

Maine Bureau of Insurance

Consumer Health Care Division

***Report on Independent Dispute Resolution,
In-Network Providers, and Denied Claims
for Calendar Year 2024***

September 2026

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Executive Summary

This report covers data from calendar year 2024 with comparisons to calendar year 2023.

There were only two IDR requests in 2024: one was settled in favor of the provider/applicant for \$8,393.48, while the other was settled privately by the parties involved. From 2023 to 2024, the Total Annual Amount of Spending on Out-of-Network Emergency Costs across all carriers increased from \$6,619,625 to \$8,954,375 (35%). The Total Number of Provider-submitted Claims increased from 4,213,508 to 6,800,211 (61%), while the Total Number of Denied Provider Claims increased from 256,928 to 428,901 (67%). The Total Percentage of Denials remained mostly stable, only increasing from 6.1% to 6.3%.

Introduction

The Superintendent of Insurance is required to produce this annual report to the Legislature regarding the IDR process and other statistics (see the full text of the statute in Appendix A). Under 24-A M.R.S. § 4303-E, out-of-network emergency healthcare providers can request IDR for bills for covered emergency services rendered by out-of-network providers. Uninsured patients with an emergency services bill of \$750 or more can also request IDR under 22 M.R.S. § 1718-D(3). All health carriers with more than one thousand covered lives—as reported to the Bureau in Rule 940 and 945 reports—must file IDR information with the Bureau. All records relating to an IDR request or proceeding are confidential,¹ therefore the presentation of IDR information in this report does not reveal identifying information about individuals involved in IDR cases.

The following information is reported by carriers who meet the one thousand covered lives threshold:

- Total Annual Amount Spent on Emergency Out-of-Network Claims;
- Number of Claims Submitted; and
- Number of Claims Denied.

Responses were received from seven carriers:

- Cigna Life and Health Insurance Company;
- Aetna Life Insurance Company;
- Anthem Health Plans of Maine;
- Community Health Options;
- Harvard Pilgrim Health Care (HPHC);
- HPHC Insurance Company; and
- UnitedHealth Care Insurance Company.

Carriers were required to provide responses in the aggregate for their Maine business, not at the plan-level.

¹ 24-A 4303-E(5)

Independent Dispute Resolution

The Bureau contracts with an IDR entity to preside over emergency services billing disputes between insurance carriers, out-of-network providers, and certain uninsured persons. Since October 1, 2023, the Bureau's IDR administrative vendor is Improve Health.

As seen in Exhibit 1, in 2024, two requests were made for IDR. One case involved neonatology (care of newborn infants), and the other case involved emergency heart surgery. One decision was made in favor of the provider/applicant. The other matter was privately settled by the parties and its case was dismissed.

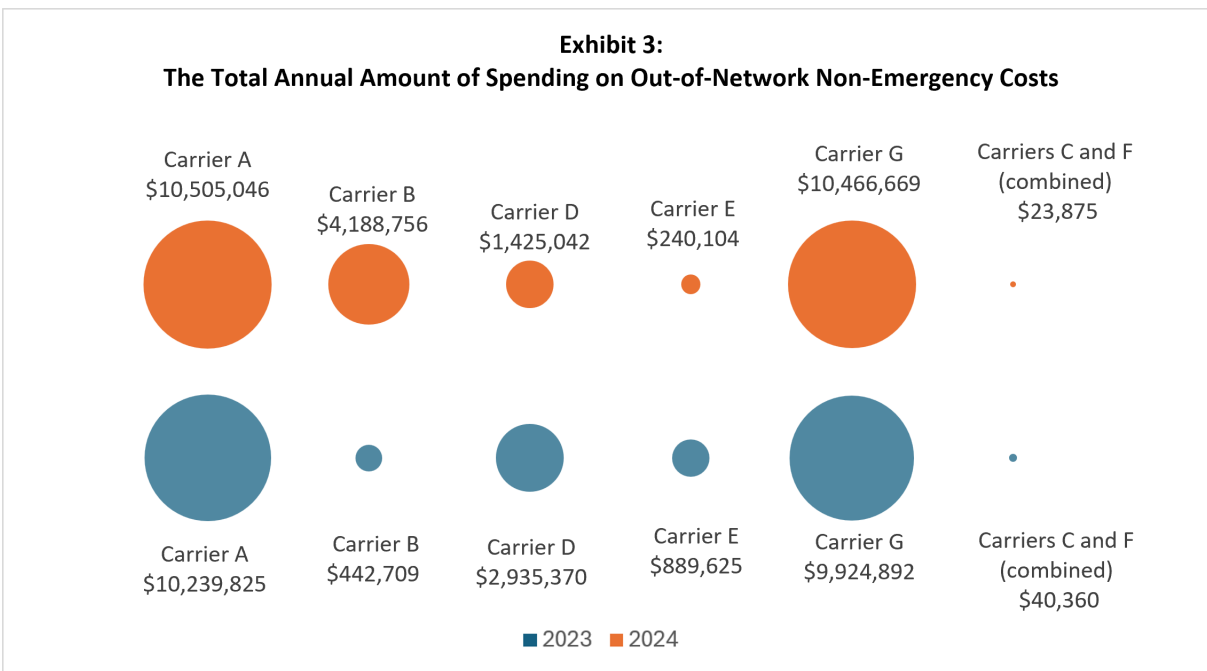
Exhibit 1: 2024 IDR Decisions		
Provider Fee	Carrier Offer	Case Decision Amount
\$8,393.48	\$1,242.72	\$8,393.48
N/A	N/A	N/A

Claims Data

As indicated by Exhibit 2, from 2023 to 2024, the Total Annual Amount of Spending on Out-of-Network Non-Emergency Costs across all carriers increased by 10%.

