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Preying On Patients

Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits

www.NationalNursesUnited.org

February 2020

ADDITIONAL RESOURCES ON HOSPITALS AND COUNTIES

In addition to this report, we have created supplemental materials available online. These include individual hospital reports that allow readers to look deeper into a specific hospital's activities. The reports include the hospital's medical debt lawsuit data, financial information, executive compensation amounts, and charity care levels.

To provide a geographic lens with which to look at the data, we have also created reports for each county in Maryland. These reports show which hospitals are filing medical debt lawsuits against the residents of each of Maryland's 24 counties. The reports also include financial and charity information on the top hospitals suing county residents.

These resources can be found at https://www.nationalnursesunited.org/preying-on-patients.

ACKNOWLEDGMENTS

We wish to thank the Maryland Volunteer Lawyers Service for generously providing data and expertise, on which we relied heavily for our analysis of Maryland's medical debt lawsuits. This report would not have been possible without access to their database of Maryland court records.

The Maryland Volunteer Lawyers Service provides free or low-cost legal representation to Marylanders with limited incomes and provides free legal help for community-based nonprofits that are working to strengthen low-income communities in Maryland. You can find more information about them at their website: https://mvlslaw.org.

Preying on Patients

Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits

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Read this first to better understand Maryland hospitals

In the state of Maryland, all hospitals are operated as not for profits. In exchange for being exempted from paying most federal, state, and local income, property, and sales taxes, not-for-profit hospitals are required to provide subsidized low-cost or free medical care, otherwise known as "charity care," to qualifying individuals. The state of Maryland also uses what's called an "all-payer system" for reimbursing hospitals for the medical treatment they provide, meaning that a state commission sets the uniform rate formula by which hospitals are paid. Built into that formula are also monies intended to help hospitals cover the costs of providing charity care, what's commonly called "charity care rate support." In other words, Maryland's not-for-profits hospitals are obligated to provide charity care but actually do not bear these costs. The state's generous hospital financing system makes the high number of these medical debt lawsuits all the more egregious.

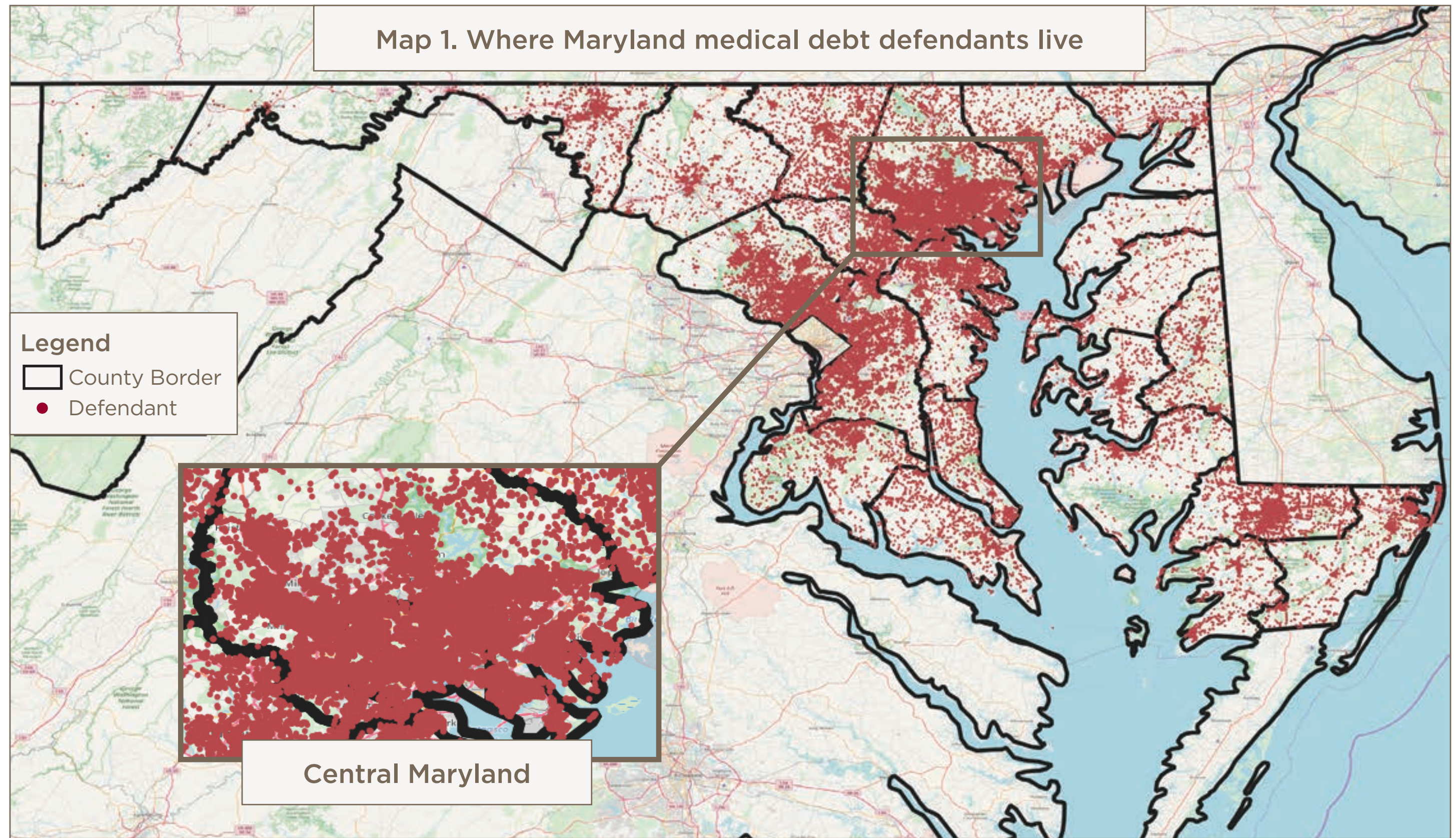
EXECUTIVE SUMMARY

The argument of this report is simple: There is no economic rationale for Maryland hospitals to sue so many of their patients, the impact of lawsuits on patients is incredibly damaging and likely deters low-income Marylanders from seeking medical care, and the General Assembly must pass legislation to protect patients by better regulating when lawsuits can be pursued as well as increasing hospitals' obligations to provide financial assistance for care.

Between 2009 and 2018, Maryland hospitals filed 145,746 medical debt lawsuits seeking $268,711,620 from patients.[1] In addition, numerous wage garnishments and liens were filed. At least 3,278 lawsuits ended with the patients filing for bankruptcy. No doubt, $268.7 million is a large amount of money, but numbers must be placed into context. During this same time period, Maryland hospitals, all of which are classified as not-for-profits, had operating revenues of almost $147 billion and $5.68 billion in net income. When compared to the hospitals' operating income and net income, the $268.7 million debt is relatively small. The amount of medical debt sought in lawsuits as a percentage of operating revenues is 0.18 percent and medical debt sought as a percentage of net income is 4.7 percent. These hospitals could easily write off these medical debts with minimal effect on their bottom line.

In addition, during the last five years,[2] the executives of these hospitals have rewarded themselves handsomely. Some 1,068 executives received $1.66 billion in aggregate compensation. Compensation amounts in excess of $1 million were paid 274 times to 112 individuals. To put the $1.66 billion in executive compensation in perspective, in the last five years Maryland hospitals posted $3.56 billion in net income. Executive compensation as a percentage of net income is 46.6 percent. Compare this to the 4.7 percent medical debt as a percentage of net income above and it becomes clear the amount sought in these lawsuits is a small fraction of hospitals' net income.

Finally, in the last five years, the amount of charity provided by Maryland hospitals, both absolutely and relatively, has declined even as hospitals receive charity care rate payer support to offset the cost of providing charity care. These hospitals could easily reclassify the medical debt in these lawsuits to charity care with little to no impact on their financial well-being. Such a move would provide immediate and lasting relief to their patients.



Before data on medical debt lawsuits is presented, a couple of issues must be mentioned. First, all the hospitals in this report are not for profit. This does not mean that they cannot make profit,[3] rather, it means that they cannot directly distribute the surplus to enrich themselves. Not-for-profits are seen as an asset to the community, and any financial surplus they generate is to be used to serve the community. In exchange for this service, these not-for-profits do not have to pay most taxes that other individuals or for-profit companies are required to pay. Not-for-profits don't have to pay federal or state income taxes, property taxes, sales taxes, and donors receive tax deductions. The tax exemptions for these not-for-profit hospitals can add up to quite substantial amounts. For example, in "Breaking the Promise of Patient Care",[4] we found that Johns Hopkins Hospital in one year, 2017, received more than $164 million in tax exemptions. Traditionally, hospitals provided care to the sick and indigent, as such charity care was a crucial part of their mission. This is no longer the case. As this report demonstrates, the provision of charity care has diminished.

Second, medical debt is different than other forms of debt. It is a matter of life and death that some patients take on medical debt: There is no choice. The patient will die without the care. Medical debt is often unpredictable, incurred accidently, or through no fault of the patient or family member. There is often no way to know how much debt will be incurred before care is provided, especially with the current complex system of hospital bills and health insurance reimbursements. Hospital billing is complex, and few people understand their bills. Furthermore, bills are riddled with errors. According to research reported in the *Wall Street Journal*, 40 to 80 percent of medical bill have errors.[5] In addition, the Maryland Insurance Administration finds that 15 to 16 percent of health insurance claims are routinely denied payment, leaving the patient scrambling to figure out what is happening.[6] Medical debt in Maryland must be handled with more care and compassion.

The fact that tens of thousands of sick and poor residents of Maryland are being victimized through medical debt lawsuits originating from wealthy and heavily subsidized nonprofit hospitals makes it clear that the state's policies on charity care and medical debt are not working.

To put an end to abusive and unnecessary medical debt lawsuits, we make two demands of Maryland's not-for-profit hospitals:

First, all Maryland not-for-profit hospitals must suspend currently open and impending medical debt lawsuits for a period of 18 months to allow time for a review and audit of all policies relating to medical debt, collections, charity care, and contracts with attorneys to collect medical debts, including to file medical debt lawsuits.

Second, Maryland's not-for-profit hospitals should declare forgiveness for all debt associated with currently outstanding medical debt lawsuits.

To ensure the volume and damage caused by medical debt lawsuits is minimized going forward, we propose the General Assembly enact the following reforms:

- Hospitals must increase who is eligible for free and reduced-cost care under financial assistance policies, including increasing the threshold for free care up to 300 percent of the federal poverty level (FPL), with a sliding scale for patients between 300 percent and 600 percent of FPL.
- Asset protections for patients with medical debt must be increased — including protecting liquid assets up to $20,000, primary residences, and motor ve hicles.
- The public and private enforcement of both financial assistance policy requirements and debt collection requirements must be enhanced.
- Medical debt collection practices must be improved by taking the following steps:
    - Ban hospitals from placing liens on primary residencies or seeking arrest warrants.
    - Ban hospitals from garnishing wages if the patient was eligible for free or reduced care costs.
    - Ban medical debt lawsuits for $5,000 or less against all patients and all medical debt lawsuits against those who were uninsured at time of service.
    - Require hospitals to offer income-based repayment plans that have reasonable terms that will allow patients to pay off their medical debt.

To make our case, this report will provide detailed tables and graphs in sections on medical debt lawsuits, the financial health of hospitals, executive compensation, and the provision of charity care.

KEY FINDINGS

- Between 2009 and 2018, Maryland's hospitals filed 145,746 lawsuits against their patients, seeking to collect $269 million in medical debt. The median amount of medical debt sought by all these lawsuits was $944. In at least 3,278 cases, the patients ultimately declared bankruptcy.[7]
- Not-for-profit Maryland hospitals successfully requested 37,370 property and wage garnishment orders between 2009 to 2018 in efforts to recover $60 million in medical debt from patients.[8]
- University of Maryland Medical System, Peninsula Regional Medical Center, and Johns Hopkins Health System filed the most medical debt lawsuits against their patients, accounting for nearly half of all cases.[9]
- By using lawsuits to collect medical debt, hospitals may be discouraging working-class and low-income Maryland residents, many from communities of color, from seeking medical care at some facilities. Patients with medical debt are more likely to ration needed care due to cost, which can endanger their health.[10] It is bitterly ironic that hospitals, as institutions dedicated to healing, have policies that contribute to patients foregoing needed medical care and services.
- Only a small number of attorneys litigated the tens of thousands of medical debt lawsuits for the hospitals. In fact, five lawyers are responsible for filing nearly two-thirds of all the lawsuits.[11]

- Over this same period in which the lawsuits were filed, Maryland hospitals posted $5.68 billion in net income and enjoyed nine straight years of positive net income. In 2018 alone, Maryland's nonprofit hospitals earned nearly $1 billion in net income.[12]
- Over just the last five years, Maryland hospitals have paid 1,068 executives almost $1.66 billion in compensation.[13] Compared as a percentage of net income, executive compensation represented 46.6 percent, while the amount sought in these lawsuits represented a mere 4.7 percent.
- As the number of medical debt lawsuits pile up, hospital-provided charity care has plummeted. Between 2009 and 2018, the annual amount of charity care provided by Maryland hospitals dropped by 36 percent, or $168 million. The collapse of the proportion of hospital resources going to charity care is even more dramatic: Charity care provided as a percentage of operating expenses fell by almost half, dropping 46 percent from 2009 to 2018.[14]
- Between 2014 and 2018, Maryland's all-payer system provided more than $1.8 billion in charity care rate support to help hospitals cover the costs of charity care. This means that hospitals are receiving substantial funding from rate payers to cover charity costs. They collectively received $119.2 million in rate support beyond what they spent on charity care, resulting in a windfall for many health systems. Over the same five-year period, Maryland hospitals filed lawsuits seeking $119.4 million in medical debt, almost the exact amount of excess rate support they received in aggregate. Of the top beneficiaries of charity care rate support, Johns Hopkins Hospital received the highest amount beyond what it spent on charity, adding over $36.3 million to the hospital's earnings.[15]
- During 2017 and 2018, Maryland hospitals on average denied charity care applications about 9.5 percent of the time. Certain hospitals, however, denied charity care applications at a much higher rate. Seven hospitals, including all four Johns Hopkins facilities, denied more than 40 percent of all charity care applications. Sixteen hospitals, including most University of Maryland facilities, rejected more than 25 percent of all charity care requests. Mt. Washington Pediatric Hospital, the sole children's hospital included in our study, rejected more than 24 percent of requests from the families of its young patients for help with their medical bills.[16] It is likely that some of these rejected applicants were in fact eligible for charity care, and that still others had significant financial need even though they did not meet Maryland's current stringent charity care eligibility criteria.[17]
- Solutions: First, all hospitals should suspend open and pending lawsuits for at least 18 months to allow a thorough review of policies surrounding this practice and forgive all current medical debts of those being sued. Second, state legislation is required to improve protections for Maryland families struggling with medical debt by reducing the volume and damage caused by medical debt lawsuits. Legislation is also needed to expand charity care requirements so that low-income patients will be able to access financial assistance.

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INTRODUCTION

In 2019, the issue of hospitals and health systems suing their patients became a much-discussed topic: numerous studies, exposés, and newspaper articles highlighted the problem. In May of 2019, we published "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits,"[18] which drew attention to the large number of lawsuits filed by Johns Hopkins Hospital against its largely poor, largely neighbors of color. The study garnered press from several news outlets including *The Baltimore Sun*;[19] in addition, *The Baltimore Sun* editorial board demanded that Johns Hopkins Hospital at least temporarily stop filing medical debt lawsuits against its poor patients.[20] Johns Hopkins Hospital has ignored this demand and continues to file lawsuits against the poor and minority communities that surround it.[21]

Unfortunately, Johns Hopkins Hospital is not the only hospital suing its patients. Indeed, it is common practice among hospitals in the United States. In the past 12 months alone, studies and articles have been published discussing this practice in Connecticut,[22] Virginia,[23] Oklahoma,[24] New Mexico,[25] and Tennessee.[26] The details across these cases follow a similar pattern. The studies find that a hospital, or hospitals, are suing thousands, if not tens of thousands, poor and low-income patients who need medical care, but are unable to pay due to being uninsured or underinsured. Many of these patients state that financial assistance and/or charity care was never discussed or offered. Debt is sent to collections, leaving the patients to be harassed by debt collectors until a medical debt lawsuit is filed. Often, a patient will not show up to a court hearing for one of several reasons: not receiving the notice, inability to get the day off work, or simply avoiding the hearing as they do not have the money to pay off the debt. Regardless of the reason, the result is always a judgment for the hospital. In many cases, the hospital is able to obtain a wage garnishment or property lien against the patient. Frequently, wage garnishments are against the hospital's own employees. For the few patients who do show up, some type of unrealistic payment scheme is offered. When the patient fails to make the payments, the hospital can then obtain a wage garnishment or a property lien. The results for patients and their families can be disastrous: their credit rating takes a hit (hurting future ability to obtain credit as well as jeopardizing future job and housing prospects), wages or property may be garnished until the debt is paid, and stress levels are increased. This is a heavy load to bear for simply obtaining needed medical care. Patients with medical debt are more likely to ration needed care due to cost,[27] which further endangers their health. It is bitterly ironic that hospitals, as institutions dedicated to healing, have practices that contribute to patients foregoing needed medical care and services.

The increased scrutiny brought by public attention to these hospital policies has brought limited reforms at some hospitals, most notably at two hospitals in Virginia — Mary Washington Hospital and the University of Virginia Health System — and one in Tennessee — Methodist Le Bonheur Healthcare. Mary Washington Hospital announced a six-month suspension of lawsuits, but would not guarantee it would not file more at a later date and will do nothing for the thousands already sued.[28] The UVA Health System stated it would provide financial assistance on a sliding scale for families making up to 400 percent of the poverty level. It also announced it would only sue patients if debt was more than a $1,000.[29] Methodist Le Bonheur Healthcare wiped out the debt sought in 5,300 medical debt lawsuits, as of Dec. 24, 2019, after scrutiny from *ProPublica*.[30] The hospital system also increased the wages of its workers after it was exposed that it was suing many of them over medical debts.[31] These reforms are improvements, but much more needs to be done to protect patient health and economic security. Patients should not have to rely on the press to shame hospitals into doing right by their communities. Moreover, the risk of being sued remains, as there is nothing preventing hospitals from returning to their former policies.

This report seeks to highlight the large number of medical debt lawsuits filed by Maryland Hospitals against patients and underscore the need for the General Assembly to enact laws to protect patients.

"These hospitals could easily reclassify medical debt in these lawsuits to charity care with little to no impact on their financial well-being. Such a move would provide immediate and lasting relief to their patients."

This report is not the first time medical debt lawsuits have been exposed in Maryland. In 2008, *The Baltimore Sun* ran a series of articles highlighting the same issues addressed above.[32] These articles prompted the General Assembly to pass legislation in an attempt to protect poor patients from the actions of hospitals. Yet, it is obvious that more needs to be done, as Maryland's hospitals are suing tens of thousands of patients every year. The General Assembly must once again address medical debt and medical debt lawsuits.

The argument of this report is simple: There is no economic rationale for Maryland hospitals to sue so many of their patients. Between 2009 and 2018, Maryland hospitals filed 145,746 medical debt lawsuits seeking $268,711,620 from patients.[33] In addition, numerous wage garnishments and liens were filed. At least 3,278 lawsuits ended with the patients filing for bankruptcy. No doubt, $268.7 million is a large amount of money, but numbers must be placed into context. During this same time period, Maryland hospitals, all of which are classified as not-for-profits, had operating revenues of almost $147 billion and $5.68 billion in net income. When compared to the hospitals' operating income and net income, the $268.7 million debt is relatively small. The amount of medical debt sought in lawsuits as a percentage of operating revenues is 0.18 percent and medical debt sought as a percentage of net income is 4.7 percent. These hospitals could easily write off these medical debts with minimal effect on their bottom line. In addition, during the last five years,[34] the executives of these hospitals have rewarded themselves handsomely. 1,068 executives received $1.66 billion in aggregate compensation. Compensation amounts in excess of $1 million were paid 274 times to 112 individuals. To put the $1.66 billion in executive compensation in perspective, in the last five years, Maryland hospitals posted $3.56 billion in net income. Executive compensation as a percentage of net income is 46.6 percent. Compare this to the 4.7 percent medical debt as a percentage of net income above and it becomes clear it is a small fraction of hospitals' total costs. Finally, in the last five years, the amount of charity provided by Maryland hospitals, both absolutely and relatively, has declined even as hospitals receive charity care rate payer support to offset the cost of providing charity care. These hospitals could easily reclassify the medical debt in these lawsuits to charity care with little to no impact on their financial well-being. Such a move would provide immediate and lasting relief to their patients.

Before data on medical debt lawsuits is presented, a couple of issues must be mentioned. First, all the hospitals in this report are not for profit. This does not mean that they cannot make profit,[35] rather, it means that they cannot directly distribute the surplus to enrich themselves. Not-for-profits are seen as an asset to the community, and any financial surplus they generate is to be used to serve the community. In exchange for this service, these not-for-profits do not have to pay most taxes that other individuals or for-profit companies are required to pay. Not-for-profits don't have to pay federal or state income taxes, property taxes, sales taxes, and donors receive tax deductions. The tax exemptions for these not-for-profit hospitals can add up to quite substantial amounts. For example, in "Breaking the Promise of Patient Care,"[36] we found that Johns Hopkins Hospital in one year, 2017, received more than $164 million in tax exemptions. Traditionally, hospitals provided care to the sick and indigent (i.e. provided charity care), as such charity care was a crucial part of their mission. This is no longer the case. As this report demonstrates, the provision of charity care has diminished. Rather than providing badly needed charity care, these not-for-profit hospitals are suing the sick and indigent.

Second, medical debt is different than other forms of debt. It is a matter of life and death that some patients take on medical debt: There is no choice. The patient will die without the care. Medical debt is often unpredictable, incurred accidently, or through no fault of the patient or family member. There is often no way to know how much debt will be incurred before care is provided, especially with the current complex system of hospital bills and health insurance reimbursements. Hospital billing is complex, and few people understand their bills. Furthermore, bills are riddled with errors. According to research reported in *The Wall Street Journal*, 40 to 80 percent of medical bill have errors.[37] In addition, the Maryland Insurance Administration finds that 15 to 16 percent of health insurance claims are routinely denied payment, leaving the patient scrambling to figure out what is happening.[38] Medical debt in Maryland must be handled with more care and compassion.

The remainder of the report will provide detailed tables and graphs in sections on medical debt lawsuits, financial health of hospitals, executive compensation, and the provision of charity care. The report will conclude with a section on proposed policy recommendations.

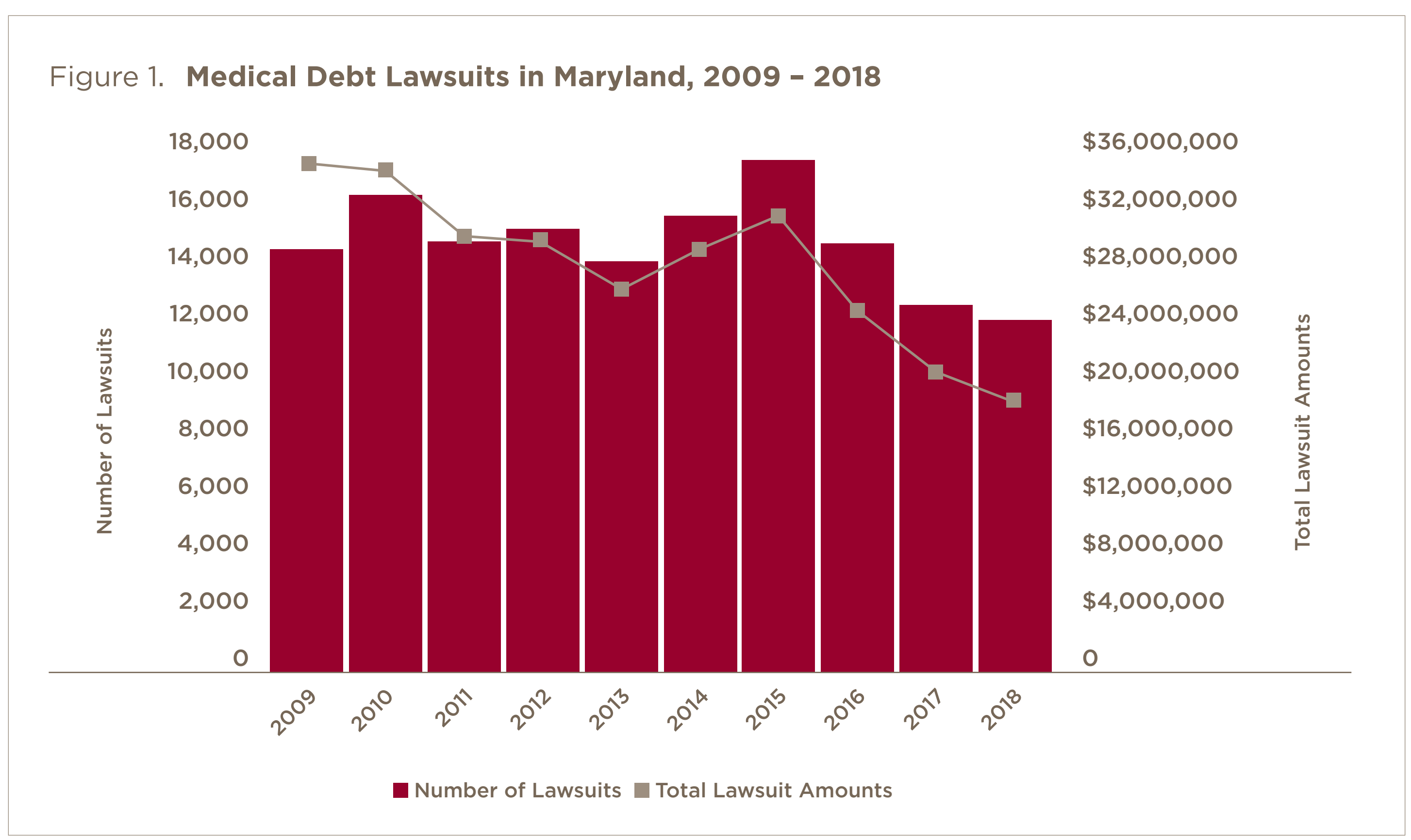
MEDICAL DEBT LAWSUITS

Maryland's hospitals are taking their patients to court over medical debt routinely and often. In the last 10 years, 42 of the 45 (93.3 percent) hospitals in this study have filed medical debt lawsuits seeking hundreds of millions of dollars. Residents of every Maryland county have had medical debt lawsuits filed against them.

Table 1. **Overall Medical Debt Lawsuits Filed by Not-for-Profit Hospitals: 2009 – 2018**[39]

Total Lawsuits	Medical Debt Targeted by Lawsuits	Median Amounts	Total Lawsuits Resulting in Garnishment	Medical Debt Targeted by Lawsuits Through Garnishments	Total Liens	Total Medical Debt Targeted by Lawsuits Through Liens	Medical Debt Lawsuits Ending in Patient Bankruptcy
145,746	$268,711,620	$944	37,370	$59,551,567	4,432	$12,503,871	3,278

Figure 1. **Medical Debt Lawsuits in Maryland, 2009 – 2018**



Medical debt and medical debt lawsuits are a major concern for residents of Maryland. According to the Urban Institute data, 17 percent of Maryland resident have medical debt in collections, with 15 percent among white communities and 21 percent in communities of color.[40] Far too many of those with medical debt will end up being sued. Table 1 above, covering the period 2009-2018, highlights the major findings of this report, showing Maryland hospitals filed 145,746 medical debt lawsuits against their patients seeking $268,711,620 in medical debt. The median amount of lawsuits filed was $944, with a range from a low of $10 to a high of $808,327. The hospitals filed 37,370 wage garnishments and 4,432 liens seeking $59,551,567 and $12,503,871, respectively. At least 3,278 lawsuits ended with the patient filing for bankruptcy.

Figure 1 and Table 2 highlight the yearly number of medical debt lawsuits and amounts sought over the 10-year period. The number of medical debt lawsuits increased steadily from 2009 with 14,299 lawsuits filed, peaking in 2015 with 17,397 cases, and have slowly decreased in the last three years. In 2018, the number of cases was around 12,000. The overall amount of medical debt sought through lawsuits has been decreasing from a high of $33,515,510 in 2009 to a low of $17,849,225 in 2018. Though the number of lawsuits has been decreasing, there were still 71,763 lawsuits filed seeking $119,433,039 in medical debt over the last five years. Even with the decline, Maryland hospitals are suing their patients far too often.

Table 2. **Medical Debt Lawsuits by Year**

Year	Medical Debt Lawsuits	Amount	Median Amount	Garnishment Total	Garnishment Amount
2009	14,299	$33,515,510	$1,060	4,050	$7,771,595
2010	16,108	$33,207,858	$1,009	4,326	$7,424,345
2011	14,651	$28,778,458	$958	4,115	$6,644,987
2012	14,998	$28,538,002	$888	4,175	$6,899,040
2013	13,927	$25,238,519	$876	3,448	$5,234,874
2014	15,459	$27,885,129	$876	3,929	$6,339,423
2015	17,397	$30,043,894	$866	4,934	$7,265,465
2016	14,509	$23,824,201	$954	4,327	$5,964,071
2017	12,455	$19,830,590	$1,003	2,775	$4,182,313
2018	11,943	$17,849,225	$938	1,291	$1,825,454
Total	**145,746**	**$268,711,386**	**$944**	**37,370**	**$59,551,567**

There are 45 acute-care hospitals included in this report. Of these, 42 have filed medical debt lawsuits over the last 10 years. Of the 45 hospitals, 31 are members of hospital systems. The hospital systems and hospitals with the largest number of lawsuits are highlighted in Table 3. The University of Maryland Medical System (11 hospitals) filed the most lawsuits, followed by independent hospital Peninsula Regional Medical. The hospital systems Johns Hopkins Health System (four hospitals), MedStar Health (seven hospitals), and LifeBridge Health (three hospitals) are the next three. Finally, independent Greater Baltimore Medical Center filed 16,780 medical debt lawsuits. These six entities accounted for 87.1 percent of all medical debt lawsuits filed and 86.6 percent of medical debt sought. For a summary of medical debt lawsuits for all the hospital systems, see Appendix 1. For more detailed hospital information, see the "Additional Resources on Hospitals and Counties" online section at https://www.nationalnursesunited.org/preying-on-patients.

