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Bulletin 460

Changes to Laws Governing Payment for Emergency Services

(Supersedes Bulletin 454)

The Superintendent directs this Bulletin to insurance carriers subject to the requirements of the Health Plan Improvement Act, drawing attention to several changes to the emergency services law enacted during the 130th Legislature and reminding carriers of their obligations to pay the ambulance provider's charged rates until October 1, 2021.

In 2020, the Maine Legislature enacted P.L. 2019, Chapter 668, An Act To Protect Consumers from Surprise Emergency Medical Bills. This law established procedures for health insurance carriers to pay out-of-network providers for covered emergency services, including an independent dispute resolution process that is available, except for ambulance services, when the amount in dispute is at least $750.[1] An interim provision for ambulance services, expiring on October 1, 2021, requires a carrier to reimburse an out-of-network provider for emergency ambulance services[2] at the out-of-network provider's rate, unless the carrier and out-of-network provider agree otherwise.[3] Two bills enacted in 2021 establish new standards for ambulance reimbursement and repealed the $750 threshold for independent dispute resolution, as explained below.

The Bureau anticipates conducting rulemaking soon to conform Bureau of Insurance Rule 365 to the new provisions of the Insurance Code. Meanwhile, the Insurance Code provisions described below, as of their respective effective dates, supersede any conflicting provisions of the Rule.

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[1] 24-A M.R.S. §§ 4303-C(2) & 4303-E; 02-031 C.M.R. ch. 365, § 6.

[2] The Maine Insurance Code defines "emergency service" and "emergency medical condition" for purposes of this law at 24-A M.R.S. § 4301-A(4-B) & (4-A), respectively.

[3] The exception in 24-A M.R.S. §§ 4303-C(2)(B) & (D) for cases when the carrier and provider "agree otherwise" requires an actual agreement between the carrier and provider. While an insurer may request a different rate from the rate specified in the applicable statute, the carrier may not require a provider to file a complaint, file an appeal, or otherwise contest a lower rate unilaterally chosen by the carrier, such as a carrier's determination of "usual, customary, and reasonable" charges.

Ambulance Services

The Legislature recently enacted P.L. 2021, Chapter 241 (L.D. 1258), An Act To Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board Related to Reimbursement Rates for Ambulance Services by Health Insurance Carriers and To Improve Participation of Ambulance Service Providers in Carrier Networks. This law changes how carriers must reimburse providers for ambulance services that are covered emergency services and adds several other requirements related to ambulance services, except for air ambulance services.[4]

Reimbursement Standards

Beginning October 18, 2021, the law will establish reimbursement requirements for both out-of-network and in-network ambulance service providers.[5] For out-of-network providers, reimbursement for covered emergency services must be at the provider's rate or 180% of the Medicare rate for that service, whichever is less, unless the carrier and provider agree otherwise. For in-network providers, reimbursement must be at the provider's rate or 200% of the Medicare rate for that service, whichever is less. For providers eligible for additional Medicare reimbursement because they are located in rural or super rural areas, the applicable percentage of Medicare must be supplemented by an additional reimbursement equal to the additional reimbursement that would be provided to a Medicare enrollee. Ambulance providers charging below 200% of the Medicare rate on the effective date of the law may not increase that charge by more than 5% annually. These reimbursement requirements will sunset on December 31, 2023.

The law also allows an out-of-network ambulance service provider to access the State's independent dispute resolution process if the provider disagrees with a carrier's payment amount for a covered emergency service and the provider and carrier cannot agree on the amount within 30 calendar days.[6]

As with other covered emergency services, carriers may only require enrollees to pay the applicable coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed if the ambulance service were rendered by a network provider.[7]

Any Willing Provider

Last, the law also requires each carrier to offer a standard contract to all ambulance service providers willing to participate in the carrier's network. The carrier's standard contract must have a minimum term of 24 months; may be terminated with at least 180 days' prior notice; and must allow the provider a minimum of 120 days to submit a claim. Until December 31, 2023, the contract must also specify a reimbursement rate that conforms to the statutory requirements described above.

