

02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

031 BUREAU OF INSURANCE

Chapter 365: STANDARDS FOR INDEPENDENT DISPUTE RESOLUTION OF EMERGENCY MEDICAL SERVICE BILLS

TABLE OF CONTENTS

| | |
|-------------|---|
| Section 1. | Authority and Purpose |
| Section 2. | Applicability and Scope |
| Section 3. | Definitions |
| Section 4. | Application for Selection as an IDRE |
| Section 5. | Conflict of Interest |
| Section 6. | Responsibilities of Carriers |
| Section 7. | Process to Submit and Resolve Disputes |
| Section 8. | Severability-Confidentiality |
| Section 9. | Effective date-Severability |
| Section 10. | Effective Date |

Section 1. Authority and Purpose

This rule is adopted pursuant to 24-A M.R.S. §§ 212 and 4303-E, to implement the Independent Dispute Resolution (IDR) process established by PL 2019, chapter 668, *An Act To Protect Consumers from Surprise Emergency Medical Bills*.

Section 2. Applicability and Scope

1. This rule shall apply to the following entities:
 - A. A carrier, including a participating self-insured health plan.
 - B. A patient who is eligible to initiate IDR under 22 M.R.S. §1718-D.
 - C. A provider that has rendered emergency services to an eligible patient, or that has rendered emergency services on an out-of-network basis to a patient covered by a carrier's health plan and is unable in good faith to negotiate agreement with the carrier on the payment amount within 30 calendar days after the carrier has given the provider notice as required in paragraph 6(1)(C).
2. This rule shall apply to the following types of bills, except in cases where the patient knowingly elected to obtain the services from an out-of-network provider:
 - A. A surprise bill for emergency services;

- B. Any other bill for covered emergency services rendered by an out-of-network provider to a person covered by an insured or self-insured health plan; and
- C. A bill totaling \$750 or more received by an uninsured person for emergency health services if the total bill for the single visit is \$750 or more regardless of the number of providers included in the bill.

Section 3. Definitions

The following definitions apply for purposes of this rule:

1. “Carrier” has the same meaning as in 24-A M.R.S. §4301-A(3). Unless the context otherwise indicates, “carrier” also includes a participating self-insured health benefit plan.
2. “Control” has the same meaning as in 24-A M.R.S. §222(2)(B).
3. “Eligible patient” means:
 - A. an uninsured person who has received a bill for emergency services totaling \$750 from one or more providers for a single visit; or
 - B. a person covered under a nonparticipating self-insured health plan who has received a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider, and did not knowingly elect to obtain the services from an out-of-network provider.
4. “Emergency services” has the same meaning as 24-A M.R.S. §4301-A(4-B).
5. “Enrollee” means a person covered by a carrier under a policy, certificate, or benefit plan.
6. “Geographic rating area” means an area designated by the Superintendent for health insurance rating purposes under 24-A M.R.S. §§ 2736-C(2)(C-1) & 2808-B(2)(C-1).
7. “Independent dispute resolution entity” or “IDRE” means an entity selected by the Superintendent pursuant to this rule to conduct the independent dispute resolution process.
8. “Material financial affiliation” means any financial interest of more than five percent of total annual revenue or total annual income of an IDRE or officer, director, or managers thereof; or arbitrator employed or engaged thereby to conduct any independent dispute review in the dispute resolution process. Revenue received from a carrier or physician by an IDRE to conduct a dispute resolution pursuant to this rule is not a material financial affiliation.
9. “Material personal affiliation” means any relationship as a spouse or domestic partner; as a child, parent, or sibling; as the child, parent, or sibling of a spouse or domestic partner; or as the spouse or domestic partner of a child, parent, or sibling.

10. “Material professional affiliation” means any physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a material financial affiliation with any expert or any officer or director of the IDRE.
11. “Out-of-network provider” means a physician, hospital, or other provider that does not have a contract with the carrier to provide services to an enrollee.
12. “Participating self-insured health benefit plan” means a self-insured health benefit plan that has elected to participate in the IDR system pursuant to 24-A M.R.S. §4303-E(2) and subsection 6(7) of this rule.
13. “Surprise bill” has the same meaning as in 24-A M.R.S §4303-C(1).