Table 3. **Hospitals and Systems that Sued the Most Patients**

Hospitals and Systems	Total Lawsuits	Percent of Total Lawsuits	Medical Debt Targeted by Lawsuits	Percent of Total Medical Debt Targeted by Lawsuits
University of Maryland Medical System	25,430	17.4%	$78,616,705	29.3%
Peninsula Regional Medical Center	21,831	15.0%	$23,997,895	8.9%
Johns Hopkins Health System	21,707	14.9%	$45,291,898	16.9%
MedStar Health	21,375	14.7%	$36,281,760	13.5%
LifeBridge Health	19,869	13.6%	$29,486,967	11.0%
Greater Baltimore Medical Center	16,780	11.5%	$18,940,601	7.0%

Table 4. **Individual hospitals with more than 1,000 medical debt lawsuits, 2009 – 2018**

Hospital	System	Total Lawsuits	Medical Debt Sought by Lawsuits	Median Amount	Total Lawsuits Resulting in Garnishment	Medical Debt Sought by Lawsuits Through Garnishments
Peninsula Regional Medical Center		21,831	$23,997,895	$491	10,142	$10,313,894
Greater Baltimore Medical Center		16,780	$18,940,601	$716	4,609	$5,608,834
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	13,742	$30,214,414	$895	352	$931,786
Sinai Hospital of Baltimore	LifeBridge Health	11,690	$17,263,061	$907	3,776	$5,464,815
University of Maryland Medical Center	University of Maryland Medical System	9,584	$45,828,278	$2,165	1,330	$5,526,833
University of Maryland Shore Medical Center[41]	University of Maryland Medical System	7,969	$14,959,294	$1,071	138	$247,255
MedStar Franklin Square Medical Center	MedStar Health	6,509	$10,879,817	$923	2,216	$3,950,878
Northwest Hospital	LifeBridge Health	5,278	$6,968,182	$881	1,550	$1,952,778
Mercy Medical Center		5,253	$5,964,312	$864	815	$920,310
Saint Agnes Healthcare	Ascension Healthcare	4,138	$6,117,483	$891	1,040	$1,540,617
MedStar Good Samaritan Hospital	MedStar Health	3,475	$5,650,172	$896	1,317	$2,254,077
MedStar Southern Maryland Hospital Center	MedStar Health	3,335	$6,443,532	$1,042	742	$1,677,445
MedStar Union Memorial Hospital	MedStar Health	3,036	$5,472,868	$957	1,028	$1,847,083
Johns Hopkins Hospital	Johns Hopkins Health System	2,967	$5,965,398	$1,409	673	$1,321,817
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	2,560	$5,089,385	$1,174	698	$1,466,303
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital[42]	University of Maryland Medical System	2,543	$6,230,184	$1,685	1,274	$3,221,097

Hospital	System	Total Lawsuits	Medical Debt Sought by Lawsuits	Median Amount	Total Lawsuits Resulting in Garnishment	Medical Debt Sought by Lawsuits Through Garnishments
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	2,406	$3,915,411	$1,016	580	$1,004,816
MedStar Harbor Hospital	MedStar Health	2,397	$3,801,081	$943	861	$1,422,687
Carroll Hospital Center	LifeBridge Health	2,373	$4,554,230	$1,113	332	$747,215
Meritus Medical Center		2,353	$7,140,184	$1,621	781	$1,863,509
University of Maryland Charles Regional Medical Center	University of Maryland Medical System	2,328	$3,223,313	$922	257	$457,338
Atlantic General Hospital		2,064	$2,112,079	$509	658	$713,308
MedStar St. Mary's Hospital	MedStar Health	1,613	$1,668,591	$722	263	$448,220
CalvertHealth Medical Center		1,422	$2,238,242	$914	216	$363,049
Anne Arundel Medical Center		1,193	$6,771,593	$3,899	216	$1,240,010
Holy Cross Hospital	Trinity Health	1,124	$2,964,239	$1,343	141	$424,142

The number of medical debt lawsuits filed by the individual hospitals is presented in Table 4. The table lists the 26 hospitals that filed more than 1,000 lawsuits over the 10 years. These hospitals account for 57.8 percent of Maryland hospitals, yet they filed 96 percent of all medical debt lawsuits over the period. Nineteen of these hospitals are part of systems. For a list of all hospitals with the number of medical debt lawsuits, see Appendix 2.

Peninsula Regional Medical Center filed the most medical debt lawsuits in Maryland, at 21,831 seeking $23,997,895 in medical debt, followed by Greater Baltimore Medical, at 16,780 seeking $18,940,601 in medical debt. Johns Hopkins Suburban Hospital finishes out the top three, at 13,472 medical debt lawsuits seeking $30,214,414 in medical debt.

Johns Hopkins Suburban has the highest amount of medical debt sought in the state. All four of the hospitals in Johns Hopkins Health System and the three hospitals in LifeBridge Health made the table with more than 1,000 cases. Six of seven hospitals in MedStar Health and four of the 11 in University of Maryland Medical System appear on the table.

Eight hospitals filed between 100 and 1000 cases and another eight hospitals filed fewer than 100 medical debt lawsuits.

No medical debt lawsuits were found for three of the hospitals: Bon Secours Hospital, Western Maryland Regional Medical Center, and Holy Cross Germantown.

Table 5. **Counties where medical debt lawsuit victims reside, 2009 – 2018**

County	Total Medical Debt Lawsuits Filed Against Residents	Medical Debt Amount	Median Amount	Total Cases Resulting in Garnishments	Garnishment Amount
Baltimore	32,617	$51,330,059	$928	9,016	$13,739,450
Baltimore City	30,070	$53,571,018	$982	8,949	$14,619,377
Wicomico	14,617	$15,987,917	$496	7,102	$6,992,859
Montgomery	9,614	$20,844,236	$1,012	666	$1,713,023
Prince George's	8,683	$20,125,033	$1,279	2,087	$5,069,043
Anne Arundel	5,823	$17,995,138	$1,239	1,210	$3,317,623
Worcester	4,312	$5,324,206	$506	1,716	$1,981,777
Howard	3,387	$6,890,331	$1,133	701	$1,285,884
Carroll	3,376	$6,550,910	$1,130	536	$1,094,992
Harford	3,311	$6,329,536	$1,050	724	$1,357,227
Charles	3,063	$5,113,519	$965	454	$1,030,415
Dorchester	2,721	$5,079,166	$959	204	$332,646
Washington	2,271	$6,446,741	$1,491	741	$1,766,314
Somerset	2,051	$2,141,205	$431	939	$865,053
Saint Mary's	1,880	$2,673,450	$808	297	$568,427
Caroline	1,827	$4,260,504	$1,034	69	$179,722
Talbot	1,739	$3,631,645	$1,084	32	$82,450
Calvert	1,417	$2,548,505	$940	229	$427,373
Frederick	1,184	$3,893,446	$1,238	133	$498,164
Queen Anne's	1,016	$2,606,825	$1,186	69	$157,290
Cecil	858	$2,274,807	$1,107	205	$362,932
Kent	647	$1,476,726	$1,267	97	$251,252
Allegany	62	$240,945	$1,306	4	$6,249
Garrett	17	$49,698	$2,826	2	$11,257

Every county had residents with medical debt lawsuits filed against them.[43] The larger urban areas, with higher population density, have more lawsuits, but no place in Maryland is immune. See "Additional Resources on Hospitals and Counties" section for detailed county information at https://www.nationalnursesunited.org/preying-on-patients.

Wage and Property Garnishments

Since 2009, hospitals used the Maryland courts to seize the wages or property of their patients in more than 37,000 cases in efforts to recover medical debts. Garnishment orders granted by the courts allow hospitals to take a portion of a patient's wages every pay period until the debt is paid, or to simply empty the patient's bank accounts to cover as much of the debt as possible.

The top private-sector employers of patients subjected to wage garnishments include notorious low-wage companies such as Walmart and Home Depot, but also the hospitals themselves. In particular, Johns Hopkins, Peninsula Regional Medical Center, and the University of Maryland Medical System requested garnishment orders against hundreds of their own employees. Public-sector workers also had their wages garnished on a massive scale, including hundreds of workers for the state of Maryland, U.S. postal workers, and public school employees.

Table 6. **Top Employers of Wage Garnishment Victims**

Rank	Private-Sector Employer
1	Walmart/Sam's Club
2	Perdue Farms
3	Johns Hopkins
4	Peninsula Regional Medical Center
5	Mountaire Farms
6	Genesis Healthcare
7	Home Depot
8	MedStar
9	University Of Maryland Medical System
10	Dove Pointe

Rank	Public-Sector Employer
1	State of MD — Central Payroll
2	USPS
3	Baltimore Public Schools

High-Volume Dockets for Maryland Medical Debt Lawsuits

Medical debt lawsuits in Maryland are typically pursued at high-volumes. On average, 40 medical debt cases were filed each day, including weekends and holidays, between 2009 and 2018. Medical debt lawsuits are often filed in bulk. There were 453 days on which 100 or more medical debt lawsuits and six days on which more than 300 medical debt lawsuits were filed. The single largest number of lawsuits filed in one day was 474 lawsuits on Dec. 9, 2009.

Medical debt lawsuits are also largely handled by a small number of attorneys. 92 percent of the 145,746 cases referenced in this report were filed by just 21 attorneys, each with more than 1,000 medical debt cases. More than 93,000 medical debt lawsuits, accounting for 64 percent of the total over 10 years, were filed by the five attorneys with the highest number of cases. The market share of these five attorneys has steadily increased over time, climbing from 48.6 percent of all medical debt cases in 2009 to 77 percent in 2018. Together, the top five attorneys filed 100 or more lawsuits on 245 days.

A single attorney was responsible for filing almost 41,000 medical debt lawsuits between 2009 and 2018, accounting for 28.1 percent of the total. In 2017 and 2018, this attorney's cases amounted to 50.8 percent and 55.1 percent of all medical debt cases filed for those years, respectively. On a single day, this attorney filed 229 medical debt lawsuits. On 59 occasions, this attorney filed 100 or more lawsuits in one day.

With such high volumes of cases, ensuring due process and just outcomes for medical debt lawsuits represents a major challenge.[44] According to a 2016 report by the National Center for State Courts, consumer debt cases receive little, if any, judicial attention, and almost always involve major power imbalances between defendants and plaintiffs.

> "Defendants in these cases were overwhelmingly unrepresented, while plaintiffs were overwhelmingly represented by attorneys, even in small-claims cases. Serious knowledge and power imbalances between plaintiffs and defendants can undermine procedural and substantive legal protections. Defendants are almost by definition persons of limited means…Coming to court may mean losing wages, finding child care, or incurring transportation costs. Generally, unrepresented defendants face attorneys whose business model is based on processing huge numbers of cases with limited effort and whose insider knowledge often enables them to achieve one-sided outcomes through defaults or onerous settlements. After securing a judgment, plaintiffs' lawyers are able to evict, garnish wages, and seize assets."[45]

For medical debt lawsuits, the imbalance of knowledge and resources between the defendant/patient and the plaintiff/hospital all but guarantees judgments for the hospital, regardless of the actual details of the case. For many patients, these judgments can jeopardize access to basic life necessities, including employment and housing. The financial impacts can last a lifetime. It is hard to deny the injustice and immorality of such a system. Maryland's not-for-profit hospitals are responsible for these lawsuits and should be compelled to immediately suspend all medical debt litigation until their debt collection practices can be revised to ensure better protection for patients. In the next section, we make clear that the hospitals of the state can easily afford to do so.

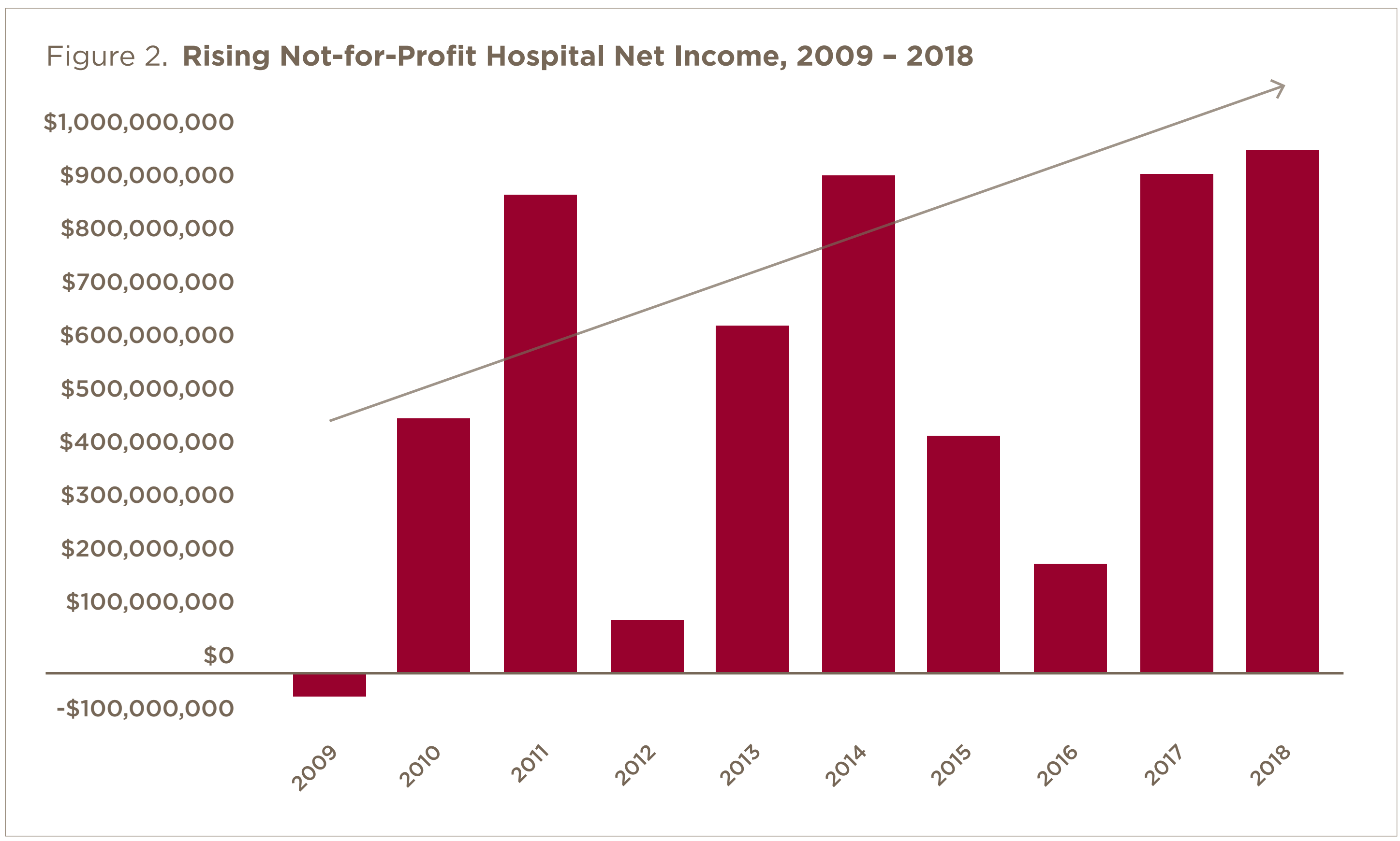
FINANCIAL HEALTH OF MARYLAND'S NOT-FOR-PROFIT HOSPITALS AND HOSPITAL SYSTEMS

This section will highlight the financial health Maryland not-for-profit hospitals have enjoyed over the last 10 years.

Table 7. **Revenue and net income for Maryland not-for-profit hospitals, 2009 – 2018**[46]

Total Operating Revenues	Total Operating Expenses	Net Income
$146,925,814,699	$142,297,804,064	$5,675,970,196

Figure 2. **Rising Not-for-Profit Hospital Net Income, 2009 – 2018**



Maryland not-for-profit hospitals have done very well over the last 10 years. The 45 hospitals included in this report earned almost $147 billion in operating revenue with $5.68 billion in net income. In the aggregate, Maryland hospitals have had nine straight years of positive net income. With a few bumps, there has been steady growth from negative net income of almost $45 million in 2009 in the depths of the Great Recession to positive net income just short of $1 billion in 2018. Over the last 10 years, total net income has approached $1 billion on four occasions. In just the last five years, net income totaled $3.56 billion, compared to $2.1 billion in the first five years.

Table 8. **Net income by year**

Year	Net Income
2009	-$44,876,023
2010	$487,261,515
2011	$912,783,928
2012	$98,395,088
2013	$661,256,760
2014	$950,764,101
2015	$453,425,911
2016	$205,849,605
2017	$954,026,436
2018	$997,082,875
Total	**$5,675,970,196**

Table 9. **Revenue and net income by individual hospitals, 2009 – 2018**

Hospital name	System	Total operating revenues	Net Income
University of Maryland Medical Center	University of Maryland Medical System	$12,606,743,000	$692,657,000
Johns Hopkins Hospital	Johns Hopkins Health System	$19,861,730,000	$609,011,000
Sinai Hospital of Baltimore	LifeBridge Health	$7,041,203,651	$362,900,864
Holy Cross Hospital	Trinity Health	$4,522,082,000	$309,793,000
Saint Agnes Healthcare	Ascension Healthcare	$4,212,130,000	$278,388,000
University of Maryland Shore Medical Center[47]	University of Maryland Medical System	$2,742,438,118	$235,973,997

Hospital name	System	Total operating revenues	Net Income
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	$2,319,937,000	$230,520,010
Greater Baltimore Medical Center		$4,563,670,239	$221,161,630
Adventist Healthcare Shady Grove Medical Center	Adventist HealthCare	$3,404,365,166	$207,610,806
Northwest Hospital	LifeBridge Health	$2,254,113,305	$189,261,632
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	$2,722,053,000	$182,209,000
MedStar Franklin Square Medical Center	MedStar Health	$4,732,365,862	$179,873,952
Mercy Medical Center		$6,181,693,000	$170,419,000
Peninsula Regional Medical Center		$3,820,391,618	$170,382,018
Anne Arundel Medical Center		$5,904,222,000	$161,933,000
Western Maryland Regional Medical Center		$3,038,037,000	$156,113,000
Carroll Hospital Center	LifeBridge Health	$2,595,252,000	$135,527,000
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	$3,099,211,000	$126,634,000
Meritus Medical Center		$2,925,273,483	$112,378,018
MedStar Union Memorial Hospital	MedStar Health	$3,415,900,000	$109,137,371
MedStar Harbor Hospital	MedStar Health	$2,003,549,625	$106,718,380
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	$2,459,510,000	$94,557,000
MedStar St. Mary's Hospital	MedStar Health	$1,410,237,991	$88,542,767
University of Maryland Harford Memorial Hospital	University of Maryland Medical System	$819,628,170	$83,511,019
University of Maryland Charles Regional Medical Center	University of Maryland Medical System	$1,067,991,147	$77,513,321
MedStar Good Samaritan Hospital	MedStar Health	$3,001,378,973	$73,484,902
Frederick Regional Health System		$3,595,001,000	$67,711,000
MedStar Montgomery Medical Center	MedStar Health	$1,492,444,653	$64,384,589

Hospital name	System	Total operating revenues	Net Income
CalvertHealth Medical Center		$1,396,539,843	$60,794,408
Mt. Washington Pediatric Hospital	University of Maryland Medical System	$538,886,154	$57,899,437
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	$5,588,855,000	$46,080,000
Union Hospital		$1,461,783,826	$34,384,226
University of Maryland Rehabilitation & Orthopaedic Institute	University of Maryland Medical System	$939,878,000	$27,829,445
Garrett Regional Medical Center		$448,577,259	$21,908,061
Adventist Healthcare Washington Adventist Hospital	Adventist HealthCare	$2,292,560,475	$20,041,393
Atlantic General Hospital		$1,007,127,955	$19,584,718
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	$1,733,746,000	$16,514,162
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital[48]	University of Maryland Medical System	$3,331,541,473	$15,536,464
Fort Washington Medical Center		$424,149,011	$6,605,068
Doctors Community Hospital		$2,136,220,394	$5,144,858
McCready Health		$180,200,900	$3,054,993
Bon Secours Baltimore Health System	Bon Secours Mercy Health	$1,167,408,938	-$10,339,713
MedStar Southern Maryland Hospital Center	MedStar Health	$2,184,984,300	-$29,264,600
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	$3,273,942,000	-$48,319,000
Holy Cross Germantown Hospital	Trinity Health	$1,006,860,170	-$69,791,000

The vast majority of individual hospitals have had positive net income for the years of 2009-2018 combined. Forty-one of 45 (91 percent) hospitals had positive net income. University of Maryland Medical Center and Johns Hopkins Hospital clearly are the most financially successful. Their net income is nearly double their next competitor. The most profitable hospitals in Maryland are part of systems: 11 of the top 12 hospitals by net income belong to systems, with University of Maryland Medical System having three hospitals, while both Johns Hopkins Health System and LifeBridge Health each have two. Two-thirds of the not-for-profit hospitals averaged more than $5 million a year in net income.

The four hospitals with negative net income are all part of systems that are very successful financially. These systems can easily subsidize their hospitals to ensure they can continue to serve their communities. Bon Secours recently merged with LifeBridge Health.[49] MedStar Health and University of Maryland Medical System each have one. Finally, Holy Cross German Hospital is part Trinity Health, a large Catholic hospital system.[50]

Table 10 highlights five Maryland-based not-for-profit health systems.[51] Johns Hopkins Health System's net income of almost $3 billion over the last 10 years is the highest in the state. Overall, these five systems have combined net income of more than $6.4 billion. Maryland's not-for-profit hospitals and hospital systems have clearly been very successful over the last 10 years.

Yet, even as these same hospitals and hospitals systems have enjoyed financial success, they continue to take their patients to court in pursuit of medical debt. There is no economic rationale for doing so. While there is no doubt that the total amount of medical debt sought through lawsuits, $269 million, is a large amount of money, it must be placed into proper context. Relative to the hospitals' operating revenue ($146 billion) and net income ($5.68 billion), $269 million is minuscule. Medical debt sought in lawsuits as percentage of operating revenue is 0.18 percent and medical debt sought as a percentage of net income is 4.7 percent. In the aggregate, these numbers are insignificant. The hospitals and hospital systems have more than enough resources to be able to continue their operations without suing their patients. If the executives of these hospitals and hospital systems are concerned about their organizations' financial health, they might be advised to examine their own compensation.

Table 10. **Revenue and net income for Maryland's hospital systems, 2009 – 2018**[52]

System Names	Operating Revenue	Net Income
Johns Hopkins Health System	$49,726,759,000	$2,932,633,000
MedStar Health	$45,807,500,000	$1,590,000,000
University of Maryland Medical System	$30,005,233,000	$1,001,890,000
LifeBridge Health	$11,837,362,000	$698,563,000
Adventist HealthCare	$7,456,976,277	$191,077,952
Total	**$144,833,830,277**	**$6,414,163,952**

EXECUTIVE COMPENSATION FOR MARYLAND'S NOT-FOR-PROFIT HOSPITALS AND SYSTEMS

The executives of Maryland's not-for-profit hospitals and hospital system have done very well for themselves over the last five years. In this time, 3,134 annual payments of compensation were made to 1,068 executives. In total, these executives received $1,659,854,574 in compensation. The compensation ranged from a low of $45,186 to a high of $15,385,616. Only seven cases exist of compensation less than the median household income in Maryland of $81,868.[53] More than $1 million in compensation was paid 274 times to 112 individuals. According to the Economic Policy Institute, the threshold to be in the top 1 percent of incomes in Maryland is $445,783.[54] 474 individuals received compensation 1,348 times that would place them in the top 1 percent income bracket for Maryland.

The executives with the highest total executive compensation over the last five years are listed in Table 12. Executives from Johns Hopkins Health System, MedStar Health, and University of Maryland Medical System occupy the top three positions. These three systems dominate the list of highest-paid executives. Johns Hopkins Health System and MedStar Health each have six executives and University of Maryland Medical System has four in the top 25. See Appendix 3 for the complete list of the 112 executives who comprise "The Merry Millionaires of Maryland" (executives who earned more than $1 million compensation in one year).

Table 11. **Executive compensation for Maryland not-for-profit hospitals and systems, last five years**[55]

Total Compensation	Number of Annual Payments to Executives	Number of Individual Executives	Number of annual payments over $1 million	Number of annual payments that put executives above the 1% of income bracket in Maryland
$1,659,854,574	3,143	1,068	274	1,348

Table 12. **Top 25 executives, aggregate compensation, last five years**

Executive	Title	Hospital/Hospital System	Sum
Ronald R Peterson	President/Trustee	Johns Hopkins Health System	$27,152,917
Kenneth A Samet	CEO & President	MedStar Health	$27,097,825
Robert A Chrencik	President And CEO	University of Maryland Medical System	$18,351,304
Michael J Curran	EVP & CFO	MedStar Health	$14,085,633
Joy Drass	EVP	MedStar Health	$12,023,842
Philip B Down	CEO	Doctors Community Hospital	$9,774,490
Ronald J Werthman	Senior VP/Finance & Treasurer.	Johns Hopkins Health System	$9,608,467
Neil Meltzer	President/CEO	Lifebridge	$9,257,760
Judy A Reitz	VP/Operations Integration	Johns Hopkins Health System	$8,404,638
Bonnie L Phipps	SVP-AH Group Operating Exec	St. Agnes Hospital	$8,353,627
Eric Wagner	EVP	MedStar Health	$7,689,392
Joanne E Pollak	SR VP, HIPAA & Internal Audit	Johns Hopkins Health System	$7,447,590
Stephen Evans	EVP	MedStar Health	$7,423,401
Thomas Mullen	Chair, Ex Officio	Mercy Medical Center	$7,224,215
Karen E Olscamp	President & CEO	University of Maryland Baltimore Washington Medical Center	$7,150,471
Brian A Gragnolati	SR VP Community Division	Johns Hopkins Health System	$6,974,350
Henry J Franey	EVP, CFO And Treasurer	University of Maryland Medical System	$6,941,498
Lyle E Sheldon	President/CEO/Director	University of Maryland Upper Chesapeake Medical Center	$6,869,349
Frank Ebert MD	Physician	Medstar Union Memorial Hospital	$6,713,540
Victoria Bayless	President And CEO	Anne Arundel Medical Center	$6,693,523
Terry Forde	President & CEO,AHC; Board, Secretary	Adventist HealthCare	$6,539,408
Pamela D Paulk	SR VP Human Resources	Johns Hopkins Health System	$5,875,226
John B Chessare MD	Director/CEO GBMC Healthcare	Greater Baltimore Medical Center	$6,446,914
Michael Mont MD	Physician	Sinai Hospital Of Baltimore Inc.	$6,365,101
Flavio W Kruter	Physician	Carroll County General Hospital	$6,015,246

Table 13 includes a list of the 10 highest annual compensation amounts for a single executive over the last five years. Ronald R. Peterson of Johns Hopkins Health System comes in with the highest annual rate, receiving more than $15 million in 2013. Peterson makes the list again with his 2018 compensation of $3.8 million, the ninth highest. Kenneth A. Samet of MedStar makes the list four times, and Robert A. Chrencik of the University of Maryland Medical System makes the list twice. The total for the top 10 compensation rates over the last five years comes to more than $62 million.

