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F I S C A L   I M P A C T   R E P O R T

SPONSOR Brandt
ORIGINAL DATE 3/6/17
LAST UPDATED
HB

SHORT TITLE Hospital Billing Guidelines
SB 384

ANALYST Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Indeterminate	Indeterminate	Indeterminate	Recurring	

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
New Mexico Hospital Association (NMHA)
Office of Attorney General (OAG)

SUMMARY

Synopsis of Bill

Senate Bill 384 (SB384) introduces a new section to the Unfair Practices Act relating to Hospital Billing.

Section 1(A) provides that a hospital shall ensure that all billing for a single episode of care that occurs at the same hospital is made in a single statement to the patient within sixty (60) days of discharge. The statement must indicate:

- Which items and services provided during the episode of care that are billed by a participating provider and which services are billed by a non-participating provider.
- For each item or service, what amount is being billed to a third-party payer; and
- What the patient's responsibility is from any third-party payer.

A hospital that does not comply with the provisions of Section 1(A) shall be in violation of the Unfair Practices Act and subject to its penalties.

The bill defines "episode of care," "hospital, " "nonparticipating provider," "participating provider," and "third-party payer."

FISCAL IMPLICATIONS

Indetermanent but potentially significant to both hospitals and patients. With respect to the Unfair Practices ACT (UPA), NMHA states:

> Under the act failure to provide the necessary information within sixty days subjects the hospital to the prospect of expensive litigation (under the Act a prevailing plaintiff is entitled to attorneys' fees if the hospital is found to have acted willfully). Furthermore, the legislation conflicts with the Act itself which requires "a false or misleading" representation. In this case, the proposed act would make a one day delay in providing the necessary information actionable under the UPA in circumstances in which there were no false or misleading representations.

Further, regarding impacts to patients, NMHA notes:

> The bill would shift a significant burden from the hospital to patients. Currently, hospitals work with insurers to try to resolve claims that aren't paid initially. Health insurers have 30 days (or 45 if claims are submitted manually instead of electronically) to decide whether to pay a claim, deny it, or request additional information. Requiring hospitals to provide final statements to patients within 60 days of discharge will make it impossible for the hospitals to attempt any negotiations with insurers. Patients may have to pay more to the hospital, based on insurer's initial determinations, then fight the insurance company to get coverage.

SIGNIFICANT ISSUES

NMHA provided an analysis describing a number of concerns, largely because hospitals lack access to, and control of, the information required to comply with the provisions of this bill. NMHA makes the following arguments:

I. Impossible timing. In some cases, it will be literally impossible for hospitals to comply with the bill's requirements within the required timeframe or within any timeframe. The reason is that the hospital is unable to assemble the necessary information to determine the portion of the bill for which the patient is responsible until the insurer has determined how much it will pay the hospital and how much the patient must pay, which is based not only on the contract between the insurer and the hospital, but also on other factors such as the amount of the patient's deductible, whether the insurer denies portions of the bill and whether there is secondary insurance, and the scope of the insurer's coverage. Furthermore, when an insurer denies a claim, the hospital must go through an elaborate and time consuming appeal process. These issues often take many months to resolve.

II. Hospitals have limited or no access to the bill's required information. Access only exists when the hospital and its employed providers are the sole providers of care and the hospital is the sole biller. More likely, when physicians or other providers are in private practice they typically do their own billing and the hospital would not have access to either a) the amount billed to the insurer and patient or b) the amount paid by the insurer.

III. Non-participating status compounds the problem of compiling information. First, the hospital may not know whether the provider is non-participating in the patient's plan and secondly, because the legal relationship is between the non-participating provider, the insurer and the

patient (and not the hospital), the hospital has no way of determining how much the provider will bill the insurer or patient and thus cannot calculate the amount of the patient is responsible for.

IV. Lack of access and control. The hospital does not have the necessary information required to enable it to determine the amount the patient will be responsible for because it neither sees nor has access to bills submitted by private providers nor does it have control over those providers.

V. Antitrust concerns. A significant impediment to compliance with the bill is the inability of hospitals to obtain billing information from non-hospital providers (irrespective of whether they are participating or not). The hospitals have neither a contractual or a legal right to that information. Furthermore, obtaining such information would provide the hospital with knowledge of the pricing arrangements of competitors, which would raise antitrust concerns.

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