130th Legislature
Senate of Maine
Senate District 20

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Introducing LD 530, "An Act To Consolidate Patient Bills by Directing Health Insurers To Collect Copayments and Deductibles"
Joint Standing Committee on Health Coverage, Insurance and Financial Services
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Good morning Senator Sanborn, Representative Tepler and honorable members of the Health Coverage, Insurance and Financial Services Committee, I am Senator Ned Claxton, I represent Senate District 20 and am honored to represent the residents of Auburn, Minot, Mechanic Falls, Poland and New Gloucester. I am pleased to present LD 530, "An Act To Consolidate Patient Bills by Directing Health Insurers To Collect Copayments and Deductibles."

The purpose of this legislation is to address two issues that patients face when dealing with their co-pays and deductibles: the timeliness of getting bills and the lack of coordination in receiving those bills. Getting this process right for outpatient care is not so complicated, but go to the hospital ED or get admitted and you leave prepared to get from 2 up to 5 bills. Our current experience is that the bills from different providers will likely arrive at your home at very different times. You are likely to be getting bills from the emergency department provider, a facility fee, the surgeon's bill, the anesthesiologist bill, and the radiologist bill. Then the hospital bill arrives after all of those. Have I mentioned the lab and the physical therapy charges?

In our current system, providers such as hospitals and doctors are obligated to collect co-pays, deductibles and other cost-sharing amounts directly from the patient.

LD 530 shifts that responsibility to the insurance companies that included the co-pays and deductibles in their plans. This bill puts the patient experience at the center of this process – getting 1 bill for co-pays and deductibles, that they then pay to the insurance company. That is where the financial contract resides, either directly or through an employer. Who knows what the co-pays and deductibles are, what percentage is covered, what the negotiated allowables are? You and I don't. The insurance company does. They handle these numbers all the time. They know what the billing will look like from the last umpteen hospitalizations that are similar to yours.

Patient at the Center. I believe we should pursue public policy based upon the system that is most efficient and user friendly for the consumer, our constituents. The goal of LD 530 is to improve the process from the perspective of the patient in two important respects.

1. **Timeliness of billing.** A major complaint this committee has often heard from individuals is that sometimes a provider sends a bill long after treatment is provided. (Three LDs this session seek to address this issue: LD 167; LD 367 and LD 951.) In addition, as noted

above, there are multiple known and surprise billers in this crazy quilt system. Earlier this session you heard bills from me and Senator Pouliot on timely billing. The only member of the public who testified stated that she received her EOB from her carrier within weeks of a service, but she did not receive her bill from the provider for over 9 months, and that was for a simple hearing test! I don't know why there was this delay. But I do know it was unnecessary. There are a variety of reasons why it takes time to produce a bill and as this committee has come to appreciate, many of them are not easily resolved with legislation.

In trying to construct a more logical billing process, what value does it bring to include providers in the process, other than to add additional risks of error and delay? Providers are good at providing, not at billing. To be competent billers, they need to assemble an array of people and software to try and keep track of the process. This is reproduced in hundreds if not thousands of provider offices in Maine, each with their own unique and occasionally flawed billing and collection processes. Remember, these are healthcare providers; they are not financial services firms. Carriers are financial services firms. Let's use LD 530 to take healthcare providers out of the process, make it more efficient and improve the timeliness and accuracy of insurance co-pay and deductible billing.

2. **Consolidation of Billing**. A second source of frustration that we hear about from our constituents is that they receive different bills from different providers at different times for the same medical event. The different providers are legitimately owed payment for their services. The issue is that patients understandably don't always know which of the many providers is independent from the hospital.

Imagine you have surgery at a hospital. You will owe a payment to the hospital for the facility, the equipment and the nurses and medicines, etc. You will also owe the surgeon. But what about the anesthesiologist and the radiologist? Do they work for the hospital? Are they in the same practice? Are they in separate practices? They provided care and are owed compensation. That's not the issue. But as the patient, do you know if you are getting just two bills, or three or four?

You know who does know? Your carrier. Your carrier receives claims from all of the providers on your care team. Carriers ask (or force) providers to bundle the different aspects of treatment into a single claim all the time. I believe the state should require carriers to bundle all the provider claims from a single encounter into a single bill to the patient.

Through the years, people have tried to corral all these provider bills and have failed. I believe we have been unsuccessful for the simple fact that billing is a hard, complex process. It is very difficult to have multiple different providers, each with their own systems, act in concert. Even if there is a single billing deadline (e.g., you must bill the patient within 6 months), as long as there are different providers, then the different bills will arrive at different times.

