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H.P. 1501 House of Representatives, February 13, 2020

An Act To Protect Consumers from Surprise Emergency Medical Bills

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Speaker GIDEON of Freeport.
Cosponsored by Senator SANBORN, H. of Cumberland and
Representatives: BICKFORD of Auburn, FECTEAU of Biddeford, FOLEY of Biddeford, HEPLER of Woolwich, MOONEN of Portland, PRESCOTT of Waterboro, TEPLER of Topsham, Senator: President JACKSON of Aroostook.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1718-D, as enacted by PL 2017, c. 218, §1 and affected by §3, is amended to read:

§1718-D. Prohibition on balance billing for surprise bills; disputes of surprise bills for uninsured patients and persons covered under self-insured health benefit plans

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

A. "Enrollee" has the same meaning as in Title 24-A, section 4301-A, subsection 5.

B. "Health plan" has the same meaning as in Title 24-A, section 4301-A, subsection 7.

B-1. "Knowingly elected to obtain the services from an out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this paragraph.

C. "Provider" has the same meaning as in Title 24-A, section 4301-A, subsection 16.

D. "Surprise bill" has the same meaning as in Title 24-A, section 4303-C, subsection 1.

E. "Visit" means any interaction between an enrollee and one or more providers for the purpose of assessing the health status of an enrollee or providing one or more health care services between the time an enrollee enters a facility and the time an enrollee is discharged.

2. Prohibition on balance billing. An out-of-network provider reimbursed for a surprise bill under Title 24-A, section 4303-C~~, subsection 2, paragraph B~~ may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out-of-pocket cost expense that would be imposed for the health care services if the services were rendered by a network provider under the enrollee's health plan. An out-of-network provider is also subject to the following with respect to any overpayment made by an enrollee.

A. If an out-of-network provider provides health care services covered under an enrollee's health plan and the out-of-network provider receives payment from the enrollee for health care services for which the enrollee is not responsible pursuant to this subsection, the out-of-network provider shall reimburse the enrollee within 30 calendar days after the earlier of the date that the provider received notice of the overpayment and the date the provider became aware of the overpayment.

B. An out-of-network provider that fails to reimburse an enrollee for an overpayment as required by paragraph A shall pay interest on the overpayment at the rate of 10% per annum beginning on the earlier of the date the provider received notice of the overpayment and the date the provider became aware of the overpayment. An enrollee is not required to request the accrued interest from the out-of-network provider in order to receive interest with the reimbursement amount.

3. Uninsured patients; disputes of surprise bills. An uninsured patient who has received a surprise bill from a provider for one or more health care services rendered during a single visit totaling $750 or more may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-C, subsection 3. The independent dispute resolution entity contracted to resolve the dispute over the surprise bill shall select either the out-of-network provider's fee or the uninsured patient's proposed payment amount in accordance with Title 24-A, section 4303-C, subsection 3. In the case of emergency or other medically necessary care, an uninsured patient may not be charged by a provider more than the amounts generally billed to a patient who has insurance covering such care as determined using the method described in 26 Code of Federal Regulations, Section 1.501(r)-5, paragraph (b)(3) or (b)(4). A provider shall hold the uninsured patient harmless for the duration of the independent dispute resolution process and may not seek payment until the independent dispute resolution process is completed. Notwithstanding Title 24-A, section 4303-C, subsection 3, paragraph F, payment for the independent dispute resolution process is the responsibility of the provider. In the event a claim includes more than one health care service rendered during a single visit, the independent dispute resolution entity may allocate the prorated independent dispute resolution costs at its discretion among providers.

4. Person covered under self-insured health benefit plan; disputes of surprise bills. A person covered under a self-insured health benefit plan that is not subject to the provisions of Title 24-A, section 4303-C pursuant to Title 24-A, section 4303-C, subsection 4 and who has received a surprise bill may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-C, subsection 3. The independent dispute resolution entity contracted to resolve the dispute over the surprise bill shall select either the out-of-network provider's fee or the covered person's proposed payment amount in accordance with Title 24-A, section 4303-C, subsection 3.

