**Maine Bureau of Insurance  
Form Filing Review Requirements Checklist  
Individual Major Medical SHORT-TERM, LIMITED-DURATION - (H16I.004)**

**Plans Issued on or after January 1, 2020**

**REVISED 10/01/2021**

**CARRIERS MUST CONFIRM COMPLIANCE AND IDENTIFY THE LOCATION (PAGE NUMBER, SECTION, PARAGRAPH, ETC.) OF THE STANDARD IN THE FORM IN THE LAST COLUMN. IF A CONTRACT DOES NOT HAVE TO MEET THIS REQUIREMENT CARRIERS MUST EXPLAIN WHY IN THE LAST COLUMN.**

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| **BENEFIT/PROVISION** REQUIREMENT | | **REFERENCE** | | DESCRIPTION OF REVIEWSTANDARDS REQUIREMENT | | **IDENTIFY LOCATION OF STANDARD IN FILING *MUST EXPLAIN IF REQUIREMENT***  *IS INAPPLICABLE* |
| **General Submission Requirements** | | | | | | |
| Electronic (SERFF) Submission Requirements | | [24-A M.R.S. §2412(2)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2412.html)  [Bulletin 360](http://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 | | [24-A M.R.S. §601(17)](http://legislature.maine.gov/statutes/24-A/title24-Asec601.html) | | $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 | | [24-A M.R.S. §2413](http://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | | Seven categories of the grounds for disapproving a filing. | |  |
| Readability | | [24-A M.R.S. §2441](http://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 | | [24-A M.R.S. §2412](http://legislature.maine.gov/statutes/24-A/title24-Asec2412.html), [§2413](http://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. | |  |
| **state definition and limitations** | | | | | | |
| Definition; contract term | [24-A M.R.S. §2849-B(1)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html) (as amended by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp))  [Bulletin 438](http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/438.pdf) | | A short-term, limited-duration policy is an individual, nonrenewable policy issued for a term that does not extend beyond December 31st of the calendar year in which the policy is issued. | |  | |
| Combined term limit | [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html) (as amended by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp)) | | An insurer or the insurer's agent or broker may issue a short-term, limited-duration policy that replaces a prior short-term, limited-duration policy as long as the combined term of the new policy and all prior policies does not exceed 24 months and the individual has not been covered under any prior short-term, limited-duration policy for at least 12 months.  All individuals making an application for coverage under a short-term, limited-duration policy must disclose any prior coverage under a short-term, limited-duration policy and the policy duration. | |  | |
| Sale through in-person encounter required | [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)(C) (enacted by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp))  [Bulletin 438](http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/438.pdf) | | An insurer or the insurer’s agent or broker may not issue a short-term, limited-duration policy unless it has been sold through an in-person encounter, which means the agent or broker and the consumer must meet in the same physical location. | |  | |
| Sale and marketing restriction | [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)(D) (enacted by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp)) | | An insurer or the insurer's agent or broker may not actively market or sell any short-term, limited-duration policy during any open enrollment period, **except for** a short-term, limited-duration policy that terminates coverage on December 31st of the calendar year in which it is sold. | |  | |
| Assessment of applicant’s eligibility for APTC or CSR under a qualified health plan | [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)(E) (enacted by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp)) | | Upon offering an individual short-term, limited-duration policy for purchase, an insurer or the insurer's agent or broker must assess an applicant for eligibility for an advanced premium tax credit (APTC) or cost-sharing reduction (CSR) for coverage under a qualified health plan (QHP) purchased on the exchange pursuant to the federal ACA, as defined in [24-A M.R.S. § 2188(1)(A)](http://legislature.maine.gov/statutes/24-A/title24-Asec2188.html), and shall provide an estimate of the cost for coverage under a QHP after applying any APTC or CSR. | |  | |
| **state and federal disclosures** | | | | | | |
| Federal notice requirement | [83 Fed Reg 38212](https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance); [45 CFR § 144.103](https://www.ecfr.gov/cgi-bin/text-idx?SID=166a44ff908fb92aa5bb42b41f7dd633&mc=true&node=se45.1.144_1103&rgn=div8) | | Short-term, limited duration policies must display prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following notice with any additional information required by applicable state law:  This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder  services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. | |  | |
