maryland
health services
cost review commission

February 28, 2023

The Honorable Josaline Peña-Melnyk
Chair, House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, MD 21401

RE: House Bill 333 – Hospitals – Financial Assistance – Medical Bill Reimbursement Process – Letter of Information

Dear Chair Peña-Melnyk and Committee Members:

The Health Services Cost Review Commission (HSCRC) submits this letter of information for House Bill 333 titled, "Hospitals – Financial Assistance – Medical Bill Reimbursement." The purpose of this letter is to provide information related to the hospital medical bill reimbursement process.

Medical debt is an important issue. Unlike other consumer debt, most consumers have limited control over whether or not they accrue medical debt. Medical debt can have a direct impact on non-medical determinants of health by limiting a patient's ability to pay for housing, food, or utilities. Medical debt may also impact the consumer's willingness to access needed health care in the future.[1] National studies show that the burden of medical debt can disproportionately impact minority communities, young adults, and low income individuals. Because of Maryland's strong laws and policies related to insurance coverage (including the expansion of Medicaid and the subsidies offered through the Maryland Health Benefit Exchange), hospital financial assistance, and hospital debt collection, medical debt is lower in Maryland than in many other states.[2] The General Assembly has taken clear action to further strengthen these laws in recent years.

HB 333 amends Health General §19-214.4, which was added to Maryland law in 2022. Health General §19-214.4 requires HSCRC, in coordination

[1] https://www.sycamoreinstitutetn.org/wp-content/uploads/2021/05/2021.05.19-FINAL-How-Medical-Debt-Affects-Health.pdf

[2] According to the federal Consumer Finance Protection Bureau (CFPB), about 12 percent of individuals in the CFPB's Consumer Credit Panel in Maryland had medical debt collections tradelines on their credit file as of December 2020. Thirty-three states (including D.C.) had higher percentages of individuals with medical debt in their credit files. The CFPB calculated the median and mean balances of medical debt for these individuals. Only Massachusetts had a lower median balance (D.C. has the same median balance as Maryland). For mean balances, only 9 states had lower amounts. https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf

with the Department of Human Services, the State-designated Health Information Exchange, the Office of the Comptroller, and the Maryland Hospital Association, to develop a process for identifying and reimbursing patients who paid for hospital services while being eligible for free hospital care. This law applies to hospital services provided between 2017 and 2021. HSCRC staff have done extensive analysis of the requirements of Health General §19-214.4 over the past year and provided feedback to the legislature through testimony on Chapter 683 (2022) and a report to the legislature from December 2022 on the refund process required by the law.[3]

Hospital Financial Assistance Requirements in Maryland

Each hospital in Maryland is required by law to provide financial assistance to the following groups of patients:

1. *Free Care*: Hospitals must provide free care to patients with incomes at or below 200 percent of the federal poverty level (FPL) and to patients who receives benefits through the federal Supplemental Nutrition Assistance Program; Maryland's State Energy Assistance Program; the federal Special Supplemental Food Program for Women, Infants, and Children; or live in a household with a child enrolled in the free and reduced cost meal program.
2. *Reduced Cost Care:* Hospitals must provide reduced-cost care to patients with income between 200 and 300 percent of FPL. Reduced-cost care is also available to patients with income below 500 percent of FPL who have a substantial amount of medical debt.[4]

Hospital financial assistance is available to both insured and uninsured patients for their out-of-pocket costs.[5] Financial assistance is available regardless of the patient's citizenship or immigration status.

HSCRC believes that access to hospital services for low income patients provided by these requirements is a key benefit of the Maryland Health Model. HSCRC builds equitable funding for this uncompensated care into all-payer rates it sets for hospitals through the uncompensated care fund. This ensures that hospitals that serve proportionally larger numbers of patients who need financial assistance have the financial resources to provide that support to patients, which, in turn, sustains access to quality hospital services for those patients.

Amounts refunded may be lower than expected

HSCRC believes that the amount of funding that is refunded to patients under this bill will be lower than some stakeholders expect because of limitations in the data sources used to generate that estimate. In 2020, HSCRC released a legislatively required report[6] that evaluated the impact on uncompensated care (UCC) costs of proposed changes to the state law that requires hospitals to provide financial assistance to patients (Health General §19-214.1). This report analyzed data from 2017 through 2018. The purpose of this report was not to determine hospital compliance with financial assistance law in these years, but rather to estimate future impact of changes to financial

[3] https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/HG19-214.4(c)_2022.pdf

[4] For patients with a family income between 300% and 500% FPL, the family must have medical debt, incurred by the family over a 12–month period, that exceeds 25% of family income. Health General § 19-214.1.