Table 13. **Top 10 executive annual salaries, last five years**

Year	Executive	Title	Hospital / Hospital System	Total
2013	Ronald R Peterson	President	Johns Hopkins Health System	$15,385,619
2017	Kenneth A Samet	CEO And President	MedStar Health	$7,751,857
2015	Robert A Chrencik	President and CEO	University of Maryland Medical System	$6,902,166
2018	Kenneth A Samet	CEO And President	MedStar Health	$6,621,128
2016	Kenneth A Samet	CEO And President	MedStar Health	$4,939,105
2015	Kenneth A Samet	CEO And President	MedStar Health	$4,389,929
2018	Karen E Olscamp	President And CEO	University of Maryland Baltimore Washington Medical Center	$4,287,021
2017	Robert A Chrencik	President And CEO	University of Maryland Medical System	$4,265,077
2018	Ronald R Peterson	Trustee	Johns Hopkins Howard County General Hospital	$3,845,705
2014	John Sernulka	President/Ex-Officio	Carrol Hospital Center	$3,687,303

Table 14. **Executive compensation by hospital, last five years combined, top 25**

Hospital name	System	Total Compensation	Number of Annual Payments to Executives	Number of Individual Executives	Number of annual payments over $1 million	Number of annual payments that put executives above the top 1% income threshold in Maryland
Johns Hopkins Hospital	Johns Hopkins Health System	$124,919,403	196	56	35	82
MedStar Union Memorial Hospital	MedStar Health	$87,225,549	90	28	32	58
University of Maryland Medical Center	University of Maryland Medical System	$80,154,293	79	26	21	76
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	$75,318,668	107	34	19	50
MedStar Southern Maryland Hospital Center	MedStar Health	$72,872,613	64	24	20	35
MedStar Good Samaritan Hospital	MedStar Health	$70,259,076	86	27	11	50
Greater Baltimore Medical Center		$64,573,261	113	35	12	53
Sinai Hospital of Baltimore	LifeBridge Health	$63,282,197	69	28	29	53
MedStar Harbor Hospital	MedStar Health	$62,037,197	73	24	9	43
MedStar Franklin Square Medical Center	MedStar Health	$59,615,118	60	20	7	41
MedStar St. Mary's Hospital	MedStar Health	$57,472,375	68	23	7	37
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	$51,722,888	96	34	12	28

Hospital name	System	Total Compensation	Number of Annual Payments to Executives	Number of Individual Executives	Number of annual payments over $1 million	Number of annual payments that put executives above the top 1% income threshold in Maryland
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	$50,739,506	75	34	9	30
University of Maryland Shore Medical Center (1)	University of Maryland Medical System	$50,441,961	96	36	8	27
Carroll Hospital Center	LifeBridge Health	$49,766,303	94	35	11	33
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	$49,559,674	58	22	11	32
Northwest Hospital	LifeBridge Health	$45,488,238	69	21	10	38
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	$45,332,630	59	14	13	22
Peninsula Regional Medical Center		$45,302,065	73	22	6	47
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	$45,245,523	81	32	7	32
MedStar Montgomery Medical Center	MedStar Health	$44,912,119	55	18	5	17
Holy Cross Hospital	Trinity Health	$44,639,989	82	29	9	24
University of Maryland Harford Memorial Hospital	University of Maryland Medical System	$43,311,673	57	17	13	22
Saint Agnes Healthcare	Ascension Healthcare	$41,192,598	58	19	5	47
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	$41,189,736	44	23	13	36

Table 14 highlights the top 25 hospitals in terms of total amount of compensation they paid their executives. The table shows the frequency with which executives received $1 million, and how many are above the threshold of the top 1 percent in income. Johns Hopkins Hospital paid its executives the most in the last five years, paying 56 executives almost $125 million, with 35 payments over $1 million and 82 payments above the top 1 percent income threshold. The hospitals of Johns Hopkins Health System, MedStar Health, and University of Maryland Medical System dominate the top 25. See Appendix 4 for all the hospitals' combined executive compensation for the last five years.

As mentioned above, the hospitals and hospitals systems paid almost $1.66 billion in executive compensation. To put that figure in perspective, in the last five years Maryland hospitals posted $3.56 billion in net income. Executive compensation as a percentage of net income is 46.6 percent, while medical deb at as a percentage of net income is only 4.7 percent.[56] Clearly, executive compensation has a much larger impact on the hospitals' financial health than the amount sought in medical debt lawsuits. Over the last five years, these 1,068 executives could have donated just 7.2 percent of their compensation and the entire amount sought in medical debt lawsuits would have been wiped out.

The highest-paid executive in this report, Ronald R. Peterson of Johns Hopkins Health System, received $15,385,619 in one year. In Baltimore, where Johns Hopkins Health System is located, the median household income for the years during the study was $46,641.[57] It would take 328 years for the median household to match Peterson's one-year compensation. When *The Baltimore Sun* did its series in 2008 on medical debt lawsuits, Peterson was asked about Johns Hopkins Hospital suing patients. He replied: "We could have bad behavior from people who are in that category of deadbeats."[58] These executives benefiting from excessive compensation are the same individuals who oversee and are ultimately accountable for hospital practices on medical debt lawsuits and charity care provisions. As will be seen in the next section, the amount of charity provided in the last five years has declined even as hospitals receive rate payer support to offset the cost of providing charity care. These executives could easily reclassify the medical debt in these lawsuits as charity care with little to no impact on their financial well-being, but such action would provide immediate and lasting relief to their patients.

"Over the last five years, these 1,068 executives could have donated just 7.2 percent of their compensation and the entire amount sought in medical debt lawsuits would have been wiped out."

CHARITY CARE AND MARYLAND'S NOT-FOR-PROFIT HOSPITAL SYSTEMS

The state of Maryland has long required that its not-for-profit hospitals provide free or reduced cost medical care to the poor. Indeed, the enormous tax subsidies these hospitals receive through their nonprofit status is in part based on the benefits that charity care provides to Maryland communities. There is no question financial assistance plays an immensely positive role in sparing the sick or injured from financial ruin. However, many of those who should be benefiting from charity care in Maryland are not. Rather, they are being sued. While the state's not-for-profit hospitals have been filing tens of thousands of lawsuits against their patients who apparently could not afford to pay for needed medical care, those same hospitals have slashed the amount of charity care they provide by hundreds of millions.

In the last five years that data is available, 2014 through 2018, the annual amount of charity care provided by Maryland hospitals has declined by more than a third, falling 36 percent since 2014. Maryland hospitals provided $168 million less in charity care in 2018 than they did in 2014 (not adjusting for inflation). The decline is even more dramatic as a portion of the cost of care provided. As a percentage of operating expenses, charity care sank by almost half, falling more than 46 percent.[59]

Figure 3. **Total Charity Care[60] Provided by Hospitals has Declined 36% in Maryland Since 2014**

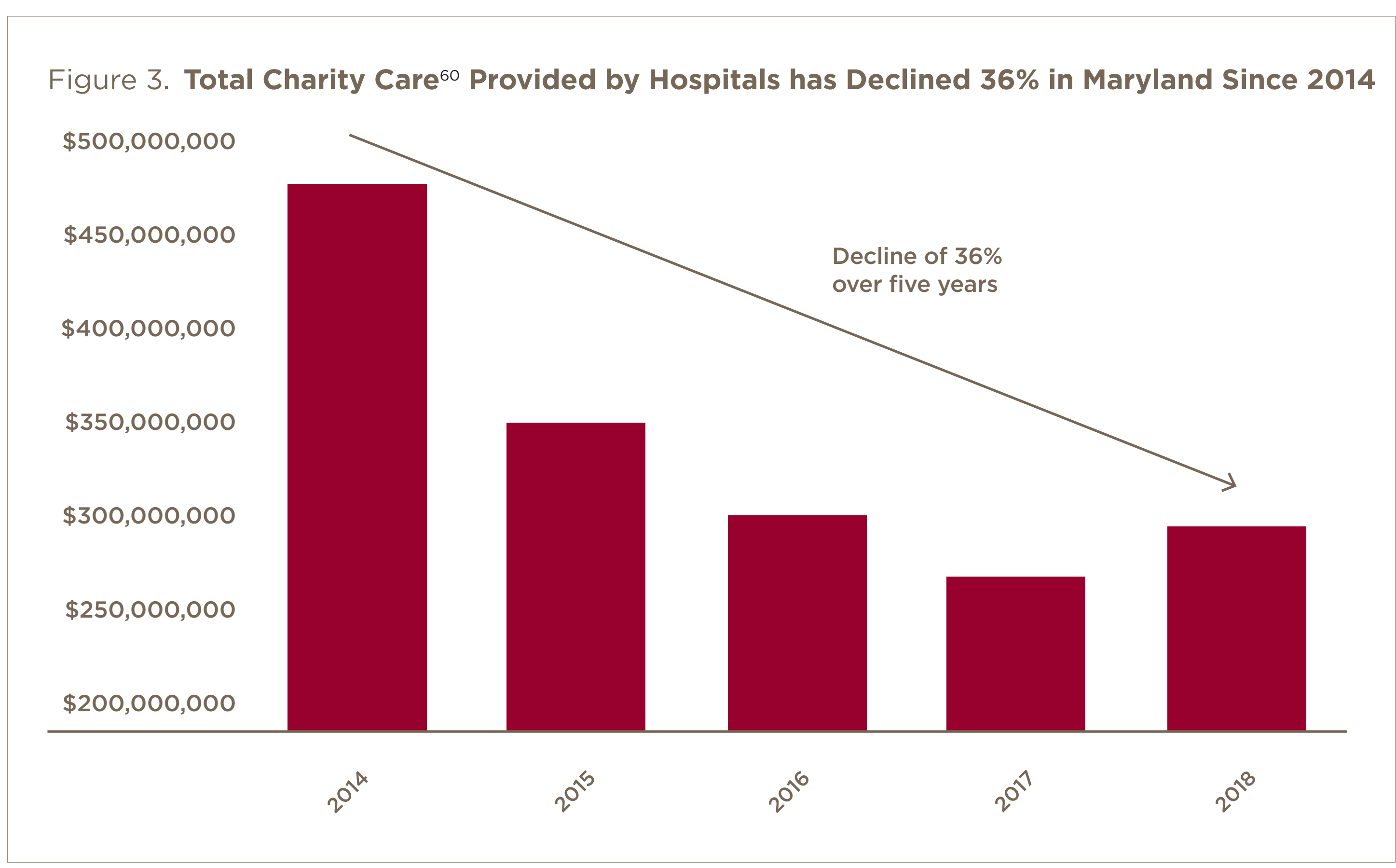


Table 15. **The percentage of charity care for all hospital expenses has declined by more than 46%**

	Charity Care Provided by Maryland Hospitals	Charity Percentage of Operating Expenses (before Rate Support)	Percent Decline in Charity Care Since 2014	Percent Decline of Charity Percentage
2014	$471,234,448	2.9%		
2015	$353,859,199	1.9%		
2016	$310,207,092	1.7%		
2017	$278,681,454	1.4%		
2018	$303,447,428	1.5%		
Total	**$1,717,429,621**	**1.9%**	**35.6%**	**46.1%**

This collapse in the amount and proportion of hospital-provided charity care over the last five years has occurred at the same time as Maryland hospitals sued 72,000 of their patients for more than $119 million in medical debt. Not surprisingly, 17 percent of Maryland residents struggle with medical debt in collections, as do more than one in five Marylanders of color.[61]

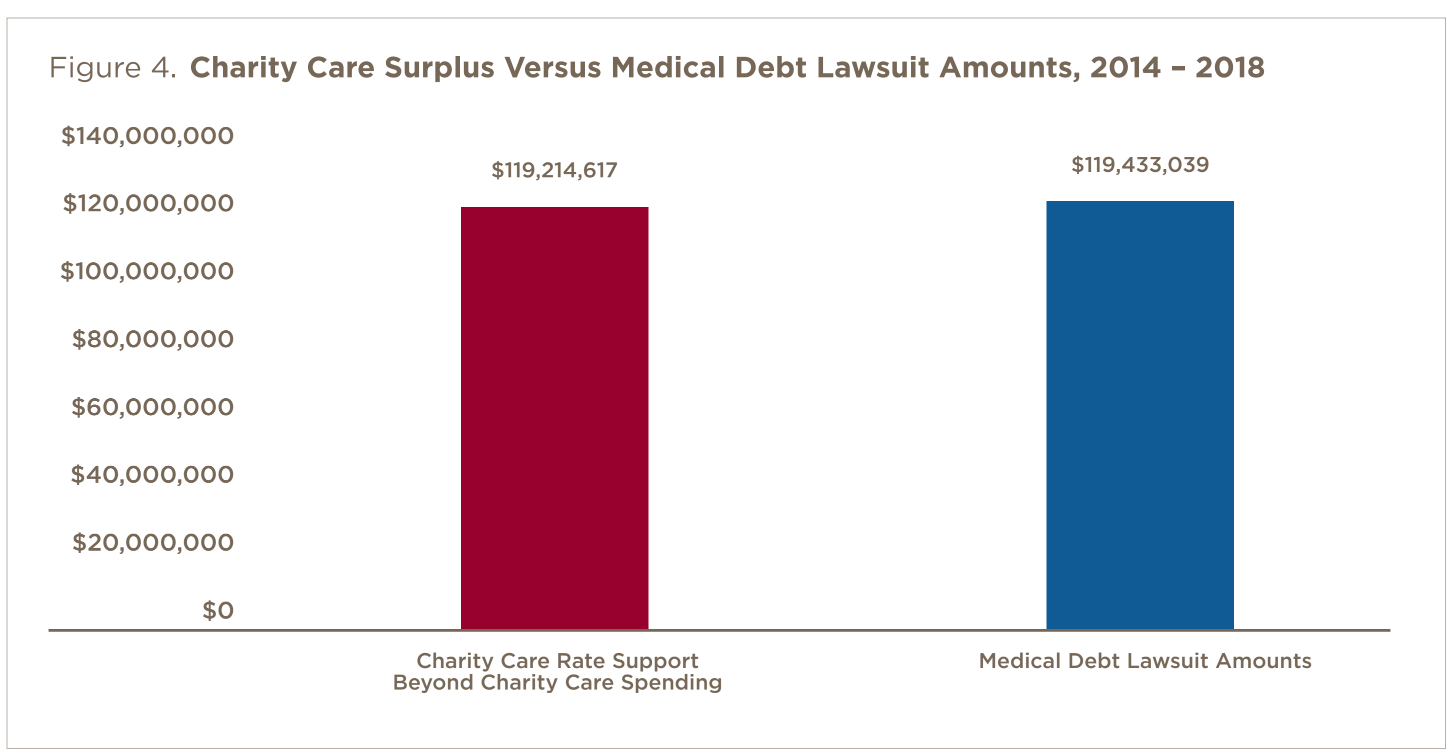
Many of those sued would have qualified for charity care based on their income levels. In our report "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits" and our review of Johns Hopkins Bayview's practice of suing its patients, we found a number of victims of lawsuits with reported incomes below the thresholds required for charity care. In addition, we spoke with a number of individuals sued by Hopkins for medical debt, whose incomes indicated they would qualify for charity at the time of care, but who professed never being informed that the financial assistance program even existed. Finally, the zip codes of those sued by Hopkins were largely concentrated in high-poverty areas, indicating that many of those sued likely struggled with poverty-level incomes.[62]

These issues are even more egregious when we consider that many of the hospitals aggressively suing their patients are experiencing financial windfalls through reducing their levels of charity care. Maryland's all-payer system, which controls the prices hospitals can charge for medical services, subsidizes hospital-provided charity care through "charity care rate support."[63] The rate support is built into the rates or charges allowed by the state and thus increases the rates they can charge, essentially passing the cost of charity care onto all those paying for health care in Maryland.[64] Amazingly, the charity care rate support provided to hospitals over the last five years has exceeded the actual cost of charity care to the hospitals by more than $119 million. That means Maryland hospitals as a whole received an extra $119 million through charity rate support beyond what they spent on charity care; in other words, they received a financial windfall.[65] This amount, coincidentally, is nearly the exact amount of medical debt the hospitals sought to recover through lawsuits over the same period.

Table 16. **Maryland's "all-payer system" provided hospitals with more than $119 million in rate support for charity care beyond what they spent, 2014 – 2018**[66]

	Charity Care Provided by Maryland Hospitals	Charity Care Rate Support Provided to Hospitals by Maryland's "All-Payer System"	Cost of Charity Care to Hospitals After Rate Support	Charity as a percent of hospital Operating Expenses (after Charity Rate Support)
2014	$471,234,448	$463,908,836	$7,325,612	1.6%
2015	$353,859,199	$420,118,812	-$66,259,613	-15.8%
2016	$310,207,092	$343,496,113	-$33,289,021	-9.7%
2017	$278,681,454	$307,579,100	-$28,897,646	-9.4%
2018	$303,447,428	$301,541,376.75	$1,906,051	0.6%
Total	**$1,717,429,621.02**	**$1,836,644,237.82**	**-$119,214,617**	**-6.5%**

Figure 4. **Charity Care Surplus Versus Medical Debt Lawsuit Amounts, 2014 – 2018**



It is important to note that the $119 million windfall from charity care rate support wasn't distributed equally among Maryland's hospitals. Johns Hopkins Hospital alone received more than $36 million in rate support in excess of its charity costs. The top 10 hospitals with the largest charity windfalls were allowed to bring in more than $138 million of rate support in excess of what they spent on charity, while 13 hospitals spent more than $55 million in charity care beyond what they received in rate support. It appears that the largest and most wealthy hospital systems, especially Johns Hopkins, benefit the most from the charity rate support system (See Appendix 5 for the charity care rate support levels for all Maryland hospitals).

Table 17. **Ranking of the top 10 hospitals that benefited the most from charity care rate support, 2014 – 2018**[67]

Hospital name	System	Charity Care Provided — Last Five Years	Charity Care Rate Support Total — Last Five Years	Charity Care Rate Support Surplus*: Last Five Years	Rank: Largest Surplus* of Charity Rate Support
Johns Hopkins Hospital	Johns Hopkins Health System	$133,216,000.00	$169,496,418.64	$36,280,418.64	1
University of Maryland Medical Center	University of Maryland Medical System	$179,526,225.83	$205,952,948.02	$26,426,722.19	2
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	University of Maryland Medical System	$76,647,841.00	$97,139,764.84	$20,491,923.84	3
Adventist Healthcare Washington Adventist Hospital	Adventist HealthCare	$52,505,403.02	$65,357,107.74	$12,851,704.72	4
MedStar Franklin Square Medical Center	MedStar Health	$37,249,257.57	$47,879,563.49	$10,630,305.92	5
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	$87,301,000.00	$94,801,795.32	$7,500,795.32	6
MedStar Union Memorial Hospital	MedStar Health	$32,241,348.44	$39,702,995.84	$7,461,647.40	7
MedStar Harbor Hospital	MedStar Health	$19,488,714.00	$26,788,827.05	$7,300,113.05	8
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	$20,706,967.08	$25,826,620.92	$5,119,653.84	9
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	$19,442,300.00	$23,295,770.26	$3,853,470.26	10

**Rate support received in excess of charity provided.*

Another indication of the anemic charity care programs of many hospitals is made clear by the percent of charity care applications denied. During 2017 and 2018, Maryland hospitals denied charity care applications only about 9.5 percent of the time. A number of hospitals, however, were much more likely to deny charity care at a higher rate. Seven hospitals, including all four Johns Hopkins facilities, denied more than 40 percent of all charity care applications. Sixteen hospitals, including most University of Maryland facilities, rejected more than 25 percent of all charity care requests.

Mt. Washington Pediatric Hospital, the one children's hospital included in our study, rejected more than 24 percent of requests from the families of its young patients for help with their medical bills. Table 18 lists the hospitals with the 20 highest charity care denial rates (See Appendix 6 for denial rates for all Maryland hospitals). It is likely that many of these rejected applicants were in fact eligible for charity care, and that still others had significant financial need even though they did not meet Maryland's current stringent charity care eligibility criteria.[68]

Table 18. **Top 20 charity care denial rates, 2017 – 2018**[69]

Hospital name	System	Licensed Beds	Application for Financial Assistance Received	Application for Financial Assistance Approved	Application for Financial Assistance Denied	Percent Charity Care Denied
Bon Secours Baltimore Health System	Bon Secours Mercy Health	72	705	129	576	81.70%
CalvertHealth Medical Center*		74	366	121	245	66.90%
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	285	886	419	467	52.70%
Adventist Healthcare Washington Adventist Hospital*	Adventist HealthCare	204	1,260	634	626	49.70%
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	455	1,130	579	551	48.80%
Johns Hopkins Hospital	Johns Hopkins Health System	1,154	1,747	928	819	46.90%
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	230	688	374	314	45.60%
Holy Cross Hospital	Trinity Health	449	8,277	4,691	3,586	43.30%
Carroll Hospital Center*	LifeBridge Health	146	338	215	123	36.40%
University of Maryland Shore Medical Center	University of Maryland Medical System	214	1,607	1,045	562	35.00%
Adventist Healthcare Shady Grove Medical Center*	Adventist HealthCare	292	1,602	1,071	531	33.10%
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	University of Maryland Medical System	365	550	375	175	31.80%
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	293	2,160	1,481	679	31.40%
University of Maryland Medical Center	University of Maryland Medical System	751	1,707	1,237	470	27.50%
University of Maryland Rehabilitation & Orthopaedic Institute	University of Maryland Medical System	137	220	161	59	26.80%

Hospital name	System	Licensed Beds	Application for Financial Assistance Received	Application for Financial Assistance Approved	Application for Financial Assistance Denied	Percent Charity Care Denied
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	263	958	711	247	25.80%
Union Hospital*		87	258	193	65	25.20%
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	170	562	422	140	24.90%
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	185	3,971	3,009	962	24.20%
Mt. Washington Pediatric Hospital	University of Maryland Medical System	102	54	41	13	24.10%

**Only one year of data available.*

Perhaps it's not surprising that the charity practices of Maryland hospitals appear insufficient at a time when those hospitals are filing lawsuits against tens of thousands of their patients over medical debt. It is likely that if the hospitals were to effectively implement their charity care programs, the lawsuits would largely be unnecessary as many of those they are suing would likely receive financial assistance.[70] Maryland's rate payers are in fact providing enough funding through charity rate support to cover the medical debts of all those being sued by the hospitals. Clearly, a key element to ending medical debt lawsuits will be increasing the amount of charity care provided by Maryland hospitals.

"Maryland's rate payers are in fact providing enough funding through charity rate support to cover the medical debts of all those being sued by the hospitals. Clearly, a key element to ending medical debt lawsuits will be increasing the amount of charity care provided by Maryland hospitals."

“By using lawsuits to collect medical debt, hospitals may be discouraging working-class and low-income Maryland residents, many from communities of color, from seeking medical care at some facilities… It is bitterly ironic that hospitals, as institutions dedicated to healing, have policies that contribute to patients forgoing needed medical care and services.”

DEMANDS AND POLICY PROPOSALS

The fact that tens of thousands of sick and poor residents of Maryland are being victimized through medical debt lawsuits originating from wealthy and heavily subsidized nonprofit hospitals makes it clear that the state's policies on charity care and medical debt are not working.

To put an end to abusive and unnecessary medical debt lawsuits, we have two demands for Maryland's not-for-profit hospitals:

- All Maryland not-for-profit hospitals suspend currently open and pending medical debt lawsuits for a period of 18 months to allow time for a review and audit of all policies relating to medical debt, collections, charity care, and contracts with attorneys to collect medical debts, including to file medical debt lawsuits.
- Maryland's not-for-profit hospitals should forgive the medical debts of those currently being sued.

To ensure the volume and damage caused by medical debt lawsuits is minimized going forward, we propose the General Assembly enact the following reforms:

- Hospitals must increase who is eligible for free and reduced-cost care under financial assistance policies, including increasing the threshold for free care up to 300 percent of the federal poverty level (FPL) with a sliding scale for patients between 300 and 600 percent of FPL.
- Asset protections for patients with medical debt must be increased — including protecting liquid assets up to $20,000, primary residences, and motor vehicles.
- The public and private enforcement of both financial assistance policy requirements and debt collection requirements must be enhanced.
- Medical debt collection practices must be improved by taking the following steps:
    - Ban hospitals from placing liens on primary residencies or seeking arrest warrants.
    - Ban hospitals from garnishing wages if patient was eligible for free or reduced care costs.
    - Ban medical debt lawsuits for $5,000 or less against all patients and all medical debt lawsuits against those who were uninsured at time of service.
    - Require hospitals to offer income-based repayment plans that have reasonable terms that will allow patients to pay off their medical debt.

Appendix 1. **Medical debt lawsuits by hospital system, 2009 – 2018**

Hospital Systems	Total Lawsuits	Medical Debt Sought by Lawsuits	Median Amount	Total Lawsuits Resulting in Garnishment	Medical Debt Sought by Lawsuits Through Garnishments
Independent Hospitals	51,912	$68,989,042	$699	17,764	$21,529,295
University of Maryland Medical System	25,430	$78,616,705	$1,416	3,527	$10,626,768
Johns Hopkins Health System	21,707	$45,291,898	$1,035	2,308	$4,737,656
MedStar Health	21,375	$36,281,760	$944	6,603	$12,027,797
LifeBridge Health	19,869	$29,486,967	$924	5,976	$8,621,324
Ascension Healthcare	4,138	$6,117,483	$891	1,040	$1,540,617
Trinity Health	1,124	$2,964,239	$1,343	141	$424,142
Adventist HealthCare	191	$963,525	$2,959	11	$43,969
Total	**145,746**	**$268,711,620**	**$944**	**37,370**	**$59,551,567**

Appendix 2. **Medical debt lawsuits by individual hospitals, 2009 – 2018**

Hospital	System	Total Lawsuits	Medical Debt Sought by Lawsuits	Median Amount	Total Lawsuits Resulting in Garnishment	Medical Debt Sought by Lawsuits Through Garnishments
Peninsula Regional Medical Center		21,831	$23,997,895	$491	10,142	$10,313,894
Greater Baltimore Medical Center		16,780	$18,940,601	$716	4,609	$5,608,834
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	13,742	$30,214,414	$895	352	$931,786
Sinai Hospital of Baltimore	LifeBridge Health	11,690	$17,263,061	$907	3,776	$5,464,815
University of Maryland Medical Center	University of Maryland Medical System	9,584	$45,828,278	$2,165	1,330	$5,526,833
University of Maryland Shore Medical Center[71]	University of Maryland Medical System	7,969	$14,959,294	$1,071	138	$247,255
MedStar Franklin Square Medical Center	MedStar Health	6,509	$10,879,817	$923	2,216	$3,950,878
Northwest Hospital	LifeBridge Health	5,278	$6,968,182	$881	1,550	$1,952,778
Mercy Medical Center		5,253	$5,964,312	$864	815	$920,310
Saint Agnes Healthcare	Ascension Healthcare	4,138	$6,117,483	$891	1,040	$1,540,617
MedStar Good Samaritan Hospital	MedStar Health	3,475	$5,650,172	$896	1,317	$2,254,077
MedStar Southern Maryland Hospital Center	MedStar Health	3,335	$6,443,532	$1,042	742	$1,677,445
MedStar Union Memorial Hospital	MedStar Health	3,036	$5,472,868	$957	1,028	$1,847,083
Johns Hopkins Hospital	Johns Hopkins Health System	2,967	$5,965,398	$1,409	673	$1,321,817
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	2,560	$5,089,385	$1,174	698	$1,466,303
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital[72]	University of Maryland Medical System	2,543	$6,230,184	$1,685	1,274	$3,221,097
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	2,406	$3,915,411	$1,016	580	$1,004,816

Hospital	System	Total Lawsuits	Medical Debt Sought by Lawsuits	Median Amount	Total Lawsuits Resulting in Garnishment	Medical Debt Sought by Lawsuits Through Garnishments
MedStar Harbor Hospital	MedStar Health	2,397	$3,801,081	$943	861	$1,422,687
Carroll Hospital Center	LifeBridge Health	2,373	$4,554,230	$1,113	332	$747,215
Meritus Medical Center		2,353	$7,140,184	$1,621	781	$1,863,509
University of Maryland Charles Regional Medical Center	University of Maryland Medical System	2,328	$3,223,313	$922	257	$457,338
Atlantic General Hospital		2,064	$2,112,079	$509	658	$713,308
MedStar St. Mary's Hospital	MedStar Health	1,613	$1,668,591	$722	263	$448,220
CalvertHealth Medical Center		1,422	$2,238,242	$914	216	$363,049
Anne Arundel Medical Center		1,193	$6,771,593	$3,899	216	$1,240,010
Holy Cross Hospital	Trinity Health	1,124	$2,964,239	$1,343	141	$424,142
MedStar Montgomery Medical Center	MedStar Health	860	$2,191,961	$1,321	173	$425,635
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	848	$1,596,844	$1,027	313	$580,064
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	785	$2,002,840	$1,527	90	$222,126
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	664	$1,629,843	$1,290	32	$65,399
University of Maryland Rehabilitation & Orthopaedic Institute	University of Maryland Medical System	600	$2,619,831	$1,650	84	$247,706
LifeBridge Health (only system info reported)	LifeBridge Health	528	$701,493	$910	318	$456,516
Union Hospital		489	$814,579	$1,006	141	$215,576
Fort Washington Medical Center		246	$511,223	$1,054	104	$171,854
Adventist HealthCare (only system info reported)	Adventist HealthCare	157	$792,683	$2,617	1	$4,347

Hospital	System	Total Lawsuits	Medical Debt Sought by Lawsuits	Median Amount	Total Lawsuits Resulting in Garnishment	Medical Debt Sought by Lawsuits Through Garnishments
MedStar Health (only system info reported)	MedStar Health	150	$173,739	$570	3	$1,773
Doctors Community Hospital		104	$222,233	$682	3	$60,297
McCready Health		92	$19,194	$133	67	$14,938
Frederick Regional Health System		81	$239,048	$1,212	12	$43,716
University of Maryland Medical System (only system info reported)	University of Maryland Medical System	47	$261,264	$1,954	3	$6,864
Mt. Washington Pediatric Hospital	University of Maryland Medical System	39	$39,468	$700	2	$1,161
Johns Hopkins Health System (only system info reported)	Johns Hopkins Health System	32	$107,290	$1,873	5	$12,934
Adventist Healthcare Washington Adventist Hospital	Adventist HealthCare	21	$112,550	$3,794	5	$15,479
University of Maryland Harford Memorial Hospital	University of Maryland Medical System	16	$123,694	$2,558	1	$15,150
Adventist Healthcare Shady Grove Medical Center	Adventist HealthCare	13	$58,292	$3,674	5	$24,142
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	7	$101,852	$15,005	3	$35,776
Garrett Regional Medical Center		4	$17,858	$2,863	0	0
Bon Secours Baltimore Health System	Bon Secours Mercy Health	0	0	0	0	0
Holy Cross Germantown Hospital	Trinity Health	0	0	0	0	0

