HB 328_PJC_Favorable_FIN.pdf

Uploaded by: Ashley Woolard

Position: FAV

Ashley Woolard, Staff Attorney
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HB 328
Hospitals – Financial Assistance Policies - Revisions
Hearing of the Senate Finance Committee
March 20, 2024
1:00 PM

FAVORABLE

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health and Benefits Equity Project advocates to protect and expand access to healthcare and safety net services for Marylanders struggling to make ends meet. We support policies and practices that are designed to eliminate economic and racial inequities and enable every Marylander to attain their highest level of health. The **PJC strongly supports HB 328**, which would prohibit Maryland's non-profit hospitals from denying free or reduced-cost care to income-eligible patients outside of the hospital's service area.

Medical debt collection has a disproportionate impact on low-income patients and communities of color. Medical debt collection not only places the financial security and housing stability of patients at risk, but it also places an immense emotional and physical burden on patients and their families and can harm the overall health of the household. Medical debt keeps low-income patients in a cycle of poverty that can be impossible to break. It takes money that comes into the household away from paying for basic needs, such as food, housing, medication and utilities. This inequity is exacerbated by the fact that many Maryland hospitals have historically failed to use their charity care funding (prior to pursuing patients in collections), a tool that would release many income-eligible patients from the burden of medical debt. This issue is a priority for PJC as many of our low-income clients who do not qualify for Medicaid coverage or have chronic illnesses experience significant challenges in affording unexpected medical bills.

Currently, not all Maryland hospitals use asset and geographic tests, allowing discretion in the criteria that each hospital uses to assess financial assistance eligibility for their patients. This can lead to unjust and inequitable outcomes for low-income patients in their applications for financial assistance depending on the hospital from which they receive care. Financial assistance is quite literally a lifeline for patients experiencing chronic illness and other unexpected health emergencies. **The availability of financial assistance for medical care should not hinge on where a patient lives and which nonprofit hospital they receive care from within the state.** HB 328 would push Maryland further in eliminating medical debt and health disparities by eliminating asset and

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geographic tests for hospital financial assistance. This simple but impactful legislation also supports the legal obligation for Maryland's nonprofit hospitals to provide free and reduced-cost care to income-eligible patients to maintain their tax-exempt status.

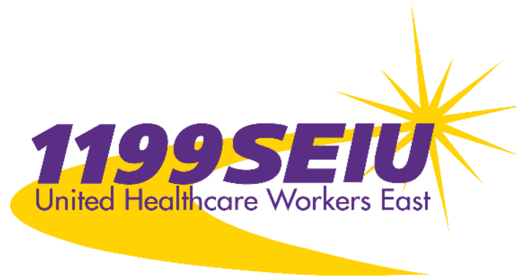
For these reasons, the Public Justice Center urges the committee to issue a **FAVORABLE** report for **HB 328.** Thank you for your consideration of our testimony. If you have any questions about this testimony, please contact Ashley Woolard at 410-625-9409 x 224 or woolarda@publicjustice.org.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

HB328 Hospital Financial Assistance Revisions FAV.

Uploaded by: Brige Dumais

Position: FAV



Testimony on **HB328**
Hospitals – Financial Assistance Policies – Revisions
Position: **FAV**

My name is Ricarra Jones and I am the Political Director of 1199SEIU United Healthcare Workers East, Maryland/DC. We are the largest healthcare workers union in the nation, representing 10,000+ members in our region. 1199SEIU urges a favorable report on HB328 to eliminate barriers to hospital financial assistance for otherwise income eligible patients. This bill is crucial for expanding access to affordable healthcare in hospitals and reducing chronic illnesses.

Maryland's nonprofit hospitals are legally required, as a condition of their tax-exempt status, to provide free and reduced cost healthcare; and the State of Maryland uses global budgeting to assist with the cost of care. Therefore, Maryland's low-income patients should not be subject to geographic regional and asset tests to receive the affordable healthcare they are entitled to. Numerous studies have demonstrated that households without medical debt have improved health outcomes. Because low-income communities have disproportionate medical debt, reducing the burden of medical debt will help to foster health equity.

Short staffing in Maryland's hospitals is at a crisis point. Low-income patients often avoid seeking healthcare due to the cost, only going to the hospital when their condition is so severe that it is more difficult, time consuming and costly to treat. Improving low-income Marylanders' access to free or reduced cost healthcare may encourage them to seek care earlier, potentially shortening their hospital stays. Shorter hospital stays can reduce unbalanced worker-to-patient ratios and open hospital bed availability more quickly. This will ease the burden on workers in short staffed facilities and reduce the long Emergency Department wait times for patients.

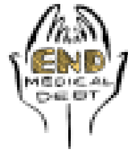
The Medical Debt Protection Act of 2021 established that patients should not have to lose their homes over medical debt. HB328 follows that same logic. Just as a patient should not have their home foreclosed on for medical debt, a patient who is income eligible for financial assistance should not have to sell their home to access affordable care. This is particularly important for our quickly ageing population. Given the short staffing crisis in Long Term Care facilities, Maryland needs to ensure that elders who want to can "age in place."

Please vote YES on HB328.

In Unity,

Ricarra Jones
Political Director
ricarra.jones@1199.org

for Senate Finance HB328 End Medical Debt MD-FAV.p
Uploaded by: End Medical Debt Maryland
Position: FAV



END MEDICAL DEBT
MARYLAND

Testimony to the Senate Finance Committee
HB328 Hospitals-Financial Assistance Policies-Revisions
Position: Favorable

March 20, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office building
Annapolis, MD 21401
cc: Members, Senate Finance Committee

Chair Beidle and Members of the Committee:

End Medical Debt Maryland is a coalition of consumer protection, labor, faith-based, civil rights, health, and patient advocates that have united together to end medical debt in Maryland. Our coalition is comprised of more than 60 organizations as well as individuals who have been impacted by medical debt-together we represent more than 400,000 Marylanders working to end the devastating impact of medical debt on families across the state.