| State disclosure/notice requirements | [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)(A) (as amended by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp))  [Bulletin 438](http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/438.pdf)  [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)(F) (enacted by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp))  [24-A M.R.S. §2849-B(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)(G) (enacted by [P.L. 2019, ch.330](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC330.asp)) | | Upon offering an individual short-term, limited-duration policy for purchase, an insurer or the insurer's agent or broker must provide written disclosure, in at least 14-point type, of the following:  (1) A summary of plan benefits, limits and exclusions in a standardized format similar to the format required for a qualified health plan (QHP) under the federal ACA that is specific to the exact policy being offered for purchase in this State, including, but not limited to, information about the circumstances in which covered benefits may be subject to balance billing and examples of how charges may be applied toward any cost sharing under the policy and billed to the individual policyholder. **The standardized format is available online at:** [www.maine.gov/pfr/insurance/regulated/insurance\_companies/rate\_form\_checklists/life\_health/additional\_non\_qhp.html](http://www.maine.gov/pfr/insurance/regulated/insurance_companies/rate_form_checklists/life_health/additional_non_qhp.html)  (2) A comparison of the short-term, limited-duration policy to a QHP in the terms, benefits and conditions of the policy, any exclusions, medical loss ratio requirements or the provisions of guaranteed renewal and continuity of coverage.  The documents and information required to be disclosed by § 2849-B(8)(A) above must also be available through the insurer’s publicly accessible website.  An insurer or the insurer's agent or broker shall provide, upon the purchase of a short-term, limited-duration policy; upon the expiration of the policy; and, if the policy is in effect during an open enrollment period, on November 1st of the calendar year in which the policy was sold, written notice of the following:  (1) Disclosure that a short-term, limited-duration policy is not considered minimum essential coverage under the federal ACA and that termination of a policy is not a qualifying event for a special enrollment period; and  (2) The dates for the next open enrollment period, the website address for the publicly accessible website of the exchange, as defined in [24-A M.R.S. § 2188(1)(A)](http://legislature.maine.gov/statutes/24-A/title24-Asec2188.html), and the toll-free telephone number for the exchange. | |  | |
| **General Policy Provisions** | | | | | | |
| Assignment of Benefits | | [24-A M.R.S. §2755](http://www.mainelegislature.org/legis/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 | | [24-A M.R.S. §2185](http://www.mainelegislature.org/legis/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. | |  |
| Classification, Disclosure, and Minimum Standards | | [Rule 755](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | | Must comply with all applicable provisions of Rule 755 including, but not limited to, Sections 4, 5, 6(A), 6(F), and Sections 7(A), 7(B), and 7(G). | |  |
| Credit toward Deductible | | [24-A M.R.S. §2723-A(3)](http://legislature.maine.gov/statutes/24-A/title24-Asec2723-A.html) | | 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. | |  |
| Death with Dignity | | [22 M.R.S. § 2140(19)](http://www.mainelegislature.org/legis/statutes/22/title22sec2140.html) | | 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 this Act. | |  |
| Explanations for any Exclusion of Coverage for work related sicknesses or injuries | | [24-A M.R.S. §2413](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2413.html) | | 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 Deductibles | | [24-A M.R.S. §2413](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2413.html) | | All policies must include clear explanations of all of the following regarding deductibles:   1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both. | |  |
| Free look period | | 24-A M.R.S. [§2717](http://legislature.maine.gov/statutes/24-A/title24-Asec2717.html) | | Policy must state that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason.  The provision shall be set forth in the policy under an appropriate caption, and if not so printed on the face page of the policy adequate notice of the provision shall be printed or stamped conspicuously on the face page.  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 as from the beginning as if the policy had not been issued. | |  |
| General format | | [24-A M.R.S. §2703](http://legislature.maine.gov/statutes/24-A/title24-Asec2703.html) | | Readability, term of policy described, cost disclosed, form number in bottom left corner. | |  |
| Genetic Information Protections | | [24-A M.R.S.  § 2159-C(2)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2159-C.html) | | A carrier may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance.  A carrier may not request, require or purchase genetic information for purposes of determining eligibility for benefits, computing premium or contribution amounts, applying any preexisting condition exclusion or any other activities related to the creation, renewal or replacement of a health insurance contract.  A carrier may not request, require or purchase genetic information with respect to an individual prior to the individual's enrollment under the plan or coverage in connection with the enrollment. | |  |
| Grace Period | | 24-A M.R.S. [§2707](http://legislature.maine.gov/statutes/24-A/title24-Asec2707.html) | | 30 days | |  |
| Legal actions | | [24-A M.R.S. §2715](http://legislature.maine.gov/statutes/24-A/title24-Asec2715.html) | | No action can be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3 years (for individual plans) (2 years for group plans) after the time written proof of loss is required to be furnished. | |  |
