$4.75

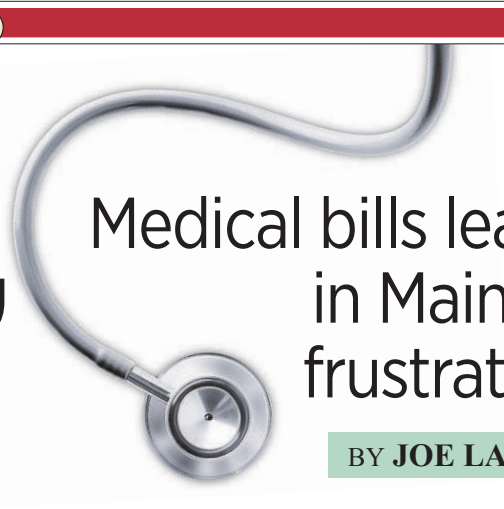
Sunday,
August 21, 2022

Maine Sunday Telegram

EST. 1862

WEATHER:
Mostly sunny and quite humid
High near 84
Details, B8

HIDDEN CHARGES, DENIED CLAIMS



Medical bills leave patients in Maine confused, frustrated, helpless

BY **JOE LAWLOR** / STAFF WRITER

Bill Bartlett received an $813 bill for a routine cardiac stress test that he had been told would cost him $45. Sean Dundon was charged $800 for having his sliced thumb examined and bandaged.

SPECIAL REPORT

Both patients faced unexpectedly huge expenses for simple medical care because so-called "facility fees" were tacked onto their bills. The fees are just one example of the arcane and complex world of medical billing that so often frustrates and confuses patients.

Patients receive bills bloated by health care providers that overcharge for services and insurance companies that deny claims without explanation. And with little clout to fight back or even negotiate, feeling helpless, they often give up and pay, worn down by a system that is as time-consuming as it is obtuse.

A public, high-stakes battle between Maine's largest hospital and its dominant insurance carrier has opened a window into the opaque world of medical billing and insurance claims, and it underscores just how powerless consumers are.

The dispute was settled last week, but the disagreement was over money. Maine Medical Center in Portland said Anthem owes it millions of dollars in overdue and unpaid claims, while Anthem contended that Maine Med has overcharged the insurer by millions of dollars.

Please see **BILLS,** Page A4

Gregory Rec/Staff Photographer

Donnalynn "Doni" Gallinger, 70, of Portland fought with insurance providers for years to cover the cost of mental health services, amassing reams of paperwork. She says her eventual success came from being extremely persistent with letters and appeals.

Brianna Soukup/Staff Photographer

Brian and Evelyn Roach with their infant son Eamon, at their home in Gray. Born premature, Eamon spent his first 80 days in the hospital, and the Roaches' insurance claims were denied. They were initially told they were on the hook for $360,000.

INSIDE

■ **NINE MAINERS OFFER** their firsthand accounts of confronting surprise fees and navigating the medical billing maze / ***Read their stories, A4-7***

■ **PROTECT YOURSELF:** Advice on how to shield against confusing bills and insurance denials / ***A7***

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Volume 135
Number 10

In moments, their housing stability went up in smoke

Portland renters displaced by a recent fire find themselves caught between their personal hardships and the broader housing crisis.

By MEGAN GRAY
Staff Writer

Bea Martin was swing dancing in a local park.

David Ericson was sleeping.

Zach Tenenbaum was buying a pack of cigarettes at 7-Eleven.

Katie Haskins was driving home.

Chris McClure was cooking stir fry.

Dale Barnard and Jamie Bailey were watching TV.

The tenants of 21 Grant St. were having a normal Monday summer evening when they suddenly became homeless. It was Aug. 8. A blaze started on the stovetop in Apt. 1.

The fire trucks came. Firefighters got the flames out in 45 minutes. The building didn't look much different from the outside except for the scorched kitchen window.

But a sign went up on the front door that said, "POSTED AGAINST OCCUPANCY."

And nine adults were thrust abruptly into the heart of southern Maine's housing crisis, with its too-few vacancies and spiking rents.

The building is owned by White Heat Realty LLC and run by Bricklight Re-

Please see **HOUSING,** Page A11

Derek Davis/Staff Photographer

Dale Barnard, 34, and Jamie Bailey, 33, currently staying with a friend in South Gardiner, had been renting a one-bedroom apartment for $1,560 at 21 Grant St. in Portland before this month's fire. They expect to pay much more to find a comparable place to live.

BILLS

Continued from **Page A1**

If the standoff had not been resolved, Maine Med would have left Anthem's provider network in January, upending Maine's entire health insurance market.

The Portland Press Herald/ Maine Sunday Telegram spent more than three months investigating the byzantine system of medical billing in Maine. The newspaper spoke with dozens of patients who have had billing problems, reviewed their invoices and explanations of benefits, interviewed health care executives and consulted experts in the field. The reporting reveals systemic shortcomings that are not limited to any one medical provider or insurer but are pervasive across the landscape. The Press Herald found that:

■ Medical bills are confusing and opaque, and sometimes carry arbitrary and hidden costs, including a common surcharge that hospitals call a "facility fee," charging hundreds of dollars simply for getting treatment in a hospital.

■ Insurance companies deny some claims for reasons that aren't clear and may never be explained, forcing patients to choose between waging drawn-out fights or paying hefty bills.

■ Costs for procedures and insurance coverage vary so widely that even patients who carefully compare prices beforehand can wind up with bills far larger than expected.

■ Even though Americans' access to insurance expanded through the Affordable Care Act, many are still underinsured and subject to massive medical bills they don't expect and may not be able to pay.

The practice of assessing facility fees – sometimes hiding such fees in other charges – increasingly contributes to some patients' surprisingly large bills.

It has long been standard practice for hospitals to shift uncompensated costs, such as care for uninsured patients who can't afford to pay their bills, to patients with insurance.

But with more patients on high-deductible plans – and insurers sometimes refusing to pay or paying only a fraction of their bills – individuals are picking up more of the tab and bearing more of the financial burden.

"The system is broken and is really in need of a major overhaul," said Dr. Julie Keller Pease, a founding member of Maine AllCare, which advocates for single-payer systems like those in Canada and the United Kingdom.

Still, any efforts to reform or overhaul the system, especially in one small state like Maine, face huge barriers.

HIDDEN FEES

Maine patients are paying hundreds of dollars extra for routine medical tests or procedures simply because the tests are occurring at hospitals. And they may have no idea, because the "facility fees" are not clearly explained and sometimes hidden on their bills.

Bill Bartlett of Kennebunkport said he called his insurance company to check on the price before getting his routine cardiac stress test last November. A few weeks later, the 60-year-old got a bill from York Hospital for the $45 he expected plus $813 for a "facility fee."

