STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

***In re*:** **Maine Community Health Options** **Maine License No. NPD214118** **NAIC Company Code 15077** **Docket No. INS-16-220**	**DECISION AND ORDER**

On December 16, 2016, Bureau of Insurance Staff, acting through a designated Advocacy Panel pursuant to 5 M.R.S. § 9054(5),[1] submitted a Petition for Enforcement to the Superintendent alleging that Maine Community Health Options ("MCHO") violated the Maine Insurance Code by underpaying a claim for air ambulance services and failing to honor its prior authorization for those services. The ambulance provider submitted a claim for $150,840, but MCHO determined that the allowable charge for the service was $20,821.25, and that after applying out-of-network cost sharing, MCHO's total responsibility for the claim would be approximately $10,000. This left the insured, MP, responsible for the remaining balance of approximately $140,000: $10,000 as out-of-network cost sharing and $130,000 as "uncovered costs" under the insurance contract.

On behalf of the Superintendent,[2] for the reasons discussed below, I conclude that the record does not support a conclusion that MCHO violated the law or the terms of its contract by imposing out-of-network cost sharing. I conclude further that MCHO provided sufficient

[1] Although the Advocacy Panel is not a separate legal entity and thus is not technically a party, it participates procedurally in the same functional capacity, acting independently from the hearing officer and his advisers and barred from *ex parte* communications pursuant to 5 M.R.S. § 9055(2)(B). Therefore, for simplicity, the Advocacy Panel and MCHO shall be referred to collectively as the "parties."

[2] On December 19, 2016, pursuant to 24-A M.R.S. § 210, Superintendent Cioppa designated Deputy Superintendent Timothy N. Schott to hear and decide this case on his behalf. On February 8, 2017, Deputy Superintendent Schott withdrew as hearing officer and Superintendent Cioppa appointed General Counsel Robert Alan Wake to serve in his place.

disclosure to MP that because the ambulance provider was not in MCHO's network, he would be responsible for up to $5,000 in additional cost sharing: the difference between the $5,000 in-network out-of-pocket limit and the $10,000 out-of-network out-of-pocket limit.

However, MCHO's prior authorization letter gave no warning to MP that he might be responsible for a far greater cost than the $10,000 out-of-pocket limit for out-of-network services. The potential "Out-of-Pocket Costs for Covered Services" that MCHO disclosed in its letter ultimately paled in comparison to the additional uncovered cost that MCHO later determined to be approximately $130,000. I conclude that MCHO's prior authorization letter failed to clearly disclose MP's policy coverage limitations and, therefore, MCHO must treat the air ambulance transportation as a fully covered out-of-network service. Specifically, MCHO must hold MP harmless from all charges for the air ambulance service that would require MP to spend more than his contractual $10,000 out-of-pocket limit for out-of-network services in 2015.

Undisputed Facts and Procedural History

The parties have submitted this case for resolution on a stipulated Statement of Agreed-Upon Facts.

MCHO enrollee MP received a lung transplant at the Cleveland Clinic in 2011, and suffered an episode of acute respiratory failure in 2015 while traveling in Texas, with systemic complications that included kidney failure and sepsis. He was placed on a ventilator in the intensive care unit of a nearby hospital.

After MP's condition was sufficiently stabilized, Aitheras Air Transport, LLC requested prior authorization from MCHO to fly him to the Cleveland Clinic for further treatment. The Cleveland Clinic was familiar with MP's case and had specialized expertise in treating transplant complications. MCHO granted the authorization the same day, effective immediately, issuing a

letter affirming that "The requested service is a covered benefit under the Plan" that insured MP, and that it has "been determined to be medically necessary and [has] been approved." Aitheras flew MP to the Cleveland Clinic the next day.

The prior authorization letter included several warnings directed to providers and one warning directed to patients, which read as follows: "**MEMBERS:** Your Out-of-Pocket Costs for Covered Services may be higher when Covered Services are provided by a Non-Plan Provider. If you are unsure if the Provider or Facility listed on this authorization letter is a Plan Provider, please contact our Member Service Associates Mon-Fri, 8am-6pm,[3] at 1-855-624-6463 (TTY/TDD: 711)." Aitheras did not participate in MCHO's network, and thus was a "Non-Plan Provider."

