# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 320: MINIMUM STANDARDS FOR ALCOHOLISM AND DRUG DEPENDENCY BENEFITS**

Table of Contents

Section 1. Authority

Section 2. Purpose

Section 3. Scope

Section 4. Definitions

Section 5. Policies Subject to Parity Requirements

Section 6. Minimum Benefits for Policies Not Subject to Parity Requirements

Section 7. Major Medical Policy

Section 8. Nonprofit Hospital or Medical Service Corporation

Section 9. Coordination With Medicare

Section 10. Effective Date

**Section 1. Authority**

 This rule is promulgated by the Superintendent pursuant to Title 24 M.R.S.A., Sections 2325-A and 2329 and Title 24-A M.R.S.A., Sections 212, 2842, 2843 and 4234-A.

**Section 2. Purpose**

 The purpose of this Rule is to clarify the requirements of Title 24 M.R.S.A., Sections 2325-A and 2329 and Title 24-A M.R.S.A., Sections 2842, 2843 and 4234-A, by establishing standards to assure equitable health care for the treatment of alcoholism and drug dependency.

**Section 3. Scope**

 This rule applies to all policies subject to Title 24 M.R.S.A., Sections 2325-A and 2329, and Title 24‑A M.R.S.A., Sections 2842 and 2843. Pursuant to those sections, this rule does not apply to employee group insurance policies issued to employers with 20 or fewer employees insured under the group policy. This rule does apply to other types of groups, such as association groups, regardless of size. This rule does not apply to health maintenance organizations.

**Section 4. Definitions**

 For purposes of this Rule, the following terms have the following meaning:

A. "Usual Charge" means the most consistent charge by a provider for a given service.

B. "Customary Charge" means a charge within the range of usual charges for a given service billed by most providers with similar training and experience taking into consideration the geographic area in which the services are provided and significant regional variations in the cost of services.

C. "Reasonable Charge" means a charge that is not more than the usual and customary charge.

D. "Allowable Charge" means the amount which would be payable for services of a preferred provider under a preferred provider arrangement prior to the application of any deductible or coinsurance.

E. "Residential Treatment" means those services defined by Title 24, Section 2329, subsection 2, paragraph B, or Title 24-A M.R.S.A., Section 2842, subsection 2, paragraph B, whether billed by the facility or by a physician or other professional.

F. "Non-residential Day Treatment" means a program of outpatient care involving visits of more than two hours but less than 24 hours per day, at least three days per week.

G. "Substance Abuse" means the illnesses of alcoholism and drug dependency as those terms are used in 24 M.R.S.A., Section 2329, and 24-A M.R.S.A., Section 2842.

**Section 5. Policies subject to parity requirements**

A. Pursuant to Title 24 M.R.S.A., Section 2325-A(5-C) and Title 24-A M.R.S.A., Section 2843(5-C), all group contracts subject to this Rule, except to the extent they cover employees of employers with 20 or fewer employees, must provide the same level of benefits for the treatment of substance abuse-related disorders as for treatment of physical illnesses.

B. With respect to residential treatment, the benefit level must be at least the greater of:

(1) The same level of benefits, if any, provided for residential treatment of physical illnesses; or

(2) Benefits meeting the following requirements:

a. Annual Maximum. The policy must provide residential treatment benefits for substance abuse of at least 30 days per calendar year or, if less, the total number of inpatient days allowed by the policy for all illnesses.

b. Coinsurance. The minimum level of benefits provided for residential treatment for substance abuse must be at least 90 percent of the charges or, if less, the percentage applicable to inpatient benefits.

c. Maximum Lifetime Residential Benefits. The policy may contain a lifetime maximum limit on the number of covered days for residential treatment of substance abuse of not less than 60 days.

This subsection applies only to residential treatment as defined by 24-A M.R.S.A. Section 2842(2)(B) that does not also meet the definition of “inpatient services" in 24-A M.R.S.A. Section 2843(3)(B). Inpatient services must be covered at the same benefit level as for physical illnesses.

