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Bulletin 437

Incorporation of the Affordable Care Act's Consumer Protections into Maine Law

This Bulletin outlines new health insurance requirements that have been added to the Insurance Code by Public Law 2019, Chapter 5 (LD 1) "An Act To Protect Health Care Coverage for Maine Families." This law preserves some of the ACA's major consumer protections by incorporating them into Maine law. Additionally, in areas where Maine law was already similar to the ACA, the law harmonizes state and federal laws, maintaining current levels of protection under the ACA or under comparable provisions of pre-ACA Maine law, whichever is stronger.

The ACA's consumer protections are incorporated into Maine law in the following areas:

1) Rating

The law makes several amendments to the rate requirements for individual and small group health plans. The statutes are amended to prohibit the family rate from being based on more than three dependent children who are under 21. 24-A M.R.S. §§ 2736-C(2), 2808-B(2)(C). The statutes also now explicitly prohibit the use of risk factors other than age, tobacco use, and geography. 24-A M.R.S. §§ 2736-C(2)(B), 2808-B(2)(B).

A carrier that varies premium rates due to age must vary the premium rate according to a uniform age curve. The Superintendent will be adopting routine technical rules to establish a uniform rate curve that is substantially similar to the age curve currently in effect under the ACA. 24-A M.R.S. §§ 2736-C(2)(D), 2808(2)(D).

The maximum rate differential due to age by ratio is 3 to 1 for those 21 and older. For enrollees under 21, the rate differential is specified in the uniform age rating curve. 24-A M.R.S. §§ 2736-C(2)(D)(9), 2808-B(2)(D)(10).

Carriers may not apply a tobacco surcharge to an individual who is participating in an evidence-based tobacco cessation strategy approved by the U.S. Food and Drug Administration. 24-A M.R.S. §§ 2736-C (2)(D)(8), 2808-B(2)(D)(9).

2) Dependent Child Coverage

Carriers are now required to offer coverage for dependent children until they turn 26, a year longer than pre-ACA Maine law. In addition, the law no longer limits eligibility to children who are unmarried, have no dependents of their own, and are either Maine residents or full-time students. 24-A M.R.S. §§ 2742-B, 2833-B, 4233-B.

3) Pre-Existing Condition Exclusions

The law deletes the provision that would previously have allowed carriers, if permitted by federal law, to exclude coverage for pre-existing conditions for up to 12 months. However, carriers may still deny coverage except during open enrollment and special enrollment periods, and the law gives the superintendent authority to set standards for open and special enrollment periods by rule. 24-A M.R.S. §§ 2850(2), 2736-C(11).

4) Rescission of Coverage

The law adds a provision prohibiting carriers from rescinding coverage, once a person is covered under a group or individual health plan, except for fraud or intentional misrepresentation of a material fact as prohibited by the terms of the contract. Carriers must also comply with applicable pre-ACA restrictions on rescission of coverage. 24-A M.R.S. §§ 2411, 2850-B(3).

5) Plan Descriptions

The law adds a requirement that health plan descriptions provided to prospective and current enrollees and to providers be in a format substantially similar to the format currently required by the ACA. In addition, carriers must post the plan descriptions on their publicly accessible websites and include links to the full certificates of coverage. 24-A M.R.S.§ 4302(1).

6) Prescription Drugs

The law prohibits carriers from reducing or terminating benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the carrier's grievance procedure or independent external review. 24-A M.R.S. § 4303(4)(E).

The law also adds a provision requiring carriers, for plan years beginning on or after the effective date of the law, to establish a process giving enrollees the opportunity for access to clinically appropriate drugs not otherwise covered by the health plan. In addition to complying with existing requirements for prior authorization procedures, the carrier must treat the drug as an essential health benefit if the request is approved, counting any cost sharing towards the plan's annual cost sharing limit. The carrier must issue its decision and notify the requesting party within 72 hours or 2 business days after receiving a request, whichever is less.[1] The carrier must also have a process for 24-hour expedited review when the enrollee's life, health, or ability to regain maximum function may be jeopardized or when the enrollee is undergoing a current course of treatment using a nonformulary drug. 24-A M.R.S. § 4311(1-A).

