CHAPTER 56-A

HEALTH PLAN IMPROVEMENT ACT

SUBCHAPTER 1

HEALTH PLAN REQUIREMENTS

§4301. Definitions

(REPEALED)

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1997, c. 604, §A1 (AMD). PL 1999, c. 256, §A1 (AMD). PL 1999, c. 609, §19 (AMD). PL 1999, c. 742, §2 (RP). PL 2001, c. 471, §A28 (RP).

§4301-A. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 1999, c. 742, §3 (NEW).]

1. Adverse health care treatment decision. "Adverse health care treatment decision" means a health care treatment decision made by or on behalf of a carrier offering or renewing a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee. "Adverse health care treatment decision" includes a rescission determination and an initial coverage eligibility determination, consistent with the requirements of the federal Affordable Care Act.
[PL 2011, c. 364, §20 (AMD).]

2. Authorized representative. "Authorized representative" means:

A. A person to whom an enrollee has given express written consent to represent the enrollee in an external review; [PL 1999, c. 742, §3 (NEW).]

B. A person authorized by law to provide consent to request an external review for an enrollee; or [PL 1999, c. 742, §3 (NEW).]

C. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review. [PL 1999, c. 742, §3 (NEW).]
[PL 1999, c. 742, §3 (NEW).]

2-A. Behavioral health care service. "Behavioral health care service" means a health care service or treatment to address mental health and substance use conditions.
[PL 2023, c. 119, §1 (NEW).]

3. Carrier. "Carrier" means:

A. An insurance company licensed in accordance with this Title to provide health insurance; [PL 1999, c. 742, §3 (NEW).]

B. A health maintenance organization licensed pursuant to chapter 56; [PL 1999, c. 742, §3 (NEW).]

C. A preferred provider arrangement administrator registered pursuant to chapter 32; [PL 1999, c. 742, §3 (NEW).]

D. A fraternal benefit society, as defined by section 4101; [PL 1999, c. 742, §3 (NEW).]

E. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24; [PL 1999, c. 742, §3 (NEW).]

F. A multiple-employer welfare arrangement licensed pursuant to chapter 81; [PL 2011, c. 364, §21 (AMD).]

G. A self-insured employer subject to state regulation as described in section 2848-A; or [PL 2011, c. 364, §21 (AMD).]

H. Notwithstanding any other provision of this Title, an entity offering coverage in this State that is subject to the requirements of the federal Affordable Care Act. [PL 2011, c. 364, §22 (NEW).]

An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.
[PL 2011, c. 364, §§21, 22 (AMD).]

4. Clinical peer. "Clinical peer" means a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States, is board certified in the same or similar specialty as typically manages the medical condition, procedure or treatment under review and whose compensation does not depend, directly or indirectly, upon the quantity, type or cost of the medical condition, procedure or treatment that the physician or other licensed health care practitioner approves or denies on behalf of a carrier.
[PL 2019, c. 171, §1 (AMD).]

4-A. Emergency medical condition. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:

A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:

(1) Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;

(2) Serious impairment of a bodily function; or

(3) Serious dysfunction of any organ or body part; or [PL 2019, c. 238, §1 (NEW).]

B. With respect to a pregnant woman who is having contractions, that there is:

(1) Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or

(2) A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital. [PL 2019, c. 238, §1 (NEW).]
[PL 2019, c. 238, §1 (NEW).]

4-B. Emergency service. "Emergency service" means a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting.
[PL 2019, c. 238, §1 (NEW).]

5. Enrollee. "Enrollee" means an individual who is enrolled in a health plan or a managed care plan.
[PL 1999, c. 742, §3 (NEW).]

6. Health care treatment decision. "Health care treatment decision" means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.
[PL 2001, c. 288, §1 (AMD).]

7. Health plan. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage not subject to the requirements of the federal Affordable Care Act. A plan that is subject to the requirements of the federal Affordable Care Act and offered in this State by a carrier, including, but not limited to, a qualified health plan offered on an American Health Benefit Exchange or a SHOP Exchange established pursuant to the federal Affordable Care Act, is a health plan for purposes of this chapter.
[PL 2011, c. 364, §23 (AMD).]

8. Independent review organization. "Independent review organization" means an entity that conducts independent external reviews of adverse health care treatment decisions.
[PL 1999, c. 742, §3 (NEW).]

9. Managed care plan. "Managed care plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:

A. Arrangements with selected providers to furnish health care services; and [PL 1999, c. 742, §3 (NEW).]

B. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan. [PL 1999, c. 742, §3 (NEW).]

A return to work program developed for the management of workers' compensation claims may not be considered a managed care plan.
[PL 1999, c. 742, §3 (NEW).]

10. Medically appropriate health care.
[PL 2001, c. 288, §2 (RP).]

10-A. Medically necessary health care. "Medically necessary health care" means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

A. Consistent with generally accepted standards of medical practice; [PL 2001, c. 288, §3 (NEW).]

B. Clinically appropriate in terms of type, frequency, extent, site and duration; [PL 2001, c. 288, §3 (NEW).]

C. Demonstrated through scientific evidence to be effective in improving health outcomes; [PL 2001, c. 288, §3 (NEW).]

D. Representative of "best practices" in the medical profession; and [PL 2001, c. 288, §3 (NEW).]

E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. [PL 2001, c. 288, §3 (NEW).]
[PL 2001, c. 288, §3 (NEW).]

11. Medical necessity.
[PL 2001, c. 288, §4 (RP).]

12. Ordinary care. "Ordinary care" means, in the case of a carrier, the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances. For a person who is an agent of a carrier, "ordinary care" means the degree of care that a person of ordinary prudence would use under the same or similar circumstances.
[PL 1999, c. 742, §3 (NEW).]

13. Participating provider. "Participating provider" means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan.
[PL 1999, c. 742, §3 (NEW).]

14. Peer-reviewed medical literature. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present supporting data that the proposed use of a drug or device is safe and effective.
[PL 1999, c. 742, §3 (NEW).]

15. Plan sponsor. "Plan sponsor" means an employer, association, public agency or any other entity providing a health plan.
[PL 1999, c. 742, §3 (NEW).]

16. Provider. "Provider" means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.
[PL 1999, c. 742, §3 (NEW).]

16-A. Provider profiling program. "Provider profiling program" means a program that uses provider data in order to rate or rank provider quality, cost or efficiency of care by the use of a grade, star, tier, rating or any other form of designation that provides an enrollee with an incentive to use a designated provider based on quality, cost or efficiency of care.
[PL 2013, c. 383, §3 (AMD).]

17. Religious nonmedical provider. "Religious nonmedical provider" means a provider who provides only religious nonmedical treatment or religious nonmedical nursing care.
[PL 1999, c. 742, §3 (NEW).]

18. Special condition. "Special condition" means a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.
[PL 1999, c. 742, §3 (NEW).]

19. Specialist. "Specialist" means an appropriately licensed and credentialed health care provider with specialized training and clinical expertise.
[PL 1999, c. 742, §3 (NEW).]

20. Standard reference compendia. "Standard reference compendia" means:

A. The United States Pharmacopeia Drug Information or information published by its successor organization; or [PL 1999, c. 742, §3 (NEW).]

B. The American Hospital Formulary Service Drug Information or information published by its successor organization. [PL 1999, c. 742, §3 (NEW).]
[PL 1999, c. 742, §3 (NEW).]

21. Urgent care. "Urgent care" means health care or treatment provided in response to exigent circumstances.
[PL 2023, c. 119, §2 (NEW).]

SECTION HISTORY

PL 1999, c. 742, §3 (NEW). PL 2001, c. 288, §§1-4 (AMD). PL 2007, c. 199, Pt. B, §1 (AMD). PL 2009, c. 439, Pt. B, §1 (AMD). PL 2011, c. 364, §§20-23 (AMD). PL 2013, c. 383, §3 (AMD). PL 2019, c. 171, §1 (AMD). PL 2019, c. 238, §1 (AMD). PL 2023, c. 119, §§1, 2 (AMD).

§4302. Reporting requirements

To offer or renew a health plan in this State, a carrier must comply with the following requirements. [PL 2007, c. 199, Pt. B, §2 (AMD).]

1. Description of plan. A carrier shall provide to prospective enrollees and participating providers, and to members of the public and nonparticipating providers upon request, information on the terms and conditions of the plan to enable those persons to make informed decisions regarding their choice of plan. A carrier shall provide this information annually to current enrollees, participating providers and the superintendent. This information must be presented in a standardized format acceptable to the superintendent. In adopting rules or developing standardized reporting formats, the superintendent shall consider the nature of the health plan and the extent to which rules or standardized formats are appropriate to the plan. All written and oral descriptions of the health plan must be truthful and must use appropriate and objective terms that are easy to understand. These descriptions must be consistent with standards developed for supplemental insurance coverage under the United States Social Security Act, Title XVIII, 42 United States Code, Sections 301 to 1397 (1988). Descriptions of plans under this subsection must be standardized so that enrollees may compare the attributes of the plans and be in a format that is substantially similar to the format required for a carrier pursuant to the federal Affordable Care Act as of January 1, 2019. After a carrier has provided the required information, the annual information requirement under this subsection may be satisfied by the provision of any amendments to the materials on an annual basis. A carrier shall post descriptions of its plans on its publicly accessible website and, in addition to the plan description, include a link to the health plan's certificate of coverage. Specific items that must be included in a description are as follows:

A. Coverage provisions, benefits and any exclusions by category of service, type of provider and, if applicable, by specific service, including but not limited to the following types of exclusions and limitations:

(1) Health care services excluded from coverage;

(2) Health care services requiring copayments or deductibles paid by enrollees;

(3) Restrictions on access to a particular provider type;

(4) Health care services that are or may be provided only by referral; and

(5) Childhood immunizations as recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and the American Academy of Pediatrics; [PL 2009, c. 439, Pt. A, §2 (AMD).]

B. Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, postpayment review and any procedures that may result in the enrollee being denied coverage or not being provided a particular service; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

C. A general description of the methods used to compensate providers, including capitation and methods in which providers receive compensation based upon referrals, utilization or cost criteria; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

D. An explanation of how health plan limitations affect enrollees, including information on enrollee financial responsibilities for payment of coinsurance or other noncovered or out-of-plan services and limits on preexisting conditions and waiting periods; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

E. The terms under which the health plan may be renewed by the plan members or enrollees, including any reservation by the health plan of any right to increase premiums; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

F. A statement as to when benefits cease in the event of nonpayment of the prepaid or periodic premium and the effect of nonpayment upon the enrollees who are hospitalized or undergoing treatment for an ongoing condition; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

G. A description of the manner in which the plan addresses the following: the provision of appropriate and accessible care in a timely fashion; an effective and timely grievance process and the circumstances in which an enrollee may obtain a 2nd opinion; timely determinations of coverage issues; confidentiality of medical records; and written copies of coverage decisions that are not explicit in the health plan agreement. The description must also include a statement explaining the circumstances under which health status may be considered in making coverage decisions in accordance with state and federal laws and that enrollees may refuse particular treatments without jeopardizing future treatment; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

H. Procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or plan formulary, if any; a description of the formulary; and a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on a plan list or plan formulary. Enrollees may request additional information related to specific drugs that are not on the drug formulary; [PL 1999, c. 742, §4 (AMD).]

I. Information on where and in what manner health care services may be obtained; [PL 1999, c. 742, §4 (AMD).]

J. A description of the independent external review procedures and the circumstances under which an enrollee is entitled to independent external review as required by this chapter; [PL 2009, c. 439, Pt. B, §2 (AMD).]

K. A description of the requirements for enrollees to obtain coverage of routine costs of clinical trials and information on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, Section 312.34, as amended; [PL 2017, c. 232, §3 (AMD).]

L. A description of a provider profiling program that may be a part of the health plan, including the location of provider performance ratings in the plan materials or on a publicly accessible website, information explaining the provider rating system and the basis upon which provider performance is measured, the limitations of the data used to measure provider performance, the process for selecting providers and a conspicuous written disclaimer explaining the provider performance ratings should only be used as a guide for choosing a provider and that enrollees should consult their current provider before making a decision about their health care based on a provider rating; and [PL 2017, c. 232, §4 (AMD).]

M. If the health plan is subject to the requirements of section 4318-A, a description of the incentives available to an enrollee and how to earn such incentives if enrolled in a health plan offering a comparable health care service incentive program designed pursuant to section 4318-A. [PL 2017, c. 232, §5 (NEW).]

[PL 2019, c. 5, Pt. A, §19 (AMD).]

2. Plan complaint; adverse decisions; prior authorization statistics. A carrier shall provide annually to the superintendent information for each health plan that it offers or renews on plan

complaints, adverse decisions and prior authorization statistics. This statistical information must contain, at a minimum:

A. The ratio of the number of complaints received by the plan to the total number of enrollees, reported by type of complaint and category of enrollee; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

B. The ratio of the number of adverse decisions issued by the plan to the number of complaints received, reported by category; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

C. The ratio of the number of prior authorizations denied by the plan to the number of prior authorizations requested, reported by category; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

D. The ratio of the number of successful enrollee appeals to the total number of appeals filed; [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

E. The percentage of disenrollments by enrollees and providers from the health plan within the previous 12 months and the reasons for the disenrollments. With respect to enrollees, the information provided in this paragraph must differentiate between voluntary and involuntary disenrollments; and [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

F. Enrollee satisfaction statistics, including provider-to-enrollee ratio by geographic region and medical specialty and a report on what actions, if any, the carrier has taken to improve complaint handling and eliminate the causes of valid complaints. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

[PL 2007, c. 199, Pt. B, §3 (AMD).]

3. Acceptable methods of providing information. A carrier may meet any of the reporting requirements set forth in this section by providing information in conformity with the requirements of the federal Health Maintenance Organization Act of 1973, 42 United States Code, Sections 280c and 300e to 300e-17 (1988), or any other applicable state or federal law or any accrediting organization recognized by the superintendent, as long as the superintendent finds that the information is substantially similar to the information required by this section and is presented in a format that provides a meaningful comparison between health plans. When the superintendent determines that it is feasible and appropriate, the information required by this section must be provided by geographic region, age, gender and type of employer or group. With respect to geographical breakdown, the information must be provided in a manner that permits comparisons between urban and rural areas.
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

4. Claims data. By February 1st of each year, a carrier that provides only administrative services for a plan sponsor shall annually file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid for each plan sponsor and the total dollar amount of claims paid for each plan sponsor.
[PL 2001, c. 457, §23 (NEW).]

5. Annual report; claims for diagnosis and treatment of Lyme disease and other tick-borne illnesses. By February 1st of each year, all carriers shall file with the superintendent for the most recent calendar year for all covered individuals in the State the total claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The filing must include information on the number of claims made for the diagnosis and treatment of Lyme disease and other tick-borne illnesses, the total dollar amount of those claims, the number of claim denials and the reasons for those denials, the number and outcome of internal appeals and the number of external appeals related to the diagnosis and treatment of Lyme disease and other tick-borne illnesses. The superintendent shall compile from all carriers this data in an annual report and submit the report by March 15th of each year to the joint

standing committee of the Legislature having jurisdiction over health insurance matters. The superintendent shall consult with the Department of Health and Human Services, Maine Center for Disease Control and Prevention to determine any additional information to be collected from carriers, beginning with data for calendar year 2011.
[PL 2009, c. 494, §5 (AMD).]

6. Reporting required pursuant to the Affordable Care Act. Notwithstanding any other requirements of this Title, a carrier shall provide to the Secretary of the United States Department of Health and Human Services, and make available to the public when required by federal law, any information required by the federal Affordable Care Act. Carriers shall provide the information to the superintendent upon request.
[PL 2011, c. 364, §24 (NEW).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §§4,5 (AMD). PL 2001, c. 457, §23 (AMD). PL 2007, c. 199, Pt. B, §§2, 3 (AMD). PL 2007, c. 561, §2 (AMD). PL 2009, c. 439, Pt. A, §2 (AMD). PL 2009, c. 439, Pt. B, §§2-4 (AMD). PL 2009, c. 494, §5 (AMD). PL 2011, c. 364, §24 (AMD). PL 2017, c. 232, §§3-5 (AMD). PL 2019, c. 5, Pt. A, §19 (AMD).

§4303. Plan requirements

A carrier offering or renewing a health plan in this State must meet the following requirements.
[PL 2007, c. 199, Pt. B, §4 (AMD).]

1. Demonstration of adequate access to providers. A carrier offering or renewing a managed care plan shall provide to its members reasonable access to health care services. A carrier may provide incentives to members to use designated providers based on cost or quality, but may not require members to use designated providers of health care services.

A. [PL 2007, c. 199, Pt. B, §5 (AMD); MRSA T. 24-A §4303, sub-1, ¶A (RP).]

B. [PL 2011, c. 90, Pt. F, §7 (RP).]

C. [PL 2011, c. 90, Pt. F, §7 (RP).]
[PL 2011, c. 90, Pt. F, §7 (RPR).]

2. Credentialing. The credentialing of providers by a carrier is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialing. A carrier shall consult with appropriately qualified health care professionals in developing its credentialing standards. [PL 2015, c. 84, §1 (AMD).]

B. All credentialing decisions, including those granting, denying or withdrawing credentials, must be in writing. The provider must be provided with all reasons for the denial of an application for credentialing or the withdrawal of credentials. A withdrawal of credentials must be treated as a provider termination and is subject to the requirements of subsection 3-A. [PL 2015, c. 84, §1 (AMD).]

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialing for not meeting the objective credentialing standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider or between a carrier and a provider network if a carrier does not contract with providers individually. [PL 2015, c. 84, §1 (AMD).]

D. A carrier shall make credentialing decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialing application from a provider. For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. Within 30 days of initial receipt of a credentialing application, a carrier shall review the entire application and, if it is incomplete, shall return it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60-day period as required in this paragraph shall notify the bureau in writing prior to the expiration of the 60-day period on that application and request authorization for an extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit in this paragraph. [PL 2021, c. 603, Pt. B, §1 (AMD).]

E. [PL 2013, c. 383, §4 (RP).]

[PL 2021, c. 603, Pt. B, §1 (AMD).]

2-A. Payment to provider for services rendered during pendency of credentialing. A carrier offering or renewing a health plan in the State shall pay claims for services rendered to an enrollee by a provider prior to credentials being granted from the date a complete application for credentialing is submitted to the carrier as long as credentials are granted to that provider by the carrier in accordance with the requirements of subsection 2. A provider intending to submit a claim pursuant to this subsection may not submit the claim until the provider has been notified by the carrier whether the provider has been credentialed and of the effective date of any credentials. If a claim is submitted prior to the date credentials are granted, the carrier may process that claim in the same manner as a claim submitted by a provider that has not been credentialed.

[PL 2015, c. 84, §2 (NEW).]

3. Provider's right to advocate for medically appropriate care. A carrier offering or renewing a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

A. For the purposes of this section, "to advocate for medically appropriate health care" means to discuss or recommend a course of treatment to an enrollee; to appeal a managed care plan's decision to deny payment for a service pursuant to an established grievance or appeal procedure; or to protest a decision, policy or practice that the provider, consistent with the degree of learning and skill ordinarily possessed by reputable providers, reasonably believes impairs the provider's ability to provide medically appropriate health care to the provider's patients. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

B. Nothing in this subsection may be construed to prohibit a plan from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

[PL 2007, c. 199, Pt. B, §6 (AMD).]

3-A. Termination of participating providers. A carrier offering or renewing a managed care plan may not terminate or nonrenew a contract with a participating provider unless the carrier provides the provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed contract termination or nonrenewal and provides an opportunity for a review or hearing in accordance with this subsection. The existence of a termination without cause provision in a carrier's contract with a provider does not supersede the requirements of this subsection. This subsection does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a provider to practice. A review or hearing of proposed contract termination must meet the following requirements.

A. The notice of the proposed contract termination or nonrenewal provided by the carrier to the participating provider must include:

(1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond;

(2) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action. A carrier shall permit a provider to review this evidence and documentation upon request;

(3) Notice that the provider has the right to request a review or hearing before a panel appointed by the carrier;

(4) A time limit of not less than 30 days from the date the provider receives the notice within which a provider may request a review or hearing; and

(5) A time limit for a hearing date that must be not less than 30 days after the date of receipt of a request for a hearing.

Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. [PL 1997, c. 163, §2 (NEW).]

B. A hearing panel must be composed of at least 3 persons appointed by the carrier and one person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty of the provider under review. A hearing panel may be composed of more than 3 persons if the number of clinical peers on the hearing panel constitutes 1/3 or more of the total membership of the panel. [PL 1997, c. 163, §2 (NEW).]

C. A hearing panel shall render a written decision on the proposed action in a timely manner. This decision must be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier or the termination or nonrenewal of the provider. [PL 1997, c. 163, §2 (NEW).]

D. A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than 60 days after the receipt by the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier. [PL 1997, c. 163, §2 (NEW).]

[PL 2007, c. 199, Pt. B, §7 (AMD).]

3-B. Prohibition on financial incentives. A carrier offering or renewing a managed care plan may not offer or pay any type of material inducement, bonus or other financial incentive to a participating provider to deny, reduce, withhold, limit or delay specific medically necessary health care services covered under the plan to an enrollee. This subsection may not be construed to prohibit pilot projects authorized pursuant to section 4320-H or to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or risk-sharing agreements that are made with respect to providers or groups of providers or that are made with respect to groups of enrollees.

[RR 2011, c. 1, §41 (COR).]

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

A. The grievance procedure must include, at a minimum, the following:

(1) Notice to the enrollee promptly of any claim denial or other matter by which enrollees are likely to be aggrieved, stating the basis for the decision, the right to file a grievance, the procedure for doing so and the time period in which the grievance must be filed;

(2) Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier;

(3) Procedures for the submission of relevant information and enrollee participation;

(4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

(5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance. [PL 2007, c. 199, Pt. B, §9 (AMD).]

B. In any appeal under the grievance procedure in which a professional medical opinion regarding a health condition is a material issue in the dispute, the aggrieved party is entitled to an independent 2nd opinion, paid for by the plan, of a provider of the same specialty participating in the plan. If a provider of the same specialty does not participate in the plan, then the 2nd opinion must be given by a nonparticipating provider. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. [PL 1999, c. 742, §9 (NEW).]

D. Notwithstanding this subsection, a group health plan sponsored by an agricultural cooperative association located outside of this State that provides health insurance coverage to members of one or more agricultural cooperative associations located within this State may employ a grievance procedure for enrollees in the group health plan that meets the requirements of the state in which the group health plan is located if enrollees in the group health plan that reside in this State have the right to independent external review in accordance with section 4312 following any adverse health care treatment decision. Any difference in the grievance procedure requirements between those of the state in which the group health plan is located and those of this State must be limited to the number of days required for notification of prior authorization for nonemergency services and the number of days required for the issuance of a decision following the filing of an appeal of an adverse health care treatment decision. Enrollees in the group health plan that reside in this State must be notified as to the grievance procedure used by the group health plan and their right to independent external review in accordance with section 4312. [PL 2003, c. 309, §1 (NEW).]

E. Health plans may not reduce or terminate benefits for an ongoing course of treatment, including coverage of a prescription drug, during the course of an appeal pursuant to the grievance procedure used by the carrier or any independent external review in accordance with section 4312. [PL 2019, c. 5, Pt. A, §20 (AMD).]

[PL 2019, c. 5, Pt. A, §20 (AMD).]

5. Identification of services provided by certified nurse practitioners, certified midwives and certified nurse midwives. All claims for coverage of services provided by certified nurse practitioners, certified midwives and certified nurse midwives must identify the certified nurse practitioners, certified midwives and certified nurse midwives who provided those services. A carrier offering or renewing a health plan in this State shall assign identification numbers or codes to certified nurse practitioners, certified midwives and certified nurse midwives who provide covered services for enrollees covered under that plan. A claim submitted for payment to a carrier by a health care provider or facility must include the identification number or code of the certified nurse practitioner, certified midwife or certified nurse midwife who provided the service and may not be submitted using the identification number or code of a physician or other health care provider who did not provide the covered service. [PL 2021, c. 79, §5 (AMD).]

6. Standing referrals to specialists. A carrier shall establish and maintain a procedure to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that special condition. If the carrier or the enrollee's primary care provider, in consultation with the carrier's medical director, determines that a standing referral is appropriate, the carrier shall ensure that the enrollee receives such a referral to a specialist. If a specialist able to treat the enrollee's special condition does not participate in the carrier's network, then the carrier shall ensure that the enrollee receives a standing referral to a nonparticipating specialist. A standing referral must be made pursuant to a treatment plan approved by the carrier's medical director in consultation with the enrollee's primary care provider. After the standing referral is made, the specialist is authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care provider, subject to the terms of the treatment plan. [PL 1999, c. 742, §10 (NEW).]

7. Continuity of care. If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. This section does not apply to provider terminations exempt from the requirements of subsection 3-A.

If a managed care contract for the provision of health insurance coverage between a plan sponsor and a carrier is replaced within the meaning of section 2849 with a different managed care contract and a health care provider that has been providing health care services to an enrollee is not in the replacement carrier's network, the replacement carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C in the same manner as if the provider had been terminated from the replacement carrier's network as of the date of the policy replacement, but only with respect to benefits that are covered under the replacement contract.

A. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment. [PL 1999, c. 742, §10 (NEW).]

B. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination except that if an enrollee is in the 2nd trimester of pregnancy at the time of the provider's termination and the provider is treating the enrollee during the pregnancy, the transitional period must extend through the provision of postpartum care directly related to the pregnancy. [PL 1999, c. 742, §10 (NEW).]

C. A carrier may make coverage of continued treatment by a provider under paragraph B conditional upon the provider's agreeing to the following terms and conditions.

(1) The provider agrees to accept reimbursement from the carrier at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier. [PL 1999, c. 742, §10 (NEW).]

[PL 1999, c. 742, §10 (NEW).]

7-A. Continuity of prescriptions. If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee's coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee's prescribing provider. Policies must include a notice of the right to request a review with the enrollee's provider, and the replacing carrier must honor the prior carrier's authorization for a period not to exceed 6 months if the enrollee's provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy.
[PL 2009, c. 439, Pt. F, §1 (NEW).]

8. Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.

A. If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must:

(1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and

(2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. [PL 2001, c. 410, Pt. B, §5 (NEW).]

