LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTY-NINTH LEGISLATURE

FIRST SPECIAL SESSION
August 26, 2019

SECOND REGULAR SESSION
January 8, 2020 to March 17, 2020

THE GENERAL EFFECTIVE DATE FOR
FIRST SPECIAL SESSION
NON-EMERGENCY LAWS IS
NOVEMBER 25, 2019

THE GENERAL EFFECTIVE DATE FOR
SECOND REGULAR SESSION
NON-EMERGENCY LAWS IS
JUNE 16, 2020

PUBLISHED BY THE REVISOR OF STATUTES
IN ACCORDANCE WITH THE MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

Augusta, Maine
2020

Analysis shall submit a report with its recommendations to the Right To Know Advisory Committee.

See title page for effective date.

CHAPTER 668
H.P. 1501 - L.D. 2105

An Act To Protect Consumers from Surprise Emergency Medical Bills

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, it is critically important that this legislation take effect before the expiration of the 90-day period; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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 and bills for out-of-network emergency services; disputes of 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 or a bill for covered emergency services under Title 24-A, section 4303-C~~, subsection 2, paragraph B~~ or, if there is a dispute, under Title 24-A, section 4303-E 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. For an enrollee subject to coinsurance, the out-of-network provider shall calculate the coinsurance amount based on the median network rate for that health care service 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 bills. An uninsured patient who has received a bill for emergency services from a provider for one or more emergency 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-E. 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-E. An uninsured patient may not be charged by a provider more than the amounts generally billed to a patient who has insurance covering emergency services 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-E, subsection 1, paragraph F, payment for the independent dispute resolution process is the responsibility of the provider. In the event a claim includes more than one emergency 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 or bills for covered emergency services rendered by an out-of-network provider. A person covered under a self-insured health benefit plan that is not subject to the provisions of Title 24-A, section 4303-E pursuant to Title 24-A, section 4303-E, subsection 2 and who has received a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E, subsection 1. The independent dispute resolution entity contracted to resolve the dispute over the 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-E, subsection 1. This subsection does not apply to a 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 and bills for out-of-network emergency services

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 elected to obtain such services from that out-of-network provider" defined. As used in this section, unless the context otherwise indicates, "knowingly elected 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 or a bill for covered emergency services rendered by an out-of-network provider:

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. For an enrollee subject to coinsurance, the carrier shall calculate the coinsurance amount based on the median network rate for that health care service;

B. ~~A~~ Except as provided for ambulance services in paragraph D, unless the carrier and out-of-network provider agree otherwise, 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; and~~ greater of:

(1) The carrier's median network rate paid for that health care service by a similar provider in the enrollee's geographic area; and

(2) The median network rate paid by all carriers for that health care service by a similar provider in the enrollee's geographic area 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;

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~~.~~;

D. A carrier shall reimburse an out-of-network provider for ambulance services that are covered emergency services at the out-of-network provider's rate, unless the carrier and out-of-network provider agree otherwise.

This paragraph is repealed October 1, 2021;

E. If an out-of-network provider disagrees with a carrier's payment amount for a surprise bill for emergency services or for covered emergency services as determined in accordance with paragraph B, 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 section 4303-E, including any payment made pursuant to section 4303-E, subsection 1, paragraph G; and

F. 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 this section or, if there is a dispute, in accordance with section 4303-E.

3. Payment after resolution of disputes. Following an independent dispute resolution determination pursuant to section 4303-E, 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-E.

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

§4303-E. Dispute resolution process for surprise bills and bills for out-of-network emergency services

1. Independent dispute resolution process. The superintendent shall establish an independent dispute resolution process by which a dispute for a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider in accordance with section 4303-C, subsection 2 may be resolved as provided in this subsection beginning no later than October 1, 2020.

A. The superintendent may select an independent dispute resolution entity to conduct the dispute resolution process. The superintendent shall adopt rules to implement a dispute resolution process that uses a standard arbitration form and includes the selection of an arbitrator from a list of qualified arbitrators developed pursuant to the rules. A qualified arbitrator must be independent; may not be affiliated with a carrier, health care facility or provider or any professional association of carriers, health care facilities or providers; may not have a personal, professional or financial conflict with any parties to the arbitration; and must have experience in health care billing and reimbursement rates. 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) 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;

(2) The out-of-network provider's previously contracted rate with the carrier, if the provider had a contract with the carrier that was terminated or expired within one year prior to the dispute; and

(3) The median network rate for 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. When the difference between the out-of-network provider's charge and the median network rate pursuant to section 4303-C, subsection 2, paragraph B, subparagraph (1), 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 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.