Aitheras submitted a claim to MCHO about two weeks later, with a billed charge of $150,840.00. To determine whether that was a usual, customary, and reasonable (UCR) charge, MCHO solicited bids from four air ambulance providers. One of the four providers was Aitheras itself, which told MCHO that it could transport a patient in MP's circumstances for $28,400, with a possible additional charge if weather or passenger weight required a second fuel stop. The Statement of Agreed-Upon Facts explicitly observes that this bid "was less than one-fifth of the amount Aitheras now claims is due."

MCHO processed the claim as an out-of-network claim. MP was covered by the MCHO Community Value Plan. For out-of-network transportation services that were provided on an emergency basis or preauthorized by MCHO, the contract obligated MCHO to pay 50% of all allowable (*i.e.*, UCR) charges after MP had satisfied his $5,000 annual deductible,[4] and to pay

[3] The authorization letter was issued on a Tuesday and MP was transported on a Wednesday.

[4] The contract also provided that MP was responsible for any applicable per-service copayment, subject to the overall out-of-pocket limit, but it did not specify a copayment for transportation.

the entire remaining allowable charge after MP had satisfied his $10,000 annual out-of-pocket limit.

However, MCHO was not liable, under the terms of the contract, for any expense that was not "consistent with a usual range of charges by Providers for the same, or similar, services, equipment, or supplies in the geographic area where the service, equipment, or supply was provided." Accordingly, on Page 51 of the contract, the policyholder is warned (*emphasis in original*): "**You may be billed by the Non-Plan Provider, and you may have to pay the balance if the claim is for more than the Maximum Allowable Charge.** This is sometimes called Balance Billing." It is stipulated that MCHO "determined that the UCR [charge] for the Aitheras Claim was $20,821.25 by averaging" the four bids it had received.

Thus, in addition to out-of-network cost sharing of up to $10,000, MP was also left responsible for the entire balance of Aitheras's bill, which was $130,018.75.

MP's contract with MCHO provided that if MP's ambulance flight was a "Medical Emergency" service, he was entitled to the benefit of the lower in-network cost sharing levels. MP filed a timely internal appeal of MCHO's claim determination, contending that he was entitled to the emergency services benefit. MCHO denied the appeal on December 4, 2015, and MP filed a second-level appeal, which MCHO received on April 5, 2016. While that appeal process was pending,[5] MP filed a complaint with the Bureau of Insurance, and proceedings on the appeal were stayed by agreement of the parties. After attempts at an agreed resolution of the complaint failed, MCHO denied MP's second-level appeal on October 26.

Meanwhile, on September 28, 2016, Superintendent Cioppa (who has not participated at any phase of the subsequent adjudicatory proceedings except to receive the filings and to

[5] MCHO had issued a decision denying the appeal shortly after it was filed, but vacated that initial decision to allow MP to exercise his right to an in-person hearing.

delegate decisionmaking authority) wrote MCHO to request that MCHO pay MP's claim on an in-network basis and hold MP harmless from any balance bill. MCHO filed an application for hearing with the Superintendent on October 28, and the Superintendent convened an adjudicatory proceeding, No. INS-16-500, and designated Deputy Superintendent Timothy N. Schott to hear and decide that case on his behalf. An Advocacy Panel was appointed and the hearing officer issued an order on November 7, by agreement of the parties, dismissing that proceeding as unripe for adjudication.

On December 16, 2016, the Advocacy Panel filed a two-count Petition for Enforcement, claiming that (1) MP's air ambulance flight was an emergency service and MCHO had violated 24-A M.R.S. § 4320-C by failing to cover that flight on an in-network basis;[6] and (2) MCHO had violated 24-A M.R.S. § 4304(4) by retrospectively denying the coverage for which it had granted prior authorization.

After a conference of counsel, the parties agreed to submit a Statement of Agreed-Upon Facts and identify the material facts that remained in dispute. The Statement was filed on February 9, 2017, with four supporting documents filed on February 10. The parties agreed that there were no disputed facts that would require an evidentiary hearing, and submitted the case for resolution on the stipulated evidentiary record. After the parties submitted their briefs, an oral argument was presented on May 10. At the close of oral argument, the time for decision was stayed by agreement of the parties while they conducted settlement negotiations. However, on July 7, the parties gave notice that they were at impasse and requested the issuance of a decision.

On August 7, for good cause shown, I extended the 30-day period for issuing my decision in this matter.

[6] Section 4320-C requires health plans to cover emergency services in accordance with the requirements of the federal Affordable Care Act (ACA). Because the contract provides MP with stronger protections than the minimum required by the ACA, it is unnecessary to decide whether the scope of Section 4320-C extends to emergency transportation services.