Bartlett only discovered the facility fee because he demanded an explanation. And before he spent months complaining and appealing, his insurance company tried to deny coverage and stick him with the bill.

"This shouldn't be my problem," said Bartlett, who appealed the denial. "I did due diligence to determine the cost ahead of time."

After Bartlett refused for months to pay the bill, Harvard Pilgrim finally paid most of it a few weeks ago, without explanation.

Jean Kolak, a spokeswoman for York Hospital, said that "when a patient receives services at York Hospital, their invoice will include a facility fee."

"The amount of this fee is created, based on a variety of factors, such as the cost of staff, equipment, technology, medications utilized, supplies and in some clinical care areas, the acuity of the patient," Kolak said in a statement.

Ann Woloson, executive director of Consumers for Affordable Health Care, a Maine-based advocacy group, said the organization is receiving increasing numbers of complaints about facility fees and may seek legislation to limit when they can be charged and require that patients be warned ahead of time.

"If facility fees are charged, the brunt of those fees should not be on the consumer," Woloson said.

Al Swallow, chief financial officer for MaineHealth, the hospital network that includes Maine Medical Center and seven other Maine hospitals, said facility fees are an industry standard. They reflect the need for hospitals to cover higher expenses than other medical providers incur, he said.

"Hospital settings have more costs than (outpatient) settings, including the fact that many of the services delivered by hospitals go uncompensated, either because of charitable care or the fact that Medicare and Medicaid do not cover the full cost of care delivered in a hospital," Swallow said in an email response to questions. "Hospital settings are also more highly regulated, and meeting those standards can add costs to delivering care in those settings."

DENIED CLAIMS

Patients can be at the mercy of insurance companies that deny claims for services they thought would be covered, and some fight their bills for years, believing that they should not be responsible.

Others just give up and pay, even though they share that belief.

Doni Gallinger of Portland did not give up, despite having claims denied by two insurance companies. But it took years for the 70-year-old to get coverage for mental health therapy.

"There was a very clear intent … to withhold services," Gallinger said. "That was a very clear objective for them."

The system is a perplexing mess, even for health care professionals.

Jill Copeland, a mental health therapist in Yarmouth, said she had to learn the ins and outs of how seven insurance companies conduct business in order to get properly reimbursed. If she didn't have to spend so much time navigating the system, she said she could see 15% to 20% more patients.

"I have waited a very long time to get paid," Copeland said. "And I am very persistent."

Getting insurance companies to fix problems related to reimbursements is often difficult.

"My experience has been in general if they get things set up right the first time, it's likely to keep going right," Copeland said. "But if something doesn't go right the first time, it feels like you might as well just give up. You can spend hours and hours and hours on the phone and be given all kinds of promises that it's fixed and then it still isn't fixed."

UNPREDICTABLE PRICES

Patients trying to navigate the health care market find dramatically different prices among medical providers. Many learn the hard way.

In 2021, Alex St. Hilaire of Westbrook got a CT scan on his abdomen at Shields Imaging Center in Brunswick; it cost about $750. The next year he had the same exact scan at Northern Light Mercy Hospital – and it cost him nearly $3,000. With a high-deductible insurance plan, Hilaire is on the hook to pay most of that total. He had no idea charges for the same service could vary so much.

Continued on next page

'It is intentionally ... confusing'

Christmas 2021 started painfully for Sean Dundon. He was at home in Portland doing some morning food prep. "The first slice of peeling potatoes, I sliced a portion of my finger off," he said.

SEAN DUNDON

Derek Davis/Staff Photographer

A Christmas Day food-prep injury landed Sean Dundon in Mercy Hospital's emergency room. The $800 bill the 54-year-old Portland man received weeks later included a $510 facility fee.

Dundon, 54, said he wanted to make sure it wasn't a serious injury, so he went to the Northern Light Mercy Hospital Emergency Department in Portland. He said he would have gone to an urgent care center but they were all closed for the holiday.

"They gave me Lidocaine (anesthetic), cleaned out the wound, wrapped it up and sent me home in half an hour," Dundon said. He didn't need stitches.

"I came home and opened presents and thought, 'This was great.'"

The bill arrived a few weeks later: $800, which included a $510 "facility fee" for using the hospital on top of about $300 in charges for the assessment and treatment.

"If there had been a sign on the wall that said there was a facility fee, I would have gone home, dressed it myself and gone (somewhere else) the next day," Dundon said.

A facility fee is charged by health care providers to cover the expense of the overall services in the building, but insurance companies will often pay only a fraction of the fee, leaving patients on the hook for the bulk of the cost.

Dundon said he tried to appeal and negotiate a lower bill but was unsuccessful. With a high-deductible insurance plan, he had to pay the entire cost himself.

"They are basically admitting they are gouging me," Dundon said. "It is intentionally obfuscating and confusing."

– Joe Lawlor

'The system is barbaric'

DONI GALLINGER

Gregory Rec/Staff Photographer

"There was a very clear intent … to withhold services," Donnalynn "Doni" Gallinger, 70, says about the insurance companies she has fought for years over coverage for mental health services. "That was a very clear objective for them."

Doni Gallinger fought for years with two insurance companies over coverage for mental health services.

When the 70-year-old enrolled in Medicare five years ago, she also purchased insurance that provided supplemental coverage for mental health. Gallinger said she was assured that her therapist – Jill Copeland, a licensed clinical professional counselor – would be included in her insurance plan.

Nevertheless, Gallinger said, the companies denied the claims.

"They just wouldn't bloody do it. They just wouldn't," she said.

Gallinger said she ended up having to pay $1,500 out-of-pocket before her mental health services were finally covered, but she spent many hours on the phone and writing letters to get the service covered. The hold-up was over the fact that standard Medicare does not reimburse for counseling by an LCPC even though her supplemental insurance plan was supposed to.

"The only answer I would ever get is that, 'We won't cover it because Medicare doesn't,'" said Gallinger, who wrote letters to Sen. Angus King and to Rep. Chellie Pingree to put pressure on the insurance companies. "There was a very clear intent … to withhold services. That was a very clear objective for them."

The only reason she eventually broke through and got it covered was by being extremely persistent with letters and appeals. In one May 2019 letter to Aetna, Gallinger was so frustrated that she wrote: "(May) God forgive you for harassing people with health problems, rather than giving them the services they have contracted and paid for."