Appendix 3. **The Merry Millionaires of Maryland — Hospital executives paid more than $1 million for a given year in compensation, last five years**

Year	Executive	Title	Hospital / Hospital System	Total
2013	Ronald R Peterson	President	Johns Hopkins Health System	$15,385,619
2017	Kenneth A Samet	CEO And President	MedStar Health	$7,751,857
2015	Robert A Chrencik	President and CEO	University of Maryland Medical System	$6,902,166
2018	Kenneth A Samet	CEO And President	MedStar Health	$6,621,128
2016	Kenneth A Samet	CEO And President	MedStar Health	$4,939,105
2015	Kenneth A Samet	CEO And President	MedStar Health	$4,389,929
2018	Karen E Olscamp	President And CEO	University of Maryland Baltimore Washington Medical Center	$4,287,021
2017	Robert A Chrencik	President And CEO	University of Maryland Medical System	$4,265,077
2018	Ronald R Peterson	Trustee	Johns Hopkins Howard County General Hospital	$3,845,705
2014	John Sernulka	President/Ex-Officio	Carrol Hospital Center	$3,687,303
2014	Kedrick Adkins	Former Key Employee	Holy Cross Hospital	$3,547,825
2018	Michael J Curran	EVP & Chief Administrative Officer	MedStar Health	$3,510,136
2014	Ronald R Peterson	President	Johns Hopkins Health System	$3,399,523
2014	Kenneth A Samet	CEO & President	MedStar Health	$3,395,806
2013	Brian A Gragnolati	SR VP Community Division	Johns Hopkins Health System	$3,366,956
2016	Joy Drass	EVP	MedStar Health	$3,237,820
2017	Michael J Curran	EVP & CFO	MedStar Health	$3,193,284
2018	Ronald R Peterson	Trustee/Vice Chairman	Johns Hopkins Hospital	$3,154,877
2017	Ronald J Werthman	Former Officer	Johns Hopkins Health System	$3,002,347
2016	Ronald R Peterson	President	Johns Hopkins Health System	$2,988,093
2018	Philip B Down	CEO	Doctors Community Hospital	$2,949,631
2016	Michael J Curran	EVP, CFO & Treasurer	MedStar Health	$2,913,696
2017	Ronald R Peterson	President/Trustee	Johns Hopkins Health System	$2,765,436
2016	James Xinis	Former President and CEO	CalvertHealth Medical Center	$2,716,296

Year	Executive	Title	Hospital / Hospital System	Total
2018	Joy Drass	EVP	MedStar Health	$2,695,899
2018	Robert A Chrencik	President And CEO - UMMS	University of Maryland Medical System	$2,615,047
2015	Ronald R Peterson	President	Johns Hopkins Health System	$2,614,246
2018	Ronald J Werthman	Trustee	Johns Hopkins Hospital	$2,599,878
2015	Michael J Curran	EVP & CFO	MedStar Health	$2,595,452
2016	Robert A Chrencik	President And CEO	University of Maryland Medical System	$2,586,434
2018	Mohanakumar Suntharalingam	President And CEO, UMMC	University of Maryland Medical System	$2,583,701
2015	Michael J Curran	Director	Medstar Southern Maryland Hospital Center	$2,565,690
2017	Joy Drass	EVP	MedStar Health	$2,522,145
2013	Robert A Chrencik	UMMS Representative	University of Maryland Medical Center Midtown Campus	$2,409,034
2016	Ronald J Werthman	Senior VP/Finance & Treas.	Johns Hopkins Health System	$2,263,454
2018	Alfred A Pietsch	SVP And CFO	University of Maryland Baltimore Washington Medical Center	$2,225,230
2016	Neil M Meltzer	President/CEO	Lifebridge	$2,156,308
2018	Neil M Meltzer	President/CEO	Lifebridge	$2,108,834
2016	John B Chessare MD	President/CEO	Greater Baltimore Medical Center	$2,107,221
2013	Thomas Mullen	Chair, Ex Officio	Mercy Medical Center	$2,098,952
2016	Bonnie L Phipps	SVP-Ah Group Operating Exec	Saint Agnes Healthcare	$2,020,096
2014	Michael Mont MD	Physician	Sinai Hospital Of Baltimore Inc.	$2,008,830
2017	Philip B Down	CEO	Doctors Community Hospital	$1,992,011
2014	Robert A Chrencik	President And CEO	University of Maryland Medical System	$1,982,580
2017	Bonnie L Phipps	Former Officer	Saint Agnes Healthcare	$1,939,678
2015	Joy Drass	EVP	MedStar Health	$1,912,701
2016	Jeffrey A Rivest	President & CEO - UMMC	University of Maryland Medical System	$1,893,806
2015	Judy A Reitz	VP/Operations Integration	Johns Hopkins Health System	$1,892,164
2018	Stephen Evans	EVP	MedStar Health	$1,889,129
2014	Michael J Curran	EVP & CFO	MedStar Health	$1,873,065
2015	Neil M Meltzer	President/CEO	Lifebridge	$1,859,612

Year	Executive	Title	Hospital / Hospital System	Total
2017	Terry Forde	President & CEO,AHC; Board, Secretary	Adventist HealthCare	$1,857,380
2015	John Sernulka	President/Ex-Officio	Carrol Hospital Center	$1,857,187
2014	Judy A Reitz	VP/Operations Integration	Johns Hopkins Health System	$1,857,109
2014	Glenn F Robbins	SVP & CMO	University of Maryland Medical System	$1,855,447
2017	Lyle E Sheldon	President/Director/ CEO-UMUCHS	University of Maryland Harford Memorial Hospital	$1,854,667
2018	Walter Ettinger	SVP & CMO UMMS	University of Maryland Medical System	$1,849,760
2014	Bonnie L Phipps	President	Saint Agnes Healthcare	$1,834,467
2015	Bonnie L Phipps	President	Saint Agnes Healthcare	$1,831,024
2014	J Richard O'Connell	Trustee/EVP & President West/ Midwest	Holy Cross Hospital	$1,819,059
2013	Judy A Reitz	VP/Operations Integration	Johns Hopkins Health System	$1,806,450
2017	Neil M Meltzer	President/CEO	Lifebridge	$1,803,225
2015	J Richard O'Connell	Director, EVP, East Group	Holy Cross Hospital	$1,802,979
2017	Stephen Evans	EVP	MedStar Health	$1,781,036
2017	Henry J Franey	CFO- UMMS/ Treasurer	University of Maryland Medical System	$1,778,844
2016	Philip B Down	CEO	Doctors Community Hospital	$1,778,534
2016	Judy A Reitz	VP/Operations Integration	Johns Hopkins Health System	$1,759,070
2018	Eric Wagner	EVP	MedStar Health	$1,715,479
2015	Michael Mont MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,707,175
2014	Joy Drass	EVP	MedStar Health	$1,655,277
2016	Michael Mont MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,628,695
2015	Joanne E Pollak	SR VP, HIPAA & Internal Audit	Johns Hopkins Health System	$1,615,829
2017	Eric Wagner	EVP	MedStar Health	$1,609,675
2018	Pamela D Paulk	Former Officer	Johns Hopkins Hospital	$1,606,148
2015	Philip B Down	CEO	Doctors Community Hospital	$1,593,104
2014	Joanne E Pollak	SR VP, HIPAA & Internal Audit	Johns Hopkins Health System	$1,589,160
2016	Joanne E Pollak	SR VP, HIPAA & Internal Audit	Johns Hopkins Health System	$1,557,407

Year	Executive	Title	Hospital / Hospital System	Total
2017	Pamela D Paulk	Former Officer	Johns Hopkins Health System	$1,554,192
2014	Warren Green	President/CEO/ Director	Lifebridge	$1,545,628
2015	Ronald J Werthman	Senior VP/Finance & Treas.	Johns Hopkins Health System	$1,538,166
2015	Steven Thompson	Executive	Johns Hopkins Health System	$1,537,105
2018	Robert Peroutka MD	Physician	MedStar Good Samaritan Hospital	$1,536,052
2018	Sheldon Stein	President and CEO	Mt. Washington Pediatric Hospital	$1,530,916
2016	Stephen Evans	EVP	MedStar Health	$1,530,828
2018	Henry J Franey	EVP, CFO And Treasurer	University of Maryland Medical System	$1,525,530
2014	Ronald J Werthman	Senior VP/Finance & Treas.	Johns Hopkins Health System	$1,523,621
2018	Samuel Ross MD	CEO	Bon Secours Baltimore Health System	$1,500,546
2014	Joseph Swedish	Former Key Employee	Holy Cross Hospital	$1,492,883
2014	Kenneth S Lewis MD JD	President/CEO	Union Hospital	$1,477,514
2018	Flavio W Kruter	Physician	Carrol Hospital Center	$1,475,065
2016	Eric Wagner	EVP	MedStar Health	$1,469,793
2014	Brian A Gragnolati	SR VP Community Division	Johns Hopkins Health System	$1,469,595
2017	Victoria Bayless	President And CEO	Anne Arundel Medical Center	$1,465,191
2014	Philip B Down	CEO	Doctors Community Hospital	$1,461,210
2018	Victoria Bayless	President And CEO	Anne Arundel Medical Center	$1,458,110
2015	Thomas Mullen	Chair, Ex Officio	Mercy Medical Center	$1,458,048
2015	Eric Wagner	EVP	MedStar Health	$1,453,230
2016	Terry Forde	President & CEO, AHC	Adventist HealthCare	$1,452,032
2015	Reginald J Davis MD	Med Director/ Physician	Greater Baltimore Medical Center	$1,451,012
2014	Margaret Naleppa	President/CEO	Peninsula Regional Medical Center	$1,446,721
2015	Terry Forde	President & CEO, AHC	Adventist HealthCare	$1,444,501
2014	Eric Wagner	EVP	MedStar Health	$1,441,215
2017	Thomas Mullen	Chair, Ex Officio	Mercy Medical Center	$1,440,938
2016	Pamela D Paulk	Former Officer	Johns Hopkins Health System	$1,434,818

Year	Executive	Title	Hospital / Hospital System	Total
2017	Mohanakumar Suntharalingam	President & CEO, UMMC	University of Maryland Medical System	$1,433,238
2014	Reginald J Davis MD	Med Director/ Physician	Greater Baltimore Medical Center	$1,417,239
2017	Flavio W Kruter	Physician	Carrol Hospital Center	$1,409,717
2016	Mohanakumar Suntharalingam	President & CEO	University of Maryland St. Joseph Medical Center	$1,399,884
2013	Joanne E Pollak	SR VP & VP HIPAA	Johns Hopkins Health System	$1,385,769
2018	David Krajewski	Executive VP/CFO	Lifebridge	$1,385,664
2016	Frank Ebert MD	Physician	Medstar Union Memorial Hospital	$1,377,918
2018	Victor A Khouzami MD	Chair/Physician	Greater Baltimore Medical Center	$1,377,530
2018	Paul Mcafee	Physician	University of Maryland St. Joseph Medical Center	$1,360,681
2016	Henry J Franey	CFO- UMMS/ Treasurer	University of Maryland Medical System	$1,359,099
2018	G Daniel Shealer Jr	Trustee	Johns Hopkins Howard County General Hospital	$1,350,232
2014	John Wang MD	Physician	Medstar Union Memorial Hospital	$1,346,383
2014	Frank Ebert MD	Physician	Medstar Union Memorial Hospital	$1,346,079
2016	W Bradford Carter MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,344,903
2018	Oliver M Johnson II	EVP	MedStar Health	$1,342,604
2017	Thomas A Kleinhanzl	President And CEO	Frederick Regional Health System	$1,338,254
2018	Frank Ebert MD	Physician	Medstar Union Memorial Hospital	$1,335,991
2014	Neil M Meltzer	President/CEO/ Director	Lifebridge	$1,329,781
2017	Frank Ebert MD	Physician	Medstar Union Memorial Hospital	$1,327,716
2015	Frank Ebert MD	Physician	Medstar Union Memorial Hospital	$1,325,836
2017	Robert Kasdin	Executive	Johns Hopkins Health System	$1,308,633
2018	Amy Perry	Former Executive Vice President	Lifebridge	$1,306,612
2016	Thomas Mullen	Chair, Ex Officio	Mercy Medical Center	$1,302,198
2015	Brian A Gragnolati	SR VP Community Division	Johns Hopkins Health System	$1,301,576
2017	Joanne E Pollak	SR VP, HIPAA & Internal Audit	Johns Hopkins Health System	$1,299,425

Year	Executive	Title	Hospital / Hospital System	Total
2016	Victoria Bayless	President and CEO	Anne Arundel Medical Center	$1,297,144
2018	Lyle E Sheldon	President/Director/ CEO-UMUCHS	University of Maryland Harford Memorial Hospital	$1,294,133
2015	Victoria Bayless	President	Anne Arundel Medical Center	$1,293,424
2018	Neal Naff	Physician	Lifebridge	$1,291,464
2018	Brian White	Executive Vice President	Lifebridge	$1,289,264
2015	Carl Schindelar	EVP	MedStar Health	$1,288,730
2017	Christine Wray	President/Director	Medstar Southern Maryland Hospital Center	$1,287,941
2017	James Nace Do	Physician	Sinai Hospital Of Baltimore Inc.	$1,283,144
2013	Ronald J Werthman	Senior VP/Finance & Treasurer	Johns Hopkins Health System	$1,280,879
2015	Stephen Evans	EVP	MedStar Health	$1,266,404
2014	Lyle E Sheldon	Presidet/CEO/ Director	University of Maryland Upper Chesapeake Medical Center	$1,266,350
2015	Lyle E Sheldon	President/Director/ CEO-UMUCHS	University of Maryland Harford Memorial Hospital	$1,266,350
2016	Kenneth S Lewis MD JD	President & CEO	Union Hospital	$1,261,082
2017	Oliver M Johnson II	EVP	MedStar Health	$1,249,301
2016	Samuel Ross MD	CEO	Bon Secours Baltimore Health System	$1,249,241
2018	David Dalury	Physician	University of Maryland St. Joseph Medical Center	$1,236,767
2015	Henry J Franey	CFO- UMMS/ Treasurer	University of Maryland Medical System	$1,235,463
2017	Amy Perry	Executive Vice President	Lifebridge	$1,234,209
2018	Christine Wray	President/Director	Medstar Southern Maryland Hospital Center	$1,233,430
2018	Margaret Naleppa	President/CEO	Peninsula Regional Medical Center	$1,228,850
2016	Martin Doordan	Former CEO	Anne Arundel Medical Center	$1,228,849
2014	Clifford Solomon	Physician	University of Maryland Baltimore Washington Medical Center	$1,227,309
2018	Bruce Wolock	Physician	University of Maryland St. Joseph Medical Center	$1,221,957
2018	John B Chessare MD	Director/CEO GBMC Healthcare	Greater Baltimore Medical Center	$1,219,810
2016	Henry Boucher MD	Physician	Medstar Union Memorial Hospital	$1,209,639

Year	Executive	Title	Hospital / Hospital System	Total
2018	Bradley Chambers	President/Director	Medstar Union Memorial Hospital	$1,209,059
2018	P Justin Tortolani MD	Director	Medstar Union Memorial Hospital	$1,208,709
2018	Zeena Dorai	Director	Medstar Union Memorial Hospital	$1,206,732
2013	William G Robertson	Secretary, President & CEO Of AHC	Adventist HealthCare	$1,206,297
2013	Sally W MacConnell	VP/Faculties	Johns Hopkins Health System	$1,200,547
2017	Ronald Delanois MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,199,908
2018	Mark R Katlic MD	Director	Sinai Hospital Of Baltimore Inc.	$1,197,642
2018	Leigh Ann Curl MD	Director	Medstar Harbor Hospital	$1,197,557
2015	Randy Davis	Physician/Former Director	University of Maryland Baltimore Washington Medical Center	$1,197,522
2015	Jeffrey A Rivest	President & CEO - UMMC	University of Maryland Medical System	$1,194,167
2015	G Daniel Shealer Jr	VP/General Counsel & Corp	Johns Hopkins Health System	$1,190,848
2014	Randy Davis	Physician/Former Director	University of Maryland Baltimore Washington Medical Center	$1,188,368
2016	Lyle E Sheldon	President/Director/ CEO-UMUCHS	University of Maryland Upper Chesapeake Medical Center	$1,187,849
2018	Barry P Ronan	President/CEO	Western Maryland Regional Medical Center	$1,187,491
2014	Ronald Delanois MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,187,031
2014	Mr Keith R Poisson	EVP & COO	Greater Baltimore Medical Center	$1,186,463
2018	Henry Boucher MD	Physician	Medstar Union Memorial Hospital	$1,181,234
2014	Victoria Bayless	President	Anne Arundel Medical Center	$1,179,654
2014	Henry Boucher MD	Physician	Medstar Union Memorial Hospital	$1,174,616
2018	Marcus Shipley	Director; Trinity Health SVP	Holy Cross Hospital	$1,173,668
2016	Richard O Davis PhD	Former Officer	Johns Hopkins Health System	$1,171,021
2018	Redonda G Miller MD	President	Johns Hopkins Hospital	$1,169,796
2014	Richard O Davis PhD	Former Officer	Johns Hopkins Health System	$1,169,250
2018	Anand Murthi MD	Medical Director	Medstar Union Memorial Hospital	$1,168,234

Year	Executive	Title	Hospital / Hospital System	Total
2016	Paul Tortolani MD	Director	Medstar Union Memorial Hospital	$1,166,682
2017	Bradley Chambers	President/Director	Medstar Union Memorial Hospital	$1,162,203
2016	Fouad Abbas MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,162,154
2016	Bimal G Rami MD	Med Director/ Physician	Greater Baltimore Medical Center	$1,160,438
2016	Anand Murthi MD	Medical Director	Medstar Union Memorial Hospital	$1,157,801
2018	Bimal G Rami MD	Med Director/ Physician	Greater Baltimore Medical Center	$1,156,880
2016	Leslie Matthews	Medical Director, Orthopedics	Medstar Union Memorial Hospital	$1,154,653
2016	Oliver M Johnson II	EVP & Secretary	MedStar Health	$1,153,075
2015	Joseph P Ross	President & CEO	Meritus Medical Center	$1,152,629
2015	Richard O Davis PhD	Former Officer	Johns Hopkins Health System	$1,150,361
2016	G Daniel Shealer Jr	VP/General Counsel & Corp	Johns Hopkins Health System	$1,148,830
2017	Barry P Ronan	President/CEO	Western Maryland Regional Medical Center	$1,145,287
2017	John W Ashworth III	SVP Network Development	University of Maryland Medical System	$1,142,293
2017	Henry Boucher MD	Physician	Medstar Union Memorial Hospital	$1,141,368
2015	Ronald Delanois MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,139,970
2017	Margaret Naleppa	President/CEO	Peninsula Regional Medical Center	$1,135,935
2018	James Nace Do	Physician	Sinai Hospital Of Baltimore Inc.	$1,135,914
2014	Jeffrey A Rivest	President & CEO - UMMC	University of Maryland Medical System	$1,135,753
2017	Brian White	Senior Vice President	Lifebridge	$1,135,582
2018	Susan Nelson	EVP & CFO	MedStar Health	$1,133,804
2017	Anand Murthi MD	Medical Director	Medstar Union Memorial Hospital	$1,133,139
2017	Joseph P Ross	President & CEO	Meritus Medical Center	$1,127,507
2014	Michael J Chiaramonte	President/Director	Medstar Southern Maryland Hospital Center	$1,126,054
2014	Kevin Sexton	Trustee; Pres & CEO Maryland Region	Holy Cross Hospital	$1,121,861
2014	Fouad Abbas MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,118,837

Year	Executive	Title	Hospital / Hospital System	Total
2017	Dennis W Pullin	President/Director	Medstar Harbor Hospital	$1,115,057
2014	Carl Schindelar	EVP	MedStar Health	$1,105,187
2015	Pamela D Paulk	SR VP Human Resources	Johns Hopkins Health System	$1,104,199
2016	Margaret Naleppa	President/CEO	Peninsula Regional Medical Center	$1,103,839
2016	Walid El Ayass MD	Physician	Peninsula Regional Medical Center	$1,101,187
2016	Thomas A Kleinhanzl	President And CEO	Frederick Regional Health System	$1,100,632
2018	Ronald Delanois MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,092,558
2017	Judy A Reitz	Former Officer	Johns Hopkins Health System	$1,089,845
2018	Keith D Persinger	SVP And Chief Perform. Off.	University of Maryland Medical System	$1,089,528
2018	Samuel Moskowitz	President/Director	Medstar Franklin Square Medical Ctr	$1,089,245
2018	Fouad Abbas MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,087,589
2016	Jason Stein	Physician	Medstar Union Memorial Hospital	$1,085,552
2014	Flavio W Kruter	Physician	Carrol Hospital Center	$1,082,931
2015	John B Chessare MD	President/CEO	Greater Baltimore Medical Center	$1,082,711
2014	G Daniel Shealer Jr	VP/General Counsel & Corp	Johns Hopkins Health System	$1,081,851
2018	Brian Mulliken	Physician	University of Maryland St. Joseph Medical Center	$1,079,608
2015	Jonathan E Gottlieb	SVP & CMO	University of Maryland Medical System	$1,078,285
2014	Mr John W Ellis	Sr. VP Strategy & Bus Dev	Greater Baltimore Medical Center	$1,077,910
2018	Ali Tabrizchi	Cardiologist	Sinai Hospital Of Baltimore Inc.	$1,072,686
2015	Kenneth S Lewis MD JD	President/CEO	Union Hospital	$1,072,592
2015	Kedrick Adkins	Former Key Employee	Holy Cross Hospital	$1,071,050
2017	Samuel Moskowitz	President/Director	Medstar Franklin Square Medical Ctr	$1,069,603
2015	Margaret Naleppa	President/CEO	Peninsula Regional Medical Center	$1,068,988
2018	Jeffrey A Matton	VP	MedStar Health	$1,067,964
2015	Oliver M Johnson II	EVP	MedStar Health	$1,067,184
2017	P Justin Tortolani MD	Director	Medstar Union Memorial Hospital	$1,065,837

Year	Executive	Title	Hospital / Hospital System	Total
2016	Amy Perry	Executive Vice President	Lifebridge	$1,065,524
2016	James Nace Do	Physician	Sinai Hospital Of Baltimore Inc.	$1,065,015
2015	Kevin Sexton	Director, Pres & CEO Maryland Region	Holy Cross Hospital	$1,064,264
2016	Leigh Ann Curl MD	Director	Medstar Harbor Hospital	$1,063,953
2016	Kenneth Lewis	Executive - Union Of Cecil	University of Maryland Medical System	$1,063,128
2016	Sally W MacConnell	SR Vice President Facilities	Johns Hopkins Health System	$1,063,088
2018	G Daniel Shealer Jr	VP & Gen Counsel, VP Corp	Johns Hopkins Hospital	$1,060,830
2016	Bradley Chambers	President/Director	MedStar Good Samaritan Hospital	$1,058,264
2018	Neil Moore	President And CEO	University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	$1,058,087
2017	Samuel Ross MD	CEO	Bon Secours Baltimore Health System	$1,055,478
2017	John B Chessare MD	President/CEO	Greater Baltimore Medical Center	$1,050,496
2017	Bimal G Rami MD	Med Director/ Physician	Greater Baltimore Medical Center	$1,048,974
2015	Leonid Selya	MD	Doctors Community Hospital	$1,048,573
2015	Nora Triola Rn PhD	Director At /, Trinity EVP & CNO	Holy Cross Hospital	$1,047,326
2018	Joseph P Ross	President & CEO	Meritus Medical Center	$1,046,594
2015	Sally W MacConnell	Vice President Facilities	Johns Hopkins Health System	$1,046,141
2016	Carl Schindelar	EVP	MedStar Health	$1,044,849
2016	Farhan Majeed	Physician	University of Maryland St. Joseph Medical Center	$1,044,144
2017	Jeffrey A Matton	VP	MedStar Health	$1,043,930
2016	Flavio W Kruter	Physician	Carrol Hospital Center	$1,043,823
2014	Henry J Franey	CFO- UMMS/ Treasurer	University of Maryland Medical System	$1,042,562
2014	Richard North MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,039,799
2018	Daniel B Smith	VP Finance & CFO	Johns Hopkins Hospital	$1,039,241
2014	Anand Murthi MD	Medical Director	Medstar Union Memorial Hospital	$1,038,648
2017	Leigh Ann Curl MD	Director	Medstar Harbor Hospital	$1,034,001

Year	Executive	Title	Hospital / Hospital System	Total
2017	Fouad Abbas MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,033,554
2017	Richard O Davis PhD	Former Officer	Johns Hopkins Health System	$1,029,932
2018	George T Grace MD	Medical Director, Reconstructive Surgery	Saint Agnes Healthcare	$1,025,206
2017	Leonid Selya	MD	Doctors Community Hospital	$1,022,007
2017	Kenneth Kozel	President/CEO	University of Maryland Shore Medical Center	$1,021,641
2016	Patricia Mc Brown Esquire	Executive	Johns Hopkins Health System	$1,021,373
2017	G Daniel Shealer Jr	VP/General Counsel & Corp Co	Johns Hopkins Health System	$1,020,446
2017	Michael Mont MD	Physician	Sinai Hospital Of Baltimore Inc.	$1,020,401
2014	Terry Forde	President & CEO	Adventist HealthCare	$1,019,222
2017	John Wang MD	Chief Of Cardiac Cath Lab	Medstar Union Memorial Hospital	$1,018,466
2015	John Wang MD	Physician	Medstar Union Memorial Hospital	$1,017,999
2018	Sherry Perkins	EVP and COO	University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	$1,017,308
2018	John Wang MD	Chief Of Cardiac Cath Lab	Medstar Union Memorial Hospital	$1,016,165
2017	John Sackett	EVP/COO, AHC; President, SGMC & BH&Ws	Adventist HealthCare	$1,013,334
2018	Michael Dabbah	Physician	University of Maryland St. Joseph Medical Center	$1,010,069
2017	Robert Saltzman MD	Physician	Northwest Hospital Center	$1,005,245
2016	Leonid Selya	MD	Doctors Community Hospital	$1,005,234
2015	Flavio W Kruter	Physician	Carrol Hospital Center	$1,003,710
2015	Anand Murthi MD	Medical Director	Medstar Union Memorial Hospital	$1,002,659
2017	Alae Zarif MD	Chief Of Staff, Ex-Officio	Atlantic General Hospital	$1,000,284

Appendix 4. **Total executive compensation by hospital, last five years combined**

Hospital name	System	Total Executives Compensation	Number of Annual Payments to Executives	Number of Individual Executives	Number of annual payments over $1 million	Number of annual payments that put executives above the top 1% income threshold in Maryland
Johns Hopkins Hospital	Johns Hopkins Health System	$124,919,403	196	56	35	82
MedStar Union Memorial Hospital	MedStar Health	$87,225,549	90	28	32	58
University of Maryland Medical Center	University of Maryland Medical System	$80,154,293	79	26	21	76
University of Maryland Shore Medical Center	University of Maryland Medical System	$50,441,961	96	36	8	27
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	$75,318,668	107	34	19	50
MedStar Southern Maryland Hospital Center	MedStar Health	$72,872,613	64	24	20	35
MedStar Good Samaritan Hospital	MedStar Health	$70,259,076	86	27	11	50
Greater Baltimore Medical Center		$64,573,261	113	35	12	53
Sinai Hospital of Baltimore	LifeBridge Health	$63,282,197	69	28	29	53
MedStar Harbor Hospital	MedStar Health	$62,037,197	73	24	9	43
MedStar Franklin Square Medical Center	MedStar Health	$59,615,118	60	20	7	41
MedStar St. Mary's Hospital	MedStar Health	$57,472,375	68	23	7	37
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	$51,722,888	96	34	12	28
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	$50,739,506	75	34	9	30
Carroll Hospital Center	LifeBridge Health	$49,766,303	94	35	11	33

Hospital name	System	Total Executives Compensation	Number of Annual Payments to Executives	Number of Individual Executives	Number of annual payments over $1 million	Number of annual payments that put executives above the top 1% income threshold in Maryland
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	$49,559,674	58	22	11	32
Northwest Hospital	LifeBridge Health	$45,488,238	69	21	10	38
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	$45,332,630	59	14	13	22
Peninsula Regional Medical Center		$45,302,065	73	22	6	47
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	$45,245,523	81	32	7	32
MedStar Montgomery Medical Center	MedStar Health	$44,912,119	55	18	5	17
Holy Cross Hospital	Trinity Health	$44,639,989	82	29	9	24
University of Maryland Harford Memorial Hospital	University of Maryland Medical System	$43,311,673	57	17	13	22
Saint Agnes Healthcare	Ascension Healthcare	$41,192,598	58	19	5	47
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	$41,189,736	44	23	13	36
Anne Arundel Medical Center		$38,344,716	66	19	6	42
University of Maryland Charles Regional Medical Center	University of Maryland Medical System	$38,300,966	62	17	5	21
Meritus Medical Center		$37,873,802	96	40	3	28
University of Maryland Rehabilitation & Orthopaedic Institute	University of Maryland Medical System	$36,442,895	64	23	5	15
Western Maryland Health System		$36,131,413	73	27	2	40