Section 4. Application for Selection as an IDRE

An entity applying for selection as an IDRE shall submit to the Superintendent an application on the form prescribed by the Superintendent. The application must describe the proposed IDRE’s organizational structure and capability to operate a statewide IDR process, including:

1. copies of its certificate of incorporation or articles of organization, bylaws or operating agreement, and, as applicable, those of its holding company or parent company;
2. its organizational chart;
3. the names and biographical information relevant to the business of independent dispute resolution services for all members of its board of directors, its officers, and its executives, including their respective roles, and responsibilities;
4. the names of all corporations and organizations that it controls, is controlled by, or is under common control with, and the nature and extent of that control;
5. its policies and procedures governing all aspects of the IDR process, including at a minimum:
 - A. a description and a chart or diagram of the sequence of steps through which a dispute will move from receipt through notification of the dispute determination to interested parties;
 - B. procedures for ensuring that the arbitrator assigned to a dispute has no prohibited material financial, material personal, or material professional affiliation. These procedures must include a requirement for a signed attestation by each arbitrator assigned to review a dispute;
 - C. procedures to ensure that each dispute is reviewed by a neutral and impartial arbitrator with training and experience in healthcare billing, reimbursement, and usual and customary charges;

- D. procedures for reporting and reviewing an arbitrator's conflicts of interest, for determining whether there is a conflict of interest, and for assigning or reassigning an IDR where a conflict is identified;
- E. procedures to ensure that reviews are conducted within the time frames specified in this rule and any required notices are provided in a timely manner;
- F. procedures to ensure the confidentiality of personal health information, personally identifiable information, and review materials;
- G. procedures to ensure adherence to the requirements of this rule by any contractor, subcontractor, agent, or employee;
- H. a description of the following:
 - (1) its ability to provide review services statewide;
 - (2) the qualifications the arbitrators retained to review payment disputes, including current and past employment history, as applicable;
 - (3) the procedures employed to ensure that arbitrators reviewing payment disputes are:
 - (a) trained in the principles of dispute resolution and the procedures and standards of the proposed IDRE;
 - (b) knowledgeable about the health care service which is the subject of the payment dispute under review; and
 - (c) trained and experienced in health care billing, reimbursement and usual and customary charges;
 - (4) the methods of recruiting and selecting neutral and impartial arbitrators and matching such reviewers to specific cases;
- I. its organizational arrangements and ongoing procedures for the identification, evaluation, resolution, and follow-up of potential and actual problems in payment dispute reviews; and the maintenance of program standards pursuant to this subdivision;
- J. written procedures documenting that:
 - (1) appropriate personnel are reasonably accessible at least 40 hours per week during normal business hours to discuss the dispute resolution process and to allow response to telephone requests; and
 - (2) a response to an answered call or recorded message shall be made no later than the next business day after the call was received;

- K. its fees, which must include disclosure of:
 - (1) the total amount that it will charge for reviews, inclusive of indirect costs, administrative fees and incidental expenses;
 - (2) the pro-rated fee that will be charged when a good faith negotiation directed by the proposed IDRE results in a settlement between a carrier and a provider;
 - (3) an application processing fee if the dispute is determined by the proposed IDRE to be ineligible for review;
 - (4) the fee that will be charged to the provider when an eligible patient requests an IDR;
 - (5) the methodology used to calculate all fees; and
 - (6) any fee charged for the configuration of a portal to receive IDR applications from out-of-network providers and eligible patients;
- L. how it provides requisite notifications, screens for material affiliations, responds during normal business hours to inquiries from the State and from interested persons regarding the dispute resolution process; and
- M. such other information as the Superintendent may require.

Section 5. Conflict of interest

1. No person may be selected as an IDRE if it owns or controls, is owned or controlled by, or is under common control with:
 - A. any national, state, or local illness, health benefit, or public advocacy group;
 - B. any national, state, or local society or association of hospitals, physicians, or other providers of health care services; or
 - C. any national, state, or local association of insurance carriers.
2. If an IDRE acquires control of, becomes controlled by, or comes under common control with any entity described in subsection 1, the IDRE shall notify the Superintendent in writing within three business days of the acquisition or exercise of control and shall consult with the Superintendent as to how to mitigate the conflict of interest.
3. Before accepting an IDR, an IDRE shall submit a sworn statement setting forth that the proposed arbitrator has no material financial, personal, or professional affiliation with:
 - A. any officer, director, or manager of the carrier;
 - B. any health care provider, physician's medical group, independent practice association, or provider of pharmaceutical products or services or durable

medical equipment that provided or supplied the health care service that is the subject of the IDR;

- C. the facility at which the health service was provided;
- D. any officer, director, partner, or manager of the physician's medical group, independent practice association, or facility that provided the health care service;
- E. the developer or manufacturer of the principal health service that is the subject of the IDR;
- F. the patient whose health care service is the subject of the IDR; or
- G. any organization described in subsection 1.

