Joint Standing Committee on Health Coverage, Insurance and Financial Services

Additional Written Comments

(received after 9:00 am 4/28/22)

- Jeff Austin, Maine Hospital Association
- Jay Mullen, MD, BlueWater Health
- Jonathan Fellers, MD
- Dan Colacino
- Anastasia Norman, MD
- Philip Caper, MD (copy of oral testimony)
- Daniel Bryant, MD

MAINE'S LEADING
VOICE FOR HEALTHCARE

MHA Survey

Anthem Hearing

April 28, 2022

Attached please find a survey of Maine hospitals that was conducted by MHA in November 2021.

The survey results demonstrate the widespread, growing frustration our members have had in the past few years.

As you can see, Maine hospitals had over $350 million in outstanding claims with Anthem a year ago. Of that amount, $120 million was outstanding for more than 90 days.

The clear message from the survey is that the claims processing relationship is simply not functioning in a way that our members can manage.

Too often, a service is provided to a patient, the patient is healed and the provider is left chasing reimbursement through a maze.

MHA will be present at the public hearing.

Thank you.

Anthem Claims Management Review Survey
Maine Hospital Association
December 2021
33 of Maine's 36 hospitals responded to the survey.

Accounts Receivable								
Please provide the outstanding AR (Billed Amount) for each category:	Total AR Outstanding	1-30 Days	31-60 Days	61-90 Days	91-180 Days	181-365 Days	366+ Days	Year of Oldest Outstanding Claim
Maine Hospitals	**350,732,749**	**152,119,896**	**49,291,964**	**25,456,893**	**40,403,038**	**46,478,347**	**35,251,797**	**Range from 2013-2020**

Customer Service								
Please identify the top challenges you experience when communicating with Anthem:	Automated messages are not helpful	Chat sessions in portal are not helpful	If able to reach someone by phone, resolution of a claim takes a long time	Long hold times during phone inquiries about claims	Long hold times during phone requests for prior authorizations	Phones are not answered or are disconnected before reaching a person	Provider rep is unresponsive to requests for assistance	Provider rep not able to answer specific claims questions
# of Hospitals Reporting as Problem	**28**	**29**	**31**	**30**	**29**	**27**	**29**	**31**

Claims Processing								
Please identify the top challenges you experience with claims processing with Anthem:	Billing requirements frequently change	Changes to coding causing downgrades in reimbursements	Incorrect denials	Lengthy appeals process	Portal does not work for all inquiries thus requiring phone calls	Repeated requests for medical records on same claim	Slow response time after inquiries	Unknown or unnecessary delays in claims processing
# of Hospitals Reporting as Problem	**16**	**29**	**30**	**30**	**28**	**30**	**33**	**20**

AIM Authorization Processing			
Please identify the top challenges you experience with authorizations processing with AIM:	Authorization response given by AIM is not correct according to Anthem claim processing	Long hold time during phone requests for prior authorizations	Phones are not answered or are disconnected before reaching a resolution
# of Hospitals Reporting as Problem	**26**	**20**	**18**

Anthem Claims Management Review Survey

General Feedback

7. What keeps you up at night with the current situation with Anthem's claims management process?	8. Do you believe your current experience with Anthem is getting:			9. If you said better, what is contributing to your experience?	10. If you said worse, what is contributing to your experience?	11. Is there any other feedback you would like to provide?
	Better	About the Same	Worse			
It appears that Anthem has stopped working with providers. They leave us frustrated and looking for answers around upaid claims. When claims are not paid, providers must be afforded meaningful assistance with obtaining timely reimbursement. Without cooperation from both sides, patients and providers are negatively impacted			X		We have reached out on numerous occasions and cannot obtain clear answers. Despite outreach attempts with provider reps, there has been no improvement in at least the past two years.	Hospitals want to partner with payers to care for patients. Now that member cost share have increased significantly, hospitals are facing a customer crisis and we need cooperation from large payers like Anthem.
Lack of responsiveness. They cannot get our network status correct on their websites and some Anthem reps tell patients that we are out of network. It feels like the mentality of Anthem has changed and they are no longer partners with the hospital.			X		We have had many issues with Anthem this year and this is just a few. Experienced difficulty in getting settlements paid to us.	
Long hold times, dropped calls, escalation process not efficient/issues not handled timely, Anthem provider rep non-responsiveness		X				
Prior auth requirements		X				
		X		New rep - hopeful that there will be more progress		Harder than any other carrier. Additional audits, higher volumes than other payers. Make up own medical criteria for levels 4/5 E&M and ER.
Claims are not being processed in a timely fashion, especially corrected claims. Anything that we appeal can take months to get resolved.			X		Long hold times, appeals process delays, messages through portal going unanswered.	Anthem used to be a quick and consistent payer, and now that is not the case.
Claim denial percentage almost equals payment percentage. Huge amount of administrative burden for providers who are trying to treat patients.			X		All of the above. Is easy to see how they are turning a profit based on all the barriers and processing issues at providers expense.	
The provider escalation process with the timeliness of supplying information and knowing what it means, very vague descriptions, if any provided.			X		We have received no updates on account that have been escalated back from March 2021. Always the answer: they have been sent over, I am doing all I can to get these resolved.	They seem to have too many health systems with one provider rep, leaving gaps with all. Anthem made a lot of changes that their claims processing system could not handle.