Hospital name	System	Total Executives Compensation	Number of Annual Payments to Executives	Number of Individual Executives	Number of annual payments over $1 million	Number of annual payments that put executives above the top 1% income threshold in Maryland
Mercy Medical Center		$35,296,181	60	17	4	40
Frederick Regional Health System		$34,932,998	99	32	2	33
Doctors Community Hospital		$32,663,248	71	23	8	23
Union Hospital		$29,016,441	64	26	3	25
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	University of Maryland Medical System	$28,891,437	70	32	4	14
Bon Secours Hospital	Bon Secours Mercy Health	$23,176,522	54	23	3	15
Atlantic General Hospital		$21,481,228	48	16	1	23
CalvertHealth Medical Center		$18,495,224	61	22	1	6
Fort Washington Medical Center		$5,366,554	24	14		1
McCready Health		$4,985,792	21	7		

Appendix 5. **Ranking of hospitals that benefited the most from charity care rate support, 2014 – 2018**[73]

Hospital name	System	Charity Care Provided — Last Five Years	Charity Care Rate Support Total — Last Five Years	Charity Care Rate Support Surplus*: Last Five Years	Rank: Largest Surplus* of Charity Rate Support
Johns Hopkins Hospital	Johns Hopkins Health System	$133,216,000.00	$169,496,418.64	$36,280,418.64	1
University of Maryland Medical Center	University of Maryland Medical System	$179,526,225.83	$205,952,948.02	$26,426,722.19	2
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	University of Maryland Medical System	$76,647,841.00	$97,139,764.84	$20,491,923.84	3
Adventist Healthcare Washington Adventist Hospital	Adventist HealthCare	$52,505,403.02	$65,357,107.74	$12,851,704.72	4
MedStar Franklin Square Medical Center	MedStar Health	$37,249,257.57	$47,879,563.49	$10,630,305.92	5
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	$87,301,000.00	$94,801,795.32	$7,500,795.32	6
MedStar Union Memorial Hospital	MedStar Health	$32,241,348.44	$39,702,995.84	$7,461,647.40	7
MedStar Harbor Hospital	MedStar Health	$19,488,714.00	$26,788,827.05	$7,300,113.05	8
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	$20,706,967.08	$25,826,620.92	$5,119,653.84	9
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	$19,442,300.00	$23,295,770.26	$3,853,470.26	10
Bon Secours Baltimore Health System	Bon Secours Mercy Health	$16,234,877.00	$20,053,416.35	$3,818,539.35	11
MedStar Montgomery Medical Center	MedStar Health	$12,886,130.00	$16,432,582.68	$3,546,452.68	12
Anne Arundel Medical Center		$20,253,154.00	$23,649,709.30	$3,396,555.30	13
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	$21,043,712.00	$24,402,127.18	$3,358,415.18	14

Hospital name	System	Charity Care Provided — Last Five Years	Charity Care Rate Support Total — Last Five Years	Charity Care Rate Support Surplus*: Last Five Years	Rank: Largest Surplus* of Charity Rate Support
MedStar St. Mary's Hospital	MedStar Health	$13,164,421.48	$16,134,544.36	$2,970,122.88	15
Carroll Hospital Center	LifeBridge Health	$7,226,042.00	$10,084,486.32	$2,858,444.32	16
Sinai Hospital of Baltimore	LifeBridge Health	$35,393,023.00	$37,959,583.27	$2,566,560.27	17
Fort Washington Medical Center		$5,841,368.00	$7,700,536.25	$1,859,168.25	18
CalvertHealth Medical Center		$23,004,284.00	$24,793,843.74	$1,789,559.74	19
Northwest Hospital	LifeBridge Health	$17,756,274.00	$19,444,491.97	$1,688,217.97	20
Saint Agnes Healthcare	Ascension Healthcare	$96,973,115.27	$98,509,291.93	$1,536,176.66	21
Greater Baltimore Medical Center		$11,815,062.00	$13,059,539.51	$1,244,477.51	22
Doctors Community Hospital		$53,494,082.00	$54,623,629.52	$1,129,547.52	23
University of Maryland Charles Regional Medical Center	University of Maryland Medical System	$9,572,552.00	$10,546,193.00	$973,641.00	24
MedStar Southern Maryland Hospital Center	MedStar Health	$16,646,288.79	$17,583,088.24	$936,799.45	25
Meritus Medical Center		$26,239,836.74	$27,128,162.89	$888,326.15	26
Union Hospital		$8,031,597.00	$8,873,209.37	$841,612.37	27
Mercy Medical Center		$91,368,182.00	$91,732,422.06	$364,240.06	28
University of Maryland Harford Memorial Hospital	University of Maryland Medical System	$12,253,270.00	$12,515,299.21	$262,029.21	29
Frederick Regional Health System		$50,842,000.00	$51,075,575.87	$233,575.87	30
Atlantic General Hospital		$14,961,755.00	$15,191,893.15	$230,138.15	31
McCready Health		$1,670,158.00	$1,854,455.32	$184,297.32	32
Peninsula Regional Medical Center		$43,627,300.00	$43,529,033.01	-$98,266.99	33

Hospital name	System	Charity Care Provided — Last Five Years	Charity Care Rate Support Total — Last Five Years	Charity Care Rate Support Surplus*: Last Five Years	Rank: Largest Surplus* of Charity Rate Support
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	$40,551,984.00	$39,794,505.21	-$757,478.79	34
Mt. Washington Pediatric Hospital	University of Maryland Medical System	$840,801.00	$0.00	-$840,801.00	35
Garrett Regional Medical Center		$13,447,237.00	$12,160,785.44	-$1,286,451.56	36
MedStar Good Samaritan Hospital	MedStar Health	$23,075,190.33	$21,788,579.20	-$1,286,611.13	37
University of Maryland Shore Medical Center	University of Maryland Medical System	$27,420,183.00	$25,371,099.64	-$2,049,083.36	38
Adventist Healthcare Shady Grove Medical Center	Adventist HealthCare	$33,500,059.97	$30,811,809.70	-$2,688,250.26	39
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	$47,449,634.00	$44,434,485.62	-$3,015,148.38	40
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	$30,252,251.60	$27,212,829.33	-$3,039,422.27	41
Holy Cross Germantown Hospital	Trinity Health	$12,150,701.49	$8,477,090.00	-$3,673,611.49	42
University of Maryland Rehabilitation & Orthopaedic Institute	University of Maryland Medical System	$8,444,000.00	$2,469,768.05	-$5,974,231.95	43
Western Maryland Regional Medical Center		$54,664,815.00	$47,629,514.10	-$7,035,300.90	44
Holy Cross Hospital	Trinity Health	$157,009,222.41	$133,374,844.87	-$23,634,377.54	45

**Rate support received in excess of charity provided.*

Appendix 6. **Charity care denial rates, 2017 – 2018 combined**[74]

Hospital name	System	Licensed Beds	Application for Financial Assistance Received	Application for Financial Assistance Approved	Application for Financial Assistance Denied	Percent Charity Care Denied
Bon Secours Baltimore Health System	Bon Secours Mercy Health	72	705	129	576	81.70%
CalvertHealth Medical Center*		74	366	121	245	66.90%
Johns Hopkins Howard County General Hospital	Johns Hopkins Health System	285	886	419	467	52.70%
Adventist Healthcare Washington Adventist Hospital*	Adventist HealthCare	204	1,260	634	626	49.70%
Johns Hopkins Bayview Medical Center	Johns Hopkins Health System	455	1,130	579	551	48.80%
Johns Hopkins Hospital	Johns Hopkins Health System	1,154	1,747	928	819	46.90%
Johns Hopkins Suburban Hospital	Johns Hopkins Health System	230	688	374	314	45.60%
Holy Cross Hospital	Trinity Health	449	8,277	4,691	3,586	43.30%
Carroll Hospital Center*	LifeBridge Health	146	338	215	123	36.40%
University of Maryland Shore Medical Center	University of Maryland Medical System	214	1,607	1,045	562	35.00%
Adventist Healthcare Shady Grove Medical Center*	Adventist HealthCare	292	1,602	1,071	531	33.10%
University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital	University of Maryland Medical System	365	550	375	175	31.80%
University of Maryland Baltimore Washington Medical Center	University of Maryland Medical System	293	2,160	1,481	679	31.40%
University of Maryland Medical Center	University of Maryland Medical System	751	1,707	1,237	470	27.50%

Hospital name	System	Licensed Beds	Application for Financial Assistance Received	Application for Financial Assistance Approved	Application for Financial Assistance Denied	Percent Charity Care Denied
University of Maryland Rehabilitation & Orthopaedic Institute	University of Maryland Medical System	137	220	161	59	26.80%
University of Maryland St. Joseph Medical Center	University of Maryland Medical System	263	958	711	247	25.80%
Union Hospital*		87	258	193	65	25.20%
University of Maryland Medical Center Midtown Campus	University of Maryland Medical System	170	562	422	140	24.90%
University of Maryland Upper Chesapeake Medical Center	University of Maryland Medical System	185	3,971	3,009	962	24.20%
Mt. Washington Pediatric Hospital	University of Maryland Medical System	102	54	41	13	24.10%
Meritus Medical Center		257	4,564	3,473	1,091	23.90%
Atlantic General Hospital*		48	599	466	133	22.20%
Anne Arundel Medical Center		415	945	762	183	19.40%
University of Maryland Harford Memorial Hospital	University of Maryland Medical System	89	2,092	1,751	341	16.30%
Greater Baltimore Medical Center		269	529	468	61	11.50%
University of Maryland Charles Regional Medical Center	University of Maryland Medical System	104	277	247	30	10.80%
McCready Health		3	242	218	24	9.90%
Doctors Community Hospital*		210	164	149	15	9.10%
Garrett Regional Medical Center*		27	671	627	44	6.60%

Hospital name	System	Licensed Beds	Application for Financial Assistance Received	Application for Financial Assistance Approved	Application for Financial Assistance Denied	Percent Charity Care Denied
MedStar Montgomery Medical Center	MedStar Health	115	4,309	4,111	198	4.60%
Mercy Medical Center		204	711	685	26	3.70%
Holy Cross Germantown	Trinity Health	80	1440	1388	52	3.60%
Western Maryland Health System		213	1611	1577	34	2.10%
Northwest Hospital*	LifeBridge Health	202	958	938	20	2.10%
MedStar Franklin Square Medical Center	MedStar Health	369	21,362	20,950	412	1.90%
MedStar Southern Maryland Hospital Center	MedStar Health	182	9,738	9,643	95	1.00%
MedStar St. Mary's Hospital	MedStar Health	109	9,979	9,886	93	0.90%
MedStar Good Samaritan Hospital	MedStar Health	206	18,846	18,675	171	0.90%
MedStar Union Memorial Hospital	MedStar Health	183	23,097	22,946	151	0.70%
MedStar Harbor Hospital	MedStar Health	133	14,412	14,329	83	0.60%
Peninsula Regional Medical Center		289	4,702	4,686	16	0.30%
Sinai Hospital of Baltimore	LifeBridge Health	448	3,278	3,268	10	0.30%
Frederick Regional Health System*		272	1,267	7,273		0.00%
Saint Agnes Healthcare*	Ascension Healthcare	287	943	992		0.00%
Fort Washington Medical Center		NA	NA	NA	NA	NA

**Includes only one year of data.*

Appendix 7. **Methodology**

For our analysis of medical debt lawsuits filed by Maryland hospitals, we limited our focus to general acute-care hospitals. For the lawsuit data, we utilized a database of court records provided by the Maryland Volunteer Lawyers Service. The MVLS' database is made up of records taken from the Maryland Judiciary Case Search website (http://casesearch.courts.state.md.us/casesearch/processDisclaimer.jis). We identified all civil cases with hospital or hospital system names for the plaintiff, which were entered into the court records in thousands of variations. We standardized the hospital names using names drawn from the American Hospital Association Annual Survey.[75] To narrow down our case data to only include medical debt lawsuits, we eliminated all case types other than contract cases and liens. We eliminated all lawsuits listing a business or organization as a defendant, and removed all cases with amounts more than $1 million. We reviewed the docket information for hundreds of cases to ensure that the lawsuits were medical debt related. We also examined the court records available at various district courts of hundreds of additional cases to ensure they were related to medical debt.

For our review of hospital and system finances, we relied upon the Maryland Health Services Cost Review Commission's (HSCRC) hospital financial disclosures and audited financial reports.

The executive compensation data presented in the report was taken from the hospitals' and systems' IRS Form 990 filings. Some executive compensation information was listed repeatedly in the filings of hospitals that belong to systems. These duplicates were removed from our calculation of statewide executive compensation amounts. Most of the executive compensation data is for the period 2014 to 2018, but a few hospitals and hospital systems have not yet filed their data for 2018. For those hospitals and hospitals systems, the period 2013 to 2017 was covered.

The data we presented on charity care and charity care rate support came from HSCRC's Maryland Hospital Community Benefit Financial Reports.

The charity care denial rates we present were calculated from data provided in the HSCRC's "Annual Report of Revenue, Expenses, and Volumes, Supplemental Schedule VIII Debt Collection/Financial Assistance Report."

Appendix 8. **Glossary**

All-payer system — Maryland is unusual among the 50 states in that a state body, the Health Services Cost Review Commission, annually determines and sets the rate at which the state's hospitals are to be reimbursed for the medical services they provide — regardless of whether the payer is a government program or a private insurer.

Charity care — While there are differing definitions of charity care, this report is referring to financially subsidized low-to-no-cost care provided by hospitals to low-income patients.

Executive compensation — The annual payments made to hospital executives, which includes salaries, bonuses, and the value of fringe benefits, as reported in the hospitals' annual tax filings.

Net income — Since all hospitals in Maryland are not-for-profit, net income refers to the monies generated when their revenues exceed expenses.

Not-for-profit Hospital — Refers to an institution supposedly not operated to generate profit, as defined by the federal Internal Revenue Service. Instead, the institution is intended to benefit the greater good of the community and, in exchange, is exempted from paying most federal, state, and local income, property, sales, and other taxes and donations to the institution are often tax deductible.

Charity care rate support — The rate at which Maryland hospitals are reimbursed by the all-payer system includes amounts intended to help them offset the costs of providing charity care. The rate support rate is determined by an average of the previous two years' worth of charity care expenses self reported by hospitals.

ENDNOTES

1 As noted elsewhere in the report, a number of Maryland hospitals did not file any medical debt lawsuits or only filed a small number of cases. The figures referenced above and throughout the report are totals for all the Maryland hospitals we included in our analysis. Please see Appendix 2 for details about individual hospitals.

2 Most of the executive compensation data is for the period 2014 to 2018, but a few hospitals and hospital systems have not yet filed their data for 2018. For those hospitals and hospitals systems, the period 2013 to 2017 was covered.

3 For not-for-profits, profits are referred to as "excess revenues over expenses." In this report, we refer to profit as "net income."

4 National Nurses United and AFL-CIO, "Breaking the Promise of Patient Care: How Johns Hopkins Hospital Management Shortchanges Baltimore and Puts Patients and the Community at Risk." December 2018. https://act.nationalnursesunited.org/page/-/files/graphics/1118_JHH_Charity Care_Report_web.pdf

5 Jessica Silver-Greenberg, "How to Fight a Bogus Bill," The Wall Street Journal. February 18, 2011. https://www.wsj.com/articles/SB10001424052 748703312904576146371931841968 (Accessed January 2, 2020).

6 "Report on Semi-Annual Clean Claims Data Filing for Calendar Year 2015," Maryland Insurance Administration, July 2017.

7 See Table 1 of this report.

8 Ibid.

9 See Table 3 of this report.

10 Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills." The Commonwealth Fund, 2005.

11 See section on High-Volume Dockets for Maryland Medical Debt Lawsuits of this report.

12 See Table 7 and 8 of this report.

13 See Table 11 of this report.

14 See Table 15 of this report.

15 See section on charity care in this report. All together, the amount of rate support provided exceeded charity care by $119.2 million, but not all hospitals benefited. Thirty-two hospitals received $174.6 million in charity care rate support beyond what they spent on charity care, while 13 hospitals spent $55.4 million on charity care beyond what they received in rate support. Please see Appendix 5 for details.

16 See Table 18 in this report.

17 AFL-CIO, National Nurses United, and Coalition for a Humane Hopkins. "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits." May 2019. https://act.nationalnursesunited.org/page/-/files/graphics/Johns-Hopkins-Medical-Debt-report.pdf and Interested Party Comments filed by AFL-CIO, https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_jh_bayview.aspx

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21 See Maryland Judiciary Case Search for updated lawsuit information: http://casesearch.courts.state.md.us/casesearch/inquiry-index.jsp

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27 Michelle M. Doty, Jennifer N. Edwards, and Alyssa L. Holmgren, "Seeing Red: Americans Driven into Debt by Medical Bills." The Commonwealth Fund, 2005.

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33 As noted elsewhere in the report, a number of Maryland hospitals did not file any medical debt lawsuits or only filed a small number of cases. The figures referenced above and throughout the report are totals for all the Maryland hospitals we included in our analysis. Please see Appendix 2 for details about individual hospitals.

34 Most of the executive compensation data is for the period 2014 to 2018, but a few hospitals and hospital systems have not yet filed their data for 2018. For those hospitals and hospitals systems, the period 2013 to 2017 was covered.

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36 National Nurses United and AFL-CIO, “Breaking the Promise of Patient Care: How Johns Hopkins Hospital Management Shortchanges Baltimore and Puts Patients and the Community at Risk.” December 2018. https://act.nationalnursesunited.org/page/-/files/graphics/1118_JHH_CharityCare_Report_web.pdf

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39 All data based on the following source except where noted: Analysis of the case records of the Maryland Judiciary, available here: Maryland Judiciary Case Search Disclaimer: http://casesearch.courts.state.md.us/casesearch/inquiry-index.jsp

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41 Includes UM Shore Medical Center at Easton, Chestertown, and Dorchester.

42 We combined Laurel Regional Hospital and Prince George’s Hospital because their financial data was reported together in previous years.

43 Please note that there were 9,183 medical debt lawsuits where the address of the defendant was not available or the defendant was from another state.

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45 Trends in State Courts, 2016; pg. 91. National Center for State Courts. https://www.ncsc.org/~/media/Microsites/Files/Trends%202016/Meeting-the-Challenges.ashx

46 Financial Information from audited financial reports and Disclosure of Hospital Financial and Statistical Data, appropriate years.

47 Includes data for University of Maryland Shore Medical Centers at Easton, Dorchester, and Chestertown.

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49 “LifeBridge Health Acquires Bon Secours Baltimore Hospital” Press Release. https://bsmhealth.org/lifebridge-health-acquires-bon-secours-baltimore-hospital/ (Accessed January 8, 2010).

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52 Audited Financial Statements, appropriate system and years.

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54 Estelle Sommeiller and Mark Price, “The New Gilded Age: Income Inequality in the US by State, Metropolitan Area, and County.” Economic Policy Institute, July 19, 2018. https://www.epi.org/publication/the-new-gilded-age-income-inequality-in-the-u-s-by-state-metropolitan-area-and-county/

55 Executive compensation was found on IRS Form 990 for appropriate years. As described on IRS Form 990, Schedule J is “For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.” Note: Multi-hospital systems often report the same executives on multiple 990 forms for individual hospitals and hospital systems. Most of the executive compensation data is for the period 2014 to 2018, but a few hospitals and hospital systems have not yet filed their data for 2018. For those hospitals and hospitals systems, the period 2013 to 2017 was covered.

56 For the period 2014 to 2018, medical debt as a percentage of net income would drop to 3.35 percent.

57 U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates.

58 See endnote 15, “In Their Debt.” *The Baltimore Sun*, December 21, 2008.

59 Charity care as a percentage of operating expenses is a figure commonly used to compare charity levels across different hospitals and over time. It measures how much a hospital spends of charity care in proportion to the total cost of medical care provided.

60 Refers to the cost of charity care as a percentage of operating expenses.

61 Debt in America: An Interactive Map. The Urban Institute. https://apps.urban.org/features/debt-interactive-map/?type=auto&variable=autoopen_pct (Accessed December 13, 2019).

62 AFL-CIO, National Nurses United, and Coalition for a Humane Hopkins. "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits." May 2019. https://act.nationalnursesunited.org/page/-/files/graphics/Johns-Hopkins-Medical-Debt-report.pdf and Interested Party Comments filed by AFL-CIO, https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_jh_bayview.aspx

63 Maryland Health Services Cost Review Commission, Community Benefits Program, Maryland Hospital Community Benefit Financial Report: FY 2014-2018.

64 Simone Singh, "Not-for-profit hospitals' provision of community benefit during the 2008 recession: An analysis of hospitals in Maryland." Journal of Hospital Administration, 2013. 3. 10.5430/jha.v3n3p7.

65 All together, the amount of rate support provided exceeded charity care by $119.2 million, but not all hospitals benefited. Thirty-two hospitals received $174.6 million in charity care rate support beyond what they spent on charity care, while 13 hospitals spent $55.4 million on charity care beyond what they received in rate support. Please see Appendix 5 for details.

66 Maryland Health Services Cost Review Commission, Community Benefits Program, Maryland Hospital Community Benefit Financial Report: FY 2014-2018.

67 Maryland Health Services Cost Review Commission, Community Benefits Program, Maryland Hospital Community Benefit Financial Report: FY 2014-2018.

68 AFL-CIO, National Nurses United, and Coalition for a Humane Hopkins. "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits." May 2019. https://act.nationalnursesunited.org/page/-/files/graphics/Johns-Hopkins-Medical-Debt-report.pdf and Interested Party Comments filed by AFL-CIO, https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_jh_bayview.aspx

69 Maryland Health Services Cost Review Commission, Annual Report of Revenue, Expenses, and Volumes, Supplemental Schedule VIII Debt Collection/Financial Assistance Report, https://hscrc.state.md.us/Pages/ar-rev.aspx

70 AFL-CIO, National Nurses United, and Coalition for a Humane Hopkins. "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits." May 2019. https://act.nationalnursesunited.org/page/-/files/graphics/Johns-Hopkins-Medical-Debt-report.pdf and Interested Party Comments filed by AFL-CIO, https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_jh_bayview.aspx

71 Includes UM Shore Medical Center at Easton, Chestertown, and Dorchester

72 We combined Laurel Regional Hospital and Prince George's Hospital because their financial data was reported together in previous years.

73 Maryland Health Services Cost Review Commission, Community Benefits Program, Maryland Hospital Community Benefit Financial Report: FY 2014-2018.

74 Maryland Health Services Cost Review Commission, Annual Report of Revenue, Expenses, and Volumes, Supplemental Schedule VIII Debt Collection/Financial Assistance Report, https://hscrc.state.md.us/Pages/ar-rev.aspx

75 In two cases, we combined facilities and modified the names we used accordingly. These include University of Maryland Capital Region Health at Laurel Regional and Prince George's Hospital, and University of Maryland Shore Medical Center.

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February 2020

Testimony of Richard Alexander, National Nurses Un
Uploaded by: Alexander, Richard
Position: FAV

WASHINGTON DC
8455 Colesville Road
Suite 1100
Silver Spring MD 20910
phone: 800-287-5021
fax: 240-235-2019

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

Maryland General Assembly

House Health and Government Operations Committee

Testimony of Richard Alexander, RN, CMSRN, National Nurses United

In Support of HB565 - Health Facilities –Hospitals –Medical Debt Protection

February 16, 2020

Chair Pendergrass, Vice Chair Peña-Melnyk, and members of the Committee, thank you for the opportunity to speak with you today.

My name is Richard Alexander. I am a registered nurse working in an orthopedic trauma unit of an acute care hospital. I am a resident of Montgomery County and a former resident of Washington County, where I attended nursing school. I am a proud member of National Nurses United, the largest union of registered nurses in the country.

At the bedside, I work every day to help victims of trauma heal. The nurses and other caregivers at my hospital care about our patients, and I know that hospitals can and should be a place of healing and comfort. Our patients should be focusing on healing from trauma, not on worrying about medical debt or the hospital suing them to collect. And it would be horrible to think that some of our patients might delay or avoid necessary care because of that worry. Patients who postpone care can get worse, and the Covid-19 pandemic has really driven home the understanding that avoiding necessary care can put lives at risk and can lead to more spread of disease.

Many of my Covid-19 patients have waited until they needed to be brought in by ambulance to receive care, because as scary as Covid-19 is, the fear of being able to pay for care was a bigger concern. Patients who postpone care because they are too worried about how they will deal with the medical bills after discharge can negatively impact outcomes and the risk of readmission increases. Putting patients first is why I became a nurse.

We have a crisis in our state. Over a ten-year period ending in 2018, more than 145,000 Marylanders were sued by hospitals for medical debt, affecting every county in the state, according to a report released last year. While the number of suits varied by county and district, each of you have hundreds or even thousands of constituents who may be the target of such suits. And many of those constituents will be put at risk of bankruptcy, will lose their homes, will have their wages garnished or their credit impacted, and may well put off future medical care or other vital necessities because of those lawsuits.

If you look at the report published by National Nurses United, entitled *Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits*, which I would ask to be submitted into the record, you can see how many residents of your counties have been impacted.

It is also worth noting that, while there are a significant number of Maryland hospitals who engage in this predatory behavior, not all of them do. I think that shows that suing low-income patients is not necessary for Maryland hospitals to thrive.

Maryland patients need the General Assembly to step forward to ensure that our hospitals not only provide the quality care that Marylanders rely on, but do so in a compassionate way. And they can certainly afford to do so. Maryland's hospitals had operating revenues over a ten-year period of $147 billion and had net income of $5.68 billion. The total amount they sued patients for was under $269 million. That means these lawsuits are only a small fraction of 1% of hospital revenue. The lawsuits are not important to hospitals' bottom lines but they can be devastating to patients.

This bill, HB565, will expand consumer protections for medical debt collection to protect patients. The key provisions of the legislation are as follows.

- The bill will prohibit hospitals from the outrageous practice of placing a lien on a patient's home.
- It will stop hospitals from the dangerous practice of garnishing wages to collect medical debt if a patient is uninsured, or qualifies for free or reduced-cost care.
- This bill requires hospitals to wait to start medical debt collections until after patients have completed their appeals to their insurance company, applied for financial assistance, or completed their requests for reconsideration of financial assistance.
- It requires hospitals to offer fair monthly payment plans to patients with fair interest rates, so that they can reasonably pay back their debt.
- The bill will prevent unnecessary damage to credit scores which can negatively impact patients and their families.
- It will prohibit hospitals from suing patients over low-value debts of $1,000 or less.

And the bill will include particular measures to ensure that many individuals who are sued over medical debt and who qualify for free or reduced cost are given every opportunity to get the financial assistance they need. Specifically, it requires hospitals to screen patients for eligibility for financial assistance before suing, and it will prohibit lawsuits against patients who were uninsured at the time they received care.

These are the most important parts of the legislation before the committee today. Additionally, it will create certain notice requirements before hospitals file lawsuits, prohibits certain claims, requires the HSCRC to report on and publish detailed data on medical debt and collections as well, so that we can have up-to-date data for reevaluating down the road, and determine if further steps need to be taken.

This committee must address the medical debt collections crisis in our state and take real, substantive steps to reform dangerous billing and collections practices of our not-for-profit hospitals. I appreciate the efforts by Delegate Charkoudian and Senator Feldman to engage with

the hospitals in our state since last year to hear their point of view and to engage with them on how best to move forward.

Nurses, doctors, and other caregivers in my community and across the state are dedicated to providing quality care to all of our patients. It is vital that our hospitals reflect the values of the people of our state and do not put the welfare of our patients at risk.

This bill, if enacted, will take an important step to protect Marylanders. Please pass this measure with a favorable recommendation and with its strong patient protection provisions intact.

Thank you for your consideration.

National Nurses United (NNU) is the largest union and professional organization of registered nurses in the country, representing more than 170,000 members, including thousands of Maryland residents. NNU works with nurses to improve patient care and working conditions at hospitals, advocate for nurses and patients, and win health care justice and quality health care for all. For more information about National Nurses United's work in Maryland, please contact Kenneth Zinn, Mid-Atlantic Regional Director, at kzinn@nationalnursesunited.org or call 240-235-2000.

Auger SB514 Testimony.pdf
Uploaded by: Auger, Deborah
Position: FAV

Medical Debt Protection Act SB514

Senate Finance Committee

Official Testimony - Favorable

My name is Deborah Auger, and I am a resident of Bel Air, MD. I am a member of the End Medical Debt Maryland Coalition. I submit this testimony **in support of SB514 the Medical Debt Protection Act**.

This legislation is critically needed, especially at this time of the pandemic. **It is unconscionable that people with relatively small medical debt can have liens put on their homes or be forced into bankruptcy when sued by hospitals for medical debt below $ 1,000.** Hospital court suits can lead people with even small amounts of medical debt to face additional legal costs, or to be evicted from their homes - compounding the very problems of poverty that lead people to be unable to afford medical bills in the first place.

I am aware that my now-deceased grandmother avoided seeking needed medical treatment out of fear that medical bills would be beyond her ability to pay. I am sure that this happens every day in every corner of our state, especially during this pandemic.

Most Maryland hospitals receive **millions of dollars in tax exemptions** each year—exemptions that are made up for by Maryland citizens with money out of their own pockets. And most have sizeable hospital foundations. Surely hospitals can well afford the greater degree of forbearance and heightened protections for people with medical debt that would be required under this legislation. **No Marylander should be forced to face wage garnishment, eviction, or bankruptcy because they have sought treatment for illness.**

I respectfully ask the Committee to offer a favorable report and move SB514 forward.

Sincerely,

Deborah A. Auger, Ph.D.
Maryland Legislative District 34B
505 Idlewild Rd.
Bel Air, MD 21014

J.Barber SB514 Favorable Testimony.pdf

Uploaded by: Barber, John

Position: FAV

Medical Debt Protection Act SB0514
Official Testimony
Position: **Favorable**

To the Senate Finance Committee:

My name is John Barber and I'm a resident of Jarrettsville, MD. I strongly support the Medical Debt Protection Act SB0514. I urge you to pass the bill in its current form to protect Marylanders from medical debt lawsuits and unjust debt collection practices.