[5] Hospital financial assistance is not available to patients in the Medicaid program (as they have no out-of-pocket expense).

[6] https://dlslibrary.state.md.us/publications/Exec/MDH/HSCRC/HB1420Ch470(2)(2020).pdf

assistance policy in the future. This meant that when HSCRC made assumptions to generate the estimate, those assumptions were designed to generate a reasonable estimate of future costs in order to ensure that policy makers understood the extent of the financial impact of the proposed policy changes.

As a component of the analysis in that report, HSCRC estimated hospitals' current performance in providing free hospital care in 2017 and 2018. HSCRC found that approximately one (1) percent of total hospital charges to individuals who likely qualified for free care were paid by those individuals. Due to limitations in existing data sets, HSCRC could not definitively determine the amount of charges that were paid. To generate the estimate, HSCRC used tax data from the Office of the Comptroller to identify patient incomes. However, approximately 50 percent of the patients did not have income data from the Office of the Comptroller, so HSCRC made assumptions about their income. For example, national data shows that 20 percent of Medicare beneficiaries have incomes below 200 percent FPL, so HSCRC applied this rate to the available data on Medicare beneficiaries. However, HSCRC could not identify specifically which Medicare beneficiaries had low incomes if there was no tax data for that beneficiary.

HSCRC also made assumptions about whether or not a patient paid a bill. The financial data used in the report includes the claim amount, but does not include whether or not that claim was paid by the patient or insurer or denied by the insurer, in which case the patient may have had no out-of-pocket costs. HSCRC also had to make assumptions about patient cost sharing amounts. Each assumption increases the possibility that the final estimate deviates from the real financial impact on patients. For these reasons, the amount refunded under Health General 19-214.4 may be lower than the estimated amount in HSCRC's 2020 report.

In addition, as the distance between the 2017-2021 time period and the implementation of the financial assistance reimbursement process expands, it will become harder to provide refunds due to difficulty in contacting patients whose contact information may have changed in the interim period.

Finally, approximately 30 percent of hospitals in Maryland use asset tests to determine eligibility for financial assistance. HSCRC was not able to determine, from the data used in the 2020 report, which patients had been denied financial assistance through a legitimate application of a hospital's asset test policy. As 2017 gets further back in time, it will be harder for patients and hospitals to determine the patient's assets in those years. If a patient was denied financial assistance due to the legitimate application of an asset test by a hospital, no refund is due to the patient under Health General 19-214.4 as passed in 2022. Hospitals with financial assistance policies that allowed for asset tests between 2017 and 2021 would need to review their records to see if the patient was reviewed for financial assistance and denied based on assets.

For these reasons, HSCRC supports the provisions of the bill that allow for incremental implementation of the refund process and evaluation of the process before continuing implementation, and would prefer that the trigger provision be set at 10 percent of the estimated amount (as in the current bill language) rather than five (5) percent, as HSCRC expects will be proposed in amendments. While patients should receive the funds they are entitled to, if the process results in minimal refunds to patients, it is reasonable to determine that continuing to implement the process is not a good investment of State or hospital resources.

An Estimate of an Error Rate is not Clear Evidence of Wrong-Doing
The HSCRC does not have any evidence that the estimated one (1) percent error rate represents intentional or negligent actions by hospitals. HSCRC's analysis in the 2020 report was not designed for compliance purposes, but rather to estimate future policy costs. HSCRC agrees with advocates that patients who are entitled to financial assistance should get that support. However, HSCRC also acknowledges that complex business processes, like billing, are expected to have a small error rate. The error rate itself is not evidence of wrongdoing on the part of the hospitals. In addition, HSCRC cannot distinguish whether the errors are due to actions (or inactions) of the hospitals or due to patients not providing hospitals with the necessary information for the hospitals to determine if the patient is eligible for financial assistance.

Under Maryland law, hospitals are required to post notices throughout the hospital informing patients of their right to apply for financial assistance. Hospitals must also inform patients how to apply for free and reduced-cost care before the patient receives scheduled medical services; before discharge; with the hospital bill; on request; and in each written communication to the patient regarding collection of the hospital bill. Despite these efforts by hospitals, patients may not realize that financial assistance is available to them. In addition, a patient must request to be considered for financial assistance and provide requested documents to the hospital. To determine which patients are eligible for financial assistance in accordance with law, hospitals must have information about the patient's income level or participation in the social service programs named above. While hospitals are required to use information that is available to them to make a determination of financial assistance, hospitals often do not have access to the information needed to make this determination without patient-supplied information. For example, hospitals do not have access to patient income data or social services program enrollment unless the patient provides that information to the hospital. Thus, if a patient has not applied for financial assistance and provided income or social services enrollment information, the hospital may not have had the information necessary to determine if that person was eligible.