General Feedback

7. What keeps you up at night with the current situation with Anthem's claims management process?	8. Do you believe your current experience with Anthem is getting:			9. If you said better, what is contributing to your experience?	10. If you said worse, what is contributing to your experience?	11. Is there any other feedback you would like to provide?
	Better	About the Same	Worse			
Anthem's inability to identify root cause, fix an issue and process all affected claims. Issues are handled as one offs causing increased accounts receivable. Often times, the one off fix will re-deny later and recoup the payment forcing you to dispute the same claim multiple times; New policies that affect reimbursement or create additional administrative burden are having a negative impact on our health system. The different rules and resources tied to Home Plans makes getting claims and issues fixed nearly impossible.			X		The lack of accountability on Anthem's part to resolve an issue. We are having to utilize large numbers of resources to follow up, dispute and escalate Anthem A/R issues and the aged A/R has grown tremendously over the last few years.	I feel we truly need access to someone who can actually process claims and override issues/denials, whether local or with a Home Plan. We also need root causes to be identified and fixed timely, including the reprocessing of all affected claims. The frequency and extent of Anthem policy changes continue to create financial and administrative burdens on the health system.
No effective communication to user/caller, unable to route. Anthem is unable to route the caller to the correct contact person or identify who that person is resulting in questions and unresolved issues.			X			There is little to no communication from Anthem staff; long holds, no returns on phone calls. Often times caller is routed to area who can not resolve then sent the caller back to the original person creating a cycle of confusion without resolution.
Provider rep does not respond timely, and often responds stating she will get back to us and doesn't			X		Lack of response, invalid diagnosis, call center is not able to answer questions, and chat answers are vague and scripted	We have multiple issues and the response times are unreasonable. Claims are denying for incorrect reasons, and reimbursed at the wrong rate often.
We continuously correspond with multiple levels of Anthem representatives with little to no improvements. Many times due to Anthems request it takes more than 90 days to even discuss issues where they could be fixed. In the last 13 months overall AR for Anthem has increased over 5 million.			X		*Lack of timely responses to acknowledge issues. *Lack of resolution which requires constant monitoring and communication with Anthem reps to ensure it stays at the front of issues. *We do business in multiple states and we have different reps as they cross state lines. So the same issues have to be addressed twice.	
			X			
			X		Decline in customer service over the past year. We have to go through multiple layers of reps and departments to get resolution. This adds time and cost to the process. Language and cultural barriers are problematic.	Frustration that Anthem REQUIRES everyone to perform according to their QHIP quality program (that has different metrics than CMS), or we face penalties on our reimbursement. Yet their quality of performance for their membership has declined and they quoted us a rate cut this year ON TOP OF QHIP. Gives the impression they don't care or understand what the industry is going through.

