§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. [PL 2019, c. 668, §3 (NEW).]

B. An independent dispute resolution entity shall make a decision within 30 days of receipt of the dispute for review. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

G. [PL 2021, c. 222, §2 (RP).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2021, c. 222, §3 (NEW).]

[PL 2021, c. 222, §§2, 3 (AMD).]

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.

[PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

[PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

C. The number of complaints the superintendent receives relating to out-of-network health care charges; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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 [PL 2019, c. 668, §3 (NEW).]

H. Any other benchmarks or information that the superintendent considers appropriate to make publicly available to further the goals of this section. [PL 2019, c. 668, §3 (NEW).]

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.

[PL 2019, c. 668, §3 (NEW).]

SECTION HISTORY

PL 2019, c. 668, §3 (NEW). PL 2021, c. 222, §§2, 3 (AMD).