TASK FORCE TO EVALUATE THE IMPACT OF FACILITY FEES ON PATIENTS

Friday, December 1, 2023
10:00 a.m. – 3:00pm

Location: Room 220 (HCIFS Committee Room)
Cross State Office Building, Augusta

Public access also available through the Maine Legislature's livestream:
https://legislature.maine.gov/Audio/#220

MEETING AGENDA

10:00 am	Welcome *Chairs, Senator Donna Bailey and Representative Poppy Arford* Commission member introductions
10:15 am	Review of Public Law 2023, chapter 410 (authorizing legislation for the task force) *OPLA staff*
10:30 am	Review of federal and state transparency requirements for hospitals and health insurance carriers regarding cost of treatment (required by resolve) *OPLA staff*
11:00 am	Review and discussion of other state laws related to facility fees (required by resolve) *OPLA staff*
11:30 am	Update on annual reporting required by Public Law 2023, chapter 410 *Maine Health Data Organization*
12:00 pm	Break
12:30 pm	Public Comment—Industry practices related to facility fees and impact of fees on patients • *Invited stakeholders: Maine Association of Health Plans, Maine Hospital Association, Maine Medical Association, Health Care Purchaser Alliance of Maine and Consumers for Affordable Health Care* • *Comment from interested parties and members of public*
2:30 pm	Information requests and next steps *OPLA staff*
3:00 pm	Adjourn

APPROVED
JULY 10, 2023
BY GOVERNOR

CHAPTER
410
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 720 - L.D. 1795

An Act to Create Greater Transparency for Facility Fees Charged by Health Care Providers and to Establish the Task Force to Evaluate the Impact of Facility Fees on Patients

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §8712, sub-§2-A is enacted to read:

2-A. Facility fees charged by health care providers. By January 1, 2024, and annually thereafter, the organization shall produce and post on its publicly accessible website a report on the payments for facility fees made by payors to the extent that payment information is already reported to the organization. The organization shall submit the report required by this subsection to the Office of Affordable Health Care established in Title 5, section 3122 and the joint standing committee of the Legislature having jurisdiction over health data reporting and health insurance matters. The joint standing committee may report out legislation based on the report to a first regular or second regular session of the Legislature, depending on the year in which the report is submitted.

For the purposes of this subsection, unless the context otherwise indicates, the following terms have the following meanings.

A. "Facility fee" means any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility or freestanding emergency facility that is intended to compensate the health care provider for the operational expenses of the health care provider, separate and distinct from a professional fee, and charged or billed regardless of how a health care service is provided.

B. "Health care provider" means a person, whether for profit or nonprofit, that furnishes bills or is paid for health care service delivery in the normal course of business. "Health care provider" includes, but is not limited to, a health system, hospital, hospital-based facility, freestanding emergency facility or urgent care clinic.

Sec. 2. Task force established. The Task Force to Evaluate the Impact of Facility Fees on Patients, referred to in this section as "the task force," is established as follows.

1. Appointments; composition. Notwithstanding Joint Rule 353, the task force consists of 8 voting members and 2 ex officio nonvoting members as follows:

A. Four members must be appointed by the President of the Senate as follows:

(1) One member of the Senate;

(2) One member representing a statewide organization supporting the interests of health care consumers;

(3) One member representing the interests of health insurance carriers; and

(4) One member with expertise, knowledge and background in health care policy;

B. Four members must be appointed by the Speaker of the House of Representatives as follows:

(1) One member of the House of Representatives;

(2) One member representing a statewide organization of retired persons;

(3) One member representing a statewide organization of hospitals; and

(4) One member representing a hospital in the State; and

C. Two ex officio nonvoting members as follows:

(1) The Director of the Office of MaineCare Services within the Department of Health and Human Services or the director's designee; and

(2) The Director of the Office of Affordable Health Care or the director's designee.

2. Chairs. The member of the Senate is the Senate chair and the member of the House of Representatives is the House chair of the task force. Notwithstanding Joint Rule 353, the chairs may appoint, as nonvoting members, individuals with expertise in health care policy, health care financing or health care delivery. Any additional members appointed pursuant to this subsection are not entitled to compensation or reimbursement under subsection 5.

3. Appointments; convening. All appointments must be made no later than 30 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force. If 30 days or more after the effective date of this Act a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

4. Duties. The task force shall:

A. Review the industry practices for charging facility fees, uses of the funds received as facility fees and impacts on patients of paying facility fees charged by health care providers;

B. Review federal transparency requirements for hospitals and health insurance carriers regarding cost of treatment, identify any gaps or redundancies between state laws and federal laws and identify any problems with enforcement of those laws;

C. Consider efforts in other states and by national organizations related to regulation of, or minimization of, facility fees and the potential effects such efforts might have on health care costs in this State; and

D. Make recommendations for changes in laws or rules regarding facility fees and medical cost transparency based on the information examined under this subsection.

5. Compensation. The legislative members of the task force are entitled to receive the legislative per diem, as set out in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force.

6. Quorum. A quorum is a majority of the voting members of the task force, including those members invited to participate who have accepted the invitation to participate.

7. Staffing. The Legislative Council shall provide staff support for the task force. To the extent needed when the Legislature is in session, the Legislative Council may contract for such staff support if sufficient funding is available.

8. Consultants; additional staff assistance. The task force may solicit the services of one or more outside consultants to assist the task force to the extent resources are available. Upon request, the Office of Affordable Health Care, the Department of Health and Human Services, the Department of Professional and Financial Regulation, Bureau of Insurance and the Maine Health Data Organization shall provide additional staffing assistance to the task force to ensure the task force has the information necessary to fulfill their duties under this section.

9. Reports. The task force shall submit a report no later than December 6, 2023 that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the committee may report out a bill based on the report to the Second Regular Session of the 131st Legislature.

10. Additional funding; sources. The task force may apply for and receive funds, grants or contracts from public and private sources to support its activities under this section.

11. Definition. For purposes of this section, "facility fees" and "healthcare provider" have the same meanings as in the Maine Revised Statutes, Title 22, section 8712, subsection 2-A.

