§4303. Plan requirements

A carrier offering or renewing a health plan in this State must meet the following requirements. [PL 2007, c. 199, Pt. B, §4 (AMD).]

1. Demonstration of adequate access to providers. A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services. A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.

A. [PL 2007, c. 199, Pt. B, §5 (AMD); MRSA T. 24-A §4303, sub-1, ¶A (RP).]

B. [PL 2011, c. 90, Pt. F, §7 (RP).]

C. [PL 2011, c. 90, Pt. F, §7 (RP).]

[PL 2011, c. 90, Pt. F, §7 (RPR).]

2. Credentialing. The credentialing of providers by a carrier is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialing. A carrier shall consult with appropriately qualified health care professionals in developing its credentialing standards. [PL 2015, c. 84, §1 (AMD).]

B. All credentialing decisions, including those granting, denying or withdrawing credentials, must be in writing. The provider must be provided with all reasons for the denial of an application for credentialing or the withdrawal of credentials. A withdrawal of credentials must be treated as a provider termination and is subject to the requirements of subsection 3-A. [PL 2015, c. 84, §1 (AMD).]

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialing for not meeting the objective credentialing standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider or between a carrier and a provider network if a carrier does not contract with providers individually. [PL 2015, c. 84, §1 (AMD).]

D. A carrier shall make credentialing decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialing application from a provider. For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. Within 30 days of initial receipt of a credentialing application, a carrier shall review the entire application and, if it is incomplete, shall return it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60-day period as required in this paragraph shall notify the bureau in writing prior to the expiration of the 60-day period on that application and request authorization for an extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier’s credentialing practices in line with the 60-day limit in this paragraph. [PL 2021, c. 603, Pt. B, §1 (AMD).]

E. [PL 2013, c. 383, §4 (RP).]

[PL 2021, c. 603, Pt. B, §1 (AMD).]

2-A. Payment to provider for services rendered during pendency of credentialing. A carrier offering or renewing a health plan in the State shall pay claims for services rendered to an enrollee by a provider prior to credentials being granted from the date a complete application for credentialing is submitted to the carrier as long as credentials are granted to that provider by the carrier in accordance with the requirements of subsection 2. A provider intending to submit a claim pursuant to this subsection may not submit the claim until the provider has been notified by the carrier whether the provider has been credentialed and of the effective date of any credentials. If a claim is submitted prior to the date credentials are granted, the carrier may process that claim in the same manner as a claim submitted by a provider that has not been credentialed.
[PL 2015, c. 84, §2 (NEW).]

3. Provider's right to advocate for medically appropriate care. A carrier offering or renewing a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]
[PL 2007, c. 199, Pt. B, §6 (AMD).]

3-A. Termination of participating providers. A carrier offering or renewing a managed care plan may not terminate or nonrenew a contract with a participating provider unless the carrier provides the provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed contract termination or nonrenewal and provides an opportunity for a review or hearing in accordance with this subsection. The existence of a termination without cause provision in a carrier's contract with a provider does not supersede the requirements of this subsection. This subsection does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a provider to practice. A review or hearing of proposed contract termination must meet the following requirements.

A. The notice of the proposed contract termination or nonrenewal provided by the carrier to the participating provider must include:

(1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond;

(2) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action. A carrier shall permit a provider to review this evidence and documentation upon request;

(3) Notice that the provider has the right to request a review or hearing before a panel appointed by the carrier;

(4) A time limit of not less than 30 days from the date the provider receives the notice within which a provider may request a review or hearing; and

(5) A time limit for a hearing date that must be not less than 30 days after the date of receipt of a request for a hearing.

Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. [PL 1997, c. 163, §2 (NEW).]

B. A hearing panel must be composed of at least 3 persons appointed by the carrier and one person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty of the provider under review. A hearing panel may be composed of more than 3 persons if the number of clinical peers on the hearing panel constitutes 1/3 or more of the total membership of the panel. [PL 1997, c. 163, §2 (NEW).]

