

# MAINE STATE LEGISLATURE

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(Filing No. S-236)

**INSURANCE AND FINANCIAL SERVICES**

Reproduced and distributed under the direction of the Secretary of the Senate.

**STATE OF MAINE**

**SENATE**

**128TH LEGISLATURE**

**FIRST REGULAR SESSION**

COMMITTEE AMENDMENT "A" to S.P. 147, L.D. 445, Bill, "An Act To Encourage Maine Consumers To Comparison-shop for Certain Health Care Procedures and To Lower Health Care Costs"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

**Sec. 1. 22 MRSA §1718-B, sub-§2, ¶D** is enacted to read:

D. Beginning January 1, 2018, at the time a referral or recommendation is made for a comparable health care service as defined in Title 24-A, section 4318-A, subsection 1, paragraph A during an in-person visit, the health care entity making that referral or recommendation shall notify a patient who has private health insurance coverage of the patient's right to obtain services from a different provider. A health care entity shall comply with this paragraph by providing a written notice at the time the health care entity recommends or refers a patient for a health care service or procedure that may qualify as a comparable health care service. A written notice provided under this paragraph must include a notification that, prior to obtaining the recommended service, the patient may review the health care price transparency tool provided by the patient's carrier or contact the patient's carrier directly via a toll-free telephone number so that the patient may consider whether the recommended provider of the comparable health care service represents the best value for the patient. A written notice provided under this paragraph must also include a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow the carrier to assist the patient in comparing prices for the comparable health care service.

**Sec. 2. 22 MRSA §8712, sub-§2**, as amended by PL 2011, c. 525, §1, is further amended to read:

**2. Payments.** The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services, comparable

**COMMITTEE AMENDMENT**

1 health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A  
2 and other services that are predominantly elective and may be provided to a large number  
3 of patients who do not have health insurance or are underinsured. The website must also  
4 be constructed to display prices paid by individual commercial health insurance  
5 companies, 3rd-party administrators and, unless prohibited by federal law, governmental  
6 payors. Beginning October 1, 2012, price information posted on the website must be  
7 posted semiannually, must display the date of posting and, when posted, must be current  
8 to within 12 months of the date of submission of the information. Payment reports and  
9 price information posted on the website must include data submitted by payors with  
10 regard to all health care facilities and practitioners that provide comparable health care  
11 services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A or services  
12 for which the organization reports data pertaining to the statewide average price pursuant  
13 to this subsection or Title 24-A, section 4318-B. Upon notice made by a health care  
14 facility or practitioner that data posted by the organization pertaining to that facility or  
15 practitioner is inaccurate or incomplete, the organization shall remedy the inaccurate or  
16 incomplete data within the earlier of 30 days of receipt of the notice and the next  
17 semiannual posting date.

18 **Sec. 3. 24-A MRSA §4302, sub-§1, ¶K**, as amended by PL 2009, c. 439, Pt. B,  
19 §3, is further amended to read:

20 K. A description of the requirements for enrollees to obtain coverage of routine costs  
21 of clinical trials and information on the manner in which enrollees not eligible to  
22 participate in clinical trials may qualify for the compassionate use program of the  
23 federal Food and Drug Administration for use of investigational drugs pursuant to 21  
24 Code of Federal Regulations, Section 312.34, as amended; ~~and~~

25 **Sec. 4. 24-A MRSA §4302, sub-§1, ¶L**, as enacted by PL 2009, c. 439, Pt. B,  
26 §4, is amended to read:

27 L. A description of a provider profiling program that may be a part of the health  
28 plan, including the location of provider performance ratings in the plan materials or  
29 on a publicly accessible website, information explaining the provider rating system  
30 and the basis upon which provider performance is measured, the limitations of the  
31 data used to measure provider performance, the process for selecting providers and a  
32 conspicuous written disclaimer explaining the provider performance ratings should  
33 only be used as a guide for choosing a provider and that enrollees should consult their  
34 current provider before making a decision about their health care based on a provider  
35 rating; ~~and~~

36 **Sec. 5. 24-A MRSA §4302, sub-§1, ¶M** is enacted to read:

37 M. If the health plan is subject to the requirements of section 4318-A, a description  
38 of the incentives available to an enrollee and how to earn such incentives if enrolled  
39 in a health plan offering a comparable health care service incentive program designed  
40 pursuant to section 4318-A.