[illegible]
Language barrier, as reps are all overseas. Experience is that reps always have to send our questions to the claims department or the eligibility department, etc. They are never able to answer themselves.
Record requests are 3X greater than any other payer and there are issues with records being attached and processed without a phone call. Chat is not consistently helpful.
Chat sessions take long amounts of time due to Anthem reps having multiple sessions open for other providers.
Provider rep only responds to senior leadership and not management that is asking the initial questions.
Claim resolution takes a long time regardless of the problem then the caller is routed back to the starting point without resolution. Long waits for surgical authorizations.
Claims and recoupment departments do not recognize CAH Method II billing
Provider reps normal response is: I have done all I can do. I am not in claims so I cannot assist.
Claims processing/medical review takes months.
Blue Card claims (out of state plans) deny in error a lot. We talk with their Anthem plan and their coverage is active, but Anthem in Maine denies for no coverage. Most of the time have to get the patient involved to resolve these processing issues.
We have claim issues that are more than a year old and still unresolved with outreach to provider.
Multiple 3rd party auditors on Anthem's side causing addt'l challenges with delays, denials, obtaining audit documentation; Anthem's inability to identify already provided documentation; Claims processing practices that contradict NUBC, Federal Register, and AMA guidelines
Many of our provider claims are denying indicating they are not credentialed but really are (8,000 in the last 3 mos.) Denying claims for no NDC when it's present on claim. Reducing E&M services based on an algorithm and then very slow to respond to the appeals, which more than 90% are overturned.
Invalid NDC numbers stated are different from what is reflected in the medical record.
Sending records and IBs multiple times thru Availity and they are not located. Delay in appeals.
Time to process medical records requests
Responses are in a circle as the caller is redirected to AIM who states that they are "not responsible" then asks the caller to call back into another.
Issues with locating the authorization on the portal. Document uploads take a long time to load leading to "session time out" and re-work.
The auths are not connecting in Anthem. These are causing invalid denials. These are systemic.
Incorrect information given from representative; communication between AIM/Anthem is inconsistent; incorrect CPT approval; denials between AIM/Anthem

TESTIMONY OF JAY MULLEN, M.D., M.B.A., F.A.C.E.P.

COMMITTEE BRIEFINGS ON HEALTH INSURANCE CARRIER PROVIDER CONTRACTING ISSUES RELATED TO ANTHEM – APRIL 28TH, 2022.

Senator Sanborn, Representative Tepler and members of the Health Coverage, Insurance & Financial Services Committee

My name is Jay Mullen. I'm an emergency physician, a member of the Board of Directors of the Maine Medical Association and Chair of the Legislative Committees for the MMA and for the Maine Chapter of the American College of Emergency Physicians.

Today I would like to add my perspectives as the CEO of BlueWater Health. BlueWater is a 100% physician owned medical group which staffs emergency physicians and non-physician providers at emergency departments at Mid Coast Hospital, Houlton Regional Hospital as well as other New England hospitals.

Until recently, we have been proud to be in-network with Anthem at all of our locations but are seriously questioning that partnership.

There are three areas that I would like to touch on.

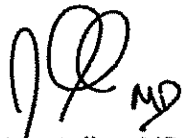
First, Anthem is not paying their bills on time. At this moment more than 25% of our bills to Anthem are more than 6 months past due. As any business owner can attest, if customers don't pay their bills in a timely fashion, cash flow becomes a significant challenge.

Second, Anthem is denying claims putting their members at medical and financial risk. The carrier is using diagnoses to refuse or reduce payment in violation of federal and state laws meant to protect patients who prudently go to ERs for evaluation of potentially life-threatening symptoms. When, after a thorough evaluation including x-rays, EKGs, lab work etc. it turns out that they have a non-emergent condition Anthem denies coverage or reduces payment. Think about a heartburn diagnosis when a patient presents thinking they might be having a heart attack. Protections like the Prudent Layperson Standard exist because the only thing anyone should have to worry about when they believe they are having an emergency is getting to the closest emergency department. I have attached a copy of a letter that Anthem was sending around a few years ago threatening "Save the ER for emergencies – or you'll be responsible for the cost."

Third, Anthem has not been an easy partner to engage in good faith negotiations. Blue Cross Blue Shield of North Carolina, for example, has been sending letters to physicians demanding as much as a 30% cut in their contracted rates. If the physician fails to comply, they are kicked out of the network. I've added an example to my testimony.

Patients use the ER in good faith, emergency physicians care for those patients in good faith and it seems reasonable that we should expect Anthem to act in good faith when they interact with their members and physicians. Right now, it doesn't appear that they are.

Respectfully,



Jay Mullen, MD, MBA, FACEP.

[Full brand name]
[Return address1]
[Return address2]
[Return city], [return state] [return zip]

May 11, 2017

[Subscriber first name] [Subscriber last name]
[Subscriber address1]
[Subscriber address2]
[Subscriber city], [Subscriber state] [Subscriber zip]

Save the ER for emergencies — Or you'll be responsible for the cost

Going to the emergency room or calling 9-1-1 is always the way to go when it's an emergency. And we've got you covered for those situations.