B. The carrier must provide to the superintendent on request complete information on the methodology and specific data used by the carrier or any 3rd party on behalf of the carrier in adjusting any claim submitted by or on behalf of the insured or enrollee. In considering the reasonableness of the methodology for calculating maximum allowable charges, the superintendent shall consider whether the methodology takes into account relevant data specific to this State if

there is sufficient data to constitute a representative sample of charge data for the same or comparable service. [PL 2001, c. 410, Pt. B, §5 (NEW).]

[PL 2001, c. 410, Pt. B, §5 (NEW).]

8-A. Protection from balance billing by participating providers. An enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection.

A. The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. [PL 2011, c. 238, Pt. A, §1 (NEW).]

B. Every provider agreement with a participating provider must be in writing and must set forth that if the carrier fails to pay for health care services as set forth in the contract, the enrollee is not liable to the provider for any sums owed by the carrier. [PL 2011, c. 238, Pt. A, §1 (NEW).]

C. A participating provider may not collect or attempt to collect any charge from an enrollee for covered health care beyond the amount permitted by the terms of the plan, notwithstanding the carrier's insolvency, the carrier's failure to pay the amount owed by the carrier, any other breach by the carrier of the provider agreement or the failure of the provider agreement to include the written hold harmless provision required by paragraph B. [PL 2011, c. 238, Pt. A, §1 (NEW).]

[PL 2011, c. 238, Pt. A, §1 (NEW).]

9. Notice of amendments to provider agreements. A carrier offering or renewing a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment. If the notice required by this subsection is provided by electronic communication, the subject line of the electronic communication must indicate that notice of an amendment to a provider agreement or manual, policy or procedure document is included in the communication and the notice of the amendment must be provided as an attachment to the communication, as a separate document.

[PL 2021, c. 311, §1 (AMD).]

REVISOR'S NOTE: (Subsection 9 as enacted by PL 2003, c. 110, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 11)

10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and [PL 2003, c. 218, §9 (NEW).]

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action. [PL 2007, c. 106, §1 (AMD).]

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.
[PL 2007, c. 106, §1 (AMD).]

11. (REALLOCATED FROM T. 24-A, §4303, sub-§9) Absolute discretion clauses. The use and enforcement of an absolute discretion clause is governed by this subsection.

A. A policy, contract, certificate or agreement offered, delivered, issued or renewed for delivery in this State by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may not contain a provision purporting to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [RR 2003, c. 1, §21 (RAL).]

B. A carrier may not enforce a provision in a policy, contract, certificate or agreement that was offered, delivered or issued for delivery in this State and has been continued or renewed by a group policy holder or individual enrollee in this State that purports to reserve sole or absolute discretion to the carrier to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this State. [RR 2003, c. 1, §21 (RAL).]
[RR 2003, c. 1, §21 (RAL).]

12. Publication of policies by carriers. A carrier must publish at least 5 individual health plans with the highest level of enrollment and at least 5 small group health plans with the highest level of enrollment on the carrier's publicly accessible website in a manner that will allow consumers to review the coverage offered under each policy. The policies posted on the website must be updated when changes are made to the policies by the carrier. The appearance of the policy on the website must duplicate the appearance of a paper copy of the policy. The bureau shall provide a link from its website to each carrier's website. A carrier must review annually which policies to post and make any necessary changes on its website. A carrier must post the required policies on its website within 90 days after the effective date of this subsection.
[PL 2009, c. 439, Pt. A, §3 (NEW).]

13. Explanation of benefits. A carrier offering an individual expense-incurred health plan to residents of this State or an expense-incurred group health plan to an employer in this State shall provide individual policyholders and group certificate holders with clear written explanations of benefit

documents in response to the filing of any claim providing for coverage of hospital or medical expenses. The explanation of benefits must include all of the following information:

A. The date of service; [PL 2009, c. 439, Pt. A, §4 (NEW).]

B. The provider of the service; [PL 2009, c. 439, Pt. A, §4 (NEW).]

C. An identification of the service for which the claim is made; [PL 2009, c. 439, Pt. A, §4 (NEW).]

D. Any amount the insured is obligated to pay under the policy for copayment or coinsurance; [PL 2009, c. 439, Pt. A, §4 (NEW).]

E. A telephone number and address where the insured may obtain clarification of the explanation of benefits; [PL 2009, c. 439, Pt. A, §4 (NEW).]

F. A notice of appeal rights; and [PL 2009, c. 439, Pt. A, §4 (NEW).]

G. A notice of the right to file a complaint with the bureau after exhausting any appeals under a carrier's internal appeals process. [PL 2009, c. 439, Pt. A, §4 (NEW).]

The superintendent shall establish by rule the minimum information and standards for explanation of benefits forms used by carriers, taking into consideration any input from stakeholders and any national standards for explanation of benefits forms. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. This subsection applies to any explanation of benefits form issued on or after January 1, 2010.
[PL 2009, c. 439, Pt. A, §4 (NEW).]

14. Policy terms. The superintendent may by rule define standard policy terms that must be used in all policies issued by carriers offering health plans in the State. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2009, c. 439, Pt. A, §5 (NEW).]

15. Uniform explanation of coverage documents and standardized definitions. A carrier offering a health plan in this State shall:

A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act; [PL 2023, c. 80, §2 (AMD).]

B. Use standard definitions of insurance-related and medical-related terms in connection with health insurance coverage as required by the federal Affordable Care Act; and [PL 2023, c. 80, §2 (AMD).]

C. Provide notice to enrollees and policyholders or certificate holders that preventive services are covered without cost sharing as provided in section 4320-A, subsection 1, but services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan. [PL 2023, c. 80, §2 (NEW).]
[PL 2023, c. 80, §2 (AMD).]

REVISOR'S NOTE: (Subsection 15 as enacted by PL 2011, c. 451, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 17)

16. Language and culture. All notices to applicants, enrollees and policyholders or certificate holders subject to the requirements of the federal Affordable Care Act must be provided in a culturally and linguistically appropriate manner consistent with the requirements of the federal Affordable Care Act.
[PL 2011, c. 364, §27 (NEW).]

17. (REALLOCATED FROM T. 24-A, §4303, sub-§15) Prohibition on "most favored nation" clauses. Participation agreements between carriers and providers are governed by this subsection.

A. A participation agreement between a carrier and a provider may not include a provision, commonly referred to as a "most favored nation" clause, that:

(1) Prohibits, or grants the carrier an option to prohibit, the provider from entering into a participation agreement with another carrier to provide services at a lower price than the payment specified in the participation agreement;

(2) Requires, or grants the carrier an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other carrier at a lower price;

(3) Requires, or grants the carrier an option of, termination or renegotiation of the existing participation agreement in the event the provider agrees to provide services to any other carrier at a lower price; or

(4) Requires the provider to disclose its reimbursement rates from other carriers. [RR 2011, c. 1, §42 (RAL).]

B. The superintendent may grant a waiver to paragraph A on application by either a carrier or a provider. A carrier or provider requesting a waiver for more than one participation agreement must file a separate application for each requested waiver. The superintendent may grant a waiver only after issuing a finding that the inclusion in the participation agreement of a most favored nation clause as described in paragraph A is not anticompetitive. A carrier or provider requesting a waiver may request a hearing on the application for a waiver in accordance with section 229. The findings and decision of the superintendent are final agency actions for the purposes of Title 5, chapter 375, subchapter 7 and, notwithstanding section 236, subsection 2, may be appealed regardless of whether a hearing was held. The superintendent's review under this paragraph is limited to the most favored nation clause, and any decision under this paragraph is for purposes of this subsection only and may not be construed as a finding or decision regarding the legality of the provision under other applicable law. [RR 2011, c. 1, §42 (RAL).]

C. Prior to the issuance of the superintendent's findings and decision on an application for a waiver pursuant to this subsection, any contract, proposal or draft legal instrument submitted to the superintendent in an application for a waiver is not a public record for the purposes of Title 1, chapter 13, except that the name and business address of the parties to an application for a waiver are public information. After the issuance of the superintendent's findings and decision, the superintendent may disclose any information that the superintendent determines is not proprietary information. For the purposes of this paragraph, "proprietary information" means information that is a trade secret or production, commercial or financial information the disclosure of which would impair the competitive position of the carrier or provider submitting the information and would make available information not otherwise publicly available. [RR 2011, c. 1, §42 (RAL).]

D. A carrier may not discriminate or retaliate against a provider for filing or opposing an application for a waiver under this subsection. [RR 2011, c. 1, §42 (RAL).]

E. A provider may not discriminate or retaliate against a carrier for filing or opposing an application for a waiver under this subsection. [RR 2011, c. 1, §42 (RAL).]

F. For the purposes of this subsection, the factors the superintendent may consider in determining whether to grant a waiver based on a finding that the inclusion of a most favored nation clause as described in paragraph A is not anticompetitive include, but are not limited to:

(1) Any reduction or limit on competition among carriers or providers;

(2) The impact on quality and availability of health care services, including the geographic distribution of providers;

(3) The size of the provider and the type of any specialty;

(4) The market share of the carrier and the provider;

(5) The impact on the price and stability of health insurance and health care services to consumers; and

(6) The impact on reimbursement rates in the provider marketplace. [RR 2011, c. 1, §42 (RAL).]

[RR 2011, c. 1, §42 (RAL).]

18. Provider contract requirements. A carrier offering a health plan must meet the requirements of this subsection with respect to a contract offered by the carrier to a provider, including a contract offered through a preferred provider arrangement, as defined in section 2671, subsection 7. This subsection does not apply to dental or vision plans.

A. If the contract for a preferred provider arrangement includes a reference to policies or procedures to which a contracting provider would be bound, all such policies and procedures must be provided to the provider for review in an easily accessible manner upon the provider's request at the time the contract is offered. [PL 2013, c. 399, §1 (NEW).]

B. Upon the provider's request at the time a contract for a preferred provider arrangement is offered, the following must be provided to a provider for review:

(1) The fee schedule or, if there is not a fee schedule for one or more of the services covered under the contract, the terms under which payment is determined. A carrier may require a provider to execute a nondisclosure agreement covering the information provided under this subparagraph; and

(2) The identity of all carriers for which the provider is agreeing to provide services to health plan enrollees. [PL 2013, c. 399, §1 (NEW).]

C. As a condition of participation in one of the carrier's preferred provider arrangements, a contract offered by a carrier may not require a provider to participate in any other carrier's network subsequently offered by the carrier or by a carrier's preferred provider arrangement. [PL 2013, c. 399, §1 (NEW).]

D. Without the provider's prior written consent, a provider's contractual participation in a carrier's preferred provider arrangement may not:

(1) Subject the provider to health plan payor requirements or fee schedules that materially differ from the terms of the provider's contract with the carrier, unless those materially different terms are set out in writing in a separate section of the contract, such as an exhibit or amendment; or

(2) Permit the terms of the provider's existing preferred provider arrangement contract to be superseded by a carrier's subsequent contract with a health plan payor. [PL 2013, c. 399, §1 (NEW).]

E. A preferred provider arrangement contract may not require a provider providing a service to an enrollee under a health plan included in the provider's contract to obtain preauthorization if the enrollee's health plan does not require prior authorization as a condition of coverage. [PL 2013, c. 399, §1 (NEW).]

F. Explanation of remittance advices or comparable documents, whether in paper or electronic form, that accompany and identify payment of a provider's claims under a carrier's contract, including contracts offered through a preferred provider arrangement, must identify the

administrator and payor of the provider's claims and include contact information. [PL 2013, c. 399, §1 (NEW).]

The requirements of this subsection do not apply to a carrier offering a health plan with respect to preferred provider arrangement contracts with a hospital or pharmacy.
[PL 2013, c. 399, §1 (NEW).]

19. Information about provider networks. A carrier offering a managed care plan shall prominently disclose to applicants, prospective enrollees and enrollees information about the carrier's provider network for the applicable managed care plan, including whether there are hospitals, health care facilities, physicians or other providers not included in the plan's network and any differences in an enrollee's financial responsibilities for payment of covered services to a participating provider and to a provider not included in a provider network. The superintendent may adopt rules that set forth the manner, content and required disclosure of the information in accordance with this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2013, c. 535, §1 (NEW).]

20. Information about prescription drugs. Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website.

A. A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours. [PL 2015, c. 260, §1 (NEW).]

B. A carrier shall provide an explanation of:

(1) The requirements for utilization review, prior authorization or step therapy for each category of prescription drug covered under a health plan;

(2) The cost-sharing requirements for prescription drug coverage, including a description of how the costs of prescription drugs will specifically be applied or not applied to any deductible or out-of-pocket maximum required under a health plan;

(3) The exclusions from coverage under a health plan and any restrictions on use or quantity of covered health care services in each category of benefits; and

(4) The amount of coverage provided under a health plan for out-of-network providers or noncovered health care services and any right of appeal available to an enrollee when out-of-network providers or noncovered health care services are medically necessary. [PL 2015, c. 260, §1 (NEW).]
[PL 2015, c. 260, §1 (NEW).]

21. Health care price transparency tools. Beginning January 1, 2018, a carrier offering a health plan in this State shall comply with the following requirements.

A. A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A, from network providers, as well as quality data for those providers, to the extent available. A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization. [PL 2017, c. 232, §6 (NEW).]

B. A carrier shall make available to the enrollee the ability to obtain an estimated cost that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the carrier shall request additional or clarifying code information, if needed, from the provider involved with the comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's provider, the carrier shall provide the anticipated charge and the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider. [PL 2017, c. 232, §6 (NEW).]

C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed comparable health care service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed comparable health care service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting the carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider. [PL 2017, c. 232, §6 (NEW).]

D. Notwithstanding the provisions of this subsection and at the request of a carrier, the superintendent may grant an additional year to comply with the provisions of this subsection as long as the carrier has demonstrated a good faith effort to comply with the provisions of this subsection and has provided the superintendent with an action plan detailing the steps to be taken by the carrier to comply with this subsection no later than January 1, 2019. [PL 2017, c. 232, §6 (NEW).]

[PL 2017, c. 232, §6 (NEW).]

22. Denial of referral by out-of-network provider prohibited. Beginning January 1, 2018, a carrier may not deny payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a direct primary care provider who is not a member of the carrier's provider network. A carrier may not apply a deductible, coinsurance or copayment greater than the applicable deductible, coinsurance or copayment that would apply to the same health care service if the service was referred by a participating primary care provider. A carrier may require a direct primary care provider making a referral who is not a member of the carrier's provider network to provide information demonstrating that the provider is a direct primary care provider through a written attestation or copy of a direct primary care agreement with an enrollee and may request additional information necessary to implement this subsection. As used in this subsection, "direct primary care provider" has the same meaning as in Title 22, section 1771, subsection 1, paragraph B.

[PL 2019, c. 178, §1 (AMD).]

22-A. Denial of referral during urgent care visit prohibited. A carrier may not deny payment for any behavioral health care service or physical therapy service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was not made by the enrollee's primary care provider as long as the enrollee's referral is made by a provider during an urgent care visit and the provider notifies the enrollee’s primary care provider of the referral. A carrier may not apply a deductible, coinsurance or copayment greater than the applicable deductible, coinsurance or copayment that would apply to the same health care service if the service was referred by the enrollee's primary care provider. A carrier may require a provider of urgent care that is making a referral to provide additional information necessary to implement this subsection.

[PL 2023, c. 119, §3 (NEW).]

23. Duplicative or incorrect claims payments. If a carrier has made a duplicative or incorrect payment on a claim with respect to a health plan:

A. If the claim payment was made to a provider, the carrier shall retroactively seek collection related to that payment directly from the provider; and [PL 2019, c. 30, §1 (NEW).]

B. The carrier may not attempt to retroactively seek collection related to the claim payment from an enrollee unless the enrollee was already paid directly for the services identified in the claim and a provider submits evidence to the carrier that the enrollee did not forward payment to the provider. After a provider has submitted evidence that the enrollee did not forward payment to the provider, a carrier may require an enrollee to provide evidence of payment to the provider. [PL 2019, c. 30, §1 (NEW).]

[PL 2019, c. 30, §1 (NEW).]

24. Practice or facility-wide prepayment review of providers. A practice or facility-wide prepayment review of the documentation or records of a provider conducted by a carrier for the purposes of identifying fraud, waste or abuse, determining whether the documentation is appropriate or adequate to support a claim for covered health care services or determining whether health care services are or were medically necessary health care as a condition of payment must be conducted in accordance with the following requirements.

A. When a carrier subjects a provider or facility to a practice or facility-wide prepayment review, the carrier shall provide a process to allow claims and documentation to be submitted to the carrier electronically for purposes of proving timely filing and tracking the carrier's compliance with time limits in other applicable laws. [PL 2021, c. 272, §1 (NEW).]

B. Claims subject to a practice or facility-wide prepayment review must be paid or disputed within 30 days as required by section 2436. Any claim that is not disputed pursuant to section 2436 or paid within 30 days by the carrier is overdue and subject to interest in accordance with section 2436. [PL 2021, c. 272, §1 (NEW).]

C. Any records of an enrollee reviewed as part of a practice or facility-wide prepayment review must be reviewed by the same reviewer to the extent possible. The reviewer who performs the practice or facility-wide prepayment review is the primary contact person for the provider related to an audit, review, denial or nonpayment of a claim. Any practice or facility-wide prepayment review that involves clinical or professional judgement must be conducted by or in consultation with a clinical peer. [PL 2021, c. 272, §1 (NEW).]

D. A carrier may not apply additional or different documentation standards beyond the standards set by the professional association of the provider subject to practice or facility-wide prepayment review if those standards are publicly available or made available to the carrier. This paragraph does not prohibit carriers from establishing or applying medical policies or clinical guidelines to determine whether a service is a covered benefit and medically necessary health care. This paragraph does not apply to claims submitted by a hospital or other health care facility. [PL 2021, c. 272, §1 (NEW).]

E. A carrier may not deny payment of a claim for covered health care services by a provider solely on the basis of a minor documentation error or omission, including, but not limited to, misspelling, use of an abbreviation or a correctable error, unless the carrier affords the provider or enrollee the opportunity to resubmit the claim to correct the identified error. [PL 2021, c. 272, §1 (NEW).]

F. If a carrier requires additional information as part of a practice or facility-wide prepayment review of a claim for covered health care services by a provider, the carrier shall inform the provider with reasonable specificity of the information needed by the carrier to adjudicate the claim. [PL 2021, c. 272, §1 (NEW).]

G. Additional information required by a carrier is considered timely filed by the provider if submitted within 30 days from the date the provider received notice from the carrier of the errors, omissions or additional information needed. [PL 2021, c. 272, §1 (NEW).]

H. A carrier shall provide information on how a provider may appeal the denial of a claim, including the mailing or e-mail address or fax number where an appeal should be sent, on its publicly accessible website or in a provider manual. [PL 2021, c. 272, §1 (NEW).]

I. A carrier shall provide an opportunity to appeal the results of an audit leading to the provider being put on a practice or facility-wide prepayment review. [PL 2021, c. 272, §1 (NEW).]

J. A carrier may not audit a provider or require that a provider's claims be subject to practice or facility-wide prepayment review as retribution for raising contract disputes. [PL 2021, c. 272, §1 (NEW).]

For the purposes of this subsection, "practice or facility-wide prepayment review" means a manual review or audit process of all, or substantially all, of a provider's claims by a carrier or the carrier's agent.

[PL 2021, c. 272, §1 (NEW).]

25. Second opinion. An enrollee in a health plan may not be required to obtain a 2nd opinion from a provider that practices in the same office location as the enrollee's provider. Notwithstanding any provision of this Title to the contrary, if the 2nd opinion is obtained from an out-of-network provider because a network provider is not available in accordance with section 4303, subsection 1 and Bureau of Insurance Rule Chapter 850: Health Plan Accountability, a carrier may not apply a deductible, coinsurance or copayment for the 2nd opinion in an amount greater than the deductible, coinsurance or copayment that would apply to the same health care service if the service were obtained from a network provider, and the amount of any coinsurance or copayment must be applied to the enrollee's in-network deductible.

[PL 2023, c. 348, §1 (NEW).]

REVISOR'S NOTE: (Subsection 25 as enacted by PL 2023, c. 382, §1 is REALLOCATED TO TITLE 24-A, SECTION 4303, SUBSECTION 26)

26. Disclosure to enrollees of cash price. A carrier may not prohibit a provider from providing an enrollee with the option of paying the provider's discounted cash price for health care services. For the purposes of this subsection, "discounted cash price" means:

A. With respect to a hospital, the discounted cash price as that term is defined in 45 Code of Federal Regulations, Section 180.20 if the hospital has a discounted cash price and does not mean the amount charged to individuals who are eligible for free care or are eligible for the amounts charged pursuant to a hospital's financial assistance policy; or [PL 2023, c. 382, §1 (NEW); RR 2023, c. 1, Pt. A, §22 (RAL).]

B. With respect to a provider that is not a hospital, the charge that applies to an enrollee who is paying for a health care service without filing any claim with a carrier. [PL 2023, c. 382, §1 (NEW); RR 2023, c. 1, Pt. A, §22 (RAL).]

[PL 2023, c. 382, §1 (NEW); RR 2023, c. 1, Pt. A, §22 (RAL).]

SECTION HISTORY

PL 1995, c. 673, Pt. C, §1 (NEW). PL 1995, c. 673, Pt. C, §2 (AFF). PL 1997, c. 163, §§1, 2 (AMD). PL 1999, c. 396, §5 (AMD). PL 1999, c. 396, §7 (AFF). PL 1999, c. 742, §§6-10 (AMD). PL 2001, c. 288, §5 (AMD). PL 2001, c. 410, Pt. B, §5 (AMD). RR 2003, c. 1, §21 (COR). PL 2003, c. 108, §1 (AMD). PL 2003, c. 110, §1 (AMD). PL 2003, c. 218, §9 (AMD). PL 2003, c. 309, §1 (AMD). PL 2003, c. 469, Pt. E, §20 (AMD). PL 2003, c. 689, Pt. B, §6 (REV). PL 2007, c. 106, §1 (AMD). PL 2007, c. 199, Pt. B, §§4-11 (AMD). PL 2009, c. 357, §1 (AMD). PL 2009,

c. 439, Pt. A, §§3-5 (AMD). PL 2009, c. 439, Pt. F, §1 (AMD). PL 2009, c. 652, Pt. A, §33 (AMD). RR 2011, c. 1, §§41, 42 (COR). PL 2011, c. 90, Pt. F, §7 (AMD). PL 2011, c. 238, Pt. A, §1 (AMD). PL 2011, c. 270, §1 (AMD). PL 2011, c. 364, §§25-27 (AMD). PL 2011, c. 451, §1 (AMD). PL 2011, c. 451, §2 (AFF). PL 2013, c. 383, §4 (AMD). PL 2013, c. 399, §1 (AMD). PL 2013, c. 535, §1 (AMD). PL 2015, c. 84, §§1, 2 (AMD). PL 2015, c. 260, §1 (AMD). PL 2017, c. 232, §§6, 7 (AMD). PL 2019, c. 5, Pt. A, §20 (AMD). PL 2019, c. 30, §1 (AMD). PL 2019, c. 178, §1 (AMD). PL 2021, c. 79, §5 (AMD). PL 2021, c. 272, §1 (AMD). PL 2021, c. 311, §1 (AMD). PL 2021, c. 603, Pt. B, §1 (AMD). PL 2023, c. 80, §2 (AMD). PL 2023, c. 119, §3 (AMD). PL 2023, c. 348, §1 (AMD). PL 2023, c. 382, §1 (AMD). RR 2023, c. 1, Pt. A, §22 (COR).

§4303-A. Provider profiling programs

1. Disclosure. At least 60 days prior to using or publicly disclosing the results of the provider profiling program, a carrier with a provider profiling program shall disclose to providers the methodologies, criteria, data and analysis used to evaluate provider quality, performance and cost, including but not limited to unit cost, price and cost-efficiency ratings. For the purposes of this subsection, the disclosure of data is satisfied by the provision by a carrier of a description of the data used in the evaluation, the source of the data, the time period subject to evaluation and, if applicable, the types of claims used in the evaluation including any adjustments to the data and exclusion from the data.
[PL 2013, c. 383, §5 (NEW).]

2. Provider profile. A carrier shall create and share with providers their provider profile at least 60 days prior to using or publicly disclosing the results of the provider profiling program.
[PL 2013, c. 383, §5 (NEW).]

3. Request for data. A provider may request a copy of its data within 30 days of the carrier's disclosure to a provider as required by subsection 2, and, upon request from a provider, a carrier shall provide to that provider the data associated with the requesting provider and all adjustments to the data used to evaluate that provider as part of the carrier's provider profiling program. The bureau shall adopt rules to establish requirements for the disclosure of data by a carrier to a provider in accordance with this subsection. The bureau shall provide in the rules for a time and manner of disclosure consistent with a carrier's ability to adopt, revise and develop an effective provider profiling program.
[PL 2013, c. 383, §5 (NEW).]

4. Appeals. A carrier shall establish a process that affords a provider the opportunity to review and dispute its provider profiling result within 30 days of being provided with its provider profile pursuant to subsection 2. The appeal process must:

A. Afford the provider the opportunity to correct material errors, submit additional information for consideration and seek review of data and performance ratings; [PL 2013, c. 383, §5 (NEW).]

B. Afford the provider the opportunity to review any information or evaluation prepared by a 3rd party and used by the carrier as part of its provider profiling program; however, if the 3rd party provides the right to review and correct that data, any appeal pursuant to this paragraph is limited to whether the carrier accurately portrayed the information and not to the underlying determination made by the 3rd party; and [PL 2013, c. 383, §5 (NEW).]

C. Allow the provider to request reconsideration of its provider profiling result and submit supplemental information, including information demonstrating any computational or data errors. [PL 2013, c. 383, §5 (NEW).]

[PL 2013, c. 383, §5 (NEW).]

5. Out-of-network providers. If a carrier has a provider profiling program that includes out-of-network providers, a carrier must meet the requirements of this section with regard to an out-of-network provider as well as for a provider in a carrier's network.
[PL 2013, c. 383, §5 (NEW).]

6. Rules. The bureau shall adopt rules necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2013, c. 383, §5 (NEW).]

SECTION HISTORY

PL 2013, c. 383, §5 (NEW).

§4303-B. Disclosure related to provider networks

1. Disclosure. Upon request, a carrier shall provide to a provider to which the carrier has decided not to offer the opportunity to participate or that the carrier has decided not to include as a participating provider in any of the carrier's provider networks a written explanation of the reason for the carrier's decision. The written explanation provided by the carrier must indicate whether the reason for not offering the provider the opportunity to contract or for not including the provider in any network was related to the provider's performance with respect to quality, cost or cost-efficiency.
[PL 2013, c. 535, §2 (NEW).]

