

BULLETIN 375

Health Insurance Changes Required by the Affordable Care Act: Form Filing, Approval and Notice Requirements

The Affordable Care Act of 2010 requires health insurance issuers to meet new minimum requirements for benefits and eligibility for coverage.¹ Some of these changes are effective on September 23, 2010, and must be implemented no later than the first plan renewal following that date.² The new requirements include prohibitions against preexisting condition exclusions for individuals age 19 and under,³ prohibitions against lifetime limits, new requirements for preventive services,⁴ and extension of dependent coverage until age 26.⁵

The Bureau of Insurance is committed to making the transition to the new federal requirements and consumer protections as timely, easy for consumers to understand, and efficient for health insurance carriers to implement as possible. The Bureau will expedite form review, expedite review of proposed modifications to “grandfathered” policies, and eliminate administrative barriers that may impede a carrier’s ability to implement the new federal consumer protections earlier than required by the Act.

The Bureau encourages carriers to implement all of the Affordable Care Act changes as soon as possible. Pursuant to 24-A M.R.S.A. § 2412(4), carriers are hereby granted a temporary limited exemption from the prior approval process for health insurance form filings. This exemption applies to the extent that the policy changes expand coverage as required by the Act or voluntarily exceed the minimum requirements.⁶ This exemption is subject to the following conditions:

- The carrier must offer or apply the modifications in a uniform manner to all similarly situated policyholders, without discrimination based on health status or other prohibited factors.
- The exemption is only from form filing requirements, not from any applicable rate filing requirements.
- The exemption expires on January 1, 2011 and all forms must be filed for approval before that date. A carrier may request an extension. The Superintendent reserves the right to request the filing of any form on a case-by-case basis.

All benefit modifications required by the Affordable Care Act, and all voluntary benefit modifications meeting the above criteria, will be considered “minor modifications” that satisfy the individual and small group guaranteed renewal requirements of the Maine Continuity of Coverage Act, 24-A M.R.S.A. § 2850 B(3)(I). Carriers that provide notice of the benefit modifications to enrollees pursuant to federal law requirements are deemed to meet the state notice requirements and a separate notice will not be required.

For efficiency, the Bureau requests all modifications to similar policy forms be submitted at the same time if possible, rather than piecemeal. Carriers may use a single amendatory endorsement to implement the new Affordable Care Act changes, and may use different versions of the

endorsement for grandfathered and non-grandfathered policyholders. Each endorsement to a particular policy should have its own unique form number and be attached separately in a SERFF filing.

¹ The Affordable Care Act (ACA) comprises the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Health Care and Education Reconciliation Act of 2010.

² The relevant provisions of the Act apply to all plan years beginning on or after September 23, 2010.

³ This requirement does not apply to grandfathered individual plans.

⁴ This requirement does not apply to grandfathered plans.

⁵ This requirement does not apply to grandfathered group plans if the dependent is eligible for job-based coverage, other than coverage under a parent's plan.

⁶ Benefit modifications may exceed the requirements of the Act by providing an earlier effective date, taking effect midterm rather than on renewal, or by applying to grandfathered policies when not required by the Act.

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NOTE: Except for the order suspending prior approval requirements, this bulletin is intended solely for informational purposes, and is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.