But starting June 1, 2017, you'll be responsible for ER costs when it's NOT an emergency (this isn't a change to your benefits plan).

If you need care now, but it's not an emergency, try these other options:

Urgent Care	Retail Health Clinic	LiveHealth Online	24/7 NurseLine
Open nights/weekends Back and joint pain, cough/cold, sinus or ear pain, sprains and strains and even x-rays	Rash, minor burns, cough, sore throat, shots, minor allergic reactions, bumps, cuts & scrapes	Visit with a doctor online 24/7 when you have a common health condition. Sign up now at livehealthonline.com or with the mobile app.	Call the 24/7 NurseLine on the back of your member ID card.

Go to **anthem.com/findurgentcare** to search for the right care option in your neighborhood.

Questions?
Give us a call at the Member Services number on the back of your ID card. You can also log in to anthem.com for a closer look at your benefits.

— Your Anthem team

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of North Carolina

November 5, 2021

[redacted]
[redacted]
[redacted]

Re: Necessity to amend rate agreement, response needed before November 21, 2021.

Dear Provider:

[redacted] is likely aware of the passage of the federal "No Surprises Act" in December of 2020, with an impending effective date of January 1, 2021. Under this law, payments from health plans to out-of-network providers in many circumstances will be set at the "Qualifying Payment Amount" (QPA) which is generally calculated at the median in-network contracted rate for the same or similar specialty within the applicable geographic area. The law applies with respect to out-of-network emergency services, out-of-network professional services at a visit to an in-network facility, and air ambulance services. It applies to our commercial networks (non-Medicare Advantage, non-Medicaid). The QPA paid by health plan to the out-of-network provider constitutes payment in full unless certain limited exceptions apply for a given QPA. These exceptions include express prior patient disclosure and consent, or successful challenge in arbitration.

This new federal law allows a significant change to Blue Cross and Blue Shield of North Carolina's contracting approach with emergency service providers, hospital-based providers, and air ambulance services. Where previous state law could result in an obligation to pay at full charges if no contract is in place, the new law sets reasonable limits on payment at the median in-network rate. Where Blue Cross NC may have previously contracted at what we deemed an inflated rate that is at least somewhat lower than charges in order to avoid paying at full charge, we are now able to seek to contract at a rate more in line with what we consider to be a reasonable, market rate.

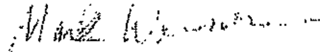
We have identified [redacted] as one of our outlier in-network providers with respect to rates. While the exact, final QPAs are not yet available pending upcoming finalization of the Rules to the No Surprises Act, the Interim Final Rules provide enough clarity to warrant a significant reduction in your contracted rate with Blue Cross NC. If we are unable to establish in-network rates more in line with a reasonable, market rate, our plan is to terminate agreements where the resulting out-of-network QPA would reduce medical expenses to the benefit of our customers' overall premiums.

Our ask of you at this point is as follows. We are seeking an immediate reduction in rates under our commercial agreement, as in interim step to the January 1, 2022 effective date of the No Surprises Act. This interim reduction will buy us breathing room to negotiate the final rates in light of the QPA amounts established in accordance with the upcoming Rules. With the interim reduction in place, we will not need to quickly terminate outlier contracts as a means of avoiding

payment levels after January 1, 2022 that are significantly higher than the default out-of-network QPA. Our reduction proposal, for a **December 15, 2021 effective date**, is **-10%**. We ask that you respond to this letter indicating your intention to agree, or providing a specific, comparable counterproposal. If we are able to reach agreement on the rate reduction we will quickly provide a simple rate amendment for your execution. If we are unable to reach agreement on the reduction, our intention is to proceed with identifying and executing on terminations of outlier contracts where the out-of-network QPA will result in significant savings to the benefit of our customers.

Thank you for your prompt attention to this request and your response before November 21, 2021. We hope and trust that we can update and maintain our ongoing partnership for January 1, 2022 and well beyond. If you have any questions, please contact Sr. Contract Manager, Sherrie Miller, Sherrie.Miller@bcbsnc.com at (919) 287-7439.