41 **Sec. 6. 24-A MRSA §4303, sub-§21** is enacted to read:

42 21. Health care price transparency tools. Beginning January 1, 2018, a carrier  
43 offering a health plan in this State shall comply with the following requirements.

1 A. A carrier shall develop and make available a website accessible to enrollees and a  
2 toll-free telephone number that enable enrollees to obtain information on the  
3 estimated costs for obtaining a comparable health care service, as defined in Title  
4 24-A, section 4318-A, subsection 1, paragraph A, from network providers, as well as  
5 quality data for those providers, to the extent available. A carrier may comply with  
6 the requirements of this paragraph by directing enrollees to the publicly accessible  
7 health care costs website of the Maine Health Data Organization.

8 B. A carrier shall make available to the enrollee the ability to obtain an estimated  
9 cost that is based on a description of the service or the applicable standard medical  
10 codes or current procedural terminology codes used by the American Medical  
11 Association provided to the enrollee by the provider. Upon an enrollee's request, the  
12 carrier shall request additional or clarifying code information, if needed, from the  
13 provider involved with the comparable health care service. If the carrier obtains  
14 specific code information from the enrollee or the enrollee's provider, the carrier shall  
15 provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based  
16 on that code information, to the extent such information is made available to the  
17 carrier by the provider.

18 C. A carrier shall notify an enrollee that the amounts are estimates based on  
19 information available to the carrier at the time the request is made and that the  
20 amount the enrollee will be responsible to pay may vary due to unforeseen  
21 circumstances that arise out of the proposed comparable health care service. This  
22 subsection does not prohibit a carrier from imposing cost-sharing requirements  
23 disclosed in the enrollee's certificate of coverage for unforeseen health care services  
24 that arise out of the proposed comparable health care service or for a procedure or  
25 service that was not included in the original estimate. This subsection does not  
26 preclude an enrollee from contacting the carrier to obtain more information about a  
27 particular admission, procedure or service with respect to a particular provider.

28 D. Notwithstanding the provisions of this subsection and at the request of a carrier,  
29 the superintendent may grant an additional year to comply with the provisions of this  
30 subsection as long as the carrier has demonstrated a good faith effort to comply with  
31 the provisions of this subsection and has provided the superintendent with an action  
32 plan detailing the steps to be taken by the carrier to comply with this subsection no  
33 later than January 1, 2019.

34 **Sec. 7. 24-A MRS §4303, sub-§22** is enacted to read:

35 **22. Denial of referral by out-of-network provider prohibited.** Beginning January  
36 1, 2018, a carrier may not deny payment for any health care service covered under an  
37 enrollee's health plan based solely on the basis that the enrollee's referral was made by a  
38 provider who is not a member of the carrier's provider network.

39 **Sec. 8. 24-A MRS §4318-A** is enacted to read:

40 **§4318-A. Comparable health care service incentive program**

41 Beginning January 1, 2019, a carrier offering a health plan in this State shall  
42 establish, at a minimum, for all small group health plans as defined in section 2808-B,  
43 subsection 1, paragraph G compatible with a health savings account authorized under

1 federal law, a health plan design in which enrollees are directly incentivized to shop for  
2 low-cost, high-quality participating providers for comparable health care services.  
3 Incentives may include, but are not limited to, cash payments, gift cards or credits or  
4 reductions of premiums, copayments or deductibles. A small group health plan design  
5 created under this section must remain available to enrollees for at least 2 consecutive  
6 years, except that any changes made to the program after 2 years, including, but not  
7 limited to, ending the incentive, may not be construed as a change to the small group  
8 health plan design for the purpose of guaranteed renewability under section 2808-B,  
9 subsection 4 or section 2850-B. A multiple-employer welfare arrangement is not  
10 considered a carrier for the purposes of this section.

11 **1. Definitions.** As used in this section, unless the context otherwise indicates, the  
12 following terms have the following meanings.

