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

**031 BUREAU OF INSURANCE**

**Chapter 745: INDIVIDUAL HEALTH INSURANCE PILOT PROJECTS FOR PERSONS UNDER 30 YEARS OF AGE**

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**SECTION 1. AUTHORITY**

This Rule is adopted by the Superintendent pursuant to 24-A M.R.S.A. §§ 212 and 2736-C.

**SECTION 2. PURPOSE**

The purpose of this Rule is to establish procedures and policies pursuant to 24-A M.R.S.A. § 2736-C(10) for submitting a pilot project proposal to provide health insurance coverage to persons under 30 years of age, to establish minimum requirements for approval of a pilot project, and to establish requirements for minimum benefits.

**SECTION 3. APPLICABILITY AND SCOPE**

This Rule applies to any health insurance carrier that offers individual expense incurred health insurance plans in the State of Maine, is marketing an individual insurance plan subject to 24-A M.R.S.A. §2736-C in this State, and has a medical-loss ratio of at least 70% in the individual market. Those carriers may issue pilot project plans only to individuals under age 30.

**SECTION 4. DEFINITIONS**

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

1. "Deductible" means the dollar amount the insured must pay directly to the provider for covered services in a plan year before any benefits subject to the deductible are payable by the plan.

2. "Coinsurance" means the percentage of eligible charges that the insured must pay directly to the provider, after any deductible applicable to the service has been satisfied.

3. “Copayment” means a flat dollar charge that must be paid by the insured directly to the provider for each service or prescription.

4. “Out-of-Pocket Expense” means an eligible charge paid by the insured directly to a provider for covered services, including deductibles, coinsurance and copayments.

5. "Eligible Charge" means:

A. An amount the provider is required to accept as payment in full for a given service under the terms of its contract with an HMO, non-profit service organization, preferred provider organization, or plan sponsor.

B. If a service is not rendered pursuant to a contract with an insurance carrier, HMO, non-profit service organization, preferred provider organization or plan sponsor, the eligible charge is the lesser of:

(1) The actual amount charged; or

1. The Usual and Customary Charge for the services provided, taking into consideration the geographic area in which the services are provided and significant regional variations in the cost of services. A relative value scale or other reasonable methodology may be used in calculating the usual and customary charge.

**SECTION 5. PROCESS FOR SUBMITTING A PILOT PROJECT PROPOSAL**

An applicant for a pilot project proposal pursuant to 24-A M.R.S.A. §2736-C(10) must file with the Superintendent an application accompanied by an application fee of $20 and provide the following information:

1. A copy of the proposed plan of insurance;

2. A detailed description of all provider networks;

3. A rate filing for the plan;

4. An explanation of how the plan will be marketed;

5. The text of the notification to be provided enrollees pursuant to Section 6 of this Rule explaining the mandatory increase in plan benefits at age 30 and their guaranteed issue rights to purchase other individual health insurance plans without being subject to a pre-existing condition exclusion; and

6. A completed Bureau of Insurance pilot project review standards checklist.

**SECTION 6. GUARANTEED ISSUE AND MANDATORY BENEFIT INCREASES**

1. The guaranteed issue requirements of 24-A M.R.S.A. §2736-C apply to plans approved pursuant to this Rule only with respect to Maine residents who apply for coverage prior to the age of 30.

2. All plans issued pursuant to this Rule must provide for a mandatory increase in benefits effective at the first annual renewal after the enrollee reaches the age of 30.

A. Benefits under the plan for persons 30 and over must be the same as benefits under one of the carrier's standardized health insurance plans (Standardized Plan A or Standardized Plan B).

B. Upon providing the enrollee with at least 60 days notice, the carrier may increase premiums to the same level as would apply to a new enrollee for one of the carrier's standardized plans.

C. The notice of rate increase must advise the enrollee of all of the carrier's other individual health insurance plans available in the State of Maine on a guaranteed issue basis pursuant to 24-A M.R.S.A. §2736-C.

D. A carrier's rate revisions for the standardized plans must reflect the combined claims experience of those who purchased the standardized plans directly and those who receive standardized plan benefits pursuant to this subsection.

3. Between the ninetieth and sixtieth day before an enrollee's thirtieth birthday, a carrier must provide the enrollee with that written notification of the mandatory increase in plan benefits and the enrollee's guaranteed issue rights submitted for approval pursuant to Section 5 of this Rule.