We are here in strong support of HB328.

HB328 expands the number of patients receiving free and low-cost hospital care by ending arbitrary asset and geographic tests used by 27 hospitals to bar patients who were eligible for low-cost care.

Everyone who qualifies for free or reduced cost care should receive it with no exceptions. Providing free care is a condition that Maryland hospitals must meet to receive the millions of dollars in tax-exemptions each year. They also are compensated for this care through our global budgeting process.

HB328 will expand free and affordable care to income-eligible patients throughout Maryland, and in so doing, reduce medical debt, and increase financial security.

For all these reasons, we support HB328 and urge a favorable report.

Best,
Brige DuMais, Coordinator

HB328.XF.SFC.LOS.hf.20240319.pdf
Uploaded by: Heather Forsyth
Position: FAV

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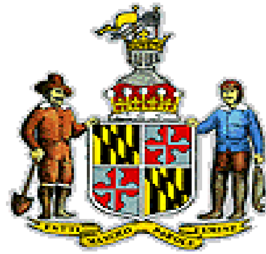

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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
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March 19, 2024

To: Senator Pamela Beidle, Chair
Senate Finance Committee

Fr: Heather Forsyth, Deputy Director, Health Education and Advocacy Unit
on behalf of the Office of the Attorney General

Re: House Bill 328 – Hospitals – Financial Assistance Policies – Revisions
(Support)

The Health Education and Advocacy Unit (HEAU) offers this letter in full support of HB328. The revisions to hospital financial assistance policies offered in this bill make two important changes to ensure such policies are offered fairly and appropriately.

First, it removes "mission and service area" language from hospital financial assistance policies. The HEAU is aware of several hospital systems that limit financial assistance to defined service areas, including specific zip codes, citing the "mission and service area" language as authority for imposing such limitations. While there has been no case law, or a formal opinion offered by the Attorney General about this language, the HEAU believes the mission and service area language was added as a factor that hospitals and the Health Services Costs Review Commission (HSCRC) could consider when determining the federal poverty level thresholds for reduced cost care, not as a barrier to reduced cost care or other debt relief provisions. The HEAU has received numerous complaints from Marylanders, otherwise eligible for hospital financial assistance, who were denied because they resided outside the hospital's mission and service area, whether or not they were aware of such geographical lines before arriving.

In one such case, a consumer presented to a hospital in distress. She described being new to the area and using an internet search to find a local emergency room. The hospital she went to was 5.5 miles from her home and was the first option in her search. She was denied financial

assistance because her home was not within the hospital's "defined service area." Though making a "one time exception" for the consumer and noting that "future exceptions may not be approved," this hospital posited to the HEAU that the consumer should have gone to the hospital closer to her, which was 5.4 miles from her home.

In another case, a 25-year-old consumer who lived in Aberdeen, had surgery at a hospital, which, according to the consumer was the closest hospital that participated with her insurance. The hospital is 19 miles from her home; the closest hospital to her home was 10 miles away. She was denied financial assistance by the chosen hospital because her home was not within the "defined service area."

In another zip code denial case, a consumer was receiving outpatient psychiatric care entirely through telehealth but was nonetheless denied financial assistance because her physical address was outside the service area.

Restricting financial assistance policies to the mission and service area ignores Marylanders who live in closer proximity to one hospital than another, but are "outside" the service area due to zip code. It ignores the reality of emergencies, of 911 service providers who follow their own rules regarding transport to hospital settings. It ignores the fact that many Marylanders live in one county but work or attend school in another, or are temporary residents in our state due to their college attendance; or that the beaches and mountains of our state invite visitors from around the state to their area, and illness and accidents do not stop occurring simply because one is on vacation.

Second, HB328 updates financial assistance policies by excluding asset testing from financial assistance eligibility. Current law excludes only the first $10,000 of monetary assets, $150,000 of home equity, an automobile, assets excluded under certain federal programs, and certain types of retirement funds. This bill would remove asset testing all together. The Office of the Attorney General supports modernizing asset tests as research has shown that overly restrictive asset limits penalize savings, harm retirees who are relying on their assets in retirement, and are counterproductive to maintaining economic security for low income families.

Families who are otherwise income eligible for financial assistance seldom have the kind of monetary assets which could pay a hospital bill without leaving them destitute. But allowing consumers to have a cushion against an unexpected economic shock protects families from eviction, allows them to pay their property taxes so they can retain their home, avoids utility interruptions, pays for car repairs, pays continuing out of pocket medical expenses, or may even supplement their monthly budgets against a fixed income. For working families, low asset limits discourage families from saving, or wipe out their savings, even if they only need help temporarily.

In addition, provision of charity care by non-profit hospitals through the application of financial assistance policies is required for hospitals to maintain their federal and state tax exempt status. A 2021 survey of Maryland hospitals by ownership reported that 47 of 48 Maryland hospitals claim non-profit status and realize significant tax savings through their tax exempt status. Studies have noted that often the benefits in tax savings status outweigh the cost

of charity care.[1] And should it be necessary, Maryland's unique all-payor model means that adjustments can be made to global budget revenue agreements if warranted.

For these reasons we urge the Senate Finance Committee to support HB328 with a favorable report.