Sincerely,



Mark Werner
Vice President, Provider Networks

FELLERS MD

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Senator Sanborn, Co-Chair
Representative Tepler, Co-Chair
Members, Joint Standing Committee on Health Coverage, Insurance, and Financial Services
100 State House Station
Augusta, ME 04333-0100

Re: Committee Briefings on Health Insurance Carrier Provider Contracting Issues Related to Anthem

Senator Sanborn, Representative Tepler, and distinguished Members of the Committee,

My name is Dr. Jonathan Fellers and I am a triple-board certified physician with clinical expertise in the diagnosis and management of co-occurring mental health and addiction disorders. As an addiction psychiatrist, I work with patients, families, and our health care system to promote high quality evidence-based screening, assessment, and treatment for substance use disorders and co-occurring mental disorders. I am also a resident of South Portland.

When I established my private practice over three years ago, I elected to accept commercial insurance. I wanted patients to have the option to use their hard-earned health benefits for my services. It did mean additional work for me, including becoming credentialed with the different insurers, abiding by the terms of the various contracts, taking on significant administrative work, and paying for a medical billing professional. For this extra effort, my patients would have their claims covered and the insurers would honor the rates detailed in our contracts and fee schedules.

In early 2021, I began noticing a discrepancy between what I billed and what insurance paid with some patients. A pattern quickly emerged: starting in January 2021, Anthem unilaterally down-coded claims that, prior to 2021, they would have honored. For example, for some patients I billed for a 30-minute appointment, but Anthem would automatically change my bill to reflect a 15-minute appointment and pay me for that instead.

Investigating the explanation of benefits for these claims revealed that a "Cotiviti edit" prompted the down-coding. Further inquiry yielded "they were purposely processed at a lower level of office visit code per the Cotiviti edit. The original office visit/E&M codes they billed are for a longer session however based on the edit and the condition/dx billed on the claim, a lower level/shorter session of visit is more applicable. This is not a system issue and you will need to send medical records to support the need and usage of a higher level of service." Our office spent hundreds of hours mailing physical copies of patient records to Anthem's headquarters in an effort to appeal the claims.

My office's frustration with Anthem's apparent disregard for our agreed upon contract and fee schedule found no audience with our multiple calls to Anthem. Telephone agents recommended speaking with Anthem provider relations, however no one had contact information for this department. Others referred us to reach out to Anthem through the Availity portal, but these repeated efforts were again unanswered. The added administrative burden to justify our work

made continuing to see patients with Anthem untenable. I made the difficult business decision to leave the Anthem network in April 2021.

Per my contract, I needed to give 90-days' notice of the termination. Three weeks prior to leaving the network in July 2021, Anthem called our office and promised to look into our concerns. We agreed to hold-off on leaving the network as a token of good faith. Unfortunately, they were unable to rectify our concerns by turning off the Cotiviti edits and paying back the down-coded claims. I left the Anthem network in September, 2021.

I am concerned that Anthem is unfairly using their oversized market position to push the limits of providers' good nature. As a solo practitioner in an Anthem-dominant state, I have felt the striking power differential in working with such a heavyweight.

Though I am no longer in-network with Anthem, I continue to see patients with Anthem insurance. We continue to experience challenges with claim processing. Anthem asserts that they "processed 92 percent of claims within 14 days and 98 percent of claims within 30 days." My office manager estimates that, though the claims are processed quickly, over 90 percent of the time that processing is incorrect and the claim must be resubmitted. Correct processing is elusive; "same patient, same codes, same everything will pay differently in back-to-back months." For some patients, we submitted claims, but we never received an explanation of benefit and we are unable to look up the claims online. By calling, we discovered that Anthem paid the member, but we would have never been informed of this if we did not call.

Details have now emerged that my experience as private practitioner in Maine was not unique. Medical professionals including physicians, physical therapists, therapists, optometrists, and chiropractors all across the country experienced the same issues with down-coding of claims and delayed claim payments. Maine psychiatrists and therapists came forward with similar experiences as mine. Of five in-network private practice psychiatrists in Maine queried, all had experienced Anthem down-coding and delayed payments. As a result of media interest and advocacy by the Maine Medical Association, I understand that Anthem has paused down-coding of behavioral health claims. Though this grassroots advocacy is encouraging, I wish to point out that **formal oversight of health insurance and protections are provided for consumers but not for health care providers.**

Respectfully,

Jonathan C Fellers, MD
Principal
Jonathan C Fellers MD PA LLC

Dan Colacino

35 Walden Fields Drive

Delmar NY 12054 April 27, 2022

To: Senator Heather Sanborn, Chair

Representative Denise Tepler, Chair

Members, Joint Standing Committee on Health Coverage, Insurance and Financial Services

I am submitting these comments in reference to the hearing on the Anthem Blue Cross Blue Shield/ MaineHealth dispute.

