

# 129th MAINE LEGISLATURE

## **SECOND REGULAR SESSION-2020**

**Legislative Document** 

No. 2111

S.P. 756

In Senate, February 18, 2020

#### An Act To Establish Patient Protections in Billing for Health Care

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 203.

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

DAREK M. GRANT Secretary of the Senate

Presented by Senator CLAXTON of Androscoggin.

Cosponsored by Representative TEPLER of Topsham and

Senators: BELLOWS of Kennebec, CARPENTER of Aroostook, HERBIG of Waldo,

President JACKSON of Aroostook, LIBBY of Androscoggin, SANBORN, H. of Cumberland,

VITELLI of Sagadahoc, Representative: Speaker GIDEON of Freeport.

1	Be it enacted by the People of the State of Maine as follows:
2	Sec. 1. 22 MRSA §1718-B, sub-§2, ¶E is enacted to read:
3	E. Within 5 days of the date a health care service or procedure is scheduled or a
4	referral or recommendation for a health care service or procedure is made, if the
5	health care service or procedure is one of the 25 highest cost health care services or
6	procedures, a health care entity shall disclose to a patient, using information from the
7	price transparency tools available on the publicly accessible website of the Maine
8	Health Data Organization established pursuant to chapter 1683:
9	(1) The average cost of the health care service or procedure in the State;
10	(2) The health care entity that has the highest cost of the health care service or
11	procedure in the State and the cost of that health care service or procedure;
12 13	(3) The health care entity that has the lowest cost of the health care service or procedure in the State and the cost of that health care service or procedure; and
14 15	(4) The average cost of the health care service or procedure at the health care facility that will provide the health care service or procedure.
13	racinty that will provide the health care service of procedure.
16	Sec. 2. 22 MRSA §1718-B, sub-§2, ¶F is enacted to read:
17	F. If a health care entity charges for use of a hospital, other health care facility or
18	health system in addition to a charge for health care services or procedures, the health
19	care entity shall disclose to a patient that a health care facility use fee will be charged
20	and identify the health care facility use fee separately on any bill or billing statement.
21	For the purposes of this paragraph, "health care facility use fee" means any fee
22 23	charged for health care services or procedures provided on an outpatient basis in a
24	hospital, other health care facility or health system that is intended to compensate the hospital, health care facility or health system for operational expenses for the
25	hospital, health care facility or health system and that is separate and distinct from a
26	charge for health care services or procedures.
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27	Sec. 3. 22 MRSA §1718-E is enacted to read:
28	§1718-E. Prohibition on billing for late billing statements
29	A health care entity, as defined in section 1718-B, subsection 1, paragraph B, is
30	prohibited from charging a patient for health care services it provided when a billing
31	statement has not been provided to the patient within 6 months of the date health care
32	services were rendered to the patient.
33	Sec. 4. 22 MRSA §1718-F is enacted to read:
34	§1718-F. Disclosure related to observation status for Medicare patients
35	A health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall
36	disclose to a patient who is covered by the federal Medicare program and who is on
37	observation status and not an admitted patient at the health care entity the following

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information:

- 1. Effect of being on observation status. That, due to the patient's being on observation status, there may be an increase in the patient's out-of-pocket costs associated with any stay at a health care entity while on observation status and not as an admitted patient; and
  - 2. Estimate of costs. An estimate of that patient's potential increased out-of-pocket costs due to being on observation status and not an admitted patient.

#### Sec. 5. 24-A MRSA §4303, sub-§24 is enacted to read:

24. Referral to an out-of-network provider. A carrier shall require a provider receiving a referral for any health care service or procedure to disclose to the enrollee whether that provider to whom the enrollee is being referred is not a member of the carrier's provider network.

### **Sec. 6. 24-A MRSA §4303, sub-§25** is enacted to read:

25. Prohibition on fees for transferring an enrollee or an enrollee's medical records. A carrier may not require any fee or other payment from any enrollee or any provider for the transfer of an enrollee between providers or for the transfer of any medical records related to an enrollee between providers unless the fee or other payment is disclosed to the enrollee or provider and is directly related to the costs associated with establishing the enrollee as a patient of the provider or transferring medical records.

19 SUMMARY

This bill makes the following changes.

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- 1. The bill requires health care entities, which includes health care practitioners and facilities, to disclose the average cost in the State for the service for which a patient has been scheduled and the entities offering the service at the highest and lowest rates in the State if the patient has been scheduled or referred for one of the 25 highest cost services or procedures.
- 2. The bill requires health care entities to disclose that a health care facility use fee will be charged and identify that fee separately on any bill provided to a patient.
- 3. The bill prohibits a health care entity from charging a patient when a billing statement has not been provided within 6 months of the date the patient received the services.
- 4. The bill requires a health care entity to disclose to a federal Medicare patient who is on observation status that the patient's observation status may increase the patient's out-of-pocket costs associated with a stay at a health care entity and the estimated increase in the patient's out-of-pocket costs.
- 5. The bill provides that a carrier must require a provider receiving a referral to disclose to the patient whether the provider is an out-of-network provider.

6. The bill prohibits a health insurance carrier from charging any fee for the transfer of a patient between providers or for the transfer of patient records between providers unless the fee is disclosed and directly related to the costs associated with making that transfer of the patient or the patient's medical records.