[4] 24-A M.R.S. § 4303-F(3). The federal No Surprises Act, signed into law in 2020, imposes protections from surprise air ambulance bills for health plan enrollees beginning on or after January 1, 2022.

[5] 24-A M.R.S. §§ 4303-F (as enacted by P.L. 2021, ch. 241) & 4303-C(2)(D) (as amended by P.L. 2021, ch. 241).

[6] 24-A M.R.S. § 4303-C(2)(E) (as amended by P.L. 2021, ch. 241).

[7] 24-A M.R.S. § 4303-C(2)(A). *See also* 24-A M.R.S. § 4320-C.

Effective Date of New Standards

The current reimbursement requirement for an ambulance service that is a covered emergency service provided by an out-of-network provider remains in force until October 1, 2021. However, the new reimbursement requirement does not take effect until October 18, 2021. Accordingly, the reimbursement requirement that applies to all other covered emergency services provided by out-of-network providers will apply to ambulance services during the interim.[8]

Thus, the applicable reimbursement requirement depends on the date of service, as follows:

Date of service	**Reimbursement Requirement**
03/18/2020 – 09/30/2021	Unless the carrier and out-of-network provider agree otherwise, the carrier must reimburse the provider at the provider's rate. *See* 24-A M.R.S. § 4303-C(2)(D); Bulletin 454.
10/01/2021 – 10/17/2021	Unless the carrier and out-of-network provider agree otherwise, the carrier must reimburse the provider at the greater of: (1) the carrier's median network rate paid for the service by a similar provider in the geographic area in which the service was rendered; or (2) the median network rate paid by all carriers for that service by a similar provider in the geographic area in which the service was rendered, as determined by the all-payer claims database maintained by the Maine Health Data Organization or, if Maine Health Data Organization claims data is insufficient or otherwise inapplicable, another independent medical claims database specified by the Superintendent. *See* 24-A M.R.S. § 4303-C(2)(B); 02-031 C.M.R. ch. 365, § 6(B). (Please refer to rule ch. 365 for additional details.)
10/18/2021 – 12/30/2023	Unless the carrier and out-of-network provider agree otherwise, the carrier must reimburse the provider at the provider's rate or 180% of the Medicare rate for that service, whichever is less, plus additional reimbursement for providers in designated rural or super rural areas. *See* P.L. 2021, Chapter 241 (amending 24-A M.R.S. § 4303-C(2)(D) and enacting 24-A M.R.S. § 4303-F, effective October 18, 2021).

[8] 24-A M.R.S. § 4303-C(2)(B).

New Eligibility of Certain Bills for Independent Dispute Resolution

The Legislature also enacted P. L. 2021, Chapter 222 (L.D. 46), "An Act To Further Protect Consumers From Surprise Medical Bills," on an emergency basis. Effective June 16, 2021, it eliminated the requirement that when the difference between the out-of-network provider's fee and the median all-carrier network rate is less than $750, the carrier must reimburse the provider's fee unless the provider's fee exceeds the 80th percentile of comparable charges.

Accordingly, out-of-network emergency provider bills for services rendered on or after June 16, 2021 that would have been ineligible for independent dispute resolution under 24-A M.R.S. § 4303-E(1)(G) may now proceed to IDR if otherwise qualified under the statute.

Superseded Provisions of Rule 365

As noted earlier, Bureau of Insurance Rule 365 will need to be amended to conform to the new requirements of the Insurance Code. Until then, because the statute controls in the event of a conflict, the following provisions of the Rule are no longer in force as of the dates indicated below:

- For all services rendered on or after June 16: Paragraphs 2(2)(C) and 2(3)(C) and Subparagraph 6(1)(B)(3),[9] which formerly established a $750 threshold for IDR and established a "pay as billed" requirement below that threshold, subject to an 80th-percentile exception.

- For all services rendered on or after October 1: Paragraph 2(3)(B), which until that date makes bills for ambulance services ineligible for IDR.

September 13, 2021

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NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.

[9] The introduction to Paragraph B(3) also includes obsolete language relating to the calculation of 80th-percentile charges.