Findings of Fact and Conclusions of Law

I. Overview

The high cost of health care is a hardship for our entire society. Unfortunately, the burden falls particularly heavily on some people. Insurance mitigates the impact, but it does not eliminate the hardship entirely.

The plan MP bought from MCHO was a "Value Plan," which imposed high cost sharing responsibilities in return for a lower premium. Thus, it was foreseeable that he could be exposed to as much as $5,000 a year in out-of-pocket costs in addition to his premium, and as much as $10,000 a year if he had to get any high-cost services on an out-of-network basis. In this case, the parties have stipulated that MP suffered his illness "outside of the coverage area for MP's Plan." Within the State of Maine, MCHO is required to maintain an adequate network, and to make alternative arrangements for providing equivalent coverage to the extent that there are gaps in the network. However, there is no similar obligation for members who need care out of state, although MCHO does have significant network capacity available in the Boston area and in New Hampshire.

The possibility that it could be impossible to take advantage of your health plan's network is one of the risks of out-of-state travel, and that risk is widely recognized by policymakers and consumer advocates as one of the gaps in the American health care system. Substantial restrictions on out-of-area benefits are not limited to locally-based carriers like MCHO, and many plans issued by other carriers are more restrictive than MP's plan, including plans operating under the federal "Multi-State Plan" program. Thus, the imposition of out-of-network cost sharing when MP was traveling far from home was consistent with the reasonable expectations of a consumer in MP's position. However, while substantial out-of-pocket costs

might have been inevitable, there is no dispute that the six-figure bill from Aitheras was extraordinary.

The ultimate question underlying this proceeding is whether it is MCHO or MP who must bear responsibility for either paying or challenging that bill. That depends upon whether MCHO violated the contract or Maine law in its preauthorization disclosure and determination of coverage limitations for the out-of-network air ambulance services provided to MP. As discussed in Part IV below, I conclude that because MCHO failed to disclose to MP that it would only cover an "allowable" charge that was about 14% of the actual charge, MCHO is prohibited by Maine law from enforcing that coverage limitation.

II. Was the Ambulance Flight "Emergency" Medical Transportation?

Picture an air ambulance flight. Striking images of rapid response to imminent danger will likely come to mind. How could air ambulance services not, by their very nature, meet any reasonable definition of the term "Medical Emergency services"?

However, it is not that simple.

The contract provides that "For Medical Emergency services rendered by a Non-Plan Provider, your Out-of-Pocket Costs will be the same as though you received care from a Plan Provider."[7] It defines "Emergency Services" to mean:

> "Those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:
> "1. placing the enrollee's physical and/or mental health in serious jeopardy;
> "2. serious impairment to bodily functions; or
> "3. serious dysfunction of any bodily organ or part."

[7] Contract, § 6(B)(2) at 51; similar language is repeated in § 6(C)(5) at 52. Because the service in question was not found to be an emergency service, it is unnecessary to decide whether this protection from out-of-network cost sharing includes full protection from balance billing.

This is identical to Maine's legal definition of "emergency services" set forth in Bureau of Insurance Rule 850, § 5(P).[8]

MP unquestionably suffered a grave medical crisis. It was unquestionably an emergency when he was first brought to the hospital. It is undisputed that his symptoms remained sufficiently severe that he needed to be flown to the Cleveland Clinic for further care. But it takes more than that to constitute an "emergency" within the meaning of the contract. Specifically, was the air ambulance necessarily an "emergency facility or setting"? Was MP's condition so serious that it required "immediate" medical attention?

The Advocacy Panel argues that an air ambulance is clearly an emergency facility or setting because it is a "highly-specialized vehicle, capable of providing emergency medical care, which was operated by Aitheras specifically to provide emergency medical transportation." This analysis makes sense up to a point. The term "emergency facility or setting" should be construed broadly, because if a service is not rendered in such a facility or setting, it cannot qualify as an emergency service under the contract, regardless of the nature of the service and the nature of the patient's immediate medical need. An air ambulance is certainly a type of facility or setting in which emergency services are often delivered; as such, it is reasonable to find that by its nature, it does meet that threshold requirement.

However, an emergency facility or setting is merely a threshold requirement. It is not the heart of the definition of emergency services. The Advocacy Panel's assertion that it "was operated by Aitheras specifically to provide emergency medical transportation" begs the question. As MCHO points out, ambulance services, including air ambulance services, are used for both emergency and non-emergency purposes. Indeed, the contract expressly distinguishes

[8] The federal definition, set forth at Public Health Service Act § 2719A(2), is narrower, encompassing only those emergency services that are performed in a hospital. *See supra* note 6.

between "emergency" and "non-emergency" ambulance services, specifically including "Non-Emergency Air transportation."

