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DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
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Bulletin 458

Clear Choice Designs for the 2022 Individual Health Insurance Market

Bureau of Insurance Rule 851, which provides the process for approving standardized "Clear Choice" cost-sharing designs, took effect on June 8, 2021. Pursuant to Section 5 of the Rule, the official 2022 Clear Choice designs for individual market health plans are hereby finalized and attached to this Bulletin as an Appendix. Until further notice, carriers may rely on this chart in preparing their 2022 individual market health plan filings.

For future plan years, Paragraph 5(1)(A) of the Rule directs an annual review with stakeholder feedback. This process permits annual updates to the plans to be made without formal rulemaking. Follow-up bulletins are anticipated, similar to the annual rate and form filing bulletins currently published by the Bureau. Amendments to the Rule itself will be made only on an as-needed basis. If concerns arise, suggestions for improvements to the Rule are welcome.

Provisions in the Rule relating to small group coverage should be regarded as placeholders. Carriers need not take those provisions into account in preparing their 2022 small group filings. Although the Insurance Code currently requires Clear Choice designs in the small group market beginning in 2022,[1] pending legislation will repeal this requirement as long as the individual and small group markets remain separate, and will link Clear Choice for small group plans to the implementation of the pooled market.[2] The provisions relating to small group coverage were adopted as proposed, consistent with existing law, in order to facilitate the prompt adoption of the Rule and provide certainty to the market regarding the Clear Choice requirements as applied to individual health plans. Additional rulemaking is anticipated after the Legislature and Governor have acted on the bill now under consideration.

[1] 24-A M.R.S. § 2793(1).

[2] L.D. 1725: "An Act To Clarify the Deferral of the Pooled Market and Link Small Employer Clear Choice to Pooling in the Made for Maine Health Coverage Act." This bill would not prohibit carriers from offering one or more Clear Choice plans to small employers on an optional basis, but any such product offering would be purely voluntary until the pooled market is implemented.

The transition to Clear Choice in the individual market in 2022 will result in significant changes to coverage for many enrollees. As with any other plan transition, carriers are expected to map their existing 2021 enrollees to their most similar 2022 plan when they make their renewal offers. If there is uncertainty about which 2022 plan is most similar to a given 2021 plan, the Bureau will work with carriers to develop the most appropriate mapping. Subsection 4(3) of the Rule specifies that as a general rule, carriers may treat this mapping as a "modification" of the prior plan rather than a "discontinuance," in accordance with the provisions of the Continuity of Coverage Act clarifying that benefit modifications required by law do not conflict with enrollees' guaranteed renewal rights.[3] The exceptions are cases where carriers go beyond the modifications the law requires, either by replacing traditional insurance coverage with HMO coverage or *vice versa,* or by choosing not to offer a more similar Clear Choice plan available. In those cases, the replacement will be subject to the "minor modification" and "best interest" tests that apply whenever a carrier voluntarily replaces an old plan with a new plan.[4] The Bureau will work with carriers to resolve any questions regarding whether a carrier has chosen not to offer a more similar Clear Choice plan than its proposed replacement.

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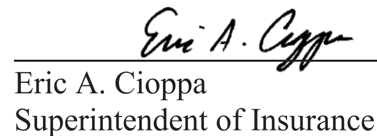

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NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.

[3] 24-A M.R.S. § 2850-B(3)(I)(3); 02-031 C.M.R. § 4(3)(A).

[4] 24-A M.R.S. §§ 2850-B(3)(G)(3) & (I)(4); 02-031 C.M.R. § 4(3)(B).

Appendix - Clear Choice Plan Design 2022

Benefits	Catastrophic	Bronze $7,500	Bronze $8,700	Bronze $7,000 HSA	Bronze $5,900 HSA	Silver $3,500	Silver $5,500	Silver $3,500 HSA	Silver $4,500 HSA	Gold $1,500	Gold $2,500	Platinum
Estimated AV Value	N/A	64.19%	64.56%	64.60%	64.70%	70.53%	70.52%	70.51%	66.38%	80.14%	77.48%	88.54%
Deductible	$8,700	$7,500	$8,700	$7,000	$5,900	$3,500	$5,500	$3,500	$4,500	$1,500	$2,500	$500
Maximum OOP	$8,700	$8,700	$8,700	$7,000	$7,050	$8,700	$7,500	$7,000	$7,000	$5,000	$6,000	$3,000
Coinsurance	0%	50%	0%	0%	50% Coins. After Ded.	40%	30%	10% Coins. After Ded.	20% Coins. After Ded.	30%	30%	20%
PCP and Behavioral Health Office Visits*	$50 for 2nd & 3rd visits then deductible	$40	$50			$30	$30			$25	$25	$20
Specialist Visit	0% Coins. After Ded.	50% Coins. After Ded.	$100			$60	$60			$50	$50	$40
Free Standing Urgent Care		$60	0% Coins. After Ded.			$40	$40			$40	$40	$25
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		50% Coins. After Ded.				40% After Deductible	30% After Deductible			30% Coins. After Ded.	30% Coins. After Ded.	20% Coins. After Ded.
Outpatient Surgery and Physician/Surgical Services												
Inpatient Hospital Services and ER												
Inpatient Physician, Rehabilitation, and Surgical Services												
Ambulance												
All other benefits												
RX - Tier 1 Generic		$25	$25			$25	$25			$25	$5 / $25	$0
RX - Tier 2 Preferred Brand		$50	0% After Deductible			$50	$50			$50	$50	$15
RX - Tier 3 NonPreferred		$100				$100	30%			$100	30% up to $300	$100
RX - Tier 4 Specialty		$250				$250	50%			$250	50% up to $600	$250
Preventive Medical Benefits	0%											
Pediatric Dental - Preventive & Diagnostic	0%											
Pediatric Dental - Restorative & Basic Services	20% Coinsurance After Deductible											
Pediatric Dental - Major Services & Medically Necessary Orthodontics	50% Coinsurance After Deductible											

* 1st PCP and Behavioral Health Office Visit have $0 copay; subsequent visits have copay before deductible except HSA plans

Before deductible