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Local Health Systems

Franklin Community Health Network
LincolnHealth
MaineHealth Care At Home
Maine Behavioral Healthcare
Memorial Hospital
Maine Medical Center
NorDx
Pen Bay Medical Center
Southern Maine Health Care
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Waldo County General Hospital
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MaineGeneral Health
Mid Coast-Parkview Health
New England Rehabilitation Hospital of Portland
St. Mary's Health System

Testimony of Katie Fullam Harris, MaineHealth in Opposition to LD 951, "An Act to Improve Transparency of Medical Billing" and LD 1353, "An Act To Require Public Posting of the Costs of Medical Procedures, Services, Medications and Equipment Delivered in Hospitals and the Reporting of Those Costs upon Request"

April 20, 2021

Senator Sanborn, Representative Tepler and distinguished members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services, I am Katie Fullam Harris of MaineHealth, and I am here to testify in opposition to both LDs 951 and 1353.

MaineHealth is Maine's largest integrated non-profit health care system that provides the full continuum of health care services to the residents of eleven counties in Maine and one in New Hampshire. Every day, MaineHealth's over 23,000 employees are committed to fulfilling our vision of "working together so our communities are the healthiest in America."

MaineHealth recognizes the importance of ensuring that patients have access to information regarding the cost of their health care. We work hard to comply with the myriad of laws that now govern such information (see attached for a list of the relevant state laws). As the laws stand today, price information for each code is available on our website as is required by federal law. In addition, Maine statute requires that hospitals:

- Provide itemized bills upon request;
- Provide the average charge for an inpatient service or an outpatient procedure, upon request, including notifying patients of that availability;
- Make available to patients the prices for all services and procedures that were provided at least 50 times in the last year, including descriptions and applicable medical codes;
- Publicly display information about the Maine Health Data Organization's website;
- Notify patients with private health insurance who are being referred for services of their right to obtain services from a different provider, including the their option to use the carrier's price transparency tool or

information provided by the carrier on the value of the service and provider in question.

- Upon request of an uninsured patient, provide an estimate of the total price of medical services to be provided in an encounter.

In addition, Comparemaine.org is a website maintained by the Maine Health Data Organization that provides easily understood data on the cost and quality of specific "shoppable" procedures and services by provider and by insurer and by geography. For example, you can find out the average cost of an EKG at each facility, as well as the patient experience and quality scores for that facility. This website is "friendly" to lay users, and, as noted above, we are required to refer patients to it.

Thus, there are a number of statutes governing the availability of price and cost information for health care consumers. We strongly believe that the bills before you are unnecessary and would only serve to complicate the information already provided.

Statutes Related to Health Care Price Transparency

Itemized Bills (22 MRSA §1712):

§1712. Itemized bills

Each hospital licensed by the State under chapter 405 shall inform all patients, or their legal guardians, in writing, at the time of the patient's discharge, that it will provide an itemized bill upon their request. [PL 1983, c. 166 (NEW).]

The request may be made by the patient or his legal guardian at discharge or at any time within 7 years after discharge. [PL 1983, c. 166 (NEW).]

The hospital shall provide an itemized bill to the person making the request within 30 days of the request. [PL 1983, c. 166 (NEW).]

Notwithstanding this section, effective July 1, 1985, each hospital shall itemize on the hospital bill of each patient the cost of nursing services provided to that patient. [PL 1983, c. 166 (NEW).]

SECTION HISTORY

PL 1983, c. 166 (NEW).

Consumer Information (22 MRSA §1718):

§1718. Consumer information

Each hospital or ambulatory surgical center licensed under chapter 405 shall, upon request by an individual, provide the average charge for any inpatient service or outpatient procedure provided by the licensee. If a single medical encounter will involve services or procedures to be rendered by one or more 3rd-party health care entities as defined in section 1718-B, subsection 1, paragraph B, the hospital or ambulatory surgical center shall identify each 3rd-party health care entity to enable the individual to seek an estimate of the total price of services or procedures to be rendered directly by each health care entity to that individual. For emergency services, the hospital must provide the average charges for facility and physician services according to the level of emergency services provided by the hospital and based on the time and intensity of services provided. The hospital or ambulatory surgical center shall prominently display a notice informing individuals of an individual's authority to request information on the average charges described in this paragraph from the hospital or ambulatory surgical center. [PL 2013, c. 560, §1 (AMD).]

1. Inpatient services.

[PL 2009, c. 71, §3 (RP).]

2. Outpatient nonemergent procedures.

[PL 2009, c. 71, §3 (RP).]

3. Emergency services.

[PL 2009, c. 71, §3 (RP).]

SECTION HISTORY

RR 2003, c. 1, §16 (COR). PL 2003, c. 469, §C15 (NEW). PL 2005, c. 391, §1 (AMD). PL 2009, c. 71, §3 (RPR). PL 2013, c. 560, §1 (AMD).

Consumer information regarding health care entity prices (22 MRSA §1718-B):

§1718-B. Consumer information regarding health care entity prices

This section applies to the disclosure of health care prices by a health care entity. [PL 2013, c. 515, §2 (NEW).]