C. A hearing panel shall render a written decision on the proposed action in a timely manner. This decision must be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier or the termination or nonrenewal of the provider. [PL 1997, c. 163, §2 (NEW).]

D. A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than 60 days after the receipt by the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier. [PL 1997, c. 163, §2 (NEW).]

[PL 2007, c. 199, Pt. B, §7 (AMD).]

3-B. Prohibition on financial incentives. A carrier offering or renewing a managed care plan may not offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary health care services covered under the plan to an enrollee. This subsection may not be construed to prohibit pilot projects authorized pursuant to section 4320-H or to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees.
[RR 2011, c. 1, §41 (COR).]

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;

(3) Procedures for the submission of relevant information and enrollee participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and

time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance. [PL 2007, c. 199, Pt. B, §9 (AMD).]

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. [PL 1999, c. 742, §9 (NEW).]

D. Notwithstanding this subsection, a group health plan sponsored by an agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision. Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312. [PL 2003, c. 309, §1 (NEW).]

E. Health plans may not reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with section 4312. [PL 2019, c. 5, Pt. A, §20 (AMD).]

[PL 2019, c. 5, Pt. A, §20 (AMD).]

5. Identification of services provided by certified nurse practitioners, certified midwives and certified nurse midwives. All claims for coverage of services provided by certified nurse practitioners, certified midwives and certified nurse midwives must identify the certified nurse practitioners, certified midwives and certified nurse midwives who provided those services. A carrier offering or renewing a health plan in this State shall assign identification numbers or codes to certified nurse practitioners, certified midwives and certified nurse midwives who provide covered services for enrollees covered under that plan. A claim submitted for payment to a carrier by a health care provider or facility must include the identification number or code of the certified nurse practitioner, certified midwife or certified nurse midwife who provided the service and may not be submitted using the identification number or code of a physician or other health care provider who did not provide the covered service. [PL 2021, c. 79, §5 (AMD).]

6. Standing referrals to specialists. A carrier shall establish and maintain a procedure to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition. If

the carrier or the enrollee's primary care provider, in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall ensure that the enrollee receives such a referral to a specialist. If a specialist able to treat the enrollee's special condition does not participate in the carrier's network, then the carrier shall ensure that the enrollee receives a standing referral to a nonparticipating specialist. A standing referral must be made pursuant to a treatment plan approved by the carrier's medical director in consultation with the enrollee's primary care provider. After the standing referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan. [PL 1999, c. 742, §10 (NEW).]

7. Continuity of care. If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. This section does not apply to provider terminations exempt from the requirements of subsection 3-A.

If a managed care contract for the provision of health insurance coverage between a plan sponsor and a carrier is replaced within the meaning of section 2849 with a different managed care contract and a health care provider that has been providing health care services to an enrollee is not in the replacement carrier's network, the replacement carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C in the same manner as if the provider had been terminated from the replacement carrier's network as of the date of the policy replacement, but only with respect to benefits that are covered under the replacement contract.

A. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment. [PL 1999, c. 742, §10 (NEW).]

B. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination except that if an enrollee is in the 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy. [PL 1999, c. 742, §10 (NEW).]

C. A carrier may make coverage of continued treatment by a provider under paragraph B conditional upon the provider's agreeing to the following terms and conditions.

(1) The provider agrees to accept reimbursement from the carrier at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier. [PL 1999, c. 742, §10 (NEW).]

[PL 1999, c. 742, §10 (NEW).]

7-A. Continuity of prescriptions. If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.
[PL 2009, c. 439, Pt. F, §1 (NEW).]

8. Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

(1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and

(2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. [PL 2001, c. 410, Pt. B, §5 (NEW).]