**Section 6. Minimum benefits for policies not subject to parity requirements**

 This section applies only to policies that are subject to this rule but are not subject to the parity requirements of Title 24-A M.R.S.A., Section 2843(5-C). Most policies subject to this rule will be subject to the parity requirements and not to this section. The exception is group policies other than employee groups, such as association groups, to the extent they cover employees of employers with 20 or fewer employees. Except as provided by Section 7, any policy subject to this section will be deemed to be in compliance with the requirements of Title 24-A M.R.S.A., Section 2842 if it provides, at a minimum, the following benefits for a covered person suffering from substance abuse:

A. Residential Treatment and Non-residential Day Treatment.

(1) Annual Maximum. The policy must provide residential treatment benefits for substance abuse of at least 30 days per calendar year. However, in no case need the total number of inpatient days allowed by the policy for all illnesses be exceeded. Two days of non-residential day treatment shall be counted as one day of residential treatment.

(2) Coinsurance. The minimum level of benefits provided for substance abuse must be at least the lesser of 90 percent of the charges or the level of benefits provided for any other illness. The coinsurance provision, if any, shall be administered uniformly regardless of whether services are rendered in a hospital or other residential or non-residential facility.

(3) Maximum Lifetime Residential Benefits. The policy may contain a lifetime maximum limit on the number of covered days for residential treatment of substance abuse of not less than 60 days. Two days of non-residential treatment shall be counted as one day of residential treatment. Services for each admission shall be according to a treatment plan.

B. Outpatient Care Other than Non-residential Day Treatment.

(1) Annual Maximum. The policy must provide an annual benefit of at least $1,500 for outpatient care for substance abuse other than non-residential day treatment.

(2) Coinsurance. The minimum level of benefits provided for outpatient care of substance abuse other than non-residential day treatment must be at least 80 percent of the usual, customary, and reasonable charge, or, if less, the coinsurance amount under the policy for other illnesses. An amount based on a relative value scale or other reasonable methodology may be substituted for the usual, customary, and reasonable charge. In the case of either a preferred provider or a non-preferred provider under a preferred provider arrangement approved pursuant to Title 24-A M.R.S.A., Section 2675, the allowable charge may be substituted for the usual, customary, and reasonable charge.

C. Deductible. The policy may contain a deductible for substance abuse benefits in one of the following ways:

(1) If the policy contains a policy deductible applicable to all benefits, substance abuse benefits may be subject to that deductible and no separate deductible for substance abuse may be required.

(2) Alternatively, the policy may contain a separate deductible for substance abuse benefits not to exceed $150 per calendar year, regardless of whether the policy contains a deductible for other illnesses.

D. Maximum Lifetime Benefits. The policy may contain a maximum lifetime benefit for substance abuse benefits of not less than $25,000 except the policy total maximum benefit, if any, need not be exceeded.

**Section 7. Major medical policy**

 This section applies only to policies that are subject to this rule but are not subject to the parity requirements of Title 24-A M.R.S.A., Section 2843(5-C). Most policies subject to this rule will be subject to the parity requirements and not to this section. The exception is group policies other than employee groups, such as association groups, to the extent they cover employees of employers with 20 or fewer employees. Any supplemental major medical Policy subject to this section will be deemed to be in compliance with the requirements of Title 24-A M.R.S.A., Section 2842 if it provides, at a minimum, the benefits provided under Section 5 above less an amount equal to the covered charges used to determine the benefit provided by any base coverage provided the same group, by an insurer or non-profit and/or hospital medical services organization. Although a supplemental major medical policy must contain the minimum required benefits, it is the intent of the Rule that a person covered under both base coverage and a supplemental major medical policy not be entitled to "stack" the substance abuse benefits of the two policies. The two policies combined need not provide, in the aggregate, more than the minimum required benefits.