4. Carriers must advise enrollees that they are nearing plan maximums when claims received by the carrier reach 75% of any annual or lifetime maximum contained in the policy and provide the enrollee with written notification regarding the guaranteed issue rights to enroll in other individual policies offered in Maine without being subject to a preexisting condition exclusion. A carrier may not enforce annual or lifetime maximums unless the required notice has been provided.

**SECTION 7. MINIMUM PLAN REQUIREMENTS FOR PERSONS UNDER 30 YEARS OF AGE**

1. A plan issued pursuant to this Rule must provide coverage for medically necessary hospital, medical, and surgical expenses, subject to the minimum benefit requirements set forth in this section. Carriers may offer pilot project plans with greater benefits.

A. The first three office visits must be covered prior to the application of any plan deductible.

(1) The first three office visits may be subject to cost sharing not greater than a $25 copayment or 20% of eligible charges for a participating provider. Additional services other than charges for the office visit may be subject to the plan deductible or to higher cost sharing, even if performed during one of the first three office visits.

(2) Enrollees may use the first three office visits for medically necessary services including, but not limited to, the following types of services.

(a) Routine care

(b) Preventive care

(c) Sick visits

(d) Eye examinations

(e) Family planning

(f) Consultations with a specialist

(g) Physical, speech, and occupational therapies

(h) Care by a chiropractor

(i) Outpatient mental health services

(j) Outpatient drug rehabilitation services

(k) Outpatient alcohol rehabilitation services

B. Prescription drug expenses must be covered.

(1) Prescription drug expenses may not be subject to any plan deductible.

(2) The first $1,500 of eligible prescription drug expenses may be subject to cost sharing not greater than:

(a) $25 copayment for a 30 day supply, or

(b) 20% of eligible charges.

(3) After the first $1,500 in eligible prescription drug charges, actuarially expected aggregate cost sharing may not exceed 50% of eligible charges, excluding out-of-pocket expenses incurred after the enrollee has reached any maximum benefit limitations included in the plan.

C. Prescription contraceptives must be covered to the same extent that coverage is provided for other prescription drugs.

D. Diabetes supplies, blood glucose monitors, insulin pumps and supplies, and infusion devices may not be subject to any plan deductible. Cost sharing may not exceed 50% of eligible charges.

E. Ambulance service and emergency room care must be covered and may not be subject to any plan deductible. Copayments or coinsurance may not exceed $150 for ambulance or $150 for emergency room care.

F. Coverage for prosthetic devices must be covered and may not be subject to any plan deductible.

G. At a minimum, the following preventive services must be covered prior to the application of any plan deductible.

(1) Screening Mammograms

(2) Prostate Cancer Screening

(3) Colorectal Cancer Screening

Actuarially expected cost sharing for in-network preventive services in the form of copayments or coinsurance may not exceed 50% of eligible charges.

H. Inpatient services must be covered.

Cost sharing for in-network inpatient services, after satisfaction of any applicable deductible, may not exceed 50% of eligible charges.

I. Outpatient services must be covered.

Cost sharing for in-network outpatient services, after satisfaction of any applicable deductible, may not exceed 50% of eligible charges.

J. Mental health and substance abuse services must be covered.

Actuarially expected aggregate cost sharing for in-network services, after satisfaction of any applicable deductible, may not exceed 50% of eligible charges.

K. Mental health parity must be offered.

Mental health benefits must be offered pursuant to 24-A M.R.S.A. §2749-C.

L. Physical therapy must be covered.

Actuarially expected aggregate cost sharing, after satisfaction of any applicable deductible, may not exceed 50% of eligible charges.

M. Exclusions

The plan may contain exclusions generally permitted under State law. Additional exclusions may be permitted if determined by the Superintendent to provide affordable individual health plans for persons under 30 years of age. Maternity benefits may be excluded only after the first three office visits. Pilot project plans offered by HMOs are not subject to the cost sharing requirements of Bureau of Insurance Rule Chapter 750. Except as otherwise provided in this Rule, HMOs may request exclusions generally permitted for non-HMO plans.

2. Additional Cost Sharing Limitations.

A. Deductible

(1) The plan may contain an annual plan year deductible not greater than $2,000.