I have worked in the health insurance field for the past 49 years, both as an insurance broker and as a senior executive with two insurance carriers. This issue is not new, nor will it be the last time two entities disagree since, at times, they seem to have cross purposes. In my experience, when the organizations are as large and have as dominant a market position, as these two do, they will work out a resolution and a termination of their contract will not be necessary.

There are three points I'd like to make;

First, the disagreement revolves around the billing of charges by the facility and the payment of claims by the insurer. The example often cited in news stories is the cost for a saline bag which I don't believe isn't fair to MaineHealth since all vendors mark up the acquisition cost of their goods based on overhead, labor, and other necessary business expenses. Therefore, the "cost" of the saline bag doesn't seem to be a good example. It does raise the question whether discounted payment of charges (POC) is the most appropriate method of reimbursement. Many insurers and provider use a prospective payment system (PPS) which is more efficient and results in fewer disputes. I don't know if these entities have looked into using diagnosis related groups (DRG) which is the method used by Medicare or even a per diem reimbursement. Both of these models have allowances for outliers in cases that are unique or more severe. No payment method is without its flaws, but it seems that a more effective reimbursement methodology could preclude future disputes.

Second, an editorial in Tuesday's Portland Press Herald by the president of the insurer referred to $20 million in refunds issued by MaineHealth as a result of overcharging. It begs the question of how that refund made its way back to the individuals, employers and employees who paid the insurance premiums and the self-funded employers who paid those claims costs directly and how it was accounted for.

Third, this situation is not, as some have suggested, a rationale for a single payer system of health care. These same disputes arise between Medicare and its contracted providers as well. Questions about DRG coding, observation days and Medicare audits are some of the examples.

This issue is not new nor is it limited to Anthem and MaineHealth. It is in the best interest of both organization's customers not only that they come to a resolution of the current issue but that they look forward to a process which could avoid this problem in the future.

Dan Colacino

McCarthyReid, Colleen

From:	Anastasia Norman <drnorman@gracehealthmaine.com>
Sent:	Friday, April 29, 2022 4:48 PM
To:	Dan Morin; McCarthyReid, Colleen; Sanborn, Heather
Subject:	physician testimony for HCIFS 4/28/2022 Committee Briefings on Health Insurance Carrier Provider Contracting Issues Related to Anthem

This message originates from outside the Maine Legislature.

Members of the Legislature,
Thank you for giving me the opportunity to provide testimony regarding the current dispute between Maine Medical Center and Anthem.

For context, I am a Board Certified Family Medicine Physician practicing in South Portland, Maine. I was employed by MaineHealth for the majority of my professional career, initially as a resident physician from 2010-2013, and then as an attending physician at Southern Maine Health Center, at their Saco Family Medicine office, from 2015-2020.
In 2020 I founded Grace Health, an independent Direct Primary Care practice in South Portland, where I work currently.

I attended the Zoom hearing yesterday, but due to patient care, was unable to be available when my turn to speak came. I will give my comments in bullet points below:

