Testimony in Support of LD 1795
An Act to Protect Patients by Prohibiting Certain Medical Facility Fees
May 11, 2023
Mike Lauze, Portland, ME

Members of the Health Coverage, Insurance and Financial Services Committee:

Below I summarize two different situations I experienced last year that really had me questioning transparency with respect to insurance, and the billing for medical services, which I believe LD 1795 can help start to address. The first is specific to a hospital related facility fee charged for services received at an urgent care plus clinic.

1. First situation, involving my son (December, 2022). My son fainted late one evening. After monitoring him, we decided to wait until the morning and call his primary care/pediatrician. The pediatrician was not able to squeeze him in that day or in a reasonable timeframe. They mentioned they take fainting seriously and that he should be checked out at an urgent care. There are two or three urgent cares within close proximity to us. I chose one associated with Maine Medical Center on Brighton Ave., and its sign from the street reads "Brighton Medical/Urgent Care Plus." We spent about four hours there that day, 30 minutes of which included nurse and PA time for my son's evaluation. The initial bill submitted to my insurer was over $1,900. I ended up paying $1,607 (I hadn't yet met the family deductible). $947 of the bill from Maine Med listed "Professional fees/urgent care." The EOB had those line items coded as "Office Visit." Had I been able to get in with our primary as a true office visit, I'd anticipate it would've been less than $200.

2. Second situation (myself). I had a trauma to my eye that required two emergency surgeries, the first in Boston on 5/31/22 and a follow up at my long-time eye care providers at Maine Eye here in Portland on 6/7/22. During that second surgery on 6/7/22, I was in the O.R. -- an outsourced surgery center on Marginal Way that Maine Eye uses after they closed their in-house surgery suite. On 6/7, I was in the O.R. between 45 minutes and an hour, never left, and the doctor had to complete three distinct procedures. She coded the event for those three procedures per protocol and for her medical notes. Upon receiving separate bills, I noticed three different facilities charges -- same date, and different codes to match the procedures. Facilities charges alone totaled $7,800 ($3400 + 2200 + 2200), of which insurance paid $3,396 and I paid $850. (Note, my portion represented co-pays due since I'd significantly passed my deductible during the 5/31 surgery). This was on top of the professional fees for those same procedures totaling over $6,200. Before paying multiple facilities fees, I requested the billing manager, his boss and the CFO consider the multiple charges. They insisted it was right, deferred to their third party billing provider, and ultimately I paid all charges I owed. It's as if the billing systems and approaches have not kept pace with an increased trend toward outsourced services and surgery centers. I have copies of the bills, available upon request.

In both situations, as best I could tell, my insurer processed and paid as outlined in the plan. In general, I am a supporter of patients knowing and owning a reasonable portion of their medical bills -- especially those portions of an annual bill related to preventative, non-emergency care. It just seems the absence of transparency and the whole process by which providers double charge (facilities fees), mark-up in anticipation of only receiving partial payment makes it impossible for patients to be responsible with overall medical care. Add on top of it, the systems are not set up to keep up with the changing care

delivery models -- even the people generating the bills cannot explain charges at the margins – and nobody could offer a reasonable explanation for why three facilities fee charges were needed for one single surgery event.

Thank you for reading my testimony.

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LD 1795

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Thank you for reading my testimony.