2. No right of action. A provider has no right of action as the result of a disclosure made in accordance with this section.
[PL 2013, c. 535, §2 (NEW).]

SECTION HISTORY

PL 2013, c. 535, §2 (NEW).

§4303-C. Protection from surprise bills and bills for out-of-network emergency services

1. Surprise bill defined. As used in this section, unless the context otherwise indicates, "surprise bill" means a bill for health care services, including, but not limited to, emergency services, received by an enrollee for covered services rendered by an out-of-network provider, when such services were rendered by that out-of-network provider at a network provider, during a service or procedure performed by a network provider or during a service or procedure previously approved or authorized by the carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. "Surprise bill" does not include a bill for health care services received by an enrollee when a network provider was available to render the services and the enrollee knowingly elected to obtain the services from another provider who was an out-of-network provider.
[PL 2019, c. 668, §2 (AMD).]

1-A. "Knowingly elected to obtain such services from that out-of-network provider" defined. As used in this section, unless the context otherwise indicates, "knowingly elected to obtain such services from that out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this subsection.
[PL 2019, c. 668, §2 (NEW).]

2. Requirements. With respect to a surprise bill or a bill for covered emergency services rendered by an out-of-network provider:

A. A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were

rendered by a network provider. For an enrollee subject to coinsurance, the carrier shall calculate the coinsurance amount based on the median network rate for that health care service; [PL 2019, c. 668, §2 (AMD).]

B. Except as provided for ambulance services in paragraph D, unless the carrier and out-of-network provider agree otherwise, a carrier shall reimburse the out-of-network provider or enrollee, as applicable, for health care services rendered at the greater of:

(1) The carrier's median network rate paid for that health care service by a similar provider in the geographic area where the service was provided; and

(2) The median network rate paid by all carriers for that health care service by a similar provider in the geographic area where the service was provided 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; [PL 2021, c. 222, §1 (AMD).]

C. Notwithstanding paragraph B, if a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent; [PL 2019, c. 668, §2 (AMD).]

D. [PL 2019, c. 668, §2 (NEW); MRSA T. 24-A §4303-C, sub-§2, ¶D (RP).]

REVISOR'S NOTE: Paragraph D was repealed October 1, 2021. PL 2021, c. 241, §1 attempted to strike the language that repealed the paragraph, but did not take effect in time.

E. 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 determined in accordance with paragraph B or paragraph D, the carrier and the out-of-network provider have 30 calendar days to negotiate an agreement on the payment amount in good faith. If the carrier and the out-of-network provider do not reach agreement on the payment amount within 30 calendar days, the out-of-network provider may submit a dispute regarding the payment and receive another payment from the carrier determined in accordance with the dispute resolution process in section 4303-E, including any payment made pursuant to section 4303-E, subsection 1, paragraph G; and [PL 2021, c. 241, §2 (AMD).]

F. The enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with this section or, if there is a dispute, in accordance with section 4303-E. [PL 2019, c. 668, §2 (NEW).]

[PL 2021, c. 222, §1 (AMD); PL 2021, c. 241, §2 (AMD).]

3. Payment after resolution of disputes. Following an independent dispute resolution determination pursuant to section 4303-E, the determination by the independent dispute resolution entity of a reasonable payment for a specific health care service or treatment rendered by an out-of-network provider is binding on a carrier, out-of-network provider and enrollee for 90 days. During that 90-day period, a carrier shall reimburse an out-of-network provider at that same rate for that specific health care service or treatment, and an out-of-network provider may not dispute any bill for that service under section 4303-E.

[PL 2019, c. 668, §2 (NEW).]

SECTION HISTORY

PL 2017, c. 218, §2 (NEW). PL 2017, c. 218, §3 (AFF). PL 2019, c. 668, §2 (AMD). PL 2021, c. 222, §1 (AMD). PL 2021, c. 241, §2 (AMD).

§4303-D. Provider directories

1. Requirement. A carrier shall make available provider directories in accordance with this section.

A. A carrier shall post electronically a current and accurate provider directory for each of its network plans with the information and search functions described in subsection 2. In making the directory available electronically, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

B. A carrier shall update each provider directory at least monthly. The carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the superintendent upon request. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

C. A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory with the information described in subsection 2 upon request of a covered person or a prospective covered person. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

D. For each network plan, a carrier shall include in plain language in both the electronic and print directories the following general information:

(1) A description of the criteria the carrier has used to build its provider network;

(2) If applicable, a description of the criteria the carrier has used to tier providers;

(3) If applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network the tier in which each is placed, whether by name, symbols, grouping or another designation, so that a covered person or a prospective covered person is able to identify the provider tier; and

(4) If applicable, that authorization or referral may be required to access some providers. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

E. A carrier shall make clear in both its electronic and print directories which provider directory applies to which network plan by including the specific name of the network plan as marketed and issued in this State. The carrier shall include in both its electronic and print directories a customer service e-mail address and telephone number or electronic link that covered persons or the general public may use to notify the carrier of inaccurate provider directory information. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

F. For the information required pursuant to subsections 2, 3 and 4 in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, a carrier shall make available through the directory the source of the information and any limitations on the information, if applicable. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

G. A provider directory, whether in electronic or print format, must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

[PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

2. Information in searchable format. A carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

A. For health care professionals:

(1) The health care professional's name;

(2) The health care professional's gender;

(3) The participating office location or locations;

(4) The health care professional's specialty, if applicable;

(5) Medical group affiliations, if applicable;

(6) Facility affiliations, if applicable;

(7) Participating facility affiliations, if applicable;

(8) Languages other than English spoken by the health care professional, if applicable; and

(9) Whether the health care professional is accepting new patients; [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

B. For hospitals:

(1) The hospital's name;

(2) The hospital's type;

(3) Participating hospital location; and

(4) The hospital's accreditation status.

This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans; and [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

C. For facilities, other than hospitals, by type:

(1) The facility's name;

(2) The facility's type;

(3) Types of services performed; and

(4) Participating facility location or locations.

This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

[PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

3. Additional information. In the electronic provider directories for each network plan, a carrier shall make available the following information in addition to all of the information available under subsection 2:

A. For health care professionals:

(1) Contact information. This subparagraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans;

(2) Board certifications. This subparagraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans; and

(3) Languages other than English spoken by clinical staff, if applicable; [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

B. For hospitals, the telephone number. This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans; and [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

C. For facilities other than hospitals, the telephone number. This paragraph does not apply to a carrier that offers network plans that consist solely of limited scope dental plans or limited scope vision plans. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

[PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

4. Information available in printed form. A carrier shall make available in print, upon request, the following provider directory information for the applicable network plan:

A. For health care professionals:

(1) The health care professional's name;

(2) The health care professional's contact information;

(3) Participating office location or locations;

(4) The health care professional's specialty, if applicable;

(5) Languages other than English spoken by the health care professional, if applicable; and

(6) Whether the health care professional is accepting new patients; [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

B. For hospitals:

(1) The hospital's name;

(2) The hospital's type; and

(3) Participating hospital location and telephone number; and [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

C. For facilities, other than hospitals, by type:

(1) The facility's name;

(2) The facility's type;

(3) Types of services performed; and

(4) Participating facility location and telephone number. [PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

The carrier shall include a disclosure in the directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the carrier's electronic provider directory on its website to obtain current provider directory information.

[PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

5. Rulemaking. The superintendent may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2017, c. 218, §2 (NEW); PL 2017, c. 218, §3 (AFF).]

SECTION HISTORY

PL 2017, c. 218, §2 (NEW). PL 2017, c. 218, §3 (AFF).

§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. [PL 2019, c. 668, §3 (NEW).]

B. An independent dispute resolution entity shall make a decision within 30 days of receipt of the dispute for review. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

G. [PL 2021, c. 222, §2 (RP).]

H. 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. [PL 2019, c. 668, §3 (NEW).]

I. 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. [PL 2021, c. 222, §3 (NEW).]

[PL 2021, c. 222, §§2, 3 (AMD).]

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.

[PL 2019, c. 668, §3 (NEW).]

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 [PL 2019, c. 668, §3 (NEW).]

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. [PL 2019, c. 668, §3 (NEW).]

[PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

C. The number of complaints the superintendent receives relating to out-of-network health care charges; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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; [PL 2019, c. 668, §3 (NEW).]

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 [PL 2019, c. 668, §3 (NEW).]

H. Any other benchmarks or information that the superintendent considers appropriate to make publicly available to further the goals of this section. [PL 2019, c. 668, §3 (NEW).]

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.
[PL 2019, c. 668, §3 (NEW).]

SECTION HISTORY

PL 2019, c. 668, §3 (NEW). PL 2021, c. 222, §§2, 3 (AMD).

§4303-F. Reimbursement for ambulance services and participation of ambulance service providers in carrier networks

1. Reimbursement for ambulance services. With respect to a bill for covered services rendered by an ambulance service provider, a carrier shall reimburse the ambulance service provider or enrollee, as applicable, as follows.

A. If the ambulance service provider participates in the carrier's network, the carrier shall reimburse at the ambulance service provider's rate or 200% of the Medicare rate for that service, whichever is less, plus any adjustment required by paragraph C. [PL 2021, c. 241, §3 (NEW).]

B. If the ambulance service provider is an out-of-network provider, the carrier shall reimburse at the ambulance service provider's rate or 180% of the Medicare rate for that service, whichever is less, plus any adjustment required by paragraph C. [PL 2021, c. 241, §3 (NEW).]

C. If the ambulance service provider is located in a rural or super rural area as designated by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services and eligible for additional Medicare reimbursement for services that were provided to a Medicare enrollee, the carrier shall increase the reimbursement to that ambulance service provider in the same amount as the additional Medicare reimbursement. [PL 2021, c. 241, §3 (NEW).]

D. If, on the effective date of this subsection, an ambulance service provider's charge for ambulance services is below 200% of the Medicare rate for that service, the ambulance service provider may not increase the charge for that service by more than 5% annually. [PL 2021, c. 241, §3 (NEW).]

E. A carrier may not require an ambulance service provider to obtain prior authorization before transporting an enrollee to a hospital, between hospitals or from a hospital to a nursing home, hospice care facility or other health care facility, as defined in Title 22, section 328, subsection 8. [PL 2023, c. 468, §2 (NEW).]

Notwithstanding this subsection, a carrier is not required to reimburse an ambulance service provider at the reimbursement rates required in this subsection for covered services delivered through community paramedicine in accordance with Title 32, section 84, subsection 4 and a carrier may require an ambulance service provider to obtain prior authorization before providing services through community paramedicine.
[PL 2023, c. 468, §2 (AMD).]

1-A. Reimbursement for nontransport services. With respect to a health plan with an effective date on or after January 1, 2024, when an ambulance service provider responds to a call for emergency services and an enrollee refuses transport to a hospital, a carrier shall reimburse that ambulance service provider for any services other than transport provided to the enrollee as follows.

A. If the ambulance service provider participates in the carrier's network, the carrier shall reimburse the ambulance service provider at the ambulance service provider's rate or 200% of the average of the Medicare rate for basic life support services and the Medicare rate for advanced life support services, whichever is less, plus any adjustment required by paragraph C. [PL 2023, c. 468, §2 (NEW).]

B. If the ambulance service provider is an out-of-network provider, the carrier shall reimburse the ambulance service provider at the ambulance service provider's rate or 180% of the average of the Medicare rate for basic life support services and the Medicare rate for advanced life support services, whichever is less, plus any adjustment required by paragraph C. [PL 2023, c. 468, §2 (NEW).]

C. If the ambulance service provider is located in a rural or super rural area as designated by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services and eligible for additional Medicare reimbursement for services that were provided to a Medicare enrollee, the carrier shall increase the reimbursement to that ambulance service provider in the same amount as the additional Medicare reimbursement. [PL 2023, c. 468, §2 (NEW).]

D. If, on the effective date of this subsection, an ambulance service provider's rate for ambulance services is below 200% of the average of the Medicare rate for basic life support and advanced life support services, the ambulance service provider may not increase the rate for that service by more than 5% annually. [PL 2023, c. 468, §2 (NEW).]
[PL 2023, c. 468, §2 (NEW).]

2. Network participation; standard contract. A carrier shall offer a standard contract to all ambulance service providers willing to participate in the carrier's provider network with the following provisions:

A. The reimbursement rate paid for ambulance services conforms to the requirements of subsection 1; [PL 2023, c. 468, §2 (AMD).]

B. The contract term is for a minimum of 24 months; [PL 2021, c. 241, §3 (NEW).]

C. The contract may be terminated as long as the party seeking to terminate the contract provides at least 180 days' prior notice; and [PL 2021, c. 241, §3 (NEW).]

D. The contract provides that an ambulance service provider has a minimum of 120 days to submit a claim. [PL 2021, c. 241, §3 (NEW).]

[PL 2023, c. 468, §2 (AMD).]

3. Exemption. This section does not apply to air ambulance services.

[PL 2021, c. 241, §3 (NEW).]

4. Medical necessity. A carrier shall consider the requirements of the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services related to medical necessity of ambulance services when establishing the carrier's own policies and guidelines related to the medical necessity and reasonableness of covered services provided by ambulance service providers.

[PL 2023, c. 468, §2 (NEW).]

SECTION HISTORY

PL 2021, c. 241, §3 (NEW). PL 2023, c. 468, §2 (AMD).

§4303-G. Provider maintenance of certification requirements

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

(WHOLE SECTION TEXT EFFECTIVE UNTIL 4/1/29)

(WHOLE SECTION TEXT REPEALED 4/1/29)

The following provisions govern maintenance of certification requirements. [PL 2023, c. 40, §1 (NEW).]

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Hospital" means a hospital licensed and operating under Title 22, chapter 404 or 405 or the parent of such institution, or a hospital subsidiary or hospital affiliate in this State that provides medical services or medically related diagnostic and laboratory services or engages in ancillary activities supporting those services. [PL 2023, c. 40, §1 (NEW).]

B. "Maintenance of certification program" means satisfactory participation in a program beyond the continuing medical education requirements currently in place by the Board of Licensure in Medicine or Board of Osteopathic Licensure, or initial board certification by a national or regional medical specialty board. [PL 2023, c. 40, §1 (NEW).]

C. "Outpatient clinical practice" means any medical practice, home care or hospice organization or other nonhospital entity providing medical care through physicians. [PL 2023, c. 40, §1 (NEW).]

D. "Physician" means an individual licensed under Title 32, chapter 36 or 48. [PL 2023, c. 40, §1 (NEW).]

[PL 2023, c. 40, §1 (NEW).]

2. Discrimination prohibited. A carrier offering a health plan in this State may not:

A. Deny reimbursement to a physician, hospital or outpatient clinical practice for services rendered because a physician does not participate in a maintenance of certification program; [PL 2023, c. 40, §1 (NEW).]

B. Provide lower reimbursement for services rendered by a physician, hospital or outpatient clinical practice because a physician does not participate in a maintenance of certification program; [PL 2023, c. 40, §1 (NEW).]

C. Prohibit a physician, hospital or outpatient clinical practice from participating in any of the carrier's provider networks because a physician does not participate in a maintenance of certification program; or [PL 2023, c. 40, §1 (NEW).]

D. Determine credentialing of a physician, hospital or outpatient clinical practice based on the status of a physician's, hospital's or outpatient clinical practice's participation in a maintenance of certification program. [PL 2023, c. 40, §1 (NEW).]

[PL 2023, c. 40, §1 (NEW).]

3. Repeal. This section is repealed April 1, 2029.

[PL 2023, c. 40, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 40, §1 (NEW).

§4304. Utilization review

The following requirements apply to health plans doing business in this State that require prior authorization by the plan of health care services or otherwise subject payment of health care services to review for clinical necessity, appropriateness, efficacy or efficiency. A carrier offering or renewing a health plan subject to this section that contracts with other entities to perform utilization review on the carrier's behalf is responsible for ensuring compliance with this section and chapter 34. [PL 2007, c. 199, Pt. B, §12 (AMD).]

1. Requirements for medical review or utilization review practices. A carrier shall appoint a medical director who is responsible for reviewing and approving the carrier's policies governing the clinical aspects of coverage determinations by any health plan that it offers or renews. A carrier's medical review or utilization review practices must be governed by the standard of medically necessary health care as defined in this chapter. A carrier shall provide clear written policies and procedures to providers and enrollees on how to obtain a prior authorization.

[PL 2023, c. 275, §1 (AMD).]

2. Prior authorization of nonemergency services. Except for a request in exigent circumstances as described in section 4311, subsection 1-A, paragraph B, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection.

A. Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. [PL 2019, c. 273, §1 (NEW).]

B. If the carrier responds to a request by a provider for prior authorization with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information. [PL 2019, c. 273, §1 (NEW).]

C. If the carrier responds that outside consultation is necessary before making a decision, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier's initial response. [PL 2019, c. 273, §1 (NEW).]

D. The prescription drug and prior authorization standards used by a carrier must be clear and readily available to enrollees, participating providers, pharmacists and other providers. With regard

to prior authorization for prescription drugs, a carrier shall comply with the requirements set forth in subsection 2-B. A provider must make best efforts to provide all information necessary to evaluate a request, and the carrier must make best efforts to limit requests for additional information. [PL 2021, c. 73, §1 (AMD).]

If a carrier does not grant or deny a request for prior authorization within the time frames required under this subsection, the request for prior authorization by the provider is granted.
[PL 2021, c. 73, §1 (AMD).]

2-A. Prior authorization of medication-assisted treatment for opioid use disorder. A carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment, except that a carrier may not impose any prior authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder. For the purposes of this subsection, "medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling.
[PL 2019, c. 273, §2 (NEW).]

2-B. Electronic transmission of prior authorization requests. If a health plan provides coverage for prescription drugs, the carrier must accept and respond to prior authorization requests in accordance with subsection 2 and this subsection through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. For the purposes of this subsection, transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission. A carrier's electronic transmission system for prior authorization requests for prescription drugs must comply with the following.

A. No later than January 1, 2022, unless a waiver is granted by the superintendent, a carrier or entity under contract to a carrier shall make available to a provider in real time at the point of prescribing one or more electronic benefit tools that are capable of integrating with at least one electronic prescribing system or electronic medical record system to provide complete, accurate, timely, clinically appropriate formulary and benefit information specific to an enrollee, including, but not limited to, the estimated cost-sharing amount to be paid by the enrollee, information on any available formulary alternatives that are clinically appropriate and information about the formulary status and the utilization review and prior authorization requirements of each drug presented. Upon a carrier's request, the superintendent may grant a waiver from the requirements of this paragraph based on a demonstration of good cause. [PL 2021, c. 73, §2 (NEW).]

B. No later than January 1, 2023, unless a waiver is granted by the superintendent, a carrier or entity under contract to a carrier shall make available to a provider in real time at the point of prescribing an electronic benefit tool that is capable of integrating with the provider's electronic prescribing system or electronic medical record system to provide complete, accurate, timely, clinically appropriate formulary and benefit information specific to an enrollee, including, but not limited to, the estimated cost-sharing amount to be paid by the enrollee, information on any available formulary alternatives that are clinically appropriate and information about the formulary status and the utilization review and prior authorization requirements of each drug presented. Upon a carrier's request, the superintendent may grant a waiver from the requirements of this paragraph based on a demonstration of good cause. [PL 2021, c. 73, §2 (NEW).]
[PL 2021, c. 73, §2 (AMD).]

2-C. Prior authorization of prescription drugs used for assessment and treatment of serious mental illness. Notwithstanding any requirement of this section to the contrary, a carrier shall approve a prior authorization request for medication on the carrier's prescription drug formulary that is prescribed to assess or treat an enrollee's serious mental illness. For the purposes of this subsection,

"serious mental illness" means a mental disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities. The superintendent may adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2021, c. 345, §1 (NEW).]

3. Background information; affirmative duty of provider. A provider has an affirmative duty to submit to the carrier the background information necessary for the carrier to complete its review and render a decision within the time period required in subsection 2. If the provider needs additional time to submit that required information, the provider must inform the carrier in a timely manner. Nothing in this section requires a provider to submit confidential information without a signed consent from the enrollee.
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

4. Revocation of prior authorization. When prior approval for a service or other covered item is granted, a carrier may not retrospectively deny coverage or payment for the originally approved service unless fraudulent or materially incorrect information was provided at the time prior approval for the service was granted.
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

5. Emergency services. When conducting utilization review or making a benefit determination for emergency services, a carrier shall provide benefits for emergency services consistent with the requirements of this subsection and any applicable bureau rule.

A. Before a carrier denies benefits or reduces payment for an emergency service based on a determination of the absence of an emergency medical condition or a determination that a lower level of care was needed, the carrier shall conduct a utilization review done by a board-certified emergency physician who is licensed in this State, including a review of the enrollee's medical record related to the emergency medical condition subject to dispute. If a carrier requests records related to a potential denial of or payment reduction for an enrollee's benefits when emergency services were furnished to an enrollee, a provider has an affirmative duty to respond to the carrier in a timely manner. This paragraph does not apply when a reduction in payment is made by a carrier based on a contractually agreed upon adjustment for health care service. [PL 2019, c. 238, §2 (NEW).]
[PL 2019, c. 238, §2 (AMD).]

6. Notice. A notice issued by a carrier or its contracted utilization review entity in response to a request by or on behalf of an insured or enrollee for authorization of medical services that advises that the requested service has been determined to be medically necessary must also advise whether the service is covered under the policy or contract under which the insured or enrollee is covered. Nothing in this subsection requires a carrier to provide coverage for services performed when the insured or enrollee is no longer covered by the health plan.
[PL 2001, c. 410, Pt. B, §6 (NEW).]

7. Requirements for an appeal of adverse health care treatment decision. An appeal of a carrier's adverse health care treatment decision must be conducted by a clinical peer. The clinical peer may not have been involved in making the initial adverse health care treatment decision unless additional information not previously considered during the initial review is provided on appeal. For the purposes of this subsection, "adverse health care treatment decision" does not include a carrier's rescission determination or a carrier's determination of initial coverage eligibility for coverage.
[PL 2019, c. 171, §2 (NEW).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §§11-13 (AMD). PL 2001, c. 288, §6 (AMD). PL 2001, c. 410, §B6 (AMD). PL 2007, c. 199, Pt. B, §§12, 13 (AMD). PL 2019, c. 171, §2 (AMD). PL 2019, c. 238, §2 (AMD). PL 2019, c. 273, §§1, 2 (AMD). PL 2021, c. 73, §§1, 2 (AMD). PL 2021, c. 345, §1 (AMD). PL 2023, c. 275, §1 (AMD).

§4304-A. Prior authorization for rehabilitative or habilitative services

1. Prior authorization for new episode of care prohibited for 12 visits. A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care. For purposes of this subsection, "new episode of care" means treatment for a new condition or treatment for a recurring condition for which an enrollee has not been treated within the previous 90 days.
[PL 2023, c. 275, §2 (NEW).]

2. Intent. This section does not limit the right of a carrier to deny a claim when an appropriate prospective or retrospective review concludes that the health care services or treatment rendered were not medically necessary.
[PL 2023, c. 275, §2 (NEW).]

SECTION HISTORY

PL 2023, c. 275, §2 (NEW).

§4305. Quality of care

A carrier offering or renewing a health plan that subjects payment of benefits for otherwise covered services to review for clinical necessity, appropriateness, efficacy or efficiency must meet the following requirements relating to quality of care. [PL 2007, c. 199, Pt. B, §14 (AMD).]

1. Internal quality assurance program. A health plan must have an ongoing quality assurance program for the health care services provided or reimbursed by the health plan.
[PL 1995, c. 673, §1 (NEW); PL 1995, c. 673, §2 (AFF).]

2. Written standards. The standards of quality of care must be described in a written document, which must be available for examination by the superintendent or by the Department of Health and Human Services.
[PL 1995, c. 673, §1 (NEW); PL 1995, c. 673, §2 (AFF); PL 2003, c. 689, Pt. B, §6 (REV).]

3. Coverage decisions. Following a determination that a particular service is covered, a carrier may not deny payment for that service based on the enrollee's age, nature of disability or degree of medical dependency.
[PL 1995, c. 673, §1 (NEW); PL 1995, c. 673, §2 (AFF).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §14 (AMD). PL 2003, c. 689, §B6 (REV). PL 2007, c. 199, Pt. B, §14 (AMD).

§4306. Enrollee choice of primary care provider

A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and physician assistants licensed pursuant to Title 32, section 2594-E or section 3270-E and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A to serve as primary care providers for managed care plans. A carrier

is not required to contract with certified nurse practitioners, physician assistants or physicians as primary care providers in any manner that exceeds the access and provider network standards required in this chapter or chapter 56, or any rules adopted pursuant to those chapters. A carrier shall allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides. [PL 2019, c. 627, Pt. A, §1 (AMD).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 396, §6 (AMD). PL 1999, c. 396, §7 (AFF). PL 1999, c. 742, §15 (AMD). PL 2007, c. 199, Pt. B, §15 (AMD). PL 2011, c. 364, §28 (AMD). PL 2019, c. 627, Pt. A, §1 (AMD).

§4306-A. Patient access to obstetrical and gynecological care

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State subject to the requirements of the federal Affordable Care Act: [PL 2011, c. 364, §29 (NEW).]

1. Authorization or referral not required. May not require authorization or referral by the carrier or any other person, including a primary care provider, in the case of a female enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology. The health care professional shall agree to otherwise adhere to the health plan's or carrier's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier; and
[PL 2011, c. 364, §29 (NEW).]

2. Treated as primary care. Shall treat the provision of obstetrical and gynecological care by a participating health care professional as described in the federal Affordable Care Act who specializes in obstetrics or gynecology, pursuant to subsection 1, as authorized by the primary care provider and the authorization of related obstetrical and gynecological items and services by that professional as the authorization of the primary care provider.
[PL 2011, c. 364, §29 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §29 (NEW).

§4307. Construction

Nothing in this chapter may be construed to: [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

1. Purchase services with own funds. Prohibit an individual from purchasing any health care services with that individual's own funds, whether these services are covered within the individual's benefit package or from another health care provider or plan, except as otherwise provided by federal or state law;
[PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

2. Additional benefits. Prohibit any plan sponsor from providing additional coverage for benefits, rights or protections not set out in this chapter;
[PL 1999, c. 742, §16 (AMD).]