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if there is sufficient data to constitute a representative sample of charge data for the same or comparable service. [PL 2001, c. 410, Pt. B, §5 (NEW).]
[PL 2001, c. 410, Pt. B, §5 (NEW).]

8-A. Protection from balance billing by participating providers. An enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection.

A. The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. [PL 2011, c. 238, Pt. A, §1 (NEW).]

B. Every provider agreement with a participating provider must be in writing and must set forth that if the carrier fails to pay for health care services as set forth in the contract, the enrollee is not liable to the provider for any sums owed by the carrier. [PL 2011, c. 238, Pt. A, §1 (NEW).]

C. A participating provider may not collect or attempt to collect any charge from an enrollee for covered health care beyond the amount permitted by the terms of the plan, notwithstanding the carrier's insolvency, the carrier's failure to pay the amount owed by the carrier, any other breach by the carrier of the provider agreement or the failure of the provider agreement to include the written hold harmless provision required by paragraph B. [PL 2011, c. 238, Pt. A, §1 (NEW).]

[PL 2011, c. 238, Pt. A, §1 (NEW).]

9. Notice of amendments to provider agreements. A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment. If the notice required by this subsection is provided by electronic communication, the subject line of the electronic communication must indicate that notice of an amendment to a provider agreement or manual, policy or procedure document is included in the communication and the notice of the amendment must be provided as an attachment to the communication, as a separate document.
[PL 2021, c. 311, §1 (AMD).]

REVISOR'S NOTE: (Subsection 9 as enacted by PL 2003, c. 110, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 11)

10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and [PL 2003, c. 218, §9 (NEW).]

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action. [PL 2007, c. 106, §1 (AMD).]

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.

[PL 2007, c. 106, §1 (AMD).]

11. (REALLOCATED FROM T. 24-A, §4303, sub-§9) Absolute discretion clauses. The use and enforcement of an absolute discretion clause is governed by this subsection.

A. A policy, contract, certificate or agreement offered, delivered, issued or renewed for delivery in this State by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may not contain a provision purporting to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [RR 2003, c. 1, §21 (RAL).]

B. A carrier may not enforce a provision in a policy, contract, certificate or agreement that was offered, delivered or issued for delivery in this State and has been continued or renewed by a group policy holder or individual enrollee in this State that purports to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [RR 2003, c. 1, §21 (RAL).]

[RR 2003, c. 1, §21 (RAL).]

12. Publication of policies by carriers. A carrier must publish at least 5 individual health plans with the highest level of enrollment and at least 5 small group health plans with the highest level of enrollment on the carrier's publicly accessible website in a manner that will allow consumers to review the coverage offered under each policy. The policies posted on the website must be updated when changes are made to the policies by the carrier. The appearance of the policy on the website must duplicate the appearance of a paper copy of the policy. The bureau shall provide a link from its website to each carrier's website. A carrier must review annually which policies to post and make any necessary changes on its website. A carrier must post the required policies on its website within 90 days after the effective date of this subsection.

[PL 2009, c. 439, Pt. A, §3 (NEW).]

13. Explanation of benefits. A carrier offering an individual expense-incurred health plan to residents of this State or an expense-incurred group health plan to an employer in this State shall provide individual policyholders and group certificate holders with clear written explanations of benefit documents in response to the filing of any claim providing for coverage of hospital or medical expenses. The explanation of benefits must include all of the following information:

A. The date of service; [PL 2009, c. 439, Pt. A, §4 (NEW).]

B. The provider of the service; [PL 2009, c. 439, Pt. A, §4 (NEW).]

C. An identification of the service for which the claim is made; [PL 2009, c. 439, Pt. A, §4 (NEW).]

D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance; [PL 2009, c. 439, Pt. A, §4 (NEW).]

E. A telephone number and address where the insured may obtain clarification of the explanation of benefits; [PL 2009, c. 439, Pt. A, §4 (NEW).]