I grew up in inner city Baltimore, and my parents often struggled to keep a roof over our heads. When I was in the fourth grade, I nearly died. I woke up to get ready for school one day and could not move. I remember being in so much pain my mom had to carry me out of the house to take me to the hospital. We went to Union Memorial. Even though I was having a medical emergency, the hospital would not operate on me until my father was present to sign paperwork that would make him liable for the bills. It took awhile to track him down while my mom and I waited in the hospital, scared and confused. I almost died because the hospital was more worried about how the surgery bill would get paid than they were about my health.

My parents lived paycheck-to-paycheck, and they were overwhelmed by the bills from my surgery. They were denied emergency medical assistance they should have qualified for. The hospital ended up garnishing my father's wages for about 10 years until the bill was paid off. Nobody should have to go through the stress these wage garnishments caused my family. I'm 45 years old as I write this today and it still breaks my heart to think about the pain my medical bills caused our family. I am begging you to pass this bill and spare more people from the suffering my family went through. Practices like wage garnishment over medical debt don't just hurt families financially, they hurt them psychologically. I respectfully urge this committee to issue a favorable report on SB0514, the Medical Debt Protection Act.

Sincerely,

John Barber

jbarber@eascarpenters.org

SB0514-FAV-DTMG-2-25-21.pdf
Uploaded by: Bartlett, Olivia
Position: FAV

Olivia Bartlett, DoTheMostGood Maryland Team

Committee: Finance Committee

Testimony on: SB0514 – Health Facilities – Hospitals – Medical Debt Protection

Position: Favorable

Hearing Date: February 25, 2021

Bill Contact: Senator Brian Feldman

DoTheMostGood (DTMG) is a progressive grass-roots organization with more than 2500 members who live in a wide range of communities in Montgomery and Frederick Counties, from Bethesda near the DC line north to Frederick and from Poolesville east to Silver Spring and Olney. DTMG supports legislation and activities that keep its members healthy and safe in a clean environment and which promote equity across all of our diverse communities. Providing efficient, cost effective health care to all Marylanders and assuring fair access to healthcare for underserved communities and the poor is a priority for DTMG. DTMG strongly supports SB0514 because hospitals in Maryland should not be suing their patients.

Medical debt is a major problem for Marylanders, especially those from low-income households and communities of color. Fifteen percent of Maryland residents report having medical debt, while 21% of those in communities of color report owing medical debts. Recognizing the high cost of hospital care, the state of Maryland already provides financial support to hospitals through the rate setting system to ensure hospitals provide free and low-cost care to patients who qualify. Despite this mandate, Maryland hospitals sue patients, including many who qualified for but didn't receive free care. Between 2009 and 2018, Maryland hospitals filed 145,746 lawsuits against former patients. In 37,370 cases patients had their wages garnished and their bank account wiped out or a lien put on their home or car. In 3,278 cases, the hospital debt drove the patient to declare bankruptcy. The median debt owed is $944.

SB0514 will, among other things, prohibit hospitals from placing a lien on a patient's home or car, prohibit hospitals from pursuing wage or bank garnishment to collect medical debt if a patient is uninsured, require hospitals to offer monthly payment plans to patients, limit monthly payments to 5% of gross monthly income, and cap interest rates at 1.5% per year. SB0514 will also prohibit hospitals from filing lawsuits to collect on low-value debts of $1,000 or less. Hospitals will also be required to report specific medical debt information to the Health Services Cost Review Commission on an annual basis, and the Commission must then make the reports public.

Maryland is behind many other states in providing these protections to residents. It is time to eliminate predatory medical debt collection practices by hospitals.

Therefore, DTMG strongly supports SB0514 and urges a **FAVORABLE** report on this bill.

Respectfully submitted,

Olivia Bartlett
Co-lead, DoTheMostGood Maryland Team
oliviabartlett@verizon.net
240-751-5599

SB0514_Bell_FAV.pdf
Uploaded by: Bell, Pamela
Position: FAV

TESTIMONY FOR SB0514

HEALTH FACILITIES – HOSPITALS – MEDICAL DEBT PROTECTION

Bill Sponsor: Senator Feldman

Committee: Finance

Person Submitting: Pamela Bell, MSN, RNC-MNN
35 East All Saints St, Unit 302
Frederick 21701

Position: FAVORABLE

I am submitting this testimony in favor of SB0514.

I believe that SB0514 is essential to protect low-income Marylanders and those without health care from overwhelming financial debt. The Bill includes clear, new language (such as "debt collector" instead of collection agency), strong guidelines, and fair timelines for debt collection. No one should have their livelihood destroyed by predatory and punitive practices when they seek health care.

Using 200% of the federal poverty level as the threshold of income for consumers receiving free and reduced-cost care might mitigate some financial loss to health care organizations. Reporting their losses to the HSCRC, including the consumer's race or ethnicity, gender, and zip code of residence, will be extremely useful. Finding, evaluating, and targeting disparities, will be much more likely.

For the reasons stated above, I recommend a **FAVORABLE** report in Committee.

SB514_PJC_Support.pdf
Uploaded by: Black, Ashley
Position: FAV

Ashley Black, Staff Attorney
Public Justice Center
201 North Charles Street, Suite 1200
Baltimore, Maryland 21201
410-625-9409, ext. 224
blacka@publicjustice.org

SB 514
Health Facilities – Hospitals – Medical Debt Protection
Hearing of the Senate Finance Committee
February 25, 2021
1:00pm

SUPPORT

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 Rights Project supports policies and practices that promote the overall health of Marylanders struggling to make ends meet, with the explicit goal of promoting strategies that work to eliminate racial and ethnic disparities in health outcomes. PJC strongly supports SB 514, which would prohibit hospitals from suing patients for debts under $1,000 and protects patients from body attachment, arrest warrants, wage garnishment, property liens and other harmful debt collection practices. It would also require hospitals to develop payment plans with low-income patients and would require each hospital to report annually to the Health Services Cost Review Commission on its debt collection practices and policies.

Medical debt collection has a disproportionate impact on low-income patients and communities of color. During the COVID-19 pandemic, the state must continue to prioritize the safety and wellbeing of Marylanders. Medical debt collection not only threatens the financial and housing security of patients, but it also places an immense emotional and physical burden on patients, their families and can harm the overall health of the household. This issue is a priority for PJC as we regularly represent low-wage workers in workers' rights matters, and some of our clients have had their already low wages garnished by hospitals to pay off a medical debt incurred for necessary services. Additionally, there are racial and gender disparities in medical debt collection as the majority of lawsuits by hospitals are filed against Black and female patients. Medical debt keeps low-income patients in a cycle of poverty that can be difficult to break. It takes money that comes into the household away from paying for basic needs, such as food, housing, medication and utilities. If passed, SB 514 would help remove the tremendous burden and damage that medical debt can have on families.

SB 514 promotes communication between hospitals and patients in debt collection. The existing debt collection tools relied on by most of Maryland's hospitals do not greatly benefit the individual hospital but do cause harm to the patient. Damaging a patient's credit rating by reporting their medical debt to a consumer reporting agency prevents the patient and their household from attaining opportunities for stability, such as home ownership.

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.

Additionally, suing patients is not profitable for hospitals as the average debt that Maryland hospitals sued patients for was $944 between 2009 and 2018.[1] Hospitals receive significantly more money from charity care funding and tax breaks than they do in suing patients. In fact, 1/3 of Maryland's hospitals have stopped suing patients to recover debts. SB 514 does not prevent hospitals from collecting on debt, but it does prevent hospitals from using debt collection tools that are inhumane and hinder upward mobility of low-income communities. It would also promote equity by allowing low-income patients who are eligible to enter a payment plan with the hospital to steadily pay off the debt. It is time for the state to require the remaining hospitals to join this shift in practice and stop going after patients for medical debt.

SB 514 would positively transform the way that patients experience medical debt collection and would promote access to medically necessary care. For robust, patient-centered reform of medical debt collection, it is critical that each component of SB 514 be preserved. For these reasons, the Public Justice Center urges the committee to issue a **FAVORABLE** report for **SB 514.** If you have any questions, please contact Ashley Black at 410-625-9409 x 224 or blacka@publicjustice.org.

[1] National Nurses United, *Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits* (2020), https://act.nationalnursesunited.org/page/-/files/graphics/0220_JHH_PreyingOnPatients_Report-opt.pdf.

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.

MD 2021 session medical debt SB514 NCLC.pdf
Uploaded by: Bosco, Jenifer
Position: FAV

NATIONAL HEADQUARTERS
7 Winthrop Square, Boston, MA
02110 (617) 542-8010

WASHINGTON OFFICE
Spanogle Institute for Consumer Advocacy
1001 Connecticut Avenue, NW, Suite 510
Washington, DC
20036 (202) 452-6252

NCLC.ORG

Maryland Senate Finance Committee

Hearing on **SB 514 – Health Facilities – Hospitals – Medical Debt Protection**

Testimony of Jenifer Bosco, National Consumer Law Center

February 23, 2021

Position -- SUPPORT

To the Members of the Senate Finance Committee:

Thank you for holding this hearing on Senate Bill 514 – Health Facilities – Hospitals – Medical Debt Protection**.** My name is Jenifer Bosco, and I am an attorney at the National Consumer Law Center, where I focus on debt collection issues that affect low-income consumers, including medical debt. The National Consumer Law Center or NCLC is a nonprofit organization that, since 1969, has used its expertise in consumer law and policy to work for consumer justice and economic security for low-income and other disadvantaged people.

Medical debt is a problem faced by millions of consumers. Even before the onset of the COVID-19 pandemic, medical debt was one of the most common types of consumer debt and the top reason that consumers are contacted by debt collectors. In 2018, 37% of non-elderly adults reported medical bill or medical debt problems over the past year.[1] According to the Consumer Financial Protection Bureau (CFPB), 59% of consumers contacted about a debt reported receiving calls and letters regarding a medical debt in collections.[2] Medical debt is a contributing

cause to more than half of all consumer bankruptcies filed.[3]

Medical debt has an even more severe impact on communities of color: 31% of non-elderly Black Americans have past-due medical bills, which exceeds the national average of 24%.[4]

Fear of medical debt should not discourage individuals from seeking testing and treatment, yet in light of the aggressive collection practices[5] used by some health care providers, many consumers report fearing medical debt more than they fear a medical diagnosis.[6]

Strong consumer protections are needed to help consumers access the healthcare that they need, without leading to financial ruin. The measures included in SB 514 would provide important protections for Maryland consumers.

Financial Assistance Plan Improvements

Maryland has a good financial assistance requirement that would be made even stronger and more evenhanded with the adoption of SB 514. Pursuant to Md. Code Ann., Health-Gen. § 19-214.1, hospitals must provide free and reduced cost care to certain patients. SB 514 would provide clarity to both patients and health care providers about the method for calculating assistance, by directing the hospital to consider financial hardships at the date of service and those that arise during the eight months after the date of service has passed. This flexibility is particularly important for patients with medical debt, since illness and accidents frequently lead to a loss of household income.[7] A patient who would not have been eligible for financial assistance before the date of service could experience loss of employment or significant financial hardship as a result of the medical crisis.

SB 514 also provides additional opportunities for patients to receive information about the availability of financial assistance, to request assistance, and to seek a review of a hospital's

decision to deny assistance. Where a patient is first denied financial assistance but is later found to be eligible, SB 514 would provide the right to a refund of amounts already paid by the patient in excess of the patient's obligation. These protections will help ensure that needy patients receive the assistance promised under Maryland law.

Debt Collection and Credit Reporting Protections

Medical debt is not discretionary. It is different from many other types of consumer debt – people do not plan to get sick or injured, and health care services are not only necessary, but can be a matter of life and death. For patients who need care but struggle to afford it, aggressive collection activities cause further harm. SB 514 contains needed protections for these consumers, who continue to face aggressive debt collection by some Maryland hospitals.[8]

SB 514 would implement significant medical debt collection and credit reporting protections for Maryland families including:

- Limits on interest or fees charged for medical debt
- Limits on credit reporting of medical debt, and clarifying the hospital's responsibility to revoke erroneous credit reporting[9]
- Pausing certain collection activities while the patient pursues insurance appeals or financial assistance appeals
- Pausing collection lawsuits for the first 180 days after the patient's first post-discharge hospital bill
- Protection of the patient's primary residence from medical liens
- Prohibition of the use of body attachments and arrest warrants for hospital bills
- Prohibition of wage garnishment where the patient was eligible for financial assistance
- Prohibition of lawsuits when the patient owes $1,000 or less, or was eligible for financial

assistance, or was uninsured when the care was provided

- Limits on the use of debt collectors to pursue hospital bills of $1,000 or less
- Notices to patients about the availability of financial assistance, payment plans and health insurance appeal rights

SB 514 also imposes essential requirements for hospitals that pursue debt collection lawsuits, clearly mandating that each complaint filed in court must be accompanied by an affidavit that the hospital has complied with Maryland medical debt collection law, has already evaluated the patient's eligibility for financial assistance, has billed the patient properly, and has attested to the correct amount of the remaining debt. These requirements will not only protect consumers, but should provide an additional barrier to prevent inappropriate, frivolous or erroneous medical debt lawsuits from clogging the court system.

While hospitals are under unique pressures during the COVID-19 pandemic, it is clear that Maryland consumers are also struggling financially. Wage garnishments and lawsuits generally have only the smallest impact on a hospital's bottom line, but can drive households into bankruptcy or poverty. The protections in SB 514 strike a better balance between the hospital's efforts to collect payment, and the need to address the growing pressures of medical debt and aggressive collection practices on healthcare consumers.

Data Reporting

The reporting requirements in SB 514 will provide needed information for the General Assembly and regulators to monitor medical debt and collections issues, and address problems as they arise. In particular, reporting on the use of debt collection by the patient's race, gender and zip code will illuminate disproportionate impacts on people of color, giving policymakers additional tools to address discriminatory practices. Publication of this information will provide

needed transparency.

In conclusion, NCLC supports Senate Bill 514, to provide consumers access to financial assistance and to better protect struggling families from harmful medical debt collection practices. If you have questions regarding this testimony, please contact Jenifer Bosco, Staff Attorney, National Consumer Law Center, at jbosco@nclc.org or 617-542-8010.

Sincerely,

Jenifer Bosco, Staff Attorney
National Consumer Law Center

[1] The Commonwealth Fund, Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured (Feb. 2019), at Table 4, https://www.commonwealthfund.org/sites/default/files/2019-02/Collins_hlt_ins_coverage_8_years_after_ACA_2018_biennial_survey_sb.pdf.

[2] Consumer Financial Protection Bureau, *Consumer Experiences with Debt Collection: Findings from the CFPB's Survey of Consumer Views on Debt* (Jan. 2017).

[3] Himmelstein et al., American Journal of Public Health, *Medical Bankruptcy: Still Common Despite the Affordable Care Act* (Feb. 6, 2019), at https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304901; CNBC, "Medical Bills Are the Biggest Cause of US Bankruptcies: Study" (July 24, 2013), at https://www.cnbc.com/id/100840148.

[4] Urban Institute, Urban Wire: Health and Health Policy, "Past-due medical debt a problem, especially for black Americans," (March 27, 2017), at https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans.

[5] The Pew Charitable Trusts, *How Debt Collectors Are Transforming the Business of State Courts* (May 6, 2020), at https://www.pewtrusts.org/en/research-and-analysis/reports/2020/05/how-debt-collectors-are-transforming-the-business-of-state-courts.

[6] NORC at the University of Chicago, *Issue Brief: Americans' Views of Healthcare Costs, Coverage and Policy*, (March 2018).

[7] See, e.g., Zajacova et al., Cancer, *Employment and income losses among cancer survivors: Estimates from a national longitudinal survey of American families* (Dec. 2015), at https://pubmed.ncbi.nlm.nih.gov/26501494/; Bennett et al., Support Cancer Care, *Changes in employment and household income during the 24 months following a cancer diagnosis* (Aug. 2009), at https://pubmed.ncbi.nlm.nih.gov/19037665/.

[8] E.g., Meredith Cohn, Baltimore Sun, "As Maryland hospitals continue to sue patients, state lawmakers call for 'guardrails'" (Feb. 28, 2020); Alec MacGillis, ProPublica, "One Thing the Pandemic Hasn't Stopped: Aggressive Medical-Debt Collection" (April 28, 2020), at https://www.propublica.org/article/one-thing-the-pandemic-hasnt-stopped-aggressive-medical-debt-collection.

[9] For more information about the harms associated with credit reporting of medical debt, *see*, National Consumer Law Center, *Don't Add Insult to Injury: Medical Debt & Credit Reports* (Nov. 2019), at https://www.nclc.org/images/pdf/debt_collection/report-dont-add-insult-nov2019.pdf.

SB514 Medical Debt Protection Act.pdf

Uploaded by: Bullis, Michael

Position: FAV

Support HB565: Medical Debt Protection Act

February 25, 2020

Senate Finance

Chair Kelley and Members of the Committee:

Centers for Independent Living provide supports and services to people with disabilities that enhance independence. Often times in the course of providing our services, we discover that consumers are overburdened by medical bills. Having a disability can be quite expensive so medical debt impacts the disability community more profoundly.

This bill would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. We believe that the passing of this bill is essential because no one should have to choose between their health and their home.

The undersigned Centers for Independent Living strongly urge a favorable report on this bill.

Katie Collins-Ihrke, Executive Director
Accessible Resources for Independence
1406B Crain Hwy South, Suite 206
Glen Burnie, MD 21061

Sarah Sorensen, Executive Director
Independence Now
12301 Old Columbia Pike, Suite 101
Silver Spring, MD 20904

Michael Bullis, Executive Director
IMAGE Center
Hampton Plaza, 300 E. Joppa Road, Suite 312
Towson, MD 21286

Dave Drezner
The Freedom Center
550 Highland Street, Suite 510
Frederick, MD 21701

Medical Debt Protection Act Testimony (1).pdf

Uploaded by: Burdett, Jake

Position: FAV

To Chair Kelley and Members of the Senate Finance Committee,

My name is Jake Burdett and I'm an Elkridge resident and member of the End Medical Debt Maryland Coalition, as well as the President of the Columbia Democratic Club in Howard County. I support the Medical Debt Protection Act (SB514).

This bill would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that the passing of this bill is essential because I believe the concept of medical debt in the first place is completely immoral. No one *chooses* to get sick or hurt, it's something that just happens to people, so why should anyone have to go into crushing debt simply to pay for their own health? Most other countries don't have medical debt because medical bills are covered by the government, and this bill would be a small step towards making sure if people do have small amounts of medical debt, they at least can't be sued for it.

Before I moved back to Howard County after graduating college in 2020, I was a student at Salisbury University on the Eastern Shore. On the Eastern Shore, like in many parts of rural America, there are not many hospitals. The main hospital network in Salisbury and the Eastern Shore, TidalHealth Peninsula Regional (formerly known as Peninsula Regional Medical Center), is one of the biggest perpetrators of these predatory lawsuits over small amounts of medical debt (the median amount of medical debt an individual is in is $944), and it saddened me to meet many low-income people during my time on the Eastern Shore who could not afford their medical bills, and would have to go in debt, having other negative consequences in their life that this bill would protect them from if passed.

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,
Jake Burdett
Columbia Democratic Club President, District 13 Resident
jakeburdett11@gmail.com ; 443-833-5051

SB514 testimony.pdf
Uploaded by: Camlin, April
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is April Camlin, and I'm a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. For my entire adult life, I have lived paycheck to paycheck, without the safety net of a savings account. Until I was able to get Medical Assistance through the Affordable Care Act, I was living uninsured, as so many Americans do. Any time I got sick, or injured, my default response was to ignore the issue, often compounding the situation, because I was afraid that a hospital visit would bankrupt me. I lived in fear of serious illness, and because every woman on my mother's side of the family have had breast cancer, this gave me a lot of anxiety. No one should ever have to choose between getting the care they need and being able to make ends meet. I am writing in favor of the Medical Debt Protection Act because I believe that healthcare is a human right, and no one deserves to go into financial ruin because they got sick. We need healthcare to be accessible to every person in this country, especially as we move through the COVID-19 crisis, a virus that is shown to have long-term negative effects in many people.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

April Camlin
District 43

SB0154 Medical Debt Protection.pdf

Uploaded by: Cantori, Renee

Position: FAV

SB0514 Health Facilities – Hospitals – Medical Debt Protection – Senator Feldman – Finance Committee

If there is anything tragic than a person fighting off severe illness to then be faced with paying off overwhelming bills and fees, often further subjecting them and their family to years long if not life-long stresses, then I don't know of it. Often families with low to medium resouces must then declare bankruptcy. What good does this do for them? The stresses associated with the illness, trying to keep a job (or jobs), making normal household payments, whatever healthcare bills they already pay, plus these additional bills, dramatically lower quality of life for these individuals and their families.

While our health care system is still inadequate for MOST families, it is so important to try to ease the burden. The protections in this bill do not go far enough, but would help do that. We should do everything we can to make sure that low-income people are not preyed upon and that they are able to keep their jobs and remain productive in the workforce, without the threat of bankruptcy hanging over their heads. The measures in SB0514 help protect the public from some of these very things happening. Please pass SB0514.

Respectfully,

Renee Cantori
Annapolis, MD

letter.pdf
Uploaded by: Carney, Maedi Tanham
Position: FAV

To the Health & Government Operations Committee / Senate Finance Committee,

My name is Maedi Tanham Carney, and I am the Executive Director of Integrated Living Opportunities and we support individuals with disabilities in Montgomery County. In addition, I am a member the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (SB565/SB514).

This bill would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. **I believe that the passing of this bill is essential because of the following reasons:**

- COVID19 has made this legislation even more necessary
- No one should have to choose between their health and their home
- The median debt for medical debt lawsuits is just $944. That is an added expense many working and middle-income families cannot afford – but hospitals that receive millions of dollars in tax breaks and grant funding can
- Wages should not be garnished for medical debt. When a working person's wages are seized, it becomes harder to afford necessities like rent or mortgage payments and transportation

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Maedi Tanham Carney

Maedi Tanham Carney
Founder & Executive Director
Integrated Living Opportunities
Building Supportive Communities
www.ilonow.org
work (202)248-7113
fax (202)248-7635
cell (202)841-8362

SEIU Testimony SUPPORTING SB 514 Medical Debt Prot

Uploaded by: Cavanagh, Terry

Position: FAV

SEIU MARYLAND & DC STATE COUNCIL
1410 Bush Street, Suite F, Baltimore, Maryland 21230

Testimony in **SUPPORT of SB 514**
Health Facilities – Hospitals – Medical Debt Protection

Senate Finance Committee
February 25, 2021
1:00 PM

Presented to: Delores G. Kelley, Chairman
By: Terry Cavanagh, Executive Director

SEIU Maryland & DC State Council urges a **Favorable Report to SB 514.**

SEIU is the largest union in North America. We unite workers in health care, public service, including public education, and property services to improve lives and the services we provide. We represent over 50,000 workers in the Maryland/DC/Virginia region. Many of our members live paycheck to paycheck and one unexpected bill can push a struggling family into a crisis. Medical debt can be the cause of that crisis.

Medical pricing is not something we can haggle over like a used car, or wait for an item to go on sale like at the supermarket. If we're sick enough and lucky enough to get to a hospital, we don't ask about pricing because we're not in a position to walk over to the next hospital to see if maybe they are offering a special of the day on the kind of treatment we need. If we're accepted, we get the treatment and deal with the costs later. Is that irresponsible? Maybe so, but should we expect that?

Too many Marylanders, who are least able to afford it, are being hounded by medical debt collectors by some of the richest hospitals in the world. SB 514 would apply a common-sense approach to this issue, protecting low-income patients, while recognizing hospitals' financial needs.

SB 514 places reasonable requirements on hospitals to report to the Health Services Cost Review Commission (HSCRC) regarding their debt collection practices, while placing needed restrictions on hospitals who have been preying on low-income patients, and not fully accessing alternative sources of payment.

Marylanders who are subject to these debt collection practices can have their lives seriously disrupted. Often the result of that disruption is greater use of public assistance, thus placing a unnecessary burden on taxpayers. By passing this bill, we will invest in our people's independence. In a state with an "all-payer" system, we should see the wisdom of providing high-quality, affordable, health care for all, while ensuring reasonable debts get repaid reasonably and responsibly.

We ask a Favorable Report on SB 514. Thank you.

SB514.pdf
Uploaded by: Crawford, Brian
Position: FAV

To the Senate Finance Committee,

My name is Brian Crawford, and I'm a Takoma Park resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (SB514).
This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential.

I respectfully urge this committee to issue a favorable report on the SB514, The Medical Debt Protection Act.

Sincerely,
Brian Crawford
Maryland Legislative District 20

MDPA Testimony Writeup.pdf
Uploaded by: Crawford, Charlie
Position: FAV

To the Senate Finance Committee,

My name is Charlie Crawford and I am a Baltimore County resident and member of the End Medical Debt Maryland Coalition submitting testimony on behalf of Sunrise Movement Baltimore. I support the Medical Debt Protection Act (SB514).

This bill is critical for protecting low and middle-income families from predatory medical debt collection lawsuits filed by hospitals and medical centers. Specifically, the bill will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that the passing of this bill is essential during the current pandemic because of the undue pressure already felt by low and middle-income Americans.

Especially during a time when many of our frontline workers are low and middle-income, protecting them from punitive medical debt collection should be one of our top priorities. A low or middle-income essential worker should not feel that they have to choose between being unable to receive the medical care they need due to their inherently high-risk work, and being unable to put food on the table.

Beyond essential workers, however, the punitive methods employed by large medical organizations for collecting debt, including placing liens on cars and homes and garnishing wages, have an enormous impact on anyone with medical debt. These practices and the related losses of income and assets make it even more difficult for a person to work their way out of debt.

Further, the median debt collected in these lawsuits is only $944. Though that cost is often too much for low and middle-income Americans to pay out of pocket, it is a drop in the bucket for medical institutions – especially considering the millions of dollars in tax breaks and funding these institutions receive specifically for serving low and middle-income patients who may be unable to pay.

For these reasons, I respectfully urge the Committee to protect low and middle income Marylanders by issuing a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Charlie Crawford

Volunteer, Sunrise Movement Baltimore

443-465-5468

crawfcharl@gmail.com

Michael Dalto testimony on SB 514.pdf
Uploaded by: Dalto, Michael
Position: FAV

To the Senate Finance Committee,

My name is Michael Dalto. I live in Baltimore and own a small consulting business called High Note Consulting. I support Senate Bill 514, the Medical Debt Protection Act.

I formerly directed the Maryland Assistive Technology Loan Program, a program in the Maryland Department of Disabilities that provides low-interest, guaranteed loans to Marylanders with disabilities to buy disability-related technology. In that capacity, I reviewed hundreds of credit reports for loan applicants with disabilities. A very high percentage – if memory serves me, at least one third – showed collections or judgments for medical debt.

I routinely asked applicants to explain their credit issues. Many reported that their medical debts were not legitimate. They explained that they had medical insurance that should have covered the charges for which they were billed, and they had tried to resolve the issues by contacting their insurance providers and hospitals or other medical service providers, but to no avail. Others reported they had been uninsured when they incurred the bills. Some told me they had very low incomes when they incurred the debts, and had never been informed by hospitals that they may have qualified for financial assistance. The great majority said they were unable to afford to repay the outstanding bills. All had suffered harm to their credit due to the debts.

SB 514 would limit the harm that aggressive collection of hospital debt inflicts on Marylanders with disabilities and others. It would require hospitals to negotiate reasonable repayment plans and limit the circumstances in which hospitals can sue patients or garnish their wages. The bill would help protect our vulnerable residents from financial ruin and destruction of their credit. I urge you to support the bill.

Thank you.

SB514 End MD.pdf
Uploaded by: DeBrosse, Ren
Position: FAV

Medical Debt Protection Act / SB514
Written Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Ren DeBrosse and I am a first-year student at Johns Hopkins University School of Medicine, District 46 Baltimore resident. I love this city so much that I decided to spend at least six years of my life here for my scientific and medical training with the Johns Hopkins institution. My relationship with the Middle East community has also grown in that time, as I have done work with the community and consider them family. I envision a future where medical care teams and communities work together to heal and it is with that vision that I support the Medical Debt Protection Act (HB565/SB514).

Part of the oath that medical students take upon entering our profession is that "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick." The system that physicians are asked to practice in, however, operates within a reality of cost of care and hospital bills that can pile up and follow a patient for life. I cannot in good conscience stand idly by while it remains legal for the hospital I am training to pursue my patients for unpaid debts. Wage garnishment, housing liens, and endless payment of interest on small medical debts all weigh on a patient's mental wellbeing as well as their ability to pursue more medical care in the future. I have heard community members say that an experience with debt has dissuaded them from pursuing the care they needed and added distrust of the medical institution that they should be able to lean on for support. How can healing take place if the very institution that claims to treat the patient, not a fever chart or cancerous growth, casts its own plague on the same patient?

With the idea of what can truly help people to heal in mind, I respectfully urge this committee to issue a favorable report on the SB514, the Medical Debt Protection Act.