TASK FORCE TO EVALUATE THE IMPACT OF FACILITY FEES ON PATIENTS

Public Law 2023, Chapter 410

Membership List

Name	Representation
Sen. Donna Bailey	Senate Chair, appointed by the President of the Senate
Rep. Poppy Arford	House Chair, appointed by the Speaker of the House
Kate Ende	Representing a statewide organization supporting the interests of health care consumers, appointed by the President of the Senate
Maureen Hensley-Quinn	Member with expertise, knowledge and background in health care policy, appointed by the President of the Senate
Kristine Ossenfort	Representing the interests of health insurance carriers, appointed by the President of the Senate
Jessica Maurer	Representing a statewide organization of retired persons, appointed by the Speaker of the House
Jeff Austin	Representing a statewide organization of hospitals, appointed by the Speaker of the House
Mark Souders	Representing a hospital in the State, appointed by the Speaker of the House
Michelle Probert (or designee)	The Director of the Office of MaineCare Services within the Department of Health and Human Services or the director's designee
Meg Garratt-Reed	The Director of the Office of Affordable Health Care or the director's designee

131st MAINE LEGISLATURE

FIRST SPECIAL SESSION-2023

Legislative Document	**No. 1795**
S.P. 720	In Senate, April 25, 2023

An Act to Protect Patients by Prohibiting Certain Medical Facility Fees

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by President JACKSON of Aroostook.
Cosponsored by Speaker TALBOT ROSS of Portland and
Senators: BALDACCI of Penobscot, DAUGHTRY of Cumberland, HICKMAN of Kennebec, INGWERSEN of York, NANGLE of Cumberland, TIPPING of Penobscot, VITELLI of Sagadahoc.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1718-H is enacted to read:

§1718-H. Hospital facility fees

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

A. "Campus" means the main buildings of a hospital; the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings; and any other area that has been determined on a case-by-case basis by the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services to be part of a hospital's campus.

B. "Facility fee" means any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility or freestanding emergency facility that is intended to compensate the health care provider for the operational expenses of the health care provider, separate and distinct from a professional fee, and charged or billed regardless of how a health care service is provided.

C. "Freestanding emergency facility" means an emergency medical care facility that is licensed under section 1811. "Freestanding emergency facility" does not include an urgent care clinic.

D. "Health care provider" means a person, whether for profit or nonprofit, that furnishes bills or is paid for health care service delivery in the normal course of business. "Health care provider" includes, but is not limited to, a health system, hospital, hospital-based facility, freestanding emergency facility or urgent care clinic.

E. "Health system" means:

(1) A parent corporation of one or more hospitals;

(2) Any entity affiliated with the parent corporation through ownership, governance, membership or other means; or

(3) A hospital and any entity affiliated with the hospital through ownership, governance, membership or other means.

F. "Hospital" means a hospital licensed under section 1811.

G. "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital where hospital or professional medical services are provided.

H. "Professional fee" means any fee charged or billed by a health care provider for professional medical services provided in a hospital-based facility.

2. Limits on facility fees. This subsection governs limits on facility fees.

A. A health care provider may not charge, bill or collect a facility fee, except for:

(1) Services provided on a campus;

(2) Services provided at a facility that includes a hospital's emergency department; or

(3) Emergency services provided at a freestanding emergency facility.

B. Notwithstanding paragraph A, a health care provider, regardless of the location of services, may not charge, bill or collect a facility fee for:

(1) Outpatient evaluation or management services; or

(2) Any other outpatient, diagnostic or imaging services identified by the department pursuant to subsection 3.

3. Identification of services. The department shall annually identify services subject to the limitations on facility fees provided in subsection 2, paragraph B that may reliably be provided safely and effectively in settings other than hospitals.

4. Annual report. A hospital, health system and freestanding emergency facility shall submit a report annually to the department relating to facility fees charged or billed during the preceding calendar year. The department shall publish the information reported pursuant to this subsection on its publicly accessible website. The report must be in a format as prescribed by the department and must include:

A. The name and full address of every facility owned or operated by the hospital, health system or freestanding emergency facility that provides services for which a facility fee is charged or billed;

B. The number of patient visits at a hospital-based facility or freestanding emergency facility for which a facility fee was charged or billed;

C. The number, total amount and range of allowable facility fees paid at a hospital-based facility or freestanding emergency facility by Medicare, the MaineCare program or private health insurance;

D. For each hospital-based facility, hospital, health system or freestanding emergency facility, the total amount of facility fees charged or billed and the total revenue received from facility fees;

E. The top 10 procedures or services, identified by procedural terminology codes used by the American Medical Association, provided by the hospital, health system or freestanding emergency facility that generated the greatest amount of gross revenue from facility fees, the number of patients charged or billed for each of the 10 procedures or services, the gross and net revenue totals for each procedure or service and the total net amount of revenue received that was derived from facility fees;

F. The top 10 procedures or services, identified by procedural terminology codes used by the American Medical Association, provided by the hospital, health system or freestanding emergency facility overall for which facility fees are charged or billed based on the number of patients charged or billed for the 10 procedures or services, including the gross and net revenue totals received for each procedure or service; and

G. Any other information related to facility fees required by the department.

5. Rules. The department may adopt rules necessary to implement this section, including, but not limited to, specifying the format and content of reports and imposing penalties for noncompliance consistent with the department's authority under this chapter.

6. Enforcement. This subsection governs enforcement of this section.

A. A violation of this section is an unfair practice in the conduct of any trade or commerce pursuant to Title 5, section 207.

B. A health care provider that violates any provision of this section or any rules adopted pursuant to this section is subject to an administrative penalty of not more than $1,000 per violation.

C. The department or its designee may audit a health care provider for compliance with the requirements of this section. The department or its designee may request copies of any books, documents, records or data that are necessary for the purposes of completing the audit. A health care provider shall make those records available and maintain records for 4 years after providing a service for which a facility fee was charged, billed or collected.

SUMMARY

This bill prohibits certain health care providers from charging, billing or collecting a facility fee in certain situations and requires annual reporting on the amount of facility fees charged or billed.

HEALTH CARE COST INSTITUTE

Facility Fees and How They Affect Health Care Prices

Policy Explainer

June 2023

What is a facility fee?

When you receive care in a hospital, you will likely receive two bills: one from the physician(s) and other clinicians who provided your care (i.e., for their professional services) and one from the hospital. The hospital bill includes charges associated with care provided by the hospital (e.g., room and board, procedures, and evaluation and management) with overhead costs (e.g., equipment, space, and support staff) baked in. A component of the overhead cost is a "facility fee," which supports the emergency room and other services the hospital must provide but which are not directly related to the care the patient received.

Increasingly, facility fees are also attached to non-hospital care that patients might receive in a setting that is owned by a hospital. This can result in the same service costing different amounts depending on whether you get it in an independent physician's office or one that is owned by a hospital, driving up costs for patients and the health system more generally.

Why would patients pay a facility fee for non-hospital services?

There is growing concern about patients being charged a "facility fee" even when they receive care outside a hospital. For example, news stories have reported patients receiving bills of more than $500 for a pediatrician office visit or over $6,000 for a minor dermatology procedure.

If a physician's office is owned by a hospital system, a patient may be charged a facility fee in addition to the bill from the physician who provides care. In these cases, the physician's office is allowed to bill as though the care was received in a hospital (e.g., including a facility charge), despite no physical change in where patients are treated, or the care they receive. As hospitals increasingly acquire physician practices, facility fees in these situations have become more common. In fact, the opportunity to charge a facility fee is one incentive for hospitals to acquire these practices, which then leads to higher prices for patients, employers, and insurers.

- HCCI data show meaningfully higher prices for the **same services** when they have a facility charge and a professional charge (i.e., for the physician's service) compared to when there is only a professional bill.
- For example, below we show average prices for three common services when (1) there is only a professional payment and (2) there are professional and facility payments.*

		
Ultrasound	$164	$339
Biopsy	$146	$791
Physician office visit	$118	$186

National data shown here. State data and methodological details available in the Downloadable Data available with this explainer.