F. A notice of appeal rights; and [PL 2009, c. 439, Pt. A, §4 (NEW).]

G. A notice of the right to file a complaint with the bureau after exhausting any appeals under a carrier's internal appeals process. [PL 2009, c. 439, Pt. A, §4 (NEW).]

The superintendent shall establish by rule the minimum information and standards for explanation of benefits forms used by carriers, taking into consideration any input from stakeholders and any national standards for explanation of benefits forms. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. This subsection applies to any explanation of benefits form issued on or after January 1, 2010.

[PL 2009, c. 439, Pt. A, §4 (NEW).]

14. Policy terms. The superintendent may by rule define standard policy terms that must be used in all policies issued by carriers offering health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2009, c. 439, Pt. A, §5 (NEW).]

15. Uniform explanation of coverage documents and standardized definitions. A carrier offering a health plan in this State shall:

A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; [PL 2023, c. 80, §2 (AMD).]

B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act; and [PL 2023, c. 80, §2 (AMD).]

C. Provide notice to enrollees and policyholders or certificate holders that preventive services are covered without cost sharing as provided in section 4320-A, subsection 1, but services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan. [PL 2023, c. 80, §2 (NEW).]
[PL 2023, c. 80, §2 (AMD).]

REVISOR'S NOTE: (Subsection 15 as enacted by PL 2011, c. 451, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 17)

16. Language and culture. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act.
[PL 2011, c. 364, §27 (NEW).]

17. (REALLOCATED FROM T. 24-A, §4303, sub-§15) Prohibition on "most favored nation" clauses. Participation agreements between carriers and providers are governed by this subsection.

A. A participation agreement between a carrier and a provider may not include a provision, commonly referred to as a "most favored nation" clause, that:

(1) Prohibits, or grants the carrier an option to prohibit, the provider from entering into a participation agreement with another carrier to provide services at a lower price than the payment specified in the participation agreement;

(2) Requires, or grants the carrier an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other carrier at a lower price;

(3) Requires, or grants the carrier an option of, termination or renegotiation of the existing participation agreement in the event the provider agrees to provide services to any other carrier at a lower price; or

(4) Requires the provider to disclose its reimbursement rates from other carriers. [RR 2011, c. 1, §42 (RAL).]

B. The superintendent may grant a waiver to paragraph A on application by either a carrier or a provider. A carrier or provider requesting a waiver for more than one participation agreement must file a separate application for each requested waiver. The superintendent may grant a waiver only after issuing a finding that the inclusion in the participation agreement of a most favored nation clause as described in paragraph A is not anticompetitive. A carrier or provider requesting a waiver may request a hearing on the application for a waiver in accordance with section 229. The findings

and decision of the superintendent are final agency actions for the purposes of Title 5, chapter 375, subchapter 7 and, notwithstanding section 236, subsection 2, may be appealed regardless of whether a hearing was held. The superintendent's review under this paragraph is limited to the most favored nation clause, and any decision under this paragraph is for purposes of this subsection only and may not be construed as a finding or decision regarding the legality of the provision under other applicable law. [RR 2011, c. 1, §42 (RAL).]

C. Prior to the issuance of the superintendent's findings and decision on an application for a waiver pursuant to this subsection, any contract, proposal or draft legal instrument submitted to the superintendent in an application for a waiver is not a public record for the purposes of Title 1, chapter 13, except that the name and business address of the parties to an application for a waiver are public information. After the issuance of the superintendent's findings and decision, the superintendent may disclose any information that the superintendent determines is not proprietary information. For the purposes of this paragraph, "proprietary information" means information that is a trade secret or production, commercial or financial information the disclosure of which would impair the competitive position of the carrier or provider submitting the information and would make available information not otherwise publicly available. [RR 2011, c. 1, §42 (RAL).]

D. A carrier may not discriminate or retaliate against a provider for filing or opposing an application for a waiver under this subsection. [RR 2011, c. 1, §42 (RAL).]