--The majority of comments were directed at Anthem's payment structure, which I agree has been problematic. But this does not tell the whole story.
--I did not see any comments (I may have missed some) regarding Maine Medical Center and MaineHealth's role in creating the current dispute.
--MaineHealth prices on almost every medical item, from imaging, to procedures, to office visits, are above-market. MaineHealth is rarely the most cost-effective option, an issue highly relevant to my patients, who either have high deductible insurance, or are uninsured.
It is not surprising to me that Anthem has balked at paying these inflated prices.
--As an example, I can draw a Thyroid Stimulating Hormone (TSH) lab in my office, send to Quest, and the total price to my patient is $8. The same lab drawn at Maine Medical Center (outpatient) is $300 ($250 NorDx + $50 draw fee). Maine Medical Center has considerably greater buying power than my small office, yet they charge over 100 times (or more) for many basic services.
--While I was employed at MaineHealth, I was generally cost-blind, and we were heavily encouraged to refer in-house. I have documentation in writing on this policy if helpful. We were 'graded' quarterly on our referrals, and if too many went to non-MaineHealth practices, we were called into a meeting to account for our behavior. It was not clear to me until I left that MaineHealth generally charged 25%-200% more than other local options, including Mercy Hospital, and smaller independent groups. For patients in the in-patient setting, the situation was even worse, as they did not have the option of asking for a lower-priced option, they were essentially held hostage to the prices set by MaineHealth, with no room for negotiation.
--I had several uninsured, or high-deductible plan patients who contested their bills at MaineHealth. One found that she had been charged for "Smoking Cessation Counseling" during her stay for a routine healthy vaginal delivery. She never smoked, and never requested the service, or spoke with anyone about smoking. I understand that she did try to contest this charge, but dropped her complaint because the administrative burden was on her to prove it DIDN'T happen (which she obviously couldn't do).
--Upgrades were made to the EPIC electronic medical record system during my last year of employment with MaineHealth with made it more difficult to refer outside the MaineHealth system. We had to take extra steps to do so, whereas it was much faster to refer to MaineHealth practices --MaineHealth has been aggressive in buying up, or

competing with, smaller independent practices. This has been the case with cardiology, and, most recently, with oncology. As smaller independent practices close and are absorbed, prices rise.
--As competition increases, however, prices fall. Up until recently, there were limited options for obtaining Coronary Artery Calcium Scoring. This is a type of CT scan that can be used to non-surgically assess a person's risk for a heart attack. The price in 2020 was around $400. As of earlier this year, Marshwood began offering the service. MaineHealth's price dropped the very next week by nearly half, to $250.
--Certificate of Need has been used to aggressively defend MaineHealth's monopoly on certain services. Our DPC group (NEDPCA) were in communication with Central Maine Medical Center in 2019 regarding the planned opening of their Topsham Outpatient Surgery Center. This center would have allowed our patients to access medically necessary outpatient procedures, such as cystoscopy, for a fraction of the cost at MaineHealth practices. CON was used to shut down this promising venture. These same patients are now traveling out of state to get procedures done, as the price in-state is unaffordable. These types of outpatient facilities are not "cherry picking" patients, the patients are "cherry picking" the facilities.
And going out of their way to do so.
--Other examples: I have patients who have driven to Canada, and flown as far as Florida and Oklahoma to have procedures such as vastectomy and colonoscopy. These trips, plus several nights stay in excellent hotels, were still significantly less expensive than having those same procedures done in-state. For patients with high-deductible plans, these cost differences, and the hassle involved, are substantial.
--Certificate of Need is a solution in search of a problem. We are not south Florida. Maine doesn't suffer from an excess of medical providers, but rather the opposite. CON works against Mainers by leading to situations like the current one, where one health system or hospital has an outsized effect on medical access. The pattern has been consistent for at least the last 15 years, and likely longer.
MaineHealth is not struggling financially. It was been in a period of continuous growth. And as soon as a smaller practice is bought up, prices increase.
--This trend of continually increasing prices does not have to continue. There are small practices which offer substantial cost savings. If our small practices can do this, then MaineHealth can do this. They can drop their prices on TSH testing, just as they dropped them on Coronary Artery Calcium Scoring. But they will be unlikely to do this willingly. CON needs to go. It is artificially restricting innovative practice models and quashing competition. And Mainers are the ones picking up the tab.

I hope the members of the legislature will take these concerns into effect, and am happy to furnish documentation for the above and answer any questions.

Thank you for your time,
Dr. Norman

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"Be kind, for everyone you meet is fighting a battle you know nothing about" --Wendy Mass

Oral Testimony - HCIFS Committee of the Maine Legislature - Takeaways from HCIFS hearing on 4-28-2022

By Philip Caper, M.D.

What we have all witnessed today is the dynamics of a failed market at work. Our flawed and ill-advised market-based for-profit and competition driven system, codified in the ACA, is behaving, not as it was intended to do, but as it was designed to do.

This is not a failure of Anthem or of Maine Health. Everybody is just doing their job, as they see it. What you're seeing is market-failure at work, and conflict created by a misalignment of incentives and of missions among the players.

Competitive markets do not, have not and will not ever work in health care, for reasons I detail in my submitted written testimony.

What was missing in this hearing, so far, is any in-depth discussion of the effects of this profit-seeking competitive behavior on "consumers" - AKA "patients". It's all about the money!