5. Applicability. Subsections 3 and 4 do not apply to an uninsured patient or person covered under a self-insured health benefit plan who knowingly elected to obtain the services from an out-of-network provider.

Sec. 2. 24-A MRSA §4303-C, as enacted by PL 2017, c. 218, §2 and affected by §3, is amended to read:

§4303-C. Protection from surprise bills

1. Surprise bill defined. As used in this section, unless the context otherwise indicates, "surprise bill" means a bill for health care services, ~~other than~~ including, but not limited to, emergency services, received by an enrollee for covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network

provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. "Surprise bill" does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.

1-A. "Knowingly elect to obtain such services from that out-of-network provider" defined. As used in this section, unless the context otherwise indicates, "knowingly elect to obtain such services from that out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this subsection.

2. Requirements. With respect to a surprise bill:

A. 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;

B. A carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the average network rate under the enrollee's health care plan as payment in full, unless the carrier and out-of-network provider agree otherwise. If an out-of-network provider disagrees with a carrier's payment amount, the carrier and the out-of-network provider have 30 calendar days to negotiate an agreement on the payment amount in good faith. If the carrier and the out-of-network provider do not reach agreement on the payment amount within 30 calendar days, the out-of-network provider may submit a dispute regarding the payment and receive another payment from the carrier determined in accordance with the dispute resolution process in subsection 3, including any payment made pursuant to subsection 3, paragraph G; and

C. Notwithstanding paragraph B, 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. Dispute resolution process for surprise bills. The superintendent shall establish an independent dispute resolution process by which a dispute for a surprise bill in accordance with subsection 2 may be resolved as provided in this subsection.

A. The superintendent may select an independent dispute resolution entity to conduct the dispute resolution process. The superintendent shall adopt rules establishing standards for the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities. An independent dispute resolution

entity shall use licensed physicians in active practice in the same or similar specialty as the physician providing the service that is subject to the dispute resolution process. To the extent practicable, the physician must be licensed in this State. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

B. An independent dispute resolution entity shall make a decision within 30 days of receipt of the dispute for review.

C. In determining a reasonable fee for the health care services rendered, an independent dispute resolution entity shall select either the carrier's payment or the out-of-network provider's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in this paragraph. In determining the reasonable fee for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

(1) Whether there is a gross disparity between the fee charged by the out-of-network provider for services rendered as compared to:

(a) Fees paid to the provider for the same services rendered by the provider to other enrollees in a carrier's health plans in which the provider is not participating; and

(b) Fees paid by the carrier to reimburse similarly qualified providers for the same services in the same region who are not participating with the carrier;

(2) The out-of-network provider's level of training, education, specialization, quality and experience and, in the case of a hospital, the teaching staff, scope of services and case mix;

(3) The out-of-network provider's contracted rates for comparable services in the same geographic area with regard to patients in health care plans in which the provider is not participating;

(4) The circumstances and complexity of the particular case, including time and place of the service;

(5) Individual patient characteristics; and

(6) The usual and customary cost of the health care service as determined by the 80th percentile of the particular health care service performed by a provider in the same or similar specialty, as determined by the all-payer claims database maintained by the Maine Health Data Organization or, if Maine Health Data Organization claims data is insufficient or otherwise inapplicable, another independent medical claims database. If authorized by rule, the superintendent may enter into an agreement to obtain data from an independent medical claims database to carry out the functions of this subparagraph.

D. If an independent dispute resolution entity determines, based on the carrier's payment and the out-of-network provider's fee, that a settlement between the carrier and out-of-network provider is reasonably likely, or that both the carrier's payment and the out-of-network provider's fee represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith

negotiation for settlement. The carrier and out-of-network provider may be granted up to 10 business days for this negotiation, which runs concurrently with the 30-day period for dispute resolution.