E. A provider may not discriminate or retaliate against a carrier for filing or opposing an application for a waiver under this subsection. [RR 2011, c. 1, §42 (RAL).]

F. For the purposes of this subsection, the factors the superintendent may consider in determining whether to grant a waiver based on a finding that the inclusion of a most favored nation clause as described in paragraph A is not anticompetitive include, but are not limited to:

(1) Any reduction or limit on competition among carriers or providers;

(2) The impact on quality and availability of health care services, including the geographic distribution of providers;

(3) The size of the provider and the type of any specialty;

(4) The market share of the carrier and the provider;

(5) The impact on the price and stability of health insurance and health care services to consumers; and

(6) The impact on reimbursement rates in the provider marketplace. [RR 2011, c. 1, §42 (RAL).]

[RR 2011, c. 1, §42 (RAL).]

18. Provider contract requirements. A carrier offering a health plan must meet the requirements of this subsection with respect to a contract offered by the carrier to a provider, including a contract offered through a preferred provider arrangement, as defined in section 2671, subsection 7. This subsection does not apply to dental or vision plans.

A. If the contract for a preferred provider arrangement includes a reference to policies or procedures to which a contracting provider would be bound, all such policies and procedures must be provided to the provider for review in an easily accessible manner upon the provider's request at the time the contract is offered. [PL 2013, c. 399, §1 (NEW).]

B. Upon the provider's request at the time a contract for a preferred provider arrangement is offered, the following must be provided to a provider for review:

(1) The fee schedule or, if there is not a fee schedule for one or more of the services covered under the contract, the terms under which payment is determined. A carrier may require a

provider to execute a nondisclosure agreement covering the information provided under this subparagraph; and

(2) The identity of all carriers for which the provider is agreeing to provide services to health plan enrollees. [PL 2013, c. 399, §1 (NEW).]

C. As a condition of participation in one of the carrier's preferred provider arrangements, a contract offered by a carrier may not require a provider to participate in any other carrier's network subsequently offered by the carrier or by a carrier's preferred provider arrangement. [PL 2013, c. 399, §1 (NEW).]

D. Without the provider's prior written consent, a provider's contractual participation in a carrier's preferred provider arrangement may not:

(1) Subject the provider to health plan payor requirements or fee schedules that materially differ from the terms of the provider's contract with the carrier, unless those materially different terms are set out in writing in a separate section of the contract, such as an exhibit or amendment; or

(2) Permit the terms of the provider's existing preferred provider arrangement contract to be superseded by a carrier's subsequent contract with a health plan payor. [PL 2013, c. 399, §1 (NEW).]

E. A preferred provider arrangement contract may not require a provider providing a service to an enrollee under a health plan included in the provider's contract to obtain preauthorization if the enrollee's health plan does not require prior authorization as a condition of coverage. [PL 2013, c. 399, §1 (NEW).]

F. Explanation of remittance advices or comparable documents, whether in paper or electronic form, that accompany and identify payment of a provider's claims under a carrier's contract, including contracts offered through a preferred provider arrangement, must identify the administrator and payor of the provider's claims and include contact information. [PL 2013, c. 399, §1 (NEW).]

The requirements of this subsection do not apply to a carrier offering a health plan with respect to preferred provider arrangement contracts with a hospital or pharmacy.
[PL 2013, c. 399, §1 (NEW).]

19. Information about provider networks. A carrier offering a managed care plan shall prominently disclose to applicants, prospective enrollees and enrollees information about the carrier's provider network for the applicable managed care plan, including whether there are hospitals, health care facilities, physicians or other providers not included in the plan's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The superintendent may adopt rules that set forth the manner, content and required disclosure of the information in accordance with this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2013, c. 535, §1 (NEW).]

20. Information about prescription drugs. Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website.

A. A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular

prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours. [PL 2015, c. 260, §1 (NEW).]

