STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BUREAU OF INSURANCE

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DPFR Commissioner

Timothy N. Schott
Acting Superintendent

TESTIMONY OF TIMOTHY N. SCHOTT
ACTING SUPERINTENDENT OF INSURANCE
BUREAU OF INSURANCE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

Neither for nor Against L.D. 1407

An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers

Presented by Representative Anne-Marie Mastraccio

Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services

April 24, 2023 at 10:00 a.m.

Senator Bailey, Representative Perry, and members of the Committee, I am Acting Superintendent of Insurance Tim Schott. I am here today to testify neither for nor against L.D. 1407.

This bill amends the Insurance Code prompt pay statute[1] and carrier requirements law[2] in the Health Plan Improvement Act in several ways.

Concerning the prompt pay statute, it would allow an administrator that "furnishes a provider network to a carrier," as well as the carrier itself, to dispute a

[1] 24-A M.R.S. § 2436.
[2] 24-A M.R.S. § 4303.

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claim. We have a substantive issue with this provision. This bill language appears intended to apply to self-insured plans through their third-party administrators.[3] However, but this would not change the fact that regulating the claims practices of self-insured ERISA plans is preempted by federal law.

Section 3 of the bill focuses on the Health Plan Improvement Act, and would expand the rights of providers concerning contract amendments with carriers:

- In addition to having the 60-day notice of material changes to fee schedules or procedural coding rules that § 4303(9) currently requires, the bill would codify a provider's right to object to the amendment. We are unsure if this provision is necessary.
- As part of the notice of the amendment, a carrier would be required to disclose a good faith estimate of its total annual financial impact on payments for all in-network Maine providers. We do not see how this aggregated total would be useful to specific providers, categories of providers, or even health systems. Any additional carrier costs in producing information would be passed along to consumers in rates.
- If the provider raises an objection, the amendment would not take effect for 18 months after the date of the notice, or if this is part of a non-renewable contract with less than 18 months left, not during this contract. This extended period could create uncertainty among carriers in developing rates. This uncertainty could result in higher premiums.

Section 3 gives the Superintendent the authority to enforce the section, but this unnecessarily duplicates the Superintendent's current authority at 24-A M.R.S. § 12-A.

[3] As defined in 24-A M.R.S. § 1901(1)

The final section of the bill places further limits on a carrier's ability to retrospectively deny a previously paid claim. Currently, a carrier can look back 12 months in a retrospective review, with limited exceptions such as fraud and duplicate payments.[4] This section of the bill would impose a 24-month limit even in those cases. Also, this section changes one of the exceptions to this timeframe from the provider having been "already paid" to "already paid in full"; we think the new language could create problems, particularly if the carrier and provider disagree on what constitutes payment in full.

Thank you, I would be glad to answer any questions now or at the work session.

[4] 24-A M.R.S. § 4303(10)