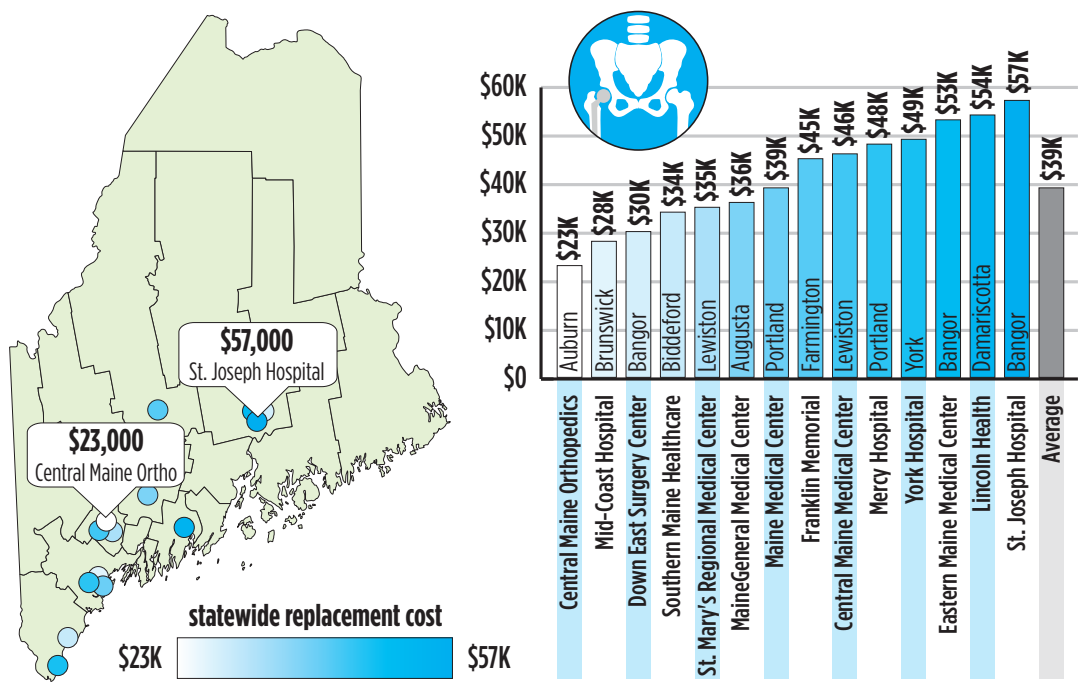
Gallinger, who lives in Portland, said that in all the time she has dealt with insurance companies, "they don't ever seem to make mistakes where there's a benefit in your favor."

She lived in Canada as a young woman and remembers learning about how the U.S. system was so different from the simpler Canadian system, which covers people without sending them into medical bankruptcy.

"When I was in Canada, we always watched in horror what was happening in the U.S. (with the health care system)," Gallinger said. "We wondered why they put up with it. The system is barbaric."

– Joe Lawlor

Hip replacement cost varies substantially depending on where surgery is done, from a low of $23,000 to a high of $57,000



SOURCE: CompareMaine.org

STAFF GRAPHIC | JAKE LAWS

‘They shouldn’t be putting me in the middle’

Photo courtesy of Ed Latham

Ed Latham, 53, of Milbridge says his insurance company has denied his claim for a hospital stay, “essentially saying it is logical to go against your doctor’s wishes for their financial considerations.”

ED LATHAM

When Ed Latham experienced chest pains in May, he checked himself into Northern Light Maine Coast Hospital in Ellsworth for observation.

The 53-year-old had three previous heart attacks, so he relied upon his cardiac surgeon’s “strong recommendation” that he be hospitalized for observation and tests. Latham said he was concerned about whether insurance would cover his six-day hospital stay, but he wasn’t going to go against his doctor’s recommendation.

“I understand their thinking of it’s better to be safe than sorry,” said Latham, who lives in Milbridge. “They didn’t want me walking out of the hospital and dropping dead on the street a few blocks away.”

Latham’s heart was OK, and he was released. A few weeks later he got a letter from his insurance company stating that the claim for his hospital stay would be denied and not covered. There was no explanation. After months of waiting, he received a few bills from the hospital totaling hundreds of dollars, but Latham said he has no idea if he’s getting more bills and could be on the hook for thousands in payments.

Latham said he called the hospital’s billing department, and they told him that it will likely be worked out between the hospital and Anthem, his insurance carrier. But in the meantime, the possibility that he could owe thousands continues to weigh on him – he still has not been told how much the bill could be.

“Why am I involved in this at all?” Latham said. “They shouldn’t be putting me in the middle of a dispute between the hospital and the insurance company about what is payable and not payable.”

Latham said the entire situation is alarming.

“The insurance company is essentially saying it is logical to go against your doctor’s wishes for their financial considerations,” Latham said.

– *Joe Lawlor*

Gregory Rec/Staff Photographer

Bill Bartlett, 60, of Kennebunkport has fought an $800 “facility fee” for a cardiac stress test he was told by his insurance company would cost just $45, far below the total charge. He says: “If I’m interested in buying a car, you don’t say, ‘How much are the tires?’”

‘They have ... charges that are invisible’

BILL BARTLETT

Bill Bartlett’s doctor recommended he get a routine cardiac stress test.

So the 60-year-old from Kennebunkport called his insurance company in advance to find out how much it would cost, giving them the name of the York Hospital-affiliated doctor’s office to make sure it was in-network and wouldn’t cost too much.

The answer: He would be responsible for $45.

It sounded reasonable, so Bartlett went for the test at York Hospital in November. The test did not show any problems with his heart.

When he got the bill in February, it was for $858 – $45 for the stress test plus $813 that was tacked on for reasons that weren’t clearly explained.

When he asked what the $813 was for, Bartlett said his insurance company, Harvard Pilgrim, told him it was a hospital facility fee, an add-on because the test occurred in a hospital. And he was told the insurance plan doesn’t cover most of the facility fee. The total facility fee was $924. Harvard Pilgrim paid $111, and the $813 balance was charged to Bartlett. After months of back-and-forth, Harvard Pilgrim paid the bill, without explanation, in late July.

Bartlett said when he initially called to complain about the charge, hospital officials were at first vague about the $813 but later confirmed that it was a facility fee.

“When a patient receives services at York Hospital, their invoice will include a facility fee,” said Jean Kolak, a spokeswoman for York Hospital, in a statement to the Portland Press Herald/Maine Sunday Telegram.

“The amount of this fee is created, based on a variety of factors, such as the cost of staff, equipment, technology, medications utilized, supplies and in some clinical care areas, the acuity of the patient,” Kolak said. “Additionally, in cases where the physician/provider is employed directly by York Hospital, a separate professional fee will also be charged.”

Kolak said the cost of the cardiac stress test and all other services at the hospital are built into the facility fee, so it is incorrect to say the stress test cost $45.

