L.D. 1740

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HEALTH COVERAGE, INSURANCE AND FINANCIAL SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

131ST LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 1119, L.D. 1740, "An Act to Support an Insured Patient's Access to Affordable Health Care with Timely Access to Health Care Prices"

Amend the bill by striking out the title and substituting the following:

'An Act to Protect a Patient's Access to Affordable Health Care with Timely Access to Health Care Prices'

Amend the bill by striking out everything after the enacting clause and inserting the following:

'PART A

Sec. A-1. 22 MRSA §1718-B, sub-§2, ¶B, as enacted by PL 2013, c. 515, §2, is amended to read:

B. A health care entity shall inform patients about the availability of prices for the most frequently provided health care services and procedures and the right of a patient to request information about the price of medical services pursuant to section 1718-C, subsection 1 or 2 by posting a notice on prominent display to patients.

Sec. A-2. 22 MRSA §1718-B, sub-§2, ¶B-1 is enacted to read:

B-1. A health care entity shall include notice of a patient's right to request information about the price of medical services pursuant to section 1718-C, subsection 1 or 2 in any written document provided to a patient prior to rendering health care treatment for the purpose of obtaining informed consent to that treatment.

Sec. A-3. 22 MRSA §1718-C, as enacted by PL 2013, c. 560, §2, is repealed and the following enacted in its place:

§1718-C. Patient request for good faith estimate or other information related to price of medical services

1. Uninsured or self-pay patient; good faith estimate. Upon the request of an uninsured or self-pay patient, a health care entity, as defined in section 1718-B, subsection

1, paragraph B, shall provide to the patient a good faith estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter as follows.

A. The health care entity shall provide the good faith estimate within the following time frames:

(1) When the medical encounter is scheduled at least 3 business days before the date the medical encounter is scheduled to be furnished or when the patient is seeking urgent care as defined in Title 24-A, section 4301-A, subsection 21, the estimate must be provided no later than one business day after the date of scheduling or the date of the request if the patient is seeking urgent care;

(2) When the medical encounter is scheduled at least 10 business days before the encounter is scheduled to be furnished, the estimate must be provided no later than 3 business days after the date of scheduling; or

(3) In all other circumstances, the estimate must be provided no later than 3 business days after the date of the request.

B. If the health care entity is unable to provide an accurate estimate of the total price of a specific medical service because the amount of the medical service to be rendered during the medical encounter is unknown in advance, the health care entity shall provide a brief description of the basis for determining the total price of that particular medical service.

C. If the single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity to enable the uninsured patient to seek an estimate of the total price of medical services to be rendered directly by each health care entity to that patient.

D. A good faith estimate must separately disclose the prices for each component of medical services, including any facility fees or fees for professional services, and the current procedural terminology codes used by the American Medical Association for those services.

E. When providing an estimate as required by this subsection, the health care entity shall also notify the uninsured patient of any financial assistance policy adopted by the health care entity and the availability of public or private health care coverage.

F. Notwithstanding other provisions of this subsection, a health care entity does not violate this subsection if it provides a good faith estimate to the patient in compliance with federal regulations.

2. Insured patient; description of medical services and current procedural terminology codes. Upon the request of an insured patient, a health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall provide to the patient a description of the medical services to be rendered directly by that health care entity during a single medical encounter and the applicable standard medical codes or current procedural terminology codes used by the American Medical Association for those services as follows.

A. The health care entity shall comply with the request within the following time frames:

(1) When the medical encounter is scheduled at least 3 business days before the date the medical encounter is scheduled to be furnished or when the patient is seeking urgent care as defined in Title 24-A, section 4301-A, subsection 21, the health care entity must respond no later than one business day after the date of scheduling or the date of the request if the patient is seeking urgent care;

(2) When the medical encounter is scheduled at least 10 business days before the encounter is scheduled to be furnished, the health care entity must respond no later than 3 business days after the date of scheduling; or

(3) In all other circumstances, the health care entity must respond no later than 3 business days after the date of the request.

B. If the single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity to enable the patient to seek a description of the medical services to be rendered directly by that 3rd-party health care entity to that patient and the applicable standard medical codes or current procedural terminology codes used by the American Medical Association for those services.