Exhibit 2: The Total Annual Amount of Spending on Out-of-Network Non-Emergency Costs, 2023-2024		
	2023	2024
Carrier A	\$10,239,825	\$10,505,046
Carrier B	\$442,709	\$4,188,756
Carrier C	\$19,110	\$9,136
Carrier D	\$2,935,370	\$1,425,042
Carrier E	\$889,625	\$240,104
Carrier F	\$21,250	\$14,739
Carrier G	\$ 9,924,892	\$10,466,669
Total	\$24,472,781	\$26,849,492

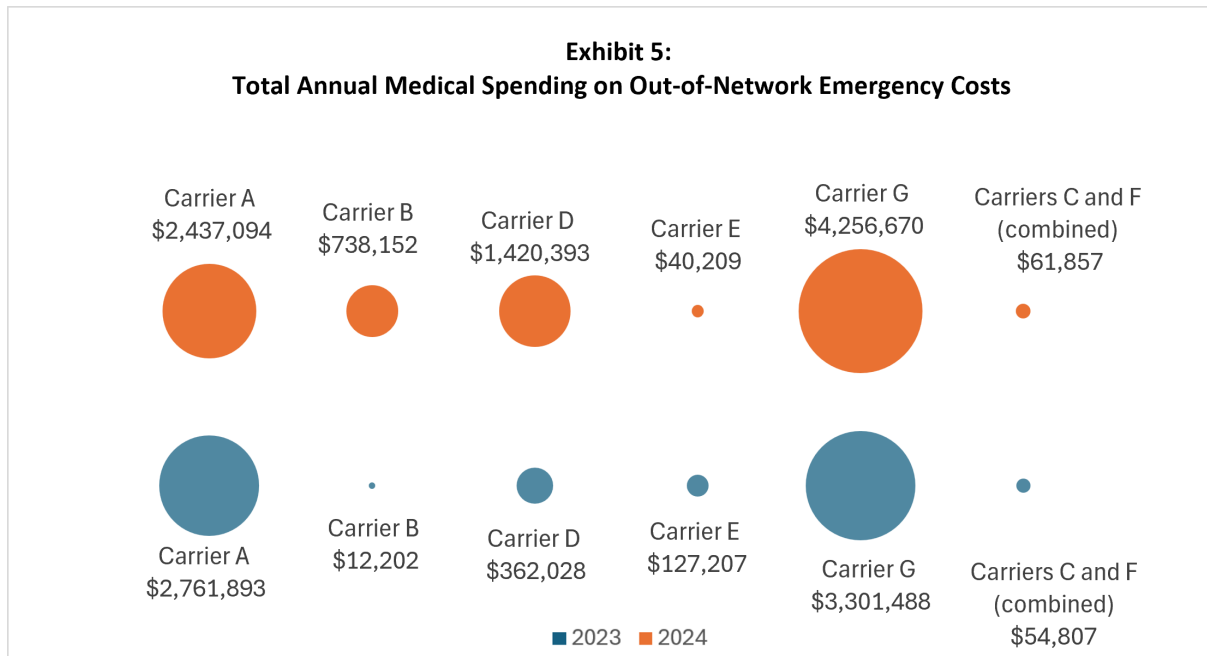
Exhibit 3 provides a visual representation of out-of-network non-emergency spending totals by year using data from Exhibit 2.



As indicated in Exhibit 4, from 2023 to 2024, the Total Annual Amount of Spending on Out-of-Network Emergency Costs across all carriers increased by 35%.

Exhibit 4: The Total Annual Amount of Spending on Out-of-Network Emergency Costs, 2023-2024		
	2023	2024
Carrier A	\$2,761,893	\$2,437,094
Carrier B	\$12,202	\$738,152
Carrier C	\$27,392	\$35,917
Carrier D	\$362,028	\$1,420,393
Carrier E	\$127,207	\$40,209
Carrier F	\$27,415	\$25,940
Carrier G	\$3,301,488	\$4,256,670
Total	\$6,619,625	\$8,954,375

