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

SPONSOR Brandt **ORIGINAL DATE** 02/24/21 **LAST UPDATED** **HB**

SHORT TITLE Hospital Billing Changes **SB** 382

ANALYST Chilton

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY21	FY22	FY23		
	(Potentially large revenue loss)	(Potentially large revenue loss)	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases) **See Financial Impact and Significant Issues below.**

Relates to 2019 Senate Bill 337, "Surprise Billing Protection Act"

SOURCES OF INFORMATION

Responses Received From
Office of the Superintendent of Insurance (OSI)
Department of Health (DOH)

No Response Received
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

Senate Bill 382 establishes a new section of the Unfair Practices Act (Chapter 57-12 NMSA 1978) to apply to hospital billing. It would require that a hospital bill from an episode of care be provided within sixty days of the end of that episode, or ninety days if the hospital were still negotiating with a third-party payer.

The bill would be required to specify which services are provided by providers participating in the patient's health plan network, and which were not, and would clearly state which parts of the bill were to be paid by the insurer and which by the patient.

Hospitals not complying with these requirements would be in violation of the Unfair Practices Act and could not bill the patient for any portion of the bill not covered by insurance, as well as being subject to other penalties set forth in that act.

The bill defines "episode of care" as any individual admission or outpatient procedure.

There is no effective date of this bill. It is assumed that the effective date is 90 days following adjournment of the Legislature.

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 382. Billing for services by state-operated hospitals might be affected severely if it could not be accomplished within the mandated timeline. There is no estimate of how much revenue would be lost.

SIGNIFICANT ISSUES

Senate Bill 382 would attempt to make billing for hospital visits more easily comprehensible for the recipient. As bills for a single hospital visit or stay often come from multiple agencies and practitioners, often listing an amount to be paid and little detail as to what is being charged for, patients often feel a lack of understanding of what they must pay, what their insurance companies will pay, and what other bills will come.

As OSI notes, "Depending on the nature of the episode of care, in addition to the hospital itself, the entities billing a patient could include a surgeon, an assistant surgeon, an emergency room doctor, an anesthesiologist, a lab, and other primary and ancillary health care service providers."

OSI comments that insurance companies usually take on the role of consolidating bills from multiple providers to provide their insured patients with a comprehensive picture of the charges resulting from a given hospital visit or stay, and that this bill would require hospitals to take on those tasks.

The Department of Health's Office of Facilities Management operates five in-patient facilities in New Mexico, the New Mexico Behavioral Health Institute in San Miguel County, Fort Bayard Medical Center in Grant County, the New Mexico State Veterans' Home in Sierra County, and Sequoyah Adolescent Treatment Center and the Turquoise Lodge Hospital in Bernalillo County. DOH expresses concern that, while complying with rapid, consolidated billing will be difficult for all hospitals in New Mexico, it would be nearly impossible for these institutions, and revenue from billing insurance carriers and patients might have to be foregone. In addition, DOH states that "DOH facilities already face challenges with maintaining billing staff; the positions have a high turnover and high vacancy rate. Any increased requirements related to this bill would cause further impact."

Regarding other New Mexico hospitals, DOH states

> Hospitals are not able to provide necessary and accurate information to determine the portion of the bill for which the patient is responsible until the insurance has determined how much it will pay the hospital and how much the patient must pay. This is based on the contract between the insurer and the hospital, the amount of the patient's deductible, any insurance denials, secondary insurance involvement, and the insurance coverage. Insurance

denials require hospitals go through heavily involved and time-consuming appeals processes that can take months to resolve.

Access to information would be challenging because the hospitals and its providers are not the sole providers for one episode of care or the sole biller. For example, patients usually have medical needs such as radiology studies, specialty labs, dialysis, or other procedures that are done by other providers. The hospital may not know whether the provider is non-participating in the patient's plan and they have no way of determining how much the provider will bill the insurance or patient; a calculation of the patient responsibility could not be done. The hospital does not see or have access to bills submitted by private providers nor is there control over other providers.

RELATIONSHIP with 2019 Senate Bill 337, the "Surprise Billing Protection Act," which defined surprise bill as one where a patient is billed for services by a provider who does not participate in his insurer's network, even if the medical facility does. The bill, which was signed by the governor, prohibited surprise billing and became section Chapter 59A- 57A NMSA 1978 and went into effect January 1, 2020.

ALTERNATIVES

OSI states that given its "interpretation of the intent of this bill, an alternative to this bill's requirements would be requiring hospitals to inform each patient prior to admission, at the time of admission, or along with the hospital bill, that the patient can expect to receive bills from several different providers who delivered services during the episode of care at the hospital."

LAC/sb