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[1] After adjusting for community benefits provided by for-profits hospitals, on average, non-profit hospitals spent 5.9% (CI: 5.8%-6.0%) of their total expenses on community benefits; 1.3% (CI: 1.2%-1.3%) on charity care; and received 4.3% (CI: 4.2%-4.4%) of total expenses in tax exemptions. A total of 38.5% of non-profit hospitals did not provide more community benefit and 86% did not provide more charity care than the value of their tax exemption. Hospitals with fewer beds, providing residency education and located in high poverty communities were more likely to provide more incremental community benefits and charity care than the value of their tax exemption, while system affiliation had a negative association. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8928013/

WDC 2024 Testimony_HB328_FINAL.pdf
Uploaded by: JoAnne Koravos
Position: FAV

Montgomery County, Maryland
Women's Democratic Club

P.O. Box 34047, Bethesda, MD 20827 www.womensdemocraticclub.org

HB 328 Hospital Financial Assistance Policies: Revisions
Health Government Operations Committee – February 14, 2024
SUPPORT

Thank you for this opportunity to submit written testimony concerning an important priority of the **Montgomery County Women's Democratic Club (WDC)** for the 2024 legislative session. WDC is one of Maryland's largest and most active Democratic clubs with hundreds of politically active members, including many elected officials.

WDC urges the passage of HB328. This bill will expand access to healthcare, increase the fairness of charity care programs, improve the financial security of economically challenged patients and support the rational and consistent use of charity care decisions across all of Maryland's hospitals. According to the Economic Action MD fact sheet, *Hospital Financial Assistance Policies: Ban Barriers to Charity Care for Eligible Patients*, 14% of Maryland voters said that they or someone in their household had medical bills or debt that they were unable to repay. (African American households comprised 23% of those unable to pay a medical bill.)

Additional relevant points supporting the need for this bill[1]:

- Even if a patient is income-eligible for free or reduced-cost care, hospitals can still deny a patient's application for financial assistance if the patient fails either 1) an asset or 2) a service/geography test.
- Although current Maryland law prevents the use of certain assets in determining eligibility, each hospital uses its own discretion to develop criteria for asset tests and service area boundaries. Service/geography tests allow hospitals to deny free or reduced cost care to income eligible patients that are outside of the hospital's service area. The result is that an income-eligible patient may receive free care at one hospital while being denied care at another hospital. Access to affordable care is currently conditioned upon where a patient becomes ill or has an emergency. This can lead to inequitable outcomes and disparities.
- Lastly, in Maryland the percentage of charity care applications denied by nonprofit hospitals ranges from 30% to a whopping 66.9%.

[1] Economic Action MD fact sheet, *Hospital Financial Assistance Policies: Ban Barriers to Charity Care for Eligible Patients*, https://econaction.org/medical-debt-protections-maryland/

Montgomery County, Maryland
Women's Democratic Club

P.O. Box 34047, Bethesda, MD 20827 www.womensdemocraticclub.org

No patient who is income-eligible should be denied free or reduced-cost care, particularly when Maryland compensates hospitals to provide this care and many hospitals fail to tap all their charity care each year.

Reducing medical debt can directly impact household finances by helping to improve credit scores and access to credit for eligible patients. Since medical debt is disproportionally held among low-income communities, reductions in the burden of medical debt can help improve the financial wellbeing and health status of significant numbers of impacted Marylanders.

We ask for your support for HB328 and strongly urge a favorable Committee report.

Tazeen Ahmad	Margaret Hadley	Cynthia Rubenstein
WDC President	WDC Subcommittee on Health	Chair, WDC Advocacy

_For Sen Finance HB328 Hospital Financial Assistan

Uploaded by: Marceline White

Position: FAV

Testimony to the Senate Finance Committee
HB328 Hospitals-Financial Assistance Policies-Revisions
Position: Favorable

March 20, 2024

The Honorable Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office building
Annapolis, MD 21401
cc: Members, Senate Finance Committee

Chair Beidle and Members of the Committee:

Economic Action Maryland (formerly the Maryland Consumer Rights Coalition) is a statewide coalition of individuals and organizations that advances economic rights and equity for Maryland families through research, education, direct service, and advocacy. Our 12,500 supporters include consumer advocates, practitioners, and low-income and working families throughout Maryland.

We are here in strong support of HB328 which builds on this committee's important work over the past few years of expanding health care access for working families and reducing medical debt. HB328 eliminates barriers for low-income households to receive free or low-cost care from hospitals and in so doing expands access to affordable health care and reduces medical debt.

All Maryland hospitals are nonprofit and are required to provide free and reduced cost care as a condition of their tax-exempt status. Maryland also has a global-budgeting policy that sets rates and provides hospitals with funds for charity care each year based on last year's expenses.

Despite this, even if a patient is income-eligible for free or reduced-cost care, hospitals can still deny a patient's application for financial assistance
if the patient fails either 1) an asset or 2) a service/geography test.

Asset tests allow hospitals to consider a household's monetary assets in addition to income eligibility. The hospital may determine that an individual is income-eligible but has assets that allow the hospital to reject the application for free or reduced cost care.

Maryland law currently prevents hospitals from considering certain assets such as retirement savings, 529 college savings accounts,
one car, and $10,000 in savings and up to $150,000 in equity in a primary residence.

Service/geography tests -allow hospitals to deny free or reduced cost care to income-eligible patients outside of the hospital's service
area.

HB328 removes the use of asset and service tests from hospital financial assistance policies.

Expands Healthcare. Everyone who qualifies for free or reduced-cost care should receive it, without exceptions. The General Assembly passed legislation HB1420/SB875 in 2020 to raise the thresholds of those who qualified for free and low-cost care. HB328 ensures that those families will receive that care without exception.