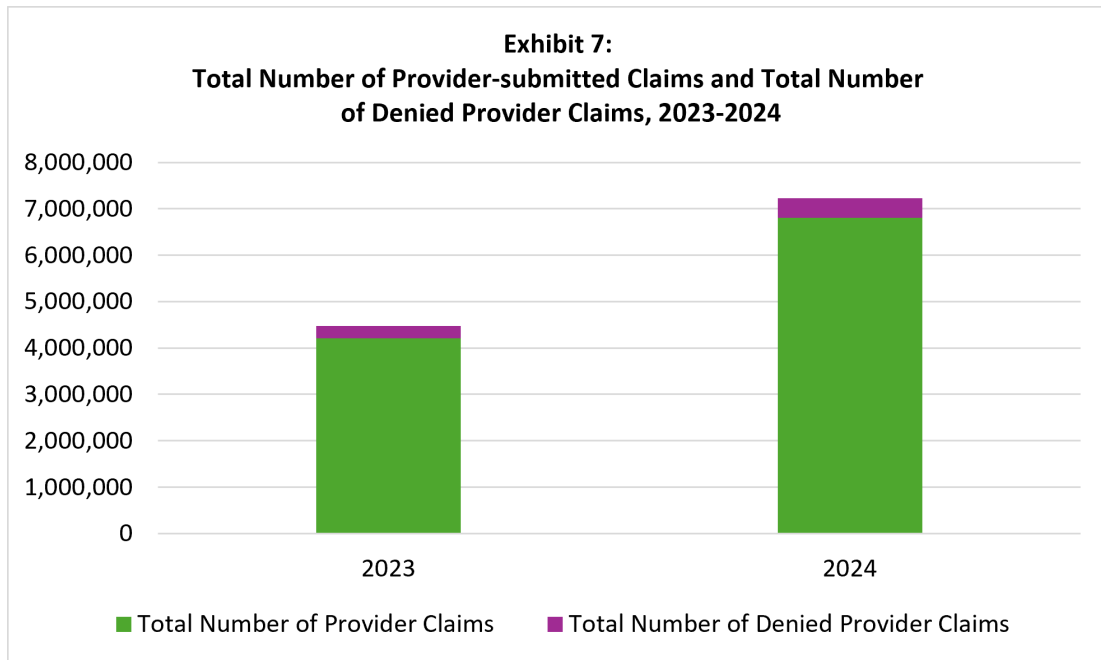
Exhibit 5 provides a visual representation of out-of-network emergency spending totals by year using data from Exhibit 4.



As indicated by Exhibit 6, the Total Number of Provider-submitted Claims increased by 61% between 2023 and 2024 while the Total Number of Denied Provider Claims increased by 67%. The Total Percentage of Denials remained mostly stable, only increasing from 6.1% to 6.3%. Two carriers, Carrier A and Carrier F, reduced their Percentage of Denials slightly by 0.5%. Carrier B had the largest increase of 6.8% to 17.5%. Percentages of Denials greater than 25% are highlighted in red in Exhibit 6.

Exhibit 6: Total Number of Provider-submitted Claims and Total Number of Denied Provider Claims, 2023-2024				
Carrier	Year	Total Submitted Claims	Total Denied Claims	Percentage of Denials
Carrier A	2024	1,745,505	152,869	8.8%
	2023	1,587,968	148,286	9.3%
Carrier B	2024	965,857	169,378	17.5%
	2023	413,123	28,231	6.8%
Carrier C	2024	568	69	12.1%
	2023	668	75	11.2%
Carrier D	2024	34,402	10,478	30.5%
	2023	36,907	9,533	25.8%
Carrier E	2024	8,842	2,739	31.0%
	2023	10,252	2,715	26.5%
Carrier F	2024	309,532	60,206	19.5%
	2023	302,795	60,461	20.0%
Carrier G	2024	3,735,505	33,162	0.9%
	2023	1,861,795	7,627	0.4%
Total	2024	6,800,211	428,901	6.3%
	2023	4,213,508	256,928	6.1%

Exhibit 7 provides a visual representation of the total numbers of Provider Claims and Denied Provider Claims from 2023 and 2024 using data from Exhibit 6.



Exhibits 8A and 8B provide additional context for the claim denials from 2024 and 2023 in Exhibit 6. The total number of denials is separated by carrier and by category of applicable reasons for denial.

In 2024 and 2023, claims in the Other category were denied primarily for the following reasons: the enrollee was not covered by the plan; the plan had no out-of-network benefits; the provider was not found under the National Provider Identifier (NPI)/ Taxpayer Identification Number (TIN); benefits exceeded plan limits; the claim was replaced; and an adjustment needed to be made to the original submission.

Exhibit 8A: The Number of Provider-submitted Claims That Were Denied and the Applicable Reason, 2024												
Carrier Code	Coding Error	Duplicate Claim	Medical Necessity /Experimental	More Info. Needed	No Prior Authorization	Out-of-Network Provider	Covered by Medicare/Other Plan	Before/After Effective Date	Services Not Covered	Claim Time Expired	Other	Total by Carrier
A	7,501	24,378	1,050	10,768	15,179	1,627	1,298	18,581	6,144	10,091	56,252	152,869
B	28,030	7,431	215	407	11,804	0	3,978	23,883	66,381	10,529	16,720	169,378
C	0	7	3	3	0	11	0	11	5	0	29	69
D	1,220	1,871	6	527	196	36	694	14	95	406	5,413	10,478
E	308	581	0	136	20	13	170	1	36	146	1,328	2,739
F	8,951	12,534	699	19,623	3,484	1,240	1,974	3,856	3,353	1,289	3,203	60,206
G	878	3,441	1,126	3,389	451	1,714	1,063	1,553	4,308	13,892	1,347	33,162
Total	46,888	50,243	3,099	34,853	31,134	4,641	9,177	47,899	80,322	36,353	84,292	

