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## Bulletin 430

### Requirement to Accept Referrals from Out-of-Network Providers

The Bureau has received questions about the interpretation and scope of recently-enacted 24-A M.R.S. § 4303(22); in particular, about its impact on the “gatekeeper” procedures traditionally employed by health maintenance organizations (HMOs). The statute provides:

**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 provider who is not a member of the carrier’s provider network.

The legislative intent is clear and unambiguous. As the title of this provision explains, carriers are prohibited, beginning this year, from denying referrals by out-of-network providers. The statutory text clarifies that referral restrictions are prohibited if they are based “solely” on the out-of-network status of the referring provider. Thus, carriers may continue to impose reasonable restrictions that do not distinguish between referring providers on the basis of network membership. However, the Maine Insurance Code no longer permits restrictions that have the purpose or effect of categorically excluding all referrals by out-of-network providers.

This means that HMOs may no longer require referrals to be made by the patient’s designated primary care provider (PCP). The Bureau recognizes that this is a significant change from standard HMO procedures. However, this statute by its terms applies to all “carriers” within the meaning of the Health Plan Improvement Act, including HMOs. The Legislature expressly exempted HMOs from a different requirement enacted by the same legislation, but not from the referral mandate.<sup>1</sup>

Similarly, carriers using tiered networks or other incentive programs that require the use of particular designated providers may not exclude the “non-designated” network providers from making referrals. The Legislature did not intend to treat network providers in a lower tier less favorably than out-of-network providers. Such an exclusion would violate 24-A M.R.S. § 4303(1) and Bureau of Insurance Rule 850, § 7(D)(5), which authorize carriers to provide incentives to use

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<sup>1</sup> Compare 24-A M.R.S. §§ 4303 (21) & (22) (applying to all carriers) with 24-A M.R.S. §§ 4318-A (exempting MEWAs) & 4318-B(1) (exempting HMOs). All of these requirements were enacted by P.L. 2017, ch. 232 (LD 445), discussed in more detail in Bulletin 424.



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providers who have been designated on the basis of cost or quality, but only if enrollees are not required to use designated providers as a condition of receiving benefits.

Some carriers have asserted that the law does not prohibit “gatekeeper” plans that require all referrals to be made by the enrollee’s designated PCP, who must be a member of the carrier’s network. Their rationale is that even though this process denies benefits whenever a referral is made by an out-of-network provider, the denial is not made “solely” on that basis because referrals by most network PCPs would also be denied. Under that interpretation, the Legislature only prohibited one specific practice – denying all referrals by out-of-network providers while placing no limitations at all on referrals by network providers. This would render the law meaningless, because it would be easy for carriers to frustrate the legislative intent to allow out-of-network providers to make referrals.

When the Legislature prohibits taking adverse actions “solely” on the basis of some suspect classification identified in the statute, and that classification, standing alone, is sufficient to determine the outcome, then the carrier has acted “solely” on the basis of that classification, as that term is used in the statute. If it is impossible for out-of-network providers to make referrals that the carrier will honor, then the carrier is violating the referral mandate by denying payment for the referred services solely on the basis of the referring provider’s out-of-network status. A similar type of antidiscrimination provision was discussed in Bulletin 334. At the time the Bulletin was issued, 24-A M.R.S. § 2916 prohibited automobile insurers from taking certain adverse actions, including premium increases, “for the sole reason that the person to whom such policy has been issued has reached a certain age.”<sup>2</sup> We concluded that the Legislature had thereby prohibited the use of advancing age as an adverse rating factor, and thus, “that an insured’s premium may not increase if the only change is the change in the age of the insured.”

This does not mean that carriers must honor all referrals made by out-of-network providers. Carriers or their designated UREs may still deny coverage based on any contractual grounds that are independent of the referring provider’s network status. In particular, they may deny the referral if the proposed service does not meet the carrier’s documented clinical review criteria, to the extent otherwise permitted by law. Carriers may also continue to reduce or deny payment, in accordance with the terms of the plan, for services rendered by non-network providers, including the office visit at which the referral was made.

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<sup>2</sup> In 2017, the scope of Section 2916 was expanded to prohibit some additional adverse actions and to extend the statute’s protection to additional insured drivers and to applicants for insurance policies. P.L. 2017, ch. 11 (L.D. 308).