B. A carrier shall provide an explanation of:

(1) The requirements for utilization review, prior authorization or step therapy for each category of prescription drug covered under a health plan;

(2) The cost-sharing requirements for prescription drug coverage, including a description of how the costs of prescription drugs will specifically be applied or not applied to any deductible or out-of-pocket maximum required under a health plan;

(3) The exclusions from coverage under a health plan and any restrictions on use or quantity of covered health care services in each category of benefits; and

(4) The amount of coverage provided under a health plan for out-of-network providers or noncovered health care services and any right of appeal available to an enrollee when out-of-network providers or noncovered health care services are medically necessary. [PL 2015, c. 260, §1 (NEW).]

[PL 2015, c. 260, §1 (NEW).]

21. Health care price transparency tools. Beginning January 1, 2018, a carrier offering a health plan in this State shall comply with the following requirements.

A. A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A, from network providers, as well as quality data for those providers, to the extent available. A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization. [PL 2017, c. 232, §6 (NEW).]

B. A carrier shall make available to the enrollee the ability to obtain an estimated cost that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the carrier shall request additional or clarifying code information, if needed, from the provider involved with the comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's provider, the carrier shall provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider. [PL 2017, c. 232, §6 (NEW).]

C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed comparable health care service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed comparable health care service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting the carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider. [PL 2017, c. 232, §6 (NEW).]

D. Notwithstanding the provisions of this subsection and at the request of a carrier, the superintendent may grant an additional year to comply with the provisions of this subsection as long as the carrier has demonstrated a good faith effort to comply with the provisions of this subsection and has provided the superintendent with an action plan detailing the steps to be taken

by the carrier to comply with this subsection no later than January 1, 2019. [PL 2017, c. 232, §6 (NEW).]

[PL 2017, c. 232, §6 (NEW).]

22. Denial of referral by out-of-network provider prohibited. Beginning January 1, 2018, a carrier may not deny payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a direct primary care provider who is not a member of the carrier's provider network. A carrier may not apply a deductible, coinsurance or copayment greater than the applicable deductible, coinsurance or copayment that would apply to the same health care service if the service was referred by a participating primary care provider. A carrier may require a direct primary care provider making a referral who is not a member of the carrier's provider network to provide information demonstrating that the provider is a direct primary care provider through a written attestation or copy of a direct primary care agreement with an enrollee and may request additional information necessary to implement this subsection. As used in this subsection, "direct primary care provider" has the same meaning as in Title 22, section 1771, subsection 1, paragraph B.

[PL 2019, c. 178, §1 (AMD).]

22-A. Denial of referral during urgent care visit prohibited. A carrier may not deny payment for any behavioral health care service or physical therapy service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was not made by the enrollee's primary care provider as long as the enrollee's referral is made by a provider during an urgent care visit and the provider notifies the enrollee’s primary care provider of the referral. A carrier may not apply a deductible, coinsurance or copayment greater than the applicable deductible, coinsurance or copayment that would apply to the same health care service if the service was referred by the enrollee's primary care provider. A carrier may require a provider of urgent care that is making a referral to provide additional information necessary to implement this subsection.

[PL 2023, c. 119, §3 (NEW).]

23. Duplicative or incorrect claims payments. If a carrier has made a duplicative or incorrect payment on a claim with respect to a health plan:

A. If the claim payment was made to a provider, the carrier shall retroactively seek collection related to that payment directly from the provider; and [PL 2019, c. 30, §1 (NEW).]

B. The carrier may not attempt to retroactively seek collection related to the claim payment from an enrollee unless the enrollee was already paid directly for the services identified in the claim and a provider submits evidence to the carrier that the enrollee did not forward payment to the provider. After a provider has submitted evidence that the enrollee did not forward payment to the provider, a carrier may require an enrollee to provide evidence of payment to the provider. [PL 2019, c. 30, §1 (NEW).]

[PL 2019, c. 30, §1 (NEW).]