Section 6. Responsibilities of Carriers

- 1. Upon receipt of a claim for covered emergency services rendered by an out-of-network provider, a carrier shall:
 - A. pay the claim based on an allowable charge calculated in accordance with paragraph B, unless the carrier and provider negotiate a different amount or the patient knowingly elected to obtain the services from an out-of-network provider. The carrier shall pay the allowable charge to the provider, subject to the following adjustments:
 - (1) Payment shall be made net of the coinsurance, copayment, deductible, and any other out-of-pocket expense for which the enrollee is responsible under subsection 3;
 - (2) To the extent that the enrollee has paid the provider more than the cost sharing required by subparagraph (1), the carrier shall pay the excess to the enrollee and deduct that amount from the payment otherwise due to the provider;
 - (3) Payment shall be made net of any amounts already paid by the carrier; and
 - (4) If the carrier is a secondary payer, the enrollee's and carrier's responsibility shall be reduced as called for by applicable coordination of benefits procedures;
 - B. determine the total amount the provider is entitled to receive for health care services rendered. The carrier's determination of median network rates shall be based on the CPT code for the claim and the geographic rating area in which the service was rendered, unless the carrier determines that the available data are insufficient or otherwise inapplicable, in which case the carrier, subject to the process of negotiation and IDR review, may use a broader geographic area or bundle of CPT codes. The provider's allowable charge shall be the greater of:

- (1) the carrier's median network rate paid for the service by a similar provider in the geographic area in which the service was rendered; and
 - (2) the median network rate paid by all carriers for that health care service by a similar provider in the geographic area in which the service was rendered 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 specified by the Superintendent after consulting with interested parties.
 - C. give notice to the provider, in a form and manner prescribed by the Superintendent, specifying the carrier's allowable charge for the service, and describing how the provider may initiate the IDR process if the carrier and provider are unable to reach agreement within 30 days;
 - D. if the carrier pays an amount less than the provider's charge, provide the enrollee with notice which shall explain that the enrollee shall incur no greater out-of-pocket costs for the services than the enrollee would have incurred with a network provider. The carrier may provide this notice on or with the explanation of benefits required under 24-A M.R.S. §4303(13); and
 - E. direct the enrollee to contact the carrier if the provider bills the enrollee for the out-of-network service for more than the amount indicated as the enrollee's responsibility on the carrier's explanation of benefits.
2. A carrier shall prominently post on its website the following information regarding surprise bills and bills for emergency services rendered by out-of-network providers, and include the same information in disclosure materials provided to enrollees:
 - A. a description of what constitutes a surprise bill;
 - B. an explanation of which surprise bills are eligible for the IDR process;
 - C. a description of the IDR process;
 - D. information on how an out-of-network provider may submit a dispute for resolution by an IDRE.
 3. A carrier shall ensure that the enrollee does not incur any greater out-of-pocket costs for the services than the enrollee would have incurred with a provider charging the carrier's median network rate. The carrier may not increase the enrollee's coinsurance if negotiation or IDR results in an increase in the applicable network rate.
 4. If an IDRE directs a carrier to engage in negotiations with an out-of-network provider, the IDRE shall specify a time period for negotiation, not to exceed ten business days, and the parties shall negotiate in good faith. If a settlement is reached, the carrier shall notify the IDRE of the settlement within two business days and shall make any additional payment to the provider within thirty days. If a settlement is not reached or the parties agree that a settlement is not attainable, the carrier shall promptly notify the IDRE within the period granted by the IDRE for negotiation.

5. If the IDRE issues a determination in favor of the provider, the carrier shall pay the provider any additional amount owed within 30 days after the date of the determination.
6. A carrier shall designate, and identify to the Superintendent, someone knowledgeable about the IDR process who shall be responsible for oversight of the carrier's compliance with the process. The carrier shall make at least one staff member available full time during normal business hours. The carrier shall respond to all inquiries from the Superintendent relating to the IDR process within five business days.
7. A self-insured employer or the administrator of a self-insured health benefit plan may elect to be treated as a carrier under this rule by filing a notice in a form and manner prescribed by the Superintendent as provided in this subsection. The plan's rights and responsibilities as a carrier apply to all services provided to enrollees after the notice of participation is received by the Superintendent, unless the plan requests a different effective date. In order for the plan's participating status to remain in effect without interruption, a renewal notice must be received before the expiration of the plan year. The initial and renewal notices must include the following:
 - A. the identity and contact information of the self-insured employer and the plan administrator;
 - B. an agreement to submit to the jurisdiction of the Superintendent and to be bound by the requirements of this rule, the applicable provisions of the Maine Insurance Code, and any order or decision made by an IDRE pursuant to this rule; and
 - C. evidence that the plan documents have been amended to reflect the applicability of the IDR process to the plan's enrollees.

