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Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

Testimony of the Maine Hospital Association

In Opposition to

LD 1937 - *An Act To Require Hospitals And Hospital-affiliated Providers To Provide Financial Assistance Programs For Medical Care*

May 12, 2025

Senator Ingwersen, Representative Meyer and members of the Health and Human Services Committee, my name is Jeffrey Austin and I am presenting testimony in opposition to LD 1937 on behalf of the Maine Hospital Association. Our members have several concerns with this legislation.

As you are aware, Maine hospitals are having one of their more difficult years. From the closure of Inland Hospital in Waterville, to layoffs in Augusta and elsewhere, to service line closures all over the state, things are tough right now.

Also, as you are aware, the state is not paying all of its Medicaid bills to hospitals right now. Hospitals are shouldering the better part of $100 million in unpaid bills due to the lack of a supplemental budget. No doubt you are also aware, the Governor's proposed budget would cut hospital physicians who treat Medicaid patients at least $75 million over five years and would also impose a new tax on hospitals.

You must be aware of the potential for significantly more difficult news from Washington D.C.

And you know, all of the different bills we have supported in this committee to try and alleviate burdens on hospitals have been met with fiscal notes.

If we had the same privilege that state agencies do to put fiscal notes on legislation, this bill would be dead.

Bottom line: Now is not the time for several new unfunded mandates on hospitals.

Even if there weren't legislative challenges, our industry faces strong headwinds. MHA had a national firm conduct a study of our finances and it found some rather alarming statistics.

Maine hospitals are near the bottom of the country in three important metrics: operating margins, debt and age of plant.

Ranking of Maine Hospitals to National Indicators

PYA | MHA

Ranking of 2023 Median Financial Metrics to U.S. States

PPS (50 states) and CAH (45 states)

Lower Score Better

	Metric	Maine PPS	Maine CAH
1	Total Margin	39	29
2	Operating Margin	46	17
3	Return on Equity	21	28
4	Current Ratio	26	33
5	Net Days in Patient A/R	42	5
6	Equity Financing Ratio	49	24
7	Cash Flow to Total Liabilities	22	31
8	Average Age of Plant	46	40
9	Occupancy Rate	21	9

- Maine PPS hospitals are the 5th poorest and the 2nd most heavily in debt in the country.
- And our facilities are the 5th oldest in the country.
- A high occupancy rate suggests that hospital resources are being effectively used and minimizing waste.

- Most of Maine's rankings were in the bottom quartile when compared nationally for PPS hospitals, as discussed in more detail on the following page.
- CAH facilities ranked slightly more favorable overall to national medians but still face challenges with aging infrastructure.
- Large percentage of hospitals are occupied by patients, operating at or near full capacity, indicating a higher demand for services.

We've always known that hospitals in Maine had it a bit tougher than hospitals in other states; this study illustrated just how tough.

This is not just our opinion.

On January 8th, Commissioner Gagne-Holmes testified that the health of providers is a concern of hers. She said: "*The health and well-being of the people of Maine depend largely on the health and well-being of the providers who deliver those services.*" With respect to policy changes resulting in more charity care, "*More uncompensated care, more charity care [is] a stressor on our hospitals.*"

Yesterday, the Portland Press Herald opined:

> *Once-tolerable cuts need to be reversed.... New funding levers need to be pulled. These emergency proposals should focus on dedicating state support to the service providers that need it most desperately.*

Hospitals have not asked for a bailout or a pay increase this session. All we have been asking: is not to be cut, taxed or otherwise harmed by legislative action. As my boss wrote earlier this year: *we just need room to breathe.*

LD 1937 – Charity Care Amendments.

If you choose to proceed, and we ask that you do not, we would request several amendments.

Please keep in mind that the law is a minimum. Our members are all non-profit and take their charitable mission seriously. Several have exceeded the existing state minimums for a long time. Our members deserve some respect to be reasonable as they have proven to be through the years.

1. **Amend family income definition to include civil union and domestic partnerships.**

The bill defines a household as only being formed by marriage; it should include civil unions and domestic partnerships.

2. **Amend family income definition to clarify that private academy and college students will include parent's income.**

The bill unnecessarily changes the definition of income that has been used in the charity care law for decades. There have been instances of wealthy, out-of-state college kids dropping their insurance (which they have to have in order to enroll in college) and then trying to use charity care. That is wrong and should not be allowed.

3. **Amend the state resident definition to match the one used by Medicaid.**

The bill unnessarily changes the definition of resident that has been used in the charity care law for decades.

4. **Clarify that the medical debt of anyone otherwise eligible for charity care who is in the state working and who is supposed to be covered by either health insurance or workers compensation insurance but was not will be the responsibility of the person's employer if such insurance would have covered the treatment had it been in place.**

We shouldn't be forced to act as charities for for-profit businesses that break the law.

