; COVID-19 vaccines. A carrier shall provide coverage for COVID19 vaccines as follows. A. A carrier shall provide coverage for any COVID-19 vaccine licensed or authorized under an emergency use authorization by the United States Food and Drug Page 4 - 130LR0653(10) Administration that is recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to an enrollee. B. A carrier may not impose any deductible, copayment, coinsurance or other cost sharing requirement for the cost of COVID-19 vaccines, including all associated costs of administration. C. A carrier may not make coverage without cost sharing as required by paragraph B dependent on any prior authorization requirement. D. A carrier may not make coverage without cost sharing as required by paragraph B dependent on the use of a provider in a carrier's network unless an enrollee is offered immunization by a network provider without additional delay and the enrollee chooses instead to obtain immunization from an out-of-network provider. |  |
| Hearing aids | [Title 24-A § 2762](https://legislature.maine.gov/statutes/24-A/title24-Asec2762.html) | Coverage is required for the purchase of hearing aids for each hearing-impaired ear, in accordance with the following: The hearing loss must be documented by a physician or audiologist licensed in this State. The hearing aid must be purchased in accordance with federal and state laws, regulations and rules for the sale and dispensing of hearing aids. The policy or contract may limit coverage to $3,000 per hearing aid for each hearing-impaired ear every 36 months. |  |
| Home health care coverage | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745.html)[Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837.html)[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M) | Policies that provide coverage on an expense incurred basis for inpatient hospital care shall make available coverage for home health care services by a home health care provider. The policy may contain a reasonable limitation on the number of home care visits and other services provided, but the number of such visits shall not be less than 90 in any continuous period of 12 months for each person covered under the policy. Each visit by an individual member of a home health care provider shall be considered as one home care visit.1. Definition of home health care services. "Home health care services" means those health care services rendered in his place of residence on a part time basis to a covered person only if: A. Hospitalization or confinement in a skilled nursing facility as would otherwise have been required if home health care was not provided; and B. The plan covering the home health services is established as prescribed in writing by a physician. There shall be no requirement that hospitalization be an antecedent to coverage under the policy.2. Home health care services shall include: A. Visits by a registered nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated; B. A physician's home or office visits or both; C. Visits by a registered physical, speech, occupational, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending physician, or both; D. Any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a physician, but only to the extent that such charges would have been covered under the contract if the covered person had remained in the hospital; and E. Visits by persons who have completed a home health aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services.3. Home health care provider.  "Home health care provider" means a home health care agency which: A. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services; B. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one physician and one registered nurse; C. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day; D. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the physician; E. Has under contract the services of a physician-advisor licensed by the State or a physician; F. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review; and G. Maintains a complete medical record on each patient. MUST PROVIDE UNLIMITED VISITS PURSUANT TO THE BENCHMARK PLAN. |  |
| Hospice Care Services | [Title 24-A § 2759](https://legislature.maine.gov/statutes/24-A/title24-Asec2759.html) | Hospice care services must be provided to a person who is terminally ill (life expectancy of 12 months or less). Must be provided whether the services are provided in a home setting or an inpatient setting. See section for further requirements. |  |
| Leukocyte Antigen Testing To Establish Bone Marrow Donor | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-I.html)-I | Must provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements: A. The enrollee must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;C. At the time of the testing, the enrollee must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; andD. The carrier may limit each enrollee to one test per lifetime. Prohibition on cost-sharing. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section. |  |
| Preventive health services Preventive health services without cost-sharing requirements including deductibles, co-payments, and co-insurance. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A[Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M)PHSA § 2713 ([75 Fed Reg 41726](https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5).130) | Must, at a minimum, provide coverage for, and may not impose cost-sharing requirements for, the following preventive services: The evidence-based items or services that have a rating of A or B in the recommendations of the USPSTF or equivalent rating from a successor organization; With respect to the individual insured, immunizations that have a recommendation from the federal DHHS, CDC, Advisory Committee on Immunization Practices; With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal DHHS, HRSA; and With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal DHHS, HRSA women's preventive services guidelines. If one of the recommendations referenced above is changed during a plan year, a carrier is not required to make changes to that health plan during the plan year. SEE SEPARATE CHECKLIST FOR SPECIFIC SERVICES. |  |
| Prostate cancer screening | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-G.html)-G | Coverage required for prostate cancer screening: Digital rectal examinations and prostate-specific antigen tests covered if recommended by a physician, at least once a year for men 50 years of age or older until age 72. |  |