Stakeholder Engagement to Develop the Refund Process
Following the passage of Health General 19-214.4 in 2022, HSCRC engaged stakeholders in an attempt to develop the refund process required by Health General 19-214.4. In the Spring of 2022, HSCRC met individually with DHS, CRISP, the Office of the Comptroller, MHA, and a representative of domestic violence advocates. In August 2022, HSCRC convened a workgroup that included consumer advocates, a representative of domestic violence advocates, a representative from a union, and hospital revenue cycle experts, in addition to statutorily required stakeholders. The workgroup met three times between August and November 2022. After each meeting, stakeholders were asked to submit written feedback on a number of topics.

Challenges with implementing Health General 19-214.4
Through the workgroup process, HSCRC identified a number of challenges with implementing Health General §19-214.4. HSCRC submitted a report to the legislature in December 2022 which describes these challenges in detail. HB 333 addresses many of the challenges raised in HSCRC's report, including most legal barriers to sharing identifiable patient information.[7]

[7] The exception is data protected by 42 C.F.R. Part 2, a federal regulation related to substance use treatment data. HSCRC does not believe that the legislature can, through state statute, authorize the

There are continued concerns about the complexity of the refund process under Health General §19-214.4. HSCRC has completed a flow chart of the likely data flow for the refund process contemplated by HB 333 (see attached) to provide an illustration of this complexity. While HB 333 will give hospitals and State agencies the legal authority to share individually identifiable data, this bill does not eliminate the real-world risk that data will be impermissibly disclosed or misused at some stage in this complicated process, potentially harming tax payers, social services beneficiaries, and/or hospital patients. Whether the benefit of the refund process outweighs the risk of potential misuse of personal data is worthy of careful consideration by the Committee.

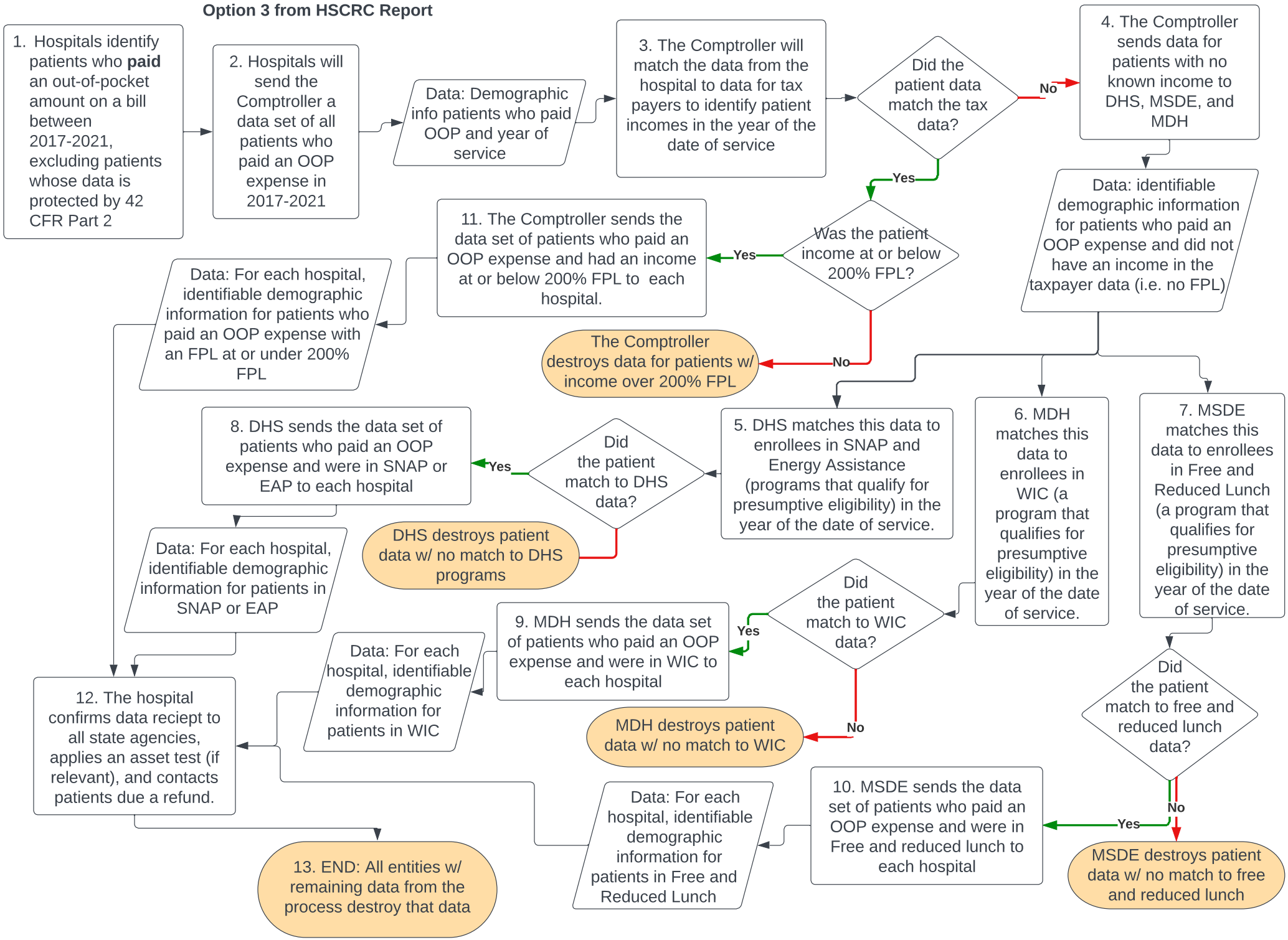
The HSCRC remains committed to ensuring that patients in Maryland have access to free and reduced-cost hospital care. Thank you for your consideration of the information in this letter. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at me at katie.wunderlich@maryland.gov or Megan Renfrew, Associate Director of External Affairs, at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Katie Wunderlich
Executive Director