Bartlett said he thinks he should have been told about the total cost when he called the insurance company to ask about the price.

“If I’m interested in buying a car, you don’t say, ‘How much are the tires?’ No, you’re asking what the whole price of the car is,” Bartlett said. “Harvard Pilgrim quoted me the price. Any additional costs are on them (York Hospital).”

Kolak said “payments for services are based on contracted rates with each payer” and that according to the contract with the insurance companies, and in the case with Medicare or Medicaid patients “we cannot waive patient responsibility” for charges.

The hospital offered to give him a payment plan, but Bartlett balked.

“Why should I go on a payment plan for something I don’t owe?” Bartlett said.

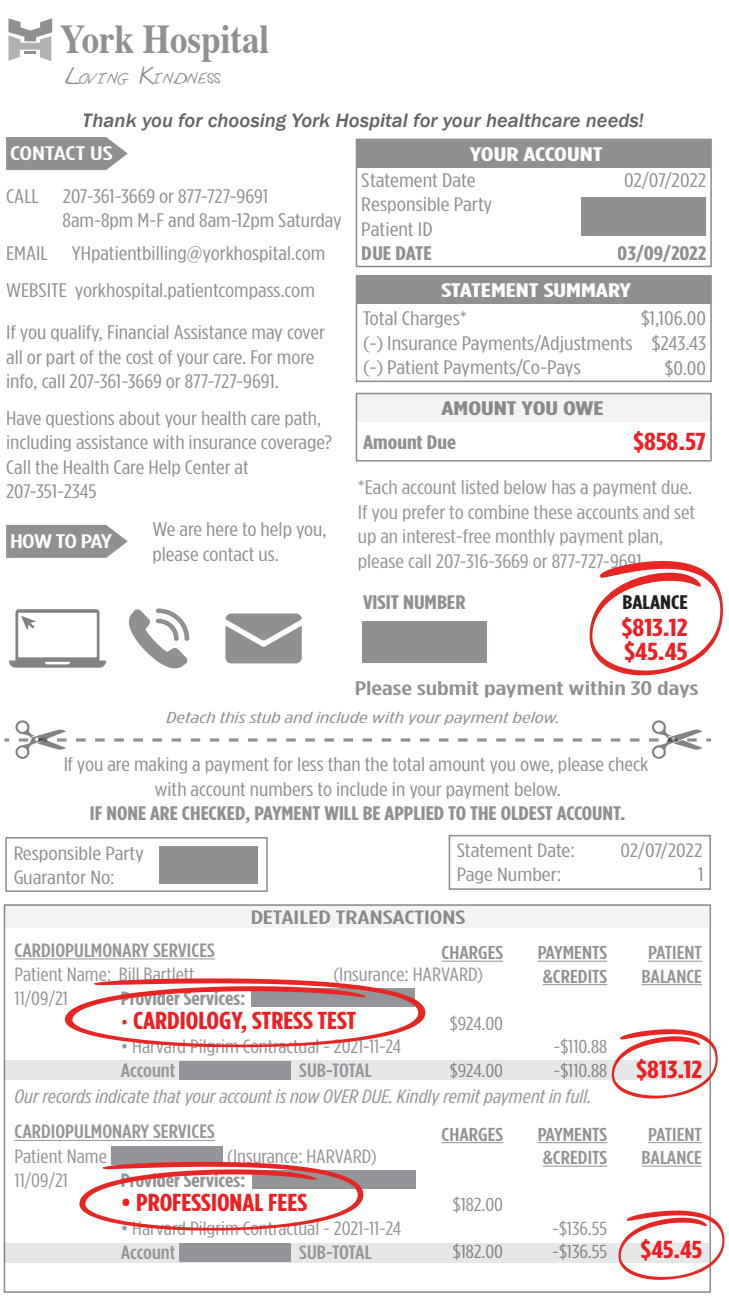
Bartlett refused to pay, and an initial appeal to Harvard Pilgrim was rejected before being paid in late July without explanation.

“They have these charges that are invisible to consumers,” Bartlett said. “This shouldn’t be my problem, I did my due diligence ahead of time to determine the cost. It’s not like I have some exotic disease. They should know what this is going to cost.”

Bartlett said that had he not been semi-retired and in good health, he may not have had the time and energy to fight the bill.

“I often wonder how many times medical providers send these bills out, and get a check back because nobody’s going to argue or spend the time to fight it?” Bartlett said.

– *Joe Lawlor*



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HOW TO PAY We are here to help you, please contact us.

YOUR ACCOUNT	
Statement Date	02/07/2022
Responsible Party	[redacted]
Patient ID	
DUE DATE	03/09/2022

STATEMENT SUMMARY	
Total Charges*	$1,106.00
(-) Insurance Payments/Adjustments	$243.43
(-) Patient Payments/Co-Pays	$0.00

AMOUNT YOU OWE	
Amount Due	$858.57

*Each account listed below has a payment due. If you prefer to combine these accounts and set up an interest-free monthly payment plan, please call 207-316-3669 or 877-727-9691

VISIT NUMBER [redacted]

BALANCE $813.12 $45.45

Please submit payment within 30 days

Detach this stub and include with your payment below.

If you are making a payment for less than the total amount you owe, please check with account numbers to include in your payment below.
IF NONE ARE CHECKED, PAYMENT WILL BE APPLIED TO THE OLDEST ACCOUNT.

Responsible Party Guarantor No: [redacted]

Statement Date: 02/07/2022
Page Number: 1

DETAILED TRANSACTIONS

CARDIOPULMONARY SERVICES	CHARGES	PAYMENTS &CREDITS	PATIENT BALANCE
Patient Name: Bill Bartlett (Insurance: HARVARD)			
11/09/21 Provider Services: [redacted]			
• CARDIOLOGY, STRESS TEST	$924.00		
• Harvard Pilgrim Contractual - 2021-11-24		-$110.88	
Account [redacted] SUB-TOTAL	$924.00	-$110.88	$813.12

Our records indicate that your account is now OVER DUE. Kindly remit payment in full.

CARDIOPULMONARY SERVICES	CHARGES	PAYMENTS &CREDITS	PATIENT BALANCE
Patient Name [redacted] (Insurance: HARVARD)			
11/09/21 Provider Services: [redacted]			
• PROFESSIONAL FEES	$182.00		
• Harvard Pilgrim Contractual - 2021-11-24		-$136.55	
Account [redacted] SUB-TOTAL	$182.00	-$136.55	$45.45

Bill Bartlett was expecting a $45 bill for his cardiac stress test. The bill he got from York Hospital is shown here, with the circled emphasis added by the Portland Press Herald/Maine Sunday Telegram. The total included a $45.45 charge for “professional fees” plus an $813.12 charge for “cardiology, stress test.” While not explained on the bill, the second unexpected charge included what is known as a facility fee. Hospitals charge such fees to pay for unreimbursed operating costs, and some insurance companies don’t cover them. Harvard Pilgrim initially told Bartlett he had to bear most of the cost for the facility fee. After months of back and forth, the insurance company paid the bill without explanation.