| Limits on priority liens | | 24-A M.R.S. [§2729-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html) | | No policy for health insurance shall provide for priority over the insured of payment for any hospital, nursing, medical or surgical services. | |  |
| Notice of Rate Increase | | 24-A M.R.S. [§2735-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2735-A.html) | | Requires that insurers provide a minimum of 60 days written notice to affected policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. It specifies the requirements for the notice. See these sections for more details. | |  |
| Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies | | 24-A M.R.S. [§5013](http://legislature.maine.gov/statutes/24-A/title24-Asec5013.html)  [Rule 275, Sec. 17(E)](http://www.maine.gov/sos/cec/rules/02/031/031c275.doc) | | There must be a notice predominantly displayed on the first page of the policy that states: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company." | |  |
| Penalty for failure to notify of hospitalization | | 24-A M.R.S. [§2749-A](http://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. | |  |
| Persons under the influence of alcohol or narcotics | | [24-A M.R.S. §2728](http://legislature.maine.gov/statutes/24-A/title24-Asec2728.html) | | Policies cannot contain the following provision: “Intoxicants 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.” | |  |
| Prohibition on preexisting condition exclusions | | 24-A M.R.S. [§2850](http://legislature.maine.gov/statutes/24-A/title24-Asec2850.html) (as amended by [P.L. 2019, ch.5](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC5.asp)) | | A contract may not impose a preexisting condition exclusion. | |  |
| Rate Filings on Individual Policies | | [24-A M.R.S.  §2736 (1)](http://legislature.maine.gov/statutes/24-A/title24-Asec2736.html) | | The filing must be received by the Bureau at least 60 days before the implementation date unless the Superintendent waives this requirement. | |  |
| Rebates | | [24-A M.R.S. §2160](http://legislature.maine.gov/statutes/24-A/title24-Asec2160.html)  [24-A M.R.S. §2163-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2163-A.html)  [Bulletin 426](http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/426.pdf) | | Are there any provisions that give the insured a benefit not associated with indemnification or loss?  Yes \_\_\_  No \_\_\_ | |  |
| Referrals by Direct Primary Care Providers | | [24-A M.R.S. § 4303(22)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html)  [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.  If a plan has procedures for enrollees to designate a specific primary care provider within the plan’s network, the carrier must treat a direct primary care service agreement as the functional equivalent of a network primary care provider designation for purposes of making referrals.  **Applicable deductible, coinsurance, or copayment**: for a covered health care service that was referred by a direct primary care provider, a carrier may not apply a deducible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the service was referred by a participating primary care provider.  **Information that a carrier may request**: a carrier may require an out-of-network direct primary care provider making a referral to provide information demonstrating that the provider is a direct primary care provider through a written attestation or a copy of a direct primary care agreement with an enrollee and may request additional information as necessary.  **Applicable Definitions:**  “Direct primary care provider” means an individual who is a licensed physician or osteopathic physician or other advanced health care practitioner who is authorized to engage in independent medical practice in this State, who is qualified to provide primary care services and who chooses to practice direct primary care by entering into a direct primary care service agreement with patients. The term includes, but is not limited to, an individual primary care provider or a group of primary care providers. [22 M.R.S. § 1771(1)(B)](http://legislature.maine.gov/legis/statutes/22/title22sec1771.html).  “Direct primary care service agreement” means a contractual agreement between a direct primary care provider and an individual patient, or the patient's legal representative, in which:    (1) The direct primary care provider agrees to provide primary care services to the individual patient for an agreed-to fee over an agreed-to period of time; and    (2) The direct primary care provider agrees not to bill 3rd parties on a fee-for-service or capitated basis for services already covered in the direct primary care service agreement.  [22 M.R.S. § 1771(1)(A)](http://legislature.maine.gov/legis/statutes/22/title22sec1771.html). | |  |
| Reinstatement | | [24-A M.R.S. §2808](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2708.html) | | 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 | | 24-A M.R.S. [§2738](http://legislature.maine.gov/statutes/24-A/title24-Asec2738.html) | | Policy must contain the terms under which the policy can or cannot be renewed. | |  |
| Required provisions | | [24-A M.R.S. §2704-2716](http://legislature.maine.gov/statutes/24-A/title24-Asec2704.html) | | Entire contract – changes, time limit on certain defenses, reinstatement, notice of claims, payment of claims, claim forms, proof of loss, right to examine and return policy. | |  |
