



MAINE ASSOCIATION  
OF  
HEALTH PLANS

September 8, 2020

Karma Lombard  
Maine Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0034

Dear Karma,

I am writing to offer comments on the proposed Rule Chapter 365 Standards for Independent Dispute Resolution of Emergency Medical Service Bills.

MeAHP's comments are primarily focused on Sections 6 and 7, the sections that designate responsibilities of carriers and outline the process to submit and resolve disputes. We also raise questions and request clarifications on other parts of the rule. For ease of understanding, I've organized our comments in linear fashion by section. At the outset, we would reiterate that surprise billing and out of network billing disputes don't exist when providers are in-network. These problems only pertain to a small number of providers in certain specialties, who refuse to contract so they can charge very high rates.

Section 2. Applicability and Scope

- 1C explains that the Rule applies to providers that have rendered eligible services and are "unable in good faith to negotiate agreement with the carrier on the payment amount within 30 calendar days." What is the starting point for the 30-day window (i.e., date of service, submission of claim, receipt of payment, carrier's receipt of notice from the provider about the dispute)?

Section 3. Definitions

- 3.5 defines "Geographic Rating Area." Since not all MeAHP member plans sell products that must adhere to state-specific geographic rating areas, we request that the definition explicitly permit the use of CMS geographic regions.
- 3.6 defines "material familial affiliation". We suggest this definition be expanded to permit inclusion of people such as unmarried partners.

## Section 6. Responsibilities of Carriers

We all found this section confusing and difficult to follow. We think it also exceeds the statutory requirements.

- 1B proposes a 3-way comparison to determine reimbursement. We have several comments/questions:
  - First, sections 6.1.B(1) and (2) appear to require an analysis of median contract rates “in the geographic area in which the service was rendered.” The Maine statute that addresses reimbursement requirements for surprise bills and bills for covered emergency services rendered by an out-of-network provider (24-A M.R.S. § 4303-C.2.B(1) and (2)) requires a similar median contract analysis but refers to rates in “the enrollee’s geographic region.” How do these two requirements reconcile when the geographic regions appear to be different (i.e., service rendered vs. enrollee’s region)?
  - Second, section 6.1.B sets out a 3-way comparison for determining reimbursement in section 6.1.B(1), (2), and (3). This does not seem consistent with the statutory structure. Except for the geographic area issue described in the bullet above, the median contract analysis in sections 6.1.B(1) and (2) seems to be intended to align with 24-A M.R.S. § 4303-C.2.B(1) and (2), which specifically addresses reimbursement requirements. The third part of section 6.1.B., however, aligns with 24-A M.R.S. § 4303-E.1. G., which seems to address an outcome of the independent dispute resolution process. The reimbursement requirements in section 6.1.B., therefore, seem to combine reimbursement requirements with an arbitration outcome. As evident in the statutory structure, carriers are not required to perform the section 6.1.B(3) analysis when determining reimbursement for every claim. As drafted, this regulation appears to go beyond the statute and imposes an unnecessary administrative burden on carriers, requiring all three metrics to be calculated for every claim received. We suggest the proposed Rule more closely mirror the statutory process using a two-prong process to establish the median rate and clarifying that 6.1.B(3) only applies in the Independent Dispute Resolution (IDR) process. Carriers should not have to pay more if a provider is comfortable and doesn’t bring an IDR.
- Section 6.1.C requires carriers to provide notice to the provider “describing how to initiate the IDR process.” Is the Bureau going to prescribe specific language for this notice, or is the language left to the carrier to determine? If the Bureau will be providing the language, when will it be available?
- Section 6.6 requires carriers to have 2 people – an officer and a staff member – responsible for compliance with this program. It appears that a staff person has to be available at least 40 hours per week. What is the Bureau’s authority for requiring

carriers to have people in these roles and to make them available 40 hours per week? If such authority exists,

- Officer is not defined.
  
- Further, the 40-hour requirement is overly broad and burdensome. A requirement to have someone available “during normal business hours” should be sufficient. The additional 40-hour requirement does not include necessary exceptions for days when the office is closed.
  
- The rule requires that “at least one staff person be available” but does not clarify the purpose for making that person available -- for example, answering calls, responding to e-mails, or addressing internal compliance. The requirement is ambiguous.
  
- Section 6.6 requires carriers to “respond to all inquiries from the Superintendent to the IDR process within three business days.” What is the authority for this requirement? If such authority exists, this window should be longer – at least 5 or 10 business days.
  
- Section 6.7 allows for an ASO to opt-in to the protections of this rule by notifying the Bureau. It would be helpful also to require plans to notify their administrators.
  - We would suggest that the BOI develop a standardized opt-in form for all self-insured groups that would be provided to the Bureau and the self-insured plan’s TPA *at least* 30 days prior the beginning or renewal of the plan year.
  
  - Further, rather than requiring changes to plan documents which may be preempted by ERISA, we would suggest that the Bureau develop a standardized notice that could be included with plan documents provided to enrollees. This follows the procedure used by other states, and would ensure that member materials reflect the applicability of the IDR process and other parts of the surprise billing law as contemplated under the rule.

### Section 7. Process to Submit and Resolve Disputes

We suggest that carriers be permitted (but not required) to defend their reimbursement rates. Clearly the law authorizes the Independent Dispute Resolution Entity (IDRE) to consider factors outlined in 24-A M.R.S. § 4303-E(1)(C)(1)-(3) as submitted by the provider, and the proposed rule allows the IDRE to collect additional information as needed from both the provider and carrier. However, in certain circumstances, carriers may wish to defend the rates without request of the IDRE. The proposed rule should permit carriers to provide supporting documentation if they choose.

- Section 7.2 sets out the required information for initiating an arbitration. Applicants also should be required to provide claim number and date of service.
- Section 7.6 allows at least 5 business days for carriers to provide information to the arbitrator after receiving a request. This window should be longer. Nevada, for example, has a similar rule and allows at 10 business days for the parties to submit information after the arbitrator's request.

Generally, this rule does not specifically address that the arbitrator has 3 options under the statute: (a) select the provider's fee, (b) select the carrier's payment, or (c) order the parties to negotiate. See 24-A MRS § 4303-E.1.C, -1. D. Does that mean that the Bureau is not making any changes to those procedures? Or are additional rules expected?

Thank you for the opportunity to provide these comments.

Sincerely,

A handwritten signature in cursive script that reads "Katherine D. Pelletreau".

Katherine D. Pelletreau  
Cc: MeAHP Board of Directors