131st MAINE LEGISLATURE

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Legislative Document	**No. 1407**
H.P. 903	House of Representatives, March 30, 2023

An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers

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

ROBERT B. HUNT
Clerk

Presented by Representative MASTRACCIO of Sanford.
Cosponsored by Representatives: PRINGLE of Windham, ZAGER of Portland.

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

Sec. 1. 24-A MRSA §2436, sub-§2, as amended by PL 1999, c. 256, Pt. I, §1, is further amended to read:

2. An insurer may dispute a claim by furnishing to the insured or beneficiary, or a representative of the insured or beneficiary, a written statement that the claim is disputed with a statement of the grounds upon which it is disputed. The statement must be based upon a reasonable investigation of the claim and must include sufficient detail to permit the insured or beneficiary to understand and respond to the insurer's position. For purposes of this subsection, a claim for payments under a policy or certificate providing health care coverage is disputed if the insurer, or an administrator that furnishes a provider network to an insurer, has denied the claim or has requested further information not previously submitted that is consistent with Bureau of Insurance Rule Chapter 850.

Sec. 2. 24-A MRSA §2436, sub-§2-A, as repealed and replaced by PL 2009, c. 613, §9, is amended to read:

2-A. For a claim submitted by a health care provider or health care facility with respect to a health plan as defined in section 4301-A, subsection 7, for purposes of this section, "undisputed claim" means a timely claim for payment of covered health care expenses that is submitted to a carrier, or an administrator that furnishes a provider network to a carrier, in conformity with the following requirements.

A. The claim must be submitted on one of the following claims forms:

(1) For a health care facility claim submitted on paper, the standard claim form, using standards approved by a national uniform billing committee;

(2) For a health care provider claim submitted on paper, the standard claim form, using standards approved by a national uniform claim committee; and

(3) For health care facility and health care provider claims submitted electronically, an electronic form using standards approved by an accredited standards committee of the American National Standards Institute.

Sec. 3. 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. 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 and an opportunity to object to the amendment. The notice must include the carrier's good faith estimate of the total annual financial impact of the amendment on the aggregate amount of 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 and in the absence of any objection to the amendment from an affected provider, 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. If a provider objects to an amendment before the expiration of the 60-day notice period, the amendment to the provider agreement or manual, policy or procedure document takes effect 18 months from the date the carrier notified the provider, except that, if there are less than 18 months remaining on the current term and the provider agreement is not renewable, the amendment may not take effect during the current term of the provider agreement. 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 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. If a carrier does not comply with this subsection, the superintendent may use any enforcement authority granted to the superintendent pursuant to this Title.

Sec. 4. 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 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:

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 but no later than 24 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was ~~incorrect~~ incorrectly made because the provider or the insured was already paid in full 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.

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.

SUMMARY

This bill amends the Maine Insurance Code in the following ways.

1. It allows a health care provider to object to a health insurance carrier's material change to a provider agreement within 60 days of receiving notice of the change and extends the date on which a change to a provider agreement takes effect based on that objection.

2. It requires a health insurance carrier to include an estimate of any adverse financial impact on a provider as part of a notice of an amendment to a provider agreement.

3. It clarifies that the requirement for interest to be paid on overdue insurance claims payments also applies to 3rd-party administrators that furnish provider networks to carriers.

4. It restricts the authority of a health insurance carrier to retroactively deny a previously paid claim to no later than 24 months from the date of the claims payment.