STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
BUREAU OF INSURANCE

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Bulletin 475

Legislative Changes Affecting Health Insurance in Maine

The following laws relating to health insurance in Maine were enacted during the Second Regular Session of the 131st Legislature.

- **An Act to Continue the Study of Community Paramedicine and to Make Changes Related to Health Insurance Coverage and Prior Authorization Requirements for Certain Ambulance Service Providers**[1]

  This bill clarifies the reimbursement rate to be paid to out-of-network ambulance service providers for covered emergency services. It prohibits a health insurance carrier from requiring an air ambulance service provider to obtain prior authorization before transporting an enrollee to a hospital or between hospitals for urgent care. The Bureau will be participating in a stakeholder group to further review these matters.

- **An Act to Support an Insured Patient's Access to Affordable Health Care with Timely Access to Health Care Prices**[2]

  This bill requires health care providers, on request of an uninsured or self-pay patient, to provide a good faith estimate of the cost of medical services to be rendered directly by that provider during a single medical encounter, within specified time frames.

  It requires the health care providers to separately disclose the prices for each component of medical services, including any facility fees or fees for professional services, and the procedure codes for those services. It requires providers to post notice, on prominent display, of a patient's right to request this information and to include the notice in the consent-to-treatment form that providers require patients to sign before receiving health care treatment or services.

  For insured patients, it requires health care providers to provide a description of the medical services to be rendered during a single medical encounter and the applicable standard medical codes or current procedural terminology (CPT) codes used by the American Medical Association (AMA) for those services and to notify the patient that the

[1] LD 1832, Public Law 2023, Chapter 591

[2] LD 1740, Public Law 2023, Chapter 584

information can be used to obtain an estimate of the patient's out-of-pocket costs from the patient's health insurance carrier. It requires health insurance carriers to respond to requests from a patient for an estimate of out-of-pocket costs based on the description of the medical services and the codes provided by the patient's health care provider.

It prohibits a health care provider from initiating or pursuing any collection action against an uninsured or self-pay patient unless the provider provided a good faith estimate to a patient that requested an estimate. The prohibition on collection action does not extend to insured patients.

It requires hospitals to comply with the price transparency requirements of the federal regulations implementing the No Surprises Act.[3]

- **An Act to Provide for Consistent Billing Practices by Health Care Providers**[4]

  This bill requires that claims for facility services submitted to health insurance carriers or administrators must identify the physical location where services are rendered.

- **An Act to Create a Liaison Program and Complaint Process Within the Bureau of Insurance for Independent Health Care Providers**[5]

  This bill requires the Bureau to establish a liaison program to assist independent health care providers with six or fewer health care practitioners, including:

  - A process to receive and investigate provider complaints;
  - Assistance in obtaining information about health insurance laws and rules; and
  - A process to receive concerns regarding regulatory or compliance issues that may have a market-wide impact.

  The bill also authorizes the Bureau to receive and investigate complaints from any provider in addition to the independent health care providers, including providers who are members of large group practices or those employed by a hospital or health system.

- **An Act to Amend the Maine Insurance Code Regarding Payments by Health Insurance Carriers to Providers**[6]

  The bill provides that a health insurance carrier may file notice of a proposed amendment to a calendar year provider agreement only four times per year: on January 1, April 1, July 1 and October 1, except for changes in response to state or federal government requirements or changes in the AMA's CPT codes. The notice must include an estimate

[3] 45 CFR Part 180, Subparts A and B, as in effect on January 1, 2024

[4] LD 1533, Public Law 2023, Chapter 521

[5] LD 1498, Public Law 2023, Chapter 590

[6] LD 1407, Public Law 2023, Chapter 574

of the aggregate annual financial impact to providers if the impact of a change in the carrier's reimbursement policy is more than $500,000.

It requires a health insurance carrier to furnish the participating provider with both a clean and a marked-up copy of the provider agreement or other document(s) being changed.