| Third Party 10 Day Notification prior to cancellation; restrictions on cancellation, termination or lapse due to cognitive impairment or functional incapacity | | 24-A M.R.S. [§2707-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html)  [Rule 580](http://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. | |  |
| Time limit on defenses | | [24-A M.R.S. §2706](http://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. | |  |
| **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 | | [24-A M.R.S. §4318-B(1)](http://legislature.maine.gov/statutes/24-A/title24-Asec4318-B.html) | | 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. | |  |
| **Eligibility/Enrollment** | | | | | | |
| Mandatory offer to extend coverage for dependent children up to 26 years of age | | [24-A M.R.S. §2742-B](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2742-B.html) (as amended by [P.L. 2019, ch.5](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC5.asp)) | | A policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child attains 26 years of age. As used in this statute, "dependent child" means the child of a person covered under an individual health insurance policy. | |  |
| Dependent children with mental or physical illness | | [24-A M.R.S. §2742-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2742-A.html) | | Requires policies to continue coverage for dependent children up to 24 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility. | |  |
| Domestic Partner Coverage | | 24-A M.R.S. [§2741-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2741-A.html) | | Mandated offer if coverage offered to spouses of married policyholders: coverage must be offered for domestic partners of policyholders at appropriate rates and under the same terms and conditions as those benefits are offered to spouses of married policyholders. This section establishes criteria defining who is an eligible domestic partner. | |  |
| **Providers/Networks** | | | | | | |
| Acupuncture Services | | [24-A M.R.S. §2745-B](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2745-B.html) | | Benefits must be made available for the services of acupuncturist if comparable services would be covered if performed by a physician. | |  |
| Coverage of certified nurse practitioners, certified midwives, and certified nurse midwives | | [Title 24-A § 2757](https://legislature.maine.gov/statutes/24-A/title24-Asec2757.html) (as amended by [P.L. 2021, ch. 79](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=76860))  [Title 24-A § 4303(5)](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) | | 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 | | [P.L. 2021, ch. 39](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=74819) | | Coverage for services provided by certified registered nurse anesthetists (CRNA) is required. | |  |
| Chiropractic Coverage | | 24-A M.R.S. [§2748](http://legislature.maine.gov/statutes/24-A/title24-Asec2748.html) | | Provide benefits for care by chiropractors at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. | |  |
| Dental Services:  Independent Practice Dental Hygienists  Dental hygiene therapist | | [24-A M.R.S. §2765](http://legislature.maine.gov/statutes/24-A/title24-Asec2765.html)  [24-A M.R.S. §2765-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2765-A.html) | | If the policy includes coverage for dental services, and the covered services are within the lawful scope of practice of an independent practice dental hygienist, then coverage must be provided for those services when performed by a independent practice dental hygienist licensed in this State.  If the policy includes coverage for dental services, and the covered services are within the lawful scope of practice of a dental hygiene therapist, then coverage must be provided for those services when performed by a dental hygiene therapist licensed in this State. | |  |
| Enrollee choice of PCP | | [24-A M.R.S. §4306](http://www.mainelegislature.org/legis/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](http://www.mainelegislature.org/legis/statutes/32/title32sec2102.html) to serve as primary care providers for managed care plans. | |  |
| Licensed clinical Professional Counselors | | [24-A M.R.S. §2744](http://legislature.maine.gov/statutes/24-A/title24-Asec2744.html) | | Must include benefits for Licensed Clinical Professional Counselor services to the extent that the same services would be covered if performed by a physician. | |  |
| Licensed pastoral counselors and marriage and family counselors | | [24-A M.R.S. §2744](http://legislature.maine.gov/statutes/24-A/title24-Asec2744.html) | | Must include benefits for licensed pastoral counselors and marriage and family therapists for mental health services to the extent that the same services would be covered if performed by a physician. | |  |
| Naturopathic doctors | | [24-A M.R.S. §4320-K](http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC340.asp) | | 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. | |  |
| Pharmacy Providers – “Any Willing Pharmacy” | | [24-A M.R.S. §4317](http://www.maine.gov/pfr/insurance/review_checklists/life_health.htm) | | 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. | |  |
| PPOs – Payment for Non-preferred Providers | | 24-A M.R.S. [§2677-A(2)](http://legislature.maine.gov/statutes/24-A/title24-Asec2677-A.html) | | The benefit level differential between services rendered by preferred providers and non-preferred providers may not exceed 20% of the allowable charge for the service rendered. | |  |
| Provider directories | | [24-A M.R.S. §4303-D](http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1073&item=3&snum=128) | | Requirements for a plan’s provider directories. | |  |