(2) The plan must provide that actual charges paid toward the deductible during the last three months of a plan year, if applied to that year's deductible, will also be applied to the next year's deductible.

(3) The following services may be, but are not required to be, subject to a deductible.

(a) Services performed by the enrollee’s physician during office visits (including the first three office visits) such as taking x-rays, performing lab tests, outpatient surgery services, detoxification or psychological testing. During the first three office visits the procedure but not the office visit may be subject to the deductible.

(b) X rays and lab tests

(c) Hospital outpatient department services

(d) Outpatient surgery services

(e) Maternity care (except during the first three office visits)

(f) The fourth and subsequent medical office visits per individual

(g) Detoxification

(h) Psychological testing.

B. Annual Out-of-Pocket Maximum

(1) The plan must include an annual out-of-pocket maximum. Total cost sharing for covered services in the form of copayments, coinsurance and any plan deductible may not exceed $10,000 per year.

(2) Medical expenses which exceed any annual per condition or sickness maximum, lifetime maximum, prescription drug maximum or other internal plan benefit maximum are not required to be applicable towards satisfying the out-of-pocket maximum.

C. Annual Per Condition or Sickness Limitations

The plan may contain a maximum annual benefit per accident or sickness, which may not be less than $50,000 per year.

D. Maximum Lifetime Benefit

The plan may contain a maximum lifetime benefit, which may not be less than $250,000, unless the plan pays at least 80% of in-network benefits for most types of covered services. Plans that pay at least 80% of in-network benefits may contain a maximum lifetime benefit not less than $100,000.

E. Aggregate Cost Sharing

Actuarially expected aggregate cost sharing for all in-network services, after satisfaction of any applicable deductible but prior to exceeding any per condition or sickness limitation or maximum lifetime benefit, may not exceed 50% of eligible charges.

**SECTION 8. LOSS RATIO REQUIREMENTS**

To be eligible to market plans to persons under 30 years of age pursuant to this Rule, a carrier must offer Standardized Plan A and Standardized Plan B and have a medical loss ratio of at least 70% in the individual market. The loss ratio is determined by dividing individual incurred claims by individual earned premiums based on recent Rule 940 reports. The number of Rule 940 reports to be used will be based on the number of member months for the individual line on the carrier's Rule 945 reports reduced by any member months associated with short-term policies as defined by 24-A M.R.S.A. §2849-B.

1. The most recent Rule 940 report must be used if the number of member months for that year is at least 12,000.

2. The sum of incurred claims and the sum of earned premiums from the two most recent Rule 940 reports must be used if (1) does not apply and the number of member months for those two years is at least 12,000.

3. The sum of incurred claims and the sum of earned premiums from the three most recent Rule 940 reports must be used if (1) and (2) do not apply and the number of member months for those three years is at least 12,000.

4. The sum of incurred claims and the sum of earned premiums from the four most recent Rule 940 reports must be used if (1) , (2) , and (3) do not apply.

**SECTION 9. REPORTING REQUIREMENTS**

Carriers offering health plans pursuant to this Rule must submit reports to the Superintendent by January 31st of each year that include all of the following information. Carriers may submit a written request for an extension of up to 15 days.

1. The total number of enrollees.

2. The number of enrollees who have left the plan.

3. The ages of new enrollees.

4. An analysis of services used by enrollees, in a format approved by the Superintendent.

5. A statement regarding the impact of the plan on premiums and availability of coverage in the individual market in Maine.

6. The number of enrollees who have reached the plan per condition or illness maximum, the plan out of pocket maximum, the plan annual maximum, or the plan lifetime maximum.

7. The number of new enrollees who had coverage within the 90 days prior to applying for the pilot project plan and the number who were uninsured. To the extent that the information is available from the enrollee’s application, the number whose prior coverage was in the individual market and the number who were dependents covered under their parents’ policies.

**SECTION 10. EFFECTIVE DATE**

(NOTE: The statute provides that plans may offer pilot project plans to persons under 30 years of age beginning July 1, 2009.)

This rule is effective May 26, 2009.

STATUTORY AUTHORITY: 24-A MRSA §2736-C sub-§10

EFFECTIVE DATE:

May 26, 2009 – filing 2009-197

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