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L.D. 1407

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HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

131ST LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT "A" to H.P. 903, L.D. 1407, "An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers"

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

'**Sec. 1. 24-A MRSA §4303, sub-§9,** as amended by PL 2021, c. 311, §1, is further amended to read:

9. Notice of amendments to provider agreements. A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date and may file such notice of a proposed amendment to a provider agreement only 4 times per calendar year on January 1st, April 1st, July 1st and October 1st, except that, at any time, a carrier may file a notice of a proposed amendment in response to a requirement of the State or Federal Government or due to a change in current procedural terminology codes used by the American Medical Association. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. If the change is to a reimbursement policy and the estimated aggregate change to participating provider reimbursement as a result of the change is more than $500,000 per year, the notice must include the carrier's good faith estimate of the total annual financial impact of the amendment on the aggregate amount of reimbursement payments made by the carrier to all providers within the State with whom the carrier has a provider agreement. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment. If

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the notice required by this subsection is provided by electronic communication, the subject line of the electronic communication must indicate that notice of an amendment to a provider agreement or manual, policy or procedure document is included in the communication and the notice of the amendment must be provided as an attachment to the communication, as a separate document. As part of the notice required under this subsection, a carrier shall provide a copy of the revised provider agreement, manual, policy or procedure document without changes being noted and a copy of the revised provider agreement, manual, policy or procedure document with changes being noted by underlining added language and by striking through deleted language.

Sec. 2. 24-A MRSA §4303, sub-§10, as amended by PL 2007, c. 106, §1, is further amended to read:

10. Limits on retrospective denials. ~~A~~ Except as provided in paragraphs C and D, a carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless~~:~~ the carrier has provided the reason for the retrospective denial in writing to the provider and the time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.

~~A. The carrier has provided the reason for the retrospective denial in writing to the provider; and~~

~~B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:~~

~~(1) The claim was submitted fraudulently;~~

~~(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;~~

~~(3) The health care services identified in the claim were not delivered by the provider;~~

~~(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;~~

~~(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or~~

~~(6) The claim payment is the subject of legal action.~~

C. The retrospective denial of a previously paid claim may be permitted from 12 months from the date of payment until no later than 36 months from the date of payment for the following reasons only:

(1) The claim payment was incorrectly made because the provider or the insured was already paid in full for the health care services identified in the claim;

(2) The health care services identified in the claim were not delivered by the provider;

(3) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(4) The claim payment is the subject of legal action.

D. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment for the following reasons only:

(1) The claim was submitted fraudulently; or

(2) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act.

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the reimbursement rates for future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment replaces the bill. The amendment makes the following changes to the Maine Insurance Code.

1. It provides that a health insurance carrier may file notice of a proposed amendment to a calendar year provider agreement only 4 times per year on January 1st, April 1st, July 1st and October 1st, except for changes in response to a requirement of the State or Federal Government or due to a change in current procedural terminology codes used by the American Medical Association.

2. It requires a health insurance carrier in certain cases to include an estimate of any adverse financial impact on a participating provider as part of a notice of an amendment to a provider agreement if the change is to a reimbursement policy.

3. It requires a health insurance carrier to provide to the participating provider both a clean and a marked-up copy of the provider agreement, manual, policy or procedure document being changed.

4. It restricts the authority of a health insurance carrier in certain cases to retroactively deny a previously paid claim to no later than 36 months from the date of the claims payment.