Exhibit 8B: The Number of Provider-submitted Claims That Were Denied and the Applicable Reason, 2023												
Carrier Code	Coding Error	Duplicate Claim	Medical Necessity/ Experimental	More Info. Needed	No Prior Authorization	Out-of-Network Provider	Covered by Medicare/Other Plan	Before/After Effective Date	Services not covered	Claim Time Expired	Other	Total by Carrier
A	5,404	26,292	672	10,286	10,280	1,343	1,969	18,056	7,202	11,161	55,621	148,286
B	328	2,523	1	1,265	4,238	170	1,119	6,357	1,179	5,369	5,682	28,231
C	0	19	3	11	0	4	0	13	1	1	23	75
D	537	2,459	44	5,519	168	85	0	18	257	0	446	9,553
E	154	747	14	1,504	20	11	0	13	61	0	191	2,715
F	7,736	11,649	1,016	19,485	3,252	1,946	2,183	4,459	4,229	359	4,147	60,461
G	51	710	454	961	67	315	610	900	731	1,788	1,040	7,627
Total	14,210	44,399	2,204	39,031	18,025	3,874	5,881	29,816	13,660	18,670	67,150	

Exhibit 9 provides a visual representation of Provider-submitted Claims That Were Denied in 2023 and 2024, separated by Applicable Reason, using data from Exhibits 8A and 8B.

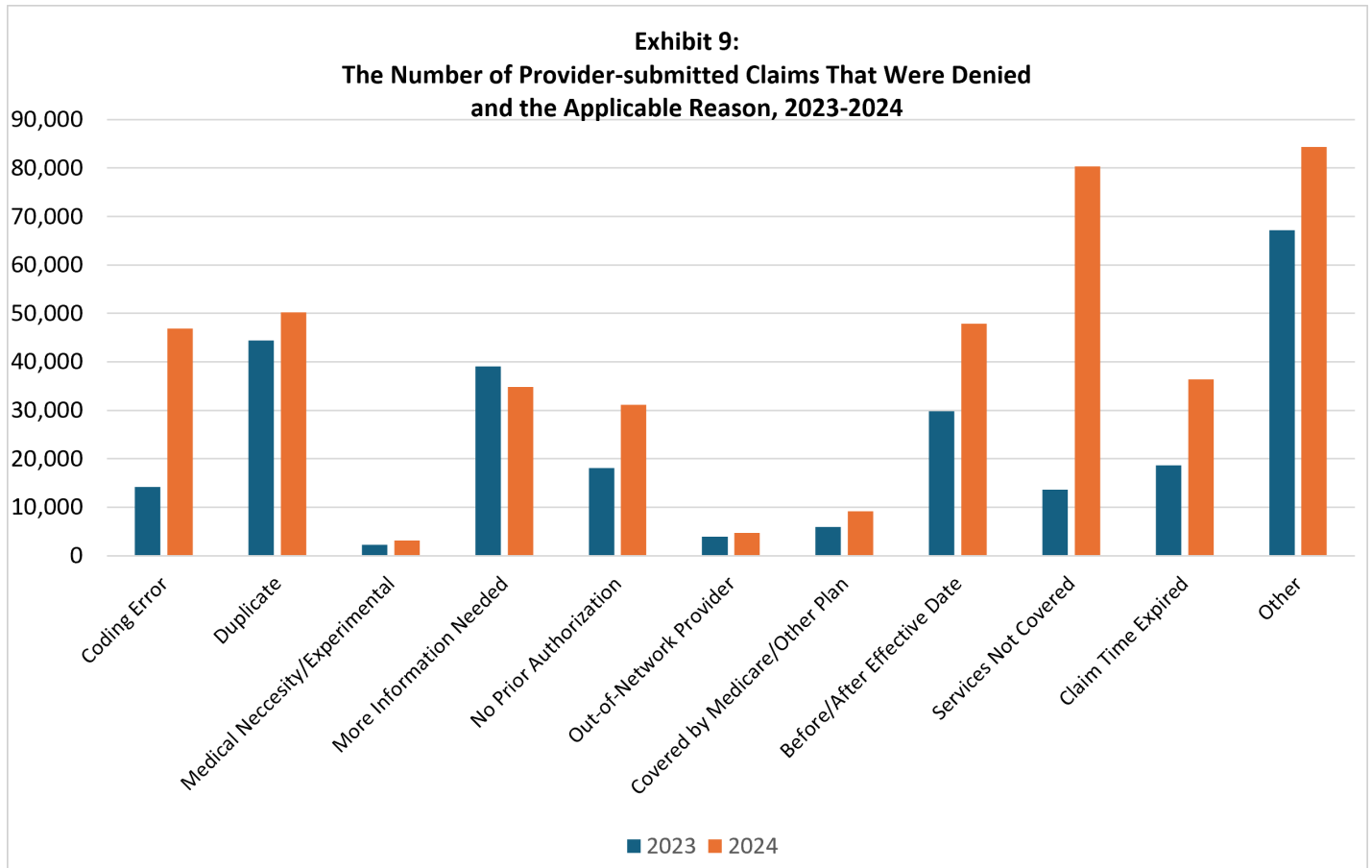


Exhibit 10 details the Number of Provider-submitted Claims That Were Downcoded² between 2023 and 2024. Notably, Carrier F's downcoded claims in the Other category increased substantially from 227 in 2023 to 3,239 in 2024 due to an increase in contract errors, duplicate claims, eligibility issues, claims processing errors, and provider billing errors.