Creates Fairness in the System. 27 hospitals of 47 Maryland hospitals use an asset or service area test. The asset tests and service area tests are not uniform-they are different and unique to each hospital. This means that a patient who qualifies by income may get free care at Hospital A but charged for care at Hospital B because they failed one of the tests.

Patients are unaware that these tests exist so are unable to choose hospitals that don't administer them. Of course, very often hospital visits happen due to emergencies and patients have no choice where they are taken.

Elimination of these tests creates clarity, consistency, and uniformity across all of Maryland's 47 hospitals. If an income-eligible patient becomes ill at Hospital A, they will qualify for assistance, just as they will at Hospital B.

Reduces Hospital Administrative Burden
Many hospitals already struggle with administering their financial assistance programs as evidenced by their low rates of charity care. Eliminating the use of asset and geographic tests and the accompanying paperwork and verification will ease the administrative burden on hospital staff.

Consequently, it should be easier for hospitals to approve more applications and rates for charity care use and denial rates should become more rational.

The Tests Are Not Needed

Twenty Maryland hospitals do not use either an asset or geography test in order to qualify applicants for free or reduced cost care. So it is not clear what purpose these tests serve since the costs of this care is already included in a hospital's global budget.

HB328 will expand health care and inject fairness, consistency, and clarity throughout our Maryland hospital system.

For all these reasons, we support HB328 and urge a favorable report.

Best,

Marceline White
Executive Director

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ID 52-2266235
Economic Action Maryland is a 501(c)(3) nonprofit organization and your contributions are tax deductible to the extent allowed by law.

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EMD Tests Fact Sheet Final (2).pdf
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Position: FAV

ECONOMIC ACTION MD

Hospital Financial Assistance Policies: Ban Barriers to Charity Care for Eligible Patients

Background

All Maryland hospitals are nonprofit and are required to provide free and reduced cost care as a condition of their tax-exempt status. Maryland also has a global-budgeting policy that sets rates and provides hospitals with funds for charity care each year based on last year's expenses.

The Problem

Even if a patient is income-eligible for free or reduced-cost care, hospitals can still deny a patient's application for financial assistance if the patient fails either 1) an asset or 2) a service/geography test.

Asset tests allow hospitals to consider a household's monetary assets in addition to income eligibility. The hospital may determine that an individual is income-eligible but has assets that allow the hospital to reject the application for free or reduced cost care.

Maryland law currently prevents hospitals from considering certain assets such as retirement savings, 529 college savings accounts, one car, and $10,000 in savings and up to $150,000 in equity in a primary residence.

Service/geography tests -allow hospitals to deny free or reduced cost care to income-eligible patients outside of the hospital's service area.

Medical Debt in Maryland

According to a September 2023 statewide poll, 14% of Maryland voters say that they or someone in their household have medical bills or debt that they are not able to repay. African-American households comprise 23% of those unable to pay a medical bill compared to 8% of white households.

Solution: HB328 Prohibit use of barriers to care for income-eligible patients

Why HB328 is Needed

Expands Access to Healthcare

No patient that is income-eligible should be denied free or reduced-cost care, particularly when Maryland pre-pays hospitals to provide this care and many hospitals fail to use all of their charity care each year.

Increases Fairness of Charity Care

Currently, not all nonprofit hospitals in Maryland use asset tests and service tests. For those that do, each hospital uses discretion to develop its own criteria for asset tests and service area boundaries. As a result, an income-eligible patient may receive free care at one hospital while being denied care at another hospital. This means access to affordable care is conditioned on where one becomes ill or has an emergency. This leads to inequitable outcomes and disparities.

Improves Financial Security, Reduces Chronic Illness

Reducing medical debt directly impacts household finances by improving credit scores[1] and access to credit. Research shows that households that have their medical debt relieved see improvements in physical and mental health outcomes as well as improved overall access to care.[2] Since medical debt is disproportionally held among low-income communities,[3] reductions in the burden of medical debt helps advance financial and health-based equity.

Supports Rational Use of Charity Care

Maryland nonprofit hospitals are required to provide free and reduced cost care to income-eligible patients as a condition of their tax-exempt status. Maryland's global budgeting provides hospitals with the funding required to provide this charity care annually. Yet, as the table below illustrates, many hospitals have high rates of charity care denial. Eliminating these tests for income eligible patients will make it easier for hospitals with high charity care denial rates to approve more applications. The costs to the hospitals for increased use of charity care is already built into the hospitals rates so they can afford these changes.

1 https://www.sciencedirect.com/science/article/abs/pii/S0047272718300707 2 https://www.nclc.org/resources/no-fresh-start-2022-will-states-let-debt-collectors-push-families-into-poverty/ 3 https://jamanetwork.com/journals/jama/fullarticle/2782187

Table 1. Hospitals Using Asset Tests & Charity Care Denial Rates, 2017-2018

Hospital Name	Percent Charity Care Denied
Anne Arundel Medical Center	19.40%
Atlantic General	22.20%
Calvert Memorial Hospital	66.90%
Carroll Hospital Center	38.40%
Christiana Care Union of Cecil Hospital	No data
Doctor's Community Hospital	9.1%
Garrett County Memorial Hospital	6.6%
GBMC	11.50%
Holy Cross Hospital	No data
Holy Cross Hospital - Germantown	3.60%
Howard County General Hospital	52.70%
Johns Hopkins Bayview Medical Center	48.80%
Johns Hopkins Hospital	46.90%
Levindale (chronic care hospital)	No data
MedStar Franklin Square Medical Center	1.90%
MedStar Good Samaritan Hospital	.90%

Table 1. Hospitals Using Asset Tests & Charity Care Denial Rates, 2017-2018 Continued

Hospital Name	Percent Charity Care Denied
MedStar Harbor Hospital	.60%
MedStar Montgomery General Hospital	4.60%
MedStar St. Mary's Hospital	.90%
MedStar Southern Maryland Hospital	1.00%
MedStar Union Memorial Hospital	.70%
Mercy Medical Center	3.70%
Northwest Hospital	2.10%
Sinai Hospital	.30%
St. Agnes Hospital	0.00%
Suburban Hospital	No data
TidalHealth Peninsula Regional Medical Center	.30%

Let’s take a step toward eliminating medical debt in Maryland, support HB328!