Why is there controversy over facility fees for non-hospital services?

Proponents argue that facility fees—even for services provided outside of the hospital—are justified because:

- They are necessary to cover higher expenses associated with hospital licensing, accreditation, and regulatory requirements.
- Hospital investment in physician practices increases access for patients, who can make appointments more easily across the continuum of care, for example if they need a specialist appointment at the affiliated hospital.
- Hospitals provide unique benefits within a community.

Others contend that facility fees are problematic because:

- Unlike services provided in an inpatient hospital setting, many outpatient services (e.g., imaging, injections, and biopsies) can and already do take place in doctors' offices safely without any changes to the care provided (e.g., the patient will receive the same supplies, technology, staffing, duration, or intensity of care as they would receive in a hospital setting).
- They may incentivize integration between hospitals and physician groups, which generally leads to higher prices without improvements in care. Higher prices tend to be passed on to patients through cost sharing and premiums, resulting in even greater affordability challenges for common services.

What are policymakers doing to address facility fees?

Policymakers have undertaken two main approaches to address (non-hospital) facility fees.

1. Require transparency around facility fees

Some states, including Connecticut, Texas, Washington, and Minnesota, require physician clinics that charge a facility fee to notify patients that the clinic is licensed as part of a hospital and the patient may receive a separate facility charge, resulting in higher out-of-pocket costs.

Another approach to improve transparency around where the service delivered is requiring facilities to bill under separate identifiers for services provided in a clinic that may be associated with a hospital but is "off campus" versus in the main hospital. This would help researchers and policymakers identify, measure, and potentially address unjustified facility fees.

2. Implement site neutral payments in commercial insurance

"Site neutrality" policy requires that payments be the same for services provided, regardless of where the patient was treated. For example, a test like an ultrasound or a physician's visit must have the same payment rate whether it's provided in a physician's office or a hospital outpatient department. This policy essentially eliminates the facility fee. Connecticut took this approach by prohibiting facility fees for select services that can be safely provided in a non-hospital setting.

Nationally, policy groups estimate that site neutral payments in commercial insurance could reduce national health expenditures by $450 billion over the next decade, including $380 billion in premiums and $70 billion in cost sharing. Site neutral payments may also to reduce vertical integration, which can mitigate rising prices for insurers and downstream costs to patients.

This project is supported by a grant from Arnold Ventures.

Maine State Legislature
OFFICE OF POLICY AND LEGAL ANALYSIS
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MEMORANDUM

TO: Members, Task Force to Evaluate the Impact of Facilities Fees on Patients

FROM: Colleen McCarthy Reid, Principal Analyst

DATE: December 1, 2023

RE: Overview of federal and state laws related to price transparency for hospitals and health insurance carriers

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I. Federal law and regulations

❒ *Federal law and regulations related to hospital price transparency*

Hospitals are required to provide clear, accessible pricing information online about the items and services they provide in two ways: (1) as a comprehensive machine-readable file with all items and services; and (2) in a display of at least 300 shoppable services in a consumer-friendly format. Under the federal rule, the penalty for noncompliance is progressive: hospitals receive a written warning and are permitted to file a corrective action plan; only if the corrective action plan is not satisfactory are hospitals then subject to civil monetary penalties.

❒ *Federal law and regulations related to good faith estimates*

Federal law also set forth requirements for health care providers to provide "good faith estimates" to patients prior to a scheduled health care service (or set of services). Currently, providers must provide these estimates to uninsured patients, but the implementation of the requirements for insured patients has been delayed pending federal rulemaking. Once federal rules are in place, health insurance health insurance carriers will also be required to provide "advance explanation of benefits" for scheduled services upon request; consumers can request advance information from their health insurance carrier about how services will be covered before they are provided. For scheduled services, consumers can submit requests and, generally within three business days, the carrier must provide written information including about whether the provider/facility participates in-network, and a good faith estimate of what the plan will pay and what patient will have to pay.

❒ *Federal law and regulations related to price information from health insurance carriers*

Most group health plans and issuers of group or individual health insurance coverage are required to disclose personalized pricing information for 500 covered items and service to their participants, beneficiaries, and enrollees through an online consumer tool, by phone, or in paper form, upon request. Cost estimates must be provided in real-time based on cost-sharing

information that is accurate at the time of the request. Detailed price information must also be made available in machine-readable files: 1) rates for all covered items and services between the plan or issuer and in-network providers; and 2) allowed amounts for, and billed charges from, out-of-network providers.

II. State laws

There are several provisions in current law that require disclosure of information about the costs of health care services and that relate to billing for health care services, including:

- 22 MRSA §1712 requiring hospitals to provide itemized bills to patients within 30 days of a request;

- 22 MRSA §1718 requiring hospitals and ambulatory surgical centers to provide the average charge for any inpatient service or outpatient procedure upon request;

- 22 MRSA §1718-B requiring health care entities to provide information about prices of most frequently provided health care services, about the MHDO's CompareMaine website and about the "right to shop" for certain services;

- 22 MRSA §1718-C requiring health care entities to provide estimate of the total price of medical services rendered during a single encounter to uninsured patients upon request, including identification of third-party health care entities, and to notify patient of charity care policy;

- 22 MRSA §1718-D prohibiting balance billing for surprise bills and out-of-network emergency services;

- 22 MRSA §1721 prohibiting a patient or patient's insurer from being charged by a health care facility for health care services provided as a result of or to correct a mistake or preventable adverse event;

- 22 MRSA §8712 requires the Maine Health Data Organization to create a publicly accessible interactive website with information related to payments for services rendered by health care facilities and practitioners to residents of the State; see MHDO's CompareMaine website. Beginning January 2024, MHDO must also post on its website and provide annual reports on payments for facilities fees made by payors to the extent the information is available; and