| Registered nurse first assistants | | 24-A M.R.S. [§2758](http://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. | |  |
| **Claims & Utilization Review** | | | | | | |
| Claim forms | | 24-A M.R.S. [§2710](http://legislature.maine.gov/statutes/24-A/title24-Asec2710.html) | | The insurer will furnish claim forms to the claimant. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy for filing of claim forms. | |  |
| Examination, autopsy | | [24-A M.R.S. §2714](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2713-A.html) | | There shall be a provision that the insurer has the right to examine the insured as often as it may reasonably require during the pendency of claim and also has the right to make an autopsy in case of death where it is not prohibited by law. | |  |
| Notice of claim | | 24-A M.R.S. [§2709](http://legislature.maine.gov/statutes/24-A/title24-Asec2709.html) | | Notice within 20 days. Failure to give notice shall not invalidate nor reduce any claim, if notice was given as soon as was reasonably possible. | |  |
| Penalty for noncompliance with utilization review | | 24-A M.R.S. [§2749-B](http://legislature.maine.gov/statutes/24-A/title24-Asec2749-B.html) | | Penalty of more than $500 for failure to provide notification under a utilization review program. | |  |
| Proof of Loss | | [24-A M.R.S. §2711](http://legislature.maine.gov/statutes/24-A/title24-Asec2711.html) | | Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. | |  |
| Protection from Surprise Bills | | [Title 24-A § 4303-C](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-C.html)(as amended by [P.L. 2021, ch. 241](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78606))  [Title 24-A § 4303-E](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-E.html)  Title 24-A § 4303-F(as enacted by [P.L. 2021, ch. 241](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78606))  [Rule 365](https://www.maine.gov/sos/cec/rules/02/031/031c365.docx) | | 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. | |  |
| UCR Definition, Required Disclosure, Protection from Balance Billing by Participating Providers | | 24-A M.R.S. [§4303(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)  [Rule 850 Sec. 7, Sub-Sec. B (5](http://www.maine.gov/sos/cec/rules/02/031/031c850.docx))  24-A M.R.S. [§4303(8)(A)](http://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) | | The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred.  Maximum allowable charges. All policies under which the insured may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.  A. 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.  Protection from balance billing by participating providers – applicable if the carrier has a provider network: an enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection.  The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's 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. | |  |
| Utilization Review &  Notice Requirements for Health Benefit Determinations | | [24-A M.R.S. §4304](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4304.html) (as amended by [P.L. 2019, ch.273](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC273.asp))  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.docx) | | **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.   **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.   * 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. | |  |
| **Grievances & Appeals** | | | | | | |
| Grievance procedure | | 24-A M.R.S. [§2747](http://legislature.maine.gov/statutes/24-A/title24-Asec2747.html) | | The policy must contain the procedure to follow if an insured wishes to file a grievance regarding policy provisions or denial of benefits. | |  |
| **GeneraL health care treatment/coverage** | | | | | | |
| AIDS | | 24-A M.R.S. [§2750](http://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.  **Any dollar limit must not be less than largest limit on any other service.** | |  |
| Anesthesia for Dentistry | | 24-A M.R.S. [§2760](http://legislature.maine.gov/statutes/24-A/title24-Asec2760.html) | | Anesthesia & associated facility charges for dental procedures are mandated benefits for certain vulnerable persons. | |  |
| Breast cancer treatment | | 24-A M.R.S. [§2745-C](http://legislature.maine.gov/statutes/24-A/title24-Asec2745-C.html) | | Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. | |  |
| Breast reduction and symptomatic varicose vein surgery (Mandated offer) | | [24-A M.R.S. §2761](http://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 | | [24-A M.R.S. §2748](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2748.html) | | Therapeutic, adjustive and manipulative services (including but not limited to chiropractic services) must be covered as follows:   1. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor. 2. Consistent with reasonable medical management techniques with respect to the method, treatment or setting for a covered service, the insurer may not discriminate based on the chiropractic provider’s license. This does not, however, govern the amount of reimbursement paid to a chiropractic provider. 3. Visit limits on therapeutic, adjustive and manipulative services will be permitted only if any such limits apply regardless of provider type. | |  |