In 2023 and 2024, common reasons for downcoded claims in the Other category for Carriers F and G were contract errors, duplicate claims, eligibility issues, hospital billing errors, and hospital bill audits.

Exhibit 10: The Number of Provider-submitted Claims That Were Downcoded and the Applicable Reason, 2023-2024							
Carrier Code	Year	Diagnostic Information Does Not Meet Claim Billed	Inadequate Documentation	Incorrect Codes Used	Services Bundled	Other	Total
A	2024	0	0	0	0	0	0
	2023	78	0	0	0	0	78
B	2024	0	215	0	0	0	215
	2023	0	162	592	3,265	0	4,019
C	2024	0	1	0	0	0	1
	2023	0	0	0	0	0	0
D	2024	0	0	0	0	0	0
	2023	0	0	0	0	0	0
E	2024	0	0	0	0	0	0
	2023	0	0	0	0	0	0
F	2024	0	264	28	103	3,239	3,634
	2023	6	481	9	13	227	736
G	2024	0	0	231	94	122	447
	2023	0	0	164	127	429	720
Total	2024	0	480	259	197	3,361	4,297
	2023	84	643	765	3,405	656	5,553

² In instructions to carriers, the Bureau defined "downcoding" as "the alteration by plan or issuer of a service code to another service code, or the alteration, addition, or removal by a plan or issuer of a modifier, if the changed code or modifier is associated with a lower Qualifying Payment Amount (QPA) than the service code or modifier billed by the provider or facility."

Exhibit 11 shows each carrier's reported Aggregate Number of In-Network High-Volume Specialists Practicing in Maine in 2023 and 2024. In both years, the most common specialists in the Other category were anesthesiologists, emergency medicine, internal medicine, pathologists, and radiologists.

Exhibit 11: The Aggregate Number of In-Network High-Volume Specialists Practicing in Maine, Per Carrier, 2023-2024										
Carrier Code	Year	Number of In-Network Facilities ³	Behavioral Health	Cardiology	Dermatology	Gastroenterology	Gynecology/Obstetrics	Ophthalmology	Orthopedic Surgery	Other
A	2024	4,505	3,682	175	99	99	223	108	193	1,896
	2023	4,255	3,417	177	75	91	203	99	178	743
B	2024	7,684	2,575	160	57	77	182	85	166	4,656
	2023	7,157	2,458	159	52	73	168	88	161	4,286
C	2024	4,277	4,955	72	69	90	201	91	190	1,540
	2023	3,992	4,261	61	67	83	185	93	156	1,516
D	2024	322	4,630	204	60	100	201	93	174	2,124
	2023	310	3,569	201	57	98	190	89	155	1,944
E	2024	322	4,630	204	60	100	201	93	174	2,124
	2023	310	3,569	201	57	98	190	89	155	1,944
F	2024	931	2,719	155	64	86	165	80	189	1,109
	2023	932	2,293	150	58	80	174	89	169	1,136
G	2024	2,073	3,114	244	95	114	327	80	241	9,146
	2023	2,008	2,893	210	58	98	303	98	214	8,464

³ In instructions to carriers, the Bureau defined "facility" as any public or private hospital, clinic, center, medical school, medical training institution, health care facility, physician's office, infirmary, dispensary, ambulatory surgical center, or other institution or location where medical or mental health care is provided to any person.

Medical Loss Ratio

Carriers must provide rebates in the large group, small group, and individual markets if they do not meet the minimum medical loss ratio⁴ in one of these markets. Exhibit 12, Exhibit 13, and Exhibit 14 show the degree to which carriers in the individual and small group markets met a statutory requirement of a medical loss ratio of 80% and the extent to which the large group market met a higher standard of 85%. Federal law requires that these ratios represent a rolling three-year average.

Carriers reported a total of \$2,129,594,783 in medical claims for 2024 in their Rule 945 reports⁵. The \$23,398,888 in out-of-network non-emergency claims reported by carriers represent 1% of that claim total.

Two additional carriers (Carrier H and Carrier I) are included in this section because though they have fewer than one thousand insureds, they are still required to meet MLR minimums.

For 2024, Carrier H was required to pay rebates of \$174,838 to large group policyholders in Maine. No other rebates were required to be paid in 2023 as a result of all the carriers meeting the minimum MLR.