Continued from previous page

“I was literally in the machine 40 seconds tops, and it cost $3,000,” St. Hilaire said.

High charges are sometimes the result of a hospital rolling in other costs and services, said Christy Jolliff, Northern Light Health’s vice president of enterprise revenue cycle, who was speaking generally, not about St. Hilaire’s bill. If a bill shows $25 for a bottle of aspirin, that fee may actually cover other materials and services.

“We don’t charge for every piece of gauze, every Q-tip that’s being used,” Jolliff said. “Oftentimes, it covers things that don’t get listed at all.”

Why do hospitals charge so much? “Because they can,” said Jim Ward, president and principal of Patient Advocates, a Gray company that works with self-insured employers to lower health care costs.

Large organizations and insurance networks have the power to negotiate with hospitals, Ward said. Individual patients don’t.

Unlike neighborhood restaurants, hospitals generally don’t compete for business with customers. Rather, they are looking to cover many running costs.

“Hospital pricing is not the same as pricing for goods in a retail store in that it is not done looking strictly at what other providers charge,” said Swallow, the MaineHealth executive. “Rather, hospitals start with the premise that they must cover their operating costs – including free care and costs not fully covered by Medicare and Medicaid – and leave enough of an operating margin to weather future adverse events and invest in new technology and infrastructure.”

SHOPPING AROUND

There are ways to reduce the odds of an unexpected bill, but they don’t offer perfect protection.

The state’s seven-year-old CompareMaine website, launched by the Maine Health Data Organization, a state agency, allows patients to compare the costs of procedures like a colonoscopy or a knee replacement. The site reveals widely varying costs across the state – a hip replacement can cost anywhere from $23,000 to $57,000.

But the site doesn’t tell patients what facilities are in network for their insurance companies – information that can dramatically affect their share of costs. And it doesn’t help patients understand how to navigate their coverage plans to control costs. It won’t tell you, for example, that it is sometimes better for patients to meet their annual deductibles before scheduling elective surgery.

In an effort to increase price transparency, the federal government has mandated that hospitals publish the “chargemaster” prices, or list prices, on their websites.

But the chargemaster prices often have little to do with what patients get charged. The list price of repairing a broken wrist may be far different than what the various insurance companies, negotiating with hospitals, have agreed to pay for that surgery.

The bill a patient receives in the mail may be a full three steps removed from the chargemaster prices.

Stephanie DuBois, a spokeswoman for Anthem, said the company encourages its patients to shop around for health care services and call to find out what Anthem will pay.

“We all know a hospital setting can be one of the most expensive places to receive care, which is why at Anthem Blue Cross and Blue Shield we invest a lot of time and resources into educating consumers about the various choices they have available to them,” DuBois said in a written statement. “Services such as imaging, labs, or prescription drug infusion are available at many non-hospital based facilities that offer consumers a convenient location, a much lower cost, and equal, if not greater, quality.”

INSURANCE GAPS PERSIST

More Americans have health insurance now than ever before because of the Affordable Care Act, which took effect in 2013. Still, about 8 percent of Mainers remain uninsured. And many others are underinsured, with high deductibles or cost-sharing arrangements that shift more of the financial burden onto them.

The proliferation of high-deductible health plans – designed to keep premiums down – means patients are paying a higher share of the bills that come in when they get sick.

While medical bankruptcy is rarer than before the ACA took effect, many patients are saddled with thousands of dollars in bills that they are unable to pay.

Continued on next page

SURPRISE MEDICAL BILLS LEAVE

Continued from previous page

Valerie Lawson, 65, of Calais said she was shocked by the $20,000 bill she received when she was temporarily uninsured last winter. She had dropped her insurance because the premiums were so high, and during that lapse she had to go to the emergency room because of hemorrhaging in her colon.

She learned what she owed when she was still weak and recovering at home. "I felt like the floor opened up beneath me, and I fell through," she said. "I thought, 'You have to be kidding me.' I was really gobsmacked."

Lawson said she gave up fighting what she believed were unfair charges and paid $14,000 to settle the bill because the fight took too much energy, and being uninsured she was in a poor negotiating position with Northern Light Eastern Maine Medical Center. She is now insured again.

But it's not only people without insurance getting large bills. People who are underinsured – often with high-deductible health plans to keep monthly premium costs low – end up paying high-cost bills.

The large number of underinsured people does more than land them with massive bills. It also contributes to inefficiencies in the health care system. The higher costs can make people reluctant to use their health care plans, delaying health services even when they need care, experts say.

"We focus on spending a lot of money later in the development of disease, when we should be focusing on prevention, early diagnosis and treatment," said Reggie Williams, vice president of the International Health Policy and Practice Innovations program at the Commonwealth Fund, a foundation in New York City that supports health care reforms.

That increases the overall cost of health care and leads to worse health outcomes, such as higher rates of infant and maternal mortality, Williams said.

"The lack of investment we have in the United States before people give birth really impacts the quality of care people have while they are pregnant and postpartum," Williams said.

REFORMS RESISTED

At the root of the problem is the way health care is financed in the United States. It is a system that is hard to defend, even for hospital administrators and insurance executives.

Yet it persists.

MaineHealth's president, Dr. Andy Mueller, said the system needs to change, and he wants to enact meaningful reforms that would move payment models away from charging fees for services to paying health care providers for keeping people healthy. Mueller said the financial incentives need to move from volume charging for services to prevention and management of chronic conditions, early diagnosis and treatment – in other words, keeping people out of the hospital.

"We can't accept the status quo," said Mueller, who became the leader of Maine's largest hospital network in 2021. "We need to fundamentally change the way we get paid."

Mueller agreed that massive reforms would be daunting. But he said MaineHealth expects to launch some pilot programs later this year that could begin to make a difference. Details of the programs – which will require a waiver from the federal Medicaid program – will be released this fall.

"Rest assured, we are working on lots of reforms that will change how we deliver care while increasing affordability," Mueller said.

But Jim Ward, the Patient Advocates president, said the headwinds against meaningful change are strong.

Any change has the potential to benefit one sector of the industry at the expense of another, and would face powerful resistance. "There's a very strong established and vested interest in maintaining the status quo," Ward said.

Some see the solution in a single-payer system – where the government pays for medical care, financed through taxes, eliminating much of the market for insurance companies. It would force hospital networks and other medical providers to accept prices set by the government – as they do with Medicare and Medicaid.

