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

(5) After January 1, 1999, terminate employment under which they were eligible for the group health plan but do not retire at that time and who satisfy the requirements of subsection 1-A, paragraph D or paragraph E;

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

Effective March 18, 2020.

CHAPTER 670

S.P. 756 - L.D. 2111

An Act To Establish Patient Protections in Billing for Health Care

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; disclosure related to referrals

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.

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.

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.

3. Referral to an out-of-network provider. A provider receiving a nonemergency referral or self-referral for any in-person health care service or procedure shall disclose to the enrollee whether that provider to whom the enrollee is being referred is a member of the provider network under the enrollee's health plan before the enrollee schedules the appointment for that service or procedure.

Sec. 2. 22 MRSA §1718-E is enacted to read:

§1718-E. Prohibition on fees for transferring a patient or a patient's medical records

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, may not require any fee or other payment from any patient for the transfer of a patient between health care entities or for the transfer of any medical records related to a patient between health care entities unless the fee or other payment is disclosed to the patient and is directly related to the costs associated with establishing the patient as a patient of the health care entity or transferring that patient's medical records. This section does not prohibit the use of current procedural technology codes used by the American Medical Association for new office visits that include the cost of care.

Sec. 3. 22 MRSA §1718-F is enacted to read:

§1718-F. Disclosure related to observation status for Medicare patients

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall disclose to a patient who is covered by the federal Medicare program and who is on observation status and not an admitted patient at the health care entity the following information in a single notice:

1. Medicare outpatient observation notice. The Medicare outpatient observation notice required under 42 Code of Federal Regulations, Section 489.20(y);

2. Impact on patient's financial liability. Notification that observation status may have an impact on the patient's financial liability; and

3. Opportunity to discuss potential financial liability. Notification that the patient may meet with a representative from the health care entity's financial office to discuss the patient's potential financial liability.

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

Effective March 18, 2020.