



# 129th MAINE LEGISLATURE

## SECOND REGULAR SESSION-2020

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Legislative Document

No. 2105

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H.P. 1501

House of Representatives, February 13, 2020

### **An Act To Protect Consumers from Surprise Emergency Medical Bills**

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Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

A handwritten signature in black ink that reads "R B. Hunt".

ROBERT B. HUNT  
Clerk

Presented by Speaker GIDEON of Freeport.

Cosponsored by Senator SANBORN, H. of Cumberland and

Representatives: BICKFORD of Auburn, FECTEAU of Biddeford, FOLEY of Biddeford, HEPLER of Woolwich, MOONEN of Portland, PRESCOTT of Waterboro, TEPLER of Topsham, Senator: President JACKSON of Aroostook.

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

2 **Sec. 1. 22 MRSA §1718-D**, as enacted by PL 2017, c. 218, §1 and affected by §3,  
3 is amended to read:

4 **§1718-D. Prohibition on balance billing for surprise bills; disputes of surprise bills**  
5 **for uninsured patients and persons covered under self-insured health benefit**  
6 **plans**

7 **1. Definitions.** As used in this section, unless the context otherwise indicates, the  
8 following terms have the following meanings.

9 A. "Enrollee" has the same meaning as in Title 24-A, section 4301-A, subsection 5.

10 B. "Health plan" has the same meaning as in Title 24-A, section 4301-A, subsection  
11 7.

12 B-1. "Knowingly elected to obtain the services from an out-of-network provider"  
13 means that an enrollee chose the services of a specific provider, with full knowledge  
14 that the provider is an out-of-network provider with respect to the enrollee's health  
15 plan, under circumstances that indicate that the enrollee had and was informed of the  
16 opportunity to receive services from a network provider but instead selected the out-  
17 of-network provider. The disclosure by a provider of network status does not render  
18 an enrollee's decision to proceed with treatment from that provider a choice made  
19 knowingly pursuant to this paragraph.

20 C. "Provider" has the same meaning as in Title 24-A, section 4301-A, subsection 16.

21 D. "Surprise bill" has the same meaning as in Title 24-A, section 4303-C, subsection  
22 1.

23 E. "Visit" means any interaction between an enrollee and one or more providers for  
24 the purpose of assessing the health status of an enrollee or providing one or more  
25 health care services between the time an enrollee enters a facility and the time an  
26 enrollee is discharged.

27 **2. Prohibition on balance billing.** An out-of-network provider reimbursed for a  
28 surprise bill under Title 24-A, section 4303-C, ~~subsection 2, paragraph B~~ may not bill an  
29 enrollee for health care services beyond the applicable coinsurance, copayment,  
30 deductible or other out-of-pocket cost expense that would be imposed for the health care  
31 services if the services were rendered by a network provider under the enrollee's health  
32 plan. An out-of-network provider is also subject to the following with respect to any  
33 overpayment made by an enrollee.

34 A. If an out-of-network provider provides health care services covered under an  
35 enrollee's health plan and the out-of-network provider receives payment from the  
36 enrollee for health care services for which the enrollee is not responsible pursuant to  
37 this subsection, the out-of-network provider shall reimburse the enrollee within 30  
38 calendar days after the earlier of the date that the provider received notice of the  
39 overpayment and the date the provider became aware of the overpayment.

1 B. An out-of-network provider that fails to reimburse an enrollee for an overpayment  
2 as required by paragraph A shall pay interest on the overpayment at the rate of 10%  
3 per annum beginning on the earlier of the date the provider received notice of the  
4 overpayment and the date the provider became aware of the overpayment. An  
5 enrollee is not required to request the accrued interest from the out-of-network  
6 provider in order to receive interest with the reimbursement amount.

