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Senator Donna Bailey, Co-Chair
Representative Anne Perry, Co-Chair
Joint Health Coverage, Insurance & Financial Services Committee
100 State House Station
Augusta, ME 04333

RE: AHIP Comments on L.D. 1795, An Act to Protect Patients by Prohibiting Certain Medical Facility Fees

To Chairs Senator Bailey, Representative Perry and Members of the Joint Health Coverage, Insurance, and Financial Services Committee,

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on LD 1795 which would prohibit facility fees under certain circumstances, and which would require an annual reporting on the amount of facility fees charged or billed.

Every American deserves access to affordable, comprehensive, high-quality coverage and care. However, health care prices continue to escalate year after year, making coverage and care less accessible for everyone. We thus appreciate the Committee's interest in lowering health care costs for Maine patients and employers by looking at how hospitals are driving up health care costs. LD 1795 makes great strides in the right direction towards achieving this important goal. The transparency requirements will help to understand the true impact of facility fees on health care costs in the State. And the limitations on facility fees will help rein in costs, but these limitations should be broadened to bring meaningful savings to Mainers.

To better understand the distribution of growing health care costs, AHIP analyzed data from commercial health insurance plans between 2018 and 2020 to determine how enrollees' premiums are spent. During this 3-year span, when all hospital spend is accounted for, it is the largest driver of premium cost at 42.2 cents per dollar.[1]

Evidence shows that consolidation in the hospital sector leads to higher health care prices for Americans.[2] Hospital-acquired physician offices commonly bill patients for facility fees, even when the hospital-owned location is off-campus and not physically proximate to the hospital's main location. In these instances, there is often no change in either the physical location, services provided, or change in the acuity of patients seen. Thus, these locations are permitted to bill facility fees solely due to hospital ownership, Studies have shown that this type of consolidation is not associated with improved health

[1] https://www.ahip.org/resources/where-does-your-health-care-dollar-go.
[2] https://ahiporg-production.s3.amazonaws.com/documents/AHIP_Statement_Senate_Judiciary_hearing_vertical_consolidation_06_12_19.pdf.

outcomes,[3] but is associated with higher physician prices, including commercial rates.[4] Thus, while patients can go to a variety of care settings to receive comparable care, their financial costs may differ dramatically depending on the setting in which their care is delivered. Most patients, however, do not know about the cost difference until after the care is provided and they receive a bill.

For example, medical imaging services are typically priced significantly higher in hospital settings versus other settings, such as outpatient imaging centers. This higher payment structure has created a perverse incentive for hospitals to acquire physician practices and convert them to off-campus, provider-based hospital outpatient departments and thus allowed providers to charge patients more with no demonstrable difference in care or outcomes.

Facility fees are not isolated to physician practices, they have also made their way into free-standing emergency departments (EDs), which have sprung up in many states. Freestanding EDs are more akin to urgent care centers but charge out-of-control prices. It has been reported that some of these sites have charged more than $1,000 for a single COVID-19 test that could be obtained elsewhere for closer to $100.[5]

These practices increase premiums and out-of-pocket costs and make care less affordable for all patients and consumers. Specifically, payment differentials across sites of service create two problems for the health care system. First, it results in increased costs to patients and their health insurance providers for individual services at the point of care. Consumers often face lower co-pays for a visit to a physician's office than a visit to a hospital facility, where they may have to pay cost sharing for a facility fee, in addition to cost sharing for professional services. Second, the prospect of higher reimbursement rates paid to hospital-affiliated practices is seen as a contributing factor to consolidation, as hospitals have an economic incentive to purchase independent physician offices to receive higher rates at those locations.[6] In fact, as of 2020, the majority of physicians in the U.S. (50.2%) worked outside of private practice.[7]

Solutions that permit comparable payment for comparable services encourage an efficient and competitive market that works for everyone. Additionally, a recent industry study found that if enacted, site-neutral payments, or the prohibition of all facility fees, would save patients and taxpayers close to $500 billion over ten years.[8]

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[3] See, e.g., Marah Noel Short, Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality;" Medical Care Research and Review (Feb. 2019); available at: https://journals.sagepub.com/doi/10.1177/1077558719828938; TG Koch, BW Wendling, NE Wilson; "The Effects of Physician And Hospital Integration On Medicare Beneficiaries' Health Outcomes;" Rev Econ Stat. 2020:1-38. doi:10.1162/rest_a_00924

[4] James Godwin, et al.; "The Association between Hospital-Physician Vertical Integration and Outpatient Physician Prices Paid by Commercial Insurers: New Evidence;" Inquiry (Mar. 2021); available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7940736/.

[5] https://www.ahip.org/documents/AHIP_1P-COVID19_TestPrices.pdf.

[6] Government Accountability Office (GAO); "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform" (Dec. 2015); GAO-16-189; available at: https://www.gao.gov/assets/gao-16-189.pdf; MedPAC Report to Congress, Chapter 3 (March 2015); available at: https://www.medpac.gov/wpcontent/uploads/import_data/scrape_files/docs/default-source/reports/chapter-3-hospital-inpatient-and-outpatientservices-march-2015-report-.pdf; MedPAC Report to Congress, Chapter 6 (June 2022); available at: https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[7] American Medical Association (AMA); "Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020;" available at: https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf.

[8] https://www.bcbs.com/sites/default/files/file-attachments/affordability/BCBSA_Issue_Brief_Site_Neutral_Payment_Proposal_2.28.23.pdf.

AHIP and its members thus support eliminating facility fees in many outpatient settings to defend patients from overpaying. Health insurance providers fight for lower prices for Mainers by using free-market tactics to negotiate lower prices with care providers and other elements of the health care ecosystem. Eliminating facility fees is a competition-enhancing approach that would improve affordability and access for everyone.

LD 1795 is a great first step towards this goal. However, we believe that it can be expanded to bring even more meaningful savings to Maine patients and employers. Currently, the prohibition on facility fees is narrowly limited to:

- Services provided at an urgent care clinic.
- Outpatient evaluation or management services at most sites.
- Specified outpatient, diagnostic, or imaging services to be determined on an annual basis.

This still allows health providers to charge facility fees for a significant portion of services whether in-hospital, in emergency departments, or in freestanding emergency facilities. As a result, Mainers will still face this surprise fee under many circumstances. Also, the Committee should also consider requiring health care providers to notify potential patients of facility fees they may incur if they receive services at that location. By broadening the limitations on facility fees and increasing transparency requirements, LD 1795 would provide much stronger consumer protections, especially when the bill contains penalty provisions.

Thank you for your consideration of our comments. AHIP and its members stand ready for further discussions on this important topic.

Sincerely,

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