| Clinical trials | | 24-A M.R.S. §4310 | | 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. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.  A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers.  Qualified enrollee**.**  An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:  A. The enrollee has a life-threatening illness for which no standard treatment is effective;  B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;  C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and  D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.  Approved clinical trial.  For the purposes of this section, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health. | |  |
| Colorectal Cancer Screening | | [24-A M.R.S. §2763](http://legislature.maine.gov/statutes/24-A/title24-Asec2763.html) (as amended by [P.L. 2019, ch.86](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC86.asp)) | | 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 as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy benefits must be paid for the screening colonoscopy as the primary procedure. | |  |
| Emergency Services | | 24-A M.R.S. §4320-C (as amended by [P.L. 2019, ch.238](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC238.asp))  24-A M.R.S. §4301-A(4-A) & (4-B) (enacted by [P.L. 2019, ch.238](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC238.asp))  24-A M.R.S. §4304(5) (enacted by [P.L. 2019, ch.238](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC238.asp)) | | The plan must cover emergency services without prior authorization. Cost-sharing requirements, expressed as a copayment amount or coinsurance rate, for out-of-network services must be the same as requirements that would apply if such services were provided in network.  **“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 health care service. | |  |
| Health care services for COVID-19 | | 24-A M.R.S.A. §4320-P  [P.L. 2021 Ch. 28 (LD 1)](https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.mainelegislature.org%2Flegis%2Fbills%2FgetPDF.asp%3Fpaper%3DSP0029%26item%3D10%26snum%3D130&data=04%7C01%7CAmanda.Maley-Alley%40maine.gov%7Cd9c04c4970a64ae932ad08d8f60c2002%7C413fa8ab207d4b629bcdea1a8f2f864e%7C0%7C0%7C637529879216465525%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=di9qlKEL6BvHLdcgaOgnhMgK2eoajT5ymNLcVm3xXhA%3D&reserved=0) | | 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 | | [24-A M.R.S. §2762](http://legislature.maine.gov/statutes/24-A/title24-Asec2762.html) (as amended by [P.L. 2019, ch.418](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC418.asp)) | | 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 healthcare coverage | | 24-A M.R.S. [§2745](http://legislature.maine.gov/statutes/24-A/title24-Asec2745.html) | | Policies providing coverage on an expense incurred basis for inpatient hospital care must make available such coverage for home health care services by a home health care provider in accordance with the requirements of this statute. | |  |
| Hospice Care Services | | 24-A M.R.S. [§2759](http://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 | | [24-A M.R.S. §4320-I](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-I.html) | | 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; and  D. 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 | | [24-A M.R.S. §4320-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-A.html) | | 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 already described and 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. | |  |
| Prostate cancer screening | | 24-A M.R.S. [§2745-G](http://legislature.maine.gov/statutes/24-A/title24-Asec2745-G.html) | | 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. | |  |
| Telehealth Services | | [Title 24-A § 4316](https://legislature.maine.gov/statutes/24-A/title24-Asec4316.html) (as amended by [P.L. 2021 ch. 291](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78725)) | | 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. | |  |
| **woman & Maternity/Infants/Children** | | | | | | |
| Abortion services | | 24-A M.R.S.  §4320-M  (enacted by [P.L.](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC274.asp)  [2019, ch.274](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC274.asp)) | | Applicable only if maternity coverage provided: Must provide coverage for abortion services in accordance with the following:   * 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. * The requirements of this law apply to all policies or contracts executed, delivered, issued for delivery, continued, or renewed in this State, and all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. | |  |
| Maternity benefits for unmarried women; dependent children | | [24-A M.R.S. §2741](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2741.html)  24-A M.R.S. §2742 | | 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 such maternity coverage is provided to married policyholders or the wives of policyholders with maternity coverage.  Coverage issued in accordance with section 2741 (above) must provide unmarried women policyholders with the coverage or option of coverage for dependent children under the same terms and conditions and at appropriate rates as are extended to married policyholders with dependents.  Financial dependency of dependent children may not be required as condition for coverage eligibility.  Coverage must also provide the same benefits to dependent children placed for adoption with the policyholder or spouse of the policyholder under the same terms and conditions as apply to natural dependent children or stepchildren of the policyholder, irrespective of whether the adoption has become final.  "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption.  "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the policyholder, member or spouse of the policyholder or member. | |  |
