TESTIMONY OF STACY BERGENDAHL

SENIOR STAFF ATTORNEY

BUREAU OF INSURANCE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

In support of L.D. 899

An Act to Strengthen the Requirements for Medical Payments Coverage

Presented by Senator Bailey

Before the Joint Standing Committee on Health Coverage, Insurance & Financial Services

March 18, 2025 at 1:00pm

Senator Bailey, Representative Gramlich, and members of the Committee, I am Stacy Bergendahl, Senior Staff Attorney of the Bureau of Insurance. I am here today to testify in support of LD 899, "An Act to Strengthen the Requirements for Medical Payments Coverage." I would also like to thank Senator Bailey for sponsoring this bill.

Medical Payments Coverage ("med pay") is a mandatory coverage in auto insurance under 29-A M.R.S. §§ 1605,1605-A. Although the minimum coverage required is $2,000, many consumers purchase higher limits. This coverage is meant to provide coverage for drivers and their passengers for medical expenses they may incur due to an automobile accident. These expenses commonly include cost sharing amounts that may be owed to a health care provider, such as co-payments and deductibles.

Changes to the insurance code, which became effective in 2019 (24-A M.R.S. § 2910-A(4)), placed requirements around the assignment of this benefit to providers, and prohibited health insurers from coordinating health insurance benefits with the med pay coverage provided by auto insurers. Subsection 4(C) prevents the insured from receiving duplicate payments from med pay and health insurance for the same medical expenses.

Over the past couple of years the Bureau has received complaints that the insured has been billed for medical expenses despite the auto insurer's payment to the billing provider from the insured's med pay benefit. I have two examples from complaints we have investigated. As you may know, our complaints are confidential, so I will not discuss specific insurers or providers, and the dollar amounts I am discussing differ slightly from those in the complaints. But these should give you real world illustrations of the issue that we are seeking to address in this legislative proposal.

Complaint 1

The insured, who had both auto insurance and health insurance, was involved in an automobile accident. The insured agreed to assign the payment from the med pay coverage to the treating provider. The med pay coverage paid the maximum benefit of $4,000 toward the provider's bill, which should have covered the insured's cost-sharing under his health insurance. The health insurer paid the provider its contracted amount. The insured then received an invoice from the provider for $4,000. The invoice showed that the health insurer had paid $4,000 less than it had actually paid. The consumer paid the $4,000 bill to the provider and then contacted the Bureau to complain that the health insurer had improperly coordinated benefits with the auto insurer. After looking into the matter, we

determined that the health insurer had in fact paid its full contracted amount to the provider, and the provider had incorrectly displayed the $4,000 med pay coverage payment as a reduction of the health insurer's payment rather than a payment toward the member's balance. We asked the health insurer to direct its network provider to refund the $4,000 to the consumer since the med pay coverage should have been treated as a payment from the member, not a payment from another insurer. The provider refunded this to the consumer (although it also later sent another bill for $4,000 to the consumer which it subsequently did not require to be paid).

Complaint 2

The insured, who had both auto insurance and health insurance, was involved in an automobile accident. The insured assigned the medical payment benefit of approximately $25,000 to the provider. The billed amount from the provider was $94,000. The provider's contracted amount with the health insurer under this person's health insurance policy was $70,000, which included $69,000 due from the health insurer and $1,000 due in cost sharing from the member. The provider billed the health insurer, which paid $69,000, its portion of the contracted amount. The provider then billed the insured for the $1,000 cost sharing amount, despite receiving $25,000 from the insured's med pay coverage. After the Bureau's investigation, this was resolved by the auto insurer agreeing to pay the $1,000 to the insured. The provider retained the auto insurer's payment to cover amounts over its contracted rate that never would have been due from the consumer.

We believe this bill would result in fairer results and less confusion for insureds. It would also ensure they receive the full benefit of the med pay

coverage they have purchased. This would not change the prohibition against health insurers coordinating benefits with the auto insurer, and it would not change the prohibition against insureds recovering a double amount for the same services. It also would not prevent providers in these situations from receiving their full contractual billing amounts from health insurers (and the appropriate cost sharing from the consumer through the med pay coverage).

The bill would require casualty insurers to take an extra precautionary step of verifying that health insurance has paid its portion of medical expenses before making a payment to the provider. By doing this, the insured can be sure that the med pay coverage will go to out-of-pocket expenses the insured owes under the health plan and prevent the billing surprises these two consumers encountered.

The bill also requires that any assignment of these benefits be done in writing. This will help avoid confusion where the insured may not be sure of the implications of assigning this benefit, and it will help ensure that the consumer will have a better understanding of the implications of this assignment on the different coverages (health and auto) involved.

One technical correction needs to be made to the bill. "Casualty insurer" should replace "carrier" in both places where it appears, as this new provision is meant to apply to casualty insurers (auto insurers), not health carriers.[1]

Thank you, I would be glad to answer any questions now or at the work session.

[1] "Carrier" is defined as an insurance company licensed to provide health insurance under 24-A M.R.S. § 4301-A(3)(A).