SB514 Support Med. Debt Finance.pdf
Uploaded by: Demchuk, Pete
Position: FAV

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS - LOCAL UNION No. 24

AFFILIATED WITH:
Baltimore-D.C. Metro Building Trades Council — AFL-CIO
Baltimore Port Council
Baltimore Metro Council — AFL-CIO
Central MD Labor Council — AFL-CIO
Del-Mar-Va Labor Council — AFL-CIO
Maryland State - D.C. — AFL-CIO
National Safety Council

AFL-CIO-CLC
BALTIMORE, MARYLAND 21230

JOHN L. RANKIN, President
DAVID W. SPRINGHAM, JR., Recording Secretary
MICHAEL J. McHALE, Financial Secretary
PETER P. DEMCHUK, Business Manager

OFFICE:
2701 W. PATAPSCO AVE
SUITE 200

Phone: 410-247-5511
FAX: 410-536-4338

Written Testimony of

Peter Demchuk, Business Manager, IBEW, LOCAL 24

Before the

Senate Finance Committee on

SB - 514 Health Facilities – Hospitals – Medical Debt Protection

SUPPORT

February 23, 2021

Dear Madame Chair Kelley, and members of the Senate Finance Committee,

Thank you for the opportunity to submit my testimony supporting Senate Bill 514.

For the record, my name is Peter Demchuk. I am a 41-year member, and the Business Manager, of the International Brotherhood of Electrical Workers Local 24, located in Baltimore. Additionally, I am a lifelong resident of Maryland currently residing in District 7 of Baltimore County.

Medical debt is a major problem for Maryland residents, especially those from low-income households and among communities of color. While the members of our union have great family health insurance some of their parents or other family members may not. That's why I am asking for your help to end predatory hospital debt collection practices. Everyone deserves a right to health care.

This is why I'm asking you to give SB 514 a favorable report.

Thank you,

Peter P. Demchuk

PPD:clr
AFL-CIO
OPEIU # 2

EMD Testimony - Gene DiGennaro.pdf
Uploaded by: DiGennaro, Gene
Position: FAV

Medical Debt Protection Act / HB565
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Gene DiGennaro, and I'm a Parkville resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act SB514.

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because in the midst of this pandemic, the last thing anyone needs is a medical bill that wipes out their ability to live comfortably.

Last August, I was unemployed due to the ongoing pandemic, on limited income, and due to a freak accident, I required four rabies shots and a full round of immunoglobulin. These are not inexpensive procedures, and even after insurance I was left with a bill that was several thousands of dollars. After a lengthy appeal with the hospital, my bill was written off and my debt was forgiven. If it were not arbitrarily forgiven, I would have been financially ruined in the middle of a pandemic. However, I understand that not all are fortunate enough to be in my position. One accident should not mean the difference between financial stability and financial ruin. This could happen to anyone.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Gene DiGennaro
3124 Texas Avenue
Baltimore, MD, 21234

sb0514_caph_favorable.pdf
Uploaded by: Doogan, Suzanne
Position: FAV

My name is Suzanne Doogan (D 43), writing on behalf of the Coalition Against Policing By Hopkins, composed of university groups and unaffiliated community groups, in support of the Medical Debt Protection Act (SB0514). We urge you to vote for this bill and stand for the wellbeing of your constituents.

SB0514 will protect Maryland residents from punitive medical debt lawsuits, and will ban hospitals from suing for medical debt $1,000 and under. Notably, it will also require hospitals to provide a refund of certain amounts collected from the guarantor of a patient who was found eligible for reduced-cost care or service.

This bill is essential because every year thousands of Marylanders are sued by hospitals in our state and many of them are forced into precarious financial situations because of predatory collections. Instead of using its prestige and power to set a state-wide example for what equitable community care could look like, medical big-wig Johns Hopkins Hospital has targeted its employees and its primarily Black and poor neighbors, and sued them over debt averaging only $1,438, which should be meaningless to such a profitable institution. Institutions, especially with a stated mission to "improve the health of the community" must not increase their wealth with funds accrued by disproportionately suing those closest to them -- disrupting their lives, dispossessing them, and terrorizing them.

There are three Johns Hopkins Hospitals -- Johns Hopkins Hospital near the Middle East neighborhood, Johns Hopkins Bayview, and a newly acquired Howard County General Hospital in Columbia. For about 145 years, Johns Hopkins Hospitals *and* Johns Hopkins University together have functioned as a powerful and profitable conglomerate institution in Baltimore. Though the Hopkins Health System is technically a non-profit, the Johns Hopkins Hospital near the Middle East *alone* pulled a gross patient revenue of $2,505,590 last year according to the American Hospital Directory -- almost 13% of our 50+ state hospitals' total gross patient revenue. The Hopkins Health System and the University are within the three largest private employers in the city.

Hopkins's origins are rooted in slavery -- Johns Hopkins himself was a slaveholder. Suing patients for medical debt is another tool of racial oppression that is used to further uphold the uneven relationship that Hopkins institutions have already established between themselves and their neighbors in East Baltimore. (See also: Black East Baltimore resident Henrietta Lacks' cells being used for highly profitable medical research without her consent in the 1950's, and today, when Black families are removed sometimes house-by-house and sometimes block-by-block for more Hopkins expansion.)

In 2019, Hopkins successfully lobbied to have its own private armed police force. Plans indicate that the police would first be deployed in the Middle East neighborhood near the Hopkins Hospital. The Hopkins police force continues to be contested by unaffiliated community members, students, faculty, and employees. In fact, JHUPD is so unpopular that it is up for repeal in the House and Senate right now.

Hopkins could be using its money to improve *real* public health by simply not suing patients or putting liens on homes, instead of spending a fortune on policing. Even though we know policing has deadly outcomes, particularly for Black and Brown people, Hopkins's argument for its private police force is public health and safety. Hopkins must provide its neighbors access to healthcare without the accompanying threat of eviction. And every hospital in Maryland must provide care without such threats.

Best,
The Coalition Against Policing By Hopkins
coalitionagainstpolicingbyhop@gmail.com

SB0514 EMD Coalition Favorable Testimony.pdf

Uploaded by: DUMAIS, BRIG

Position: FAV

MEDICAL DEBT PROTECTION ACT / SB 0514

Official Testimony of End Medical Debt Maryland
Position: **FAVORABLE**

To Chair Kelley and Members of the Senate Finance Committee,

My name is Brig Dumais and I am the Chair of End Medical Debt Maryland. Our coalition is composed of 49[1] organizations and dozens of community members. We are labor unions, faith leaders, patient advocates, consumer rights proponents, lawyers, healthcare providers, and people directly impacted by medical debt. Collectively, we represent over 300,000 Marylanders.

We proudly endorse SB0514: The Medical Debt Protection Act, and ask the Committee to issue a **favorable** report, and not water down the bill with amendments. This legislation is a gender, racial, and class equity issue. There are concerning disparities by which Marylanders are sued for medical debt; lawsuits are disproportionately filed against people of color (with Black neighborhoods particularly targeted by these predatory lawsuits), women, single parents, low-income people, and essential workers. Many of those who have been sued hold more than one of these identities.

Because of the COVID-19 pandemic, the Medical Debt Protection Act is more important than ever before. When people are afraid to seek the medical care they need because they know they cannot afford it, our public health challenge of protecting communities from this highly contagious virus is made all the more difficult. Experts have demonstrated that it costs Maryland and our communities more when illnesses go untreated; practices that deter patients from pursuing care not only harm our patients, but are more expensive in the long run. Additionally, COVID-19 has been found to cause long-term effects in many patients, in ways we do not fully understand yet. This means Marylanders who have survived COVID-19 will need to either seek more healthcare they cannot afford, or choose not seek care and see their health deteriorate as a result. No one should have to make this choice.

Today, at least 17% of Marylanders have medical debt in collections. Between 2009-2018, hospitals filed medical debt lawsuits against nearly 146,000 Marylanders. Over 37,370 wage garnishments were sought, and 4,432 liens were passed on homes. Hospitals in Maryland are given generous tax breaks and millions of dollars in charity care funding specifically to provide healthcare to low-income people. From 2014-2018, hospitals reported $119,214,617 in unspent charity care funding, which is almost the exact amount of money they sought in medical debt lawsuits during the same time-period. This demonstrates that the medical debt lawsuits they are filing is more about punishing patients than their bottom line, and that the sky will *not* fall on Maryland hospitals when the Medical Debt Protection Act goes into effect.

The Medical Debt Protection Act will eliminate wage garnishments over medical debt. Essential workers at Walmart, Home Depot, Johns Hopkins Hospital, University of Maryland Medical System, Maryland State employees, postal workers, and public-school employees are most likely to be sued and have their wages garnished for unpaid medical bills. Wage garnishment is a punitive measure that harms patients and does not ultimately help hospitals collect on debt. When a working person’s wages are seized, it becomes harder to afford necessities like rent or mortgage payments and transportation. If a worker loses

[1] See page 3 for the full list of coalition partners

their home, it becomes more challenging to stay employed. If a worker loses their car, they may not be able to get to and from work. These problems can cause them to lose their jobs, leaving no wages left to even garnish while creating devastating impacts on the patients' lives and their families, and requiring more state spending on unemployment. Prohibiting wage garnishments benefits patients struggling with medical debt *and* Maryland taxpayers as a whole.

We must ban predatory medical debt lawsuits, and a critical element to achieving that goal includes preventing lawsuits from being filed against patients for $1,000 and under. The median amount that patients in Maryland are sued for is just $944. These low sums are a drop in the bucket for wealthy institutions that receive generous tax breaks and charity care funds specifically to provide healthcare to low-income people. On the other hand, for a working family, $944 is enough to break the bank and create or exacerbate a cycle of poverty. While we believe that hospitals can and should ban lawsuits against patients for $5,000, as we proposed in the 2020 legislation, we appreciate Delegate Charkoudian's willingness to accommodate the Maryland Hospital Association's objections to the proposed $5,000 cap by reducing the amount prohibited by 80% from to $1,000. Since Delegate Charkoudian made this compromise in good faith, we hope this good faith will be returned by ensuring the prohibition on lawsuits for $1,000 or less remains in the final version of this bill.

The Medical Debt Protection Act will prohibit liens from being placed on homes for unpaid medical bills. This is especially urgent during COVID-19 because public health experts agree that the best ways to slow the spread of this deadly virus are to practice good hygiene and stay home as much as possible. People who lose their homes because of medical debt won't have those options. Keeping people housed is in everyone's best interest.

Additionally, I would like to address what this bill does *not* do. It does not prevent debt collection, and it does not cancel debts. You may hear those talking points from our opposition, but they are simply untrue. Additionally, one-third of Maryland's hospitals already voluntarily do not sue their patients for debt, demonstrating that it is entirely possible for the remainder of Maryland's hospitals to do the same. SB0514 took into consideration best practices from other states; it is not reinventing the wheel. Our neighbor, Delaware, has banned bank account garnishments. Another neighbor, Pennsylvania, along with North Carolina, South Carolina, and Texas, have banned wage garnishments. Our neighbors in Washington D.C. and 8 other states already prohibit liens on homes. There is no reason we can't do the same here in Maryland.

The time to pass the Medical Debt Protection Act is now. Maryland's patients cannot wait any longer for the solutions this bill will provide. **We strongly urge this Committee to issue a favorable report on SB0514: Medical Debt Protection Act, including the provisions that ban medical debt lawsuits for $1,000 and under, that prohibit liens on homes, and put an end to wage garnishments.** Thank you.

Respectfully,

Brig Dumais, *Coalition Chair*, End Medical Debt Maryland
On behalf of 49 partner organizations named below
brigette.dumais@1199.org, 443-243-2078

End Medical Debt Maryland Coalition Partners

1199SEIU United Healthcare Workers East
Maryland Consumer Rights Coalition
Progressive Maryland
National Nurses United
Accessible Resources for Independence
Baltimore Women United
ATU Local 689
CASA in Action
Baltimore Teachers Union
CASH Campaign of Maryland
Coalition Against Policing by Hopkins
Greater Baltimore DSA
Healthcare NOW of Maryland
Housing our Neighbors
IBEW Local 26
Lower Shore Progressive Caucus
Maryland Legislative Coalition
Maryland State AFL-CIO
Maryland Volunteer Lawyers Service
MD/DC Alliance for Retired Americans
Not Without Black Women
Peer Wellness & Recovery Services
Public Justice Center
SEIU 32BJ
Special Needs Navigator
Sunrise Baltimore
MICA Organizers and Activists
UFCW Local 1994 MCGEO
Maryland NAACP
Maryland Center on Economic Policy
UFCW Local 400
Metropolitan Washington Council AFL-CIO
Our Revolution Maryland
The Freedom Center
Independence Now
Integrated Living Opportunities
Disability Rights Maryland
Patient Providers LLC
Women's Democratic Club of Montgomery County
FreeState Justice
M.E.Action
IUOE Local 37
Maryland Professional Employees Council Local 6197
Marylanders for Patient's Rights
Unitarian Universalist Legislative Ministry of Maryland
IBEW Local 24
ATU Local 1300
AFSCME Council 3
Poor People's Campaign, Maryland
Image Center of Maryland
Montgomery County Democratic Socialists of America
and additional unaffiliated community members

SB 514 - Medical Debt Protection.pdf
Uploaded by: Edwards, Donna
Position: FAV

MARYLAND STATE & D.C. AFL-CIO

AFFILIATED WITH NATIONAL AFL-CIO

7 School Street • Annapolis, Maryland 21401-2096

Office. (410) 269-1940 • Fax (410) 280-2956

President
Donna S. Edwards

Secretary-Treasurer
Gerald W. Jackson

SB 514 – Health Facilities – Hospitals – Medical Debt Protection
Senate Finance Committee
February 25, 2021

SUPPORT

Donna S. Edwards
President
Maryland State and DC AFL-CIO

Madam Chair and members of the Committee, thank you for the opportunity to submit testimony in support of SB 514 – Health Facilities – Hospitals – Medical Debt Protection. My name is Donna S. Edwards, and I am the President of the Maryland State and District of Columbia AFL-CIO. On behalf of the 340,000 union members, I offer the following comments.

Working Marylanders often must choose between medical care and feeding their families. During medical emergencies, no such choice exists, and for the uninsured and underinsured this can lead to medical debt that can be prohibitively expensive to pay off in a timely fashion. What this inevitably leads to is people having their medical bills sent to collections, having their wages garnished, being sued by hospitals, and sometimes having liens placed on their homes.

SB 514 levels the playing field for hard-working Marylanders who experience a medical emergency, by eliminating the most egregious debt-collection practices of Maryland hospitals, requiring hospitals provide payment plan options instead of lump sum demands, and giving patients more breathing room to file health insurance appeals over contested billing. Hospitals will no longer be able to place a lien on a patient's home, garnish wages, sue patients over medical bills while health insurance appeals are ongoing, report unpaid medical bills to credit reporting agencies for at least 180 days, or file lawsuits to collect on debts that are $1000 or less.

SB 514 helps working Marylanders by requiring hospitals to offer monthly payment plans to patients at low interest (no greater than 1.5% per year simple interest), with payments that cannot exceed 5% of the patient's grows monthly income. These simple changes are impactful for patients, but they are also beneficial for hospitals trying to recoup costs. Demanding lump-sum payments and/or suing patients with no money is not an effective way to mitigate their losses. Providing patients with low interest, or no interest, monthly payment options to financially struggling patients will yield more debt repayments.

SB 514 increases reporting from Maryland hospitals. On an annual basis, each hospital must submit a report to the Health Services Cost Review Commission (HSCRC) detailing the number of patients by race/ethnicity, gender, and zip code who have been the subject of debt-collection actions by the hospital or medical debt collection services, the number of patients who are subject to medical debt, and the total dollar amount of services provided by the hospital but not collected. Greater data collection on medical debt is necessary for policymakers in Annapolis to make informed decisions about the depth and breadth of medical debt problem in Maryland and will inform how they can best craft solutions to address it in the future.

SB 514 is expansive in its protections for working Marylanders, but in no way is it hard for hospitals to implement. Maryland's "not-for-profit" hospitals recorded $5.6 billion in profits over the ten-year period from 2009 to 2018, while demanding payment of nearly $269 million in medical debt from patients. Through generous State and Local tax exemptions, hospitals are thriving businesses, paid once by the patients and secondly by Maryland taxpayers. It is time to take care of struggling Marylanders by providing them with an avenue to pay their debt without the fear of being sued, losing their homes, or having their wages garnished. Medical emergencies are stressful and fearful events. With the COVID-19 pandemic upon us, job insecurity and medical insecurity are both at an all-time high. Essential workers, living paycheck-to-paycheck should need not worry about having the wages garnished or losing the homes, on top of the stress they already face on a daily basis.

We ask for a favorable report on SB 514.

SB 514- Medical Debt Protection Act- Support UULM-
Uploaded by: Egan, Ashley
Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of SB 514:
The Medical Debt Protection Act

To: Senator Delores G. Kelly and members of the Senate Finance Committee

From: Betty McGarvey Crowley, Christine Hager, Ph.D, and Valerie Hsu
Health Task Force, Unitarian Universalist Legislative Ministry of Maryland

Date: February 25, 2021

The Unitarian Universalist Legislative Ministry of Maryland (UULM-MD) has been a statewide advocacy organization since 2005, with members in 23 Unitarian Universalist congregations throughout the state. SB 514, The Medical Debt Protection Act, will protect Maryland families from aggressive hospital lawsuits over outstanding medical debt, and we urge a favorable report from the committee.

In Maryland, hospitals regularly sue their patients over outstanding medical bills. Over 145,700 lawsuits were filed in the span of 10 years from 2009-2018, and even religiously-affiliated hospitals whose stated purposes are to serve “the least of these” have filed suit. The median amount of these lawsuits was $944. The hospitals have shown no mercy.

We have heard stories from families whose homes have been threatened by liens from the same hospitals they trusted to care for their loved ones; from people being harassed over the debt of late family members even as they grieve; from Marylanders who avoid seeking necessary healthcare for fear of the costs; from single parents who find their wages garnished as they struggle to make next month’s rent.

The UULM-MD exists to represent and advocate for liberal religious values in Maryland. Our legislative positions are grounded in our spiritual calling to enact a vision for a world community in which justice for all is a lived reality. As Unitarian Universalists, we affirm and promote the worth and dignity of every person, whether they are sick or well; this is the first principle of Unitarian Universalism, the foundational motivating principle that undergirds the values we express in the world.

The current hospital practice of suing patients over outstanding medical debt is a demoralizing tactic meant to further humiliate already-struggling families. It is a punitive practice that undermines the dignity of Marylanders who depend on our state’s hospitals for healthcare they require—the very dignity we affirm at the core of our religious identity. As Unitarian Universalists, we believe all humans are worthy of quality, transparent, compassionate healthcare.

That's why we strongly support SB 514. This bill will require hospitals to demonstrate a good-faith effort to work with patients to develop realistic payment plans that reimburse hospitals without causing unnecessary stress for patients. It will prevent hospitals from placing liens on homes and limit wage garnishments, because Marylanders work hard to provide for their families, and they should not be punished for being sick. The bill will also prohibit hospitals from suing for debts $1,000 and under, putting an end to lawsuits over small medical bills; hospitals will still be able to seek reimbursement via collections and other avenues, but patients will be protected from the debilitating burden of lawsuits. While this bill does not guarantee every person's equal access to quality, transparent, and compassionate healthcare, it is a necessary step in that direction.

As the legislative advocacy representatives of Unitarian Universalist congregations across the state, we strongly support SB 514, The Medical Debt Protection Act, because it affirms, honors, and protects the inherent worth and dignity of every person. We urge this committee to do the same.

Betty McGarvie Crowley, Chris Hager, and Valerie Hsu,
UULM-MD Health Task Force

SB0514 - A. Esposito Testimony.pdf

Uploaded by: Esposito, Ashley

Position: FAV

Testimony on SB0514

Medical Debt Protection Act

Position: **FAVORABLE**

Good afternoon Madame Chair. My name is Ashley Esposito. I'm a proud mom in Baltimore City and I have medical debt. I support the medical debt protection act and I ask the committee to offer a favorable report. As new parents with a miracle baby, in the middle of a pandemic, isolated from support, and doing our best, the largest stress we're experiencing is this dark cloud of medical debt with the hospital.

My family probably has some of the best insurance policies in the state, which makes us one of the lucky ones. We still experienced medical debt due to copays from OB/GYN care, IVF, and specialist care. I paid over $1400 a month for insurance coverage. Because I used COBRA and the coverage I didn't think I would fall into debt -- but I was wrong. Billing issues on the hospitals' end resulted in debt over $2000+ plus a $500 fee to store our other embryos. We weren't asked by the hospital for copays at our appointments, and they accumulated leaving my family with unmanageable debt despite the hospital telling us we owed $0.

The hospital passed our debt off to a collection agency who calls me multiple times a day and threatens to take action. It's psychologically damaging to have to take phone calls where I'm treated like a bad person for seeking medical treatment. Our opponents make the false claims that preventing lawsuits will prevent hospitals from collecting debts. For me, the demeaning phone calls and damage to my credit score is more than enough incentive to pay my bills. However if I were to be sued, fees from the lawsuit and the time I'd have to take off work would actually make it harder for me to repay the medical debt.

I can't afford to pay the debt off in full. SB514 would require income based repayment plans not exceeding 5% of monthly income, and cap interest rates at 1.5%. This would make it so much easier for my family to pay off our debt. We recently learned that we could have a lien put on our home and/or have our wages garnished for unpaid medical bills. If this were to happen, it would be devastating

for my family. Thankfully the Medical Debt Protection Act would prohibit wage garnishments and home liens.

We need a legislative solution to these problems because it shouldn't be the patient's responsibility to deal with predatory medical debt practices while we are supposed to be focused on healing. SB514 will ensure that families like mine are treated fairly and are not at risk to have their lives disrupted or ruined over medical debt. It’s hard enough dealing with a medical situation, so punitive hospital practices shouldn’t add onto that stress. I urge the committee to vote YES on this bill with no weakening amendments.

SB514_Testimony.pdf
Uploaded by: Fisher, Max
Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee:

My name is Max Fisher, and I am a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

Medical debt is one of the most insidious traps in which poor people find themselves. The median amount of medical debt in the state of Maryland is under $1000. Even this relatively small amount of debt places a significant, and in some cases insurmountable burden on many working families. More than 3000 Maryland families have filed for bankruptcy due to medical debt over the last decade. Meanwhile, hospitals in Maryland receive millions of dollars in state funding and tax breaks to provide charity care, much of which goes unspent. This bill will allow some of our most vulnerable neighbors to escape the predatory medical debt trap, while providing a financially responsible mechanism for doing so.

My personal story. My partner is within 2x the federal poverty line – the threshold below which this legislation is targeted. Two years ago, a case of bad luck landed her in the ER. Medical debt soon followed. Over the course of time, we were able to pay off her bills through good fortune in employment. But it was bad luck that put her in debt, and I often think about how bad luck in employment could have drowned her in debt. What precarity. The stress caused by even just the THREAT of this material harm negatively impacted our lives, and we were the lucky ones. Many are not so lucky. This bill removes such luck from the equation, and it cannot come soon enough for those already afflicted with medical debt and those who do not yet know that they will become victims of this predatory system.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Max Fisher

Legislative District 45
1511 Guilford Ave Suite C502, Baltimore, MD 21202
Max.fisher815@gmail.com
(240) 444-7497

BTU Testimony in support of HB 565_ SB 514 (1).pdf

Uploaded by: Gaber, Corey

Position: FAV

Testimony
Medical Debt Protection Act of 2021, SB514
Position: FAVORABLE

To the Senate Finance Committee,

My name is Corey Gaber and I'm a Baltimore City resident, a middle school ELA educator, a Vice President on the Baltimore Teachers Union Executive Board, and a member of the End Medical Debt Maryland Coalition. I enthusiastically support the Medical Debt Protection Act (HB565/SB514).

This bill would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt.

I believe that the passing of this bill is essential because as a City Schools educator I've seen first hand the impact on students when their families must choose between essential health care and going broke. It's hard to learn when your parents are stressed about an unnecessary lawsuit that could literally mean the difference between affording rent and food for the month, or not. I had a former student whose father was being sued by Johns Hopkins Hospital suddenly miss a lot of school days because he had to stay home and watch his baby sister while his dad dealt with the variety of appointments associated with the suit. In addition to being unnecessarily punitive these suits attempt to squeeze money out of folks who are already broke, and so they don't even achieve their intended goal, and bring a host of harmful side effects.

On behalf of the 7000+ members of the Baltimore Teachers Union, and the families we serve, I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Corey Gaber
Elementary Schools VP on the Baltimore Teachers Union Executive Board
Email: cbgaber@gmail.com
Phone: 410-458-3820

Medical Debt Protection Act.pdf
Uploaded by: Glass, Lee
Position: FAV

Medical Debt Protection Act / HB565
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Lee Reginald Glass, and I'm a Silver Spring resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential **because Marylanders with desperate, necessary past medical needs should be offered some protection from economic ruin as the result of a situation beyond their control.**

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Lee R. Glass
District 20
glass.lee@gmail.com

Testimony02232021.pdf
Uploaded by: GLASSCHO, STEVEN
Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**

To Chair Kelley and Members of the Senate Finance Committee,

My name is STEVEN GLASSCHO, and I'm a Maryland resident and a member of the End Medical Debt Maryland Coalition and an officer representing over 2200 employees of MTA. I support SB0514, the Medical Debt Protection Act, and I ask the Committee to issue a favorable report.

The Medical Debt Protection Act will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because the effect on the working people trying to maintain their monthly bills, feed their families in these difficult times is becoming a Herculean task with seemingly no way out.

I can still remember the sensitive stories my peers would share with me about the stress of paying their monthly bills while trying to pay off their medical debt because everyone does not have quality insurance with their employers but still trying to make a way. I urge this committee to remember the less fortunate that we serve everyday to make their lives more manageable with sensible legislation and education to keep people from falling into this situation over and over again
I respectfully urge this committee to issue a favorable report on SB0514: The Medical Debt Protection Act, with no amendments that water-down the bill.

Sincerely,

STEVEN GLASSCHO
Financial Secretary- Treasurer Local #1300 ATU
443-842-1459

Testimony for SB514 must be submitted between 10 AM and 3PM on Tuesday, February 23rd, and the hearing will be on Thursday, February 25th. Below are steps on how to submit testimony on the MD General Assembly website:

Medical Debt Protection Act Testimony.pdf
Uploaded by: Grosman, Katharina
Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**

To the House Health & Government Operations Committee

My name is Katharina Grosman, and I'm a Baltimore resident. I strongly support the Medical Debt Protection Act (SB514/HB565) and urge you to do the same on behalf of all Marylanders facing immoral lawsuits during a time of need.

This bill is of utmost importance, especially during a global health pandemic. SB514 will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because it reduces the harm inflicted on families who are struggling financially. These families are already going through enough as is, facing a medical debt lawsuit should be the last of anyone's worry when they are ill or recovering from illness.

Currently, it is permitted to garnish 50% of wages of someone owing medical debt. Wages were withheld from almost 9,000 families in Baltimore City alone between the years of 2009 and 2018. The reality is that if half of my wages were garnished, I would no longer be able to afford rent. This is true for many residents in Maryland, and especially true for the hundreds of thousands of Marylanders working for minimum wage or close to it. This punitive practice only further perpetuates the problems plaguing our communities. With mounting medical debt and garnished wages because of it, families are essentially evicted and forced to find another living situation. This could lead to being houseless, and put families in unstable and potentially dangerous situations. SB514 would greatly reduce this harmful, immoral practice.

I respectfully urge this committee to issue a favorable report on the SB514/HB565, the Medical Debt Protection Act. It is the right thing to do.

Sincerely,

Katharina Grosman
District 40

Johns-Hopkins-Medical-Debt-report.pdf
Uploaded by: Guillemard, Claude
Position: FAV

TAKING NEIGHBORS TO COURT:

JOHNS HOPKINS HOSPITAL MEDICAL DEBT LAWSUITS

AFL-CIO

COALITION FOR A HUMANE HOPKINS

MAY 2019

Summary

This report presents findings on Johns Hopkins Hospital's (JHH) practices in suing its patients for medical debt. Since 2009, JHH filed more than 2,400 lawsuits in Maryland courts seeking the repayment of $4.8 million in alleged medical debt from former patients, with a median amount of $1,438, based on review of thousands of electronic case dockets and hundreds of case files. Case file research of defendants who live in sampled zip codes within a three-mile radius of the hospital revealed JHH's widespread use of hardball tactics such as wage and property garnishments and years'-long pursuit of patients just to collect a median amount of $1,089 of alleged medical debt per patient in neighborhoods close to the hospital. JHH lawsuits against patients who live within these sampled zip codes largely affected African American Baltimore residents, accounting for 86% of defendants where demographic information is available. Many of these lawsuits seek to recover only the amount outstanding after insurance coverage is applied, including Medicare and Medicaid.

Our review of hundreds of case files suggests that the majority of individuals sued by JHH are residents of Baltimore, the hospital's neighbors, and are likely working class, poor and marginalized. They often are working people who already are likely to struggle with debt in the hundreds or thousands of dollars. These lawsuits can exacerbate existing personal financial hardship and often have dire consequences for patients and their families, while the amounts sought by JHH typically are trivial in relation to the hospital's revenue. In 2018, medical debt sought by JHH in court accounted for less than one-tenth of 1% of JHH's operating revenue.

Our review of hundreds of case files suggests that the majority of individuals sued by JHH are residents of Baltimore, the hospital's neighbors, and are likely working class, poor and marginalized.

