Maine Bureau of Insurance

Consumer Health Care Division

2023 Report on Independent

Dispute Resolution, In-Network Providers, and Denied Claims

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The 129th Maine Legislature enacted P.L. 2019, chapter 668, "An Act to Protect Consumers From Surprise Emergency Bills" on March 18, 2020. The law establishes a process by which healthcare providers, persons covered by self-insured/ERISA plans, and certain uninsured patients can request resolution of disputes involving bills for covered emergency services rendered by out-of-network providers.

Under 24-A M.R.S. § 4303-E(4), the Superintendent of Insurance must annually report to the Legislature regarding the Independent Dispute Resolution (IDR) process and related topics (see Appendix A). All health carriers[1] with more than 1,000 covered lives — as reported to the Bureau in Rule 940 and 945 reports — must file this information. This is the report for calendar year 2023.

The following information is reported by carriers who meet the 1,000 covered lives threshold:

- Total Annual Amount Spent on Emergency Out-of-Network Claims
- Number of Claims Submitted
- Number of Claims Denied

Responses were received from seven carriers: Cigna Health Care, Aetna Life Insurance Company, Anthem of Maine, Community Health Options, Harvard Pilgrim Health Care, HPHC Insurance Company Inc., and United Health Care. Carriers were required to provide responses in the aggregate for their Maine business and not at the plan specific level.

Sixteen IDR decisions were issued in 2023. Of those decisions, one was made in favor of the respondent health plan and fifteen in favor of the provider applicant. All of the cases involved emergency care for premature births and newborns.

[1] "Carrier" is defined by 24-A M.R.S. § 4301-A(3) 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.

The following chart shows the provider's fee, the insurer's offer, and the amount awarded through IDR:

Case	Provider Fee	Carrier Offer	Case Decision Amount
4363[2]	$38,592.60	$13,314.64	$38,592.60
4847[3]	$4,387.74	$1,949.84	$4,387.74
6527	$10, 469.94	$2,847.03	$10,469.94
6658	$77, 698.71	$25,442.33	$77, 698.71
6206	$1,489.86	$618.00	$1,489.86
6843	$5,422.13	$4,700.00	$4,700.00
6207[4]	$124,208.51	$36,830.69	$124,205.51
7618	$6,715.52	$2,476.03	$6,715.52
6372	$12,551.28	$4,243.32	$12,551.28
7907	$5,734.00	$2,954.80	$5,734.00
7908	$42,400.30	$18,226.46	$42,400.30
7909	$5,446.80	$2,472.80	$5,446.80
7910	$9,554.94	$2,954.22	$9,554.94
7911	$4,771.41	$2,061.00	$4,771.41
7620	$12,644.28	$5,160.00	$12,644.28
40597[5]	$51, 686.15	$10, 934.16	$51, 686.15
Total	$413,774.17	$137,185.32	$413,049.04

The total annual amount of spending on out-of-network nonemergency costs:

Carrier A	$2,761,893
Carrier B	$442,709
Carrier C	$19,110
Carrier D	$2,935,370
Carrier E	$ 889,625
Carrier F	$ 21,250
Carrier G	$ 9,924,892
Total	$16,994,849

[2] IDR Request was received in 2022 and a decision was originally issue in 2022. A corrected decision was issued on January 24, 2023.

[3] IDR request was received in 2022, and a decision was originally issued in 2022. A corrected decision was issued on May 17, 2023.

[4] IDR request was received in 2022, but the decision was issued in 2023.

[5] IDR request was received in 2023, and a decision was originally issued in 2023. A corrected decision was issued on January 9, 2024.

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

Carrier A	$2,761,893
Carrier B	$12,202
Carrier C	$27,392
Carrier D	$362,028
Carrier E	$127, 207
Carrier F	$27,415
Carrier G	$3,301,488
Total	$6,619,625

Total number of provider-submitted claims and total number of denials:

	Total Provider Claims	Total Denied Provider Claims
A	1,587,968	148,286
B	413,123	28,231
C	668	75
D	12,119	7,566
E	3,170	1,859
F	302,795	60,461
G	1,861,795	7,627
Total	2,164,590	254,105

The number of provider-submitted claims that were denied and the applicable reason:

Carrier	Coding	Duplicate	Experimental / Not Necessary	More Info. Needed	No PA	OONP	Other Plan	Before/After Effective Date	Services not covered	Claim Time Expired	Other	Total by Carrier
A	5,404	26,292	672	10,286	10,280	1,343	1,969	18,056	7,202	11,161	55,621[6]	148,286
B	328	2,523	1	1,265	4,238	170	1,119	6,357	1,179	5,369	5,682[7]	28,231
C	0	19	3	11	0	4	0	13	1	1	23	75
D	206	5,818	97	1,439	40	0	0	3,519	442	38,746	96[8]	50,403
E	60	1,662	34	253	3	0	0	22	107	9,517	0	11,658
F	7,736	11,649	1,016	19,485	3,252	1,946	2,183	4,459	4,229	359	4,147[9]	60,461
G	51	710	454	961	67	315	610	900	731	1,788	1,040[10]	7,627
Total	13,785	48,673	2,277	33,700	17,880	3,778	5,881	33,326	13,891	66,941	66,609	

[6] Most common reasons for "Other" response: adjustment made to original submission: 28, 963; System generated RAC (Reject Action Code) EOB detail checked: 16,737; Unknown: 4,023; Cxt Rule 25 Always Bundled Denied: 792; Claim in Second/Third month of Grace Period: 1,209; Resubmit Claim to Related Company: 510; Original claim processed incorrectly: 877.

[7] Most common reasons for "Other" response: benefit maximum reached: 500; Physician Assistant Needs to Bill Under Supervising 2,774; Provider Not Found Under NPI/TIN: 2,408.

[8] Most common reasons for "Other" response: Claim edits issue: 94; Same/Similar Service Performed Recently:2

[9] Most common reasons for "Other" response: Dependent Not Covered under Plan: 167, Benefits exceeded plan limits: 3,980.

[10] Most common reasons for "Other" response: Member not effective: 986; Provider Billed Incorrectly: 54

The number of provider-submitted claims that were downcoded[11] and the applicable reason:

	Diag. info does not meet claim billed	Errors in Transcription	Inadequate Docs.	Wrong Code	Bundled	Other	Total by Carrier
A	78	0	0	0	0	0	78
B	0	0	162	592	3,265	0	3,989
C	0	0	0	0	0	0	0
D	0	0	0	0	0	0	0
E	0	0	0	0	0	0	0
F	6	0	481	9	13	227[12]	736
G	0	0	0	164	127	429[13]	720
Total	78	0	643	756	3,405	656	5,523

Improvements to the IDR Application Process

One of the changes the Bureau made in the administration of the IDR process is the initial screening of the application for IDR. During the first several years of the program's operation, the IDR vendor performed the initial screening of the dispute's eligibility for IDR. As of October 1, 2023, two forms were added to the Bureau's website for prospective IDR applicants to use: one for out-of-network providers and one for uninsured patients.[14] Now, when the application is filed online, it goes directly to Bureau staff for review. If the application is deemed to be eligible, the Bureau forwards the information to the IDR vendor to set up and administer the case. The forms can be found at the following links:

https://www.maine.gov/pfr/insurance/form/independent-dispute-resolution-o

https://www.maine.gov/pfr/insurance/form/independent-dispute-resolution-u

[11] "Downcoding" is defined as "the alteration by plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower Qualifying Payment Amount (QPA) than the service code or modifier billed by the provider or facility," and "facility" as "any public or private hospital, clinic, center, medical school, medical training institute, health care facility, physician's office, infirmary, dispensary, ambulatory surgical center, or other institution or location where medical or mental health care is provided to any person."

[12] Audits, Payment per member benefits.

[13] Drug testing code exceeds limit of seven (7) drug classes per date of service: 337; claim lines containing procedure codes that are inconsistent with member's age: 2; claim lines with procedure codes which have components (professional/technical) to prevent overpayment: 90.

[14] In addition to out-of-network providers of emergency services, P.L. 2019 chapter 688 permits uninsured patients with bills totaling $750 or more received for emergency services during a single visit to use Maine's IDR process to dispute the bill.

Summary

Few providers are using the IDR process to resolve out-of-network emergency bills. During 2023, sixteen IDR decisions were issued. It is not clear whether the low number of IDR requests indicate that providers are satisfied with the amount carriers are paying for out-of-network emergency services or are instead choosing to resolve disputes with patients on their own.

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.

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 [PL 2019, c. 668, §3 (NEW).]

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.