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Frequently provided health care services and procedures" means those health care services and procedures that were provided by the health care entity at least 50 times in the preceding calendar year. [PL 2013, c. 515, §2 (NEW).]

B. "Health care entity" means a health care practitioner, as defined in section 1711-C, subsection 1, paragraph F; a group of health care practitioners; or a health care facility, as defined in section 1711-C, subsection 1, paragraph D, that charges patients for health care services and procedures. A health care entity does not include a pharmacy or a pharmacist. [PL 2013, c. 515, §2 (NEW).]

[PL 2013, c. 515, §2 (NEW).]

2. Requirements. The following requirements apply to health care entities.

A. A health care entity shall have available to patients the prices of the health care entity's most frequently provided health care services and procedures. The prices stated must be the prices that the health care entity charges patients directly when there is no insurance coverage for the services or procedures or when reimbursement by an insurance company is denied. The prices stated must be accompanied by descriptions of the services and procedures and the applicable standard medical codes or current procedural technology codes used by the American Medical Association. [PL 2013, c. 515, §2 (NEW).]

B. A health care entity shall inform patients about the availability of prices for the most frequently provided health care services and procedures. [PL 2013, c. 515, §2 (NEW).]

C. A health care entity shall prominently display in a location that is readily accessible to patients information on the price transparency tools available from the publicly accessible website of the Maine Health Data Organization established pursuant to chapter 1683 to assist consumers with obtaining estimates of costs associated with health care services and procedures. [PL 2013, c. 515, §2 (NEW).]

D. Beginning January 1, 2018, at the time a referral or recommendation is made for a comparable health care service as defined in Title 24-A, section 4318-A, subsection 1, paragraph A during an in-person visit, the health care entity making that referral or recommendation shall notify a patient who has private health insurance coverage of the patient's right to obtain services from a different provider. A health care entity shall comply with this paragraph by providing a written notice at the time the health care entity recommends or refers a patient for a health care service or procedure that may qualify as a comparable health care service. A written notice provided under this paragraph must include a notification that, prior to obtaining the recommended service, the patient may review the health care price transparency tool provided by the patient's carrier or contact the patient's carrier directly via a toll-free telephone number so that the patient may consider whether the recommended provider of the comparable health care service represents the best value for the patient. A written notice provided under this paragraph must also include a description of the service or the applicable standard medical codes or current procedural terminology codes used by the

American Medical Association sufficient to allow the carrier to assist the patient in comparing prices for the comparable health care service. [PL 2017, c. 232, §1 (NEW).]

A health care entity that does not routinely render services directly to patients in an office setting may satisfy this subsection by providing the information on its publicly accessible website.

[PL 2017, c. 232, §1 (AMD).]

SECTION HISTORY

PL 2013, c. 515, §2 (NEW). PL 2017, c. 232, §1 (AMD).

Estimate of the total price of a single medical encounter for an uninsured patient (22 MRSA §1718-C):

§1718-C. Estimate of the total price of a single medical encounter for an uninsured patient

Upon the request of an uninsured patient, a health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall provide within a reasonable time of the request an estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter. If the health care entity is unable to provide an accurate estimate of the total price of a specific medical service because the amount of the medical service to be consumed during the medical encounter is unknown in advance, the health care entity shall provide a brief description of the basis for determining the total price of that particular medical service. If a single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity to enable the uninsured patient to seek an estimate of the total price of medical services to be rendered directly by each health care entity to that patient. When providing an estimate as required by this section, a health care entity shall also notify the uninsured patient of any charity care policy adopted by the health care entity. [PL 2013, c. 560, §2 (NEW).]

Prohibition on balance billing for surprise bills and bills for out-of-network emergency services; disputes of bills for uninsured patients and persons covered under self-insured health benefit plans; disclosure related to referrals (22 MRSA §1718-D):

§1718-D. Prohibition on balance billing for surprise bills and bills for out-of-network emergency services; disputes of bills for uninsured patients and persons covered under self-insured health benefit plans; disclosure related to referrals

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Enrollee" has the same meaning as in Title 24-A, section 4301-A, subsection 5. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

B. "Health plan" has the same meaning as in Title 24-A, section 4301-A, subsection 7. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

B-1. "Knowingly elected to obtain the services from an out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider

with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this paragraph. [PL 2019, c. 668, §1 (NEW).]

C. "Provider" has the same meaning as in Title 24-A, section 4301-A, subsection 16. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

D. "Surprise bill" has the same meaning as in Title 24-A, section 4303-C, subsection 1. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

E. "Visit" means any interaction between an enrollee and one or more providers for the purpose of assessing the health status of an enrollee or providing one or more health care services between the time an enrollee enters a facility and the time an enrollee is discharged. [PL 2019, c. 668, §1 (NEW).]

[PL 2019, c. 668, §1 (AMD).]