- 24-A MRSA §4303, subsection 21 requires health insurance carriers to make information available to consumers about estimated costs of certain comparable health care services (Physical and occupational therapy services; radiology and imaging services; laboratory services; and Infusion therapy services). Carriers may comply by providing this information on its publicly accessible website or by consumers to the publicly accessible health care costs website of the Maine Health Data Organization.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
Connecticut	Conn. Gen. Stat. § 19a-906; Conn. Gen. Stat. § 19a-508c; Conn. H.B. 6669 (2023)	• Prohibits a hospital or health system from charging a facility fee on telehealth services or specific health care evaluation and management (E/M) services provided on a hospital campus outside of an emergency department. • Requires providers/health systems to give patients notice at the time the appointment is made if/when they do charge facility fees and post signs in their common areas outlining that in plain language. • Requires a health care provider to provide a standardized bill to patients that lists any facility fee and include contact information for filing an appeal. • Requires each hospital and health system to submit annual to the State reports on facility fees collected. • Prohibits telehealth providers and hospitals from charging facility fees for telehealth services.
Colorado	Colo. Rev. Stat. § 6-20-102; Colo. Rev. Stat. § 25.5-4-216	• Prohibits the collection of a facility fee from a patient for preventive services that are not covered by a patient's insurance • Requires providers/health systems to give patients notice at the time the appointment is made that they charge facility fees and post signs in their common areas • Requires a health care provider to issue a standardized bill to patients that lists any facility fee and include contact information for filing an appeal. • Authorizes a report on facility fees to be completed by October 2024.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
Florida	Fla. Stat. § 395.1041; Fla. Stat. § 395.301	• Requires hospital owned outpatient emergency departments to post signs in their common areas that they charge facility fees. • Requires facility fees to be included in good faith estimates provided to patients.
Georgia	Ga. Code Ann. § 33-20E-24	• Prohibits insurers from being required to pay a facility fee to a hospital for telehealth services unless the hospital is the originating site.
Indiana	Ind. Code Ann. § 16-51-1-11; Ind. Code Ann. §§ 16-21-6-3; Ind. Code Ann. §§ 25-1-9.8-11; Ind. Code Ann. §§16-21-17-1; 16-21-17-2	• Bans facility fees by prohibiting an insurer or other person responsible for the payment of the cost services from accepting a bill submitted on an "institutional provider form", which is what hospitals use to bill for facility fees, for services provided in an office setting • Limits the restrictions in this bill to non-profit health systems with more than $2 billion in patient service revenue in 2021. • Requires providers to supply, upon request, a good faith estimate of the amount the provider intends to charge for services, including any charge for use of the provider facility, at least five days before a scheduled appointment. • Requires ambulatory outpatient surgical centers to post on their website the standard charge per item or service, including facility fees. • Requires each hospital to file an annual report to the state including information on facility fees collected.
Maryland	Md. Ins. Code § 19-349.2; Md. Ins. Code § 15-139	• Requires providers/health systems to give patients notice at the time the appointment is made that they charge facility fees, including expected amounts and how a patient can file a complaint about a facility fee. • Requires each hospital to file an annual report to the Health Services Cost Review Commission including information on outpatient facility fees collected.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
		• Prohibits providers from charging facility fees for telehealth services unless they are not authorized to bill a professional fee separately for the service. • Prohibits hospitals from charging facility fees for administering COVID-19 vaccines and monoclonal antibody infusions and injections.
Massachusetts	Mass. Ann. Laws ch. 111, §§ 228; Mass. Ann. Laws ch. 176O, §§ 6, 23	• Requires providers/health systems to give patients notice at the time the appointment is made that they charge facility fees, including expected amounts. • Requires insurers explain any facility fee a consumer may be responsible to pay in its evidence of coverage and allow opportunity for enrollees to request and obtain facility fee estimates.
Minnesota	Minn. Stat. Ann. § 62J.824 (2022)	• Requires providers/health systems to give patients notice prior to the delivery of non-emergency services that they may charge facility fees, including for telehealth services
New York	N.Y. Public. Health Law § 2830-2	• Prohibits the collection of a facility fee from a patient for preventive services, or any service not covered by the patient's insurance, unless the patient received prior notification that a facility fee would be charged. • Requires providers/health systems to give patients notice in advance that they charge facility fees and post signs in their common areas outlining that.
Ohio	Ohio Rev. Code § 4743.09	• Prohibits a health care professional from charging a patient or a health plan issuer a facility fee when providing telehealth services.
Texas	Tex. Health and Safety Code §241.222; §254.1555; §254.156	• Requires facilities to notify patients that they may be charged a facility fee, including median amounts of fees charged.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
		• Prohibits freestanding emergency departments from charging facility fees on drive-thru services, and requires freestanding emergency departments to notify patients that they may be charged a facility fee, including the amount.
Washington	Wash. Rev. Code § 70.01.040; Rev. Code Wash. § 4.43.735	• Requires providers/health systems to give patients notice prior to the delivery of non-emergency services that they may charge facility fees. • Prohibits a telehealth distant site or a hospital that is an originating site for audio-only telemedicine from charging a facility fee.

Sources: National Conference of State Legislatures;

"State Laws to Promote Fair Billing" November 2023 Issue Brief, United States of Care, https://unitedstatesofcare.org/new-resource-state-successes-passing-laws-to-promote-fair-billing/

"Regulating Outpatient Facility Fees: States Are Leading the Way to Protect Consumers" July 2023 Issue Brief, Georgetown University Center on Health Insurance Reforms, https://georgetown.app.box.com/v/statefacilityfeeissuebrief

National Academy of State Health Policy Legislative Tracker: State Legislative Action to Lower Health System Costs, https://nashp.org/state-legislative-action-to-lower-health-system-costs/

MHDO Maine Health Data Organization

Information | Insight | Improvement

Annual Reporting Requirement

22 MRSA §8712, sub-§2-A. Facility fees charged by health care providers. By January 1, 2024, and annually thereafter, the organization shall produce and post on its publicly accessible website a report on the payments for facility fees made by payors to the extent that payment information is already reported to the organization. The organization shall submit the report required by this subsection to the Office of Affordable Health Care established in Title 5, section 3122 and the joint standing committee of the Legislature having jurisdiction over health data reporting and health insurance matters. The joint standing committee may report out legislation based on the report to a first regular or second regular session of the Legislature, depending on the year in which the report is submitted.

Definitions

For the purposes of this subsection, unless the context otherwise indicates, the following terms have the following meanings.

A. **"Facility fee"** means any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility or freestanding emergency facility that is intended to compensate the health care provider for the operational expenses of the health care provider, separate and distinct from a professional fee, and charged or billed regardless of how a health care service is provided.

B**. "Health care provider"** means a person, whether for profit or nonprofit, that furnishes bills or is paid for health care service delivery in the normal course of business. "Health care provider" includes, but is not limited to, a health system, hospital, hospital-based facility, freestanding emergency facility or urgent care clinic.

Summary of First Annual Report

Part I: Focus is level-setting on definitions and standards specific to various data elements in the MHDO all-payer claims data that allow us to identify a payment which is associated with services rendered within a hospital facility (facility) and services provided by a healthcare provider (professional) outside of the hospital setting.

Note: claims data submitted to the MHDO is governed per the requirements defined in 90-590 Chapter 243, *Uniform Reporting System for Health Care claims Data Sets.* The submission requirements align with the standards set forth by the National Uniform Billing Committee (NUBC), which is the *governing body for forms and codes used in medical claims billing in the US for hospitals, nursing homes, hospice, home health agencies and other providers.*

Summary of First Annual Report

Part II: Produce baseline data set that displays facility and professional fees by health care setting and procedure.

Calculate total amounts for facility and or professional fees across all applicable CompareMaine procedures. Resulting output will be displayed by health care setting (e.g., hospital, ambulatory surgical center, urgent care clinic).

CompareMaine

CompareMaine reports payment information for procedures and services at the following health care settings: hospitals, surgical centers, diagnostic imaging centers, health centers, laboratories, and clinics.