13 A. "Comparable health care service" means nonemergency, outpatient health care  
14 services in the following categories:

15 (1) Physical and occupational therapy services;

16 (2) Radiology and imaging services;

17 (3) Laboratory services; and

18 (4) Infusion therapy services.

19 B. "Program" means the comparable health care service incentive program  
20 established by a carrier pursuant to this section.

21 **2. Filing with superintendent.** Plans filed with the superintendent pursuant to this  
22 section must disclose, in the summary of benefits and explanation of coverage, a detailed  
23 description of the incentives available to a plan enrollee. The description must clearly  
24 detail any incentives that may be earned by the enrollee, including any limits on such  
25 incentives, the actions that must be taken in order to earn such incentives and a list of the  
26 types of services that qualify under the program. This subsection may not be construed to  
27 prevent a carrier from directing an enrollee to the carrier's website or toll-free telephone  
28 number for further information on the program in the summary of benefits and  
29 explanation of coverage. The superintendent shall review the filing made by the carrier  
30 to determine if the carrier's program complies with the requirements of this section.

31 **3. Availability of program; notice to enrollees.** Annually at enrollment or renewal,  
32 a carrier shall provide notice about the availability of the program to an enrollee who is  
33 enrolled in a health plan eligible for the program as required by section 4302, subsection  
34 1, paragraph M.

35 **4. Additional types of nonemergency health care services or procedures.**  
36 Nothing in this section precludes a carrier from including additional types of  
37 nonemergency health care services or procedures in its program.

38 **5. No administrative expense.** An incentive payment made by a carrier in  
39 accordance with this section is not an administrative expense of the carrier for rate  
40 development or rate filing purposes.

1           6. Study and evaluation. Beginning March 1, 2020 and annually thereafter, the  
2 superintendent shall undertake a study and evaluation of the programs created by carriers  
3 as required by this section. The superintendent may request information on enrollment  
4 and use of incentives earned by enrollees of a carrier as necessary. By April 15, 2020 and  
5 annually thereafter, the superintendent shall submit an aggregate report relating to the  
6 performance of the programs, the use of incentives, the incentives earned by enrollees  
7 and the cumulative effect of the programs to the joint standing committee of the  
8 Legislature having jurisdiction over health insurance matters.

9           7. Rules. The superintendent may adopt rules as necessary to implement this  
10 section. Rules adopted pursuant to this subsection are major substantive rules as defined  
11 in Title 5, chapter 375, subchapter 2-A.

12           8. Repeal. This section is repealed January 1, 2024.

13           Sec. 9. 24-A MRSA §4318-B is enacted to read:

14           §4318-B. Access to lower-priced services

15           1. Services from out-of-network provider; lower prices. Beginning January 1,  
16 2019, if an enrollee covered under a health plan other than a health maintenance  
17 organization plan elects to obtain a covered comparable health care service as defined in  
18 section 4318-A, subsection 1, paragraph A from an out-of-network provider at a price  
19 that is the same or less than the statewide average for the same covered health care  
20 service based on data reported on the publicly accessible health care costs website of the  
21 Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service  
22 from the out-of-network provider at the provider's charge and, upon request by the  
23 enrollee, shall apply the payments made by the enrollee for that comparable health care  
24 service toward the enrollee's deductible and out-of-pocket maximum as specified in the  
25 enrollee's health plan as if the health care services had been provided by an in-network  
26 provider. A carrier may use the average price paid to a network provider for the covered  
27 comparable health care service under the enrollee's health plan in lieu of the statewide  
28 average price on the Maine Health Data Organization's publicly accessible website as  
29 long as the carrier uses a reasonable method to calculate the average price paid and the  
30 information is available to enrollees through a website accessible to the enrollee and a  
31 toll-free telephone number that provide, at a minimum, information relating to  
32 comparable health care services. The enrollee is responsible for demonstrating to the  
33 carrier that payments made by the enrollee to the out-of-network provider should be  
34 applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this  
35 section. The carrier shall provide a downloadable or interactive online form to the  
36 enrollee for the purpose of making such a demonstration and may require that copies of  
37 bills and proof of payment be submitted by the enrollee. For the purposes of this section,  
38 "out-of-network provider" means a provider located in Massachusetts, New Hampshire or  
39 this State that is enrolled in the MaineCare program and participates in Medicare.