A better vision is to regulate a few carriers to collect all of the claims from various providers and, once adjudicated, to send a single bill to the patient.

Consolidation is not mandated in the bill. It is a goal best accomplished through rulemaking. There are technical aspects to defining an encounter that are best left to such a process. However, my hope is that by shifting responsibility back to the carrier, we can then ask for billing consolidation.

Objections. Let me briefly attempt to address some of the objections you will likely hear.

Providers vs. Carriers. Much of the conversation will involve a debate about fairness between providers & carriers. Each side of this debate can probably make a compelling case for why the other should have the task of collecting co-pays and deductibles.

The simple fact of the matter is that either providers or carriers will have to do this task. Whoever is burdened with the task will be unhappy and I am sympathetic to that. Currently, providers have this task and I know it is a pain for them. Carriers don't have this task today and I understand that they don't want it. Either way, someone has to have this responsibility.

Once the back-and-forth of claim adjudication is over, the carriers (not the providers) possess all the information necessary to collect payment from the patient. The biggest piece of information at the end of claim adjudication is where does the patient stand with respect to the deductible? That is information the carriers have. Carriers are already obligated to contact patients with the Explanation of Benefits document. So, it's not as if carriers are unaccustomed to contacting patients after care is provided.

Impact on Premiums**.** Probably the strongest objection you will hear from carriers is a claim that premiums will increase if this change is made. Clearly, the workload will increase for carriers. But the workload will decrease for others in this system. In fact, the efficiency gains are such that there will be more in saved work by the thousands of providers than there will be in increased work for carriers. Some bills don't get paid and bad debts are absorbed by providers. Carriers will now have to absorb some of those debts. There is no reason to suspect that bad debts in the system will increase. This bill changes which entity has to deal with the bad debt. It is simply too early to know what the impact will be on premiums.

Some may suggest that the state should somehow force the providers to reduce their rates to carriers to account for the reduced costs and reduced bad debt that the providers will encounter. It's not clear how that would be accomplished. Furthermore, the state did not require carriers to increase reimbursement rates during the many years that carriers have increased patient deductibles and shifted risk to providers.

Providers have successfully shifted some of their billing costs and bad debt losses on to carriers during contract negotiations over the past 30 years. Since we trusted providers to take care of themselves at the bargaining table for years, we should similarly trust carriers to take care of themselves at the bargaining table should this legislation pass.

Legislation Only Impacts Some Carriers/Plans. Obviously, Maine can't regulate all insurance products. But that is an issue that this committee deals with all the time as you review legislation. If this were a successful objection, then there would be very little for you to do.

Bureau of Insurance Impact. This bill will undoubtedly involve some increased workload for the Bureau. I think that is a good thing because I don't think anyone is closely watching how patients are billed now. Oversight of providers rests with DHHS and licensing boards. They are focused, rightly in my opinion, on healthcare services. Is someone really watching provider billing practices? By shifting billing to carriers, oversight shifts to the Bureau. Maine's Bureau of Insurance has an excellent track record of keeping an eye on carriers and looking out for consumers. I think billing fits nicely within their portfolio of responsibility.

No Other State Has Done This. I don't consider that a problem. Why aren't other states making it easier for their constituents by crafting a responsible, simpler billing system? Maine can lead.

Conclusion. This bill is quite modest from the perspective of the patient. It doesn't eliminate co-insurance. It doesn't reduce prices. But it does move us to a more coherent and understandable billing system.

Over the past few decades, we didn't keep, carriers from creating high deductible plans and increasing out-of-pocket costs for our constituents. That would have been radical. But now that this aspect of healthcare billing has been in place for a number of years, two clear problems for patients are obvious.

First, forcing doctors to send and collect bills is an inefficient and unnecessary step that impacts patients by delaying billing and introducing risks of errors, all for no gain. It's a step we can easily eliminate to improve efficiency.

Second, a system where each provider sends their own bills is a burden on patients. The bills come at different times and from different directions. This is burden without any benefit. And again, it's a burden that can be easily fixed if we choose to fix it.

This bill provides us an opportunity to make the medical billing process less confusing for patients and to make the process more efficient. I respectfully ask that the committee vote on LD 530 as Ought to Pass.

Thank you and I would welcome the opportunity to try and answer any of your questions now or at the work session.