3. Provider participation. Require a carrier to admit to a managed care plan a provider willing to abide by the terms and conditions of the managed care plan; or
[PL 1999, c. 742, §16 (AMD).]

4. Treatment by religious nonmedical providers. With respect to coverage of treatment by religious nonmedical providers:

A. Restrict or limit the right of a carrier to include a religious nonmedical provider as a participating provider in a managed care plan; [PL 1999, c. 742, §17 (NEW).]

B. Require a carrier to:

(1) Utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(2) Use medical professionals or criteria to decide enrollee access to religious nonmedical providers;

(3) Utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(4) Compel an enrollee to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious nonmedical provider; or [PL 1999, c. 742, §17 (NEW).]

C. Require a carrier to exclude religious nonmedical providers because the providers do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider. [PL 1999, c. 742, §17 (NEW).]

[PL 1999, c. 742, §17 (NEW).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §§16,17 (AMD).

§4308. Indemnification

A contract between a carrier offering or renewing a health plan and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with a claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct. [PL 2007, c. 199, Pt. B, §16 (AMD).]

1. Indemnification.
[PL 1999, c. 742, §18 (RP).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF). PL 1999, c. 742, §18 (RPR). PL 2007, c. 199, Pt. B, §16 (AMD).

§4309. Adoption of rules

The superintendent shall adopt rules and establish standards for health plans in order to carry out the purposes of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter II-A. [PL 1995, c. 673, Pt. C, §1 (NEW); PL 1995, c. 673, Pt. C, §2 (AFF).]

SECTION HISTORY

PL 1995, c. 673, §C1 (NEW). PL 1995, c. 673, §C2 (AFF).

§4309-A. Compliance with the Affordable Care Act

1. Carriers. A carrier shall comply with all applicable requirements of the federal Affordable Care Act.
[PL 2011, c. 364, §30 (NEW).]

2. Superintendent. The superintendent may enforce and administer this section through all powers provided under this Title and Title 24. The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments adopted pursuant to this subsection, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2011, c. 364, §30 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §30 (NEW).

§4310. Access to clinical trials

1. Qualified enrollee. An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

A. The enrollee has a life-threatening illness for which no standard treatment is effective; [PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness; [PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and [PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C. [PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

[PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

2. Coverage. A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

[PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

3. Payment. A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers.

[PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

4. Approved clinical trial. For the purposes of this section, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

[PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2003, c. 517, Pt. B, §31 (NEW).]

SECTION HISTORY

PL 1999, c. 742, §19 (NEW). PL 1999, c. 742, §21 (AFF). PL 2003, c. 517, §B31 (AMD).

§4311. Access to prescription drugs

1. Formulary. If a health plan provides coverage for prescription drugs but the coverage limits such benefits to drugs included in a formulary, a carrier shall:

A. Ensure participation of participating physicians and pharmacists in the development of the formulary; [PL 2017, c. 429, Pt. A, §1 (AMD).]

B. Provide exceptions to the formulary limitation when a nonformulary alternative is medically indicated, consistent with the utilization review standards in section 4304; [PL 2017, c. 429, Pt. A, §1 (AMD).]

C. Provide an enrollee with at least 60 days' written notice of an adverse change to a formulary, except that a carrier may provide less than 60 days' notice when a prescription drug is being removed from the formulary because of concerns about safety. The notice must use a conspicuous font and inform the enrollee of the adverse change to the formulary and advise the enrollee to consult with the enrollee's provider about the change. For the purposes of this paragraph, "adverse change to a formulary" means a change that removes a drug currently prescribed for that enrollee from the formulary applicable to the enrollee's health plan or a change that moves the prescribed drug to a tier with a higher cost-sharing requirement if the carrier uses a formulary with tiers; [PL 2017, c. 429, Pt. A, §1 (NEW).]

D. If a prescription drug is removed from a formulary, notify an enrollee affected by the change of the enrollee's ability to request an exception to the formulary limitation pursuant to paragraph B and provide a form for the enrollee to use to request an exception. If an enrollee has already received prior authorization for that drug, the carrier shall continue to honor the existing authorization until it expires, as long as the enrollee continues to be covered under the same health plan and the drug has not been removed from the formulary because of concerns about safety; and [PL 2017, c. 429, Pt. A, §1 (NEW).]

E. Except when a drug has been removed because of concerns about safety, if a drug has been removed from a formulary and a request for an exception to a formulary limitation submitted by or on behalf of an enrollee is received prior to the effective date of the proposed change, continue to provide coverage for that drug until the carrier has rendered a decision on the enrollee's request for an exception to the formulary limitation. [PL 2017, c. 429, Pt. A, §1 (NEW).]

[PL 2017, c. 429, Pt. A, §1 (AMD).]

1-A. Access to clinically appropriate prescription drugs. For plan years beginning on or after the effective date of this subsection, a carrier must allow an enrollee, the enrollee's designee or the person who has issued a valid prescription for the enrollee to request and gain access to a clinically appropriate drug not otherwise covered by the health plan. The carrier's process must comply with section 4304 and with this subsection. If the carrier approves a request under this subsection for a drug not otherwise covered by the health plan, the carrier must treat the drug as an essential health benefit, including counting any cost sharing toward the plan's annual limit on cost sharing and including it when calculating the plan's actuarial value.

A. The carrier must determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has issued the valid prescription for the enrollee of its coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. A carrier that grants coverage under this paragraph must provide coverage of the drug for the duration of the prescription, including refills. [PL 2019, c. 273, §3 (AMD).]

B. The carrier must have a process by which an expedited review may be requested in exigent circumstances. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug. When an

expedited review has been requested, the carrier must determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has provided a valid prescription for the enrollee of its coverage decision within 24 hours following receipt of the request. A carrier that grants coverage under this paragraph must provide coverage of the drug for the duration of the exigency. [PL 2019, c. 5, Pt. A, §21 (NEW).]

[PL 2019, c. 273, §3 (AMD).]

2. Coverage of approved drugs and medical devices. A carrier that provides coverage for prescription drugs and medical devices may not deny coverage of a prescribed drug or medical device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

[PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

2-A. Coverage of prescription during emergency declared by the Governor. Except as provided in this subsection, a carrier shall provide coverage for the furnishing or dispensing of a prescription drug in accordance with a valid prescription issued by a provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor in accordance with Title 37-B, section 742. This subsection does not apply to coverage of prescribed contraceptive supplies furnished and dispensed pursuant to section 2756, 2847-G or 4247 or coverage of opioids prescribed in accordance with limits set forth in Title 32.

[PL 2021, c. 28, Pt. B, §1 (NEW).]

3. Construction. This section may not be construed to require a carrier to provide coverage of prescription drugs or medical devices.

[PL 1999, c. 742, §19 (NEW); PL 1999, c. 742, §21 (AFF).]

4. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2003, c. 517, Pt. B, §32 (NEW).]

SECTION HISTORY

PL 1999, c. 742, §19 (NEW). PL 1999, c. 742, §21 (AFF). PL 2003, c. 517, §B32 (AMD). PL 2017, c. 429, Pt. A, §1 (AMD). PL 2019, c. 5, Pt. A, §21 (AMD). PL 2019, c. 273, §3 (AMD). PL 2021, c. 28, Pt. B, §1 (AMD).

§4312. Independent external review

An enrollee has the right to an independent external review of a carrier's adverse health care treatment decision made by or on behalf of a carrier offering or renewing a health plan in accordance with the requirements of this section. An enrollee's failure to obtain authorization prior to receiving an otherwise covered service may not preclude an enrollee from exercising the enrollee's rights under this section. [PL 2007, c. 199, Pt. B, §17 (AMD).]

1. Request for external review. An enrollee or the enrollee's authorized representative shall make a written request for external review of an adverse health care treatment decision to the bureau. Except as provided in subsection 2, an enrollee may not make a request for external review under a group plan until the enrollee has exhausted all levels of a carrier's internal grievance procedure and may not make a request for external review under an individual plan until the enrollee has exhausted one level of a carrier's internal grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under a carrier's

internal grievance procedure. An enrollee may not be required to pay any filing fee as a condition of processing a request for external review.
[PL 2011, c. 364, §31 (AMD).]

2. Expedited request for external review. An enrollee or an enrollee's authorized representative is not required to exhaust a carrier's internal grievance procedure in accordance with subsection 1 before filing a request for external review if:

A. The carrier has failed to make a decision on an internal grievance within the time period required or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal; [PL 2011, c. 364, §32 (AMD).]

B. The carrier and the enrollee mutually agree to bypass the internal grievance procedure; [PL 1999, c. 742, §19 (NEW).]

C. The life or health of the enrollee is in serious jeopardy; [PL 2011, c. 364, §32 (AMD).]

D. The enrollee has died; or [PL 2011, c. 364, §32 (AMD).]

E. The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services. [PL 2011, c. 364, §32 (NEW).]
[PL 2011, c. 364, §32 (AMD).]

3. Notice to enrollees. A carrier shall notify an enrollee of the enrollee's right to request an external review in large type and easy-to-read language in a conspicuous location on the written notice of an adverse health care treatment decision. The notice must include:

A. A description of the external review procedure and the requirements for making a request for external review; [PL 1999, c. 742, §19 (NEW).]

B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier; [PL 1999, c. 742, §19 (NEW).]

C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and [PL 1999, c. 742, §19 (NEW).]

D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau. [PL 1999, c. 742, §19 (NEW).]
[PL 1999, c. 742, §19 (NEW).]

4. Independent external review; bureau oversight. The bureau shall oversee the external review process required under this section and shall contract with approved independent review organizations to conduct an external review and render an external review decision. At a minimum, an independent review organization approved by the bureau shall ensure the selection of qualified and impartial reviewers who are clinical peers with respect to the adverse health care treatment decision under review and who have no professional, familial or financial conflict of interest relating to a carrier, enrollee, enrollee's authorized representative or health care provider involved in the external review.
[PL 1999, c. 742, §19 (NEW).]

5. Independent external review decision; timelines. An external review decision must be made in accordance with the following requirements.

A. In rendering an external review decision, the independent review organization must give consideration to the appropriateness of the requested covered service based on the following:

(1) All relevant clinical information relating to the enrollee's physical and mental condition, including any competing clinical information;

(2) Any concerns expressed by the enrollee concerning the enrollee's health status; and

(3) All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by the carrier or the carrier's utilization review entity. [PL 1999, c. 742, §19 (NEW).]

B. An external review decision must be issued in writing and must be based on the evidence presented by the carrier and the enrollee or the enrollee's authorized representative. An enrollee may submit and obtain evidence relating to the adverse health care treatment decision under review, attend the external review, ask questions of any representative of the carrier present at the external review and use outside assistance during the review process at the enrollee's own expense. [PL 1999, c. 742, §19 (NEW).]

C. Except as provided in paragraph D, an external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the bureau. [PL 1999, c. 742, §19 (NEW).]

D. An external review decision must be made as expeditiously as an enrollee's medical condition requires but in no event more than 72 hours after receipt of a completed request for external review if the time frame for review required under paragraph C would seriously jeopardize the life or health of the enrollee or would jeopardize the enrollee's ability to regain maximum function. [PL 1999, c. 742, §19 (NEW).]

E. The carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an external review under this section. [PL 1999, c. 742, §19 (NEW).]

[PL 1999, c. 742, §19 (NEW).]

6. Binding nature of decision. An external review decision is binding on the carrier. An enrollee or the enrollee's authorized representative may not file a request for a subsequent external review involving the same adverse health care treatment decision for which the enrollee has already received an external review decision pursuant to this section. An external review decision made under this section is not considered final agency action pursuant to Title 5, chapter 375, subchapter II.
[PL 1999, c. 742, §19 (NEW).]

7. Funding. A carrier against which a request for external review has been filed shall pay the cost of the independent external review to the bureau.
[PL 1999, c. 742, §19 (NEW).]

7-A. Confidentiality. Except as provided in this subsection, all records of the bureau or an independent review organization relating to an external review request or external review proceeding are confidential and not a public record under Title 1, chapter 13.

A. A party to an external review may obtain from the independent review organization a transcript or recording of the external review hearing and a copy of any evidence introduced by the opposing party. [PL 2013, c. 274, §1 (NEW).]

B. The superintendent shall disseminate to the Legislature and to the public aggregate information related to external reviews conducted by independent review organizations on an annual basis, including:

(1) The number of external review requests by carrier, the number of decisions in favor of the enrollee, the number of decisions upholding the carrier's benefit determination and the number of external review requests resolved prior to the issuance of a decision; and

(2) The categories of external review requests by carrier. The categories may not include personally identifiable information or specific medical condition. The categories must include, but are not limited to, medical necessity, out-of-network referrals, inpatient care, behavioral health, prescription drugs and experimental or investigational treatment. [PL 2013, c. 274, §1 (NEW).]

[PL 2013, c. 274, §1 (NEW).]

8. Rules. The bureau may adopt rules necessary to carry out the requirements of this section, including, without limitation, criteria for determining when multiple denials of benefits to the same enrollee for the same or similar reasons are considered the same adverse health care treatment decision. Notwithstanding the requirements of section 4309, rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[PL 1999, c. 742, §19 (NEW).]

9. Rights. This section may not be construed to remove or limit any legal rights or remedies of an enrollee or other person under state or federal law, including the right to file judicial actions to enforce rights.

[PL 1999, c. 742, §19 (NEW).]

10. Applicability. Decisions relating to the following health care services are subject to review pursuant to other review processes provided by applicable federal or state law and may not be reviewed pursuant to this section:

A. Health care services provided through Medicaid, Medicare, Title XXI of the Social Security Act or services provided under these programs through contracted health care providers; [PL 1999, c. 742, §19 (NEW).]

B. Health care services provided to inmates by the Department of Corrections; or [PL 1999, c. 742, §19 (NEW).]

C. Health care services provided pursuant to a health plan not subject to regulation by the State. [PL 1999, c. 742, §19 (NEW).]

[PL 1999, c. 742, §19 (NEW).]

SECTION HISTORY

PL 1999, c. 742, §19 (NEW). PL 2007, c. 199, Pt. B, §17 (AMD). PL 2011, c. 364, §§31, 32 (AMD). PL 2013, c. 274, §1 (AMD).

§4313. Carrier liability; cause of action

1. Duty of ordinary care; cause of action. An enrollee may maintain a cause of action against a carrier offering or renewing a health plan in accordance with the following.

A. A carrier has the duty to exercise ordinary care when making health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee and is liable for damages as provided in this section for harm to an enrollee proximately caused by the failure of the carrier or its agents to exercise such ordinary care. [PL 1999, c. 742, §19 (NEW).]

B. A carrier is also liable for damages as provided in this section for harm to an enrollee proximately caused by the health care treatment decisions made by its agents who are acting on the carrier's behalf and over whom the carrier exercised control or influence in the health care treatment decisions that result in the failure to exercise ordinary care. [PL 1999, c. 742, §19 (NEW).]

[PL 2007, c. 199, Pt. B, §18 (AMD).]

2. Exhaustion of internal and external review. An enrollee may not maintain a cause of action under this section unless the enrollee or the enrollee's representative:

A. Has exhausted all levels of the carrier's internal grievance procedure in accordance with this chapter; and [PL 1999, c. 742, §19 (NEW).]

B. Has completed the independent external review process required under section 4312. [PL 1999, c. 742, §19 (NEW).]

[PL 1999, c. 742, §19 (NEW).]

3. Limitation on cause of action. An action under this section must be initiated within 3 years from the earlier of the date of issuance of the written external review decision under section 4312 or the date of issuance of the underlying adverse first-level appeal or first-level grievance determination notice.

[PL 1999, c. 742, §19 (NEW).]

4. Jurisdiction; notice and filing. The Superior Court has original jurisdiction over a cause of action under this section. The requirements for notice and filing of a cause of action under this section are governed by the Maine Rules of Civil Procedure.

[PL 1999, c. 742, §19 (NEW).]

5. Corporate practice of medicine. Section 4222, subsection 3 or any other law in this State prohibiting a carrier from practicing medicine or being licensed to practice medicine may not be asserted as a defense by a carrier in any action brought pursuant to this section.

[PL 1999, c. 742, §19 (NEW).]

6. No obligation for benefits. This section does not create any obligation on the part of a carrier to provide an enrollee any health care treatment or service that is not covered by the enrollee's health plan policy or contract.

[PL 1999, c. 742, §19 (NEW).]

7. Admissibility of external review decision. An external review decision is admissible in an action under this section.

[PL 1999, c. 742, §19 (NEW).]

8. Affirmative defense. It is an affirmative defense to any action asserted against a carrier under this section that the carrier or any agent for whose conduct the carrier is liable did not control, influence or participate in the health care treatment decision.

[PL 1999, c. 742, §19 (NEW).]

9. Damages. In a cause of action under this section, the award of damages must be made in accordance with this subsection.

A. Actual or compensatory damages may be awarded. [PL 1999, c. 742, §19 (NEW).]

B. Noneconomic damages awarded may not exceed $400,000. [PL 1999, c. 742, §19 (NEW).]

C. Punitive damages may not be awarded. [PL 1999, c. 742, §19 (NEW).]

[PL 1999, c. 742, §19 (NEW).]

10. Professional negligence. This section does not create any new or additional liability on the part of a carrier for harm caused to an enrollee that is attributable to the professional negligence of a treating physician or other health care practitioner.

[PL 1999, c. 742, §19 (NEW).]

11. Employer liability. This section does not create any liability on the part of an employer that assumes risk on behalf of its employees or an employer group purchasing organization.

[PL 1999, c. 742, §19 (NEW).]

12. Exemption. This section does not apply to workers' compensation, medical malpractice, fidelity, suretyship, boiler and machinery, property or casualty insurance.
[PL 1999, c. 742, §19 (NEW).]

13. Limitation on remedy. The cause of action under this section is the sole and exclusive private remedy under state law for an enrollee against a carrier for its health care treatment decisions that affect the quality of the diagnosis, care or treatment provided to an enrollee, except that this subsection may not be construed to prohibit an enrollee or an enrollee's authorized representative from seeking other remedies specifically available under other provisions of this Title.
[PL 1999, c. 742, §19 (NEW).]

14. Wrongful death action. Notwithstanding subsection 13, an enrollee or an enrollee's authorized representative may bring a cause of action against a carrier for its health care treatment decisions to seek a remedy under either this section or under Title 18-C, section 2-807, but may not seek remedies under both this section and Title 18-C, section 2-807.
[PL 2017, c. 402, Pt. C, §76 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

SECTION HISTORY

PL 1999, c. 742, §19 (NEW). PL 2007, c. 199, Pt. B, §18 (AMD). PL 2017, c. 402, Pt. C, §76 (AMD). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. B, §14 (AFF).

§4314. Access to eye care providers

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Eye care provider" means a participating provider who is an optometrist licensed to practice optometry pursuant to Title 32, chapter 34-A, or an ophthalmologist licensed to practice medicine pursuant to Title 32, chapter 48. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

B. "Eye care services" means those urgent health care services related to the examination, diagnosis, treatment and management of conditions, illnesses and diseases of the eye and related structures that are provided to treat conditions, illnesses or diseases of the eye that if not treated within 24 hours present a serious risk of harm. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

C. "Contractual discount" means a percentage or other reduction from a provider's usual and customary rate for a covered service or covered material required under a participating provider agreement. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

D. "Covered material" means a material for which benefits are provided under a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

E. "Covered service" means a service for which benefits are provided under a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

F. "Limited benefit vision insurance plan" means a plan offered or administered by a carrier that covers only vision care or any other plan offered or administered by a carrier that includes vision care benefits and is not a health plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

G. "Materials" means ophthalmic devices, including, but not limited to, lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatuses, prisms, lens treatments and coating, contact lenses and prosthetic devices to correct, relieve or treat defects or abnormal conditions of the human eye or its adnexa. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

H. "Services" means the professional work performed by an eye care provider. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

I. "Vision insurance" means a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan. [PL 2015, c. 171, §1 (NEW); PL 2015, c. 171, §4 (AFF).]

[PL 2015, c. 171, §1 (AMD); PL 2015, c. 171, §4 (AFF).]

2. Coverage of eye care services. A carrier that provides coverage for eye care services as part of a health plan shall provide coverage for eye care services in accordance with the following.

A. An enrollee may receive eye care services from an eye care provider participating in the enrollee's health plan without the prior approval or authorization of the enrollee's primary care provider for a maximum of 2 visits, one initial visit and one follow-up visit, for each occurrence requiring urgent care as described in subsection 1, paragraph B. A carrier may not retrospectively deny coverage under this section on the basis that the eye care services received by the enrollee did not meet the requirements of subsection 1, paragraph B. In order to receive continuing benefits for treatment related to the initial visit, an enrollee must receive the approval of the enrollee's primary care provider for any visit after the 2nd visit. Within 3 working days of the initial visit, the eye care provider shall send to the enrollee's primary care provider a report containing the enrollee's complaint, related history, examination results, initial diagnosis and recommendations for treatment. If the eye care provider does not send a report to the primary care provider within 3 working days, the carrier is not obligated to provide benefits for the self-referred visits under this paragraph and the enrollee is not liable to the eye care provider for any unpaid fees. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

B. A carrier shall ensure that all eye care providers participating in the carrier's health plans are included on any publicly accessible list of participating providers for the carrier. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

C. A carrier shall allow each eye care provider participating in the carrier's health plans to furnish covered eye care services to enrollees without discrimination between classes of eye care providers and to provide the eye care services permitted by the eye care provider's license. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

[PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

3. Prohibitions. A carrier or a subsidiary or subcontractor of a carrier may not:

A. Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other health care services under a health plan; [PL 2015, c. 171, §2 (AMD); PL 2015, c. 171, §4 (AFF).]

B. Require an eye care provider to hold hospital privileges as a condition of participation as a provider under a health plan; [PL 2015, c. 171, §2 (AMD); PL 2015, c. 171, §4 (AFF).]

C. Require in an agreement with an eye care provider that the eye care provider provide services or materials to an enrollee in a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan at a specified or limited fee unless the services or materials are a covered service or a covered material under the health plan or limited benefit vision insurance plan; [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

D. Restrict or limit, directly or indirectly, in an agreement with an eye care provider, the eye care provider's choice of sources and suppliers of services or materials provided by the eye care provider to an enrollee or the optical laboratories used by the eye care provider; [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

E. Change any term, contractual discount or reimbursement rate contained in an agreement with an eye care provider without notice to the eye care provider at least 60 days before the change is implemented; [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

F. Require in an agreement with an eye care provider that the eye care provider participate in other vision insurance as a condition of joining an insurer's provider network for a health plan that provides coverage for vision care or eye care services or a limited benefit vision insurance plan; or [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

G. Enter into an agreement with an eye care provider that is longer than 2 years from the date the agreement is first signed. [PL 2015, c. 171, §2 (NEW); PL 2015, c. 171, §4 (AFF).]

[PL 2015, c. 171, §2 (AMD); PL 2015, c. 171, §4 (AFF).]

4. Construction. This section may not be construed as:

A. Requiring coverage for routine eye examinations; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

B. Creating coverage for any health care service that is not otherwise covered under the terms of a health plan; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

C. Requiring a carrier to include as a participating provider every willing provider or health care professional who meets the terms and conditions of a health plan; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

D. Preventing an enrollee from seeking eye care services from the enrollee's primary care provider in accordance with the terms of the enrollee's health plan; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

E. Increasing or decreasing the scope of practice of optometry or ophthalmology as defined in Title 32; [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

F. Requiring eye care services to be provided in a hospital or similar health care facility; or [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

G. Notwithstanding the definition of eye care services in subsection 1, paragraph B, prohibiting a carrier from requiring an enrollee to receive prior approval or authorization from a primary care provider for any subsequent surgical procedures. [PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

[PL 2001, c. 408, §1 (NEW); PL 2001, c. 408, §2 (AFF).]

5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[PL 2003, c. 517, Pt. B, §33 (NEW).]

6. Enforcement. A violation of this section by a carrier or a subsidiary or subcontractor of a carrier is enforced by the superintendent under the authority granted by section 12-A.

[PL 2015, c. 171, §3 (NEW); PL 2015, c. 171, §4 (AFF).]

SECTION HISTORY

PL 2001, c. 408, §1 (NEW). PL 2001, c. 408, §2 (AFF). PL 2003, c. 517, §B33 (AMD). PL 2015, c. 171, §§1-3 (AMD). PL 2015, c. 171, §4 (AFF).

§4314-A. Coverage for early refills of prescription eye drops

1. Required coverage. A carrier offering a health plan in this State shall provide coverage for one early refill of a prescription for eye drops if the following criteria are met:

A. The enrollee requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed; [PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

B. The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized; [PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

C. The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription; [PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

D. The prescription has not been refilled more than once during the period authorized by the prescribing health care provider prior to the request for an early refill; and [PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

E. The prescription eye drops are a covered benefit under the enrollee's health plan. [PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

[PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

2. Cost sharing. A carrier may impose a deductible, copayment or coinsurance requirement for an early refill under this section as permitted under the health plan.

[PL 2015, c. 91, §1 (NEW); PL 2015, c. 91, §2 (AFF).]

SECTION HISTORY

PL 2015, c. 91, §1 (NEW). PL 2015, c. 91, §2 (AFF).

§4315. Coverage of prosthetic devices

1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg.

[PL 2003, c. 459, §1 (NEW); PL 2003, c. 459, §2 (AFF).]

2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for:

A. A prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee; and [PL 2021, c. 741, §1 (NEW).]

B. With respect to an enrollee under 18 years of age, in addition to coverage of a prosthetic device required by paragraph A, a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that meets the medical needs of the enrollee for recreational purposes, as applicable, to maximize the enrollee’s ability to ambulate, run, bike and swim and to maximize upper limb function. [PL 2021, c. 741, §1 (NEW).]

[PL 2021, c. 741, §1 (AMD).]

3. Prior authorization. A carrier may require prior authorization for prosthetic devices in the same manner as prior authorization is required for any other covered benefit.

[PL 2003, c. 459, §1 (NEW); PL 2003, c. 459, §2 (AFF).]

4. Repair or replacement. Coverage under this section must also be provided for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by the enrollee's provider.

[PL 2003, c. 459, §1 (NEW); PL 2003, c. 459, §2 (AFF).]

5. Coverage under managed care plan. If coverage under this section is provided through a managed care plan, a carrier may require that prosthetic services be rendered by a provider who contracts with the carrier and that a prosthetic device be provided by a vendor designated by the carrier.
[PL 2003, c. 459, §1 (NEW); PL 2003, c. 459, §2 (AFF).]