It shortens certain time limits for health insurance carriers to retroactively deny previously paid claims. Most situations that are exempt from the general 12-month time limit will now be subject to a 36-month time limit.

- **An Act to Ensure Access to Pain Management Services in Health Insurance Plans**[7]

  This bill requires health insurance carriers to develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, nonopioid, nonnarcotic pain management services and nonmedication pain management services that serve as alternatives to the prescribing of opioid or narcotic medication. Carriers are required to file their plans with the Bureau for approval. The Bureau must consider the adequacy of access to a broad spectrum of pain management services under a carrier's plan and whether any policies adopted by the carrier may create unduly preferential coverage of and access to prescribed opioids for pain management without consideration of other pain management services. The bill requires carriers to distribute educational materials to network providers about the pain management access plan and to post information about the plan on the carrier's website.

  The Bureau will be issuing a request for information to health insurance carriers to meet this requirement.

- **Resolve, Directing the Superintendent of Insurance to Collect Data from Health Insurers Related to Prescription Drug Coverage of Generic Drugs and Biosimilars**[8]

  This resolve requires the Bureau to request data from health insurance carriers that, at a minimum, provides information related to each carrier's placement of generic drugs and biosimilars on the carrier's prescription drug formulary, including whether a generic drug or biosimilar is available on the carrier's formulary with a lower out-of-pocket cost to an enrollee than the equivalent branded drug and whether the carrier imposes any limitation on coverage of a generic drug or biosimilar or imposes a restriction on a pharmacy that makes it more difficult for an enrollee to obtain coverage of or access to a generic drug or biosimilar than the equivalent branded drug.

  The Bureau will be issuing a request for information to health insurance carriers to meet this requirement.

[7] LD 2096, Public Law 2023, Chapter 661

[8] LD 2114, Resolves 2023, Chapter 177

- **An Act Concerning Prior Authorizations for Health Care Provider Services**[9]

  This bill permits a provider that is actively treating an enrollee to act as the enrollee's authorized representative for purposes of grievances and appeals of health insurance carrier decisions without requiring prior written authorization from the enrollee. A provider actively treating an enrollee must notify the enrollee at least 14 days before filing a grievance or appeal and within seven days after filing a grievance or appeal or withdrawing a grievance or appeal, and also permits an enrollee to affirmatively object to the provider's action.

  It requires carriers to allow prior authorization approvals to be effective for a two (2)-week period before and after a specific date. It also prohibits carriers from denying claims for nonemergency services that were within the scope of the enrollee's coverage, pending medical necessity review, and prohibits carriers from imposing a penalty of more than 15% of the contractually allowed amount for the services that required prior authorization approval on the provider for failing to obtain a prior authorization.

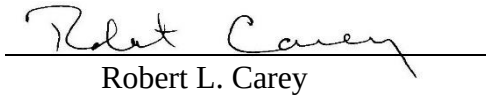
  It prohibits carriers from making determinations of medical necessity based on whether those services are provided by participating or nonparticipating providers. The bill also provides that, if a patient needs immediate post-evaluation or post-stabilization services, a carrier is prohibited from requiring prior authorization for those services provided during the same encounter. If post-evaluation or post-stabilization services necessitate inpatient care, a carrier is permitted to impose prior authorization for those services but is required to respond to the prior authorization request within 24 hours. If the provider does not receive a determination from the carrier within 24 hours, the care is deemed approved until the carrier affirmatively notifies the provider otherwise.

  It requires carriers to report certain information related to prior authorization determinations and also requires the Bureau to annually report aggregate data for carriers, including posting information on the Bureau's website.

  It requires the Bureau to collect data from health insurance carriers related to prior authorization determinations for calendar years 2021 through 2023 and report this information to the Legislature in 2025.

  The Bureau will be issuing a request for information to health insurance carriers to meet this requirement.

May 24, 2024



Robert L. Carey
Superintendent of Insurance

[9] LD 796, Public Law 2023, Chapter 680

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