| Reconstructive surgery after mastectomy | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-C.html)-CPHSA § 2727 | Coverage with for inpatient breast cancer treatment must be provided for the duration determined by the attending physician. If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include: Reconstruction of the breast on which the mastectomy was performed (all stages);Surgery and reconstruction of the other breast to produce symmetrical appearance; Prostheses; and Treatment of physical complications at all stages of mastectomy. Does not limit mastectomy to cancer diagnosis. |  |
| Telehealth Services | [Title 24-A § 4316](https://legislature.maine.gov/statutes/24-A/title24-Asec4316.html) | Carrier must provide coverage for telehealth services if the service would be covered if it were provided through in-person consultation and as long as the provider is acting within the scope of practice of the provider’s license with regard to telehealth services. Can’t put any restriction on the prescribing of medication through telehealth that could otherwise be prescribed in-person. The availability of health care services may not be considered for the purposes of demonstrating provider network adequacy. |  |
| **WOMEN & MATERNITY** |  |  |  |
| Mammogram screenings | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-A.html)-A[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A | If radiological procedures are covered, benefits must be made available for screening mammography at least once a year for women 40 years of age and over. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive. |  |
| Maternity and routine newborn care | [Title 24-A § 2743](https://legislature.maine.gov/statutes/24-A/title24-Asec2743-A.html)-APHSA § 2725([45 CFR § 148.170](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1170)) | Benefits must be provided for maternity (length of stay)and routine newborn care, in accordance with "Guidelines for Perinatal Care" as determined by attending provider and mother. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother. |  |
| Maternity benefits for unmarried women; dependent children | [Title 24-A § 2741](https://legislature.maine.gov/statutes/24-A/title24-Asec2741.html)[Title 24-A § 2742](https://legislature.maine.gov/statutes/24-A/title24-Asec2742.html) | Applicable only if maternity and dependent child coverage provided: must provide, at appropriate rates, the same maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage under the same terms and conditions as is provided to married policyholders or the wives of policyholders with maternity coverage. |  |
| Newborn coverage | [Title 24-A § 2743](https://legislature.maine.gov/statutes/24-A/title24-Asec2743.html) | Newborns must be automatically covered under the plan from the moment of birth for the first 31 days. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. |  |
| Obstetrical and gynecological care | [Title 24-A § 4306](https://legislature.maine.gov/statutes/24-A/title24-Asec4306-A.html)-APHSA § 2719A ([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual),[45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1138).138) | May not require authorization or referral by the carrier or any other person, including a primary care provider, in the case of a female enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology.A group health plan, or health insurance issuer offering group orindividual health insurance coverage, described in paragraph (2) maynot require authorization or referral by the plan, issuer, or any person(including a primary care provider described in paragraph (2)(B)) inthe case of a female participant, beneficiary, or enrollee who seekscoverage for obstetrical or gynecological care provided by aparticipating health care professional who specializes in obstetrics orgynecology. |  |
| Pap tests | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-E.html)-E[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-APHSA § 2713 (45 CFR 147) ACA 1001 | Benefits must be provided for cervical cancer screening tests. |  |
| Postpartum Care | [Title 24-A § 2743](https://legislature.maine.gov/statutes/24-A/title24-Asec2743-B.html)-B[Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834-D.html)-D[Title 24-A § 4234](https://legislature.maine.gov/statutes/24-A/title24-Asec4234-F.html)-F | Individual contracts (§2743-B), Group Contracts (§2834-D) and Health Maintenance Organizations (§4234-F) providing maternity benefits must provide postpartum care services for 12 months following childbirth. Must meet standards of the American College of Obstetricians and Gynecologists, as outlined in the “Optimizing Postpartum Care” opinion published May 2018. Must include coverage for a postpartum care plan, contact with patient within 3 weeks of end of pregnancy, a comprehensive postpartum visit, treatment of complications of pregnancy and childbirth, assessment of risk factors for cardiovascular disease, and care related to pregnancy loss.  |  |
| **INFANTS & CHILDREN** |  |  |  |
| Coverage for Autism | [Title 24-A § 2768](https://legislature.maine.gov/statutes/24-A/title24-Asec2768.html) | Must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is 10 years of age or under in accordance with this section. |  |
| Early Childhood Intervention | [Title 24-A § 2767](https://legislature.maine.gov/statutes/24-A/title24-Asec2767.html) | Individual health insurance policies must provide coverage for children's early intervention services in accordance with the requirements of this section. "Children's early intervention services" is defined in this section. |  |
| Infant Formula | [Title 24-A § 2764](https://legislature.maine.gov/statutes/24-A/title24-Asec2764.html) | Coverage of amino acid-based elemental infant formula must be provided when a physician has diagnosed and documented one of the following: Symptomatic allergic colitis or proctitis; Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; A history of anaphylaxis Gastroesophageal reflux disease that is nonresponsive to standard medical therapies Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider Cystic fibrosis; or Malabsorption of cow milk-based or soy milk-based formula Medical necessity is determined when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. Coverage for amino acid-based elemental infant formula under a policy, contract or certificate issued in connection with a health savings account may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate. |  |
| Medical food coverage for inborn error of metabolism | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-D.html)-D | Must provide coverage for metabolic formula and up to $3,000 per year for prescribed modified low-protein food products. |  |
