DEPARTMENT OF
Professional & Financial Regulation
STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

2021 Report on Independent Dispute Resolution (IDR)

Prepared by the Maine Bureau of Insurance
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2021 Report on Independent Dispute Resolution (IDR)

The 129th Legislature enacted P.L. 2019, chapter 668 "An Act to Protect Consumers From Surprise Emergency Bills". The law established a process by which healthcare providers, persons covered by a self-insured/ERISA plan, and certain uninsured patients can request resolution of certain billing disputes involving bills for covered emergency services rendered by out-of-network medical service providers. The Bureau of Insurance has contracted with Maximus Federal Services to facilitate the independent dispute resolution (IDR) process under 24-A M.R.S. § 4303-E(1) and Bureau of Insurance Rule Chapter 365.

Under 24-A M.R.S. § 4303-E(4), the Superintendent of Insurance must annually report to the Legislature a list of enumerated factors regarding the IDR process and related topics. Maximus provided the information in item 1. To collect the information in items 2-6, we sent carriers questions encompassing the elements noted in the law (Appendix A). Carrier responses are reflected accordingly. The information provided for Items 7 and 8 are based on the Bureau's information.

The information provided in this report is for the period of January 1, 2021 through December 31, 2021.

We received responses from: Aetna Life Insurance Company and Aetna Health, Inc., Anthem of Maine, Community Health Options, Harvard Pilgrim Health Care, HPHC Insurance Company Inc., and United Health Care. Although Cigna Health Care administers self-insured plans that may participate in IDR pursuant to 24-A M.R.S. § 4303-E(2) , only insurers that meet the definition of "carrier" in 24-A M.R.S. § 4301-A(3)[1] are required to report information to the Bureau. We requested that carriers provide responses in the aggregate for their Maine business and not at the plan specific level.

[1] "Carrier" is defined as: "A. An insurance company licensed in accordance with this Title to provide health insurance; B. A health maintenance organization licensed pursuant to chapter 56; C. A preferred provider arrangement administrator registered pursuant to chapter 32; D. A fraternal benefit society, as defined by section 4101; E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; G. A self-insured employer subject to state regulation as described in section 2848-A; or H. Notwithstanding any other provision of this Title, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act.

These are the responses to the information requested in 24-A M.R.S. § 4303-E(4):

1) The number of independent dispute resolutions in 2021: There were 19 requests for Independent Dispute Resolution. There were 16 decisions in favor of the health plan and 3 requests for IDR were withdrawn. Per the statute, each case involved emergency medicine, specifically emergency room evaluation and patient management charges. The following chart shows the amounts of initiating final offers from the provider, the insurer's final offer, and the amount awarded to the provider through IDR:

	Initiating Final Offer	**Responding Final Offer**	**Case Decision Amount**
1	$908.00	$263.50	$263.50
2	$908.00	$212.50	$212.50
3	$908.00	$263.50	$263.50
4	$326.00	$104.32	$104.32
5	$908.00	$267.67	$267.67
6	$908.00	$297.41	$297.41
7	$616.00	$187.37	$187.37
8	$908.00	$267.67	$267.67
9	$326.00	$104.32	$104.32
10	$617.00	$208.19	$208.19
11	$616.00	$208.19	$208.19
12	$326.00	$115.91	$115.91
13	$908.00	$297.41	$297.41
14	$616.00	$160.46	$160.46
15	$326.00	$115.91	$115.91
16	$908.00	$297.41	$297.41

2) The percentage of in-network facilities and hospital-based professionals by high-volume specialty, as defined as high volume specialists by Rule 850 § 7(B)(2) in addition to behavioral health providers as discussed in § 7(B)(3). (The relevant excerpts of Rule 850 are provided in Appendix B.)

Carrier	Behavioral Health	Gynecology/ Obstetrics	Cardiology	Dermatology	Ophthalmology	Orthopedic Surgery	Gastroenterology
A	96.4%	85.7%	100%	100%	100%	100%	90.9%
B	94%	98%	98%	100%	100%	99%	100%
C	57%	85%	88%	85%	87%	85%	85%
D[2]	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%
E[3]	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%	89.5%
F[4]	100%/92%	68%	73%	67%	76%	74%	64%

[2] To determine the percentage, the carrier utilized 13,108 as the total number of all providers in Maine. This figure is provided by CoverME as the number of all providers in Maine. Based on the carrier's contracting methodology, it currently has 11,790 providers in Maine, resulting in 89.95% of all Maine providers being in network.

[3] To determine the percentage, the carrier utilized 13,108 as the total number of all providers in Maine. This figure is provided by CoverME as the number of all providers in Maine. Based on the carrier's contracting methodology, it currently has 11,790 providers in Maine, resulting in 89.95% of all Maine providers being in network.

[4] The carrier reported the behavioral health facilities as 100% and the behavioral health providers as 92%.