6. Exclusions. Except as provided in subsection 2, paragraph B for an enrollee under 18 years of age, coverage is not required pursuant to this section for a prosthetic device that is designed exclusively for an athletic purpose.
[PL 2021, c. 741, §2 (AMD).]

7. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2003, c. 517, Pt. B, §34 (NEW).]

8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.
[PL 2003, c. 688, Pt. I, §2 (NEW).]

9. Report. No later than June 30, 2028, each carrier that issues a health plan subject to this section shall report to the superintendent on its experience pursuant to this section for plan years 2024, 2025, 2026 and 2027. The report must be in a form prescribed by the superintendent and must include the number of claims and the total amount of claims paid in this State for the services required by this section. The superintendent shall aggregate this data by plan year in a report and submit the report to the joint standing committee of the Legislature having jurisdiction over health coverage and insurance matters no later than November 1, 2028.
[PL 2021, c. 741, §3 (NEW).]

SECTION HISTORY

PL 2003, c. 459, §1 (NEW). PL 2003, c. 459, §2 (AFF). PL 2003, c. 517, §B34 (AMD). PL 2003, c. 688, §§I1,2 (AMD). PL 2009, c. 603, §1 (AMD). PL 2009, c. 603, §2 (AFF). PL 2021, c. 741, §§1-3 (AMD).

§4316. Coverage for telehealth services

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Mobile health device" means a wearable device used to track health and wellness, including, but not limited to, a heart rate and respiratory monitor, an electrocardiogram monitor and a glucose monitor. [PL 2019, c. 289, §2 (NEW).]

A-1. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as amended. [PL 2019, c. 649, §3 (NEW).]

B. "Store and forward transfers" means transmission of an enrollee's recorded health history through a secure electronic system to a provider. [PL 2019, c. 289, §2 (NEW).]

B-1. "Asynchronous encounters" means the interaction or consultation between an enrollee and the enrollee’s provider or between providers regarding the enrollee through a system with the ability to store digital information, including, but not limited to, still images, video, audio and text files, and other relevant data in one location and subsequently transmit such information for interpretation at a remote site by health professionals without requiring the simultaneous presence of the patient or the health professionals. [PL 2021, c. 291, Pt. A, §4 (NEW).]

B-2. "Synchronous encounters" means a real-time interaction conducted with interactive audio or video connection between an enrollee and the enrollee's provider or between providers regarding the enrollee. [PL 2021, c. 291, Pt. A, §4 (NEW).]

C. "Telehealth," as it pertains to the delivery of health care services, means the use of information technology and includes synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring. [PL 2021, c. 291, Pt. A, §4 (AMD).]

D. "Telemonitoring," as it pertains to the delivery of health care services, means the use of information technology to remotely monitor an enrollee's health status via electronic means, allowing the provider to track the enrollee's health data over time. Telemonitoring may be synchronous or asynchronous. [PL 2021, c. 291, Pt. A, §4 (AMD).]

E. [PL 2021, c. 291, Pt. A, §4 (RP).]

[PL 2021, c. 291, Pt. A, §4 (AMD).]

2. Parity for telehealth services. A carrier offering a health plan in this State may not deny coverage on the basis that the health care service is provided through telehealth if the health care service would be covered if it were provided through in-person consultation between an enrollee and a provider and as long as the provider is acting within the scope of practice of the provider's license and in accordance with rules adopted by the board, if any, that issued the provider's license related to standards of practice for the delivery of a health care service through telehealth. Coverage for health care services provided through telehealth must be determined in a manner consistent with coverage for health care services provided through in-person consultation. If an enrollee is eligible for coverage and the delivery of the health care service through telehealth is medically appropriate, a carrier may not deny coverage for telehealth services. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to a comparable service provided through in-person consultation. A carrier may not exclude a health care service from coverage solely because such health care service is provided only through a telehealth encounter, as long as telehealth is appropriate for the provision of such health care service. [PL 2021, c. 291, Pt. A, §5 (AMD).]

3. Coverage for telehealth services. Except as provided in this section, a carrier shall provide coverage for any medically necessary health care service delivered through telehealth as long as the following requirements are met.

A. The health care service is otherwise covered under an enrollee's health plan. [PL 2019, c. 289, §2 (NEW).]

B. The health care service delivered by telehealth is of comparable quality to the health care service delivered through in-person consultation. [PL 2019, c. 289, §2 (NEW).]

C. Prior authorization is required for telehealth services only if prior authorization is required for the corresponding covered health care service. An in-person consultation prior to the delivery of services through telehealth is not required. [PL 2019, c. 289, §2 (NEW).]

D. Coverage for telehealth services is not limited in any way on the basis of geography, location or distance for travel. [PL 2019, c. 289, §2 (NEW).]

E. The carrier shall require that a clinical evaluation is conducted either in person or through telehealth before a provider may write a prescription that is covered. [PL 2019, c. 289, §2 (NEW).]

F. The carrier shall provide coverage for the treatment of 2 or more persons who are enrolled in the carrier's health plan at the same time through telehealth, including counseling for substance use disorders involving opioids. [PL 2019, c. 289, §2 (NEW).]

G. The carrier may not place any restriction on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that is more restrictive than any requirement in state and federal law for prescribing medication through in-person consultation. [PL 2021, c. 291, Pt. A, §6 (NEW).]

[PL 2021, c. 291, Pt. A, §6 (AMD).]

4. Telemonitoring requirements. A carrier shall provide coverage for telemonitoring if:

A. The telemonitoring is intended to collect an enrollee's health-related data, including, but not limited to, pulse and blood pressure readings, that assist a provider in monitoring and assessing the enrollee's medical condition; [PL 2019, c. 289, §2 (NEW).]

B. The telemonitoring is medically necessary for the enrollee; [PL 2019, c. 289, §2 (NEW).]

C. The enrollee is cognitively and physically capable of operating the mobile health devices or the enrollee has a caregiver willing and able to assist with the mobile health devices; and [PL 2021, c. 293, Pt. A, §29 (AMD).]

D. The enrollee's residence is suitable for telemonitoring. If the residence appears unable to support telemonitoring, the telemonitoring may not be provided unless necessary adaptations are made. [PL 2019, c. 289, §2 (NEW).]

[PL 2021, c. 293, Pt. A, §29 (AMD).]

5. Coverage for telephonic services.

[PL 2021, c. 291, Pt. A, §7 (RP).]

6. Utilization review. This section does not prohibit or limit a carrier from conducting a utilization review for telehealth services as long as the utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

[PL 2019, c. 289, §2 (NEW).]

7. Provider eligibility. In order to be eligible for reimbursement under this section, a provider providing health care services through telehealth must be acting within the scope of the provider's license. A carrier may not impose additional credentialing requirements or prior approval requirements for a provider as a condition of reimbursement for health care services provided under this section unless those credentialing requirements or prior approval requirements are the same as those imposed for a provider that does not provide health care services through telehealth.

[PL 2019, c. 289, §2 (NEW).]

8. Telehealth equipment. A carrier may not require a provider to use specific telecommunications technology and equipment as a condition of coverage under this section as long as the provider uses telecommunications technology and equipment that comply with current industry interoperability standards and that comply with standards required under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated under that Act.

[PL 2019, c. 289, §2 (NEW).]

9. Medicare coverage policy. A carrier may provide coverage for health care services delivered through telehealth that is consistent with the Medicare coverage policy for interprofessional Internet consultations. If a carrier provides coverage consistent with the Medicare coverage policy for interprofessional Internet consultations, the carrier may also provide coverage for interprofessional Internet consultations that are provided by a federally qualified health center or rural health clinic as defined in 42 United States Code, Section 1395x, subsection (aa)(1993).

[PL 2019, c. 649, §4 (NEW).]

10. Network adequacy. The availability of health care services through telehealth may not be considered for the purposes of demonstrating the adequacy of a carrier's network pursuant to section 4303, subsection 1 and Bureau of Insurance Rule Chapter 850: Health Plan Accountability.
[PL 2021, c. 291, Pt. A, §8 (NEW).]

SECTION HISTORY

PL 2009, c. 169, §1 (NEW). PL 2019, c. 289, §2 (RPR). PL 2019, c. 649, §§3, 4 (AMD). RR 2019, c. 2, Pt. A, §28 (COR). PL 2021, c. 291, Pt. A, §§4-8 (AMD). PL 2021, c. 293, Pt. A, §29 (AMD).

§4317. Pharmacy providers

1. Contracts with pharmacy providers. Notwithstanding section 2672, section 4307, subsection 3 and Title 32, chapter 117, subchapter 8, a carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers.

This subsection may not be construed to limit a carrier's ability to offer an enrollee incentives, including variations in premiums, deductibles, copayments or coinsurance or variations in the quantities of medications available to the enrollee, to encourage the use of certain preferred pharmacy providers as long as the carrier makes the terms applicable to the preferred pharmacy providers available to all pharmacy providers. For purposes of this subsection, a preferred pharmacy provider is any pharmacy willing to meet the specified terms, conditions and price that the carrier may require for its preferred pharmacy providers.
[PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

2. Prompt payment of claims. Notwithstanding section 2436, the following provisions apply to the payment of claims submitted to a carrier by a pharmacy provider.

A. For purposes of this subsection, the following terms have the following meanings.

(1) "Applicable number of calendar days" means:

(a) With respect to claims submitted electronically, 21 days; and

(b) With respect to claims submitted otherwise, 30 days.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

B. A contract entered into by a carrier with a pharmacy provider with respect to a prescription drug plan offered by a carrier must provide that payment is issued, mailed or otherwise transmitted with respect to all clean claims submitted by a pharmacy provider, other than a pharmacy that dispenses drugs by mail order only or a pharmacy located in, or under contract with, a long-term care facility, within the applicable number of calendar days after the date on which the claim is received. For purposes of this subsection, a claim is considered to have been received:

(1) With respect to claims submitted electronically, on the date on which the claim is transferred; and

(2) With respect to claims submitted otherwise, on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission of the claim. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

C. If payment is not issued, mailed or otherwise transmitted by the carrier within the applicable number of calendar days after a clean claim is received, the carrier shall pay interest to the pharmacy

provider at the rate of 18% per annum. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

D. A claim is considered to be a clean claim if the carrier involved does not provide notice to the pharmacy provider of any deficiency in the claim within 10 days after the date on which an electronically submitted claim is received or within 15 days after the date on which a claim submitted otherwise is received. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

E. If a carrier determines that a submitted claim is not a clean claim, the carrier shall immediately notify the pharmacy provider of the determination. The notice must specify all defects or improprieties in the claim and list all additional information or documents necessary for the proper processing and payment of the claim. If a pharmacy provider receives notice from a carrier that a claim has been determined to not be a clean claim, the pharmacy provider shall take steps to correct that claim and then resubmit the claim to the carrier for payment. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

F. A claim resubmitted to a carrier with additional information pursuant to paragraph E is considered to be a clean claim if the carrier does not provide notice to the pharmacy provider of any defect or impropriety in the claim within 10 days of the date on which additional information is received if the claim is resubmitted electronically or within 15 days of the date on which additional information is received if the claim is resubmitted otherwise. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

G. A claim submitted to a carrier that is not paid by the carrier or contested by the plan sponsor within the applicable number of calendar days after the date on which the claim is received by the carrier is considered to be a clean claim and must be paid by the carrier. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

H. Payment of a clean claim under this subsection is considered to have been made on the date on which the payment is transferred with respect to claims paid electronically and on the date on which the payment is submitted to the United States Postal Service or common carrier for delivery with respect to claims paid otherwise. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

I. A carrier shall pay all clean claims submitted electronically by electronic transfer of funds if the pharmacy provider so requests or has so requested previously. In the case when the payment is made electronically, remittance may be made by the carrier electronically. [PL 2009, c. 519, §1 (NEW); PL 2009, c. 519, §2 (AFF).]

J. For a contract entered into or renewed on or after January 1, 2021, the contract entered into by a carrier with a pharmacy provider with respect to a prescription drug plan offered by a carrier may not contain a provision that purports to directly or indirectly charge the pharmacy provider or hold the pharmacy provider responsible for any fee related to a clean claim:

(1) That is not apparent at the time the carrier processes the claim;

(2) That is not reported on the remittance advice of a claim adjudicated by the carrier; or

(3) After the initial claim is adjudicated by the carrier. [PL 2019, c. 643, §1 (NEW).]

For purposes of this subsection, a contract entered into by a carrier with a pharmacy provider with respect to a prescription drug plan offered by a carrier includes any contract with respect to a prescription drug plan offered by the carrier under which a pharmacy provider is legally obligated, either directly or through an intermediary.
[PL 2019, c. 643, §1 (AMD).]

3. Exception. Subsections 1 and 2 do not apply to any medical assistance or public health programs administered by the Department of Health and Human Services, including, but not limited to, the Medicaid program and the elderly low-cost drug program under Title 22, section 254-D.

[PL 2011, c. 443, §5 (AMD).]

4. Participation in contracts. A pharmacy benefits manager may not require a pharmacist or pharmacy to participate in one network in order to participate in another network. The pharmacy benefits manager may not exclude an otherwise qualified pharmacist or pharmacy from participation in one network solely because the pharmacist or pharmacy declined to participate in another network managed by the pharmacy benefits manager.
[PL 2011, c. 443, §6 (NEW).]

5. Prohibition. The written contract between a carrier and a pharmacy benefits manager may not provide that the pharmacist or pharmacy is responsible for the actions of the insurer or a pharmacy benefits manager.
[PL 2011, c. 443, §6 (NEW).]

6. Pharmacy benefits manager duties. All contracts must provide that, when the pharmacy benefits manager receives payment for the services of a pharmacist or pharmacy, the pharmacy benefits manager shall distribute the funds in accordance with the time frames provided in this subchapter.
[PL 2011, c. 691, Pt. A, §23 (AMD).]

7. Complaints, grievances and appeals. A pharmacy benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy solely as a result of the pharmacist's or pharmacy's filing of a complaint, grievance or appeal. This subsection is not intended to restrict the pharmacy's and pharmacy benefits manager's ability to enter into agreements that allow for mutual termination without cause.
[PL 2011, c. 443, §6 (NEW).]

8. Denial or limitation of benefits. A pharmacy's benefits manager may not terminate the contract of or penalize a pharmacist or pharmacy for expressing disagreement with a carrier's decision to deny or limit benefits to an enrollee or because the pharmacist or pharmacy assists the enrollee to seek reconsideration of the carrier's decision or because the pharmacist or pharmacy discusses alternative medications.
[PL 2011, c. 443, §6 (NEW).]

9. Written notice required. At least 60 days before a pharmacy's benefits manager terminates a pharmacy's or pharmacist's participation in the pharmacy benefits manager's plan or network, the pharmacy benefits manager shall give the pharmacy or pharmacist a written explanation of the reason for the termination, unless the termination is based on:

A. The loss of the pharmacy's license or the pharmacist's license to practice pharmacy or cancellation of professional liability insurance; or [PL 2011, c. 443, §6 (NEW).]

B. A finding of fraud. [PL 2011, c. 443, §6 (NEW).]

At least 60 days before a pharmacy or pharmacist terminates its participation in a pharmacy benefits manager's plan or network, the pharmacy or pharmacist shall give the pharmacy benefits manager a written explanation of the reason for the termination.
[PL 2011, c. 443, §6 (NEW).]

10. Audits. Notwithstanding any other provision of law, when an on-site audit of the records of a pharmacy is conducted by a pharmacy benefits manager, the audit must be conducted in accordance with the following criteria.

A. A finding of overpayment or underpayment must be based on the actual overpayment or underpayment and not a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs, unless the projected overpayment or denial is a part of a settlement agreed to by the pharmacy or pharmacist. [PL 2011, c. 443, §6 (NEW).]

B. The auditor may not use extrapolation in calculating recoupments or penalties. [PL 2011, c. 443, §6 (NEW).]

C. Any audit that involves clinical or professional judgment must be conducted by or in consultation with a pharmacist. [PL 2011, c. 443, §6 (NEW).]

D. Each entity conducting an audit shall establish an appeals process under which a pharmacy may appeal an unfavorable preliminary audit report to the entity. [PL 2011, c. 443, §6 (NEW).]

E. This subsection does not apply to any audit, review or investigation that is initiated based on or involves suspected or alleged fraud, willful misrepresentation or abuse. [PL 2011, c. 443, §6 (NEW).]

F. Prior to an audit, the entity conducting an audit shall give the pharmacy 10 days' advance written notice of the audit and the range of prescription numbers and the range of dates included in the audit. [PL 2013, c. 71, §1 (NEW).]

G. A pharmacy has the right to request mediation by a private mediator, agreed upon by the pharmacy and the pharmacy benefits manager, to resolve any disagreements. A request for mediation does not waive any existing rights of appeal available to a pharmacy under this subsection or subsection 11. [PL 2013, c. 71, §1 (NEW).]

H. The requirements of section 4303, subsection 10 apply to claims audited under this subsection. [PL 2013, c. 71, §1 (NEW).]

[PL 2013, c. 71, §1 (AMD).]

11. Audit information and reports. A preliminary audit report must be delivered to the pharmacy within 60 days after the conclusion of the audit under subsection 10. A pharmacy must be allowed at least 30 days following receipt of the preliminary audit to provide documentation to address any discrepancy found in the audit. A final audit report must be delivered to the pharmacy within 90 days after receipt of the preliminary audit report or final appeal, whichever is later. A charge-back, recoupment or other penalty may not be assessed until the appeal process provided by the pharmacy benefits manager has been exhausted and the final report issued. Except as provided by state or federal law, audit information may not be shared. Auditors may have access only to previous audit reports on a particular pharmacy conducted by that same entity.

[PL 2011, c. 443, §6 (NEW).]

12. Maximum allowable cost.

[PL 2019, c. 469, §6 (RP); PL 2019, c. 469, §9 (AFF).]

13. Prohibition on excessive copayments or charges; disclosure not penalized.

[PL 2019, c. 469, §7 (RP); PL 2019, c. 469, §9 (AFF).]

REVISOR'S NOTE: §4317. Prohibition against maximum aggregate benefit provisions (As enacted by PL 2009, c. 588, §1 and affected by §3 is REALLOCATED TO TITLE 24-A, SECTION 4318)

SECTION HISTORY

RR 2009, c. 2, §70 (RAL). PL 2009, c. 519, §1 (NEW). PL 2009, c. 519, §2 (AFF). PL 2009, c. 588, §1 (NEW). PL 2009, c. 588, §3 (AFF). PL 2011, c. 443, §§5, 6 (AMD). PL 2011, c. 691, Pt. A, §23 (AMD). PL 2013, c. 71, §1 (AMD). PL 2015, c. 450, §1 (AMD). PL 2017, c. 44, §1 (AMD). PL 2019, c. 469, §§6, 7 (AMD). PL 2019, c. 469, §9 (AFF). PL 2019, c. 643, §1 (AMD).

§4317-A. Prescription drug coverage; out-of-pocket expenses for coinsurance

1. Out-of-pocket expenses for coinsurance within health plan's total limit. If a carrier that provides coverage for prescription drugs does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits provided under a health plan, the carrier shall establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to

coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

2. Adjustment of out-of-pocket limits. A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B.
[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

3. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in accordance with this chapter.
[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

4. Terms consistent with federal law. For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
[PL 2011, c. 611, §1 (NEW); PL 2011, c. 611, §2 (AFF).]

SECTION HISTORY

PL 2011, c. 611, §1 (NEW). PL 2011, c. 611, §2 (AFF).

§4317-B. Orally administered cancer therapy

1. Coverage. A carrier that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section.
[PL 2013, c. 449, §1 (NEW); PL 2013, c. 449, §2 (AFF).]

2. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication.
[PL 2013, c. 449, §1 (NEW); PL 2013, c. 449, §2 (AFF).]

SECTION HISTORY

PL 2013, c. 449, §1 (NEW). PL 2013, c. 449, §2 (AFF).

§4317-C. Coverage for prescription insulin drugs; limit on out-of-pocket costs

1. Definition. As used in this section, "insulin" has the same meaning as in Title 32, section 13786-D, subsection 1, paragraph A.
[PL 2019, c. 666, Pt. A, §1 (NEW).]

2. Limit on out-of-pocket costs. A carrier that provides coverage for prescription insulin drugs may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for that coverage that results in out-of-pocket costs to the enrollee that exceed $35 per prescription for a 30-day supply of covered prescription insulin drugs, regardless of the amount of insulin needed to fill the enrollee's insulin prescriptions.
[PL 2019, c. 666, Pt. A, §1 (NEW).]

3. Other cost sharing. This section does not prevent a carrier from setting an enrollee's cost-sharing requirement for one or more insulin drugs at an amount lower than the maximum amount specified in this section.
[PL 2019, c. 666, Pt. A, §1 (NEW).]

4. Rules. The superintendent may adopt rules to implement and administer this section to align with applicable federal requirements. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2019, c. 666, Pt. A, §1 (NEW).]

SECTION HISTORY

PL 2019, c. 666, Pt. A, §1 (NEW).

§4317-D. Coverage of HIV prevention drugs

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "CDC guidelines" means guidelines related to the nonoccupational exposure to potential HIV infection, or any subsequent guidelines, published by the federal Department of Health and Human Services, Centers for Disease Control and Prevention. [PL 2021, c. 265, §4 (NEW).]

B. "HIV prevention drug" means a preexposure prophylaxis drug, post-exposure prophylaxis drug or other drug approved for the prevention of HIV infection by the federal Food and Drug Administration. [PL 2021, c. 265, §4 (NEW).]

C. "Post-exposure prophylaxis drug" means a drug or drug combination that meets the clinical eligibility recommendations provided in CDC guidelines following potential exposure to HIV infection. [PL 2021, c. 265, §4 (NEW).]

D. "Preexposure prophylaxis drug" means a drug or drug combination that meets the clinical eligibility recommendations provided in CDC guidelines to prevent HIV infection. [PL 2021, c. 265, §4 (NEW).]
[PL 2021, c. 265, §4 (NEW).]

2. Coverage required. A carrier offering a health plan in this State shall provide coverage for an HIV prevention drug that has been prescribed by a provider. Coverage under this section is subject to the following.

A. If the federal Food and Drug Administration has approved one or more HIV prevention drugs that use the same method of administration, a carrier is not required to cover all approved drugs as long as the carrier covers at least one approved drug for each method of administration with no out-of-pocket cost. [PL 2021, c. 265, §4 (NEW).]

B. A carrier is not required to cover any preexposure prophylaxis drug or post-exposure prophylaxis drug dispensed or administered by an out-of-network pharmacy provider unless the enrollee's health plan provides an out-of-network pharmacy benefit. [PL 2021, c. 265, §4 (NEW).]

C. A carrier may not prohibit, or permit a pharmacy benefits manager to prohibit, a pharmacy provider from dispensing or administering any HIV prevention drugs. [PL 2021, c. 265, §4 (NEW).]
[PL 2021, c. 265, §4 (NEW).]

3. Limits on prior authorization and step therapy requirements. Notwithstanding any requirements in section 4304 or 4320-N to the contrary, a carrier may not subject any HIV prevention drug to any prior authorization or step therapy requirement except as provided in this subsection. If the federal Food and Drug Administration has approved one or more methods of administering HIV

prevention drugs, a carrier is not required to cover all of the approved drugs without prior authorization or step therapy requirements as long as the carrier covers at least one approved drug for each method of administration without prior authorization or step therapy requirements. If prior authorization or step therapy requirements are met for a particular enrollee with regard to a particular HIV prevention drug, the carrier is required to cover that drug with no out-of-pocket cost to the enrollee.
[PL 2021, c. 265, §4 (NEW).]

4. Coverage for laboratory testing related to HIV prevention drugs. A carrier offering a health plan in this State shall provide coverage with no out-of-pocket cost for laboratory testing recommended by a provider related to the ongoing monitoring of an enrollee who is taking an HIV prevention drug covered by this section.
[PL 2021, c. 265, §4 (NEW).]

SECTION HISTORY

PL 2021, c. 265, §4 (NEW).

§4317-E. Coverage for emergency supply of chronic maintenance drugs

1. Definition. As used in this section, unless the context otherwise indicates, "chronic maintenance drug" has the same meaning as in Title 32, section 13786-F, subsection 1.
[PL 2021, c. 566, §1 (NEW).]

2. Coverage required. A carrier offering a health plan in this State must make available coverage for an emergency supply of a chronic maintenance drug dispensed pursuant to Title 32, section 13786-F in the same manner as coverage for other drugs under the health plan. A carrier may impose any deductible, copayment, coinsurance or other cost-sharing requirement for the chronic maintenance drug as long as the amount of the deductible, copayment, coinsurance or other cost-sharing requirement is applied in the same manner as if the chronic maintenance drug were dispensed as prescribed by a provider.
[PL 2021, c. 566, §1 (NEW).]

3. Application. This section does not apply to a health plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2).
[PL 2021, c. 566, §1 (NEW).]

SECTION HISTORY

PL 2021, c. 566, §1 (NEW).

§4318. Prohibition against maximum aggregate benefit provisions

(REALLOCATED FROM TITLE 24-A, SECTION 4317)

(REPEALED)

SECTION HISTORY

RR 2009, c. 2, §70 (RAL). PL 2011, c. 364, §33 (AMD). PL 2019, c. 5, Pt. A, §22 (RP).

§4318-A. Comparable health care service incentive program

Beginning January 1, 2019, a carrier offering a health plan in this State shall establish, at a minimum, for all small group health plans as defined in section 2808-B, subsection 1, paragraph G compatible with a health savings account authorized under federal law, a health plan design in which enrollees are directly incentivized to shop for low-cost, high-quality participating providers for comparable health care services. Incentives may include, but are not limited to, cash payments, gift cards or credits or reductions of premiums, copayments or deductibles. A small group health plan

design created under this section must remain available to enrollees for at least 2 consecutive years, except that any changes made to the program after 2 years, including, but not limited to, ending the incentive, may not be construed as a change to the small group health plan design for the purpose of guaranteed renewability under section 2808-B, subsection 4 or section 2850-B. A multiple-employer welfare arrangement is not considered a carrier for the purposes of this section. [PL 2017, c. 232, §8 (NEW).]

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Comparable health care service" means nonemergency, outpatient health care services in the following categories:

(1) Physical and occupational therapy services;

(2) Radiology and imaging services;

(3) Laboratory services; and

(4) Infusion therapy services. [PL 2017, c. 232, §8 (NEW).]