Organizational Sign on Letter HB328 (1).pdf

Uploaded by: Marceline White

Position: FAV

Testimony to the Senate Finance Committee

HB328 Hospitals-Financial Assistance Policies-Revisions

Position: Favorable

March 20, 2024

The Honorable Pamela Beidle, Chair

Senate Finance Committee

Annapolis, MD 21401

cc: Members, Finance Committee

Honorable Chair Beidle and Members of the Committee,

We are writing today in strong support of HB 328.

HB 328 ensures that income-eligible Maryland residents receive free or reduced-cost care by eliminating additional barriers to charity care some nonprofit hospitals have put in place.

As nonprofit hospitals, Maryland's hospital systems receive substantial tax benefits and, in return, are required to provide free and low-cost care to income eligible residents. Additionally, through Maryland's unique global budgeting system, hospitals are compensated through rate-setting for the charity care that they anticipate spending based on the prior year's expenses. Therefore, the benefits to the hospital in terms of tax breaks are substantial while the costs are built into Maryland's rate-setting system.

Despite this, 27 Maryland nonprofit hospitals create barriers to low-income patients accessing free or low-cost care. These tests deny struggling households the charity care that they are entitled to by law, and that the General Assembly expanded in 2020. One test, the asset test, varies by hospital but may, for example, eliminate a household with two cars from receiving free or discounted care. Another test, the service area test, is used by hospitals to limit charity care to patients who live within a certain radius of the hospital. In urban areas, patients may live

between several hospitals and would not know which one to go to since these geographic boundaries are not publicized In an emergency, patients are sent to whatever hospital is nearest, so even if a patient did know which hospital would provide them with charitable care, they are not given a choice in the matter.

There are 47 hospitals in Maryland and 20 do not use any tests. At these 20 hospitals, if a patient is eligible for free or discounted care, they receive it. That should be the case statewide. Passage of HB328 will bring consistency, clarity, and fairness to hospital financial assistance statewide. It will expand financial assistance to eligible patients that need it at this critical time.

For all these reasons, we urge a favorable report on HB 328.

Signed,

Zoe Gallagher, Policy Associate Economic Action Maryland

Marceline White, Executive Director, Economic Action Maryland

Matthew Girardi, Political and Communications Director, ATU Local 689

Michael Dalto, President, High Note Consulting, LLC.

Lonia Muckle, Senior Policy Associate, CASH Campaign of Maryland

Ninfa Amador, Policy Analyst, CASA

Ashley Esposito, Executive Director, Baltimore Renters United

Camila Reynolds-Dominguez, Policy Advocate and Legal Impact Coordinator, FreeState Justice

Ashley Woolard, Lead Attorney, Health & Benefits Equity Project, Public Justice Center

Kayla Mock, Political & Legislative Director, United Food & Commercial Workers Union Local 400

Patty Snee, Statewide Healthcare Campaigns Organizer, Progressive Maryland

Margaret Hadley, RN, MS, Chair, Health Care Advocacy, Women's Democratic Club of Montgomery County

Claudia Wilson Randall, Executive Director, Community Development Network of MD

Crossover HB 328 - FIN - HSCRC - LOS.docx.pdf
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Position: FAV

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March 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401

RE: House Bill 328 - Hospitals - Financial Assistance Policies - Revisions – Letter of Support

Dear Chair Beidle and Committee Members:

The Health Services Cost Review Commission (HSCRC) requests that the Committee favorably report House Bill 328, "Hospitals - Financial Assistance Policies - Revisions." Hospitals differ in their current financial assistance eligibility policies related to geographic restrictions and the use of asset tests.This bill will benefit consumers by increasing access to hospital financial assistance and increase consistency in eligibility for patients regardless of the hospital they use.

Restricting Eligibility Based on Service Area Burdens Patients

Maryland law requires general acute care and chronic care hospitals to provide reduced-cost care to patients with family incomes between 200% and 300% of federal poverty level (FPL) and patients with family incomes below 500% of FPL who have a substantial amount of medical debt. Under current law, hospitals may restrict eligibility for reduced cost care to the hospital's service area. Some hospitals have included this restriction to eligibility for reduced cost care in their financial assistance policies.

A hospital's service area is based on zip codes. A zip code is included in a hospital's service area if at least 50% of the residents of that zip code who had a hospital visit in the year visited that specific hospital. There are a number of reasons why a consumer that lives outside of a hospital's service area may choose to use that hospital, including availability of specialty care, emergencies that occur during personal or business travel,

or simply personal preference. Whether or not a patient qualifies for reduced cost care should not be conditioned on their residence in a set of zip codes.

Maryland law requires hospitals to provide free care to patients with family incomes under 200% of the FPL. Hospitals may not, under current law, disqualify a patient for free care based on the hospital's service area. HSCRC believes that the policy for free care and for reduced cost care should be consistent. Whether you qualify for free care or reduced cost care, where you live should not determine your eligibility for financial help.