Who is at fault is this mess? When you put the fox in charge of the chicken coop, and the chickens begin to disappear, you don't blame the fox for being a fox. You have to ask "who put the fox in charge?"

This is a failure of public policy. No other wealthy country in the world has relied on a market-based, competitive system to control healthcare costs and protect the quality of care, and assure access medical care.

I hope today's hearing has demonstrated some of the reasons why that is the case, and has helped you to understand why the problems this hearing was intended to address are crying out for systemic and transformational changes.

Tinkering with the ACA will never produce the kind of changes that are needed.

Anything less is just kicking the can down the road - and guarantees that we will be back next year, the year after that and a decade from now -talking about the same problems.

This committee - and the legislature - has to think outside the box. That box is the belief that our for-profit, competitive and market-based system of health care is the right policy. What' needed is transformational change.

It's time to realize that the grand American experiment in market-based, profit-seeking and competitive health care has failed.

What we need is to return to a system based upon patient welfare - not money - sound health planning and cooperation among non-profit sources of financing, and health care delivery entities (including doctors) and patients.

Dirigo!

Maine can lead the way in showing how it can be done. That is absolutely do-able. 80-90 percent of the problems you heard described today would go away if this were done. The problem is not one of financial resources - we're now spending too much as is, and could fund universal coverage out of the waste in what we're now spending.

This problem is almost entirely a political one, and the legislature is the key to solving it. After all, our state and federal legislatures put the fox in charge of the chicken coop in the first place. Now, the state and federal legislatures are going to have to take responsibility for the mess, and fix the situation, as hard as that is going to be.

Activation of PL 391 is one path that this can be done.

If that could be done, the only remaining question the beneficiaries of this change (all of the people of Maine) would ask is "Why did it take so long?"

Written testimony regarding Anthem/MaineHealth dispute
HCIFS Committee meeting 4/26/22

I know this special meeting of the HCIFS Committee is devoted to resolving the dispute between Anthem and MaineHealth, but I think the need to have such a meeting makes the more important point that our current commercial insurance-based system needs to reformed. For example, the Portland Press' April 22 editorial regarding the dispute pointed out five problems associated with funding health care the way we do now:

1 - Billing for many hospital charges individually (line items, like the vintage bottle of saline), an approach which presents a huge (and expensive) accounting challenge to both insurer and hospital, and a huge frustration to patients.
2 - High charges for certain items, seemingly unrelated to "the actual cost of a service": "… as this case shows, we can't rely on market forces to control health care costs."
3 - The need to increase charges to insurers to cover unreimbursed care.
4 - Delays in payment by Anthem, at least, and in Georgia, Virginia, and Indiana as well as Maine.
5 - The ability of a provider (or presumably an insurer if they feel the funding arrangement is not fair to them) to end their contract, leaving patients in the lurch.

"MaineHealth and Anthem should work out their differences" the editorial concluded. This sounds sensible, and is the goal of this meeting, but hardly goes far enough. Dr. Larry Kaplan, in his April 23 letter on the Anthem-MaineHealth dispute, pointed the way to a real solution to these problems: mandating the legislature (through the ballot) to "pass a universal single-payer health plan by 2024." Last year, of course, the Legislature passed into law a severely amended version of just such a bill--LD 1045, An Act to Support Universal Health Care--which anticipated each of the five problems the editorial identified:

1 - To eliminate line-item charging, it proposed global budgets: "annual budgets for institutional providers. These budgets must consist of an operating and a capital budget. An institution's annual budget must be set to cover its anticipated health care services for the next year based on past performance and projected changes in prices and health care service levels."
2 - Charges for drugs and equipment would be negotiated: "Develop and implement a program to negotiate prices paid by the Maine Health Care Plan for covered pharmaceuticals, medical supplies [like saline], including biological products, and medically necessary assistive equipment at the lowest possible cost on an annual basis."
3 - There would be no uncompensated care prompting cost inflating or shifting: "Ensure all residents of this State are covered uniformly and unrelated to their employment status."
4 - Timely payment would be required by the law: "Provide adequate and timely payments to providers."
5 - Because this publicly funded system would be created by the legislature, presumably only legislators elected by the people (the patients), not unelected boards of corporations, could void the "contract" with providers.

As the editorial observed: "We ought to have a more rational system – one where health care keeps us healthy and insurance coverage gives us peace of mind."

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