The real question is whether there was an "immediate" medical need for the service in question. It is not reasonably in dispute that at the time the service was provided, MP's health, and very likely his life, still depended on receiving ongoing medical attention. But he was already receiving that attention. The phrase "absence of immediate medical attention," when used as a defining criterion for whether a service qualifies as "emergency service," must be understood as relating in some way to that particular service. Otherwise, almost any in-patient service would qualify for "emergency" service benefits. The contract expressly says the opposite. Even when the hospitalization is the result of an emergency medical condition, emergency coverage at an out-of-network hospital is time-limited, so that "your Out-of-Pocket Costs will be at the Plan Provider level only until your condition reasonably allows you to be transferred to a Hospital that is a Plan Provider." (*Contract, 2(C)(1) at 13*.)

Furthermore, consistent with Rule 850, the contract expressly distinguishes between emergency services and "Urgent Care," which is defined as "Medical care or treatment with respect to which the application of the time periods for making non-urgent Prior Approval decisions could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or, in the opinion of an attending Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim." The point of that distinction is that there is a fundamental difference between an urgent need to make decisions quickly and an immediate need for action with no time to worry about the cost of the service.

Based on Agreed-Upon Facts, I find that MP's situation remained "urgent" at the time of the air transportation service but had stabilized to the point where it was no longer an "emergency." The parties do not dispute that he had a compelling need to be flown to the Cleveland Clinic, but MP's "immediate" medical needs were already being taken care of. The parties stipulated that the Cleveland Clinic agreed to "accept the patient pending bed availability and the logistics of travel," while in the meantime, the hospital in Texas "was capable of providing prophylactic treatment for MP and was prepared to continue to provide treatment, including a bronchoscopy with BAL, if there was a significant delay in transfer to a tertiary care facility."

This is reinforced by the way MP's providers handled the transfer from Texas to Cleveland. They took the time to seek prior authorization and waited until the next day to fly MP to Cleveland. MCHO made clear that only non-emergency transportation was subject to a prior authorization process. The Advocacy Panel correctly warns that this cannot be the dispositive factor, because patients should not be caught in a Catch-22 where efforts to "seek clarity" that a service is covered end up penalizing them by denying benefits. However, in the circumstances of this case, the process of requesting prior authorization is additional evidence that corroborates the finding that MP's transfer to Cleveland was not treated as an emergency at the time it happened.

III. Did MCHO Properly Disclose MP's Out-of-Network Cost Sharing Responsibility?

Although MCHO's contract did not obligate it to treat the out-of-network air ambulance claim as the equivalent of an in-network claim, this is not the end of the inquiry. The Maine Insurance Code also gives consumers protections intended to ensure that they do not incur unforeseen charges without a clear understanding of the consequences. *See*, *e.g.*, 24-A M.R.S.

§§ 4303(8), 4304(6). The Advocacy Panel contends MCHO failed to comply with those requirements, and "should have indicated in the Approval Notice that: (1) the service was being provided by a non-plan provider; and (2) that the claim would not be treated as an emergency service."

If the claim was not filed as an emergency claim, there is no legal basis for bootstrapping a requirement for the carrier to give explicit notice that the claim was not processed as an emergency claim. Carriers cannot be required to anticipate and answer every question that was never asked. There is no evidence in the record of any claim or suggestion that this flight was an "emergency service" until MP filed his appeal, weeks after MCHO issued the disputed notice. Furthermore, by stating clearly that out-of-pocket costs would be higher if the provider was a Non-Plan Provider, MCHO did place MP on notice that it was not treating the claim as an emergency claim or any other type of claim that would entitle him to network-level cost sharing whether or not the provider was in network.