7 **3. Uninsured patients; disputes of surprise bills.** An uninsured patient who has  
8 received a surprise bill from a provider for one or more health care services rendered  
9 during a single visit totaling \$750 or more may dispute the bill and request resolution of  
10 the dispute using the process under Title 24-A, section 4303-C, subsection 3. The  
11 independent dispute resolution entity contracted to resolve the dispute over the surprise  
12 bill shall select either the out-of-network provider's fee or the uninsured patient's  
13 proposed payment amount in accordance with Title 24-A, section 4303-C, subsection 3.  
14 In the case of emergency or other medically necessary care, an uninsured patient may not  
15 be charged by a provider more than the amounts generally billed to a patient who has  
16 insurance covering such care as determined using the method described in 26 Code of  
17 Federal Regulations, Section 1.501(r)-5, paragraph (b)(3) or (b)(4). A provider shall hold  
18 the uninsured patient harmless for the duration of the independent dispute resolution  
19 process and may not seek payment until the independent dispute resolution process is  
20 completed. Notwithstanding Title 24-A, section 4303-C, subsection 3, paragraph F,  
21 payment for the independent dispute resolution process is the responsibility of the  
22 provider. In the event a claim includes more than one health care service rendered during  
23 a single visit, the independent dispute resolution entity may allocate the prorated  
24 independent dispute resolution costs at its discretion among providers.

25 **4. Person covered under self-insured health benefit plan; disputes of surprise**  
26 **bills.** A person covered under a self-insured health benefit plan that is not subject to the  
27 provisions of Title 24-A, section 4303-C pursuant to Title 24-A, section 4303-C,  
28 subsection 4 and who has received a surprise bill may dispute the bill and request  
29 resolution of the dispute using the process under Title 24-A, section 4303-C, subsection  
30 3. The independent dispute resolution entity contracted to resolve the dispute over the  
31 surprise bill shall select either the out-of-network provider's fee or the covered person's  
32 proposed payment amount in accordance with Title 24-A, section 4303-C, subsection 3.

33 **5. Applicability.** Subsections 3 and 4 do not apply to an uninsured patient or person  
34 covered under a self-insured health benefit plan who knowingly elected to obtain the  
35 services from an out-of-network provider.

36 **Sec. 2. 24-A MRSA §4303-C,** as enacted by PL 2017, c. 218, §2 and affected by  
37 §3, is amended to read:

38 **§4303-C. Protection from surprise bills**

39 **1. Surprise bill defined.** As used in this section, unless the context otherwise  
40 indicates, "surprise bill" means a bill for health care services, ~~other than~~ including, but not  
41 limited to, emergency services, received by an enrollee for covered services rendered by  
42 an out-of-network provider, when such services were rendered by that out-of-network  
43 provider at a network provider, during a service or procedure performed by a network

1 provider or during a service or procedure previously approved or authorized by the carrier  
2 and the enrollee did not knowingly elect to obtain such services from that out-of-network  
3 provider. "Surprise bill" does not include a bill for health care services received by an  
4 enrollee when a network provider was available to render the services and the enrollee  
5 knowingly elected to obtain the services from another provider who was an out-of-  
6 network provider.

7 **1-A. "Knowingly elect to obtain such services from that out-of-network**  
8 **provider" defined.** As used in this section, unless the context otherwise indicates,  
9 "knowingly elect to obtain such services from that out-of-network provider" means that  
10 an enrollee chose the services of a specific provider, with full knowledge that the  
11 provider is an out-of-network provider with respect to the enrollee's health plan, under  
12 circumstances that indicate that the enrollee had and was informed of the opportunity to  
13 receive services from a network provider but instead selected the out-of-network  
14 provider. The disclosure by a provider of network status does not render an enrollee's  
15 decision to proceed with treatment from that provider a choice made knowingly pursuant  
16 to this subsection.

17 **2. Requirements.** With respect to a surprise bill:

18 A. A carrier shall require an enrollee to pay only the applicable coinsurance,  
19 copayment, deductible or other out-of-pocket expense that would be imposed for  
20 health care services if the services were rendered by a network provider;

21 B. A carrier shall reimburse the out-of-network provider or enrollee, as applicable,  
22 for health care services rendered at the average network rate under the enrollee's  
23 health care plan as payment in full, unless the carrier and out-of-network provider  
24 agree otherwise. If an out-of-network provider disagrees with a carrier's payment  
25 amount, the carrier and the out-of-network provider have 30 calendar days to  
26 negotiate an agreement on the payment amount in good faith. If the carrier and the  
27 out-of-network provider do not reach agreement on the payment amount within 30  
28 calendar days, the out-of-network provider may submit a dispute regarding the  
29 payment and receive another payment from the carrier determined in accordance with  
30 the dispute resolution process in subsection 3, including any payment made pursuant  
31 to subsection 3, paragraph G; and

32 C. Notwithstanding paragraph B, if a carrier has an inadequate network, as  
33 determined by the superintendent, the carrier shall ensure that the enrollee obtains the  
34 covered service at no greater cost to the enrollee than if the service were obtained  
35 from a network provider or shall make other arrangements acceptable to the  
36 superintendent.