[1] The 72-hour alternative deadline was added by P.L. 2019, Ch. 273 (LD 705), effective September 19, 2019.

7) Minimum Medical Loss Ratio

The explicit cross-references in the Insurance Code to the ACA and its implementing regulations have been replaced by a provision preserving the MLR calculation in substantially its current form (which includes the credibility adjustments and the three-year rolling average), and giving the Superintendent rulemaking authority to adopt technical rules. The law also repeals a provision allowing the minimum MLR for individual coverage to be reduced below 80% with federal approval. 24-A M.R.S. §§ 2736-C(5), 4319-A.

8) Guaranteed Issue

The law adds a provision extending guaranteed issue to the large group market, and also referencing existing requirements for individual and small group health plans and for guaranteed renewal. 24-A M.R.S. § 4319-A.

9) No Lifetime or Annual Limits on Health Plans

Health insurance plans currently regulated under the ACA may not establish lifetime limits on the dollar value of benefits or annual limits on the dollar value of essential benefits. A health plan that included an annual dollar limit on January 1, 2019, as permitted by applicable law (for example, a grandfathered plan with limits on specific benefits, as permitted before the ACA under former 24-A M.R.S. § 4318), may retain or increase that limit as long as it remains continuously in force, but may not impose any new limits or reduce any existing limit on renewal. 24-A M.R.S. § 4320.

10) Essential Health Benefits; Limits on Cost Sharing

A new section of the Insurance Code has been added which requires individual and small group health plans to provide essential health benefits that are substantially similar to those currently required in Maine under the ACA. Those benefits were established by the Centers for Medicare and Medicaid Services (CMS) in accordance with its "benchmark" regulation. Essential benefits are classified in ten categories: 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; and pediatric services, including oral and vision care to the extent currently required by the ACA. Individual and small group plans must also provide coverage at the actuarial value "metal" levels currently required by the ACA. 24-A M.R.S. §§ 4320-D(1), (2), (4).

In addition, the ACA's requirement to cap out-of-pocket expenses for in-network essential health benefits has been incorporated into state law. The annual maximum-out-of-pocket expense must be adjusted annually in a manner substantially similar to the ACA's adjustment formula. This requirement applies to the large group market as well as the individual and small group markets. Although large group plans are not required to include the full suite of essential benefits, they must identify which plan benefits are considered "essential" for purposes of the prohibition against annual limits and the requirement to cap enrollees' out-of-pocket expenses, in a manner substantially similar to the process currently established under the ACA's implementing regulations. 24-A M.R.S. § 4320-D(1), (3), (4).

11) Nondiscrimination

The law preserves the protections required by the ACA and its implementing regulations, as of the effective date of the law, against discrimination on the basis of race, color, national origin, sex, sexual orientation, gender identity, age, or disability. It requires carriers to take reasonable steps to provide meaningful access for people with limited proficiency in English and to ensure effective methods of communication with disabled people. Protections for transgender individuals include a prohibition against categorical coverage exclusions or limitations for all health services related to gender transition, and a prohibition against the arbitrary imposition of sex-specific or gender-specific coverage limitations or cost sharing. 24-A M.R.S. § 4320-L.

12) Mental Health Benefits

The law makes mandated mental health benefits consistent across all market sectors. Formerly, mental health coverage was a mandated benefit under state law for groups with more than 20 covered employees and a mandated offer for smaller groups and for individuals and families. However, the ACA now requires mental health coverage in all individual and small group plans as part of the essential health benefit package. Therefore, Maine's mandated benefit requirement has been extended to apply to all individual and group health plans, and the minimum coverage requirements for individual plans have been revised to include the same eleven conditions specified in the group plan mandate. 24-A M.R.S. §§ 2749-C, 2843, 4234-A.

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