There are currently 318 health care procedures reported on CompareMaine that fall into one of the following categories:

- Cardiology
- Chiropractic
- Diagnostic
- Emergency Department
- Infusions Therapy
- Integrative Medicine (osteopathic manipulative treatment)
- Laboratory
- Behavioral Health
- Obstetric/Gynecological
- Office Visits
- Outpatient Surgical Procedures
- Physical and Occupational Therapy
- Radiology and Imaging

Facility Fee Task Force Presentation

December 1, 2023

Ann Woloson, Executive Director

Consumers for Affordable Health Care

Consumers for Affordable Health Care

Maine's Consumers Assistance Program

- Marketplace enrollment assistance (CoverME.gov)
- MaineCare enrollment assistance
- Insurance appeals and denials assistance

Information and Services

- Public policy research and advocacy
- Workshops and trainings
- Assister ListServ
- Toll Free HelpLine

Facility Fee Conundrum

Hospitals allowed to charge patients a fee, on top of the tab for medical services, to help cover hospital costs. Hospital admissions decreasing - outpatient services increasing.

- Vertical integration (consolidation - hospitals absorbing more physician/specialty practices, urgent-care centers, walk-in clinics, and standalone surgery complexes.
- Number of doctors who have left independent practices to work at hospitals has doubled over the last decade – leading to higher costs.*
- Consumers bear the brunt - face increased out-of-pocket costs as well as higher premiums from these (facility fees) extra charges.**

*Study finds vertical integration in medicine is leading to higher costs and worse health outcomes, Robert O'Neill, Harvard Kennedy School, 3/2/23.

**Facility Fees 101: What is all the Fuss About? Linda J. Blumberg, Christine H. Monahan, Health Affairs Forefront, 8/4/23.

High Deductible Health Plans (HDHP)

- More than half (55.7%) of American private-sector workers were enrolled in HDHPs in 2021, the highest on record — up from 30.3% in 2013.

- 76.2% of private-sector workers in Maine enrolled in HDHPs work at firms with more than 50 workers — the highest in the U.S. and more than 20 percentage points higher than the national average.*

- HDHP can have a family deductible of over $14,000 — creating plenty of space to get trapped under medical debt.**

*Rate of Workers Enrolled in High Deductible Health Plans Jumps for 8th Year in Row to record 55.7%, Jacqueline DeMarco, Jan 30, 2023/ Kaiser Family Foundation 2022 Employer Health Benefits Survey.

**High-deductible health plans are causing medical debt. It's time to fix them. Michael Waterbury , Benefits Pro, January 06, 2022

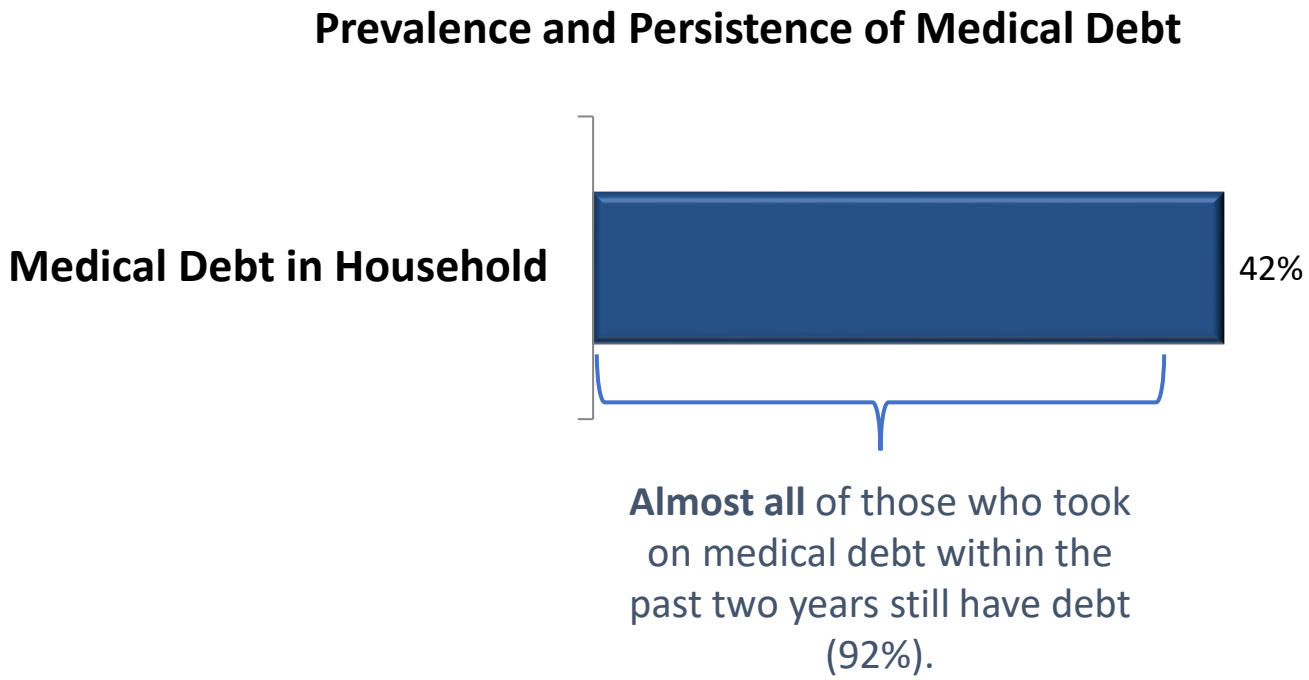
Examining Views Towards Health Care in Maine (February 2023)

Survey Conducted on Behalf of Maine Consumers for Affordable Health Care

by:

Digital Research inc DRI

Almost half of Maine households have medical debt.



