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Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

COMMENTS OF THE MAINE HOSPITAL ASSOCIATION

In Opposition To

L.D. 953 - *An Act to Protect Maine Patients Regarding Hospital Price Transparency*

L.D. 1191 - *An Act Regarding Transparency of Medical Billing*

L.D. 1143 - *An Act to Address Late Medical Billing by Limiting Hospital Billing to One Year*

April 24, 2023

Senator Bailey, Representative Perry and members of the Heath Care, Insurance and Financial Services Committee, my name is Jeffrey Austin and I am here on behalf of the Maine Hospital Association to testify in opposition to these three bills.

Essentially, the federal government has jumped into this space in a very real way and these bills are either unnecessary or far weaker than the federal laws.

1. **LD 953.**

- Proposed Section 2150-N (lines 5-10). This section is unnecessary.

Maine DHHS Division of Licensing enforces both state law and federal law. They serve as both state surveyors (inspectors) and federal surveyors. We don't object to the concept of incorporating federal law into state law, but we think it may be redundant.

We do have a concern with the drafting. It references the specific 2023 version of the federal law in line 7. If the law is changed by the federal government in the future, hospitals would be in the untenable position of having to follow both the updated law and the 2023 version of the law.

Finally, if you were to move forward, there is a mirror federal transparency provision for carriers (45 CFR Parts 147 and 158). Shouldn't that be incorporated in state law as well? Why only hospitals?

- Proposed Section 2150-O (rest of the bill). This section is unreasonable.

This is the penalty provision, and it is unreasonable and unlike anything we know of in Maine law (or any law for that matter).

A penalty for violation of the law under this bill would be:

1. Hospitals would forgo all payment for any service received by the patient, AND
2. Hospitals would have to pay the patient a penalty in the amount of the price of the service.

So, if the price of the service is $10,000 the hospital would forgo the $10K payment they are owed and would have to pay the patient $10K. Accordingly, in this hypothetical, the penalty to the hospital would be $20,000 for violation of a transparency rule. This seems entirely unreasonable and inconsistent with penalty provisions in state and federal law.

That is not to say that hospitals don't face significant financial penalties under federal law. In the first year of enforcement, CMS fined four hospitals from other states six-figure penalties. However, those fines followed the federal progressive penalty structure.

Please oppose LD 953.

2. LD 1191.

Senator Bennet submitted similar legislation last session (LD 951). We will reiterate some of our testimony from 2021.

- Proposed section 1718-C(2) (lines 18-30). This appears to be the existing language in LD 1718-C and while we don't object to this existing language, we believe it should be repealed based upon the much more extensive federal "No Surprises Act" obligations to provide good faith estimates for the uninsured.

- Proposed Section 1718-C(3) (lines 31-26). This provision should be rejected as the No Surprises Act federal provision is forthcoming for the insured. If this part of the bill does go forward, we would request three changes.

The federal "No Surprises Act" requires providers and carriers to work together to produce upfront price and cost (to the consumer) estimates. The rollout of the provisions in the federal law are in two stages: (1) the uninsured and (2) the insured.

The AHA summarized the new requirement as follows:

> *Health care providers (both individual practitioners and facilities) will be required to share "good faith estimates" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured). The estimate will need to include the expected billing and diagnostic codes for all items and services included in the estimate. The provider would need to determine the patient's health coverage status and develop the*

good faith estimate at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider will need to furnish the information within three business days of a patient requesting a service or scheduling a service. This requirement will go into effect Jan. 1, 2022.

Notably for this bill, the "*good faith estimate*" (GFE) means a notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a convening provider, convening facility, co-provider, or co-facility. So, labs would appear to be covered.

The provisions dealing with the uninsured went into effect on January 1, 2022 (45 CFR §149.610). CMS has posted a 100-page power point online about the GFE for the uninsured and the related dispute resolution process.

The provisions dealing with the insured are still in development (CMS issued a request for information last year that closed in November.)

Notice that the information has to be given to the carrier and not the patient. This is because carriers will have to provide an Advanced EOB (Explanation of Benefits) that takes the information sent by the provider and translates it into the impact on the insured. This is similar to existing Maine law (§1718-B).

Finally, I would reiterate what I said two years ago on this topic:

"*Our suggestion is that you reject the legislation on these topics that has been proposed for this year and you compare the existing state laws with the incoming federal scheme to see which state laws could be repealed. I truly believe it's all of them or almost all aspects of them.*"

I would encourage you to do this – turn this bill into a resolve and have the Office of Affordable Healthcare summarize all these new federal provisions, identify gaps and identify redundancies in Maine law that can now be repealed.

If you are going to move forward, we would suggest three changes. First, this section should be an "upon request" provision. That is, price information should be provided upon request, not automatically. Second, this section should not include Medicaid and Medicare patients.

Third, with respect to laboratories, the law should acknowledge that sometimes the provider taking the sample (primary care office) may not own the lab analyzing the specimen. So, the law should only require providers to give the price for labs they own (fed law fully addresses this issue).

- Section 2 of the bill. We oppose this provision. (See testimony on LD 1143 below).

Please oppose 1191.

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3. **LD 1143.**

- Proposed Section 1728. We oppose this bill.

This bill is filed every session and has been defeated every session.

Our objection is not to the goal of the bill; consumers should be informed in a timely way of the amount they may owe for a medical service.

However, providers can't send a bill to a patient until the provider knows how much the patient owes. Providers don't know what a patient is going to owe, insurance carriers do.

Hospitals and other providers send a claim to the carrier first, the carrier processes the claim, pays the hospital whatever it is going to pay and then informs the provider what the patient responsibility is, if any.

The first step – providers sending claims to the carriers – is governed by contract and most contracts require claims to be submitted within 90-120 days. The vast majority of claims are made much sooner than the deadline in the contract.

The next step – carrier processing of the claim –can be either very quick or take a great deal of time. Most claims are processed quickly. However, a small share, 10% or so, take longer and those claims tend to be the larger, more complex and more expensive claims.

We could spend a long time arguing over whose fault it is that carrier processing takes so long. I think it is fair to say that we would point the finger at the carriers – they would probably point a finger back at us. The truth is that we both own the process to some degree.

From the patient's perspective, it doesn't matter; in those 10% of cases a bill is received long after care was provided. That is troubling.

This legislation forces providers to bear 100% the risk for a process we do not 100% control. That is unfair and bad public policy.

As you know, health care is unlike most other services in that there is a third-party (an insurance carrier) who pays most of the bill for the service. It is also unlike most other services because payment is not made until months after the service is received.

Even with a third-party insurance company and complicated billing process, patients overwhelmingly get their bills within 6 months. It does take longer in a number of cases. We wish it weren't so, but we can't lose payment on large claims when we don't control the process.

Hospitals offered a better system two years ago but our idea was rejected.

Please oppose LD 1143.

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