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Bulletin 434

Referrals by Out-of-Network Direct Primary Care Providers

(Supersedes Bulletin 430)

In 2017, the Legislature prohibited health insurance carriers from denying payment for in-network health care services solely because the referring provider is not in the carrier's network. In response to questions about the scope of the law, I issued Bulletin 430, which clarified that the referral law applies to all types of carriers, including health maintenance organizations (HMOs), and prohibits any restrictions that have the purpose or effect of categorically excluding all referrals by out-of-network providers.

I am now issuing this Bulletin to replace Bulletin 430, because new legislation enacted in May 2019 makes significant changes to the law.¹ In particular, carriers will only be required to honor referrals made by a direct primary care provider who has a contractual relationship with the enrollee. As amended, effective 90 days after adjournment of the 129th Legislature's First Regular Session, the referral law will read as follows:

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.

¹ P.L. 2019, ch. 178 (L.D. 1197), *amending* 24-A M.R.S. § 4303(22).



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Title 22, § 1771(1)(B) defines the term “direct primary care provider” as “an individual who is a licensed physician or osteopathic physician or other advanced health care practitioner who is authorized to engage in independent medical practice in this State, who is qualified to provide primary care services and who chooses to practice direct primary care by entering into a direct primary care service agreement with patients. The term includes, but is not limited to, an individual primary care provider or a group of primary care providers.”

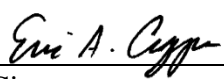
Thus, the scope of the law as amended is simple and straightforward. It applies only when there is a direct primary care service agreement (DPCSA)² between the enrollee and the referring provider. When a provider has demonstrated that it has a DPCSA with the enrollee, the carrier must honor any referral made by that provider on the same terms that it would honor a referral made by a participating primary care provider. If the plan has procedures for enrollees to designate a specific primary care provider within the plan’s network, the carrier must treat a DPCSA as the functional equivalent of a network primary care provider designation.

The law only requires parity, not preferential treatment, as to DPCSAs. The carrier may continue to apply its usual cost sharing requirements, benefit limitations, and reasonable clinical review criteria to the services referred by the DPCSA provider, as long as they would apply to any other referring provider and do not have the purpose or effect of discriminating against DPCSA providers.

The law applies only to services referred by the DPCSA provider. There is no requirement to cover services rendered by the DPCSA provider, including the visit at which the referral is made, except to the extent that coverage is otherwise required under the terms of the plan.

However, the current law remains in force until the amendment takes effect as described in the second paragraph of this Bulletin. Until then, carriers must continue to approve referrals and process claims in accordance with the standards spelled out in Bulletin 430.

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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.

² The relevant definitions and standards are at 22 M.R.S. § 1771.