B. "Program" means the comparable health care service incentive program established by a carrier pursuant to this section. [PL 2017, c. 232, §8 (NEW).]

[PL 2017, c. 232, §8 (NEW).]

2. Filing with superintendent. Plans filed with the superintendent pursuant to this section must disclose, in the summary of benefits and explanation of coverage, a detailed description of the incentives available to a plan enrollee. The description must clearly detail any incentives that may be earned by the enrollee, including any limits on such incentives, the actions that must be taken in order to earn such incentives and a list of the types of services that qualify under the program. This subsection may not be construed to prevent a carrier from directing an enrollee to the carrier's website or toll-free telephone number for further information on the program in the summary of benefits and explanation of coverage. The superintendent shall review the filing made by the carrier to determine if the carrier's program complies with the requirements of this section.
[PL 2017, c. 232, §8 (NEW).]

3. Availability of program; notice to enrollees. Annually at enrollment or renewal, a carrier shall provide notice about the availability of the program to an enrollee who is enrolled in a health plan eligible for the program as required by section 4302, subsection 1, paragraph M.
[PL 2017, c. 232, §8 (NEW).]

4. Additional types of nonemergency health care services or procedures. Nothing in this section precludes a carrier from including additional types of nonemergency health care services or procedures in its program.
[PL 2017, c. 232, §8 (NEW).]

5. No administrative expense. An incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.
[PL 2017, c. 232, §8 (NEW).]

6. Study and evaluation. Beginning March 1, 2020 and annually thereafter, the superintendent shall undertake a study and evaluation of the programs created by carriers as required by this section. The superintendent may request information on enrollment and use of incentives earned by enrollees of a carrier as necessary. By April 15, 2020 and annually thereafter, the superintendent shall submit an aggregate report relating to the performance of the programs, the use of incentives, the incentives earned by enrollees and the cumulative effect of the programs to the joint standing committee of the Legislature having jurisdiction over health insurance matters.
[PL 2017, c. 232, §8 (NEW).]

7. Rules. The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2017, c. 232, §8 (NEW).]

8. Repeal.
[PL 2023, c. 224, §1 (RP).]

SECTION HISTORY

PL 2017, c. 232, §8 (NEW). PL 2023, c. 224, §1 (AMD).

§4318-B. Access to lower-priced services

1. Services from out-of-network provider; lower prices. Beginning January 1, 2019, if an enrollee covered under a health plan other than a health maintenance organization plan elects to obtain a covered comparable health care service as defined in section 4318-A, subsection 1, paragraph A from an out-of-network provider at a price that is the same or less than the statewide average for the same covered health care service based on data reported on the publicly accessible health care costs website of the Maine Health Data Organization, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's charge and, upon request by the enrollee, shall apply the payments made by the enrollee for that comparable health care service toward the enrollee's deductible and out-of-pocket maximum as specified in the enrollee's health plan as if the health care services had been provided by an in-network provider. A carrier may use the average price paid to a network provider for the covered comparable health care service under the enrollee's health plan in lieu of the statewide average price on the Maine Health Data Organization's publicly accessible website as long as the carrier uses a reasonable method to calculate the average price paid and the information is available to enrollees through a website accessible to the enrollee and a toll-free telephone number that provide, at a minimum, information relating to comparable health care services. The enrollee is responsible for demonstrating to the carrier that payments made by the enrollee to the out-of-network provider should be applied toward the enrollee's deductible or out-of-pocket maximum pursuant to this section. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of making such a demonstration and may require that copies of bills and proof of payment be submitted by the enrollee. For the purposes of this section, "out-of-network provider" means a provider located in Massachusetts, New Hampshire or this State that is enrolled in the MaineCare program and participates in Medicare.
[PL 2017, c. 232, §9 (NEW).]

2. Rules. The superintendent may adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2017, c. 232, §9 (NEW).]

3. Repeal.
[PL 2023, c. 224, §2 (RP).]

SECTION HISTORY

PL 2017, c. 232, §9 (NEW). PL 2023, c. 224, §2 (AMD).

§4319. Rebates

1. Rebates required. Carriers must provide rebates in the large group, small group and individual markets if the medical loss ratio under subsection 2 is less than the minimum medical loss ratio under subsection 3.
[PL 2019, c. 5, Pt. A, §23 (AMD).]

2. Medical loss ratio. For purposes of this section, the medical loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively, plus any credibility adjustment. For the purposes of this subsection:

A. The numerator is the amount expended on reimbursement for clinical services provided to enrollees and activities that improve health care quality; and [PL 2011, c. 90, Pt. D, §5 (NEW).]

B. The denominator is 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. [PL 2011, c. 90, Pt. D, §5 (NEW).]
[PL 2019, c. 5, Pt. A, §23 (AMD).]

3. Minimum medical loss ratio. The minimum medical loss ratio is:

A. In the large group market, 85%; [PL 2011, c. 90, Pt. D, §5 (NEW).]

B. In the small group market, 80%; and [PL 2011, c. 90, Pt. D, §5 (NEW).]

C. In the individual market, 80%. [PL 2019, c. 5, Pt. A, §23 (AMD).]
[PL 2019, c. 5, Pt. A, §23 (AMD).]

4. Rules. The superintendent may adopt rules to implement this section in a substantially similar manner as required under the federal Affordable Care Act in effect as of January 1, 2019, including, but not limited to, rules establishing the period for which the medical loss ratio is calculated. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2019, c. 5, Pt. A, §23 (NEW).]

SECTION HISTORY

PL 2011, c. 90, Pt. D, §5 (NEW). PL 2019, c. 5, Pt. A, §23 (AMD).

§4319-A. Guaranteed issue

A carrier offering a health plan in this State in the individual, small group or large group market must offer to an individual or group in the State all health plans that are approved for sale in the applicable market and must accept any individual or group that applies for any of those health plans in accordance with the requirements of section 2736-C, subsection 3 and section 2808-B, subsection 4 and section 2850-B. [PL 2019, c. 5, Pt. A, §24 (NEW).]

SECTION HISTORY

PL 2019, c. 5, Pt. A, §24 (NEW).

§4319-B. Medical loss ratio reporting for dental insurance plans

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dental plan" means a plan providing dental care services to an enrollee who is insured by a carrier. "Dental plan" does not include:

(1) A health plan with embedded dental benefits offered by a carrier;

(2) A self-funded employer group health or dental plan, including the group health plan or dental plan provided pursuant to Title 5, section 285 if that health plan or dental plan is self-funded in any given year; or

(3) A plan providing dental care services determined by the superintendent to be a noncredible plan. [PL 2021, c. 529, §1 (NEW).]

B. Notwithstanding section 4301-A, subsection 5, "enrollee" means an individual who is enrolled in an individual or group dental plan. [PL 2021, c. 529, §1 (NEW).]

[PL 2021, c. 529, §1 (NEW).]

2. Dental loss ratio defined. For purposes of this section, the dental loss ratio is the ratio of the numerator to the denominator as described in paragraphs A and B, respectively. For purposes of this subsection:

A. The numerator is the sum of:

(1) The amount expended for clinical dental services provided to enrollees as defined in rule in accordance with subsection 3;

(2) The amount expended on activities that improve dental care quality as defined in rule in accordance with subsection 4; and

(3) The amount of claims payments identified through fraud reduction efforts; and [PL 2021, c. 529, §1 (NEW).]

B. The denominator is the total amount of premium revenue, excluding federal and state taxes and licensing and regulatory fees paid and after accounting for any payments pursuant to federal law. [PL 2021, c. 529, §1 (NEW).]

The numerator described in paragraph A may not include administrative cost expenditures as defined in rule in accordance with subsection 5.
[PL 2021, c. 529, §1 (NEW).]

3. Expenditures for clinical dental services. The superintendent shall define "clinical dental services" in rule to be consistent with similar expenditures for clinical services used for reporting of medical loss ratio by carriers offering health plans in the State.
[PL 2021, c. 529, §1 (NEW).]

4. Activities that improve dental care quality. The superintendent shall define "activities that improve dental care quality" in rule to be consistent with similar activities related to quality that are permitted for reporting of medical loss ratio by carriers offering health plans in this State such as case management; oral health assessments; identifying and addressing ethnic, cultural or racial disparities in effectiveness of best clinical practices and evidence-based medicine; quality reporting; and health information technology.
[PL 2021, c. 529, §1 (NEW).]

5. Administrative cost expenditures. The superintendent shall define "administrative cost expenditures" in rule to be consistent with similar cost expenditures used for reporting of medical loss ratio by carriers offering health plans in the State such as financial administrative expenses, marketing and sales expenses, commissions, distribution expenses, claims operations expenses, utilization review expenses, network operations expenses, charitable expenses, board, bureau or association fees and payroll expenses.
[PL 2021, c. 529, §1 (NEW).]

6. Dental loss ratio reporting. Beginning in 2023, on or before July 31st annually, a carrier offering a dental plan in effect during the preceding calendar year shall file a report with the bureau of the carrier's dental loss ratio for the preceding calendar year organized by market segment according to guidance issued by the superintendent.

A. Within 90 days of receiving any report required under this subsection, the superintendent shall post the report on the bureau's publicly accessible website. [PL 2021, c. 529, §1 (NEW).]

B. If verification of information contained in a report filed under this subsection is necessary, the carrier has 30 days to submit any information required by the superintendent. [PL 2021, c. 529, §1 (NEW).]

C. For the initial report filed by a carrier on or before July 31, 2023, the carrier shall include dental loss ratio information for calendar years 2020 and 2021 in addition to information for calendar year 2022. [PL 2021, c. 529, §1 (NEW).]

[PL 2021, c. 529, §1 (NEW).]

7. Average dental loss ratio; identifying dental plans with dental loss ratio deviating from average. The superintendent shall aggregate the dental loss ratio reports filed by each carrier pursuant to subsection 6 by market segment. The superintendent shall calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period, including data for the dental loss ratio reporting year that is being reported and the data for the 2 prior dental loss ratio reporting years, and identify as outliers dental plans that fall outside 2 standard deviations of the average dental loss ratio. If the average dental loss ratio in a market segment declines over time, the superintendent may identify as outliers dental plans that fall outside one standard deviation of the average dental loss ratio or establish by rule a minimum average dental loss ratio for use in calculating outliers.

[PL 2021, c. 529, §1 (NEW).]

8. Authority for review. For those dental plans identified as outliers in accordance with subsection 7, the superintendent shall conduct a review and require the carrier of a dental plan identified as an outlier to submit additional relevant financial information as requested by the superintendent. The superintendent may require the carrier to submit a remediation plan including but not limited to measures such as rate revisions or benefit modifications. Any action taken by the superintendent pursuant to this subsection is limited to the dental plans identified as outliers.

[PL 2021, c. 529, §1 (NEW).]

9. Rules. The superintendent may adopt rules to implement this section, including development of a common reporting form. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2021, c. 529, §1 (NEW).]

SECTION HISTORY

PL 2021, c. 529, §1 (NEW).

§4320. No lifetime or annual limits on health plans

A carrier offering a health plan in the individual, small group or large group market, as those markets are defined under applicable federal law, may not: [PL 2019, c. 5, Pt. A, §25 (AMD).]

1. Establish lifetime limits. Establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or

[PL 2011, c. 364, §34 (NEW).]

2. Establish annual limits. Establish annual limits on the dollar value of essential benefits.

[PL 2019, c. 5, Pt. A, §25 (AMD).]

3. Application. This section applies to health plans offered or renewed in this State in the individual, small group and large group markets, as those markets are defined under applicable federal law. A health plan may contain annual dollar limits to the extent allowed under the federal Affordable Care Act as of January 1, 2019 if the plan has been continuously renewed since that date, but the plan may not impose any new limits or reduce any existing limit in effect as of January 1, 2019.

[PL 2019, c. 5, Pt. A, §25 (NEW).]

REVISOR'S NOTE: §4320. Payment reform pilot projects (As enacted by PL 2011, c. 270, §2 is REALLOCATED TO TITLE 24-A, SECTION 4320-H)

SECTION HISTORY

RR 2011, c. 1, §43 (RAL). PL 2011, c. 270, §2 (NEW). PL 2011, c. 364, §34 (NEW). PL 2019, c. 5, Pt. A, §25 (AMD).

§4320-A. Coverage of preventive and primary health services

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State shall, at a minimum, provide coverage for and may not impose cost-sharing requirements for preventive and primary health services as required by this section. [PL 2019, c. 653, Pt. C, §1 (AMD).]

1. Preventive services. A health plan must, at a minimum, provide coverage for:

A. The evidence-based items or services that have a rating of A or B in the recommendations of the United States Preventive Services Task Force or equivalent rating from a successor organization; [PL 2017, c. 343, §1 (NEW).]

B. With respect to the individual insured, immunizations that have a recommendation from the federal Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices and that are consistent with the recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians or the American College of Obstetricians and Gynecologists or a successor organization; [PL 2017, c. 343, §1 (NEW).]

C. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration that are consistent with the recommendations of the American Academy of Pediatrics or a successor organization; and [PL 2017, c. 343, §1 (NEW).]

D. With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal Department of Health and Human Services, Health Resources and Services Administration women's preventive services guidelines that are consistent with the recommendations of the American College of Obstetricians and Gynecologists women's preventive services initiative. [PL 2017, c. 343, §1 (NEW).]

[PL 2017, c. 343, §1 (NEW).]

2. Change in recommendations. If a recommendation described in subsection 1 is changed during a health plan year, a carrier is not required to make changes to that health plan during the plan year.

[PL 2017, c. 343, §1 (NEW).]

3. Primary health services. An individual or small group health plan with an effective date from January 1, 2021 to December 31, 2022 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copayments for the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year count toward the deductible. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent shall conduct a study analyzing the effects of this subsection on premiums based on experience in plan years 2020 and 2021. The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2021, c. 638, §1 (AMD).]

3-A. Parity in cost sharing for primary care and behavioral health office visits; individual or small group health plan. An individual or small group health plan with an effective date on or after

January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year and may not apply a deductible or coinsurance to the 2nd or 3rd primary care and 2nd or 3rd behavioral health office visits in a plan year. Any copayments for primary care office visits and behavioral health office visits in a plan year count toward the deductible. After the first behavioral health office visit, a health plan may not apply a copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 638, §2 (NEW).]

3-B. Parity in cost sharing for primary care and behavioral health office visits; group health plan. A group health plan, other than a small group health plan subject to subsection 3-A, with an effective date on or after January 1, 2023 must provide coverage without cost sharing for the first primary care office visit and first behavioral health office visit in each plan year. After the first behavioral health office visit, a health plan may not apply a copayment amount to a behavioral health office visit that is greater than the copayment for a primary care office visit. For the purposes of this subsection, "behavioral health office visit" means an office visit to address mental health and substance use conditions. This subsection does not apply to a plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the benefits required by this section are permissible benefits in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2). The superintendent may adopt rules as necessary to address the coordination of the requirements of this subsection for coverage without cost sharing for the first primary care visit and the requirements of this section with respect to coverage of an annual well visit. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 638, §3 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW). PL 2017, c. 343, §1 (AMD). PL 2019, c. 653, Pt. C, §1 (AMD). PL 2021, c. 638, §§1-3 (AMD).

§4320-B. Extension of dependent coverage

A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act, and offer coverage for a dependent child with a disability in accordance with section 4320-R. [PL 2021, c. 520, §7 (AMD).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW). PL 2021, c. 520, §7 (AMD).

§4320-C. Emergency services

If a carrier offering a health plan provides or covers any benefits with respect to services in an emergency facility or setting, the plan must cover emergency services without prior authorization. Cost-sharing requirements, such as a deductible, copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in

network, and any payment made by an enrollee pursuant to this section must be applied to the enrollee's in-network cost-sharing limit. The enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with section 4303-C or, if there is a dispute, in accordance with section 4303-E. A carrier offering a health plan in this State shall also comply with the requirements of section 4304, subsection 5. [PL 2019, c. 668, §4 (AMD).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW). PL 2019, c. 238, §3 (AMD). PL 2019, c. 668, §4 (AMD).

§4320-D. Comprehensive health coverage

Notwithstanding any other requirements of this Title, a carrier offering a health plan in this State shall, at a minimum, provide coverage that incorporates an essential health benefits package consistent with the requirements of this section. [PL 2019, c. 5, Pt. B, §1 (AMD).]

1. Essential health benefits package; definition. As used in this section, "essential health benefits package" means, with respect to any health plan, coverage that:

A. Provides for the essential health benefits in accordance with subsection 2; [PL 2019, c. 5, Pt. B, §1 (NEW).]

B. Limits cost sharing for coverage in accordance with subsection 3; and [PL 2019, c. 5, Pt. B, §1 (NEW).]

C. Provides for levels of coverage in accordance with subsection 4. [PL 2019, c. 5, Pt. B, §1 (NEW).]

[PL 2019, c. 5, Pt. B, §1 (NEW).]

2. Substantially similar to federal Affordable Care Act; required categories. With respect to any individual or small group health plan offered on or after January 1, 2020, a carrier shall provide essential health benefits that are substantially similar to that of the essential health benefits required in this State for a health plan subject to the federal Affordable Care Act as of January 1, 2019. Essential health benefits required for a health plan must include at least the following general categories and the items and services covered within the categories:

A. Ambulatory patient services; [PL 2019, c. 5, Pt. B, §1 (NEW).]

B. Emergency services; [PL 2019, c. 5, Pt. B, §1 (NEW).]

C. Hospitalization; [PL 2019, c. 5, Pt. B, §1 (NEW).]

D. Maternity and newborn care; [PL 2019, c. 5, Pt. B, §1 (NEW).]

E. Mental health and substance use disorder services, including behavioral health treatment; [PL 2019, c. 5, Pt. B, §1 (NEW).]

F. Prescription drugs; [PL 2019, c. 5, Pt. B, §1 (NEW).]

G. Rehabilitative and habilitative services and devices; [PL 2019, c. 5, Pt. B, §1 (NEW).]

H. Laboratory services; [PL 2019, c. 5, Pt. B, §1 (NEW).]

I. Preventive and wellness services and chronic disease management; and [PL 2019, c. 5, Pt. B, §1 (NEW).]

J. Pediatric services, including oral and vision care, to the extent required by the federal Affordable Care Act as of January 1, 2019. [PL 2019, c. 5, Pt. B, §1 (NEW).]

[PL 2019, c. 5, Pt. B, §1 (NEW).]

3. Cost-sharing limitations. With respect to any health plan offered on or after the effective date of this subsection, a carrier shall limit cost sharing on an annual basis in a manner that is consistent with the annual limits established for a health plan subject to the federal Affordable Care Act as of January 1, 2019 and as adjusted by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, or, if the Centers for Medicare and Medicaid Services does not establish annual limits on cost sharing, the superintendent shall adopt rules establishing annual limits on cost sharing under this subsection that are calculated in substantially the same manner as the Centers for Medicare and Medicaid Services calculated the annual limit in the most recent year it calculated the annual limit.
[PL 2019, c. 5, Pt. B, §1 (NEW).]

4. Levels of coverage. Carriers shall offer coverage at levels that are substantially similar to the levels of coverage required for health plans subject to the federal Affordable Care Act as of January 1, 2019. The superintendent may adopt rules defining such levels of coverage. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2019, c. 5, Pt. B, §1 (NEW).]

5. Rule of construction. This section may not be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this section.
[PL 2019, c. 5, Pt. B, §1 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW). PL 2019, c. 5, Pt. B, §1 (AMD).

§4320-E. Reinsurance, risk corridors and risk adjustment

1. Transitional reinsurance program. The superintendent shall establish a transitional reinsurance program for calendar years 2014, 2015 and 2016 as required by Section 1341 of the federal Affordable Care Act.
[PL 2011, c. 364, §34 (NEW).]

2. Risk corridors. A carrier shall make any payments required under the risk corridors program established by the Secretary of the United States Department of Health and Human Services for calendar years 2014, 2015 and 2016 as required by Section 1342 of the federal Affordable Care Act.
[PL 2011, c. 364, §34 (NEW).]

3. Risk adjustment. The superintendent shall establish a risk adjustment program as required by Section 1343 of the federal Affordable Care Act.
[PL 2011, c. 364, §34 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW).

§4320-F. Oversight of plans offered on the American Health Benefit Exchange and the SHOP Exchange

1. Superintendent's authority preserved. Except as otherwise expressly provided by applicable law, the requirements established by this Title, Title 24 and rules adopted by the superintendent continue to apply to carriers and health plans and are not extinguished or modified in any way by:

A. Certification of a health plan as a qualified health plan or any other determination made by the American Health Benefit Exchange or the SHOP Exchange pursuant to the federal Affordable Care Act; or [PL 2011, c. 364, §34 (NEW).]

B. Recognition by the applicable federal agency of a carrier as a qualified nonprofit health insurance issuer or as an issuer of multistate qualified health plans, or of a health plan as a multistate qualified health plan, pursuant to the federal Affordable Care Act. [PL 2011, c. 364, §34 (NEW).]

[PL 2011, c. 364, §34 (NEW).]

2. Coordination with exchanges. The superintendent has all additional powers and duties conferred upon a state insurance regulator with respect to the American Health Benefit Exchange and the SHOP Exchange by the federal Affordable Care Act. The superintendent may enter into agreements with the American Health Benefit Exchange and the SHOP Exchange relating to coordination of responsibilities, and such agreements may provide for the superintendent to assume additional authority relating to the certification of qualified health plans or the authorization of a carrier to participate in the American Health Benefit Exchange or the SHOP Exchange.
[PL 2011, c. 364, §34 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW).

§4320-G. Applicability to health plans grandfathered under the Affordable Care Act

A health plan that is exempt from certain requirements of the federal Affordable Care Act because it has grandfathered status is also exempt, to the same extent, from substantially similar provisions in this Title and Title 24 enacted after January 1, 2011, except to the extent that those provisions state that they apply to grandfathered health plans. [PL 2011, c. 364, §34 (NEW).]

SECTION HISTORY

PL 2011, c. 364, §34 (NEW).

§4320-H. Payment reform pilot projects

(REALLOCATED FROM TITLE 24-A, SECTION 4320)

1. Pilot projects. Beginning March 1, 2012, the superintendent may authorize pilot projects in accordance with this subsection that allow a health insurance carrier that offers health plans in this State to implement payment reform strategies with providers through an accountable care organization to reduce costs and improve the quality of patient care. For purposes of this section, "accountable care organization" means a group of health care providers operating under a payment agreement to provide health care services to a defined set of individuals with established benchmarks for the quality and cost of those health care services consistent with federal law and regulation.

A. The superintendent may approve a pilot project between a carrier and an accountable care organization that utilizes payment methodologies and purchasing strategies, including, but not limited to: alternatives to fee-for-service models, such as blended capitation rates, episodes-of-care payments, medical home models and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies. [RR 2011, c. 1, §43 (RAL).]

B. Prior to approving a pilot project, the superintendent shall consider whether the proposed pilot project is consistent with the principles for payment reform developed by the Advisory Council on Health Systems Development established under former Title 2, section 104. [RR 2011, c. 1, §43 (RAL).]

[RR 2011, c. 1, §43 (RAL).]

2. Rulemaking. The superintendent shall establish by rule procedures and policies that facilitate the implementation of a pilot project pursuant to this section, including, but not limited to, a process for a health insurance carrier's submitting a pilot project proposal and minimum requirements for approval of a pilot project. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A and must be adopted no later than December 1, 2011.
[RR 2011, c. 1, §43 (RAL).]

3. Report. Beginning in 2013, the superintendent shall report by March 1st annually to the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters

on the status of any pilot project approved by the superintendent pursuant to this section. The report must include an analysis of the cost and benefits of any approved pilot project in reducing health care costs, including any impact on premiums, and in improving the quality of care.
[RR 2011, c. 1, §43 (RAL).]

4. Evaluation. During the First Regular Session of the 129th Legislature, the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters shall conduct an evaluation of the effectiveness of any pilot project approved by the superintendent pursuant to this section and make a determination whether to continue, amend or repeal the authorization for the pilot project. The joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out a bill based on the evaluation to the First Regular Session of the 129th Legislature.
[RR 2011, c. 1, §43 (RAL).]

5. Construction. This section may not be construed to restrict or limit the right of a carrier to engage in activities expressly permitted by this Title or to require a carrier to obtain prior approval as a pilot project to engage in those activities.
[RR 2011, c. 1, §43 (RAL).]

SECTION HISTORY

RR 2011, c. 1, §43 (RAL).

§4320-I. Coverage for the cost of testing for bone marrow donation suitability

1. Required coverage. A carrier offering a health plan in this State shall provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The enrollee covered under the health plan must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization; [PL 2013, c. 603, §1 (NEW); PL 2013, c. 603, §2 (AFF).]

B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a; [PL 2013, c. 603, §1 (NEW); PL 2013, c. 603, §2 (AFF).]

C. At the time of the testing, the enrollee covered under the health plan must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; and [PL 2013, c. 603, §1 (NEW); PL 2013, c. 603, §2 (AFF).]

D. The carrier may limit each enrollee to one test per lifetime. [PL 2013, c. 603, §1 (NEW); PL 2013, c. 603, §2 (AFF).]
[PL 2013, c. 603, §1 (NEW); PL 2013, c. 603, §2 (AFF).]

2. Prohibition on cost-sharing. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section.
[PL 2013, c. 603, §1 (NEW); PL 2013, c. 603, §2 (AFF).]

SECTION HISTORY

PL 2013, c. 603, §1 (NEW). PL 2013, c. 603, §2 (AFF).

§4320-J. Coverage for abuse-deterrent opioid analgesic drug products

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse. [PL 2015, c. 371, §1 (NEW); PL 2015, c. 371, §2 (AFF).]

B. "Cost sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense associated with a health plan. [PL 2015, c. 371, §1 (NEW); PL 2015, c. 371, §2 (AFF).]

C. "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form. [PL 2015, c. 371, §1 (NEW); PL 2015, c. 371, §2 (AFF).]
[PL 2015, c. 371, §1 (NEW); PL 2015, c. 371, §2 (AFF).]

2. Required coverage. A carrier offering a health plan in this State shall provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan. An increase in enrollee cost sharing to achieve compliance with this section may not be implemented.
[PL 2015, c. 371, §1 (NEW); PL 2015, c. 371, §2 (AFF).]