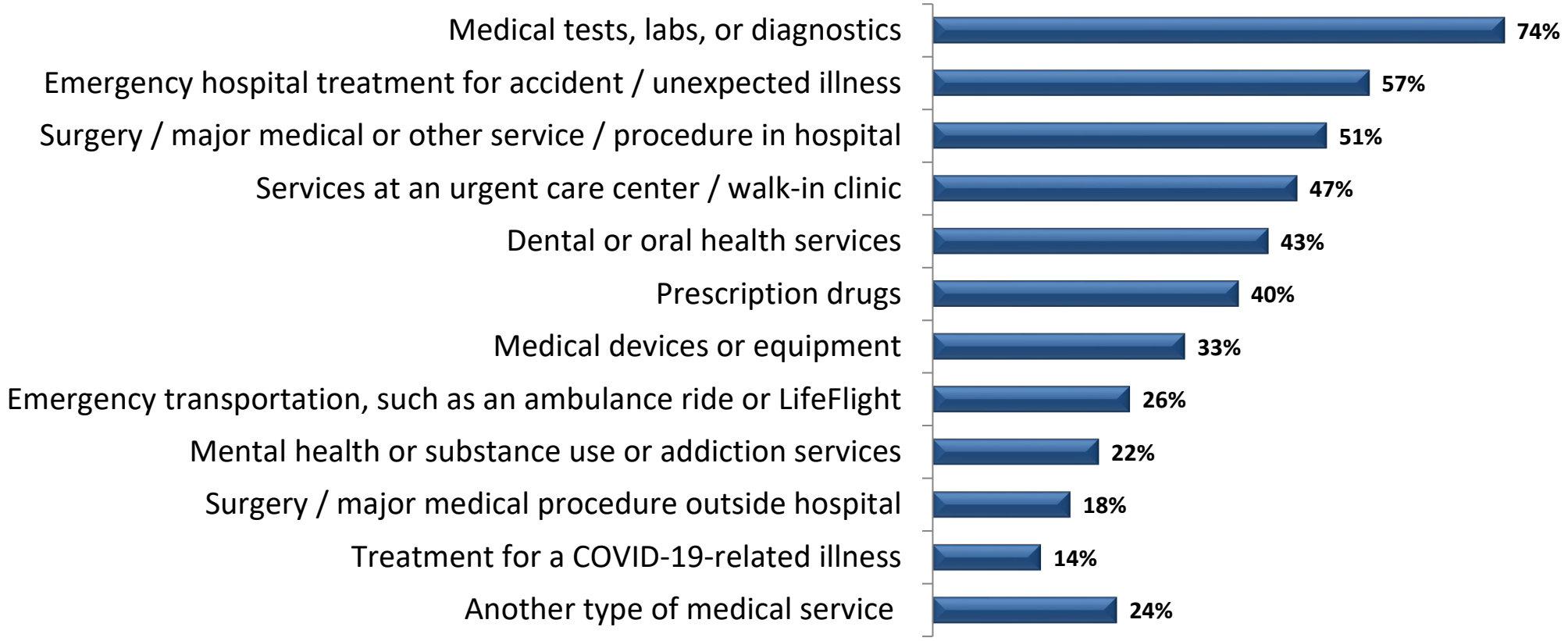
(n=500)

In the past two years, have you or anyone in your immediate family taken on debt or received bills you couldn't pay from a medical health care service, procedure, tests, medical device, or prescription drugs? / Do you currently have any medical debt?

Three out of four Mainers with medical debt say diagnostics contributed to their debt.
More than half say emergency room treatment contributed to their debt.
Four out of ten say urgent care, dental care, surgery, or prescription drugs contributed to their debt.

Contributors to Medical Debt

(% who say service type has contributed to debt)



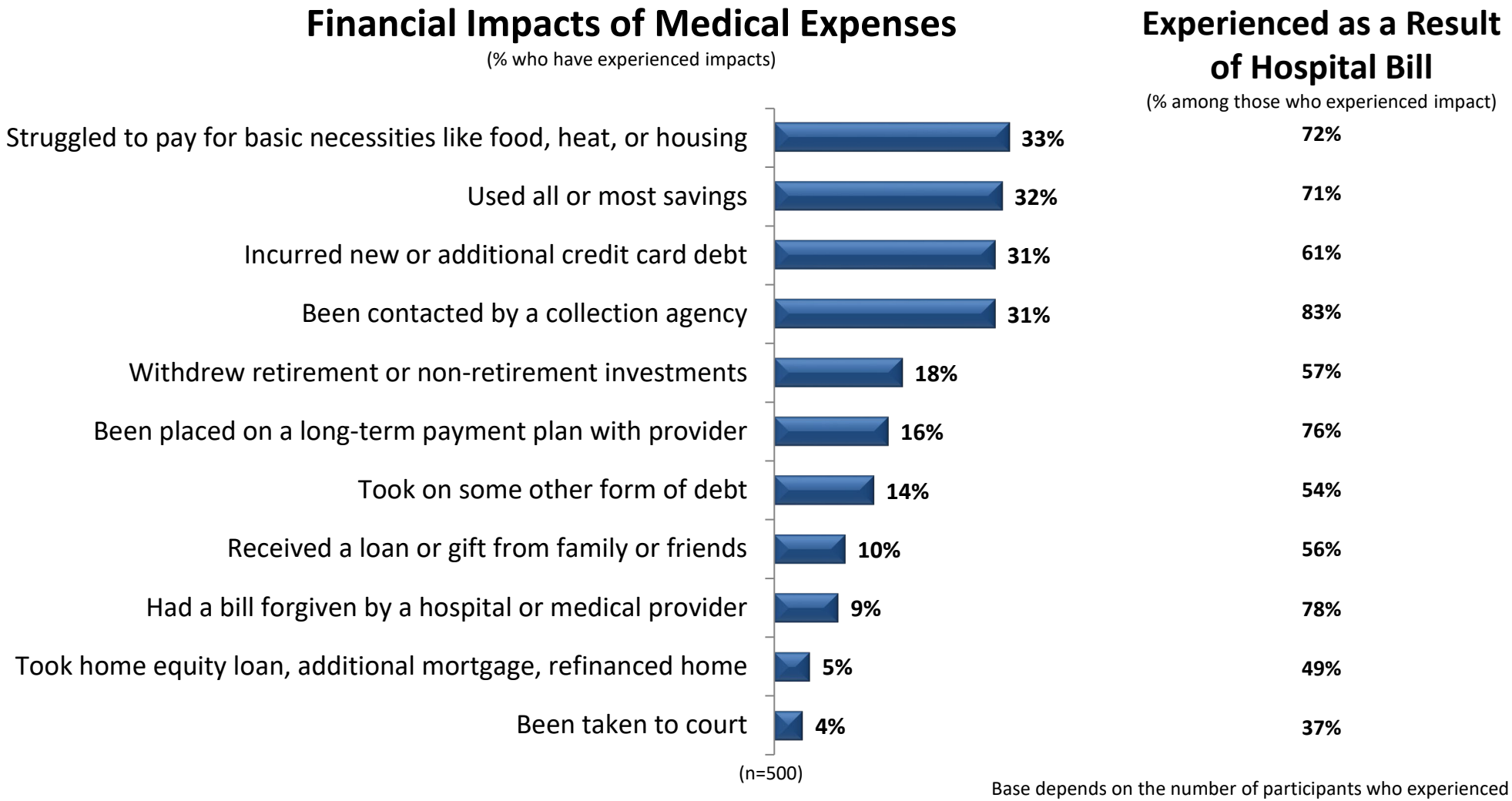
Among those who have had medical debt themselves or who have a family member with medical debt in the past 2 years (n=233)

Did any of the following contribute to your/your family member's medical debt?

Six out of ten Maine families experienced at least one of the impacts below as a result of medical bills. Many struggled to pay for necessities, used savings, incurred credit card debt, or were contacted by a collection agency, most often due to a bill from a hospital.

62% of Maine families have experienced at least one of these impacts.

On average, Maine families have experienced **almost three** of these impacts.



Base depends on the number of participants who experienced impact.

In the last two years, have you or any member of your immediate family experienced the following as a result of any medical expenses? / Did you or any member of your immediate family experience the following as a result of a hospital bill, specifically?