In attempting to calculate the denominator for the percentage of in-network providers, the BOI contacted Maine Health Data Organization (MHDO) for the total number of providers in Maine. MHDO responded that it was in the process of developing a provider directory based on claims and hospital reporting data. The BOI then contacted the Board Of Medicine, but the Board only tracks physicians, not nurse practitioners, psychologists, social workers, facilities or osteopathic doctors. Finally, we reached out to the Maine Office of the Health Insurance Marketplace who responded that they do not maintain a list of providers and the statistics used on CoverMe.Gov are based on carrier reports. Accordingly, we asked carriers to provide the percentage of in-network providers, which is reported in Item 2. Explanations of carrier calculations are contained in the footnotes.

3) The total annual amount of spending on out-of-network emergency costs:

Carrier A	$4,318,195
Carrier B	$ 27,684
Carrier C	$ 336,517
Carrier D	$2,477,574
Carrier E	$ 462,733
Carrier F	$ 0.00

4) The aggregate number of in-network high-volume specialists:

Carrier	Behavioral Health	Gynecology obstetrics	Cardiology	Dermatology	Ophthalmology	Orthopedic Surgery	Gastroenterology
A	3,185	251	180	63	87	171	98
B	2,839	180	174	58	86	145	70
C	4,110	164	105	39	78	161	58
D	1,884	161	121	46	83	129	84
E	1,884	161	121	46	83	129	84
F[5]	2,824	251	198	60	87	229	101

5) The amount each carrier paid to out-of-network providers for nonemergency services:

Carrier A	$12,919,579
Carrier B	$ 369,305
Carrier C	$ 702,152
Carrier D	$ 3,248,899
Carrier E	$ 774,849
Carrier F	$ 320,792

[5] The carrier reported behavioral health facilities and behavioral health providers combined.

6) The number of claims submitted by a provider that were either denied or downcoded and the applicable reason:

Carrier	# Downcoded	Reasons	# Denied	Most Common Reasons
A	9,225	Reduced based on diagnostic information	140, 720	More clinical information needed/coding, billing or modifier error /no referral/incomplete claim/expense prior to or after in-force coverage/patient covered by Medicare or other health plan/out-of-network provider/experimental, investigational or not medically necessary.
B	22		1,488	Requested information not received/
C[6]	42,398	Carrier did not distinguish between reasons for downcoding vs. denial	30, 816	Non-covered charges/service bundled with others/claim line denied by external claims editing system/code submitted for informational purposes/incidental[7]/ coverage terminated/no prior authorization or PA denial/service not authorized/duplicate claim/time for claim filing expired.
D[8]	N/A	N/A	10,394	Coding error, prior authorization denial, benefit not covered/limited, duplicate/incomplete claim, member ineligible, medical necessity, out-of-network provider.
E[9]	N/A	N/A	2,978	Coding error, prior authorization denial, benefit not covered/limited, duplicate/incomplete claim, member ineligible, medical necessity, out-of-network provider.
F[10]	N/A	N/A	4,176	Various

7) The number of written complaints the Consumer Health Care Division received relating to out-of-network health care charges: 21

8) An analysis of the impact of IDR, with respect to both emergency services and other health care services, on premium affordability and the breadth of provider networks:

[6] The carrier reported 42,398 as "partially denied claims".
[7] Procedure not recommended for reimbursement when submitted with one of the following: a more comprehensive procedure, a procedure that results in overlap of services, procedures that are medically impossible or improbable to be performed together on the same service date.
[8] The carrier did not report any downcoded claims.
[9] The carrier did not report any downcoded claims.
[10] The carrier did not report any downcoded claims.

IDR is only available for out-of-network emergency services. Thus, IDR would not directly impact the cost of other out-of-network services. During 2021, the IDR process was not used sufficiently to have impact on premium affordability or provider networks.

Summary

During 2021, only two carriers used the independent dispute resolution process in Maine to resolve out of network emergency bills. We are unsure whether this means that providers are satisfied with the amount carriers are paying for out-of-network emergency services or whether the IDR process is still too new.

Appendix A

§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. (Repealed by PL 2021, c. 222, §2)

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.

I. Following a determination by an independent dispute resolution entity of a reasonable fee for a particular health care service, an out-of-network provider may not initiate the dispute resolution process under this subsection for that same health care service for a period of 90 days.

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.

Appendix B

Relevant Sections of Rule 850

Section 7. Access to Services

In addition to the requirements of Title 24-A, Chapter 56 or otherwise required by rule a carrier offering a managed care plan is subject to the requirements of this section.

2) **Specialty Care**. To ensure reasonable access to specialty care practitioners within its delivery system, the carrier shall:

a) Define the types of practitioners who serve as high-volume specialty care practitioners. At a minimum, high-volume specialties shall include obstetrics/gynecology, cardiology, dermatology, ophthalmology, orthopedic surgery, gastroenterology, and other specialties that the carrier determines to be high-volume.

3) **Behavioral Health Care.** Carriers shall ensure the reasonable availability of behavioral health care practitioners.