24. Practice or facility-wide prepayment review of providers. A practice or facility-wide prepayment review of the documentation or records of a provider conducted by a carrier for the purposes of identifying fraud, waste or abuse, determining whether the documentation is appropriate or adequate to support a claim for covered health care services or determining whether health care services are or were medically necessary health care as a condition of payment must be conducted in accordance with the following requirements.

A. When a carrier subjects a provider or facility to a practice or facility-wide prepayment review, the carrier shall provide a process to allow claims and documentation to be submitted to the carrier electronically for purposes of proving timely filing and tracking the carrier's compliance with time limits in other applicable laws. [PL 2021, c. 272, §1 (NEW).]

B. Claims subject to a practice or facility-wide prepayment review must be paid or disputed within 30 days as required by section 2436. Any claim that is not disputed pursuant to section 2436 or paid within 30 days by the carrier is overdue and subject to interest in accordance with section 2436. [PL 2021, c. 272, §1 (NEW).]

C. Any records of an enrollee reviewed as part of a practice or facility-wide prepayment review must be reviewed by the same reviewer to the extent possible. The reviewer who performs the practice or facility-wide prepayment review is the primary contact person for the provider related to an audit, review, denial or nonpayment of a claim. Any practice or facility-wide prepayment review that involves clinical or professional judgement must be conducted by or in consultation with a clinical peer. [PL 2021, c. 272, §1 (NEW).]

D. A carrier may not apply additional or different documentation standards beyond the standards set by the professional association of the provider subject to practice or facility-wide prepayment review if those standards are publicly available or made available to the carrier. This paragraph does not prohibit carriers from establishing or applying medical policies or clinical guidelines to determine whether a service is a covered benefit and medically necessary health care. This paragraph does not apply to claims submitted by a hospital or other health care facility. [PL 2021, c. 272, §1 (NEW).]

E. A carrier may not deny payment of a claim for covered health care services by a provider solely on the basis of a minor documentation error or omission, including, but not limited to, misspelling, use of an abbreviation or a correctable error, unless the carrier affords the provider or enrollee the opportunity to resubmit the claim to correct the identified error. [PL 2021, c. 272, §1 (NEW).]

F. If a carrier requires additional information as part of a practice or facility-wide prepayment review of a claim for covered health care services by a provider, the carrier shall inform the provider with reasonable specificity of the information needed by the carrier to adjudicate the claim. [PL 2021, c. 272, §1 (NEW).]

G. Additional information required by a carrier is considered timely filed by the provider if submitted within 30 days from the date the provider received notice from the carrier of the errors, omissions or additional information needed. [PL 2021, c. 272, §1 (NEW).]

H. A carrier shall provide information on how a provider may appeal the denial of a claim, including the mailing or e-mail address or fax number where an appeal should be sent, on its publicly accessible website or in a provider manual. [PL 2021, c. 272, §1 (NEW).]

I. A carrier shall provide an opportunity to appeal the results of an audit leading to the provider being put on a practice or facility-wide prepayment review. [PL 2021, c. 272, §1 (NEW).]

J. A carrier may not audit a provider or require that a provider's claims be subject to practice or facility-wide prepayment review as retribution for raising contract disputes. [PL 2021, c. 272, §1 (NEW).]

For the purposes of this subsection, "practice or facility-wide prepayment review" means a manual review or audit process of all, or substantially all, of a provider's claims by a carrier or the carrier's agent.
[PL 2021, c. 272, §1 (NEW).]

25. Second opinion. An enrollee in a health plan may not be required to obtain a 2nd opinion from a provider that practices in the same office location as the enrollee's provider. Notwithstanding any provision of this Title to the contrary, if the 2nd opinion is obtained from an out-of-network provider because a network provider is not available in accordance with section 4303, subsection 1 and Bureau of Insurance Rule Chapter 850: Health Plan Accountability, a carrier may not apply a deductible, coinsurance or copayment for the 2nd opinion in an amount greater than the deductible, coinsurance or copayment that would apply to the same health care service if the service were obtained

from a network provider, and the amount of any coinsurance or copayment must be applied to the enrollee's in-network deductible.
[PL 2023, c. 348, §1 (NEW).]