Section 7. Process to Submit and Resolve Disputes

1. The out-of-network provider or eligible patient requesting IDR (the "applicant") shall submit an application in a form and manner prescribed by the Superintendent.
2. The applicant shall provide the following information, to the extent known to the applicant:
 - A. the name and contact information of the patient, the provider or providers, and, unless the applicant is an uninsured patient, the carrier or self-insured health benefit plan;
 - B. the fee that is the subject of the dispute and a copy of the bill;
 - C. the claim number or numbers and date or dates of service;
 - D. if the application is submitted by a provider, the following additional information:
 - (1) the provider's level of training, education, and experience;

- (2) an explanation of the circumstances and complexity of the particular case, including time and place of the service;
 - (3) individual patient characteristics, if relevant; and
 - (4) the provider's usual charge for comparable services rendered to uninsured patients, patients treated on an out-of-network basis, patients treated under contracts with other carriers or self-insured plans, and, if applicable, patients treated under a contract with the carrier or plan involved in the dispute that was terminated or that expired within one year before the date the service was rendered;
 - E. an agreement to be bound by the outcome of the IDR, to submit to the jurisdiction of the Superintendent and the courts of this State, and if the applicant is an out-of-network provider, to refrain from billing the enrollee more than the applicable out-of-pocket costs permitted by 22 M.R.S. §1718(D)(2).
 - F. any other information the applicant deems relevant; and
 - G. an attestation affirming that the information provided by the applicant is true and accurate.
3. An eligible patient shall not be required to pay the provider's fee in order to be eligible to submit the dispute for review by an IDRE.
 4. If the Superintendent chooses to screen applications for eligibility, the Superintendent shall promptly notify all parties upon determining that an application is ineligible for IDR, and shall assign each eligible application to an IDRE and promptly forward the application materials to the assigned IDRE. Otherwise, the Superintendent shall assign each application to an IDRE, which shall screen the application for eligibility within three business days. The IDRE shall contact the applicant, and any other party that might have the necessary information, if additional information is needed to determine eligibility of the request for IDR. The IDRE shall allow a reasonable time, not less than three business days, to submit the information and provide an explanation of where the information should be sent. If the information is not submitted, the IDRE shall make a second request and allow one business day to submit the information.
 5. Within three business days after an application has been determined to be eligible, the IDRE shall assign an arbitrator and notify the patient, the provider or providers, and, if applicable, the carrier or self-insured plan. The notification shall include:
 - A. the name and contact information of the IDRE and the assigned arbitrator;
 - B. a brief description of the process, and the parties' rights and responsibilities, including:
 - (1) if the IDR was initiated by the provider, an explanation that the disputed bill is the carrier's responsibility and the patient's cost-sharing obligation cannot be increased as a result of the IDR; and

- (2) if the patient is enrolled in a nonparticipating self-insured plan, an explanation that any participation by the plan in the IDR process, including the provision of any requested information, is voluntary; and
- C. an explanation of how and where each party may send the arbitrator any additional information it considers important to a clear understanding and fair resolution of the dispute, and the deadline for submitting such information.
- 6. The arbitrator may request information at any time from the patient, the provider or providers, and the carrier or self-insured plan, and shall advise the requested party that if a partial response or no response is received, the dispute will be decided based on the available information. Any party shall provide the information requested within the time requested, which shall be no less than five business days after the request is received, and shall attest that the information provided is true and complete.
- 7. In resolving a dispute, the IDRE must consider all relevant factors, including but not limited to the factors identified in 24-A M.R.S. §4303-E(1)(C)(1)-(3).
- 8. The IDRE shall issue its decision within thirty days after its receipt of a completed application.
- 9. The party responsible for payment of the IDRE's fee, or its share of the fee in the case of a negotiated settlement, shall pay the IDRE within 90 days after the issuance of the decision or submission of the settlement agreement.

Section 8. Confidentiality

Except as provided in statute and this rule, all records of the Bureau or an IDRE relating to an IDR request or proceeding are confidential and not a public record under Title 1, chapter 13.

Section 8. 9. Severability

If any section, term, or provision of this rule shall be deemed invalid for any reason, any remaining section, provision, or definition shall remain in full force and effect.

Section 9. 10. Effective date

This rule is effective October 24, 2020. This rule applies to all IDR applications relating to services rendered on or after October 1, 2020. The 2022 amendments are effective May 1, 2022. The 2025 amendments are effective _____, 2025.

STATUTORY AUTHORITY:

24-A MRS §§ 212, 4303-E

EFFECTIVE DATE:

October 24, 2020 – filing 2020-220

AMENDED:

May 1, 2022 – filing 2022-070

APAO WORD VERSION CONVERSION (IF NEEDED) AND ACCESSIBILITY CHECK: July 18,
2025