§4302. Reporting requirements

To offer or renew a health plan in this State, a carrier must comply with the following requirements. [PL 2007, c. 199, Pt. B, §2 (AMD).]

1. Description of plan. A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans and be in a format that is substantially similar to the format required for a carrier pursuant to the federal Affordable Care Act as of January 1, 2019. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. A carrier shall post descriptions of its plans on its publicly accessible website and, in addition to the plan description, include a link to the health plan's certificate of coverage. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type;

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics; [PL 2009, c. 439, Pt. A, §2 (AMD).]

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisting conditions and waiting periods; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary; [PL 1999, c. 742, §4 (AMD).]

I. Information on where and in what manner health care services may be obtained; [PL 1999, c. 742, §4 (AMD).]

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; [PL 2009, c. 439, Pt. B, §2 (AMD).]

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended; [PL 2017, c. 232, §3 (AMD).]

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating; and [PL 2017, c. 232, §4 (AMD).]

M. If the health plan is subject to the requirements of section 4318-A, a description of the incentives available to an enrollee and how to earn such incentives if enrolled in a health plan offering a comparable health care service incentive program designed pursuant to section 4318-A. [PL 2017, c. 232, §5 (NEW).]

[PL 2019, c. 5, Pt. A, §19 (AMD).]

2. Plan complaints and adverse decisions statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan complaints and adverse decisions statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

C. [PL 2023, c. 680, Pt. B, §1 (RP).]

D. The ratio of the number of successful enrollee appeals overturning the original denial to the total number of appeals filed; [PL 2023, c. 680, Pt. B, §1 (AMD).]

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

[PL 2023, c. 680, Pt. B, §1 (AMD).]

2-A. Reporting of information related to prior authorization. In addition to the information required to be provided under subsection 2, a carrier shall annually report to the superintendent the following information related to prior authorization determinations for the prior calendar year:

A. A list of all items and services that require prior authorization; [PL 2023, c. 680, Pt. B, §2 (NEW).]

B. The number and percentage of standard prior authorization requests that were approved, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

C. The number and percentage of standard prior authorization requests that were denied, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

D. The number and percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

E. The number and percentage of prior authorization requests for which the time frame for review was extended and the request approved, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

F. The number and percentage of expedited prior authorization requests that were approved, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

G. The number and percentage of expedited prior authorization requests that were denied, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

H. The average and median time that elapsed between the submission of a request and a determination by the carrier, for standard prior authorizations, aggregated for all items and services; [PL 2023, c. 680, Pt. B, §2 (NEW).]

I. The average and median time that elapsed between the submission of a request and a decision by the carrier for expedited prior authorizations, aggregated for all items and services; and [PL 2023, c. 680, Pt. B, §2 (NEW).]

J. The average and median time that elapsed between the submission of a concurrent care prior authorization request to extend a course of treatment and a determination by the carrier, aggregated for all items and services. [PL 2023, c. 680, Pt. B, §2 (NEW).]

[PL 2023, c. 680, Pt. B, §2 (NEW).]

2-B. Data reporting; utilization review data. Beginning April 1, 2025 and April 1st of each year thereafter, the superintendent shall collect the information required under subsections 2 and 2-A, together with the utilization review information collected pursuant to section 2749, and post this information on the bureau's publicly accessible website.
[PL 2023, c. 680, Pt. B, §3 (NEW).]

3. Acceptable methods of providing information. A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973, 42 United States Code, Sections 280c and 300e to 300e-17 (1988), or any other applicable state or federal law or any accrediting organization recognized by the superintendent, as long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a meaningful comparison between health plans. When the superintendent determines that it is feasible and appropriate, the information required by this section must be provided by geographic region, age, gender and type of employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

4. Claims data. By February 1st of each year, a carrier that provides only administrative services for a plan sponsor shall annually file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid for each plan sponsor and the total dollar amount of claims paid for each plan sponsor.
[PL 2001, c. 457, §23 (NEW).]

5. Annual report; claims for diagnosis and treatment of Lyme disease and other tick-borne illnesses. By February 1st of each year, all carriers shall file with the superintendent for the most recent calendar year for all covered individuals in the State the total claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The filing must include information on the number of claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses, the total dollar amount of those claims, the number of claim denials and the reasons for those denials, the number and outcome of internal appeals and the number of external appeals related to the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The superintendent shall compile from all carriers this data in an annual report and submit the report by March 15th of each year to the joint standing committee of the Legislature having jurisdiction over health insurance matters. The superintendent shall consult with the Department of Health and Human Services, Maine Center for Disease Control and Prevention to determine any additional information to be collected from carriers, beginning with data for calendar year 2011.
[PL 2009, c. 494, §5 (AMD).]

6. Reporting required pursuant to the Affordable Care Act. Notwithstanding any other requirements of this Title, a carrier shall provide to the Secretary of the United States Department of Health and Human Services, and make available to the public when required by federal law, any information required by the federal Affordable Care Act. Carriers shall provide the information to the superintendent upon request.
[PL 2011, c. 364, §24 (NEW).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §§4,5 (AMD). PL 2001, c. 457, §23 (AMD). PL 2007, c. 199, Pt. B, §§2, 3 (AMD). PL 2007, c. 561, §2 (AMD). PL 2009, c. 439, Pt. A, §2 (AMD). PL 2009, c. 439, Pt. B, §§2-4 (AMD). PL 2009, c. 494, §5 (AMD). PL 2011, c. 364, §24 (AMD). PL 2017, c. 232, §§3-5 (AMD). PL 2019, c. 5, Pt. A, §19 (AMD). PL 2023, c. 680, Pt. B, §§1-3 (AMD).