Consumer Facility Fee Stories - Sierra

ER visit for possible appendicitis. Given an IV with antibiotics and Tylenol. Spent about 5 minutes in exam room with Doctor.

- Total bill was over $9,000, $4,605 of which was a facility fee charge. The balance she needed to pay after insurance was $2,507.
- Confused by the facility fee charge. Was told it's the charge for using the ER.
- Afraid the bill would go to collections. Tried to set up a payment plan. Only option was a six-month payment plan in which she'd pay almost $500/month. She had some savings but needed that money to go toward her living expenses, like rent.

"I know the medical bill is my responsibility because I received the services, but I would have liked to have had a heads up and some sort of estimate of how much my bill was going to be. That may have altered my choice of going to the ER. If I had known the bill was going to be $9,000 before insurance, I would have done something differently. Maybe I would have gone to an urgent care."

Consumer Stories: Laura

Knee injury needed prompt attention. Sought care at a hospital walk-in clinic. Seen by a Physician Assistant (PA) who ordered x-rays that were immediately performed across the hall inside the walk-in clinic.

- Received a bill that included a facility fee for the interaction with the PA and another identical facility fee for the x-rays. (Each facility fee was ambiguously labeled “clinic visit” on the bill.)
- Would not have noticed there were two facility fees for the same visit, but the hospital billed her directly for one of the facility fees after Medicare denied that part of the hospital’s claim. (Note: Providers cannot bill a beneficiary for charges denied by Medicare)
- After paying the bill and nearly a year of disputing the charge, she received a refund from the hospital for the duplicate facility fee (check stub stated “a refund as a result of your requested inquiry”).

“As a well-informed consumer, I was aware that a facility fee might be tacked onto my bill although no information was given to me at the time of my visit to this outpatient clinic. What I did not expect was that (the hospital) would charge a facility fee for each service provided during the same visit in the same clinic.”

“Nor did I expect that during at least five phone calls with the hospital’s billing office, they would continue to rebuff (and even hang up) my protestations about the duplicate facility fee and the practice of billing me for charges denied by Medicare. The hospital repeatedly insisted that the charge was correct and told me that Medicare was to blame.”

Consumer Stories: Mike

Trauma to one eye required two emergency surgeries – Follow up surgery provided at a surgery center in Maine. He was in the O.R. for under an hour, never leaving the OR. Doctor completed three distinct procedures. Event was coded as three procedures.

- Received separate bills with three different facilities charges -- same date, and different codes to match the procedures. Facilities charges alone totaled $7,800 ($3400 + 2200 + 2200).
- This was on top of the professional fees for those same procedures totaling over $6,200.

“Even the people generating the bills cannot explain charges… – and nobody could offer a reasonable explanation for why three facilities fee charges were needed for one single surgery event.”

States Action on Facility Fee Issues

States implementing or proposing limits on facility fees:

- Colorado
- Connecticut
- Indiana
- Minnesota
- New Hampshire
- Ohio
- Texas
- Washington

Some resources

Facility Fees 101: What is all the Fuss About? Linda J. Blumberg, Christine H. Monahan. Health Affairs Forefront, August 4, 2023

> *Facility fee charges are becoming more common as hospital systems have accelerated their purchase of ambulatory settings and practices, leading to higher overall costs for outpatient care. Consumers bear the brunt of this, as they face increased out-of-pocket costs as well as higher premiums from these extra charges.*

Policymakers look to curb facility fees in outpatient setting Judith Garber, LOWN Institute, May 17, 2023

> *Should Medicare pay more for the same service delivered in an outpatient facility when it's owned by a hospital?...facility fees have become a big issue, …site-neutral payments, a policy change that federal and state policymakers are considering... Taxpayers and Medicare beneficiaries would be the biggest winners.*

State Policies to Address Vertical Consolidation in Health Care National Academy of State Health Policy, August 8, 2020

> *Like all cost-control efforts, transparency is a first step to shine a light on the practice and put patients on notice that they may receive bills for facility fees due to corporate acquisition. However, transparency alone does not ameliorate the problem of facility fees nor does it shield a patient from incurring a facility fee.*

Patients are getting blindsided by "facility fees," and state are taking action Markian Hawryluk, ALM/BenefitsPro, April 07, 2023

> *At least eight states agree such charges are questionable. They have implemented limits on facility fees or are moving to clamp down on the charges.*

Ann Woloson, Executive Director awoloson@mainecahc.org

Consumer Assistance Program HelpLine

1-800-965-7476

helpline@mainecahc.org

www.mainecahc.org

Consumers for Affordable Health Care

Harvard Pilgrim Health Care

Overview of Facility Fees

For the Legislative Task Force to Evaluate the Impact of Facility Fees on Patients

December 1, 2023

a Point32Health company

How Carriers View Facility Fees

- Major component of healthcare expense

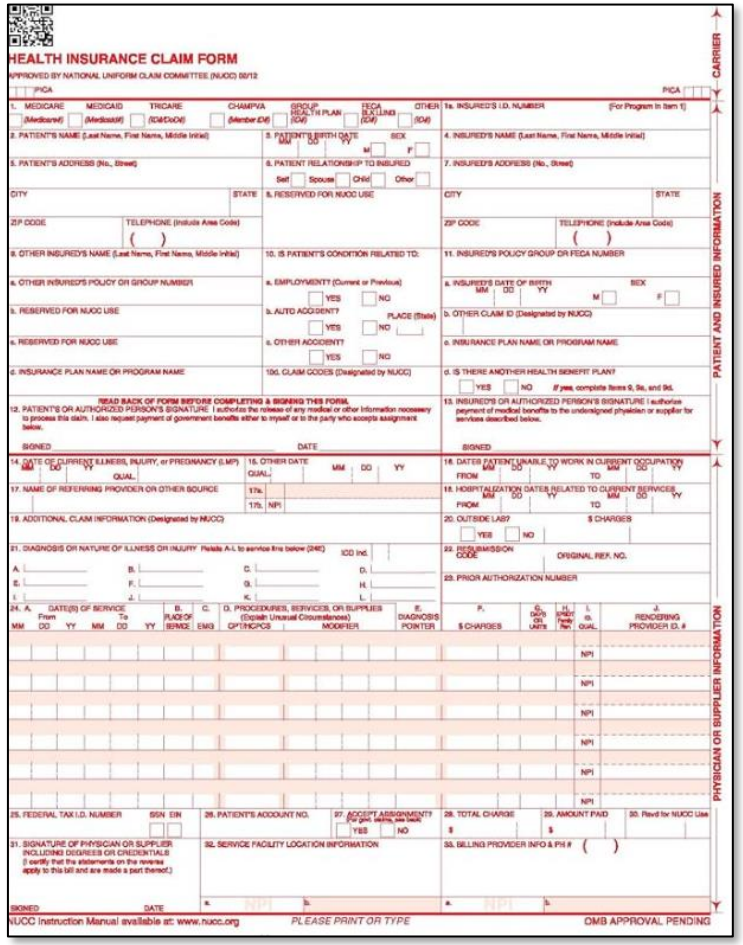
Type of Service	Percent of PMPM Total Cost
Hospital Inpatient	20%
Hospital Outpatient	36%
Professional/Ancillary	20%
Retail (non-hospital) Pharmacy	24%