For more information regarding carriers' premiums collected and expenses paid across individual, small group, and large group markets in 2024, please visit

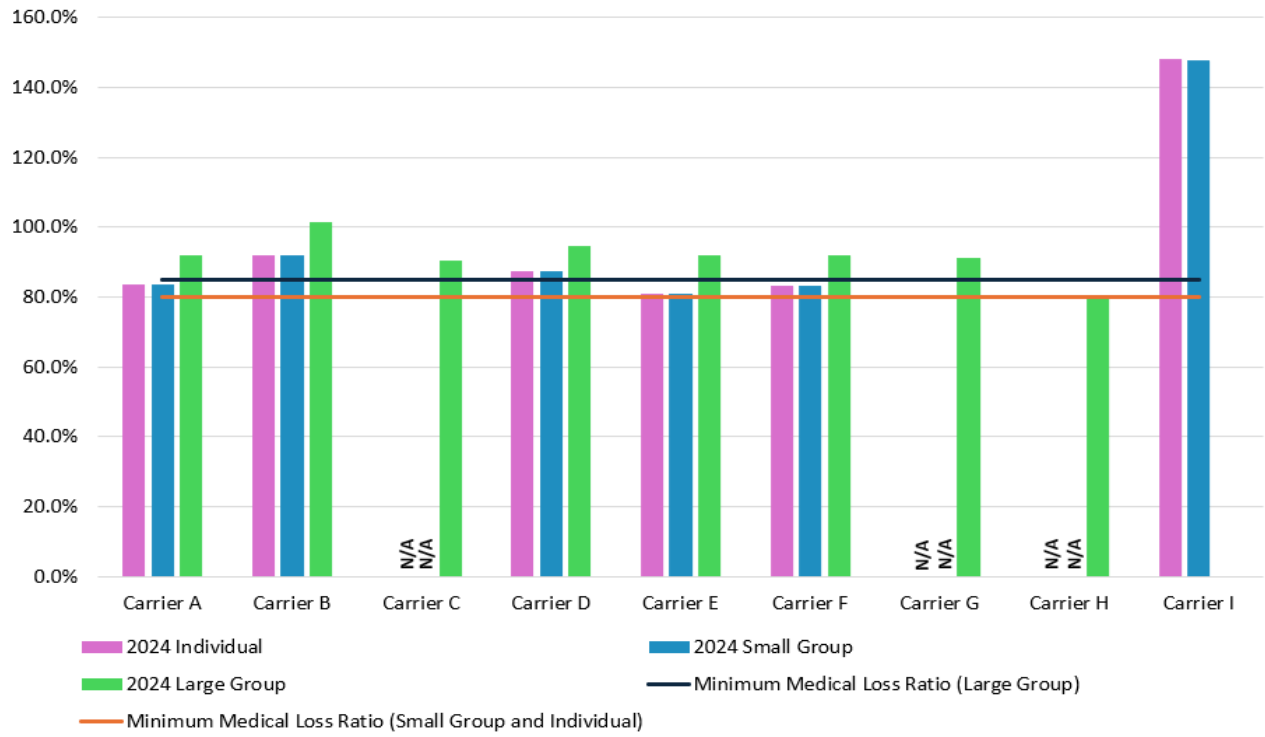
<https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr/insurance/files/inline-files/2024-945-Charts-Graphs.pdf>.

