Maine Medical Association

Karen Saylor, MD, President | Jeffrey S. Barkin, MD, President-Elect | Erik N. Steele, DO, FAAFP, Chair, Board of Directors
Andrew B. MacLean, JD, CEO | Dan Morin, Director of Communications & Government Affairs

TO: The Honorable Heather Sanborn, Chair
The Honorable Denise Tepler, Chair
Members, Joint Standing Health Coverage, Insurance and Financial Services

FM: Dan Morin, Director of Communications and Government Affairs

DATE: February 11, 2021

RE: **Opposed**
LD 167—An Act To Limit Late Medical Billing to 6 Months
LD 367—An Act To Require Timely Billing for Health Care Services

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The Maine Medical Association is the state's largest professional physician organization representing more than 4300 physicians, residents, and medical students in Maine whose mission is to support Maine physicians, advance the quality of medicine in Maine and promote the health of all Maine residents.

Both bills have identical text. They each prohibit a "health care entity", as defined in state law, from charging a patient for health care services it provided when a billing statement has not been provided to the patient within 6 months of the date health care services were rendered to the patient.

The Maine Medical Association opposes both bills for several reasons based on feedback from numerous independent physician practices.

In most instances, medical offices do not bill a patient directly until the remit or the explanation of benefits (EOB) is received. Some commercial payers encourage practices NOT to bill the patient until the plan has processed and adjudicated the claim. Circumstances where claims frequently take 6+ months to adjudicate include the following:

- Workers Compensation
- Motor Vehicle Accidents
- Tricare
- CHAMPVA (the VA is actually one of the worst offenders, and can take up to two years to process claims)
- Medicare
- MaineCare
    - Many patients with Medicare or Medicare replacement plans primary have a supplemental insurance company. Again, would not leave enough time if asking for medical records or denials appeals.
- Some carrier claims for Exchange-based high deductible plans
- Claims where there is a primary and a secondary payer
- Claims that go through a payer appeal process
- Many managed care payers also allow an appeal process which typically takes several months to complete.

If Maine law required us to bill within 6 months in all instances, we would be forced either to bill patients directly before their health plan has adjudicated (and paid) the claim, or we would be forced to eat the cost of the service ourselves.

A question that arose through internal dialogue from one medical practice discussed the potential impacts of this bill is what would constitute "billing the patient" under the bills? For example, if the practice sends an electronic bill and patient claims not to have received it, does that count under the proposed rule? Further, if the practice asks a patient for updated contact information and patient does not provide, and bill goes to wrong plan or wrong address, is the practice on the hook for failing to timely bill?

One example provided from an oncology practice member outlined a pathology claim that was billed in March, and after a denial, appealing with medical records, etc. they were finally paid in December—a full nine months necessary for the revenue cycle due to administrative requests.

Overall, if passed into law, would negatively impact on medical practices and their patients.

If LD 167 or LD 367 passes, we have been told to anticipate that medical practices healthcare entities and organizations may start sending patients informational bills at the same time they sent claims to payers. This would be understood by some to allow the practices, healthcare entity, provider, or organization to meet its obligation of billing the patient within 6 months. However, this would likely cause:

1. more confusion from the patients/guarantors,
2. increase calls from patients to customer service/billing depts and
3. increase administrative costs.

Health care providers, entities and organizations want to ensure we are being patient friendly, and generally bill as soon as they can by sending timely statements and still meeting the various obligations already set forth by government payers, Worker comp and managed care payers. Medical practices strive to do this in an administratively efficient manner. The proposed bills seem simple, well-intentioned, and aim to assist Maine patients; but every response we received from each independent physician practice we asked stated it would be administratively burdensome and potentially unfriendly to the patients they serve.

Medical practices cannot bill a final patient balance until they know what the final payments and adjustments are from the payors. If the Committee chooses to put a clock on providers for billing, then we would suggest it should start ticking from the date the payor makes payment rather from the date of service.

Thank you for your acceptance and review of our comments. We will be available to work on any potential amendments before the work session and intend to be in virtual attendance for the discussion.

DETAILED EXAMPLES ON FOLLOWING PAGE

Worker's compensation (WC) claim example:
Health care entities, providers and organizations are not allowed (by State regulation) to bill the patient until the WC claim is either controverted or resolved. A WC claim/case can take months or years to settle.

a. If a WC case is not resolved within 6 months of the original service date, but is controverted at month 7, the submission of the claim by the health care provider, entity, etc. to the health insurance (assuming there is health insurance) would be submitted after 6 months of the date of service. Once the health insurance adjudicates the claim, then the healthcare entity, provider or organization would bill the patient. Many WC claims are not resolved within 6 months of the date of service; thereby delay sending the patient a billing statement.
b. If no health insurance, then the healthcare entity, provider, or organization, under LD167 could not bill the patient.
c. If the health insurance is billed but then does not pay or pays its' obligation or adjudicates the claim, the proposed LD167 would prohibit a healthcare provider, entity, organization from collecting deductibles, patient co-shares/co-insurance or payments for non-covered services.

Medicare participation:

a. A provider agrees not to bill the Medicare beneficiary for covered services.
b. The provider agrees to bill the patient after Medicare adjudicates the claim(s).
c. Medicare allows for claims to be submitted past 6 months of service.
d. Medicare's timelines for appeal processed are greater than 6 months from the original date of service.
e. When **Medicare is secondary**, a healthcare entity, provider or organization cannot balance bill the patient until Medicare adjudicates the claims. There are many individual circumstances that could prevent the 2nd claim from being adjudicated before the 6-month window.
f. Medicare cannot be billed "conditionally" until at least 120 days after the claim is originally sent to a liability carrier (see below).

Auto or homeowners:

- If a patient asks a health care entity, provider or organization to bill a liability carrier such as auto or homeowners, most providers do that. However, if LD167 passes, most providers will not.
- Providers would submit claims to the patients' health insurance in order to ensure that the provider, health care entity or organization gets paid timely and can bill the patient timely. (This protocol is allowed by payers as long as the accident information and other required information is submitted on the claim form).
- In those cases, the patient is typically required, by the health insurance payer, to complete a coordination of benefits form or accident form. If the patient fails to do this timely, it could prevent the healthcare entity, provider, or organization from billing the patient for deductibles, co-insurances, etc.
- With Medicare, a health care entity, provider or organization must wait a minimum of 120 days from the original claim date before billing Medicare conditionally for potential liability claims such as auto, home, etc.