| Pediatric Dental | [45 CFR § 155.1065](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.155&rgn=div5#se45.1.155_11065)[45 CFR § 156.115](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1115)(a)(6) | Please demonstrate compliance with dental benefits pursuant to the FEDVIP plan by completing the Benchmark Pediatric Dental checklist using the FEDVIP Benchmark Plan Benefits Chart for specific coverage information. Coverage should continue until the end of the plan year in which the enrollee turns 19 years of age. Continuation of coverage beyond the 19th birthday month required if non-coverage would negatively affect care. |  |
| Pediatric Services | [45 CFR § 156.115](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1115)(a)(6) | Coverage for pediatric services should continue until the end of the plan year in which the enrollee turns 19 years of age. Issuers are encouraged to cover services under the pediatric services EHB category beyond the 19th birthday month if non-coverage of those services after that time would negatively affect care. |  |
| Require Private Insurance Coverage for Donor Breast Milk | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-V | Coverage for medically necessary pasteurized donor breast milk is required. |  |
| **MENTAL HEALTH & SUBSTANCE ABUSE SERVICES / COVERAGE** |  |  |  |
| Mental health coverage | [Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-D[Rule 330](https://www.maine.gov/sos/cec/rules/02/031/031c330.doc) | The contract must provide coverage for treatment of certain mental illnesses (including substance use disorders), as diagnosed by specific providers, and the coverage must meet the following parity requirements:• benefits for treatment and diagnosis of mental illnesses must be provided under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illness;• providers may be required to furnish data substantiating that initial/continued treatment is medically necessary, and in determining medical necessity, the same criteria must be used for medical treatment for mental illness as for physical illness under the policy;• if benefits for physical illness are provided on an expense-incurred basis, the benefits required for mental illness may be delivered separately under a managed care system;• contracts may not have separate maximums, deductibles, coinsurance amounts, out-of-pocket limits in a benefit period of not more than 12 months, or separate office visit limits, for physical illness and mental illness;• contracts may not impose a limitation on benefits for mental illness unless the same limitation is also imposed for physical illness;• copayments for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance for physical illness; and• a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.The contract must provide for medically necessary health care for a person suffering from mental illness, and such medically necessary health care must include, but is not limited to: • inpatient care; • day treatment services; • outpatient services; and • home health care services. |  |
| Mental health parity and substance use disorder benefits | PHSA § 2726 ([45 CFR § 156.115](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1115)(a)(2)) | Extends mental health parity requirements into EHB for nongrandfathered individual and small group plans. |  |
| Mental health services provided by certain professionals | [Title 24-A § 2744](https://legislature.maine.gov/statutes/24-A/title24-Asec2744.html) | A covered person is entitled to reimbursement for services performed by one of the following professionals if the policy reimburses for those services and those services are within the professional’s lawful scope of practice:• Psychologist licensed to practice in Maine;• Certified social worker licensed for independent practice of social work in Maine;• Licensed clinical professional counselor licensed for independent practice of counseling in Maine;• Licensed nurse certified by the American Nurses’ Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing;• Marriage and family therapist licensed as such in Maine;• Licensed pastoral counselor licensed as such in Maine. |  |
| Improve Access to Behavioral Health Services by Limiting Cost Sharing  | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A(3)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A(3-A)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A(3-B)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-R | §4320-A, sub-§3. Primary Health Services. Minor changes to effective dates, limiting it to individual or small group plans with effective dates from January 1, 2021 to December 31, 2022.§4320-A, sub-§3-A. With respect to individual and small group health plans with an effective date on or after January 1, 2023, the law requires that, following the first visit provided without cost sharing, the copayment amount for a behavioral health office visit not be greater than the copayment amount for a primary care office visit and that any copayments for a primary care office visit and a behavioral health office visit count toward the deductible. §4320-A, sub-§3-B. With respect to a group health plan other than a small group health plan with an effective date on or after January 1, 2023, the law requires that coverage be provided without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and that, following the first visit, the copayment amount for a behavioral health office visit not be greater than the copayment amount for a primary care office visit. 24-A MRSA §4320-R is enacted to read: §4320-R. Implementation of federal mental health parity laws 1. Nonquantitative treatment limitation; definition. For the purposes of this section, "nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment. 2. Compliance with federal mental health parity laws. A carrier offering a health plan in this State providing health coverage for mental health and substance use disorder services pursuant to sections 2749-C, 2842, 2843, 4234-A and 4320-D and Title 24, sections 2325-A and 2329 must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any amendments to, and any federal guidance or regulations relevant to, that Act, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3). 3. Implementation of federal mental health parity laws. The superintendent shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any amendments to and federal guidance or regulations relevant to that Act, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3). 4. Reports to superintendent. As part of the report submitted to the superintendent, and subsequently reported by the superintendent to the Legislature, pursuant to section 2749-C, subsection 4, section 2843, subsection 7, section 4234-A, subsection 10 and Title 24, section 2325-A, subsection 8, a carrier shall submit information to the superintendent demonstrating compliance with the federal mental health parity laws. 5. Repeal. This section is repealed April 30, 2028.  |  |