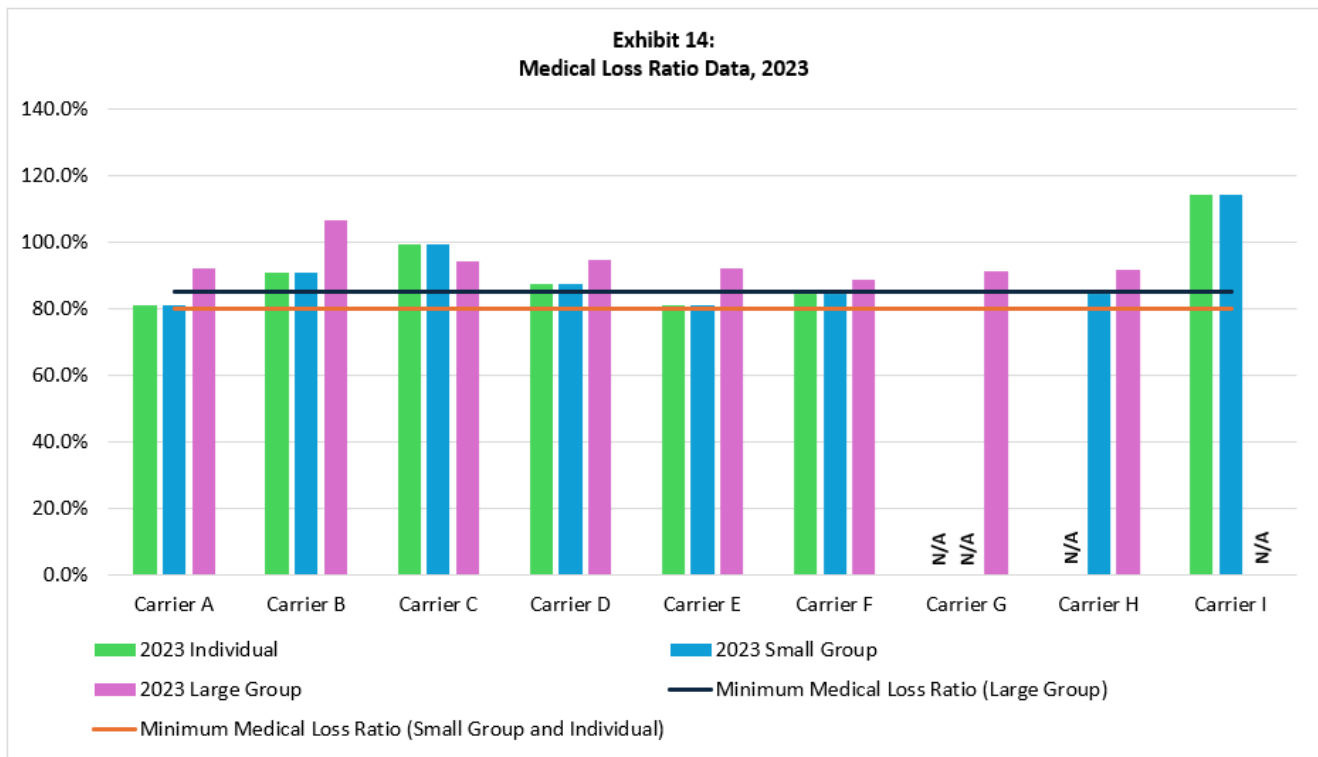
Exhibit 12: Medical Loss Ratio Data, 2023-2024						
Carrier	2023			2024		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group
Carrier A	81.0%	81.0%	92.0%	83.6%	83.6%	91.8%
Carrier B	91.0%	91.0%	106.7%	91.9%	91.9%	101.4%
Carrier C	99.4%	99.4%	94.1%	N/A	N/A	90.3%
Carrier D	87.5%	87.5%	94.8%	87.5%	87.5%	94.8%
Carrier E	80.9%	80.9%	92.0%	80.9%	80.9%	92.0%
Carrier F	84.4%	84.4%	88.6%	83.2%	83.2%	91.8%
Carrier G	N/A	N/A	91.4%	N/A	N/A	91.2%
Carrier H	N/A	84.5%	91.5%	N/A	N/A	79.8%
Carrier I	114.3%	114.3%	N/A	148.2%	147.8%	N/A

⁴ "Medical loss ratio" is defined in 24-A M.R.S. §4319 (2) as the ratio of the amount expended on reimbursement for clinical services provided to enrollees and activities that improve health care quality (the numerator), and the total amount of premium revenue excluding federal and state taxes and licensing and regulatory fees paid and after accounting for payments or receipts for risk adjustment, risk corridors and reinsurance pursuant to federal law (the denominator). These amounts are subject to any credibility adjustment.

⁵ Rule 945, Annual Report Supplement for Health Insurers, was promulgated pursuant to 24-A M.R.S. §423-D

Exhibit 13:
Medical Loss Ratio Data, 2024





Conclusion

Few providers are using the IDR process to resolve out-of-network emergency bills. During 2024, two IDR decisions were issued. It is not clear whether the low number of IDR requests indicates that providers are satisfied with the amount carriers are paying for out-of-network emergency services or whether they are instead choosing to resolve disputes on their own; additionally, it is unclear if uninsured persons are choosing to resolve disputes on their own.

Appendix A

24-A M.R.S. § 4303-E. Dispute resolution process for surprise bills and bills for out-of-network emergency services

1. Independent dispute resolution process. The superintendent shall establish an independent dispute resolution process by which a dispute for a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider in accordance with section 4303-C, subsection 2 may be resolved as provided in this subsection beginning no later than October 1, 2020.

A. The superintendent may select an independent dispute resolution entity to conduct the dispute resolution process. The superintendent shall adopt rules to implement a dispute resolution process that uses a standard arbitration form and includes the selection of an arbitrator from a list of qualified arbitrators developed pursuant to the rules. A qualified arbitrator must be independent; may not be affiliated with a carrier, health care facility or provider or any professional association of carriers, health care facilities or providers; may not have a personal, professional or financial conflict with any parties to the arbitration; and must have experience in health care billing and reimbursement rates. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

B. An independent dispute resolution entity shall make a decision within 30 days of receipt of the dispute for review.

C. In determining a reasonable fee for the health care services rendered, an independent dispute resolution entity shall select either the carrier's payment or the out-of-network provider's fee. The independent dispute resolution entity shall determine which amount to select based upon the conditions and factors set forth in this paragraph. In determining the reasonable fee for a health care service, an independent dispute resolution entity shall consider all relevant factors, including:

- (1) The out-of-network provider's level of training, education, specialization, quality and experience and, in the case of a hospital, the teaching staff, scope of services and case mix;
- (2) The out-of-network provider's previously contracted rate with the carrier, if the provider had a contract with the carrier that was terminated or expired within one year prior to the dispute; and
- (3) The median network rate for the particular health care service performed by a provider in the same or similar specialty, as determined by the all-payer claims database maintained by the Maine Health Data Organization or, if Maine Health Data Organization claims data is insufficient or otherwise inapplicable, another independent medical claims database. If authorized by rule, the superintendent may enter into an agreement to obtain data from an independent medical claims database to carry out the functions of this subparagraph.