37 **3. Dispute resolution process for surprise bills.** The superintendent shall establish  
38 an independent dispute resolution process by which a dispute for a surprise bill in  
39 accordance with subsection 2 may be resolved as provided in this subsection.

40 A. The superintendent may select an independent dispute resolution entity to conduct  
41 the dispute resolution process. The superintendent shall adopt rules establishing  
42 standards for the dispute resolution process, including a process for certifying and  
43 selecting independent dispute resolution entities. An independent dispute resolution

1 entity shall use licensed physicians in active practice in the same or similar specialty  
2 as the physician providing the service that is subject to the dispute resolution process.  
3 To the extent practicable, the physician must be licensed in this State. Rules adopted  
4 pursuant to this paragraph are routine technical rules as defined in Title 5, chapter  
5 375, subchapter 2-A.

6 B. An independent dispute resolution entity shall make a decision within 30 days of  
7 receipt of the dispute for review.

8 C. In determining a reasonable fee for the health care services rendered, an  
9 independent dispute resolution entity shall select either the carrier's payment or the  
10 out-of-network provider's fee. The independent dispute resolution entity shall  
11 determine which amount to select based upon the conditions and factors set forth in  
12 this paragraph. In determining the reasonable fee for a health care service, an  
13 independent dispute resolution entity shall consider all relevant factors, including:

14 (1) Whether there is a gross disparity between the fee charged by the out-of-  
15 network provider for services rendered as compared to:

16 (a) Fees paid to the provider for the same services rendered by the provider  
17 to other enrollees in a carrier's health plans in which the provider is not  
18 participating; and

19 (b) Fees paid by the carrier to reimburse similarly qualified providers for the  
20 same services in the same region who are not participating with the carrier;

21 (2) The out-of-network provider's level of training, education, specialization,  
22 quality and experience and, in the case of a hospital, the teaching staff, scope of  
23 services and case mix;

24 (3) The out-of-network provider's contracted rates for comparable services in the  
25 same geographic area with regard to patients in health care plans in which the  
26 provider is not participating;

27 (4) The circumstances and complexity of the particular case, including time and  
28 place of the service;

29 (5) Individual patient characteristics; and

30 (6) The usual and customary cost of the health care service as determined by the  
31 80th percentile of the particular health care service performed by a provider in the  
32 same or similar specialty, as determined by the all-payer claims database  
33 maintained by the Maine Health Data Organization or, if Maine Health Data  
34 Organization claims data is insufficient or otherwise inapplicable, another  
35 independent medical claims database. If authorized by rule, the superintendent  
36 may enter into an agreement to obtain data from an independent medical claims  
37 database to carry out the functions of this subparagraph.

38 D. If an independent dispute resolution entity determines, based on the carrier's  
39 payment and the out-of-network provider's fee, that a settlement between the carrier  
40 and out-of-network provider is reasonably likely, or that both the carrier's payment  
41 and the out-of-network provider's fee represent unreasonable extremes, the  
42 independent dispute resolution entity may direct both parties to attempt a good faith

1 negotiation for settlement. The carrier and out-of-network provider may be granted  
2 up to 10 business days for this negotiation, which runs concurrently with the 30-day  
3 period for dispute resolution.

4 E. The determination of an independent dispute resolution entity is binding on the  
5 carrier, out-of-network provider and enrollee and is admissible in any court  
6 proceeding between the carrier, out-of-network provider and enrollee or in any  
7 administrative proceeding between this State and the provider.

8 F. When an independent dispute resolution entity determines the carrier's payment is  
9 reasonable, payment for the dispute resolution process is the responsibility of the out-  
10 of-network provider. When the independent dispute resolution entity determines the  
11 out-of-network provider's fee is reasonable, payment for the dispute resolution  
12 process is the responsibility of the carrier. When a good faith negotiation directed by  
13 the independent dispute resolution entity results in a settlement between the carrier  
14 and the out-of-network provider, the carrier and the out-of-network provider shall  
15 evenly divide and share the prorated cost for dispute resolution.

