§4303-C. Protection from surprise bills and bills for out-of-network emergency services

1. Surprise bill defined. As used in this section, unless the context otherwise indicates, "surprise bill" means a bill for health care services, including, but not limited to, emergency services, received by an enrollee for covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. "Surprise bill" does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.
[PL 2019, c. 668, §2 (AMD).]

1-A. "Knowingly elected to obtain such services from that out-of-network provider" defined. As used in this section, unless the context otherwise indicates, "knowingly elected to obtain such services from that out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this subsection.
[PL 2019, c. 668, §2 (NEW).]

2. Requirements. With respect to a surprise bill or a bill for covered emergency services rendered by an out-of-network provider:

A. A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider. For an enrollee subject to coinsurance, the carrier shall calculate the coinsurance amount based on the median network rate for that health care service; [PL 2019, c. 668, §2 (AMD).]

B. Except as provided for ambulance services in paragraph D, unless the carrier and out-of-network provider agree otherwise, a carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the greater of:

(1) The carrier's median network rate paid for that health care service by a similar provider in the geographic area where the service was provided; and

(2) The median network rate paid by all carriers for that health care service by a similar provider in the geographic area where the service was provided 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 specified by the superintendent; [PL 2021, c. 222, §1 (AMD).]

C. Notwithstanding paragraph B, if a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent; [PL 2019, c. 668, §2 (AMD).]

D. [PL 2019, c. 668, §2 (NEW); MRSA T. 24-A §4303-C, sub-§2, ¶D (RP).]

REVISOR'S NOTE: Paragraph D was repealed October 1, 2021. PL 2021, c. 241, §1 attempted to strike the language that repealed the paragraph, but did not take effect in time.

E. If an out-of-network provider disagrees with a carrier's payment amount for a surprise bill for emergency services or for covered emergency services as determined in accordance with paragraph

B or paragraph D, the carrier and the out-of-network provider have 30 calendar days to negotiate an agreement on the payment amount in good faith. If the carrier and the out-of-network provider do not reach agreement on the payment amount within 30 calendar days, the out-of-network provider may submit a dispute regarding the payment and receive another payment from the carrier determined in accordance with the dispute resolution process in section 4303-E, including any payment made pursuant to section 4303-E, subsection 1, paragraph G; and [PL 2021, c. 241, §2 (AMD).]

F. The enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with this section or, if there is a dispute, in accordance with section 4303-E. [PL 2019, c. 668, §2 (NEW).]

[PL 2021, c. 222, §1 (AMD); PL 2021, c. 241, §2 (AMD).]

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

[PL 2019, c. 668, §2 (NEW).]

SECTION HISTORY

PL 2017, c. 218, §2 (NEW). PL 2017, c. 218, §3 (AFF). PL 2019, c. 668, §2 (AMD). PL 2021, c. 222, §1 (AMD). PL 2021, c. 241, §2 (AMD).