Other countries, such as Canada, the United Kingdom, France and Spain, and much of the developed world, have instituted single-payer systems or universal coverage.

Liberal politicians and advocates in the United States, such as Sen. Bernie Sanders of Vermont, have long called for a single-payer model, which Sanders describes as "Medicare for all." Conservatives have opposed the idea, calling it socialized medicine.

Other substantial but less sweeping reforms that are often discussed include lowering the age eligibility for Medicare from 65 to 55 or 50 and giving people a "public option" for health insurance. But action on such fronts does not seem to be on the horizon, and much narrower changes are hard fought.

Even a modest reform that attracted bipartisan support – letting Medicare negotiate prices with drug manufacturers – took decades of advocacy. The Medicare reform, which finally cleared Congress and was signed into law by President Biden last week as part of the Inflation Reduction Act, will also limit annual out-of-pocket prescription costs for Medicare patients to $2,000.

A proposal championed by U.S. Sen. Susan Collins, R-Maine, would have capped insulin copays at $35 per month. The Inflation Reduction Act that passed Congress included this copay limit for Medicare patients, but not for the rest of the population. Collins and other advocates hope to bring forward a separate bill to pass a broader insulin cap.

'LEFT HOLDING THE BAG'

Woloson, executive director of Consumers for Affordable Health Care, said it's difficult to enact reforms that benefit patients given the competing interests of the major players in the market, such as hospitals, insurance companies and drug manufacturers.

"When you adjust something over here, you have to adjust over there," Woloson said. "The consumer is always left holding the bag. What works best for hospitals or insurance companies might not work for patients."

Continued on next page

'Why was this so stressful and confusing?'

BRIAN AND EVELYN ROACH

Evelyn Roach of Gray gave birth to her first child in October.

Eamon was born six weeks premature and needed to stay in Maine Medical Center's neonatal intensive care unit for about two months. While he's now healthy and at home, Roach and her husband, Brian, spent months fearing they would wind up hundreds of thousands of dollars in debt for their new baby's medical care.

The couple brought Eamon home Dec. 31. They had set aside money for the pregnancy and birth because they have a high-deductible insurance plan and expected out-of-pocket costs totaling a few thousand dollars. But shortly after bringing the baby home, the couple got letters from her insurance company stating their claims were denied and that they would be on the hook for the full cost of his care: $360,000.

She and her husband made numerous calls to Anthem and MaineHealth, the parent organization of Maine Med. She said they never got a clear answer about why the claim was denied.

Brianna Soukup/Staff Photographer

Brian and Evelyn Roach hold Eamon at their home in Gray. The couple, who faced a $360,000 bill after Eamon was born, said they never got a clear answer about why their claim was initially denied.

"It's a massive amount of money. It's almost incomprehensible," Brian Roach said while still trying to get answers in May. "How would we go about paying for this?"

"No one (ever) said this is wrong and you won't be charged for it," Evelyn Roach said.

Finally, in June they got a bill from Anthem in Maine showing they didn't owe any money. They had already met their out-of-pocket deductible of $6,600 earlier in 2021.

"We were so relieved," Evelyn Roach said shortly after receiving the news. "It was adding unnecessary stress to an already stressful situation."

But they still do not know why the claim was initially denied.

"It's unclear to me what happened," Evelyn Roach said. "Whenever I spoke with someone, they were always kind and trying to be helpful, but I could tell no one really could tell me what was going on."

She said they notified the insurance within a week of Eamon being born that he was being added to her insurance policy, meeting that insurance requirement.

Evelyn and Brian have different insurance policies through their employers, so they think this may have been an effort by Anthem of Maine – Evelyn's policy – to get Anthem of Illinois – Brian's insurance coverage – to cover the birth. But no one has confirmed that.

Evelyn Roach said the experience made her feel helpless.

"Eamon needed to be in the hospital after he was born, and we shouldn't have had this hanging over our heads," she said. "Why was this so stressful and confusing?"

– Joe Lawlor

'Why are we paying crazy bills like this?'

ALEX ST. HILAIRE

Alex St. Hilaire needed a CT scan twice in the past two years for abdominal pain he was experiencing.

The tests were identical. In both cases the 31-year-old's symptoms turned out to be false alarms. But the two bills he received were starkly different.

In February 2021, St. Hilaire went to Shields Imaging in Brunswick for a CT scan and ended up with a bill of $742. Because he has a high-deductible health insurance plan, St. Hilaire knew he was going to pay the bulk of the cost, and the bill was in the ballpark of what he was expecting.

In February 2022, the Westbrook resident needed another scan. He was having difficulty scheduling one, so he asked his doctor's office to give him other places to try. He was referred to Northern Light Mercy Hospital in Portland, where he went for the same CT abdominal scan conducted at Shields Imaging the previous year.

The cost: $2,900.

"I was expecting $600 to $700. I was not expecting $3,000," St. Hilaire said. With the high-deductible plan, he was on the hook for most of the money, although he was able to get a discount to $2,500 by immediately paying in full.

All for a procedure that took less than five minutes.

"I remember the tech saying, 'All right, done.' I was literally in the machine 40 seconds tops, and it cost $3,000," St. Hilaire said. "It didn't ruin my year, but certainly I could have done something else with that money."

Gregory Rec/Staff Photographer

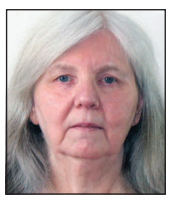
Alex St. Hillaire of Westbrook had two CT scans done a year apart. The first cost $700; the second one was nearly $3,000.

St. Hilaire said it doesn't make any sense that the same procedure could have such wildly different costs.

It's a painful lesson learned by countless health care consumers in the U.S., where all kinds of medical costs vary widely for the same procedures. In Maine, for example, a hip replacement can cost $30,000 in one hospital and $60,000 in another.

"Why are we paying crazy bills like this?" he said.

– Joe Lawlor



'It just grinds you down, just no way out of it'

VALERIE LAWSON

Valerie Lawson said she knew she was rolling the dice in early 2021 when she chose to be without health insurance temporarily.

At age 64 and only a year away from qualifying for Medicare, she could no longer afford to pay her health insurance premiums through the Affordable Care Act. A few weeks later, the Biden administration increased subsidies for middle-class people like Lawson nearing retirement age, and she quickly signed back up.

But during the month that she was uninsured, Lawson experienced hemorrhaging in her colon and had to be hospitalized at Northern Light Eastern Maine Medical Center in Bangor. Her condition didn't require surgery, but the bill for a two-day hospital stay totaled $21,000.