D. If an independent dispute resolution entity determines, based on the carrier's payment and the out-of-network provider's fee, that a settlement between the carrier and out-of-network provider is reasonably likely, or that both the carrier's payment and the out-of-network provider's fee represent unreasonable extremes, the independent dispute resolution entity may direct both parties to attempt a good faith negotiation for settlement. The carrier and out-of-network provider may be granted up to 10 business days for this negotiation, which runs concurrently with the 30-day period for dispute resolution.

E. The determination of an independent dispute resolution entity is binding on the carrier, out-of-network provider and enrollee and is admissible in any court proceeding between the carrier, out-of-network provider and enrollee or in any administrative proceeding between this State and the provider.

F. When an independent dispute resolution entity determines the carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network provider. When the independent dispute resolution entity determines the out-of-network provider's fee is reasonable, payment for the dispute resolution process is the responsibility of the carrier. When a good faith negotiation directed by the independent dispute resolution entity results in a settlement between the carrier and the out-of-network provider, the carrier and the out-of-network provider shall evenly divide and share the prorated cost for dispute resolution.

G. The superintendent shall enforce the determination of an independent dispute resolution entity pursuant to this subsection or any agreement made by a carrier and an out-of-network provider after the conclusion of the independent dispute resolution process pursuant to this subsection. The superintendent may use any powers provided to the superintendent under this Title.

H. Following a determination by an independent dispute resolution entity of a reasonable fee for a particular health care service, an out-of-network provider may not initiate the dispute resolution process under this subsection for that same health care service for a period of 90 days.

2. Self-insured health benefit plans. An entity providing or administering a self-insured health benefit plan exempted from the applicability of this section under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) may elect to be subject to the provisions of this section to resolve disputes with respect to a surprise bill for emergency services or a bill for covered emergency services from an out-of-network provider. In the event an entity providing or administering a self-insured health benefit plan elects to be subject to the provisions of this section, the provisions of this section apply to a self-insured health benefit plan and its members in the same manner as the provisions of this section apply to a carrier and its enrollees. To elect to be subject to the provisions of this section, the entity shall provide notice, on an annual basis, to the superintendent, on a form and in a manner prescribed by the superintendent, attesting to the entity's participation and agreeing to be bound by the provisions of this section. The entity shall amend the health benefit plan, coverage policies, contracts and any other plan documents to reflect that the provisions of this section apply to the plan's members.

3. Information required from carriers. As part of the carrier's annual public regulatory filings made to the superintendent, a carrier shall submit in a form and manner determined by the superintendent information related to:

A. The use of out-of-network providers by enrollees and the impact on premium affordability and benefit design; and

B. The number of claims submitted by a provider to the carrier that are denied or down coded by the carrier and the reason for the denial or down coding determination.

4. Report from superintendent. On or before January 31st annually, beginning January 1, 2022, the superintendent shall report the following information received from all carriers in the aggregate:

A. The number of requests for independent dispute resolution filed pursuant to this section between January 1st and December 31st of the previous calendar year, including the percentage of all claims that

were subject to dispute. For each independent dispute resolution determination, the carrier shall provide aggregate information that does not identify any provider, carrier, enrollee or uninsured patient involved in each determination about:

- (1) Whether the determination was in favor of the carrier, out-of-network provider or uninsured patient;
- (2) The payment amount offered by each side of the independent dispute resolution process and the award amount from the independent dispute resolution determination;
- (3) The category and practice specialty of each out-of-network provider involved, as applicable; and
- (4) A description of the health care service that was subject to dispute;

B. The percentage of facilities and hospital-based professionals, by specialty, that are in network for each carrier in this State as reported in access plans submitted to the superintendent;

C. The number of complaints the superintendent receives relating to out-of-network health care charges;

D. Annual trends on health benefit plan premium rates, the total annual amount of spending on inadvertent and emergency out-of-network costs by carriers and medical loss ratios in the State to the extent that the information is available;

E. The number of physician specialists practicing in the State in a particular specialty and whether they are in network or out of network with respect to the carriers that administer the state employee group health plan under Title 5, section 285, the Maine Education Association benefits trust health plan, the qualified health plans offered pursuant to the federal Affordable Care Act and other health benefit plans offered in the State;

F. A summary of the information submitted to the superintendent pursuant to subsection 3 concerning the number of claims submitted by health care providers to carriers that are denied or down coded by the carrier and the reasons for the denials or down coding determinations;

G. An analysis of the impact of this section, with respect to both emergency services and other health care services, on premium affordability and the breadth of provider networks; and

H. Any other benchmarks or information that the superintendent considers appropriate to make publicly available to further the goals of this section.

The superintendent shall submit the report to the joint standing committee of the Legislature having jurisdiction over health insurance matters and shall post the report on the bureau's publicly accessible website.

5. Confidentiality. Except as provided in this subsection, all records of the bureau or an independent dispute resolution entity relating to an independent dispute resolution request or proceeding are confidential and not a public record under Title 1, chapter 13.