| Improve Children’s Mental Health by Requiring Coverage for Evidence Based Treatment | [Title 24-A § 2749-C](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-C.html)[Title 24-A § 2749-C](https://legislature.maine.gov/statutes/24-A/title24-Asec2749-C.html)(1)(B)[Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)(3)(A-3)[Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)(5-C)(B)[Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)(5-C)[Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)(5-D)[Title 24-A § 4234](https://legislature.maine.gov/statutes/24-A/title24-Asec4234-A.html)-A(3)(A-3)[Title 24-A § 4234](https://legislature.maine.gov/statutes/24-A/title24-Asec4234.html)-A(6)(B) | Health insurance carriers may not deny treatment for mental health treatment services that use evidence-based practices and are determined to be medically necessary health care for an individual 21 years of age or younger. The law defines "evidence-based practices" as clinically sound and scientifically based policies, practices and programs that reflect expert consensus on the prevention, treatment and recovery science, including, but not limited to, policies, practices and programs published and disseminated by the Substance Abuse and Mental Health Services Administration and the Title IV-E Prevention Services Clearinghouse within the United States Department of Health and Human Services, the What Works Clearinghouse within the United States Department of Education, Institute of Education Sciences and the California Evidence-Based Clearinghouse for Child Welfare within the California Department of Social Services, Office of Child Abuse Prevention. The law also makes technical changes to state law requirements related to mental health parity to be consistent with federal law and regulations. Changes to the mental health parity provisions were initially codified in state law in Public Law 2019, chapter 5, Part D, but these technical changes were not included at that time.  |  |
| **PRESCRIPTION DRUGS** |  |  |  |
| Abuse-deterrent opioid analgesic drug products | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-J.html)-J | Must provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan. An increase in enrollee cost sharing to achieve compliance with this section may not be implemented. "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse. "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form. |  |
| Continuity of Prescription Drugs | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(7)(A) | If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee’s coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee’s prescribing provider. Policies must include a notice of the carrier’s right to request a review with the enrollee’s provider, and the replacing carrier must honor the prior carrier’s authorization for a period not to exceed 6 months if the enrollee’s provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy. |  |
| Contraceptives | [Title 24-A § 2756](https://legislature.maine.gov/statutes/24-A/title24-Asec2756.html) | If the plan provides coverage for prescription drugs or outpatient medical services, it must cover all prescription contraceptives approved by the federal FDA or for outpatient contraceptive services, respectively, to the same extent coverage is provided for other prescription drugs or outpatient medical services. The coverage must include coverage for contraceptive supplies in accordance with the requirements set forth in this section. "Outpatient contraceptive services" and "contraceptive supplies" are defined in this section. |  |
| Coverage for HIV Prevention Drugs | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-D.html)-D | A. If the FDA has approved one or more HIV prevention drugs that use the same method of administration, a carrier must cover at least one approved drug for each method of administration with no out-of-pocket cost. B. A carrier is not required to cover pre- or post-exposure prophylaxis drug dispensed or administered by an out-of-network pharmacy provider unless the enrollee's health plan provides an out-of-network pharmacy benefit. C. A carrier may not prohibit a pharmacy from dispensing or administering any HIV prevention drugs. |  |
| Diabetes supplies | [Title 24-A § 2754](https://legislature.maine.gov/statutes/24-A/title24-Asec2754.html) | Contracts must cover medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if a physician certifies that the equipment and services are necessary, and the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health. |  |
| Drug Mail Order Opt-Out | [45 CFR § 156.122](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1122)(e) | A health plan that is required to cover the EHB package cannot have a mail-order only prescription drug benefit. |  |
| Early refills of prescription eye drops  | [Title 24-A § 4314](https://legislature.maine.gov/statutes/24-A/title24-Asec4314-A.html)-A | If prescription eye drops are a covered benefit under the health plan, the coverage must include one early refill of a prescription for eye drops if the criteria set forth in Section 4314-A is met. |  |
| Electronic transmission of prior authorization requests for prescription drugs | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-B)[Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2) | If a health plan provides coverage for prescription drugs, the carrier must accept and respond to prior authorization requests through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. Transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission.A carrier's electronic transmission system for prior authorization requests for prescription drugs must comply with the requirements of the statute. (For 2023 and beyond, a carrier’s electronic benefit tool(s) must integrate with all of its providers’ systems.) Upon request, the superintendent may grant a waiver from the requirements on a demonstration of good cause. The prescription drug and prior authorization standards used must be clear and readily available to enrollees, participating providers, pharmacists and other providers. |  |