SECTION HISTORY

PL 2015, c. 371, §1 (NEW). PL 2015, c. 371, §2 (AFF).

§4320-K. Coverage for services provided by a naturopathic doctor

1. Services provided by a naturopathic doctor. A carrier offering a health plan in this State shall provide coverage for health care services performed by a naturopathic doctor licensed under Title 32, chapter 113-B, subchapter 3 when those services are covered services under the health plan when performed by any other health care provider and when those services are within the lawful scope of practice of the naturopathic doctor.
[PL 2017, c. 340, §1 (NEW).]

2. Limits; deductible; copayment; coinsurance. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided by a naturopathic doctor as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers.
[PL 2017, c. 340, §1 (NEW).]

3. Network participation. A carrier shall demonstrate that the carrier's provider network includes reasonable access, in accordance with section 4303, to all covered services that are within the lawful scope of practice of a naturopathic doctor. A carrier may not exclude a provider from participation in the carrier's provider network solely because the provider is a naturopathic doctor as long as the provider is willing to meet the same terms and conditions as other participating providers. This subsection does not require a carrier to contract with all naturopathic doctors or require a carrier to provide coverage under a health plan for any service provided by a participating naturopathic doctor that is not within the health plan's scope of coverage.
[PL 2017, c. 340, §1 (NEW).]

4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2017, c. 340, §1 (NEW).]

SECTION HISTORY

PL 2017, c. 340, §1 (NEW).

§4320-L. Nondiscrimination

1. Nondiscrimination. An individual may not, on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability, be excluded from participation in, be denied benefits of or otherwise be subjected to discrimination under any health plan offered in accordance with this Title. A carrier may not in offering, providing or administering a health plan:

A. Deny, cancel, limit or refuse to issue or renew a health plan or other health-related coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability; [PL 2019, c. 5, Pt. C, §2 (NEW).]

B. Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability in a health plan or other health-related coverage; [PL 2019, c. 5, Pt. C, §2 (NEW).]

C. Deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available; [PL 2019, c. 5, Pt. C, §2 (NEW).]

D. Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or [PL 2019, c. 5, Pt. C, §2 (NEW).]

E. Otherwise deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual. [PL 2019, c. 5, Pt. C, §2 (NEW).]

Nothing in this subsection is intended to determine or restrict a carrier from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.
[PL 2019, c. 5, Pt. C, §2 (NEW).]

2. Meaningful access for individuals with limited English proficiency. A carrier shall take reasonable steps to provide meaningful access to each enrollee or prospective enrollee under a health plan who has limited proficiency in English.
[PL 2019, c. 5, Pt. C, §2 (NEW).]

3. Effective communication for persons with disabilities. A carrier shall take reasonable steps to ensure that communication with an enrollee or prospective enrollee in a health plan who is an individual with a disability is as effective as communication with other enrollees or prospective enrollees.
[PL 2019, c. 5, Pt. C, §2 (NEW).]

SECTION HISTORY

PL 2019, c. 5, Pt. C, §2 (NEW).

§4320-M. Coverage for abortion services

1. Required coverage. A carrier offering a health plan in this State that provides coverage for maternity services shall provide coverage for abortion services for an enrollee in accordance with this section.
[PL 2019, c. 274, §5 (NEW).]

2. Limits; copayment. A health plan that provides coverage for the services required by this section may contain provisions for maximum benefits and reasonable limitations and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.
[PL 2023, c. 347, §1 (AMD).]

2-A. Cost sharing prohibited. Notwithstanding subsection 2, a health plan with an effective date on or after January 1, 2024 may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of abortion services. This subsection does not apply to a health plan offered for use with a health savings account unless the federal Internal Revenue Service determines that the requirements in this subsection are permissible in a high deductible health plan as defined in the federal Internal Revenue Code, Section 223(c)(2).
[PL 2023, c. 347, §2 (NEW).]

3. Application. Except for a religious employer granted an exclusion as provided in subsection 4, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
[PL 2019, c. 274, §5 (NEW).]

4. Exclusion for religious employer. A religious employer may request and a carrier shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective enrollees and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing a carrier to exclude coverage for abortion services that are necessary to preserve the life or health of a covered enrollee. For the purposes of this section, "religious employer" means an employer that is a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121(w)(3)(A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c)(3).
[PL 2019, c. 274, §5 (NEW).]

5. Protection of federal funds. If the superintendent determines enforcement of this section may adversely affect the allocation of federal funds to the State, the superintendent may grant an exemption from the requirements of this section, but only to the minimum extent necessary to ensure the continued receipt of federal funds.
[PL 2019, c. 274, §5 (NEW).]

REVISOR'S NOTE: §4320-M. Step therapy as enacted by PL 2019, c. 295, §1 is REALLOCATED TO TITLE 24-A, SECTION 4320-N

SECTION HISTORY

PL 2019, c. 274, §5 (NEW). PL 2023, c. 347, §§1, 2 (AMD).

§4320-N. Step therapy

(REALLOCATED FROM TITLE 24-A, SECTION 4320-M)

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Clinical practice guidelines" means a systematically developed statement to assist prescriber and enrollee decisions about appropriate health care for specific clinical circumstances and conditions. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

B. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a carrier or utilization review organization to determine the medical necessity and appropriateness of health care services. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

C. "Medically necessary," with respect to health services and supplies, means appropriate, under the applicable standard of care, to improve or preserve health, life or function; to slow the deterioration of health, life or function; or for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

D. "Pharmaceutical sample" means a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

D-1. "Serious mental illness" means a mental disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, that results in serious functional impairment that substantially interferes with or limits one or more major life activities. [PL 2021, c. 345, §2 (NEW).]

E. "Stable on a prescription drug" means, with respect to an enrollee, receiving a positive therapeutic outcome on a prescription drug selected by the enrollee's health care provider for the enrollee's medical condition. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

F. "Step therapy override exception determination" means a determination based on a review of an enrollee's or prescriber's request for an override, along with supporting rationale and documentation, that the step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

G. "Step therapy protocol" means a protocol that establishes a specific sequence in which prescription drugs for a specified medical condition are medically necessary for a particular enrollee and are covered under a pharmacy or medical benefit by a carrier, including self-administered and physician-administered drugs. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

H. "Utilization review organization" means an entity that conducts a utilization review, other than a carrier performing a utilization review for its own health benefit plans. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

[PL 2021, c. 345, §2 (AMD).]

2. Clinical review criteria. Clinical review criteria used to establish a step therapy protocol must be based on clinical practice guidelines that:

A. Recommend that the prescription drugs be taken in the specific sequence required by the step therapy protocol; [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

B. Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

(1) Requiring members to disclose any potential conflicts of interest with entities, including carriers and pharmaceutical manufacturers, and recuse themselves from voting if they have a conflict of interest;

(2) Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

(3) Offering opportunities for public review and comments; [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

C. Are based on high-quality studies, research and medical practice; [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

D. Are created by an explicit and transparent process that:

(1) Minimizes biases and conflicts of interest;

(2) Explains the relationship between treatment options and outcomes;

(3) Rates the quality of the evidence supporting recommendations; and

(4) Considers relevant patient subgroups and preferences; and [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

E. Are continually updated through a review of new evidence, research and newly developed treatments. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

[PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

3. Absence of clinical practice guidelines. In the absence of clinical practice guidelines that meet the requirements in subsection 2, peer-reviewed publications may be substituted.
[PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

4. Consideration of atypical populations and diagnoses. When establishing a step therapy protocol, a utilization review organization shall also take into account the needs of atypical patient populations and diagnoses when establishing clinical review criteria.
[PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

5. Construction. This section may not be construed to require carriers or the State to set up a new entity to develop clinical review criteria used for step therapy protocols.
[PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

6. Exceptions process. When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a carrier or utilization review organization through the use of a step therapy protocol, the enrollee and prescriber must have access to a clear, readily accessible and convenient process to request a step therapy override exception determination from that carrier or utilization review organization.

A. A carrier or utilization review organization may use its existing medical exceptions process to provide step therapy override exception determinations, and the process established must be easily accessible on the carrier's or utilization review organization's website. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

B. A carrier or utilization review organization shall expeditiously grant a step therapy override exception determination if:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction in or physical or mental harm to the enrollee;

(2) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the enrollee and the known characteristics of the prescription drug regimen;

(3) The enrollee has tried the required prescription drug while under the enrollee's current or previous health insurance or health plan, or another prescription drug in the same

pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse reaction;

(4) The required prescription drug is not in the best interest of the enrollee, based on medical necessity;

(5) The enrollee is stable on a prescription drug selected by the enrollee's health care provider for the medical condition under consideration while on a current or previous health insurance or health plan; or

(6) The prescription drug selected by the enrollee's health care provider is intended to assess or treat the enrollee's serious mental illness.

Nothing in this paragraph may be construed to encourage the use of a pharmaceutical sample for the sole purpose of meeting the requirements for the granting of a step therapy override exception determination. [PL 2021, c. 345, §§3-5 (AMD).]

C. Upon the granting of a step therapy override exception determination, the carrier or utilization review organization shall authorize coverage for the prescription drug prescribed by the prescriber. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

D. A carrier or utilization review organization shall grant or deny a request for a step therapy override exception determination or an appeal of a determination within 72 hours, or 2 business days, whichever is less, after receipt of the request. If exigent circumstances, as described in section 4311, subsection 1-A, paragraph B, exist, a carrier or utilization review organization shall grant or deny the request within 24 hours after receipt of the request. The carrier shall provide coverage for the prescription drug prescribed by the prescriber during the pendency of the request for a step therapy override exception determination or an appeal of a determination. If a carrier or utilization review organization does not grant or deny the request within the time required under this paragraph, the exception or appeal is granted. [RR 2019, c. 1, Pt. A, §26 (RAL); PL 2019, c. 295, §1 (NEW).]

E. An enrollee may appeal a step therapy override exception determination. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

F. This section does not prevent:

(1) A carrier or utilization review organization from requiring an enrollee to try a generic drug, as defined in Title 32, section 13702-A, subsection 14, or an interchangeable biological product, as defined in Title 32, section 13702-A, subsection 14-A, prior to providing coverage for the equivalent brand-name prescription drug; or

(2) A health care provider from prescribing a prescription drug that is determined to be medically necessary. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

[PL 2021, c. 345, §§3-5 (AMD).]

7. Rules. The superintendent may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2019, c. 295, §1 (NEW); RR 2019, c. 1, Pt. A, §26 (RAL).]

SECTION HISTORY

PL 2019, c. 295, §1 (NEW). RR 2019, c. 1, Pt. A, §26 (RAL). PL 2021, c. 345, §§2-5 (AMD).

§4320-O. Coverage for services provided by a physician assistant

1. Services provided by a physician assistant. A carrier offering a health plan in this State shall provide coverage for health care services performed by a physician assistant licensed under Title 32, section 2594-E or 3270-E when those services are covered services under the health plan when

performed by any other health care provider and when those services are within the lawful scope of practice of the physician assistant.
[PL 2019, c. 627, Pt. A, §2 (NEW).]

2. Limits; deductible; copayment; coinsurance. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided by a physician assistant as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers.
[PL 2019, c. 627, Pt. A, §2 (NEW).]

3. Network participation. A carrier shall demonstrate that the carrier's provider network includes reasonable access, in accordance with section 4303, to all covered services that are within the lawful scope of practice of a physician assistant. A carrier may not exclude a provider from participation in the carrier's provider network solely because the provider is a physician assistant as long as the provider is willing to meet the same terms and conditions as other participating providers. This subsection does not require a carrier to contract with all physician assistants or require a carrier to provide coverage under a health plan for any service provided by a participating physician assistant that is not within the health plan's scope of coverage.
[PL 2019, c. 627, Pt. A, §2 (NEW).]

4. Billing. A carrier shall authorize a physician assistant to bill the carrier and receive direct payment for a medically necessary service the physician assistant provides to an enrollee and identify the physician assistant as provider in the billing and claims process for payment of the service. A carrier may not impose on a physician assistant a practice, education or collaboration requirement that is inconsistent with or more restrictive than a requirement of state law or board or agency rules.
[PL 2019, c. 627, Pt. A, §2 (NEW).]

SECTION HISTORY

PL 2019, c. 627, Pt. A, §2 (NEW).

§4320-P. Coverage for health care services for COVID-19

Notwithstanding any requirements of this Title to the contrary, a carrier offering a health plan in this State shall provide, at a minimum, coverage as required by this section for screening, testing and immunization for COVID-19. [PL 2021, c. 28, Pt. A, §3 (NEW).]

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "COVID-19" means the coronavirus disease 2019 resulting from SARS-CoV-2, severe acute respiratory syndrome coronavirus 2, and any virus mutating from that virus. [PL 2021, c. 28, Pt. A, §3 (NEW).]

B. "Surveillance testing program" means a structured program of asymptomatic testing at a community or population level to understand the incidence or prevalence of COVID-19 in a group. "Surveillance testing program" does not include a program of testing that occurs less often than once per month per individual. [PL 2021, c. 28, Pt. A, §3 (NEW).]
[PL 2021, c. 28, Pt. A, §3 (NEW).]

2. Testing. A carrier shall provide coverage for screening and testing for COVID-19 as follows.

A. A carrier shall provide coverage for screening and testing for COVID-19, except when such screening and testing is part of a surveillance testing program. [PL 2021, c. 28, Pt. A, §3 (NEW).]

B. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the costs of COVID-19 screening and testing, including all associated costs of administration. [PL 2021, c. 28, Pt. A, §3 (NEW).]

C. A carrier may not make coverage without cost sharing as required by paragraph B dependent on any prior authorization requirement. [PL 2021, c. 28, Pt. A, §3 (NEW).]

D. A carrier may not make coverage without cost sharing as required by paragraph B dependent on the use of a provider in a carrier's network unless an enrollee is offered screening and testing by a network provider without additional delay and the enrollee chooses instead to obtain screening from an out-of-network provider or to be tested by an out-of-network laboratory. [PL 2021, c. 28, Pt. A, §3 (NEW).]

E. For the purposes of this subsection, with respect to COVID-19 screening and testing rendered by an out-of-network provider, a carrier shall reimburse the out-of-network provider in accordance with section 4303-C, subsection 2, paragraph B. [PL 2021, c. 28, Pt. A, §3 (NEW).]

[PL 2021, c. 28, Pt. A, §3 (NEW).]

3. Immunization; COVID-19 vaccines. A carrier shall provide coverage for COVID-19 vaccines as follows.

A. A carrier shall provide coverage for any COVID-19 vaccine licensed or authorized under an emergency use authorization by the United States Food and Drug Administration that is recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to an enrollee. [PL 2021, c. 28, Pt. A, §3 (NEW).]

B. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement for the cost of COVID-19 vaccines, including all associated costs of administration. [PL 2021, c. 28, Pt. A, §3 (NEW).]

C. A carrier may not make coverage without cost sharing as required by paragraph B dependent on any prior authorization requirement. [PL 2021, c. 28, Pt. A, §3 (NEW).]

D. A carrier may not make coverage without cost sharing as required by paragraph B dependent on the use of a provider in a carrier's network unless an enrollee is offered immunization by a network provider without additional delay and the enrollee chooses instead to obtain immunization from an out-of-network provider. [PL 2021, c. 28, Pt. A, §3 (NEW).]

[PL 2021, c. 28, Pt. A, §3 (NEW).]

4. Rules. The superintendent may adopt rules to implement and administer this section to align with any applicable federal requirements. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2021, c. 28, Pt. A, §3 (NEW).]

REVISOR'S NOTE: §4320-P. Coverage for services provided by a certified registered nurse anesthetist (As enacted by PL 2021, c. 39, §1 is REALLOCATED TO TITLE 24-A, SECTION 4320-Q)

SECTION HISTORY

PL 2021, c. 28, Pt. A, §3 (NEW). PL 2021, c. 39, §1 (NEW).

§4320-Q. Coverage for services provided by a certified registered nurse anesthetist

(REALLOCATED FROM TITLE 24-A, SECTION 4320-P)

1. Services provided by a certified registered nurse anesthetist. A carrier offering a health plan in this State shall provide coverage for health care services performed by a certified registered nurse anesthetist licensed under Title 32, chapter 31 when those services are covered services under the health plan when performed by any other health care provider and when those services are within the lawful scope of practice of the certified registered nurse anesthetist.

[PL 2021, c. 39, §1 (NEW); RR 2021, c. 1, Pt. A, §23 (RAL).]

2. Limits; deductible; copayment; coinsurance. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided by a certified registered nurse anesthetist as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to the same service provided by other health care providers.
[PL 2021, c. 39, §1 (NEW); RR 2021, c. 1, Pt. A, §23 (RAL).]

3. Network participation. A carrier may not prohibit a certified registered nurse anesthetist from participating in the carrier's provider network or billing the carrier directly solely because the provider is a certified registered nurse anesthetist as long as the provider is willing to meet the same terms and conditions as other participating providers. This subsection does not require a carrier to contract with all certified registered nurse anesthetists or require a carrier to provide coverage under a health plan for any service provided by a participating certified registered nurse anesthetist that is not a covered service under the plan.
[PL 2021, c. 39, §1 (NEW); RR 2021, c. 1, Pt. A, §23 (RAL).]

4. Claim submission. Services billed by a certified registered nurse anesthetist must be submitted using the current standardized claim form for professional services approved by the Federal Government and submitted electronically.
[PL 2021, c. 39, §1 (NEW); RR 2021, c. 1, Pt. A, §23 (RAL).]

SECTION HISTORY

PL 2021, c. 39, §1 (NEW). RR 2021, c. 1, Pt. A, §23 (RAL).

§4320-R. Mandatory offer of coverage for certain adults with disabilities

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent child" has the same meaning as in section 4233-B, subsection 1. [PL 2021, c. 520, §8 (NEW).]

B. "Disability" means a physical, mental, intellectual or developmental disability that renders a person incapable of self-sustaining employment. [PL 2021, c. 520, §8 (NEW).]
[PL 2021, c. 520, §8 (NEW).]

2. Offer of coverage. A health plan subject to the requirements of the federal Affordable Care Act that offers coverage for a dependent child must offer such coverage, at the option of the parent, for a dependent child with a disability, regardless of age.
[PL 2021, c. 520, §8 (NEW).]

3. Proof of disability. A parent shall furnish proof of a dependent child's disability to the carrier within 31 days of the dependent child's attainment of the limiting age established in section 4320-B and subsequently as may be required by the carrier, but the carrier may not require proof more frequently than annually after the 2-year period following the dependent child's attainment of the limiting age.
[PL 2021, c. 520, §8 (NEW).]

REVISOR'S NOTE: §4320-R. Implementation of federal mental health parity laws (As enacted by PL 2021, c. 638, §4 is REALLOCATED TO TITLE 24-A, SECTION 4320-T)

SECTION HISTORY

PL 2021, c. 520, §8 (NEW).

§4320-S. Coverage for dental services for cancer patients

1. Required coverage. Except as provided in subsection 2, a carrier offering a health plan in this State shall provide coverage for medically necessary dental procedures in accordance with the following for an enrollee who has been diagnosed with cancer.

A. Coverage must be provided for fluoride treatment and dental procedures that are medically necessary to reduce the risk of infection or eliminate infection or to treat tooth loss or decay in an enrollee prior to beginning cancer treatment, including chemotherapy, biological therapy or radiation therapy treatment. [PL 2021, c. 683, §1 (NEW).]

B. Coverage must be provided for dental procedures that are medically necessary to reduce the risk of infection or eliminate infection or to treat tooth loss or decay that are the direct or indirect result of cancer treatment, including chemotherapy, biological therapy or radiation therapy treatment. [PL 2021, c. 683, §1 (NEW).]

C. Coverage required under this subsection must include coverage for laboratory assessments, medications and treatments. [PL 2021, c. 683, §1 (NEW).]

[PL 2021, c. 683, §1 (NEW).]

2. Routine preventive dental care not required. A carrier is not required to provide coverage for routine preventive dental care, including cleaning and sealants.

[PL 2021, c. 683, §1 (NEW).]

REVISOR'S NOTE: §4320-S. Coverage for fertility services (As enacted by PL 2021, c. 692, §1 is REALLOCATED TO TITLE 24-A, SECTION 4320-U)

SECTION HISTORY

PL 2021, c. 683, §1 (NEW).

§4320-T. Implementation of federal mental health parity laws

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

(WHOLE SECTION TEXT EFFECTIVE UNTIL 4/30/28)

(WHOLE SECTION TEXT REPEALED 4/30/28)

(REALLOCATED FROM TITLE 24-A, SECTION 4320-R)

1. Nonquantitative treatment limitation; definition. For the purposes of this section, "nonquantitative treatment limitation" means a limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment.

[PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

2. Compliance with federal mental health parity laws. A carrier offering a health plan in this State providing health coverage for mental health and substance use disorder services pursuant to sections 2749-C, 2842, 2843, 4234-A and 4320-D and Title 24, sections 2325-A and 2329 must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any amendments to, and any federal guidance or regulations relevant to, that Act, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3).

[PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

3. Implementation of federal mental health parity laws. The superintendent shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any amendments to and federal guidance or regulations relevant to that Act, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3), by:

A. Proactively ensuring compliance by insurers, health maintenance organizations and nonprofit hospital or medical service organizations that execute, deliver, issue for delivery, continue or renew individual policies or individual and group health care contracts; [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

B. Evaluating all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations; [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

C. Performing parity compliance market conduct examinations of carriers that execute, deliver, issue for delivery, continue or renew individual policies or individual and group health care contracts, particularly market conduct examinations that focus on nonquantitative treatment limitations, including, but not limited to, prior authorization, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates and geographic restrictions; and [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

D. Requesting that carriers submit comparative analyses during the form review process demonstrating how they design and apply nonquantitative treatment limitation, both as written and in operation, for mental health and substance use disorder benefits as compared to how they design and apply nonquantitative treatment limitation, as written and in operation, for medical and surgical benefits. [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

The superintendent may adopt rules, as authorized under section 212, as may be necessary to effectuate any provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

4. Reports to superintendent. As part of the report submitted to the superintendent, and subsequently reported by the superintendent to the Legislature, pursuant to section 2749-C, subsection 4, section 2843, subsection 7, section 4234-A, subsection 10 and Title 24, section 2325-A, subsection 8, a carrier shall submit the following information to the superintendent:

A. A description of the process used to develop or select the medically necessary health care criteria for mental health and substance use disorder benefits and the process used to develop or select the medically necessary health care criteria for medical and surgical benefits; [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

B. Identification of all nonquantitative treatment limitations that are applied to mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits. The report must include information demonstrating that each nonquantitative treatment limitation that applies to mental health and substance use disorder benefits also applies to medical and surgical benefits within any classification of benefits; and [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

C. The results of an analysis that demonstrate that for the medically necessary health care criteria described in paragraph A and for each nonquantitative treatment limitation identified in paragraph B, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medically necessary health care criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits. At a minimum, the results of the analysis must:

(1) Identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(2) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

(3) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(4) Identify and describe the comparative analyses, including the results of the analyses, used to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(5) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses in this paragraph indicate that the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, including 45 Code of Federal Regulations, Sections 146.136, 147.136, 147.160 and 156.115(a)(3). [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

Information submitted by a carrier to the superintendent pursuant to this subsection is public information in accordance with section 216, except for information that a carrier requests be designated as confidential and the superintendent has determined is proprietary information. For the purposes of this subsection, "proprietary information" means information that is a trade secret or business or financial information the disclosure of which would impair the competitive position of a carrier or that would result in significant detriment to a carrier if the information were made available to the public. [PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

5. Repeal. This section is repealed April 30, 2028.
[PL 2021, c. 638, §4 (NEW); RR 2021, c. 2, Pt. A, §80 (RAL).]

SECTION HISTORY

PL 2021, c. 638, §4 (NEW). RR 2021, c. 2, Pt. A, §80 (RAL).

§4320-U. Coverage for fertility services

(REALLOCATED FROM TITLE 24-A, SECTION 4320-S)

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Experimental fertility procedure" means a procedure for which the published medical evidence is not sufficient for the American Society for Reproductive Medicine, its successor organization or a comparable organization to regard the procedure as established medical practice. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

B. "Fertility diagnostic care" means procedures, products, medications and services intended to provide information about an individual's fertility, including laboratory assessments and imaging studies. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

C. "Fertility patient" means an individual or couple with infertility, an individual or couple who is at increased risk of transmitting a serious inheritable genetic or chromosomal abnormality to a child or an individual unable to conceive as an individual or with a partner because the individual or couple does not have the necessary gametes for conception. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

D. "Fertility preservation services" means procedures, products, medications and services, intended to preserve fertility, consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine, its successor

organization or a comparable organization for an individual who has a medical or genetic condition or who is expected to undergo treatment that may directly or indirectly cause a risk of impairment of fertility. "Fertility preservation services" includes the procurement and cryopreservation of gametes, embryos and reproductive material and storage from the time of cryopreservation for a period of 5 years. Storage may be offered for a longer period of time. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

E. "Fertility treatment" means procedures, products, medications and services intended to achieve pregnancy that results in a live birth with healthy outcomes and that are provided in a manner consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine, its successor organization or a comparable organization. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

F. "Gamete" means a cell containing a haploid complement of deoxyribonucleic acid that has the potential to form an embryo when combined with another gamete. "Gamete" includes sperm and eggs. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

G. "Infertility" means the presence of a demonstrated condition recognized by a provider as a cause of loss or impairment of fertility or a couple's inability to achieve pregnancy after 12 months of unprotected intercourse when the couple has the necessary gametes for conception, including the loss of a pregnancy occurring within that 12-month period, or after a period of less than 12 months due to a person's age or other factors. Pregnancy resulting in a loss does not cause the time period of trying to achieve a pregnancy to be restarted. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

[PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

2. Required coverage. A carrier offering a health plan in this State shall provide coverage as provided in this subsection and as set forth in rules adopted by the bureau to an enrollee:

A. For fertility diagnostic care; [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

B. For fertility treatment if the enrollee is a fertility patient; and [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

C. For fertility preservation services. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

[PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

3. Limitations on coverage. A health plan that provides coverage for the services required by this section may include reasonable limitations to the extent that these limitations are not inconsistent with the following requirements and rules adopted by the bureau.