- "Facility" is generally synonymous with hospital
  - Almost all payments to hospitals are considered facility fees
- Most non-hospital provider groups are not paid facility fees, they are paid professional fees only
  - Some small exceptions occur

Hospital vs Non-hospital Sites of Care

- Hospital extensions that typically bill facility fees
  - Some clinics
  - Infusion centers
    - XYZ hospital recently had an infusion center contract that was paid on professional schedule
      - Revenue was considered too low
      - Closed the contract, reverted billing to the hospital
- Primary care, specialists, private practices etc, are not permitted to bill as facility
  - Provider relationships, negotiations, and member services are some control mechanisms

CMS 1500 vs UB-04 claim forms



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

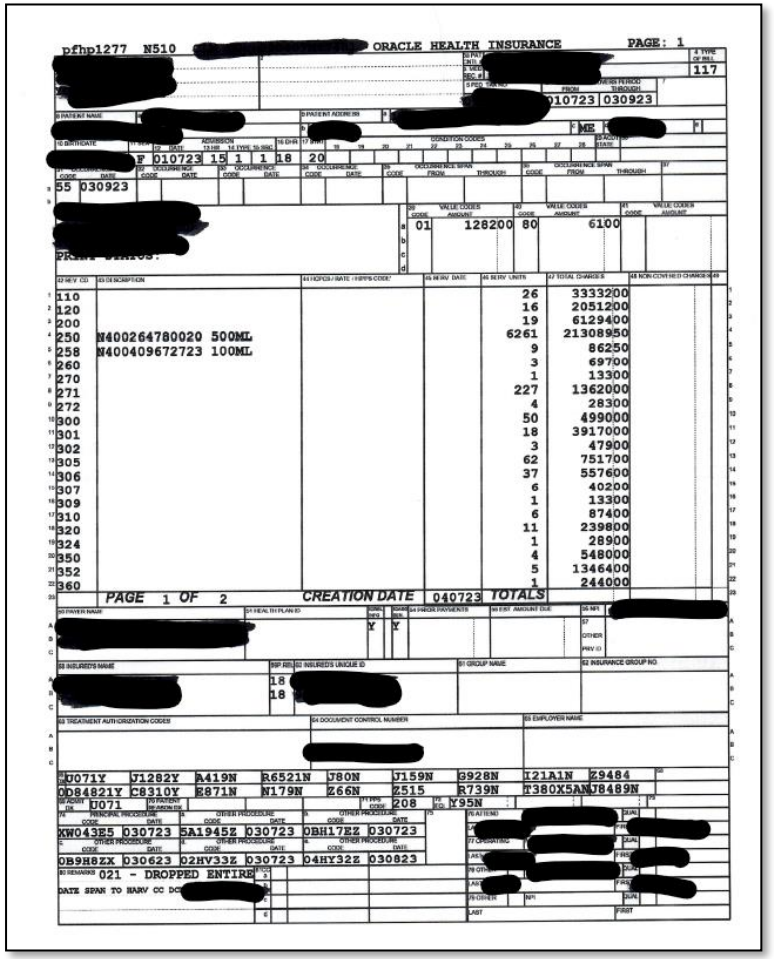
PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



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260		3	69700
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271		227	1362000
272		4	28300
300		50	499000
301		18	3917000
302		3	47900
305		62	751700
306		37	557600
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360		1	244000

PAGE 1 OF 2 CREATION DATE 040723 TOTALS

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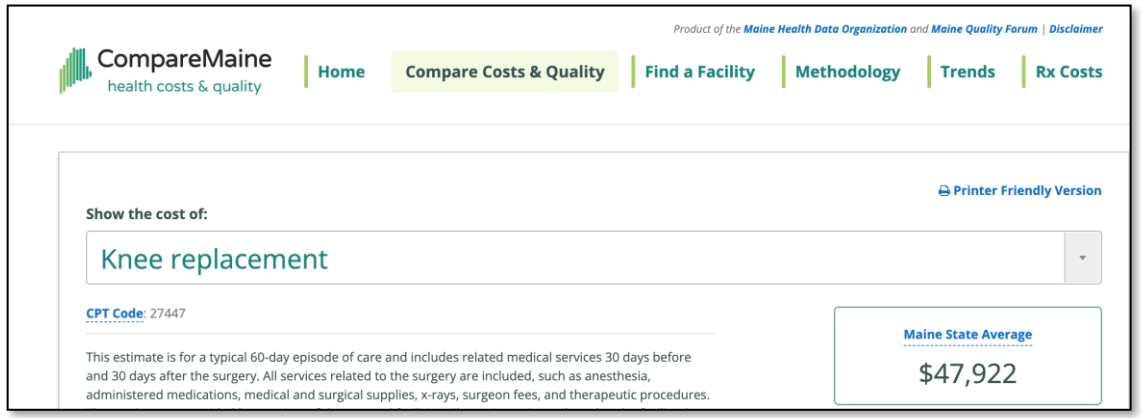
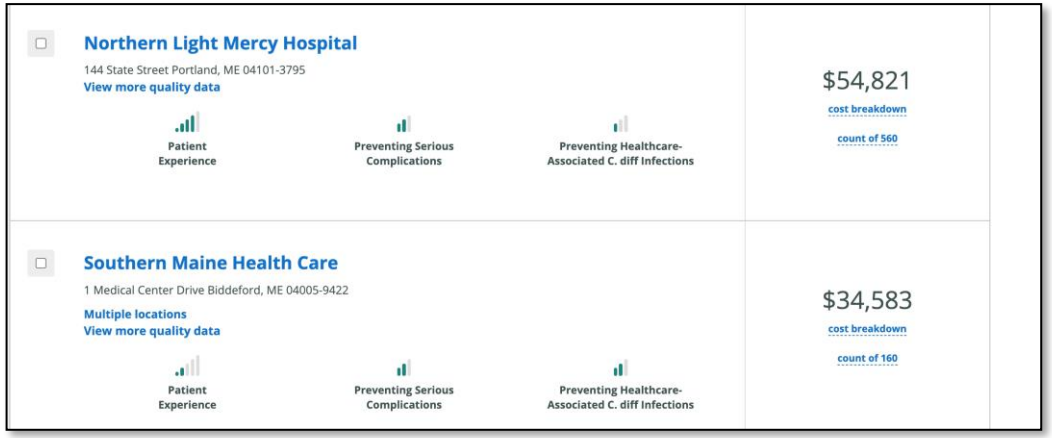
Facility Fees Vary by the Site of Service





Fee Schedules and Chargemasters

- Carriers generally own professional fee schedules
  - Typically updated once per year following CMS
- Hospitals own their chargemasters
  - Can change or increase fees as deemed necessary
  - Revenue codes are large categories of charges that do not show substantial detail