On the other hand, it is a closer question whether MCHO was obligated to determine and expressly disclose whether or not Aitheras was a network provider. After multiple incidents in which carriers had preauthorized services as "medically necessary," but denied the subsequent claims for benefits on other grounds, the Legislature enacted 24-A M.R.S. § 4304(6), which requires that any prior authorization "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." After further incidents in which carriers failed to provide adequate notice, the Bureau of Insurance issued Bulletin 397 to clarify that if only limited coverage is provided, the carrier may not simply tell the consumer that the

service is covered: "If the carrier determines that coverage for the service is limited in any way, this limitation must be identified with specificity in the notice."[9]

MCHO argues that out-of-network cost sharing is a type of coverage, not a limitation on coverage. That is not a distinction a consumer could reasonably be expected to understand. If services are covered with a $10,000 out-of-pocket limit rather than the usual $5,000 limit, that is something most of us would understand to be a "limitation." However, that is a limitation that MCHO's prior authorization notice did adequately "identify with specificity." Immediately after describing the service that had been authorized, the notice had a one-paragraph warning specifically addressed to "**MEMBERS**," devoted exclusively to the potential for out-of-network cost sharing and providing a toll-free number to call if the member "is unsure if the Provider or Facility listed on this authorization letter is a Plan Provider."

There is no evidence that anyone was under the misapprehension that Aitheras was in MCHO's network. Perhaps an affirmative obligation to review and disclose the specific provider's network status each time a prior authorization is granted might be helpful to other consumers, but if the decision is made to impose such a requirement, it needs to be done prospectively. Carriers need to know the rules they will be required to follow—which is why the Superintendent issues bulletins to clarify the specific application of general principles to recurring situations. This is not one of the situations identified as a problem in Bulletin 397, and there is no basis from which carriers could reasonably infer that they have failed to provide legally sufficient warning if they tell consumers that they could be at risk of out-of-network cost sharing and provide a procedure for clarifying whether their provider is in or out of the network.

[9] At oral argument MCHO asserted that it has no obligation to pay attention to bulletins issued by the Superintendent because they do not have any independent force of law. That attitude is unfortunate. While bulletins are not legal authority in their own right, they do represent the regulator's considered interpretation of the relevant law.

Although MCHO provided MP with the information that he would be subject to higher cost sharing if Aitheras was an out-of-network provider, I remain concerned that a patient in MP's position is not necessarily in a meaningful position to act on that information. While the prior authorization process seems to work reasonably well when patients have made a conscious decision to see an out-of-network provider and pay the extra cost, serious illnesses present different problems. They create a multitude of impairments, stresses, distractions, and competing needs, and there might be a need for carriers to re-examine their processes for handling claims submitted on behalf of patients in that situation. I am encouraged that the parties report that although they were unable to agree on a resolution in this case, they are diligently working to come to an understanding regarding how any similar situations should be handled going forward.

While I have found that this record contains no evidence that MP had any reasonable expectation of being able to access MCHO's network, or to obtain network-level coverage under the emergency clause or any other applicable exception to the general requirements of the contract, MCHO has a more thorough understanding of the circumstances of this claim. Should MCHO decide to re-examine this claim and waive some or all of the otherwise applicable out-of-network cost sharing, such a decision would be within its discretion and would not violate its fiduciary obligation to conserve its limited resources for the collective benefit of all its members.

IV. Did MCHO Clearly Disclose MP's Potential Responsibility for a Balance Bill of Approximately $130,000?

Although MCHO acted within its rights in imposing cost sharing of up to $10,000 and provided sufficient notice of that cost sharing obligation, that was the least of MP's problems, because the parties agree that for out-of-network services, the contract makes MP "liable to the

provider for any amounts over the Maximum Allowable Charge, with no limit on MP's potential out-of-pocket *[sic]* costs."

This stipulation highlights a significant ambiguity in the term "out-of-pocket costs." Like the stipulation, the contract is not a model of clarity.[10] It imposes absolute dollar limits on "Out-of-Pocket Cost," and defines that term to mean "The portion of the cost of services for which the Member is personally responsible." The definition goes on to explain that "Out-of-Pocket Costs include Copayments, Coinsurance, and Deductibles," but it does not say they do **not** include a provider's balance bill. A balance bill is something the ordinary consumer might be expected to think of as an out-of-pocket cost, and it is unquestionably a "portion of the cost of services for which the Member is personally responsible." However, MCHO asserted at oral argument (notwithstanding the stipulation) that a balance bill is not an out-of-pocket cost within the meaning of the contract, and therefore is not subject to the contractual $10,000 limit. This appears to be consistent with the narrower definition of the term used in the ACA's implementing regulations.

Looking at the contract as a whole, rather than singling out the definition in isolation, this is the correct interpretation. It is unambiguous that the contract does not treat charges by out-of-network providers as "allowable charges" if they exceed a charge that is usual, customary, and reasonable (UCR). Therefore, no coverage is provided for such excess charges. This limitation does not frustrate the reasonable expectations of the insured, because it is unreasonable to expect that once the $10,000 out-of-pocket limit has been satisfied, an insurer would agree to take on blank-check liability for any additional amount an out-of-network provider might ask for, whether or not that bill is usual, customary, or reasonable.