| Maternity and routine newborn care | | 24-A M.R.S. §2743-A | | Applicable only if maternity coverage provided: Must provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology.  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. | |  |
| Screening Mammograms | | 24-A M.R.S. [§2745-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2745-A.html) | | 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. | |  |
| Autism Spectrum Disorders | | [24-A M.R.S. §2768](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2768.html) | | Must provide coverage for autism spectrum disorders for an individual covered under a policy who is 10 years of age or under in accordance with the following:   1. The policy must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. 2. The policy must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary. 3. The policy may not include any limits on the number of visits. 4. The policy may limit coverage for applied behavior analysis to $36,000 per year.  An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. 5. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition. This does not require coverage of prescription drugs if prescription drug coverage is not provided by the policy. | |  |
| Early Childhood Intervention | | [24-A M.R.S. §2767](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2767.html) | | Must provide coverage for children's early intervention services in accordance with this subsection.  A referral from the child's primary care provider is required.  The policy or contract may limit coverage to $3,200 per year for each child not to exceed $9,600 by the child's 3rd birthday.    “Children's early intervention services” means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20  United States Code, Section 1411. | |  |
| Infant Formula | | [24-A M.R.S. §2764](http://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:   1. Symptomatic allergic colitis or proctitis; 2. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; 3. A history of anaphylaxis 4. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies 5. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider 6. Cystic fibrosis; or 7. 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 | | 24-A M.R.S. [§2745-D](http://legislature.maine.gov/statutes/24-A/title24-Asec2745-D.html) | | Must provide coverage for metabolic formula and up to $3,000 per year for prescribed modified low-protein food products. | |  |
| Newborn Children Coverage | | [24-A M.R.S. §2743](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2743.html) | | Policies providing coverage on an expense-incurred basis must provide that benefits are payable for a newly born child of the insured or subscriber from the moment of birth for the first 31 days.  This must include coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.  If payment of premium is required to provide coverage for a child, the policy may require that notice of birth and payment of the premium be furnished within 31 days after the date of birth in order to have coverage continue beyond the 31-day period. The payment may be required to be retroactive to the date of birth. | |  |
| **Prescription Drugs** | | | | | | |
| Abuse-deterrent opioid analgesic drug products | | [24-A M.R.S. §4320-J](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-J.html) | | 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. | |  |
| Contraceptives | | 24-A M.R.S. [§2756](http://legislature.maine.gov/statutes/24-A/title24-Asec2756.html) | | All contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services.  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 for at least one contraceptive supply within each method of contraception that is identified by the federal Food and Drug Administration to prevent an unwanted pregnancy and prescribed by a health care provider.  B. If there is a therapeutic equivalent of a contraceptive supply within a contraceptive method approved by the federal Food and Drug Administration, an insurer may provide coverage for more than one contraceptive supply and may impose cost-sharing requirements as long as at least one contraceptive supply within that method is available without cost sharing.  C. If an individual's health care provider recommends a particular contraceptive supply approved by the federal Food and Drug Administration for the individual based on a determination of medical necessity, the insurer shall defer to the provider's determination and judgment and shall provide coverage without cost sharing for the prescribed contraceptive supply.  D. 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. | |  |
| Coverage for HIV Prevention Drugs | | Title 24-A § 4317-D (as established by [P.L. 2021, ch. 265](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78669)) | | 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 | | 24-A M.R.S. [§2754](http://legislature.maine.gov/statutes/24-A/title24-Asec2754.html) | | Must provide coverage for the 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:  1. The insured's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and  2. 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. | |  |