40           2. Rules. The superintendent may adopt rules as necessary to implement this  
41 section. Rules adopted pursuant to this subsection are routine technical rules as defined  
42 in Title 5, chapter 375, subchapter 2-A.

43           3. Repeal. This section is repealed January 1, 2024.'

**SUMMARY**

1  
2 This amendment replaces the bill. The amendment requires carriers offering health  
3 plans in the State, beginning January 1, 2019, to establish a small group health plan  
4 design, for all small group health plans compatible with health savings accounts  
5 authorized under federal law, in which enrollees are directly incentivized to shop for  
6 comparable health care services from low-cost, high-quality providers. The amendment  
7 defines "comparable health care service" as a nonemergency, outpatient health care  
8 service in the following 4 categories: physical and occupational therapy services;  
9 radiology and imaging services; laboratory services; and infusion therapy services. The  
10 amendment requires the Superintendent of Insurance to study and evaluate the incentive  
11 programs used by carriers and report annually to the Legislature beginning March 1,  
12 2020. These provisions are repealed on January 1, 2024.

13 Beginning January 1, 2018, the amendment requires carriers to develop and make  
14 available a website and toll-free telephone number to allow enrollees to obtain  
15 information about estimated costs for obtaining comparable health care services from  
16 network providers. The amendment permits a carrier to direct enrollees to the publicly  
17 accessible health care costs website of the Maine Health Data Organization.

18 Beginning January 1, 2019, the amendment requires carriers upon request by an  
19 enrollee to apply the amount paid for a comparable health care service provided by an  
20 out-of-network provider toward the enrollee's member cost sharing as specified in the  
21 enrollee's health plan as if the health care services were provided by a network provider,  
22 as long as the cost of the out-of-network service is the same or less than the statewide  
23 average payment for the same service based on data reported on the publicly accessible  
24 health care costs website of the Maine Health Data Organization. A carrier may use the  
25 average network price paid by the carrier in lieu of the statewide average payment for the  
26 same service based on data reported on the publicly accessible health care costs website  
27 of the Maine Health Data Organization. The amendment defines an out-of-network  
28 provider as a provider located in Maine, Massachusetts or New Hampshire that is  
29 enrolled in the MaineCare program as a provider and that participates in Medicare. This  
30 provision is repealed January 1, 2024.

31 The amendment also requires providers to notify patients of their right to obtain  
32 comparable health care services from a different provider at the time a provider makes a  
33 referral or recommendation for a comparable health care service during an in-person visit.

**FISCAL NOTE REQUIRED**

**(See attached)**



# 128th MAINE LEGISLATURE

LD 445

LR 484(02)

## An Act To Encourage Maine Consumers To Comparison-shop for Certain Health Care Procedures and To Lower Health Care Costs

Fiscal Note for Bill as Amended by Committee Amendment "A" (S-236)  
 Committee: Insurance and Financial Services  
 Fiscal Note Required: Yes

### Fiscal Note

Potential current biennium savings - All Funds  
 Minor cost increase - Other Special Revenue Funds

#### Fiscal Detail and Notes

Beginning January 1, 2019, carriers in the State must offer, on all small group health plans compatible with a health savings account, a health plan designed to incentivize shopping for comparable health care services. The State Employee Health Plan (SEHP) is not a small group plan and is not required to provide an incentivied plan. However, the SEHP could create a plan to provide incentives (i.e. cash payments, gift cards or premium credits) for members who shop for and receive a lower cost, but similar quality, health care service. If enough members receive these lower cost services, the SEHP could realize savings. The potential savings are dependant on the SEHP setting up an incentivied plan and on member behavior modification, which will only happen through education about the program. No estimate of potential savings can be made at this time.

Any additional costs to the Department of Professional and Financial Regulation to adopt the changes in this bill are expected to be minor and can be absorbed within existing budgeted resources.