2. Prohibition on balance billing. An out-of-network provider reimbursed for a surprise bill or a bill for covered emergency services under Title 24-A, section 4303-C or, if there is a dispute, under Title 24-A, section 4303-E may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out-of-pocket cost expense that would be imposed for the health care services if the services were rendered by a network provider under the enrollee's health plan. For an enrollee subject to coinsurance, the out-of-network provider shall calculate the coinsurance amount based on the median network rate for that health care service under the enrollee's health plan. An out-of-network provider is also subject to the following with respect to any overpayment made by an enrollee.

A. If an out-of-network provider provides health care services covered under an enrollee's health plan and the out-of-network provider receives payment from the enrollee for health care services for which the enrollee is not responsible pursuant to this subsection, the out-of-network provider shall reimburse the enrollee within 30 calendar days after the earlier of the date that the provider received notice of the overpayment and the date the provider became aware of the overpayment. [PL 2019, c. 668, §1 (NEW).]

B. An out-of-network provider that fails to reimburse an enrollee for an overpayment as required by paragraph A shall pay interest on the overpayment at the rate of 10% per annum beginning on the earlier of the date the provider received notice of the overpayment and the date the provider became aware of the overpayment. An enrollee is not required to request the accrued interest from the out-of-network provider in order to receive interest with the reimbursement amount. [PL 2019, c. 668, §1 (NEW).]

[PL 2019, c. 668, §1 (AMD).]

3. Uninsured patients; disputes of bills. An uninsured patient who has received a bill for emergency services from a provider for one or more emergency health care services rendered during a single visit totaling $750 or more may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E. The independent dispute resolution entity contracted to resolve the dispute over the surprise bill shall select either the out-of-network provider's fee or the uninsured patient's proposed payment amount in accordance with Title 24-A, section 4303-E. An uninsured patient may not be charged by a provider more than the amounts generally billed to a patient who has insurance covering

emergency services as determined using the method described in 26 Code of Federal Regulations, Section 1.501(r)-5, paragraph (b)(3) or (b)(4). A provider shall hold the uninsured patient harmless for the duration of the independent dispute resolution process and may not seek payment until the independent dispute resolution process is completed. Notwithstanding Title 24-A, section 4303-E, subsection 1, paragraph F, payment for the independent dispute resolution process is the responsibility of the provider. In the event a claim includes more than one emergency health care service rendered during a single visit, the independent dispute resolution entity may allocate the prorated independent dispute resolution costs at its discretion among providers.

[PL 2019, c. 668, §1 (NEW).]

REVISOR'S NOTE: (Subsection 3 as enacted by PL 2019, c. 670, §1 is REALLOCATED TO TITLE 22, SECTION 1718-D, SUBSECTION 5)

4. Person covered under self-insured health benefit plan; disputes of surprise bills or bills for covered emergency services rendered by an out-of-network provider. A person covered under a self-insured health benefit plan that is not subject to the provisions of Title 24-A, section 4303-E pursuant to Title 24-A, section 4303-E, subsection 2 and who has received a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E, subsection 1. The independent dispute resolution entity contracted to resolve the dispute over the bill shall select either the out-of-network provider's fee or the covered person's proposed payment amount in accordance with Title 24-A, section 4303-E, subsection 1. This subsection does not apply to a person covered under a self-insured health benefit plan who knowingly elected to obtain the services from an out-of-network provider.

[PL 2019, c. 668, §1 (NEW).]

5. (REALLOCATED FROM T. 22, §1718-D, sub-§3) Referral to an out-of-network provider. A provider receiving a nonemergency referral or self-referral for any in-person health care service or procedure shall disclose to the enrollee whether that provider to whom the enrollee is being referred is a member of the provider network under the enrollee's health plan before the enrollee schedules the appointment for that service or procedure.

[RR 2019, c. 2, Pt. A, §25 (RAL).]

SECTION HISTORY

PL 2017, c. 218, §1 (NEW). PL 2017, c. 218, §3 (AFF). PL 2019, c. 668, §1 (AMD). RR 2019, c. 2, Pt. A, §24 (COR). RR 2019, c. 2, Pt. A, §25 (AMD).

Disclosure related to observation status for Medicare patients (22 MRSA §1718-F):

§1718-F. Disclosure related to observation status for Medicare patients

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall disclose to a patient who is covered by the federal Medicare program and who is on observation status and not an admitted patient at the health care entity the following information in a single notice: [PL 2019, c. 670, §3 (NEW).]

1. Medicare outpatient observation notice. The Medicare outpatient observation notice required under 42 Code of Federal Regulations, Section 489.20(y);

[PL 2019, c. 670, §3 (NEW).]

2. Impact on patient's financial liability. Notification that observation status may have an impact on the patient's financial liability; and

[PL 2019, c. 670, §3 (NEW).]

3. Opportunity to discuss potential financial liability. Notification that the patient may meet with a representative from the health care entity's financial office to discuss the patient's potential financial liability.

[PL 2019, c. 670, §3 (NEW).]

SECTION HISTORY

PL 2019, c. 670, §3 (NEW).