C. The health care entity shall also notify the patient that the patient may use the information provided to request an estimate of the out-of-pocket costs expected to be paid by the patient from the patient's health insurance carrier.

D. When providing the information required by this subsection, the health care entity shall also notify the insured patient of any financial assistance policy adopted by the health care entity and the availability of other public or private health insurance coverage.

E. Notwithstanding this subsection, if federal regulations are implemented that set forth requirements for health care entities to provide estimates to an insured patient, a health care entity shall comply with federal regulations and does not commit a violation of this subsection.

Sec. A-4. 22 MRSA §1718-J is enacted to read:

§1718-J. Prohibition of collection actions for noncompliance with good faith estimate requirements for uninsured or self-pay patients

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Collection action" means any of the following actions:

(1) Attempting to collect a debt from a patient or patient guarantor by referring the debt directly or indirectly to a debt collector, collection agency or other 3rd party retained by or on behalf of a health care entity;

(2) Suing the patient or patient guarantor or enforcing an arbitration or mediation clause in any health care entity documents, including contracts, agreements, statements and bills; or

(3) Directly or indirectly causing a report to be made to a consumer reporting agency.

B. "Collection agency" has the same meaning as "debt collector" has in Title 32, section 11002, subsection 6.

C. "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to 3rd parties. "Consumer reporting agency" includes any person defined in 15 United States Code, Section 1681a(f). "Consumer reporting agency" does not include any business entity that exclusively provides check verification or check guarantee services.

D. "Health care entity" has the same meaning as in section 1718-B, subsection 1, paragraph B.

E. "Items or services" means all items and services, including individual items and services and service packages, that are provided by a health care entity to a patient in connection with an inpatient admission or an outpatient visit for which the patient is charged.

F. "Patient guarantor" means the individual held responsible for a patient's bill.

2. Failure to comply with good faith estimate requirements; relief from collection action. A health care entity that has not provided a good faith estimate in material compliance with section 1718-C, subsection 1 on the date that items or services are purchased by a patient or provided to a patient may not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services. Unless a health care entity can demonstrate that the health care entity provided a good faith estimate to the patient as requested, the health care entity or hospital may not further pursue a collection action against the patient or patient guarantor.

Sec. A-5. 24-A MRSA §4303, sub-§21, as enacted by PL 2017, c. 232, §6, is amended to read:

21. Health care price transparency tools. Beginning January 1, 2018, a carrier offering a health plan in this State shall comply with the following requirements.

A. A carrier shall develop and make available a website accessible to enrollees and a toll-free telephone number that enable enrollees to obtain information on the estimated costs for obtaining a comparable health care service, as defined in Title 24-A, section 4318-A, subsection 1, paragraph A, from network providers, as well as quality data for those providers, to the extent available. A carrier may comply with the requirements of this paragraph by directing enrollees to the publicly accessible health care costs website of the Maine Health Data Organization.

B. A carrier shall make available to the enrollee through a toll-free telephone number the ability to obtain an estimated cost of a scheduled health care service or a comparable health care service that is based on a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association provided to the enrollee by the provider. Upon an enrollee's request, the carrier shall request additional or clarifying code information, if needed, from the provider involved with the scheduled health care service or comparable health care service. If the carrier obtains specific code information from the enrollee or the enrollee's provider, the carrier shall provide the anticipated ~~charge~~ allowed amount and

the enrollee's anticipated out-of-pocket costs based on that code information, to the extent such information is made available to the carrier by the provider. Notwithstanding other provisions of this paragraph, a carrier does not commit a violation of this paragraph if the carrier complies with federal regulations for price transparency relating to an estimate of an enrollee's cost-sharing responsibility.

C. A carrier shall notify an enrollee that the amounts are estimates based on information available to the carrier at the time the request is made and that the amount the enrollee will be responsible to pay may vary due to unforeseen circumstances that arise out of the proposed scheduled health care service or comparable health care service. This subsection does not prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the proposed scheduled health care service or comparable health care service or for a procedure or service that was not included in the original estimate. This subsection does not preclude an enrollee from contacting the carrier to obtain more information about a particular admission, procedure or service with respect to a particular provider.