2. 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 to resolve disputes with respect to a surprise bill for emergency services or a bill for covered emergency services from an out-of-network provider. 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.

3. 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.

4. 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 3 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. 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. 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 section 4303-C or, if there is a dispute, in accordance with section 4303-E. A carrier offering a health plan in this State shall also comply with the requirements of section 4304, subsection 5.

Sec. 5. Review of reimbursement rates for ambulance services. The Emergency Medical Services' Board shall convene a stakeholder group, including the Maine Ambulance Association, representatives of municipal and private ambulance services, health insurance carriers and the Department of Professional and Financial Regulation, Bureau of Insurance, to review issues related to reimbursement rates for ambulance services. The stakeholder group shall:

1. Consider current reimbursement rates paid by carriers and other payors for ambulance services for ambulance providers participating in carrier networks and for ambulance providers that are out of network;

2. Consider the reimbursement rates required under the Maine Revised Statutes, Title 24-A, section 4303-C for emergency services rendered by out of network providers and the availability of the dispute resolution process under Title 24-A, section 4303-E to those providers;

3. Determine the ambulance providers that participate in carrier networks and identify any barriers to participation in those networks; and

4. Develop recommendations for improving the participation of ambulance services in carrier networks, including proposals to provide assistance with contract negotiation or to amend the reimbursement rates required under law.

The Emergency Medical Services' Board shall submit a report, including any recommendations, to the joint standing committee of the Legislature having jurisdiction over health coverage, insurance and financial services matters no later than February 1, 2021. The joint standing committee may report out a bill based on the report to the First Regular Session of the 130th Legislature.

Sec. 6. Appropriations and allocations. The following appropriations and allocations are made.

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Administrative Services - Professional and Financial Regulation 0094

Initiative: Provides allocation in fiscal year 2020-21 for software development.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$25,000
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$25,000

Administrative Services - Professional and Financial Regulation 0094

Initiative: Provides allocation to establish one part-time Insurance Actuarial Assistant position and All Other costs beginning October 1, 2020.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
All Other	$0	$2,616
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$2,616

Insurance - Bureau of 0092

Initiative: Provides allocation to establish one part-time Insurance Actuarial Assistant position and All Other costs beginning October 1, 2020.

OTHER SPECIAL REVENUE FUNDS	2019-20	2020-21
POSITIONS - LEGISLATIVE COUNT	0.000	0.500
Personal Services	$0	$39,605
All Other	$0	$6,684
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$46,289

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF DEPARTMENT TOTALS	2019-20	2020-21
OTHER SPECIAL REVENUE FUNDS	$0	$73,905
DEPARTMENT TOTAL - ALL FUNDS	$0	$73,905

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

Effective March 18, 2020.

CHAPTER 669

S.P. 754 - L.D. 2108

An Act Regarding Health Insurance Options for Town Academies

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this legislation must take effect before the expiration of the 90-day period to ensure retired employees of academies approved for tuition purposes may retain their health insurance; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

Sec. 1. 5 MRSA §285, sub-§1, ¶G, as amended by PL 2001, c. 439, Pt. XX, §2 and amended by PL 2007, c. 58, §3, is further amended to read:

G. Subject to subsection 1-A, employees in any of the categories denominated in paragraphs A to F-1 ~~and,~~ paragraph F-3 and paragraph L who:

(1) On April 26, 1968, have retired and who were covered under group health plans that by virtue of Public Law 1967, chapter 543 were terminated;

(2) After April 26, 1968, retire and who on the date of their retirement are currently enrolled in this group health plan as employees;

(3) After December 2, 1986, and after reaching normal retirement age, cease to be members of the Legislature and are recipients of retirement allowances from the Maine Public Employees Retirement System based upon creditable service as teachers, as defined by section 17001, subsection 42. This paragraph also applies to former members who were members on December 2, 1986;

(4) After December 2, 1986, and not yet normal retirement age, cease to be members of the Legislature and are recipients of retirement allowances from the Maine Public Employees Retirement System based upon creditable service as teachers, as defined by section 17001, subsection 42. This paragraph also applies to former members who were members on December 2, 1986; or