"When I first heard the total amount on the phone, I felt like the floor opened up beneath me, and I fell through. I thought, 'You have to be kidding me.' I was really gobsmacked," said Lawson, who lives in the Washington County town of Robbinston.

So Lawson – still weak from her hospital stay – took it upon herself to examine every aspect of her bill, to see what could be challenged.

"It was exhausting," she said. "I was still quite ill. I couldn't even stand up for 5 minutes at a time, I was so weak."

She looked over the charges and found they were consistently higher than the official "chargemaster" prices published on the hospital's website. The chargemaster prices are the initial price set by the hospital, but they are often different than the charges negotiated with individual insurance companies. In one case, an iron IV infusion to help speed her recovery cost more than $3,000, when the chargemaster price indicated it should have been only about $50.

"If I had known how much that was going to cost me, I would have said, 'No, thank you, I'll have a steak at home," Lawson said. She said Northern Light never gave her a reason for the price.

The hospital offered her a 25 percent discount on the overall bill, which she took, and is now paying off about $14,000.

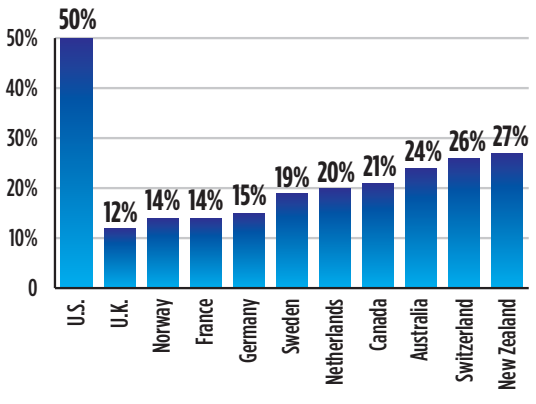
While Lawson now qualifies for Medicare – and with supplemental insurance shouldn't have to worry about getting socked with any more giant bills – she said the money she spent means that she will have to delay her retirement from her work in website design.

"You really go through the wringer when this happens," Lawson said. "It just grinds you down, just no way out of it. I eventually just gave up."

– Joe Lawlor

Costs limit access to health care

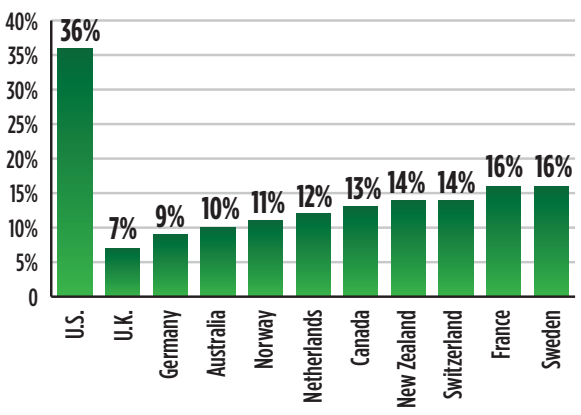
Percentage of those surveyed in each country with below-average income who reported cost-related problems getting medical care.



STAFF GRAPHIC | JAKE LAWS
SOURCE: Commonwealth Fund, 2021

Inability to pay medical bills

Percentage of people earning below average incomes who said they had serious problems paying or were unable to pay a medical bill.



SOURCE: Commonwealth Fund, 2021
STAFF GRAPHIC | JAKE LAWS

Protect yourself against unexpected costs, insurance denials

The medical billing system can be a nightmare to navigate. Here's some advice.

By JOE LAWLOR
Staff Writer

The U.S. health care system is such a maze to navigate that trying to minimize medical bills is a time-consuming and difficult chore.

It's the equivalent of a "full-time job to figure out what insurance is going to pay," said Ann Woloson, executive director of Consumers for Affordable Health Care, a Maine-based patient advocacy group.

But there are ways to help reduce bills and limit costs.

Just as prevention is the best medicine for keeping healthy, planning ahead is one of the best ways to avoid large and unexpected medical bills. Instead of automatically going wherever your primary care physician refers you for screenings and other procedures, for instance, shop around to make sure you won't be charged more than necessary. Once you go through with a procedure, it's far more difficult to negotiate a better price.

Costs of surgeries, health screenings and lab tests can vary widely. A simple preventive or screening colonoscopy can cost as little as $254 or as much as $4,290 depending on location, according to the www.compare-maine.org website.

That website is a good place to start when comparing costs. But the least expensive provider you find for a given service — whether it be delivering a baby, an EKG or a hip replacement — is not necessarily where you want to go, Woloson said. Patients need to ensure they are getting quality care, but also not paying excessive amounts. It's a tricky balance, she said.

In general, avoid routine screenings and medical services in a hospital, as the extra fees they often tack on could add hundreds, sometimes thousands of dollars, to your bill.

Your insurance carrier also plays a major role in your final cost, so checking with your carrier is also an important step. Your carrier may suggest a different provider than your doctor does.

If you go to a provider outside your network, what you have to pay may be higher even if the total cost is lower, Woloson said.

It's also important to understand the ins and outs of your health care plan. If you have a high-deductible plan and you've already met your deductible for the year, it makes sense to schedule health care services during the same calendar year, rather than waiting until January when your deductible resets. Also, if you know you will need a procedure in an upcoming year, you may want to set aside money in a health savings account. Doing so lets you put untaxed income aside to pay for health care services, effectively using the tax break to lower your costs. Contributions to a health savings account are also tax-deductible.

If you get a bill that doesn't make sense or is higher than expected, the first step is to ask for an itemized breakdown or explanation.

If you are still being charged more than you believe is fair, you can appeal. But that is difficult because your negotiating power as an individual is limited.

To begin an appeal of an insurance claim denial, follow the directions on your insurance forms.

If you ultimately find that a procedure or service isn't covered, your health care provider may be willing to give you a discount as high as 25 percent, and may also give you a discount if you pay your bill promptly in full. You should ask for discounts whenever possible, Woloson said, as often a provider will agree to one to get a bill paid sooner.

For free assistance on a medical bill, call the Consumers for Affordable Health Care helpline at 800-965-7476 on any weekday from 8:30 a.m. to 4:30 p.m.

If your appeals to your insurance company or health care providers fail, you can also file a complaint with the Maine Bureau of Insurance.

Some disputes can also be taken to court, but it's a good idea to consult an attorney before initiating legal action.

'Their policies are consistently changing'

DAVID SANBORN

Once a year David Sanborn of South Berwick gets an endoscopy for his throat to make sure a pre-cancerous condition doesn't return.

And every year he has to fight with his insurance company over the bill.

His medical provider is in the insurance company's network, but his doctor sends the biopsy to an out-of-network lab. His insurance company, Cigna, has billed him for the entire cost of the lab work – $4,300 – every year.