~~D. Notwithstanding the provisions of this subsection and at the request of a carrier, the superintendent may grant an additional year to comply with the provisions of this subsection as long as the carrier has demonstrated a good faith effort to comply with the provisions of this subsection and has provided the superintendent with an action plan detailing the steps to be taken by the carrier to comply with this subsection no later than January 1, 2019.~~

PART B

Sec. B-1. 22 MRSA §1718-I is enacted to read:

§1718-I. Hospital price transparency

1. Compliance with federal regulations. A hospital must comply with the price transparency requirements established in 45 Code of Federal Regulations, Part 180, Subparts A and B, as in effect on January 1, 2024.

2. Standard format; rules. A hospital must provide price transparency data in a standardized format established in rule by the Maine Health Data Organization. The Maine Health Data Organization shall adopt by rule a standardized format for a hospital to disclose price transparency data that is the same or substantially similar to any format required by federal regulations. Rules adopted pursuant to this subsection are routine technical rules as described in Title 5, chapter 375, subchapter 2-A.

3. Failure to comply. A hospital that fails to comply with subsection 2 or any rule adopted by the Maine Health Data Organization may be subject to a fine for failure to comply under section 8705-A. Notwithstanding any provision of law to the contrary, the Maine Health Data Organization shall retain any fine collected from a hospital for a failure to comply with this section pursuant to a compliance action taken under section 8705-A.

4. Determination of material compliance; notice. Upon a determination that a hospital is not in material compliance with subsections 1 and 2, the Maine Health Data Organization shall notify the hospital that the hospital is not in material compliance and require the hospital to take corrective action within 60 days to become materially compliant. The Maine Health Data Organization shall adopt by rule standards for material

compliance that align with federal regulations. Rules adopted pursuant to this subsection are routine technical rules as described in Title 5, chapter 375, subchapter 2-A.'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment is the minority report of the committee and replaces the bill.

Part A incorporates some of the components of the bill and does the following.

Upon request of an uninsured or self-pay patient, it requires health care entities to provide a good faith estimate of the cost of medical services to be rendered directly by that health care entity during a single medical encounter. It requires the information to be provided within the following time frames:

1. When a medical encounter is scheduled at least 3 business days before the date the medical encounter is scheduled to be furnished or when a patient is seeking urgent care, the estimate must be provided no later than one business day after the date of scheduling or the date of the request;

2. When a medical encounter is scheduled at least 10 business days before the encounter is scheduled to be furnished, the estimate must be provided no later than 3 business days after the date of scheduling; or

3. In all other circumstances, the estimate must be provided no later than 3 business days after the date of the request.

It requires the health care entity to separately disclose the prices for each component of medical services, including any facility fees or fees for professional services, and the procedure codes for those services. It requires health care entities to post notice on prominent display of a patient's right to request this information and include the notice in a patient's written consent to treatment form that must be signed prior to receiving health care treatment or services.

For insured patients, it requires health care entities to provide a description of the medical services to be rendered during a single medical encounter and the applicable standard medical codes or current procedural terminology codes used by the American Medical Association for those services and to notify the patient that the information can be used to obtain an estimate of the patient's out-of-pocket costs from the patient's health insurance carrier. It requires health insurance carriers to respond to requests from a patient for an estimate of out-of-pocket costs based on the description of the medical services and the codes provided by the patient's health care entity.

It prohibits a health care entity from initiating or pursuing any collection action against an uninsured or self-pay patient for items or services provided on a date the health care entity has provided those items or services to a patient unless the health care entity provided a good faith estimate to a patient that requested an estimate. The prohibition on collection action does not extend to insured patients.

Part B incorporates some of the components of L.D. 953, "An Act to Protect Maine Patients Regarding Hospital Price Transparency." Part B does the following.

1. It requires that hospitals comply with the price transparency requirements established in 45 Code of Federal Regulations, Part 180, Subparts A and B as in effect on January 1, 2024.

2. It requires a hospital to provide price transparency data in a standardized format as established by rule by the Maine Health Data Organization.

3. It provides that a hospital that fails to comply with the price transparency requirements established by the Maine Health Data Organization may be subject to a fine for noncompliance.