A. A carrier may not impose a waiting period. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

B. A carrier may not use any prior diagnosis or prior fertility treatment as a basis for excluding, limiting or otherwise restricting the availability of coverage required by this section. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

C. A carrier may not impose any limitations on coverage for any fertility services based on an enrollee's use of donor gametes, donor embryos or surrogacy. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

D. A carrier may not impose different limitations on coverage for, provide different benefits to or impose different requirements on a class of persons protected under Title 5, chapter 337 than those of other enrollees. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

E. Any limitations imposed by a carrier must be based on an enrollee's medical history and clinical guidelines adopted by the carrier. Any clinical guidelines used by a carrier must be based on current

guidelines developed by the American Society for Reproductive Medicine, its successor organization or a comparable organization, must cite with specificity any data or scientific reference relied upon, must be maintained in written form and must be made available to an enrollee in writing upon request. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

[PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

4. Certain services not required. This section does not require a carrier to provide coverage for:

A. Any experimental fertility procedure; or [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

B. Any nonmedical costs related to donor gametes, donor embryos or surrogacy. [PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

[PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

5. Rules. The superintendent may adopt rules to implement the requirements of this section, including, without limitation, cost-sharing, benefit design and clinical guidelines. In adopting rules under this subsection, the superintendent shall consider the clinical guidelines developed by the American Society for Reproductive Medicine, its successor organization or a comparable organization. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2021, c. 692, §1 (NEW); RR 2021, c. 2, Pt. A, §81 (RAL).]

SECTION HISTORY

PL 2021, c. 692, §1 (NEW). RR 2021, c. 2, Pt. A, §81 (RAL).

§4320-V. Coverage for donor breast milk

1. Required coverage. A carrier offering a health plan in this State shall provide coverage for pasteurized donor breast milk provided to an infant eligible for coverage under the health plan if a physician or physician assistant licensed under Title 32, chapter 36 or 48 or an advanced practice registered nurse licensed under Title 32, chapter 31 signs an order stating that:

A. The infant is medically or physically unable to receive maternal breast milk or participate in breastfeeding or the infant's parent is medically or physically unable to produce maternal breast milk in quantities sufficient for the infant; and [PL 2023, c. 229, §1 (NEW).]

B. The infant:

(1) Was born at a birth weight of less than 1,500 grams;

(2) Has a gastrointestinal anomaly or metabolic or digestive disorder or is recovering from intestinal surgery and the infant's digestive needs require additional support;

(3) Is not appropriately gaining weight or growing;

(4) Has formula intolerance and is experiencing weight loss or difficulty feeding;

(5) Has low blood sugar;

(6) Has congenital heart disease;

(7) Has received or will receive an organ transplant; or

(8) Has another serious medical condition for which donor breast milk is medically necessary. [PL 2023, c. 229, §1 (NEW).]

[PL 2023, c. 229, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 229, §1 (NEW).

SUBCHAPTER 2

CONSUMER HEALTH CARE DIVISION

§4321. Consumer Health Care Division

1. Division established. The Consumer Health Care Division, referred to in this section as the "division," is established within the Bureau of Insurance. The division shall work in coordination with other bureau sections and staff to accomplish the duties set forth in subsection 4.
[PL 1997, c. 792, §3 (NEW).]

2. Director. The Director of the Consumer Health Care Division, referred to in this section as the "director," is the head of the Consumer Health Care Division. The director is appointed by the superintendent and is subject to the approval of the Commissioner of Professional and Financial Regulation. The director is subject to the Civil Service Law.
[PL 2005, c. 294, §23 (AMD).]

3. Staff. The superintendent may hire or assign personnel as determined necessary to perform the duties of the division subject to the approval of the Commissioner of Professional and Financial Regulation and subject to the Civil Service Law. The personnel are supervised by the director in consultation with the superintendent. The qualifications of those personnel must reflect the needs and responsibilities relating to the division's duties under this subchapter.
[PL 1997, c. 792, §3 (NEW).]

4. Duties. The duties of the division include:

A. Providing access to the division through a toll-free number; [PL 1997, c. 792, §3 (NEW).]

B. Providing information to consumers regarding health care plan options and obtaining health care coverage and services. The division may not make any specific recommendations regarding commercially offered products; [PL 1997, c. 792, §3 (NEW).]

C. Assisting enrollees to understand their rights and responsibilities under health care plans; [PL 1997, c. 792, §3 (NEW).]

D. Providing information to consumers on health care plan performance by distributing materials and utilizing existing resources relating to health care plan performance; [PL 1997, c. 792, §3 (NEW).]

E. Providing assistance to enrollees with complaints relating to health care plans, when appropriate. The division may assist enrollees with quality-of-care complaints by coordinating with the appropriate state health professional licensing boards and other appropriate state and federal oversight bodies with authority over quality-of-care complaints. The division shall defer any issues of professional competence to the appropriate state health professional licensing boards; [PL 1997, c. 792, §3 (NEW).]

F. Collecting and disseminating information regarding health care plans, quality assurance programs and quality improvement and coordinating information with other public entities or agencies involved in the delivery, funding or regulation of health care; [PL 1997, c. 792, §3 (NEW).]

G. Acting as an information resource in the development of policies and programs that protect consumer interests and rights under health care plans by:

(1) Analyzing, evaluating and monitoring the development and implementation of federal, state and local laws, regulations, rules and other governmental policies and actions that pertain to the health, safety, welfare and rights of health care consumers; and

(2) Identifying practices and policies that may affect access to quality health care, including, but not limited to, practices relating to marketing of health care plans and accessibility of services and resources for under-served areas and vulnerable populations. The division may refer these issues to the appropriate state or federal regulatory agency with jurisdiction over these practices and policies; [PL 1997, c. 792, §3 (NEW).]

H. Promoting coordination between the division and other organizations that assist consumers, including, but not limited to, legal assistance providers serving low-income health care consumers and other health care consumers, health insurance counseling assistance programs, the long-term care ombudsman program pursuant to Title 22, section 5106, subsection 11-C and assistance programs for individuals with disabilities established under federal or state law; [PL 1997, c. 792, §3 (NEW).]

I. Collecting and disseminating information regarding the activities of the division; [PL 1997, c. 792, §3 (NEW).]

J. Submitting an annual report by January 1st of each year to the Commissioner of Professional and Financial Regulation, the Consumer Health Care Division Advisory Council and the joint standing committee of the Legislature having jurisdiction over insurance matters describing the activities carried out by the division in the year for which the report is prepared, analyzing the data available to the division and evaluating the problems experienced by consumers; and [PL 1997, c. 792, §3 (NEW).]

K. Performing other duties as the superintendent may prescribe. [PL 1997, c. 792, §3 (NEW).]
[PL 1997, c. 792, §3 (NEW).]

SECTION HISTORY

PL 1997, c. 792, §3 (NEW). PL 2005, c. 294, §23 (AMD).

§4322. Consumer Health Care Division Advisory Council

(REPEALED)

SECTION HISTORY

PL 1997, c. 792, §3 (NEW). PL 2003, c. 689, §B7 (REV). PL 2005, c. 294, §24 (RP).

SUBCHAPTER 2-A

HEALTH INSURANCE CONSUMER ASSISTANCE PROGRAM

§4326. Health Insurance Consumer Assistance Program

1. Establishment. The Health Insurance Consumer Assistance Program, referred to in this section as "the consumer assistance program," is established to provide support for consumers, including prospective consumers, of health insurance, referred to in this section as "consumers," and to customer assistance programs and public and private health insurance assistance programs.
[PL 2019, c. 522, §1 (NEW).]

2. Consumer assistance program services. The services provided by the consumer assistance program may include:

A. Assisting consumers with filing complaints and appeals with a group health plan, health insurance carrier or independent review organization and providing information about the internal and external appeal and grievance processes of a group health plan, health insurance carrier or independent review organization; [PL 2019, c. 522, §1 (NEW).]

B. Collecting, tracking and quantifying inquiries regarding health insurance and problems encountered by consumers; [PL 2019, c. 522, §1 (NEW).]

C. Educating consumers on their rights and responsibilities with respect to health insurance coverage; [PL 2019, c. 522, §1 (NEW).]

D. Assisting consumers with obtaining health insurance coverage by providing information, referrals or other assistance; [PL 2019, c. 522, §1 (NEW).]

E. Assisting with obtaining federal health insurance premium tax credits under Section 36B of the United States Internal Revenue Code of 1986, as amended; and [PL 2019, c. 522, §1 (NEW).]

F. Providing information to the public about the services of the consumer assistance program through a comprehensive outreach program and a toll-free telephone number. [PL 2019, c. 522, §1 (NEW).]

[PL 2019, c. 522, §1 (NEW).]

3. Contract for operation. The Attorney General shall contract with a nonprofit, independent health insurance consumer assistance entity, which may not be an insurer, to operate the consumer assistance program.
[PL 2019, c. 522, §1 (NEW).]

4. Report. The operator of the consumer assistance program shall report to the Attorney General, according to the requirements of the contract under subsection 1, on aggregate data relevant to the services provided by and activities of the consumer assistance program, and annually, by January 15th, the Attorney General shall report to the joint standing committee of the Legislature having jurisdiction over health insurance matters on the aggregate data.
[PL 2019, c. 522, §1 (NEW).]

5. Funding. The State shall provide necessary funding for the consumer assistance program.
[PL 2021, c. 206, §1 (NEW).]

SECTION HISTORY

PL 2019, c. 522, §1 (NEW). PL 2021, c. 206, §1 (AMD).

SUBCHAPTER 3

DOWNSTREAM RISK

§4331. Definitions

As used in this subchapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 1999, c. 609, §20 (NEW).]

1. Bonus. "Bonus" means a payment a carrier makes to a downstream entity beyond any salary, fee-for-service payment, capitation or returned withhold.
[PL 1999, c. 609, §20 (NEW).]

2. Capitation. "Capitation" means a set dollar payment per patient per unit of time, usually per month, that a carrier pays a health care practitioner, institutional provider or downstream entity to cover a specified set of services and administrative costs without regard to the actual number or nature of services provided. The services covered may include the downstream entity's own services, referral services or all medical services.
[PL 1999, c. 609, §20 (NEW).]

3. Downstream entity. "Downstream entity" means a person other than a carrier that has assumed all or part of the insurance risk of one or more health plans under a contractual relationship with a

carrier or another downstream entity. An employer exempt from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a downstream entity.
[PL 1999, c. 609, §20 (NEW).]

4. Downstream risk arrangement. "Downstream risk arrangement" means an arrangement that transfers insurance risk from a carrier to a downstream entity.
[PL 2003, c. 428, Pt. H, §6 (AMD).]

5. Payments. "Payments" means any amounts the carrier pays the downstream entity for services the downstream entity furnishes directly, plus amounts paid for administration and amounts paid in whole or in part based on use and costs of referral services such as withhold amounts, bonuses based on referral levels and any other compensation to the downstream entity to influence the use of referral services. Bonuses and other compensation that are not based on referral levels, such as bonuses based solely on quality of care furnished, patient satisfaction and participation on committees, are not considered payments for purposes of this subchapter.
[PL 1999, c. 609, §20 (NEW).]

6. Physician group. "Physician group" means a partnership, association, corporation, individual practice association or other group of physicians that distributes income from the practice among members. An individual practice association is a physician group only if the association is composed of individual physicians and has no subcontracts with physician groups.
[PL 1999, c. 609, §20 (NEW).]

7. Potential payments. "Potential payments" means the maximum anticipated total amount, based on the most recent year's utilization and experience and any current or anticipated factors that may affect costs, to be paid for a defined set of referral services for the carrier's subscribers and for which the downstream entity assumes by contract financial risk, to some extent, for the costs of such services. The methodology for determining potential payments must be filed by the carrier with the bureau.
[PL 1999, c. 609, §20 (NEW).]

8. Referral services. "Referral services" means any specialty, inpatient, outpatient or laboratory services that a downstream entity orders or arranges, but does not furnish directly.
[PL 1999, c. 609, §20 (NEW).]

9. Risk-sharing arrangement. "Risk-sharing arrangement" means an arrangement between a carrier and a downstream entity in which the carrier continues to pay providers for a defined set of services subject to an annual reconciliation process in which costs incurred by the carrier are compared with budgeted or targeted amounts for such services and that may, if payments are different than the budgeted amount, create financial liability of the downstream entity to the carrier or the carrier to the downstream entity provided the carrier holds or retains control of any funds in excess of those required to satisfy current claims obligations or direct payment to providers for services rendered pending reconciliation.
[PL 1999, c. 609, §20 (NEW).]

10. Risk threshold. "Risk threshold" means the maximum risk, if the risk is based on referral services, to which a downstream entity may be exposed under a downstream risk arrangement without being at substantial financial risk.
[PL 1999, c. 609, §20 (NEW).]

11. Withhold. "Withhold" means a percentage of payments or set dollar amounts that a carrier deducts from a downstream entity's service fee, capitation or salary payment and that may or may not be returned to the downstream entity, depending on specific predetermined factors.
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW). PL 2003, c. 428, §H6 (AMD).

§4332. Safe harbor and waiver

1. Authority for safe harbor. Notwithstanding any other provisions of this Title or Title 24, including, without limitation, sections 4341 and 4342, an arrangement between a carrier and a downstream entity with which the carrier has contracted to provide or arrange for the provision of services that allows the downstream entity to accept a limited degree of insurance risk is permitted and such a risk arrangement is deemed not to be engaging in the business of insurance by the downstream entity if:

A. The arrangement does not involve substantial insurance risk or substantial enrollment risk as described in section 4334; and [PL 1999, c. 609, §20 (NEW).]

B. The arrangement meets the requirements of sections 4335 and 4336. [PL 1999, c. 609, §20 (NEW).]

[PL 1999, c. 609, §20 (NEW).]

2. Waiver for downstream risk arrangements that exceed risk threshold described in section 4334. Carriers and downstream entities that wish to develop downstream risk arrangements that exceed the risk threshold described in section 4334 may jointly request that the superintendent grant a waiver that allows the downstream entity to accept a limited degree of insurance risk without being licensed as an insurer, a health maintenance organization or an insurance administrator. The joint request for a waiver must include a plan for managing financial exposure, based upon reasonable enrollment and utilization projections and upon the contracts, parties and features proposed, sufficient to quantify in dollars per quarter and per annum all elements of downstream risk to be assumed by the downstream entity. All other risk arrangements are prohibited unless the arrangements meet the appropriate licensing standards or are expressly permitted by the superintendent.

[PL 1999, c. 609, §20 (NEW).]

3. Continuing obligation to subscribers. A carrier contracting with a downstream entity remains obligated to its subscribers for the delivery of health care benefits consistent with existing state law. The carrier remains responsible for compliance with all applicable laws.

[PL 1999, c. 609, §20 (NEW).]

4. Certain incentives prohibited. A downstream risk arrangement may not contain incentives for the downstream entity or participating provider to limit or deny medically necessary care to enrollees.

[PL 1999, c. 609, §20 (NEW).]

5. Requirements still applicable. The application of the safe harbor provisions in subsection 1 or a waiver of licensing requirements granted pursuant to this section does not exempt the downstream entity from any other licensure or prior approval requirements applicable to activities conducted by the downstream entity, including, but not limited to, utilization review licensure, insurance administrator licensure or preferred provider arrangement registration.

[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4333. Requirements for downstream risk arrangements

1. Permissible downstream risk arrangements. Downstream entities that do not exceed the risk threshold described in section 4334 may enter into downstream risk arrangements only if:

A. The requirements of section 4332, subsection 1 and sections 4335 and 4336 are met; and [PL 1999, c. 609, §20 (NEW).]

B. No specific payment is made directly or indirectly under the plan to a provider as an inducement to reduce or limit medically necessary services furnished to an enrollee. [PL 1999, c. 609, §20 (NEW).]

[PL 1999, c. 609, §20 (NEW).]

2. Prohibited downstream risk payments. A specific payment of any kind may not be made directly or indirectly under the incentive plan to a downstream entity as an inducement to reduce or limit covered medically necessary services under the carrier's contract furnished to an enrollee. Indirect payments include offerings of monetary value such as stock options or waivers of debt measured in the present or future.

[PL 1999, c. 609, §20 (NEW).]

3. Applicability. This section applies to risk arrangements between carriers and downstream entities with which they contract to provide medical services to enrollees. This section also applies to subcontracting arrangements.

[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4334. Substantial insurance risk; substantial enrollment risk

1. Substantial insurance risk. Substantial insurance risk is risk based on the use or costs of referral services only, when the downstream entity is at risk for more than 25% of potential payments by the carrier to the downstream entity.

[PL 1999, c. 609, §20 (NEW).]

2. Substantial enrollment risk. Substantial enrollment risk exists when a carrier enters into a risk arrangement with a downstream entity involving more than 25% of the enrollees served by the carrier in the State unless the risk arrangement is a risk-sharing arrangement.

[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4335. Contractual provisions

Full copies of contracts and summary descriptions of contracts must be provided to the superintendent. The following provisions must be included in contracts between a carrier and a downstream entity: [PL 1999, c. 609, §20 (NEW).]

1. Enrollee not liable. A provision in all relevant contracts between a carrier and a downstream entity or between a downstream entity and a participating provider of health care services stating that if the carrier fails to pay for health care services as set forth in the contract, the enrollee may not be liable to the provider for any sums owed by the carrier;

[PL 1999, c. 609, §20 (NEW).]

2. Maintenance of books, accounts and records. A provision for the maintenance of books, accounts and records by the downstream entity and the carrier to verify that transactions, including the risk transfer, are clearly, accurately and completely recorded, in accordance with generally accepted accounting principles and disclosed in writing;

[PL 1999, c. 609, §20 (NEW).]

3. Prohibition on assignment of rights or obligations. A provision prohibiting the assignment of any rights or obligations under the contract in the absence of the consent of the carrier;

[PL 1999, c. 609, §20 (NEW).]

4. Right to object to subcontractor. A provision granting the carrier the right to be advised of and the right to object to any subcontractor with whom the downstream entity proposes to contract with respect to services required to be performed by the downstream entity under its contract with the carrier;
[PL 1999, c. 609, §20 (NEW).]

5. Termination of contract. A provision for the termination of the contract, including the right to immediately terminate the contract upon a valid order issued by the superintendent or another lawful authority;
[PL 1999, c. 609, §20 (NEW).]

6. Compliance with utilization review laws, rules and licensing requirements. A provision requiring the downstream entity to comply with utilization review laws, rules and licensing requirements appropriate to the functions the downstream entity has contracted to undertake on behalf of the carrier;
[PL 1999, c. 609, §20 (NEW).]

7. Ability to perform. A provision requiring the downstream entity to advise the carrier in a timely manner of relevant matters that may have a material effect on the downstream entity's ability to perform under the contract, including, but not limited to:

A. Whether the downstream entity or participating provider is subject to an administrative order, a cease and desist order, a fine or a license suspension; and [PL 1999, c. 609, §20 (NEW).]

B. Whether legal action has been taken that may have a material effect on the downstream entity's financial condition or the downstream entity's ability to perform under the contract; and [PL 1999, c. 609, §20 (NEW).]
[PL 1999, c. 609, §20 (NEW).]

8. Incorporation by reference. A provision requiring the contract between a carrier and a downstream entity to be attached to all contracts between the downstream entity and those of the entity's participating providers contractually obligated to provide services to the carrier's enrollees under the contract between the carrier and the downstream entity.
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4336. Disclosure requirements for organizations with downstream risk arrangements

1. Disclosure to superintendent. Each carrier shall provide information concerning the carrier's downstream risk arrangements as required or requested by the superintendent. The disclosure must contain the following information in sufficient detail to enable the superintendent to determine whether the risk arrangement complies with the following requirements:

A. Whether services not furnished by the downstream entity are covered by the risk arrangement. If the services furnished by the downstream entity are covered by the risk arrangement, disclosure of other aspects of the plan need not be made; [PL 1999, c. 609, §20 (NEW).]

B. The type of risk arrangement; for example, withhold, bonus, capitation; [PL 1999, c. 609, §20 (NEW).]

C. If the risk arrangement involves a withhold or bonus, the percent of the withhold or bonus; [PL 1999, c. 609, §20 (NEW).]

D. The panel size, the number of enrollees covered by the downstream entity and the total number of enrollees covered by the carrier in the State; and [PL 1999, c. 609, §20 (NEW).]

E. In the case of capitated downstream entities, capitation payments paid to primary care providers for the most recent year broken down by percent for primary care services, referral services to

specialists, hospital services and other types of provider services, including, but not limited to, nursing home and home health agency services. [PL 1999, c. 609, §20 (NEW).]
[PL 1999, c. 609, §20 (NEW).]

2. Annual disclosure. A carrier shall provide this information to the superintendent at least annually. A carrier shall provide the capitation data required under subsection 1 for the previous calendar year to the superintendent by April 1st of each year.
[PL 1999, c. 609, §20 (NEW).]

3. Disclosure to enrollees. A carrier shall provide the following information to any enrollee upon request:

A. Whether the prepaid plan uses a downstream risk arrangement that affects the use of referral services; and [PL 1999, c. 609, §20 (NEW).]

B. The type of risk arrangement. [PL 1999, c. 609, §20 (NEW).]
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4337. Requirements related to subcontracting arrangements

1. Physician groups. A carrier that contracts with a downstream entity that places the individual physician members at substantial financial risk for services they do not furnish shall disclose to the superintendent any incentive plan between the downstream entity and the entity's individual physicians that bases compensation to the physician on the use or cost of services furnished to enrollees. The disclosure must include the information specified in section 4336, subsection 1.
[PL 1999, c. 609, §20 (NEW).]

2. Intermediate entities. A carrier that contracts with a downstream entity, other than a physician group, for the provision of services to enrollees shall disclose to the superintendent any risk arrangement between the entity and a physician or physician group that bases compensation to the physician or physician group on the use or cost of services furnished to enrollees. The disclosure must include the information required to be disclosed under section 4336, subsection 1.
[PL 1999, c. 609, §20 (NEW).]

3. Sanctions against the carrier. The superintendent may apply intermediate sanctions if the superintendent determines that a carrier fails to comply with the requirements of this section.
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4338. Downstream risk arrangements that exceed risk threshold described in section 4334

The superintendent may waive downstream risk arrangements from licensure requirements that exceed the risk threshold described in section 4334 if the downstream risk arrangement meets the contractual and disclosure requirements established under section 4332 and the criteria set forth in sections 4339 to 4342 and is determined by the superintendent not to prejudice enrollee interests. [PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4339. Contractual provisions to demonstrate financial viability

If a carrier applies for a waiver under section 4332, subsection 2, the carrier may demonstrate the financial viability and condition of the downstream entity through the terms of the contract, including one or more of the following: [PL 1999, c. 609, §20 (NEW).]

1. Books, accounts and records. A contractual provision authorizing the carrier to access the downstream entity's books, accounts and records according to terms and conditions on which the carrier and the downstream entity agree;
[PL 1999, c. 609, §20 (NEW).]

2. Financial statements. A contractual provision requiring the downstream entity to provide to the carrier interim unaudited financial statements on a regular and ongoing basis as well as an annual financial statement, accompanied by a certified public accountant's opinion, appropriate to the magnitude of risk involved;
[PL 1999, c. 609, §20 (NEW).]

3. Reserves. A contractual provision authorizing the carrier to receive information regarding the downstream entity's reserves;
[PL 1999, c. 609, §20 (NEW).]

4. Letter of credit. A contractual provision requiring the downstream entity to post a letter of credit or other acceptable financial security;
[PL 1999, c. 609, §20 (NEW).]

5. Fees. A contractual provision under which the carrier withholds fees payable to the downstream entity or to the providers for which it acts;
[PL 1999, c. 609, §20 (NEW).]

6. General liability insurance. A contractual provision requiring the downstream entity to carry general liability insurance and requiring participating providers to carry professional liability insurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity;
[PL 1999, c. 609, §20 (NEW).]

7. Surety bond. A contractual provision requiring the downstream entity to secure a surety bond to cover the downstream entity's performance under the contract; or
[PL 1999, c. 609, §20 (NEW).]

8. Excess of loss insurance. A contractual provision requiring the downstream entity to secure excess of loss insurance or reinsurance in an amount and from an insurer mutually acceptable to the carrier and the downstream entity.
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4340. Financial viability

Each carrier and downstream entity requesting a waiver shall file with the superintendent a plan for managing financial exposure under those downstream risk arrangement contracts and thereafter operate in substantial conformance with the terms of that plan and of the corresponding waiver. At least 60 days before any material change in a filed and approved exposure management plan, the carrier and downstream entity shall file for the superintendent's review and approval a modified plan, along with any changes in related contracts. [PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4341. Limitations on premium transfer

The superintendent may deny a request for waiver based on any of the following characteristics: [PL 1999, c. 609, §20 (NEW).]

1. Transfer of 30% of annual aggregate premium. A contract by which 30% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to a single downstream entity. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments; or
[PL 1999, c. 609, §20 (NEW).]

2. Transfer of 75% of annual aggregate premium. Multiple contracts by which 75% or more of the carrier's annual aggregate premium with respect to a contract, plan or product is transferred to one or more downstream entities. This transfer is the sum of capitated payments plus the sum of amounts returnable to the carrier through incentive payments or other risk adjustments.
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4342. Related provisions

The superintendent may deny a request for waiver based on any of the following characteristics: [PL 1999, c. 609, §20 (NEW).]

1. Carrier controlled. An arrangement with a downstream entity that has control of the carrier. "Control" has the same meaning as defined in section 222, subsection 2, paragraph B;
[PL 1999, c. 609, §20 (NEW).]

2. Transfer of claims processing, payment or adjudication. An arrangement by which the claims processing, claims payment or claims adjudication functions are transferred to the downstream entity from the carrier. This section may not be construed to authorize the superintendent to deny a request based on the transfer of utilization review functions from the carrier to the downstream entity;
[PL 1999, c. 609, §20 (NEW).]

3. Transfer of managerial control. An arrangement by which managerial control of the carrier's information system is transferred to the downstream entity;
[PL 1999, c. 609, §20 (NEW).]

4. Overlap between officers or directors. An arrangement in which there is overlap between the officers or directors of the downstream entity and the carrier; or
[PL 1999, c. 609, §20 (NEW).]

5. Transfer of more than 1/12 of annual capitated payments. An arrangement that transfers more than 1/12 of the annual capitated payments at one time to the downstream entity.
[PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).

§4343. Rules

The superintendent may adopt rules establishing application procedures and specific standards for meeting the requirements pursuant to this subchapter. Rules adopted pursuant to this subchapter are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. [PL 1999, c. 609, §20 (NEW).]

SECTION HISTORY

PL 1999, c. 609, §20 (NEW).