| Formulary Drug List | [45 CFR § 156.122](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1122)(d) | A health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, OPM, and the general public. Issuers’ formulary drug lists must include any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained. Must be a public website, without requiring an access account. |  |
| Information about prescription drugs | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(20) | Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website. A. A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours. B. A carrier shall provide an explanation of: (1) The requirements for utilization review, prior authorization or step therapy for each category of prescription drug covered under a health plan; (2) The cost-sharing requirements for prescription drug coverage, including a description of how the costs of prescription drugs will specifically be applied or not applied to any deductible or out-of-pocket maximum required under a health plan; (3) The exclusions from coverage under a health plan and any restrictions on use or quantity of covered health care services in each category of benefits; and (4) The amount of coverage provided under a health plan for out-of-network providers or noncovered health care services and any right of appeal available to an enrollee when out-of-network providers or noncovered health care services are medically necessary. |  |
| No Prior Authorization or step therapy for mental illness drugs | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-C)[Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-N.html)-N | Carrier must approve all prior authorizations for drugs to treat serious mental illness. No step therapy for such drugs. Serious mental illness means mental illness must result in serious functional impairment that substantially interferes with or limits one or more major life activities. |  |
| Off-label use of prescription drugs for cancer and HIV or AIDS | [Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-E.html)-E[Title 24-A § 2745](https://legislature.maine.gov/statutes/24-A/title24-Asec2745-F.html)-F | If providing coverage for prescription drugs, must provide coverage for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS. |  |
| Orally Administered Cancer Therapy | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-B.html)-B | If providing coverage for cancer chemotherapy treatment, must provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section. This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication. |  |
| Prescription drug access | [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html) | Formulary: if the plan provides coverage for prescription drug and limits the coverage to drugs included in a formulary, the coverage must meet the requirements set forth in Section 4311(1).Access to clinically appropriate drug not otherwise covered by the plan: a carrier must allow enrollees to request and gain access to clinically appropriate drugs not otherwise covered by the plan in accordance with the criteria and timeframes set forth in Section 4311(1-A), including an expedited review process. If a request is approved, the drug must be treated as an essential health benefit, including counting any cost-sharing toward the plan’s annual cost-sharing limit and when calculating the plan’s actuarial value.Approved drugs and medical devices: if the plan provides coverage for prescription drugs and medical devices, coverage cannot be denied on the basis that the use of the drug or device is investigational if the intended use is included in the labeling authorized by the FDA or is recognized in one of the standard reference compendia or in peer-reviewed medical literature. |  |
| Prescription Drug Coverage | [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) § 6(F)(1)(i) | Must provide coverage for out-of-hospital prescription drugs and medications. Cost sharing for the drug benefit shall not exceed 50% on average. If there is a separate maximum for this benefit, it shall be at least $1,500 per year. |  |
| Prescription Drug Coverage During Emergency Declared by the Governor | [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html) (2-A) | Except as provided in this subsection, a carrier shall provide coverage for the furnishing or dispensing of a prescription drug in accordance with a valid prescription issued by a provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor in accordance with Title 37-B, section 742. This subsection does not apply to coverage of prescribed contraceptive supplies furnished and dispensed pursuant to section 2756, 2847-G or 4247 or coverage of opioids prescribed in accordance with limits set forth in Title 32. |  |
| Prescription drug coverage out-of-pocket limit | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-A.html)-A | If prescription drug coverage does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits under the plan, the carrier must establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance (to the extent not inconsistent with the ACA). This requirement does not prohibit or limit a carrier’s ability to establish specialty tiers for prescription drug coverage, make medical necessity determinations, or enforce prior authorization/utilization review procedures. |  |
| Prescription Drug Exception Process & External Exception Review and Notice of adverse change to formulary | [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html)(1-A) [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html)(1-A)(A) [Title 24-A § 4311](https://legislature.maine.gov/statutes/24-A/title24-Asec4311.html)(1-A)(B) [45 CFR § 156.122](https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=b42306efce6315cebabd40ff77e68069&pitd=20180719&n=pt45.1.156&r=PART&ty=HTML#se45.1.156_1122)(C) | A carrier must allow an enrollee, the enrollee's designee or the person who has issued a valid prescription for the enrollee to request and gain access to a clinically appropriate drug not otherwise covered by the health plan. The carrier's process must comply with section 4304 and with this subsection. Treatment as EHB. If the carrier approves a request under this subsection for a drug not otherwise covered by the health plan, the carrier must treat the drug as an essential health benefit, including counting any cost sharing toward the plan’s annual limit on cost sharing and including it when calculating the plan’s actuarial value. Decision within 72 hours or 2 business days, whichever is less: The carrier must notify the enrollee, the enrollee's designee if applicable, and the person who has issued a valid prescription for the enrollee of its coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. A carrier that grants coverage must provide coverage of the drug for the duration of the prescription, including refills. Expedited review within 24 hours in exigent circumstances: The carrier must have a process for requesting an expedited review in exigent circumstances. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee’s life, health or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug. The carrier must determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee if applicable, and the person who has issued a valid prescription for the enrollee of its coverage decision within 24 hours following receipt of the request. If coverage granted, the carrier must cover the drug for the duration of the exigency. External Exception Review: If the health plan denies an exception request for a non-formulary drug, the issuer must have a process for an enrollee, the enrollee’s designee, or the enrollee’s prescribing physician (or other prescriber, as appropriate) to request that an independent review organization review the exception request and the denial of that request by the plan.(i) The independent review organization would have to make its determination and the health plan would have to notify the enrollee or enrollee’s designee and the prescribing physician (or other prescriber, as appropriate) no later than 72 hours after the time it receives the external exception review request.(ii) If the initial exception request is for an expedited review and that request is denied by the plan, then the independent review organization would have to make its coverage determination and provide appropriate notification no later than 24 hours after the time it receives the external exception review request. Notice of adverse change: must provide at least 60 days' written notice to an enrollee of an adverse change to a formulary; less than 60 days' notice is allowed when a drug is being removed from the formulary due to safety concerns. "adverse change to a formulary" means a change that removes a drug currently prescribed for that enrollee from the formulary applicable to the enrollee's health plan or a change that moves the prescribed drug to a tier with a higher cost-sharing requirement if the carrier uses a formulary with tiers Notice must use conspicuous font Notice must inform enrollee of the change and advise enrollee to consult with provider about the change If a drug is removed from a formulary, must notify an enrollee affected by the change of the ability to request an exception and provide a form for requesting exception If an enrollee has already received prior authorization for the drug, must continue to honor the authorization until it expires, as long as the enrollee continues to be covered under the same plan and the drug has not been removed due to safety concerns If a drug has been removed from a formulary (except if removed due to safety concerns), and an exception request is received prior to the effective date of the change, must continue to cover the drug until a decision is reached on the exception request. |  |
| Prescription insulin drugs | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-C.html)-C | A carrier that provides coverage for prescription insulin drugs may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for that coverage that results in out-of-pocket costs to the enrollee that exceed $35 per prescription for a 30-day supply of covered prescription insulin drugs, regardless of the amount of insulin needed to fill the enrollee's insulin prescriptions. This maximum amount does not prevent a carrier from setting an enrollee’s cost-sharing requirement for one or more insulin drugs at a lower amount. For purposes of this statute, “insulin” includes various types of insulin analogs and insulin-like medications, regardless of activation period or whether the solution is mixed before or after dispensation.”  32 M.R.S. § 13786-D(1)(A) (enacted by P.L. 2019, Ch. 666). |  |
| Prescription synchronization | [Title 24-A § 2769](https://legislature.maine.gov/statutes/24-A/title24-Asec2769.html) | If a health plan provides coverage for prescription drugs, a carrier: A. Shall permit and apply a prorated daily cost-sharing rate to a prescription that is dispensed by a pharmacist in the carrier's network for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling the prescription for less than a 30-day supply is in the best interest of the patient and the patient requests or agrees to less than a 30-day supply in order to synchronize the refilling of that prescription with the patient's other prescriptions; B. May not deny coverage for the dispensing of a medication prescribed for the treatment of a chronic illness that is made in accordance with a plan developed by the carrier, the insured, the prescriber and a pharmacist to synchronize the filling or refilling of multiple prescriptions for the insured. The carrier shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon in order to synchronize the patient's prescriptions; and C. May not use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions must be paid in full for each prescription dispensed, regardless of any prorated copay for the insured or fee paid for alignment services. 2.  Application; exclusion. The requirements of this section do not apply to a prescription for: A. Solid oral doses of antibiotics; or B. Solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist a patient with compliance. |  |
| Prior authorization of medication-assisted treatment for opioid use disorder | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-A) | A carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment, except that a carrier may not impose any prior authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder. "Medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling. |  |