**Section 8. Non-profit hospital or medical service corporation**

 This section applies only to contracts that are subject to this rule but are not subject to the parity requirements of Title 24 M.R.S.A., Section 2325-A (5-C). Most contracts subject to this rule will be subject to the parity requirements and not to this section. The exception is group contracts other than employee groups, such as association groups, to the extent they cover employees of employers with 20 or fewer employees. For purposes of this Rule, group contracts issued jointly by a nonprofit hospital service corporation and a nonprofit medical service corporation will be considered as one contract.

 Any group contract subject to this section will be deemed to be in compliance with 24 M.R.S.A. Section 2329, if it provides, at a minimum, the following benefits for a covered person suffering from substance abuse:

A. Residential Treatment and Non-residential Day Treatment.

(1) Annual Maximum. The contract must provide residential treatment benefits for substance abuse of at least 30 days per calendar year. However, in no case need the total number of inpatient days allowed by the contract for all illnesses be exceeded. Two days of non-residential day treatment shall be counted as one day of residential treatment.

(2) Coinsurance. The minimum level of benefits provided for substance abuse must be at least the lesser of 90 percent of the charges or the level of benefits provided for any other illness. The coinsurance provision, if any, shall be administered uniformly regardless of whether services are rendered in a hospital or other residential or non-residential facility.

(3) Maximum Lifetime Residential Benefits. The contract may contain a lifetime maximum limit on the number of covered days for residential treatment of substance abuse of not less than 60 days. Two days of non-residential treatment shall be counted as one day of residential treatment. Services for each admission shall be according to a treatment plan.

B. Outpatient Care Other than Non-residential Day Treatment.

(1) Annual Maximum. The contract must provide an annual benefit of at least $1,500 for outpatient care for substance abuse other than non-residential day treatment.

(2) Coinsurance. The minimum level of benefits provided for outpatient care of substance abuse other than non-residential day treatment must be at least 80 percent of the usual, customary and reasonable charge, or, if less, the coinsurance amount under the contract for other illnesses. An amount based on a relative value scale or other reasonable methodology may be substituted for the usual, customary, and reasonable charge. In the case of either a preferred provider or a non-preferred provider under a preferred provider arrangement approved pursuant to Title 24, Section 2337 or Title 24-A M.R.S.A., Section 2675, the allowable charge may be substituted for the usual, customary, and reasonable charge.

C. Deductible. The contract may contain a deductible for substance abuse benefits in one of the following ways:

(1) If the contract contains a contract deductible applicable to all benefits, substance abuse benefits may be subject to that deductible and no separate deductible for substance abuse may be required.

(2) Alternatively, the contract may contain a separate deductible for substance abuse benefits not to exceed $150 per calendar year, regardless of whether the policy contains a deductible for other illnesses.

D. Maximum Lifetime Benefits. The contract may contain a maximum lifetime benefit for substance abuse benefits of not less than $25,000 except the contract total maximum benefit, if any, need not be exceeded.

**Section 9. Coordination with Medicare**

 Any policy or contract subject to this Rule may limit or exclude benefits for substance abuse treatment services to the extent benefits would otherwise duplicate and be secondary to benefits provided by the United States Health Insurance for by the Aged Act, Title XVIII of the Social Security Amendments of 1965, Public Law 89-97 as amended (Medicare). To the extent Medicare may provide benefits for substance abuse less than the minimum required by this Rule, contracts and policies other than Medicare supplement policies subject to Title 24-A M.R.S.A., Chapter 67, must cover the difference between Medicare and minimum required benefits.

**Section 10. Effective date**

 The provisions of this Rule are effective June 1, 1984. The 1993 amendments to this Rule apply to policies and certificates executed, delivered, issued for delivery, or renewed on or after July 15, 1993. The 2004 amendments to this rule are effective March 1, 2004.

EFFECTIVE DATE:

 June 1, 1984

AMENDED:

 July 15, 1993

EFFECTIVE DATE (ELECTRONIC CONVERSION):

 January 14, 1997

AMENDED:

 March 1, 2004 - filing 2004-63

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18, 2025