Asset Tests are Unequal and may Discourage Patients from Applying for Financial Assistance

Maryland law allows, but does not require, hospitals to use asset tests in determining eligibility for both free care (for patients with family incomes under 200% FPL) and reduced cost care. Twenty-seven of the forty-five hospitals that are required to provide financial assistance use asset tests. As noted in HSCRC's 2021 report on policy proposals related to reduced cost care "This leads to unequal results for consumers depending on the hospital they visit" (page 1). Particularly concerning is that only one motor vehicle is protected from the asset test. For most families in Maryland, vehicles are crucial to accessing work, groceries, health care, and other necessary services.

The use of asset tests also complicates the hospital financial assistance application and increases the burden on patients to apply. Patients are required to report their monetary assets, the worth of their home, and the value of their vehicles. This complexity may discourage patients from applying. Eliminating the asset tests will allow HSCRC and hospitals to simplify the hospital financial assistance application.

Maryland funds Uncompensated Care through Hospital Global Budgets

HSCRC funds hospital uncompensated care (UCC) through all-payer rates.This means that hospitals receive funding for the financial assistance they provide to patients and for "bad debt" (bills that patients have not paid). On a statewide basis, there is no gap between the UCC experienced by hospitals in a year and the increase in hospital rates to fund UCC in the next year. HSCRC expects that our existing uncompensated care funding policy can support the changes proposed by this bill and believes that this bill will benefit patients. This bill will likely increase the amount of financial assistance provided by hospitals to patients, relieving financial burdens for those patients. Some of

the increased financial assistance provided to patients will be offset by reductions in bad debt. Financial assistance and bad debt are the two components of uncompensated care. Bad debt negatively impacts patients who are being pursued for bills and potentially having a negative impact on their credit report. The substitution between bad debt and financial assistance will limit the increase in UCC due to this bill.

UCC Funding is not based on Geography or Asset Tests
HSCRC provides uncompensated care funding to a hospital regardless of whether the patient that received the financial assistance is a resident of the hospital's service area. HSCRC does not condition UCC funding on a hospital using an asset test. Hospitals that provide reduced cost care to patients outside of their service area already receive funding for all of the reduced cost care they provide to patients. Similarly, UCC funding is available for all of the financial assistance a hospital provides, whether or not that hospital applies an asset test.

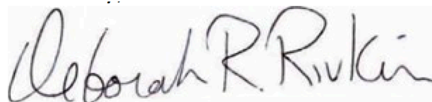
UCC is Fully Funded on a Statewide Basis
HSCRC builds funding for UCC into state-wide hospital rates each year. The amount of funding for UCC in rates equals the actual state-wide average UCC, as a percent of global budget revenue (GBR), that hospitals experienced in the prior year. On a state-wide basis, hospitals are compensated for the UCC they experienced in the prior year.

HSCRC's UCC Methodology is designed to Sustainably and Equitably Fund Hospital UCC
Because different hospitals experience different amounts of UCC relative to their individual GBRs, HSCRC redistributes funding between hospitals through the UCC pool. The purpose of the UCC pool is to provide additional financial support to hospitals with higher amounts of UCC relative to the statewide average, funded by the difference from hospitals that have lower amounts of UCC relative to the statewide average. The UCC pool does not add additional funding to state-wide hospital rates. Rather, the contributions to the pool are approximately equal to the distributions made from the pool. This redistribution of funds has an equity benefit: this additional support for hospitals with higher amounts of UCC helps maintain hospital access for communities that struggle to afford healthcare. It also results in lower prices in these hospitals (relative to if there were no UCC pool).

Each year, HSCRC determines the amount that each hospital will either contribute to the UCC pool or withdraw from the UCC pool. This amount is a blend of the actual amount of UCC the hospital experienced in the past year and the amount of UCC that HSCRC would expect the hospital to have based on a number of criteria (the "predicted UCC"). Hospitals with a higher blended UCC amount get a payment from the UCC pool and hospitals with a lower blended UCC amount must pay into the UCC pool. The use of "predicted UCC" in the formula helps to control UCC growth in the state by incentivizing hospitals to responsibly collect payments from patients who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers. The use of "predicted" UCC in the formula means that some hospitals may not receive full reimbursement for the actual amount of UCC the hospital experienced in the prior year. This only occurs when that hospital's actual UCC is growing faster than the statewide average growth in UCC, which suggests that the hospital may not be doing enough to collect bad debt from patients who can pay their bills.

The Commission urges a favorable report on HB 328, to simplify financial assistance applications and to provide greater fairness for consumers. Thank you for your consideration of the information in this letter. If you have any questions or if I may provide you with any further information, please do not hesitate to contact me at 410-991-7422 or deborah.rivkin@maryland.gov, or Jon Kromm, Executive Director, at jon.kromm@maryland.gov.

Sincerely,



Deborah Rivkin
Director, Government Affairs

Attachments:

- **Appendix A: Hospital Financial Assistance Requirements in Maryland**

- **Appendix B: Hospital Financial Assistance: Use of Asset Tests by Maryland Hospitals**
- **Appendix C: UCC Funding Methodology**

Appendix A: Hospital Financial Assistance Requirements in Maryland

Each general acute and chronic care hospital in Maryland is required by law to provide financial assistance to the following 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 receive 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.[1]

Hospital financial assistance is available to both insured and uninsured patients for their out-of-pocket costs.[2] Financial assistance is available regardless of the patient's citizenship or immigration status. Hospital financial assistance is different from medical assistance (i.e. Medicaid). Patients who are eligible for medical assistance should apply for that coverage instead of using hospital financial assistance.

