BASIS STATEMENT AND SUMMARY OF COMMENTS
BUREAU OF INSURANCE RULE CHAPTER 365
STANDARDS FOR INDEPENDENT DISPUTE RESOLUTION OF
EMERGENCY MEDICAL SERVICE BILLS
2022 AMENDMENTS

Chapter 365 has been amended pursuant to the Notice of Rulemaking issued December 3, 2021. A public hearing was convened via audio-visual link on January 5, 2022, and the public comment period deadline was January 17, 2022. Chapter 365 was originally adopted on October 24, 2020.

The amendments are proposed in accordance with 24-A M.R.S. §§ 212, 4303-C, and 4303-E.

The purpose of the proposed amendments is to conform the current rule to the October 1, 2021 repeal of 24-A M.R.S. § 4303-C(2)(D), which formerly governed reimbursement for out-of-network emergency ambulance services, and to the changes to the Insurance Code enacted by PL 2021, c. 222 (LD 46, An Act To Further Protect Consumers from Surprise Medical Bills), repealing the requirement for carriers to pay billed charges that do not exceed the 80th percentile rate if the amount in dispute is less than $750.

Comments

No one offered information for the Bureau to consider at the hearing. The following persons submitted timely written comments:

Kristine Ossenfort
Senior Government Relations Director
Anthem Blue Cross Blue Shield

Katherine Pelletreau
Executive Director
Maine Association of Health Plans (MeAHP)

Kevin Lewis
Chief Executive Officer
Community Health Options

A. Summary of comments and Bureau of Insurance responses

1. Former Section 2(3)(B), exclusion for ambulance services

Comment: Apart from a general expression of support by Community Health Options for the other proposed amendments, the only comments we received related to the repeal of Section 2(3)(B). All three commenters objected to the repeal of this provision, which currently makes bills for ambulance services ineligible for IDR. They asserted that IDR for ambulance services is unnecessary and conflicts with the comprehensive framework for ambulance reimbursement under 24-A M.R.S. § 4303-F, recently enacted by PL 2021, c. 241 (LD 1258, An Act To Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board Related to Reimbursement

Rates for Ambulance Services by Health Insurance Carriers and To Improve Participation of Ambulance Service Providers in Carrier Networks).

MeAHP and CHO stated that as a result of actions taken by the Legislature and the Bureau over the last couple of years, there is strong regulation around ambulance services including the prohibition of balance billing and the standardization of payment rates from commercial insurers. The recommendations of the Maine EMS Subcommittee to the Legislature were incorporated into LD 1258 specifically to control ground ambulance transportation reimbursement, both in and out of network, through the end of 2023. Given these developments, the commenters see no need for IDR for these services.

Anthem echoed these points. They explained further that 24-A M.R.S. § 4303-C(2)(D), which formerly governed charges for out-of-network ambulance services, was repealed on October 1, 2021 by a sunset provision. Anthem acknowledged that under the structure of Section 4303-C as originally enacted, the effect of the sunset would have been to make emergency ambulance billing disputes subject to IDR. If Paragraph D had simply sunset without replacement, reimbursement for out-of-network ambulance services would have defaulted to the general methodology provided for under section 4303-C(2)(B), with initial reimbursement based on the "greater of" median network rate, followed by access to the IDR provisions of Section 4303-E. However, the 130th Legislature did establish a comprehensive reimbursement framework for out-of-network emergency ambulance bills. Chapter 241 enacted 24-A M.R.S. § 4303-F, which requires reimbursement at the lesser of the billed charge or a percentage of the Medicare rate for the service, until December 31, 2023. Therefore, according to the commenters, the reimbursement of out-of-network ambulance providers is dictated by statute and, as a result, there is nothing to subject to an IDR process. Anthem stated that the IDR decision criteria in section 4303-E(1) are not applicable when the Legislature has mandated the reimbursement amount. Any determination that is not either the billed charge or the applicable Medicare rate would result in reimbursement impermissible under section 4303-F(1).

Anthem further stated that, if the Bureau determines that ambulance services must be included in the rule, then any IDR must be limited to whether the carrier has correctly calculated the applicable Medicare rate and any rural or super-rural adjustment. Any other determination would result in an impermissible reimbursement amount.

Bureau Response: We understand the carriers' position that IDR should be unnecessary when a payment methodology is established by legislation, but that is precisely the framework the Legislature established for IDR in general under 24-A M.R.S. § 4303-C(2): a specific formula for a carrier's initial payment to the provider, followed by the right under Paragraph E to invoke the IDR process 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 Anthem observed, the only exception to IDR, as set forth in Paragraph B, is "as provided for ambulance services in paragraph D." But Paragraph D has been repealed, so all emergency services, including emergency ambulance services, are within the scope of Paragraph E.

The situation is more complicated because the Legislature intended to amend 24-A M.R.S. § 4303-C(2)(D) rather than repealing it. However, the section of Chapter

241 attempting to amend that paragraph was determined to be invalid because Chapter 241 did not take effect until October 18, 2021, which was after the sunset date.

Nevertheless, the analysis of the proposed amendments is not affected by any statutory conflicts or inconsistencies this situation might have created. Anthem was not correct when it argued that "even if Paragraph D had not been repealed, the reimbursement of out-of-network ambulance providers is dictated by statute and, as a result, there is nothing to subject to an IDR process." To the contrary, if Paragraph D had not been repealed, the statute as amended by Chapter 241 would unambiguously make emergency ambulance bills subject to IDR, because Chapter 241 expressly amended 24-A M.R.S. § 4303-C(2)(E) to make IDR available after a provider is reimbursed "determined in accordance with Paragraph B or paragraph D" – and Paragraph D, had it not been repealed, would have been amended by Chapter 241 to incorporate by reference the new reimbursement framework under Section 4303-F.

The argument that the BOI should limit IDR to a determination of whether the carrier has correctly calculated the applicable rate according to Section 4303-F would negate the entire IDR process. By the same argument, IDR for other out-of-network emergency services would only determine whether the rates were correctly calculated under Section 4303-C(2)(B). That is not the framework the Legislature established. 24-A M.R.S. §§ 4303-C(2)(B) and 4303-F provide criteria for the carrier to calculate the initial reimbursement, but if the provider disagrees and seeks IDR, then 24-A M.R.S. § 4303-E(1)(C) provides a different set of criteria for the arbitrator to apply. The arbitrator's task under the statute is "determining a reasonable fee for the health care services rendered," not reviewing the accuracy of the carrier's calculations. There is no conflict that would negate the applicability of Section 4303-E to ambulance bills. Arguments that the rates calculated under Section 4303-F should be considered inherently "reasonable," within the meaning of Section 4303-E, are properly directed to the arbitrator if and when an IDR proceeding is initiated.

Therefore, the amendments are adopted as proposed.