| Prosthetic devices to replace an arm or leg. | [Title 24-A § 4315](https://legislature.maine.gov/statutes/24-A/title24-Asec4315.html)[42 USC 1395m](https://www.law.cornell.edu/uscode/text/42/1395m) | Coverage must be provided, at a minimum, for prosthetic devices to replace, in whole or in part, an arm or leg to the extent that they are covered under the Medicare program. Coverage for repair or replacement of a prosthetic device must also be included. Exclusion for micro-processors was removed effective 1/2011.1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg. 2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee. 8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.(h) Payment for prosthetic devices and orthotics and prosthetics (1) General rule for payment (A) In general Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B). (B) Payment basis Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of— (ii) the actual charge for the item; or (iii) the amount recognized under paragraph (2) as the purchase price for the item. Coverage should be applied as follows:1. Coinsurance shall NOT exceed 20%, AFTER deductible in the plan. 2. HSA’s are NOT subject to the 20% requirement but coinsurance may not exceed that for other services. 3. DME and other prosthetic devices are NOT subject to the 20%, so it would be helpful to clarify in the schedule of benefits, summary of benefits and coverage, and the plan and benefits template how each category is paid out. 4. Out Of Network is NOT subject to 20%, unless there is no in-network available then OON should be billed as in-network i.e. 20%. |  |
| Step therapy requirements | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-N | Step therapy requirements when a carrier provides prescription drug coverage, and coverage of a prescription drug is restricted through the use of a step therapy protocol. |  |
| Third Party Prescription Act (Any Willing Pharmacy) | [Title 32 § 13771](https://www.mainelegislature.org/legis/statutes/32/title32sec13771.html)[Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317.html)[Bulletin 377](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/377.pdf) | A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers. |  |
| Access to Prescription Contraceptives | [Title 24 § 2332-J](https://www.mainelegislature.org/legis/statutes/24/title24sec2332-J.html)(4)[Title 24-A § 2756](https://legislature.maine.gov/statutes/24-A/title24-Asec2756.html)(3)[Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-G.html)-G(4)[Title 24-A § 4247](https://legislature.maine.gov/statutes/24-A/title24-Asec4247.html)(4) | 24 MRSA §2332-J, sub-§4; 24-A MRSA §2756, sub-§3; 24-A MRSA §2847-G, sub-§4; and 24-A MRSA §4247, sub-§4 all now require the following coverage: Coverage of contraceptive supplies. Coverage required under this section must include coverage for contraceptive supplies in accordance with the following requirements. For purposes of this section, "contraceptive supplies" means all contraceptive drugs, devices and products approved by the federal Food and Drug Administration to prevent an unwanted pregnancy. A. Coverage must be provided without any deductible, coinsurance, copayment or other cost-sharing requirement. B. If the federal Food and Drug Administration has approved one or more therapeutic equivalents of a contraceptive supply, an insurer is not required to cover all those therapeutically equivalent versions in accordance with this subsection, as long as at least one is covered without any deductible, coinsurance, copayment or other cost-sharing requirement in accordance with this subsection. C. Coverage must be provided for the furnishing or dispensing of prescribed contraceptive supplies intended to last for a 12-month period, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider.Application: to all policies, contracts, and certificates executed, continued or renewed on or after January 1, 2023. |  |
| Dispensing an Emergency Supply of Chronic Maintenance Drugs | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-E.html)-E[Title 32 § 13786-F](https://legislature.maine.gov/statutes/32/title32sec13786-F.html) | §4317-E. Coverage for emergency supply of chronic maintenance drugs 1. Definition. "Chronic maintenance drug" has the same meaning as in Title 32, section 13786-F, subsection 1. "Chronic maintenance drug" means a medication prescribed to treat a chronic, long-term condition and that is taken on a regular, recurring basis. A pharmacist may dispense an emergency supply of a chronic maintenance drug to a patient without a prescription if the pharmacist is unable to obtain authorization to refill the prescription from a health care provider and the pharmacist has a record of the prescription in the name of the patient, including the amount of the drug dispensed in the most recent prescription or the standard unit of dispensing the drug, and that record does not indicate that no emergency supply is permitted. A pharmacist may dispense an emergency supply of a chronic maintenance drug to a patient as long as the following conditions are met: 1. The drug dispensed may not be a controlled substance included in Schedules I and II under the federal Controlled Substances Act; 2. The amount dispensed may not exceed a 30-day supply or, if the standard unit of dispensing exceeds a 30-day supply, may not exceed the smallest standard unit of dispensing, except that, if the drug is included on Schedule III or IV of the federal Controlled Substances Act, the amount dispensed may not exceed a 7-day supply; 3. The pharmacist may not dispense the chronic maintenance drug in an emergency supply to the same patient more than twice in a 12-month period; and 4. The pharmacist must determine, in the pharmacist’s professional judgment, that the prescription is essential to sustain the life of the patient or to continue therapy for a chronic condition of the patient and that failure to dispense the drug could reasonably produce undesirable health consequences or cause physical or mental discomfort. The law requires that the pharmacist notify the practitioner who issued the prescription or another practitioner responsible for the patient's care no later than 72 hours after the emergency supply is dispensed. Public Law 2021, chapter 566 also requires health insurance carriers to make available coverage in all health plans for an emergency supply of a chronic maintenance drug dispensed in this manner. Any cost-sharing requirement applicable to that chronic maintenance drug may be imposed by a health insurer on an emergency supply.  |  |
| **ADDITIONAL STATE REQUIREMENTS NOT REQUIRED IN POLICY/CERTIFICATE** |  |  |  |