The law sets minimum standards. Hospitals are permitted to offer more generous financial assistance policies. This leads to variation between hospitals of the level of support provided to patients.

[1] For patients with a family income between 301% 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.

[2] Hospital financial assistance is not available to patients in the Medicaid program as they have no out-of-pocket expenses.

Appendix B: Hospital Financial Assistance: Use of Asset Tests by Maryland Hospitals

Under Maryland law (Health General 19-214.1(b)(8) and COMAR 10.37.10.26) hospitals are allowed to include asset tests as a criteria for financial assistance eligibility. In total, 27 hospitals use asset tests or consider assets in determining eligibility for financial aid.

If a hospital includes an asset test in their financial assistance policy, the law prevents the hospital from considering the following assets when determining financial assistance eligibility as shown in HG 19-214.1(b)(8)(ii) and (iii):

"1. At a minimum, the first $10,000 of monetary assets;
2. A safe harbor equity of $150,000 in a primary residence;
3. Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred–compensation plans qualified under the Internal Revenue Code or nonqualified deferred–compensation plans;
4. One motor vehicle used for the transportation needs of the patient or any family member of the patient;
5. Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and
6. Prepaid higher education funds in a Maryland 529 Program account.

(iii) Monetary assets excluded from the determination of eligibility for free and reduced–cost care under subparagraph (ii) of this paragraph shall be adjusted annually for inflation in accordance with the Consumer Price Index."

Hospitals that use asset tests differ in the components of those asset tests. The provisions of asset test policies may vary from hospital to hospital for those hospitals that use asset tests.

The following hospitals use asset tests in their financial assistance policies.

Table: Hospitals with Financial Assistance Policies that include Asset Tests

Health System	**Hospital**
Ascension	St. Agnes Hospital
ChristianaCare	Union Hospital of Cecil County
	Johns Hopkins Bayview Medical Center
	Johns Hopkins Hospital
	Johns Hopkins Howard County Medical Center
John Hopkins Medicine	Suburban Hospital
	Lifebridge Carroll County Hospital Center
	Lifebridge Levindale Hospital
	Lifebridge Northwest Hospital
Lifebridge	Lifebridge Sinai Hospital
	Anne Arundel Medical Center
Luminis Health	Doctors Community Medical Center
	MedStar Franklin Square Hospital
	MedStar Good Samaritan Hospital
	MedStar Harbor Hospital
	MedStar Montgomery General Hospital
	MedStar Southern Maryland Hospital Center
	MedStar St. Mary's Hospital
Medstar	MedStar Union Memorial Hospital Center
	Atlantic General Hospital
	Calvert Health
	Greater Baltimore Medical Center
Independent Hospitals	Mercy Medical
TidalHealth	Peninsula Regional
	Holy Cross
Trinity Health	Holy Cross Germantown
WVU Medicine	Garrett Regional Medical Center

Appendix C: UCC Funding Methodology

The UCC methodology is a cornerstone of the HSCRC's all payer system. In addition to equitably supporting financial assistance for low income patients, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.[3]

The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percent of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in RY 2024, HSCRC staff will use RY 2022 statewide UCC experience of 4.29 percent to determine the UCC amount built into all hospital rates.
2. **Hospital Payments or Contributions to the UCC Fund**
   The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.
   i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital[4]. (See Appendix II).
   ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad

[3] Other states have struggled to maintain sustainable uncompensated care funds. One example is New Jersey. H S Berliner, S Delgado, "The rise and fall of New Jersey's uncompensated care fund", J Am Health Policy. Sep-Oct 1991;1(2):47-50. https://pubmed.ncbi.nlm.nih.gov/10112731/.

[4] Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts

debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),[5] payer type, and site of care as independent variables in the logistic regression. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.

iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).

iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

[5] "The Area Deprivation Index ...allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest …. including] factors for...income, education, employment, and housing quality." https://www.neighborhoodatlas.medicine.wisc.edu/

Exhibit 1: UCC Methodology Example ($ Millions)

		Step 1		Step 2 (i)	Step 2 (ii)	Step 2 (iii)	Step 2 (iv)
	A	B	C = A X B	D	E	F = Avg D & E	G = (F-B) X A
	GBR	Prior Year Statewide UCC Rate	UCC Funding Provided in Rates	Prior Year Actual Hospital-Specific UCC Rate	Predicted Hospital-specific UCC Rate	Hospital-Specific 50/50 Blend	(Payment into) or Withdrawal from UCC Fund
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

Testimony in support of crossover bill HB0328.pdf

Uploaded by: Richard KAP Kaplowitz

Position: FAV

CROSSOVER BILL HB328_RichardKaplowitz_FAV

3/20/2024

Richard Keith Kaplowitz
Frederick, MD 21703

TESTIMONY ON CROSSOVER BILL HB#/0328 – FAVORABLE

Hospitals - Financial Assistance Policies – Revisions

TO: Chair Beidle, Vice Chair Klausmeier and members of the Finance Committee

My name is Richard K. Kaplowitz. I am a resident of District 3. I am submitting this testimony in support of crossover bill HB#0328, Hospitals - Financial Assistance Policies – Revisions

Health care should be treated as a human right. The mission of a hospital or medical facility should be to assist in the maintenance of the health of the community they are located in. Placing administrative barriers to delivery of care based on an ability to pay contradicts this mission.