5. **Clarifies that the expansion of the mandatory charity care threshold from 150% to 200% is only for the uninsured.**

The current unfunded mandate is that hospitals provide charity care up to 150% of the federal poverty level.

Even the current law is too generous now that Maine people with income from 100% to 150% of the federal poverty level can get virtually free commercial coverage via the exchanges. This limit should be reduced to 100% not expanded to 200%.

However, if you choose to expand it up to 200%, that should only be for the uninsured.

Maine hospitals should not be forced to act as charities for the insurance industry. They have crafted high deductible plans that shift risk back to consumers.

If policy changes are needed, we would implore you to go to the Insurance Committee and have the insurance companies use their millions in profits to actually pay for people's medical care instead of forcing us to provide charity care to people WITH insurance.

6. Requires the recipient of charity care to notify the hospital of any change that might effect eligibility (same as Medicaid requires).

This is the same rule DHHS has in place for Medicaid.

7. Change the review deadlines from 15 days and 30 days to 30 days and 45 days.

The deadlines in this bill are unreasonable. The state gets 45-days for MaineCare applications.

8. Deletes the interpretation requirement.

Interpretive obligations exist under federal law. We ask that thee not be state laws directly on the same topic as federal regulations.

9. Creates a deadline for a recipient of notices to apply for charity care.

Most of this legislation is imposing obligations on the providers of free care. Virtually no obligations or expectations are placed on the recipients of free care.

Since the bill mandates that we provide notices to potential recipients in several different ways, there should be some obligation on the recipient to act. They should not be allowed to ignore notices and fail to take the necessary steps to apply for charity care. Their failure to apply in a timely ways costs the system a lot of unnecessary expense and delay. Most programs have deadlines to apply, free care should too.

10. Modifies the definition of income to add-back any income that is subject to taxation by the State of Maine.

If the state can take an income stream through taxation, we should be allowed to count that exact same income stream for charity care purposes.

11. Eliminates the translation requirement because it is inconsistent with federal law and is unduly burdensome given proposed section 12.

It is simply non-sensical to have 33 hospitals repeat the work this legislation requires the state to do. There is a federal law directly on point on translation mandates, there is no need to alter it.

12. **Again clarifies that the expansion of charity care from 150% to 200% is only for the uninsured.**

13. **Eliminates the requirement that paper copies be in every waiting room in a hospital; clarifies that only notice of where to obtain paper copies is required.**

This was actually one of the most objectionable items to our members. We simply don't do this any more. There used to be times when we had brochure kiosks with a lot of paper copies of things. We just don't now. We don't object to notices being posted, but we do object to mandates to put paper copies of applications in every waiting room.

14. **Deletes the word "accessible" from the obligation to post an application online.**

Not sure what that adds to the sentence.

15. **Clarifies that information on charity care may be either on the bill or with the bill.**

Minor, technical change.

16. **Deletes the unreasonable penalty that a hospital may not bill for a service not covered by a free care policy if the hospital fails to provide notice.**

We're not Dominoes pizza. If there is a violation of a regulation, it should be handled by DHHS through its enforcement powers.

17. **Changes the new regulation for eligibility for payment plans to be more reasonable.**

Maine has never mandated payment plans. We're not aware of Maine imposing payment plan obligations on any other private industry.

We don't even charge interest for owed debts; unlike the state which does charge interest.

Other legislation being enacted this year will significantly hamper our ability to collect debts.

We believe this entire section is unreasonable.

If you move forward two changes should be made. The eligibility criteria should be modified and a threshold should be used so that we don't need to do de minimis payment plans.

18. **Deletes the obligation to change our computer systems to accommodate the submission of applications online.**

This is also one of the items that was most objectionable to some of our members. Similar to DHHS, computer system changes are very expensive.

19. **Creates a deadline on the patient who is in collections to notify the collection agency of any potential charity care eligibility.**

Again, collections processes are expensive. Individuals should not be required to raise a defense in a timely manner.

A few notes. We only propose to delete a few items in their entirety. Most of these amendments are modifications to the unfunded mandates in the bill.

Several amendments attempt to keep us consistent with Medicaid policy or federal law.

Some amendments reduce expensive unfunded mandates to change our computer systems; we should be afforded the same deference you afford the state when they object.

The fact that some of our members voluntarily do some of these things now is not an acceptable reason to mandate it on everyone.

Finally, this bill should have a fiscal note. Half of our members are CAH hospitals and receive cost-based reimbursement. As such, when you mandate their costs increase, the state has to absorb some of those costs via Medicaid reimbursement.

We don't have a precise figure given the many changes in this legislation, but it is in the hundreds of thousands of dollars. That should be reflected in a fiscal note.