| Early refills of prescription eye drops | | [24-A M.R.S. §4314-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4314-A.html) | | If prescription eye drops are a covered benefit under the plan, must provide coverage for one early refill of a prescription for eye drops if the following criteria are met:  A. The enrollee requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed;  B. The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized;  C. The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription; and  D. The prescription has not been refilled more than once during the period authorized by the prescribing health care provider prior to the request for an early refill.  Cost sharing. A carrier may impose a deductible, copayment or coinsurance requirement for an early refill under this section as permitted under the health plan. | |  |
| No Prior Authorization or step therapy for mental illness drugs | | [Title 24-A § 4304(2-C)](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html) (as amended by [P.L 2021, ch. 345](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78789))  [24-A M.R.S. §4320-N](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-N.html) (as amended by [P.L 2021, ch. 345](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78789)) | | 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 | | 24-A M.R.S. [§2745-E](http://legislature.maine.gov/statutes/24-A/title24-Asec2745-E.html), [§2745-F](http://legislature.maine.gov/statutes/24-A/title24-Asec2745-F.html) | | 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 | | [24-A M.R.S. §4317-B](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4317-B.html) | | 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 Coverage During Emergency Declared by the Governor | | [24-A M.R.S.A. §4311 (2-A)](https://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4311.html)  [P.L. 2021 Ch. 28 (LD 1)](https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.mainelegislature.org%2Flegis%2Fbills%2FgetPDF.asp%3Fpaper%3DSP0029%26item%3D10%26snum%3D130&data=04%7C01%7CAmanda.Maley-Alley%40maine.gov%7Cd9c04c4970a64ae932ad08d8f60c2002%7C413fa8ab207d4b629bcdea1a8f2f864e%7C0%7C0%7C637529879216465525%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=di9qlKEL6BvHLdcgaOgnhMgK2eoajT5ymNLcVm3xXhA%3D&reserved=0) | | 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 access | | [24-A M.R.S. §4311](http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC429.asp) (as amended by [P.L. 2019, ch.5](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC5.asp) and [P.L. 2019, ch.273](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC273.asp)) | | A carrier that provides coverage for prescription drugs and medical devices may not deny coverage of a prescribed drug or medical device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.  **Formularies.** The following requirements apply if a plan limits prescription drug coverage to drugs in a formulary:  Exceptions: must allow exceptions to the formulary when a nonformulary alternative is medically indicated consistent with the UR standards in §4303.  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.   **Access to clinically appropriate prescription drugs:** 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 the following:  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. | |  |
| Prior authorization of medication-assisted treatment for opioid use disorder | | 24-A M.R.S. §4304(2-A) (enacted by [P.L. 2019, ch.273](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC273.asp)) | | 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. | |  |
| Electronic transmission of prior authorization requests for prescription drugs | | [Title 24-A § 4304(2-B)](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)  [Title 24-A § 4304(2)](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)  (as amended by [P.L. 2021, ch. 73](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=76852)) | | 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 2022, a carrier is only required to have one electronic benefit tool, which does not have to integrate with every provider’s system. 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. | |  |
| Step therapy requirements | | 24-A M.R.S. §4320-M (as enacted by [P.L. 2019, ch.295](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC295.asp)) | | 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. | |  |
| **Mental Health & substance abuse Services/COVERAGE** | | | | | | |
| Mental health coverage | | 24-A M.R.S. [§2749-C](http://legislature.maine.gov/statutes/24-A/title24-Asec2749-C.html) (as amended by [P.L. 2019, ch.5](http://www.mainelegislature.org/legis/bills/bills_129th/chapters/PUBLIC5.asp))  24-A M.R.S. [§4320-D](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-D.html) | | Benefits (including financial requirements and treatment limitations) cannot be less extensive than for physical illnesses.  All individual contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual as defined in section 2843, subsection 3, paragraph A-1, except for those that are designated as "V" codes by the Diagnostic and Statistical Manual:    (1) Psychotic disorders, including schizophrenia;   (2) Dissociative disorders;   (3) Mood disorders;   (4) Anxiety disorders;   (5) Personality disorders;   (6) Paraphilias;   (7) Attention deficit and disruptive behavior disorders;   (8) Pervasive developmental disorders;   (9) Tic disorders;   (10) Eating disorders, including bulimia and anorexia; and   (11) Substance use disorders.  For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. | |  |
| Mental health services provided by counseling professionals. | | [24-A M.R.S. §2744(3)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2744.html) | | A policy providing coverage for mental health services must offer coverage for those services when performed by a counseling professional licensed in this State and who meets other criteria set forth in this statute. | |  |