Financial assistance should be provided to all people who require it without finding ways to deny it to those of our residents most in need to care but unable to afford it. Eligibility for free and reduced-cost care should be looking for ways to include persons and not ways to eliminate anyone from consideration for that care. The cost of medical care on the overall availability of monies a household possesses should not impoverish that family or person by consuming an unreasonable amount of their financial resources. Household assets that produce income for a household or provide housing should not be part of any formula used to calculate what reduced cost or free care should be made available.

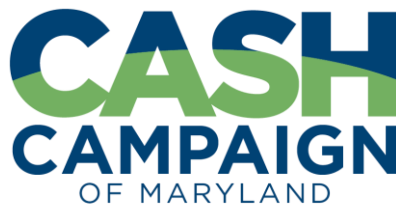
Ezekiel 34:16 “I will seek the lost, and I will bring back the strayed, and I will bind up the injured, and I will strengthen the weak, and the fat and the strong I will destroy.[a] I will feed them in justice.” tells us that The Lord wants us to take care of one another as a response to what the Lord wants to happen. My Jewish faith convinces me it is a commandment for us to feed and house and clothe and take care of the poor. This bill is an ethical and moral imperative for our medical care system.

I respectfully urge this committee to return a favorable report on CROSSOVER BILL HB328.

03.19 (Crossover) - HB 328 - Hospitals - Financial

Uploaded by: Robin McKinney

Position: FAV



HB 328 - Hospitals - Financial Assistance Policies - Revisions
Finance Committee
March 20, 2024
<u>SUPPORT</u>

Chair Beidle, Vice-Chair Klausmeier and members of the committee, thank you for the opportunity to submit testimony in support of House Bill 328. This bill removes barriers for low-income Marylanders to receive financial assistance at hospitals.

The CASH Campaign of Maryland promotes economic advancement for low-to-moderate income individuals and families in Baltimore and across Maryland. CASH accomplishes its mission through operating a portfolio of direct service programs, building organizational and field capacity, and leading policy and advocacy initiatives to strengthen family economic stability. CASH and its partners across the state achieve this by providing free tax preparation services through the IRS program 'VITA', offering free financial education and coaching, and engaging in policy research and advocacy. **Almost 4,000 of CASH's tax preparation clients earn less than $10,000 annually. More than half earn less than $20,000.**

CASH is a member of the End Medical Debt Maryland Coalition, and we support House Bill 328.

All Maryland hospitals are nonprofit and are required to provide free and reduced cost care as a condition of their tax-exempt status. Maryland also has a global-budgeting policy that sets rates and provides hospitals with funds for charity care each year based on last year's expenses. Even if a patient is income-eligible for free or reduced-cost care, hospitals can still deny a patient's application for financial assistance if the patient fails either 1) an asset or 2) a service/geography test.

Currently, not all nonprofit hospitals in Maryland use asset tests and service tests. For those that do, each hospital uses discretion to develop its own criteria for asset tests and service area boundaries. As a result, an income-eligible patient may receive free care at one hospital while being denied care at another hospital. This means access to affordable care is conditioned on where one becomes ill or has an emergency. This leads to inequitable outcomes and disparities. According to a September 2023 statewide poll, 14% of Maryland voters say that they or someone in their household have medical bills or debt that they are not able to repay. African American households comprise 23% of those unable to pay a medical bill compared to 8% of white households.

It is crucial to pass HB 328, as it prohibits the use of barriers to care for income-eligible patients.

<u>Thus, we encourage you to return a favorable report for HB 328.</u>

XHB328_FinancialAssistancePolicyRev_LOC.pdf
Uploaded by: Jake Whitaker
Position: UNF

Maryland
Hospital Association

March 20, 2024

To: The Honorable Pamela Beidle, Chair, Senate Finance Committee

Re: Letter of Concern - House Bill 328 - Hospitals - Financial Assistance Policies - Revisions

Dear Chair Beidle:

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment on House Bill 328. Maryland hospitals have only one core mission: to provide the best patient care possible. Hospitals believe every person should receive the care they need without financial worry or hardship and care for every person who comes through their doors—regardless of ability to pay. They make every effort to inform patients about available financial assistance, including free or reduced-cost care.

We appreciate the intent behind HB 328 but have concerns with the unintended consequences these revisions will have on Maryland's Total Cost of Care Model and future iterations of our waiver with the Centers for Medicare and Medicaid Services (CMS). As we enter negotiations with CMS for our next waiver period, we ask legislators and the Health Services Cost Review Commission not to mandate further changes to hospitals' financial assistance and debt collection policies until we have gathered data from the statutes enacted in 2020, 2021, 2022, and 2023—for which we are awaiting regulations in some cases.

HB 328 would remove the option for hospitals to align their policies on reduced-cost medically necessary care and payment plans in accordance with the mission and service area of the hospital. This provision allows hospitals to prioritize the delivery of care based on local needs and demographics, existing community health needs assessments, and maintaining access to health care services for all Marylanders. Hospitals need flexibility to set financial assistance policies to ensure they prudently allocate resources to the communities they serve.

HB 328 also would prohibit hospitals from considering household monetary assets to determine eligibility for free and reduced-cost care. Asset tests are a common practice for determining whether an individual or family qualifies for financial services. For example, both Maryland Medicaid and Social Security Supplemental Security Income require asset tests to determine eligibility.

MHA recognizes the importance of advancing affordable health care for all Marylanders, and we are working with our members to identify areas of potential compromise, if necessary. We look forward to working with the sponsor and other stakeholders on this important issue.

Maryland
Hospital Association

For these reasons, we request a ***unfavorable*** report on HB 328.

For more information, please contact:
Jake Whitaker, Director, Government Affairs
Jwhitaker@mhaonline.org