16 G. In a dispute for a surprise bill, when the difference between the out-of-network  
17 provider's charge and the average network rate under the enrollee's health plan  
18 pursuant to subsection 2, paragraph B, including any applicable enrollee cost sharing,  
19 is less than \$750, a carrier shall reimburse the out-of-network provider directly for  
20 the provider's charges and the enrollee cost sharing for the services rendered as long  
21 as the provider's charges do not exceed the 80th percentile of charges for the  
22 particular health care service performed by a health care professional in the same or  
23 similar specialty and provided in the same geographical area as reported in a  
24 benchmarking database specified by the superintendent and maintained by a  
25 nonprofit organization that is not affiliated with and does not receive funding from a  
26 carrier. An out-of-network provider may dispute more than one bill with the same  
27 carrier for the same health care service under this subsection as long as the total of  
28 the bills with that carrier for that health care service exceeds \$750.

29 H. The superintendent shall enforce the determination of an independent dispute  
30 resolution entity pursuant to this subsection or any agreement made by a carrier and  
31 an out-of-network provider after the conclusion of the independent dispute resolution  
32 process pursuant to this subsection. The superintendent may use any powers provided  
33 to the superintendent under this Title.

34 **4. Self-insured health benefit plans.** An entity providing or administering a self-  
35 insured health benefit plan exempted from the applicability of this section under the  
36 federal Employee Retirement Income Security Act of 1974, 29 United States Code,  
37 Sections 1001 to 1461 (1988) may elect to be subject to the provisions of this section. In  
38 the event an entity providing or administering a self-insured health benefit plan elects to  
39 be subject to the provisions of this section, the provisions of this section apply to a self-  
40 insured health benefit plan and its members in the same manner as the provisions of this  
41 section apply to a carrier and its enrollees. To elect to be subject to the provisions of this  
42 section, the entity shall provide notice, on an annual basis, to the superintendent, on a  
43 form and in a manner prescribed by the superintendent, attesting to the entity's  
44 participation and agreeing to be bound by the provisions of this section. The entity shall

1 amend the health benefit plan, coverage policies, contracts and any other plan documents  
2 to reflect that the provisions of this section apply to the plan's members.

3 **5. Information required from carriers.** As part of the carrier's annual public  
4 regulatory filings made to the superintendent, a carrier shall submit in a form and manner  
5 determined by the superintendent information related to:

6 A. The use of out-of-network providers by enrollees and the impact on premium  
7 affordability and benefit design; and

8 B. The number of claims submitted by a provider to the carrier that are denied or  
9 down coded by the carrier and the reason for the denial or down coding  
10 determination.

11 **6. Report from superintendent.** On or before January 31st annually, beginning  
12 January 1, 2022, the superintendent shall report the following information received from  
13 all carriers in the aggregate:

14 A. The number of requests for independent dispute resolution filed pursuant to this  
15 section between January 1st and December 31st of the previous calendar year,  
16 including the percentage of all claims that were subject to dispute. For each  
17 independent dispute resolution determination, the carrier shall provide aggregate  
18 information that does not identify any provider, carrier, enrollee or uninsured patient  
19 involved in each determination about:

20 (1) Whether the determination was in favor of the carrier, out-of-network  
21 provider or uninsured patient;

22 (2) The payment amount offered by each side of the independent dispute  
23 resolution process and the award amount from the independent dispute resolution  
24 determination;

25 (3) The category and practice specialty of each out-of-network provider  
26 involved, as applicable; and

27 (4) A description of the health care service that was subject to dispute;

28 B. The percentage of facilities and hospital-based professionals, by specialty, that are  
29 in network for each carrier in this State as reported in access plans submitted to the  
30 superintendent;

31 C. The number of complaints the superintendent receives relating to out-of-network  
32 health care charges;

33 D. Annual trends on health benefit plan premium rates, the total annual amount of  
34 spending on inadvertent and emergency out-of-network costs by carriers and medical  
35 loss ratios in the State to the extent that the information is available;

36 E. The number of physician specialists practicing in the State in a particular specialty  
37 and whether they are in network or out of network with respect to the carriers that  
38 administer the state employee group health plan under Title 5, section 285, the Maine  
39 Education Association benefits trust health plan, the qualified health plans offered  
40 pursuant to the federal Affordable Care Act and other health benefit plans offered in  
41 the State;

1           F. A summary of the information submitted to the superintendent pursuant to  
2           subsection 5 concerning the number of claims submitted by health care providers to  
3           carriers that are denied or down coded by the carrier and the reasons for the denials or  
4           down coding determinations;

5           G. An analysis of the impact of this section, with respect to both emergency services  
6           and other health care services, on premium affordability and the breadth of provider  
7           networks; and

8           H. Any other benchmarks or information that the superintendent considers  
9           appropriate to make publicly available to further the goals of this section.