Attachment: Option 3 Flow Chart

sharing of this data. The only way to share this data for the purpose of the refunds contemplated by HB 333 would be to request consent to share the data from each patient. Requiring that hospitals seek this consent will add significant time and complexity to the reimbursement process. The Committee should balance these factors with the benefit of providing refunds to these patients in determining how to address the issue of including these patients.


Option 3 from HSCRC Report
1. Hospitals identify patients who paid an out-of-pocket amount on a bill between 2017-2021, excluding patients whose data is protected by 42 CFR Part 2
2. Hospitals will send the Comptroller a data set of all patients who paid an OOP expense in 2017-2021
Data: Demographic info patients who paid OOP and year of service
3. The Comptroller will match the data from the hospital to data for tax payers to identify patient incomes in the year of the date of service
Did the patient data match the tax data?
No
4. The Comptroller sends data for patients with no known income to DHS, MSDE, and MDH
Yes
Was the patient income at or below 200% FPL?
Yes
11. The Comptroller sends the data set of patients who paid an OOP expense and had an income at or below 200% FPL to each hospital.
Data: For each hospital, identifiable demographic information for patients who paid an OOP expense with an FPL at or under 200% FPL
No
The Comptroller destroys data for patients w/ income over 200% FPL
Data: identifiable demographic information for patients who paid an OOP expense and did not have an income in the taxpayer data (i.e. no FPL)
5. DHS matches this data to enrollees in SNAP and Energy Assistance (programs that qualify for presumptive eligibility) in the year of the date of service.
6. MDH matches this data to enrollees in WIC (a program that qualifies for presumptive eligibility) in the year of the date of service.
7. MSDE matches this data to enrollees in Free and Reduced Lunch (a program that qualifies for presumptive eligibility) in the year of the date of service.
Did the patient match to DHS data?
Yes
8. DHS sends the data set of patients who paid an OOP expense and were in SNAP or EAP to each hospital
DHS destroys patient data w/ no match to DHS programs
Data: For each hospital, identifiable demographic information for patients in SNAP or EAP
Did the patient match to WIC data?
Yes
9. MDH sends the data set of patients who paid an OOP expense and were in WIC to each hospital
Data: For each hospital, identifiable demographic information for patients in WIC
No
MDH destroys patient data w/ no match to WIC
Did the patient match to free and reduced lunch data?
No
Yes
10. MSDE sends the data set of patients who paid an OOP expense and were in Free and reduced lunch to each hospital
MSDE destroys patient data w/ no match to free and reduced lunch
Data: For each hospital, identifiable demographic information for patients in Free and Reduced Lunch
12. The hospital confirms data reciept to all state agencies, applies an asset test (if relevant), and contacts patients due a refund.
13. END: All entities w/ remaining data from the process destroy that data