REVISOR'S NOTE: (Subsection 25 as enacted by PL 2023, c. 382, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 26)

26. Disclosure to enrollees of cash price. A carrier may not prohibit a provider from providing an enrollee with the option of paying the provider's discounted cash price for health care services. For the purposes of this subsection, "discounted cash price" means:

A. With respect to a hospital, the discounted cash price as that term is defined in 45 Code of Federal Regulations, Section 180.20 if the hospital has a discounted cash price and does not mean the amount charged to individuals who are eligible for free care or are eligible for the amounts charged pursuant to a hospital's financial assistance policy; or [PL 2023, c. 382, §1 (NEW); RR 2023, c. 1, Pt. A, §22 (RAL).]

B. With respect to a provider that is not a hospital, the charge that applies to an enrollee who is paying for a health care service without filing any claim with a carrier. [PL 2023, c. 382, §1 (NEW); RR 2023, c. 1, Pt. A, §22 (RAL).]

[PL 2023, c. 382, §1 (NEW); RR 2023, c. 1, Pt. A, §22 (RAL).]

SECTION HISTORY

PL 1995, c. 673, Pt. C, §1 (NEW). PL 1995, c. 673, Pt. C, §2 (AFF). PL 1997, c. 163, §§1, 2 (AMD). PL 1999, c. 396, §5 (AMD). PL 1999, c. 396, §7 (AFF). PL 1999, c. 742, §§6-10 (AMD). PL 2001, c. 288, §5 (AMD). PL 2001, c. 410, Pt. B, §5 (AMD). RR 2003, c. 1, §21 (COR). PL 2003, c. 108, §1 (AMD). PL 2003, c. 110, §1 (AMD). PL 2003, c. 218, §9 (AMD). PL 2003, c. 309, §1 (AMD). PL 2003, c. 469, Pt. E, §20 (AMD). PL 2003, c. 689, Pt. B, §6 (REV). PL 2007, c. 106, §1 (AMD). PL 2007, c. 199, Pt. B, §§4-11 (AMD). PL 2009, c. 357, §1 (AMD). PL 2009, c. 439, Pt. A, §§3-5 (AMD). PL 2009, c. 439, Pt. F, §1 (AMD). PL 2009, c. 652, Pt. A, §33 (AMD). RR 2011, c. 1, §§41, 42 (COR). PL 2011, c. 90, Pt. F, §7 (AMD). PL 2011, c. 238, Pt. A, §1 (AMD). PL 2011, c. 270, §1 (AMD). PL 2011, c. 364, §§25-27 (AMD). PL 2011, c. 451, §1 (AMD). PL 2011, c. 451, §2 (AFF). PL 2013, c. 383, §4 (AMD). PL 2013, c. 399, §1 (AMD). PL 2013, c. 535, §1 (AMD). PL 2015, c. 84, §§1, 2 (AMD). PL 2015, c. 260, §1 (AMD). PL 2017, c. 232, §§6, 7 (AMD). PL 2019, c. 5, Pt. A, §20 (AMD). PL 2019, c. 30, §1 (AMD). PL 2019, c. 178, §1 (AMD). PL 2021, c. 79, §5 (AMD). PL 2021, c. 272, §1 (AMD). PL 2021, c. 311, §1 (AMD). PL 2021, c. 603, Pt. B, §1 (AMD). PL 2023, c. 80, §2 (AMD). PL 2023, c. 119, §3 (AMD). PL 2023, c. 348, §1 (AMD). PL 2023, c. 382, §1 (AMD). RR 2023, c. 1, Pt. A, §22 (COR).

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