10          The superintendent shall submit the report to the joint standing committee of the  
11          Legislature having jurisdiction over health insurance matters and shall post the report on  
12          the bureau's publicly accessible website.

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

14                 **§4303-E. Payment after resolution of surprise bill disputes**

15                 Following an independent dispute resolution determination pursuant to section  
16                 4303-C, subsection 3, the determination by the independent dispute resolution entity of a  
17                 reasonable payment for a specific health care service or treatment rendered by an out-of-  
18                 network provider is binding on a carrier, out-of-network provider and enrollee for 90  
19                 days. During that 90-day period, a carrier shall reimburse an out-of-network provider at  
20                 that same rate for that specific health care service or treatment and an out-of-network  
21                 provider may not dispute any bill for that service under section 4303-C.

22                 **Sec. 4. 24-A MRSA §4320-C**, as amended by PL 2019, c. 238, §3, is further  
23                 amended to read:

24                 **§4320-C. Emergency services**

25                 If a carrier offering a health plan provides or covers any benefits with respect to  
26                 services in an emergency facility or setting, the plan must cover emergency services  
27                 without prior authorization. Cost-sharing requirements, ~~expressed~~ such as a deductible,  
28                 copayment amount or coinsurance rate, for out-of-network services are the same as  
29                 requirements that would apply if such services were provided in network, and any  
30                 payment made by an enrollee pursuant to this section must be applied to the enrollee's in-  
31                 network cost-sharing limit. Except with respect to a surprise bill for emergency services  
32                 as provided for in section 4303-C, the enrollee's responsibility for payment for covered  
33                 out-of-network emergency services must be limited so that if the enrollee has paid the  
34                 enrollee's share of the charge as specified in the plan for in-network services, the carrier  
35                 shall hold the enrollee harmless from any additional amount owed to an out-of-network  
36                 provider for covered emergency services and make payment to the out-of-network  
37                 provider in accordance with subsection 1. A carrier offering a health plan in this State  
38                 shall also comply with the requirements of section 4304, subsection 5.

39                 **1. Payments for out-of-network emergency services.** With respect to any bill for  
40                 covered emergency services by an out-of-network provider, except for a surprise bill as  
41                 defined in section 4303-C, subsection 1, the following provisions apply.



1 A. A carrier shall reimburse the out-of-network provider or enrollee, as applicable,  
2 for health care services rendered at the average network rate under the enrollee's  
3 health care plan as payment in full, unless the carrier and out-of-network provider  
4 agree otherwise.

5 B. If a carrier cannot reach an agreement under paragraph A with an out-of-network  
6 provider that is not subject to the requirements in this chapter, the carrier shall hold  
7 the enrollee harmless.

8 C. An out-of-network provider may not collect or attempt to collect any charge from  
9 an enrollee for covered health care services under this section beyond the applicable  
10 coinsurance, copayment, deductible or other out-of-pocket cost expense that would  
11 be imposed for the health care services if the services were rendered by a network  
12 provider under the enrollee's health plan, notwithstanding the carrier's insolvency, the  
13 carrier's failure to pay the amount owed by the carrier or any other breach by the  
14 carrier of any provider agreement. If an out-of-network provider provides covered  
15 emergency services and the provider receives payment from the covered person for  
16 services for which the covered person is not responsible pursuant to this section, the  
17 provider shall reimburse the covered person within 30 calendar days after the earlier  
18 of the date that the overpayment was reported to the provider and the date the  
19 provider became aware of the overpayment. An out-of-network provider that fails to  
20 reimburse a covered person as required by this paragraph for an overpayment shall  
21 pay interest on the overpayment at the rate of 10% per annum beginning on the  
22 earlier of the date the provider received the notice of the overpayment and the date  
23 the provider became aware of the overpayment. The covered person is not required to  
24 request the accrued interest from the out-of-network provider in order to receive  
25 interest with the reimbursement amount.

26

## SUMMARY

27 This bill amends the law providing consumer protection for surprise medical bills to  
28 include surprise bills for emergency services. In the event of a dispute with respect to a  
29 surprise medical bill, the bill directs the Superintendent of Insurance to develop an  
30 independent dispute resolution process to determine a reasonable payment for health care  
31 services.