E. The determination of an independent dispute resolution entity is binding on the carrier, out-of-network provider and enrollee and is admissible in any court proceeding between the carrier, out-of-network provider and enrollee or in any administrative proceeding between this State and the provider.

F. When an independent dispute resolution entity determines the carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network provider. When the independent dispute resolution entity determines the out-of-network provider's fee is reasonable, payment for the dispute resolution process is the responsibility of the carrier. When a good faith negotiation directed by the independent dispute resolution entity results in a settlement between the carrier and the out-of-network provider, the carrier and the out-of-network provider shall evenly divide and share the prorated cost for dispute resolution.

G. In a dispute for a surprise bill, when the difference between the out-of-network provider's charge and the average network rate under the enrollee's health plan pursuant to subsection 2, paragraph B, including any applicable enrollee cost sharing, is less than $750, a carrier shall reimburse the out-of-network provider directly for the provider's charges and the enrollee cost sharing for the services rendered as long as the provider's charges do not exceed the 80th percentile of charges for the particular health care service performed by a health care professional in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database specified by the superintendent and maintained by a nonprofit organization that is not affiliated with and does not receive funding from a carrier. An out-of-network provider may dispute more than one bill with the same carrier for the same health care service under this subsection as long as the total of the bills with that carrier for that health care service exceeds $750.

H. The superintendent shall enforce the determination of an independent dispute resolution entity pursuant to this subsection or any agreement made by a carrier and an out-of-network provider after the conclusion of the independent dispute resolution process pursuant to this subsection. The superintendent may use any powers provided to the superintendent under this Title.

4. Self-insured health benefit plans. An entity providing or administering a self-insured health benefit plan exempted from the applicability of this section under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) may elect to be subject to the provisions of this section. In the event an entity providing or administering a self-insured health benefit plan elects to be subject to the provisions of this section, the provisions of this section apply to a self-insured health benefit plan and its members in the same manner as the provisions of this section apply to a carrier and its enrollees. To elect to be subject to the provisions of this section, the entity shall provide notice, on an annual basis, to the superintendent, on a form and in a manner prescribed by the superintendent, attesting to the entity's participation and agreeing to be bound by the provisions of this section. The entity shall

amend the health benefit plan, coverage policies, contracts and any other plan documents to reflect that the provisions of this section apply to the plan's members.

5. Information required from carriers. As part of the carrier's annual public regulatory filings made to the superintendent, a carrier shall submit in a form and manner determined by the superintendent information related to:

A. The use of out-of-network providers by enrollees and the impact on premium affordability and benefit design; and

B. The number of claims submitted by a provider to the carrier that are denied or down coded by the carrier and the reason for the denial or down coding determination.

6. Report from superintendent. On or before January 31st annually, beginning January 1, 2022, the superintendent shall report the following information received from all carriers in the aggregate:

A. The number of requests for independent dispute resolution filed pursuant to this section between January 1st and December 31st of the previous calendar year, including the percentage of all claims that were subject to dispute. For each independent dispute resolution determination, the carrier shall provide aggregate information that does not identify any provider, carrier, enrollee or uninsured patient involved in each determination about:

(1) Whether the determination was in favor of the carrier, out-of-network provider or uninsured patient;

(2) The payment amount offered by each side of the independent dispute resolution process and the award amount from the independent dispute resolution determination;

(3) The category and practice specialty of each out-of-network provider involved, as applicable; and

(4) A description of the health care service that was subject to dispute;

B. The percentage of facilities and hospital-based professionals, by specialty, that are in network for each carrier in this State as reported in access plans submitted to the superintendent;

C. The number of complaints the superintendent receives relating to out-of-network health care charges;

D. Annual trends on health benefit plan premium rates, the total annual amount of spending on inadvertent and emergency out-of-network costs by carriers and medical loss ratios in the State to the extent that the information is available;

