APPROVED | CHAPTER
JUNE 19, 2017 | 232
BY GOVERNOR | PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND SEVENTEEN

S.P. 147 - L.D. 445

An Act To Encourage Maine Consumers To Comparison-shop for Certain Health Care Procedures and To Lower Health Care Costs

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1718-B, sub-§2, ¶D is enacted to read:

D. Beginning January 1, 2018, at the time a referral or recommendation is made for a comparable health care service as defined in Title 24-A, section 4318-A, subsection 1, paragraph A during an in-person visit, the health care entity making that referral or recommendation shall notify a patient who has private health insurance coverage of the patient's right to obtain services from a different provider. A health care entity shall comply with this paragraph by providing a written notice at the time the health care entity recommends or refers a patient for a health care service or procedure that may qualify as a comparable health care service. A written notice provided under this paragraph must include a notification that, prior to obtaining the recommended service, the patient may review the health care price transparency tool provided by the patient's carrier or contact the patient's carrier directly via a toll-free telephone number so that the patient may consider whether the recommended provider of the comparable health care service represents the best value for the patient. A written notice provided under this paragraph must also include a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow the carrier to assist the patient in comparing prices for the comparable health care service.

Sec. 2. 22 MRSA §8712, sub-§2, as amended by PL 2011, c. 525, §1, is further amended to read:

2. Payments. The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology ~~and,~~ surgical services, comparable health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A and other services that are predominantly elective and may be provided to a large number

of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors. Beginning October 1, 2012, price information posted on the website must be posted semiannually, must display the date of posting and, when posted, must be current to within 12 months of the date of submission of the information. Payment reports and price information posted on the website must include data submitted by payors with regard to all health care facilities and practitioners that provide comparable health care services as defined in Title 24-A, section 4318-A, subsection 1, paragraph A or services for which the organization reports data pertaining to the statewide average price pursuant to this subsection or Title 24-A, section 4318-B. Upon notice made by a health care facility or practitioner that data posted by the organization pertaining to that facility or practitioner is inaccurate or incomplete, the organization shall remedy the inaccurate or incomplete data within the earlier of 30 days of receipt of the notice and the next semiannual posting date.

Sec. 3. 24-A MRSA §4302, sub-§1, ¶K, as amended by PL 2009, c. 439, Pt. B, §3, is further amended to read:

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; ~~and~~

Sec. 4. 24-A MRSA §4302, sub-§1, ¶L, as enacted by PL 2009, c. 439, Pt. B, §4, is amended to read:

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

Sec. 5. 24-A MRSA §4302, sub-§1, ¶M is enacted to read:

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.

Sec. 6. 24-A MRSA §4303, sub-§21 is enacted to read:

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.

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.

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.

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.

Sec. 7. 24-A MRSA §4303, sub-§22 is enacted to read:

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 provider who is not a member of the carrier's provider network.

Sec. 8. 24-A MRSA §4318-A is enacted to read:

§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.

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.

B. "Program" means the comparable health care service incentive program established by a carrier pursuant to this section.

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.

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.

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.

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.

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.

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.

8. Repeal. This section is repealed January 1, 2024.

Sec. 9. 24-A MRSA §4318-B is enacted to read:

§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.

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.

3. Repeal. This section is repealed January 1, 2024.