| Access to lower-priced comparable health care services from out-of-network providers, online form for enrollees | [Title 24-A § 4318](https://legislature.maine.gov/statutes/24-A/title24-Asec4318-B.html)-B(1)[Title 24-A § 4318](https://legislature.maine.gov/statutes/24-A/title24-Asec4318-A.html)-A(1)(A) | If an enrollee covered under a health plan other than a health maintenance organization plan elects to obtain a covered comparable health care service as defined in section 4318-A, subsection 1, paragraph A (referenced below) from an out-of-network provider at a price that is the same or less than the statewide average for the same covered health care service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's charge and, upon request by the enrollee, shall apply the payments made by the enrollee for that comparable health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by an in-network provider. A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the statewide average price on the Maine Health Data Organization's publicly accessible website as long as the carrier uses a reasonable method to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee and a toll-free telephone number that provide, at a minimum, information relating to comparable health care services. The enrollee is responsible for demonstrating to the carrier that payments made by the enrollee to the out-of-network provider should be applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this section. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of making such a demonstration and may require that copies of bills and proof of payment be submitted by the enrollee. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare. "Comparable health care service" means nonemergency, outpatient health care services in the following categories: (1) Physical and occupational therapy services;(2) Radiology and imaging services;(3) Laboratory services; and(4) Infusion therapy services. |  |
| Health care price transparency tools; website, toll-free telephone number, and cost estimates | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(21)[Title 24-A § 4318](https://legislature.maine.gov/statutes/24-A/title24-Asec4318.html)-A(1)(A) | A carrier offering a health plan in this State shall comply with the following requirements. A. A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A (referenced below), from network providers, as well as quality data for those providers, to the extent available. A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization. B. A carrier shall make available to the enrollee the ability to obtain an estimated cost that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the carrier shall request additional or clarifying code information, if needed, from the provider involved with the comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's provider, the carrier shall provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider. C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed comparable health care service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed comparable health care service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting the carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider. "Comparable health care service" means nonemergency, outpatient health care services in the following categories: (1) Physical and occupational therapy services;(2) Radiology and imaging services;(3) Laboratory services; and(4) Infusion therapy services. |  |
| Posting of plan descriptions and certificate of coverage | [Title 24-A § 4302](https://legislature.maine.gov/statutes/24-A/title24-Asec4302.html)(1) | A carrier shall post descriptions of its plans that meet the requirements of 24-A M.R.S. § 4302(1) on its publicly accessible website, and in addition to the plan description, a link to the health plan’s certificate of coverage. |  |
| Appropriate Accounting for Cost-Sharing by Health Insurance Carriers and Pharmacy Benefits Managers | [Title 24-A § 4349](https://legislature.maine.gov/statutes/24-A/title24-Asec4349.html)(6) | Health insurance carriers and their pharmacy benefits managers must include cost-sharing amounts paid on behalf of an insured when calculating the insured's contribution to any out-of-pocket maximum, deductible or copayment when a drug does not have a generic equivalent or was obtained through prior authorization, a step therapy override exception or an exception or appeal process. The law requires that a third party who pays any amount on behalf of a covered person for a covered prescription drug must notify the covered person prior to or within 7 days of the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available and prohibits the conditioning of the assistance on enrollment in a specific health plan or type of health plan. The requirements do not apply when their application to a person who has a health savings account would result in a covered person’s ineligibility for that health savings account under federal law, except for items or services that are determined to be preventive care. The requirements apply to prescription drug benefits provided pursuant to a contract or policy of insurance by a carrier or a pharmacy benefits manager on behalf of a carrier on or after January 1, 2023.  |  |
| Clear Choice Plan Designs | [Title 24-A § 2793](https://legislature.maine.gov/statutes/24-A/title24-Asec2793.html)[Rule 851](https://www.maine.gov/sos/cec/rules/02/031/031c851.docx) | Plans shall follow the cost share structure provided by Title 24-A §2793 and [Rule 851](https://www.maine.gov/sos/cec/rules/02/031/031c851.docx).CoverME.gov recommends that all on-exchange plan names are 50-characters or less to ensure that plan names display correctly in the CoverME.gov portal. You must include your company name, but you may abbreviate the company name if needed.The Bureau understands that not all plan names may be shortened to meet the 50 character guideline suggested by CoverME.gov, however it is expected that carriers attempt to comply. At most, marketplace plan names should not exceed 80 characters, including spaces. |  |
| Credentialing Requirements | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(2) |  Within 30 days of initial receipt of a credentialing application, a carrier shall review the entire application and determine whether it is complete. If not, the carrier must return the application with a comprehensive list of items to be completed on the application.Within 60 days of initial receipt of a completed credentialing application, a carrier shall grant or deny the application, or, if unable to complete a credentialing decision, must so notify the BOI in writing within that 60 day period, and request authorization for an extension of time. The request for extension shall include a detailed explanation of the reasons why it cannot be completed within the time permitted, or, if not specific to that application, a remediation plan to bring the carrier’s credentialing practices into compliance with the 60-day limit. |  |
| Disclosure to Enrollees of Cash Price  | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(25) | A carrier may not prohibit a provider from providing an enrollee with the option of paying the provider's discounted cash price for health care services. |  |