E. The number of physician specialists practicing in the State in a particular specialty and whether they are in network or out of network with respect to the carriers that administer the state employee group health plan under Title 5, section 285, the Maine Education Association benefits trust health plan, the qualified health plans offered pursuant to the federal Affordable Care Act and other health benefit plans offered in the State;

F. A summary of the information submitted to the superintendent pursuant to subsection 5 concerning the number of claims submitted by health care providers to carriers that are denied or down coded by the carrier and the reasons for the denials or down coding determinations;

G. An analysis of the impact of this section, with respect to both emergency services and other health care services, on premium affordability and the breadth of provider networks; and

H. Any other benchmarks or information that the superintendent considers appropriate to make publicly available to further the goals of this section.

The superintendent shall submit the report to the joint standing committee of the Legislature having jurisdiction over health insurance matters and shall post the report on the bureau's publicly accessible website.

Sec. 3. 24-A MRSA §4303-E is enacted to read:

§4303-E. Payment after resolution of surprise bill disputes

Following an independent dispute resolution determination pursuant to section 4303-C, subsection 3, the determination by the independent dispute resolution entity of a reasonable payment for a specific health care service or treatment rendered by an out-of-network provider is binding on a carrier, out-of-network provider and enrollee for 90 days. During that 90-day period, a carrier shall reimburse an out-of-network provider at that same rate for that specific health care service or treatment and an out-of-network provider may not dispute any bill for that service under section 4303-C.

Sec. 4. 24-A MRSA §4320-C, as amended by PL 2019, c. 238, §3, is further amended to read:

§4320-C. Emergency services

If a carrier offering a health plan provides or covers any benefits with respect to services in an emergency facility or setting, the plan must cover emergency services without prior authorization. Cost-sharing requirements, ~~expressed~~ such as a deductible, copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network, and any payment made by an enrollee pursuant to this section must be applied to the enrollee's in-network cost-sharing limit. Except with respect to a surprise bill for emergency services as provided for in section 4303-C, the enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with subsection 1. A carrier offering a health plan in this State shall also comply with the requirements of section 4304, subsection 5.

1. Payments for out-of-network emergency services. With respect to any bill for covered emergency services by an out-of-network provider, except for a surprise bill as defined in section 4303-C, subsection 1, the following provisions apply.

A. A carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the average network rate under the enrollee's health care plan as payment in full, unless the carrier and out-of-network provider agree otherwise.

B. If a carrier cannot reach an agreement under paragraph A with an out-of-network provider that is not subject to the requirements in this chapter, the carrier shall hold the enrollee harmless.

C. An out-of-network provider may not collect or attempt to collect any charge from an enrollee for covered health care services under this section beyond the applicable coinsurance, copayment, deductible or other out-of-pocket cost expense that would be imposed for the health care services if the services were rendered by a network provider under the enrollee's health plan, notwithstanding the carrier's insolvency, the carrier's failure to pay the amount owed by the carrier or any other breach by the carrier of any provider agreement. If an out-of-network provider provides covered emergency services and the provider receives payment from the covered person for services for which the covered person is not responsible pursuant to this section, the provider shall reimburse the covered person within 30 calendar days after the earlier of the date that the overpayment was reported to the provider and the date the provider became aware of the overpayment. An out-of-network provider that fails to reimburse a covered person as required by this paragraph for an overpayment shall pay interest on the overpayment at the rate of 10% per annum beginning on the earlier of the date the provider received the notice of the overpayment and the date the provider became aware of the overpayment. The covered person is not required to request the accrued interest from the out-of-network provider in order to receive interest with the reimbursement amount.

SUMMARY

This bill amends the law providing consumer protection for surprise medical bills to include surprise bills for emergency services. In the event of a dispute with respect to a surprise medical bill, the bill directs the Superintendent of Insurance to develop an independent dispute resolution process to determine a reasonable payment for health care services.