[10] Any contractual ambiguity must be construed against MCHO.

There is no dispute that the Aitheras bill was not usual, customary, and reasonable.[11] It was more than five times the amount Aitheras subsequently told MCHO was a fair price for the service. Even that subsequent bid was more than 36% higher than the average of the four bids submitted to MCHO.

However, MCHO cannot have it both ways. If a balance bill in excess of UCR charges is not an out-of-pocket cost within the meaning of the contract, it cannot be an out-of-pocket cost within the meaning of the prior authorization letter. The Legislature has recognized that it is particularly important to warn consumers when services are subject to UCR limitations or similar limitations on allowable charges. 24-A M.R.S. § 4303(8). Although MCHO did include a disclosure on Page 51 of an 80-page contract, consumers cannot be expected to have that language at their fingertips and be able to understand how to resolve the conflict between the language of the contract and the language of the prior authorization letter—particularly on the facts of this case involving services for urgent care provided on the heels of an emergency hospitalization.

MCHO's prior authorization letter warned that MP would be at risk of higher "Out-of-Pocket Costs for Covered Services" unless Aitheras was a network provider. But MP's contract promised that those "Out-of-Pocket Costs for Covered Services" were subject to an annual limit of $10,000. It did not warn him that approximately 87% of Aitheras's bill, slightly more than $130,000, would simply not be considered "Costs for Covered Services." If the balance bill was simply uncovered, then it is irrelevant whether Bulletin 397 was a correct statement of the law, because the notice MCHO provided was insufficient on its face. To say only that "The requested

[11] However, I find that MCHO did not accurately determine the Maximum Allowable Charge when it averaged the bids it received. The contract defines UCR as a charge that is "consistent with a usual range of charges" in that area for the same or similar services. A price does not need to be below the average price to be consistent with the usual range.

service is a covered benefit under the plan," without clarifying that the covered benefit is $10,000 while the balance bill (in this case, $130,000) is totally outside the scope of coverage, violated the legal requirement for MCHO to disclose whether or not the preauthorized service was truly "covered" (and, if it was not, to clearly disclose any limitations on the coverage). Therefore, MCHO must hold MP harmless from the balance bill.

To be clear, I am not ordering MCHO to pay Aitheras anything. MCHO is free to pay the bill, provide MP with a defense against the bill, institute its own legal action against Aitheras, negotiate a fair price with Aitheras, or take any other alternative course of action, as long as the costs of that course of action are borne by MCHO rather than by MP.

Although I have concluded that MCHO violated certain disclosure requirements of the Insurance Code, I am not imposing any penalties for the violation. The Advocacy Panel made no specific request for disciplinary sanctions, only for remedial measures to protect MP and for "such other and further relief as the Hearing Officer deems appropriate." I do not find that MCHO's violation was willful; MCHO and MP were both victims of a provider's billing practices that substantially exceeded the usual, customary, and reasonable range. In these circumstances, no further relief is in order beyond the remedial measures I have ordered.

Order and Notice of Appeal Rights

The Petition for Enforcement is *GRANTED* insofar as it requests an order that MCHO hold MP harmless from balance billing, and is otherwise *DENIED.* Pursuant to 24-A M.R.S. § 12-A(2), MCHO shall *CEASE AND DESIST* from handling MP's claim for benefits in any manner that would make MP responsible for any cost for the service rendered by Aitheras that

exceeds the difference between his $10,000 out-of-pocket limit and the aggregate amount of any other covered out-of-pocket costs incurred by MP during 2015.

This Decision and Order is final agency action of the Superintendent of Insurance, within the meaning of the Maine Administrative Procedure Act, 5 M.R.S. § 8002(4). It may be appealed to the Superior Court in the manner provided for by 24-A M.R.S. § 236, 5 M.R.S. §§ 11001 through 11008, and M.R. Civ. P. 80C. Any party to the proceeding may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by this Decision and Order may initiate an appeal within forty days after the issuance of this Decision and Order. There is no automatic stay pending appeal. Application for stay may be made in the manner provided in 5 M.R.S. § 11004.

PER ORDER OF THE SUPERINTENDENT OF INSURANCE

August 15, 2017

ROBERT ALAN WAKE
Designated Hearing Officer