"Every single time it's been a different problem, and every time they are trying to stick me with a lab bill," Sanborn said. "Their policies are consistently changing. It's aggravating. It's a procedure I am going to need next year and the year after that and for the rest of my life. It should be paid."

So far, the 46-year-old has been able to eventually get the cost covered. But he said it's infuriating to have to go through the hassle every time.

Sanborn said he could have his doctor seek a different lab, but doesn't want to compromise on his care.

"When my doctor decides this is the best lab to send the sample to, I'm not inclined to argue with my doctor," he said. "He's the expert."

– *Joe Lawlor*

Gregory Rec/Staff Photographer

David Sanborn of South Berwick continually has to fight his insurance company over a $4,300 lab bill for an annual endoscopy, a preventative measure to make sure a pre-cancerous condition hasn't recurred.

'It's discouraging and frustrating'

SIMONNE MALINE

Simonne Maline has osteoarthritis in both knees. She uses walking sticks to get around, and for more than a decade she has relied on periodic injection treatments to keep the pain manageable and avoid surgery.

Now, however, the 56-year-old is so far unable to get the same treatment that has helped her in the past because it may not be covered by her plan.

"It's discouraging and frustrating and makes me angry that my life is limited because of insurance and money," said Maline, who lives in Winthrop. "And it's not even based on science. It boggles my mind. Life shouldn't have to be this hard to get care."

Maline said her insurance company turned her down two years ago when she requested SynVisc-One injections. She is being required to try another treatment first before her doctor can request the SynVisc-One injections again, and it's not clear another request would succeed.

She fell on the concrete floor in her garage last fall, further aggravating her left knee. The treatment injects a gel that lubricates the knee. The company's website says some insurance plans will cover the procedure, while others won't.

The cost of a SynVisc-One is about $1,000 to $2,000 plus the cost of a health professional to give the injection. It's far less than the $30,000 or higher price of knee surgery, which she said she will likely need if she can't get the treatments.

The injections – which she has undergone three times in the past 15 or so years – have provided years of pain relief and mobility. But in recent years insurance companies have balked at paying for the treatments because it's ineffective in some cases.

Shawn Patrick Ouellette/Staff Photorapher

Simonne Maline, 56, of Winthrop uses walking sticks at her Winthrop home. Already mired in medical debt, Maline has struggled to get her insurance to cover treatments to manage the pain of osteoarthritis.

"I have a proven history of the treatments working for me, so this should be the first line of defense for me," said Maline, who happens to be executive director of the nonprofit Consumer Council System of Maine, which advocates for improvements in public policy for mental health services.

Instead, she will have to try cortisone shots that, based on past experience, she believes will not work. If the gel injections are not approved after that, she will have to wait more than six months for knee surgery.

And not only would a knee replacement surgery be more costly for the system, but the recovery time from surgery would mean she could not care for her husband, who uses a wheelchair and is disabled from a brain injury. Knee surgery for Maline would mean her husband would need to go to a nursing home.

Maline also has about $25,000 in medical debt as a breast cancer survivor and needing three surgeries related to her cancer and other medical problems. For three years in a row, she hit her $7,000 out-of-pocket maximum with her insurance plans. So even though she's insured, it's put her into debt.

"When you look at what you have to pay out of pocket, it becomes a huge financial burden that becomes insurmountable," Maline said.

– *Joe Lawlor*

Continued from previous page

Some have tried to reform the system at the state level. Massachusetts launched a system that sharply reduced the rates of the uninsured and inspired the federal Affordable Care Act. In recent years, the state established a health care cost commission, but it has little regulatory power.

Maryland has worked for decades to regulate costs and reduce incentives to over-treat patients. The state regulates and sets hospital prices and places all the hospitals under a single "global budget," which means the finances for hospitals in Maryland are all lumped into one budget.

But Maryland's efforts have yielded mixed results, according to recent studies.

Woloson said such efforts are important incremental steps, but they don't represent substantial progress. "They're not there yet," she said.

Maine continues to study the feasibility of reforms. Last year, the state approved the Office of Affordable Health Care, which is studying a number of reform possibilities, including allowing people to "buy" Medicaid coverage, expanding Medicaid and the Children's Health Insurance Program and further increasing subsidies for ACA plans using state dollars.

The reforms, like the Affordable Care Act, tend to focus on expanding access to insurance rather than addressing problems with pricing and out-of-pocket costs.

SINGLE-PAYER A TOUGH SELL

Pease, of Maine AllCare, the advocate for single-payer systems, said anything short of single-payer will always be lacking.

"In single-payer systems like Canada, the doctor sends off the bill for services to the government, and they get paid a few days or few weeks later," Pease said. "It's very automatic and removes inefficiencies. Insurance companies just add another layer of bureaucracy, denying payments, requiring prior approval of services. They're the middleman."

But no state has enacted a single-payer system, and the political climate does not appear conducive to a national single-payer system. Proposals in recent years to establish single-payer in Maine have stalled out on numerous occasions.

Vermont came close in the early 2010s, but ultimately abandoned it over the complexity of a small state going it alone and the difficulties in a state financing the system.

California is considering a single-payer system, but a bill to create one failed to get a vote in the state assembly this February.

Single-payer also may not be a panacea.

Mueller, the MaineHealth CEO, said that a single-payer system would not necessarily be an improvement. If the government did not put enough money into the system, there could be massive cuts to health care services.

The way it is now, if there are cuts in government-funded Medicare and Medicaid, health care systems have the flexibility to make up for lost revenue by increasing costs to private insurers.

Health care systems would potentially lose that ability under a single-payer system, Mueller said. So, if public funding for a single-payer system was insufficient or inconsistent, it could result in cost-cutting and ultimately a declining quality of health care, he said.

Dan Colacino, vice president of the Maine Association of Health Underwriters, which represents brokers that sell insurance, said the success of a single-payer system would be subject to the push and pull of state budget negotiations.

"It moves the cost of health care from individuals and employers onto the state," Colacino said. "The increase in taxes would be huge."

Without meaningful change, Maine patients are largely left to navigate the medical billing maze on their own, learning one painful lesson at a time.

Sean Dundon's teaching moment came on Christmas Day, when he sliced off a portion of his thumb peeling potatoes. The trip to Northern Light Mercy Hospital for an assessment and a bandage – he didn't even need stitches – cost him about $300 for the actual treatment and another $500 for a hospital facility fee he had to use his deductible to pay.

Dundon said the system is "intentionally obfuscating and confusing" and it shouldn't be. "If there had been a sign on the wall that said there was a facility fee, I would have gone home, dressed it myself and gone (somewhere else) the next day."

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