JHH often uses wage garnishments as a tactic to recover money from its patients. To garnish wages, the hospital first must obtain a court judgment before proceeding to force employers to withhold earnings from a JHH patient's paycheck. Since 2009, the employer with the most garnishment requests is Johns Hopkins itself, including JHH and Johns Hopkins University. Together, these Johns Hopkins employers account for 10% of JHH's wage garnishment actions. The suits brought against its own employees often are for amounts in the hundreds or thousands of dollars to recoup amounts not covered by its own employee health benefit

programs. In the private sector, Amazon and Walmart are the most frequently targeted employers by JHH for garnishment actions. Dozens of cases also reveal that JHH patients filed for bankruptcy at least in part because of their medical debt burden.

This report serves as a follow-up to a 2008 investigative series by The Baltimore Sun covering the debt collection practices of Maryland hospitals.[1] The Sun found that JHH and Johns Hopkins Bayview Medical Center filed approximately 14,000 collections lawsuits between 2003 and 2008.[2] This report examines JHH's medical debt litigation from 2009–2018. Case records reveal an initial decline in the number of suits filed, followed by a dramatic rise in medical debt litigation by the hospital since 2012 (See Figure B, page 5).

In the 2008 Baltimore Sun investigation, Johns Hopkins claimed it only targets "deadbeats" for medical debt litigation.[3] In response to the investigation, the Johns Hopkins Health System (JHHSC) stated it does not sue "the vast majority" of people who cannot afford to pay.[4] Today, JHHSC's official policy states that legal suits are used "when sufficient assets are available to satisfy the patient's debt."[5]

JHH is a not-for-profit institution that receives tens of millions annually in federal, state and local tax breaks intended to benefit the community in which it is located.[6] These community benefits include providing charity care or discounted care to low-income patients who lack insurance, or who lack enough insurance to cover their often substantial out-of-pocket expenses. Maryland law requires that acute care hospitals such as JHH provide "at a minimum, free medically necessary care to patients with family income at or below 200 percent of the federal poverty level [and] reduced cost medically necessary care to patients with family incomes between 200 and 300 percent of the federal poverty level."[7] Case records show that some patients taken to court by JHH likely could have qualified for free or reduced costs.

In 2017 alone, JHH received $164.4 million in tax exemptions and $25 million in rate support to provide charity care, $3.3 million of which was in excess of charity care provided.

JHH receives rate support (i.e., public funding) to provide charity care, which is care provided at discounted costs to low-income patients who lack insurance or enough insurance to cover substantial out-of-pocket expenses. Rate support, or public funding, provided to Maryland hospitals is based on a calculation of the "combination of bad debts and charity care."[8] In 2017 alone, JHH received $164.4 million in tax exemptions and $25 million in rate support to provide charity care, $3.3 million of which was in excess of charity care provided.[9] The joint National Nurses Union (NNU)/AFL-CIO report "Breaking the Promise of Patient Care," released in December 2018, explored these issues in detail, finding that between 2014 and 2017, JHH received $33.1 million more in rate support than it provided in charity care.[10] Even though JHH receives public funding to provide care, it still pursues patients in court for medical debt. JHH's excess charity care funds from 2017 alone could have been used to forgive nearly all the $3.4 million sought in medical debt cases filed by JHH in Maryland courts from 2015 to 2018.

In Baltimore city, 32% of the nonwhite population has medical debt in collections, as does 19% of the white population,[11] demonstrating a substantial need for a far more compassionate approach on the part of JHH to poor and working people seeking medical care. Through its aggressive use of medical debt litigation, JHH continues to expose itself to reputational harm while creating a financially toxic environment that makes life more difficult for thousands of working people and their families in the Baltimore community. To make good on its mission to provide the highest quality of care and service for all people, JHH should cease suing its neighbors for medical debt, reform its financial assistance policies and practices, and apply the excess it receives from the state of Maryland for charity care to full use for the benefit of the Baltimore community.

NATION/WORLD DECEMBER 21, 2008

In their debt

By Fred Schulte and James Drew | investigations@baltsun.com

Maryland hospitals have stepped up debt collection, sometimes from the poor, and Gov. O'Malley demands review

NATION/WORLD DECEMBER 22, 2008

Their day in court

By Fred Schulte and James Drew | investigations@baltsun.com

Hospital debt collection lawsuits can zoom through the courts, pitting experienced law firms against ill-informed defendants

NATION/WORLD DECEMBER 22, 2008

Loose rules

By James Drew and Fred Schulte | investigations@baltsun.com

Maryland hospitals have fought back efforts by lawmakers to tighten the oversight of their collection policies

FIGURE A

Introduction

In December 2008, The Baltimore Sun published an investigative series uncovering medical debt litigation practices by Maryland hospitals between 2003 and 2008 (Figure A). In this time period, Maryland hospitals were awarded more than $100 million in judgments against patients, even winning claims covered by Medicaid for bills the government plan did not cover, which Maryland forbids, according to the Sun.[12] More specifically, the investigation found that JHH and Johns Hopkins Bayview Medical Center filed approximately 14,000 collections lawsuits between 2003 and 2008. Ronald R. Peterson, the former president of the JHHSC who now serves as a president emeritus of the JHHSC and special adviser to the dean/CEO of Johns Hopkins Medicine,[13] was quoted in the series stating that:

> *"...the board of trustees expects us to have prudent business practices. We could have bad behavior from people who are in that category of* ***deadbeats."***[14]

But the Baltimore Sun series showed that those who are taken to court often are working people who have difficulty paying their medical bills, even though JHH states that it only sues patients whom they deem have the ability to pay. The investigation also found that JHH pursued debt with higher frequency than many of its peers. In fact, Bon Secours Hospital stopped pursuing patient debt lawsuits in Maryland[15] and Virginia in 2008 because the hospital's leadership determined that doing so is contrary to the hospital's mission to provide quality health care to all.[16] In response to the Sun investigation, Hopkins stated that less than 1% of unpaid hospital bills are pursued with legal action by the JHHS Corporation.[17] Yet it remains unclear how the hospital actually chooses which patients to target for legal action.

JHH is taking its patients to court even as Americans find it increasingly difficult to pay their medical bills. In 2014, 43 million Americans had unpaid medical debts,[18] accounting for approximately 13% of the population in the United States.[19] According to a 2017 Federal Reserve report on the economic well-being of U.S. households, 25% of respondents reported they had skipped medical treatments in the previous year due to costs.[20] Furthermore, 44% of

JHH is taking its patients to court even as Americans find it increasingly difficult to pay their medical bills. In 2014, 43 million Americans had unpaid medical debts, accounting for approximately 13% of the population in the United States.

the adults surveyed said that if confronted with an unexpected $400 emergency expense, they would not be able to pay it without selling personal items or borrowing money.[21] A 2018 poll also found Americans forgoing care because of cost at high rates, with 40% of Americans skipping a recommended medical test or treatment, and 44% responding that "they did not go to a doctor when they were sick or injured" in the last year.[22]

Working people living paycheck to paycheck are the most vulnerable to unanticipated medical debt because they often can't afford insurance, but are not poor enough to qualify for Medicaid. Out-of-pocket health care costs have risen from $250 per year in 1980 to more than $1,400 in 2016.[23] Most people depend on their employers for health insurance coverage, yet employers increasingly are shifting health plan costs to employees. As a result, workers face rising out-of-pocket costs on a combination of deductibles, co-pays and co-insurance. For those outside the direct employer structure, even after implementation of the Affordable Care Act (ACA), 45% of nonelderly adults lacking insurance still could not afford it.[24] Despite these challenges, JHH still files medical debt lawsuits against patients by the hundreds annually in Maryland courts, even though the hospital's mission is to "...set the standard for patient care [and] ... afford solace and enhance the surrounding community."[25]

Out-of-pocket health care costs have risen from $250 per year in 1980 to more than $1,400 in 2016.

Nonprofit hospitals like JHH are supposed to serve as a stop-gap, providing care for those who would have difficulty paying otherwise. JHHSC, which includes JHH, has a policy to provide financial assistance to patients who are

> *"uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation."* [26]

JHH receives rate support (i.e. ,public funding) to provide charity care. But as noted in the joint NNU/AFL-CIO report "Breaking the Promise of Patient Care," JHH received $33.1 million more in rate support than it provided in charity care between 2014 and 2017 alone.[27] Maryland state law requires hospitals, at minimum, to provide free medically necessary care for those below 200% of federal poverty line, and reduced cost requirements for families between 200% to 500% of the federal poverty line (Appendix B).[28]

JHHSC states it only pursues patients in courts if it deems they have the ability to pay their alleged medical debt costs. But a review of cases for this report revealed that some patients pursued in court by JHH likely would have qualified for charity care under state law requirements. And a review of JHH's financial assistance application documents (Appendix A) shows JHH is not making charity care as accessible as it should, especially since in recent years the hospital has been fully reimbursed by the state of Maryland for providing such care. The legal actions taken by JHH against patients are a disservice to community members, especially those who could have qualified for charity care.

Medical Debt Litigation by JHH After the Baltimore Sun Investigation (2009–2018)

This report examines Johns Hopkins Hospital's continued use of litigation to collect on medical debt in Maryland courts since the 2008 Baltimore Sun investigation. Researchers created a database of thousands of electronic case dockets from the Maryland Judiciary Case Search internet database and reviewed hundreds of case file documents from Maryland district courts between Jan. 1, 2009, and Dec. 12, 2018, in which JHH is listed as plaintiff.

Since January 2009, JHH has filed at least 2,657 cases in the state of Maryland as a plaintiff.[29] Of these 2,657 cases, more than 2,400 were lawsuits seeking repayment of $4.8 million in alleged unpaid medical debt from former patients (Figure C).[30] The median claim amount of these medical debt lawsuits is $1,438.

Although the number of cases filed by JHH dropped precipitously in the first three years after the 2008 Sun investigation and has remained lower than its pre-recession levels, JHH has initiated debt collections cases by the hundreds annually since 2012 (Figure B). From 2009 to 2018, the annual number of these lawsuits filed by JHH has increased substantially, with only 20 cases filed in 2009, compared with 535 filed in 2016 (Figure C). Moreover, it is evident that JHH has been pursuing medical debt collections through the Maryland courts more frequently in the past five years.

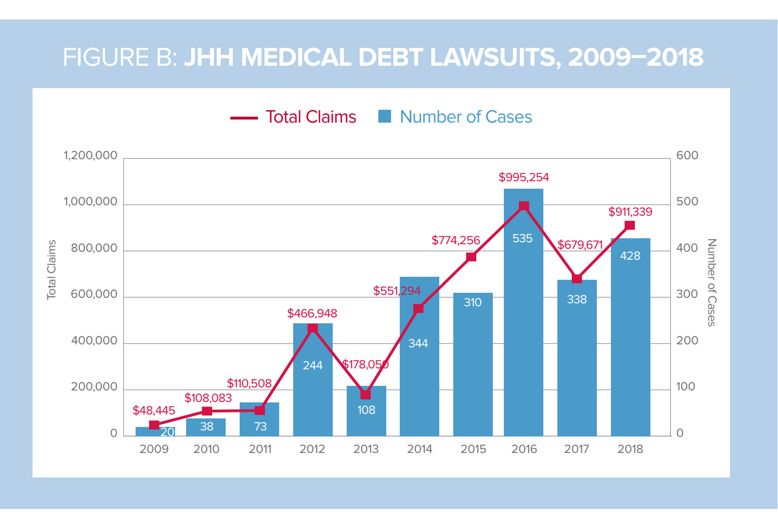


FIGURE B: **JHH MEDICAL DEBT LAWSUITS, 2009–2018**

MEDICAL DEBT VICTIM SPEAKS OUT

BONITA BORDLEY*

Bonita is a former Baltimore public school teacher and a Baltimore City resident. In 2015, her daughter had surgery after a car accident and in 2017, Johns Hopkins Hospital sued Bonita for nearly $14,000. A judgment was ruled against Bonita last year and she is burdened with debts she cannot pay. Bonita says JHH never offered her financial assistance.

*U.S. District Court for Maryland, Case No. 10100203312017.

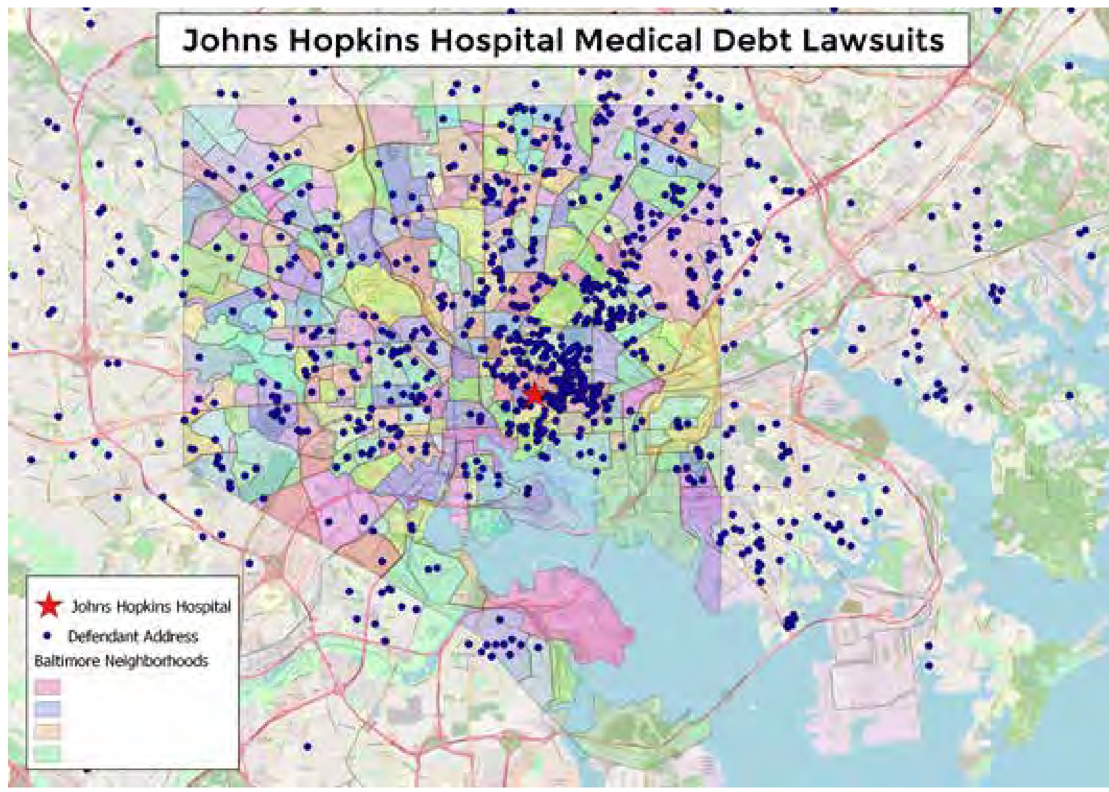
Figure C: JHH MEDICAL DEBT LAWSUITS BY YEAR

	Number of Lawsuits	Total Medical Debt Sued For	Median Amount Per Lawsuit
2009	20	$48,445	$1,889
2010	38	$108,083	$1,665
2011	73	$110,508	$1,068
2012	244	$466,948	$1,231
2013	108	$178,050	$1,180
2014	344	$551,294	$1,297
2015	310	$774,256	$1,621
2016	535	$995,254	$1,398
2017	338	$679,671	$1,466
2018	428	$911,339	$1,704
Total	**2,438**	**$4,823,848**	**$1,438***

*This is the median of all 2,438 individual cases.

During this period, JHH filed more lawsuits in district court in Baltimore City than in any other court, accounting for 46% of the medical debt lawsuits filed by the hospital since 2009.[31] In a review of defendant addresses, it is clear the neighborhoods that experience the highest density and clustering of lawsuits are those closest to the hospital, in East Baltimore (Figure D).

FIGURE D: NEIGHBORHOOD STATISTICAL AREA BOUNDARIES CREATED FROM 2010 CENSUS BLOCK GEOGRAPHY, 2009–2018[32]

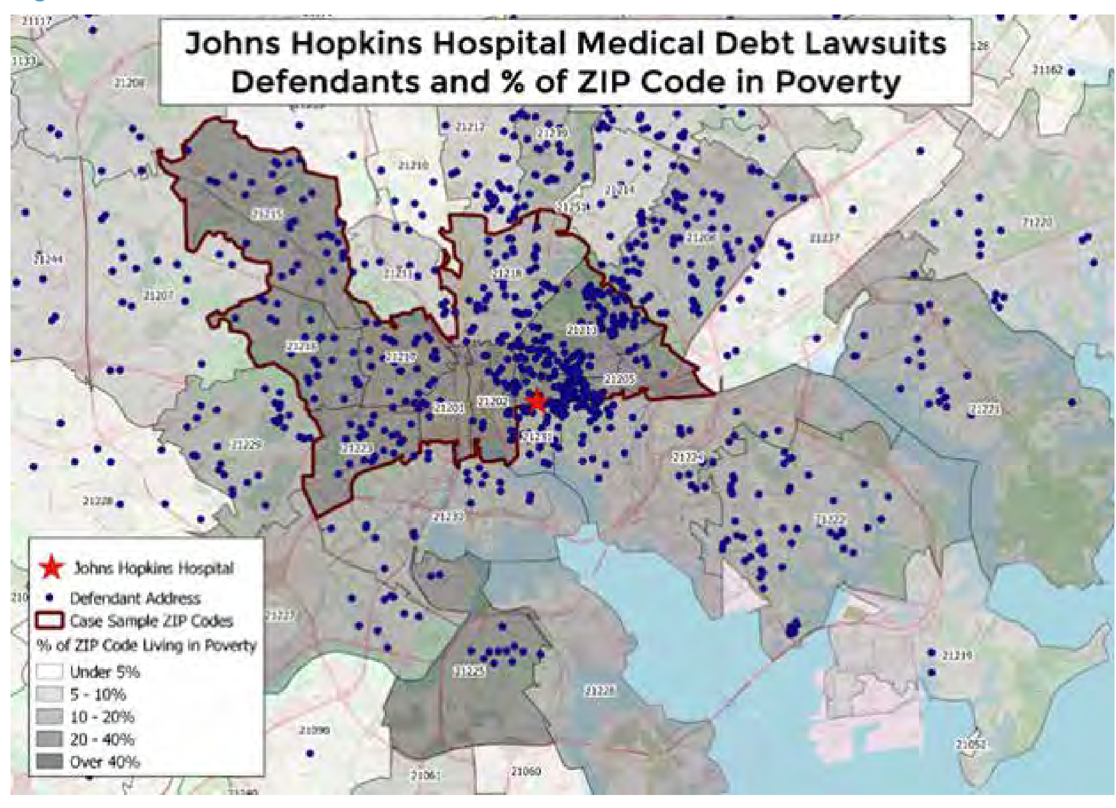


These lawsuits affected Baltimore city residents living in economically distressed neighborhoods. Of the top 10 zip codes where JHH medical debt defendants reside, nine are located in the city of Baltimore. The 21213 zip code area, which contains the largest number of residents sued by JHH, has a population that is 90% African American and has a poverty rate nearly triple the state average. The average median household income in this zip code is $34,917, or just 44% of the statewide average.[33] Of the 10 zip codes with the highest number of patients sued by JHH, nine have poverty rates higher than the state average, five have child poverty rates more than double the state average, and all areas have median household incomes below the state average.

Figure E: TOP 10 ZIP CODES WITH MOST JHH MEDICAL DEBT LAWSUITS, 2009–2018

Zip	Baltimore City[34]	Residents Sued	% in Poverty	% of Children Living in Poverty	% African American	% Asian	% Hispanic or Latino	% White	Median Household Income
21213	Yes	153	28.2	36.5	89.6	0.4	1.3	6.8	$34,917
21206	Yes	143	14.0	19	71.4	2.1	3.0	21.8	$50,975
21234	Yes	90	8.8	11.2	28.5	5.2	4.2	60.4	$61,748
21205	Yes	89	37.1	49.4	68.8	1.0	14.8	16.9	$28,675
21222	Yes	77	14.4	19	11.7	3.5	5.3	75.1	$50,644
21218	Yes	74	24.5	36.7	61.2	5.0	3.9	26.7	$43,352
21224	Yes	70	17.7	32.4	16.4	3.0	19.1	58.8	$65,501
21221	No	57	13.2	19.8	28.0	1.2	4.6	64.1	$53,215
21207	Yes	55	13.0	17.1	84.6	1.6	2.7	8.7	$59,013
21231	Yes	52	19.8	31.3	30.4	4.4	10.6	51.3	$69,979
MD Overall	--	--	**9.7**	**12.9**	**29.7**	**6.2**	**9.6**	**51.9**	**$78,916**

Figure F: JHH MEDICAL DEBT LAWSUIT DEFENDANT ADDRESSES, 2009–2018



For this report, researchers read and analyzed court documents of 273 cases filed against patients since September 2015 with an address in the zip codes highlighted in Figure F, all of which are within a three-mile radius of the hospital. These zip codes have a poverty rate almost three times as high as the statewide poverty rate, and a childhood poverty rate more than three times as high as the state childhood poverty rate. They are more distressed than 90% of other U.S. zip codes, and suffer from joblessness rates nearly double Maryland rates (Figure G).

Figure G: **ECONOMIC PROFILE OF SAMPLED ZIP CODES AROUND JHH**

Zip Code	Median Household Income	% Living in Poverty	Children Living in Poverty	Adults Not Working[35]	Distress Index[36]
21201	$32,208	31.6%	47.5%	31.5%	93.7%
21202	$37,034	31.1%	43.5%	49.5%	94.4%
21205	$27,680	35.8%	50.8%	44.6%	95.0%
21213	$33,015	28.1%	38%	41.3%	92.5%
21215	$36,763	26.6%	36.8%	41.3%	92.0%
21216	$34,892	26.5%	45%	40.9%	94.2%
21217	$27,065	34.8%	49.3%	45.7%	97.3%
21218	$39,598	25.3%	34.4%	35.2%	94.2%
21223	$26,583	39.4%	49.1%	48.4%	97.2%
Maryland	**$76,067**	**9.9%**	**13.3%**	**23.0%**	NA

Demographic data, including data on race, was available in more than 100 of the reviewed case files,[37] revealing that 86% of defendants sued by Johns Hopkins Hospital in our sample set are African American (Figure H). In Baltimore city, 32% of the nonwhite population has medical debt in collections ($520 median in collections), compared with 19% of the white population ($466 median in collections).[38] These percentages are higher than the Maryland statewide average of 21% nonwhite ($470 median in collections), compared with 15% white ($445 median in collections).[39]

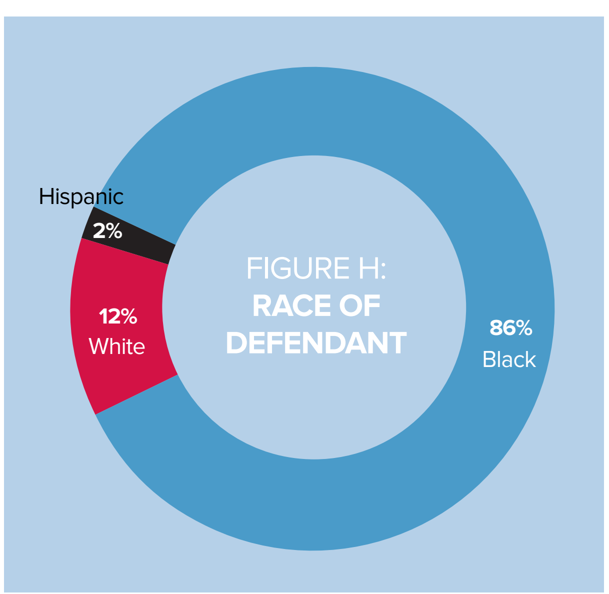
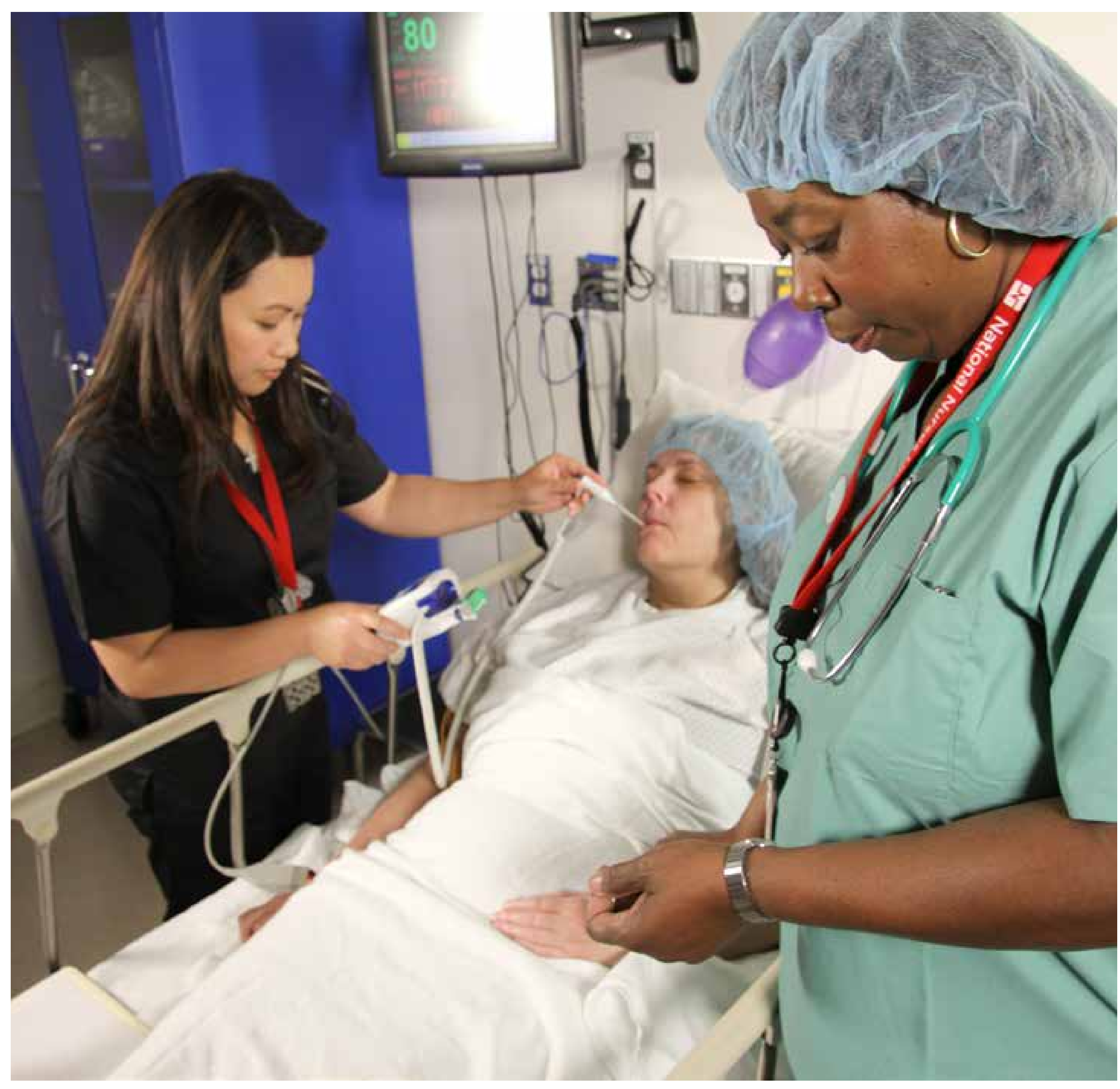


FIGURE H: **RACE OF DEFENDANT**

Review of the case files of defendants with addresses in the sampled zip codes near JHH also found that JHH took patients to court for as little as $280, and the median amount of the medical debt sought was $1,089. Some patients are pursued for years and assessed court fees and post-judgment interest charges that increased the amount owed to the hospital.[40] In one case, an African American woman in her late 50s was pursued by JHH for three years for an original claim of $445 that grew to $720 with interest, court costs and attorney fees. The case closed because the defendant agreed to pay $50/month to JHH for the original debt and additional costs accrued during the lawsuit.[41] In addition, JHH employed the use of aggressive collections tactics, such as wage and property garnishments, which are detailed in the following section of the report.

While JHH is well situated to make a positive, welcoming impact within its local community as an employer and health care provider, its legal pursuit of its neighbors and often its own employees, who likely work for low wages or live paycheck to paycheck, sends a less welcoming message. And, as noted in the previous NNU/AFL-CIO report "Breaking the Promise of Patient Care," the economically distressed neighborhoods surrounding JHH are marked not only by poverty but also by poor health outcomes. For example, life expectancy in Old Town/Middle East is 70.4 years, and in Clifton-Berea is 66.9 years, compared with 80 years in the United States as a whole.[42] Despite this, JHH uses resources to pursue legal action against patients for arguably negligible amounts of medical debt. Instead, JHH should use these resources to address public health disparities in its own community.



WHO REPRESENTS JHH IN MEDICAL DEBT LITIGATION

JHH is represented by multiple law firms and collections agencies for medical debt collections in Maryland courts (Figure I). The Law Office of John E. Lindner, P.A., which focuses on medical and consumer debt recovery and collections from an office in Timonium, Maryland, in Baltimore County,[43] is the most frequently listed lawyer representing JHH in medical debt cases. Lindner's firm has received three complaints filed with the Consumer Financial Protection Bureau,[44] with another six complaints made to the Better Business Bureau since 2016.[45] Complaints with the Better Business Bureau include wage garnishment errors, seeking debt that is not owed and communication issues, such as nonfunctioning phone lines. All of these complaints were confirmed by online responses from the Law Office of John E. Lindner. Patients and JHH should be concerned that the lawyer most frequently representing JHH is alleged to have such practices.

FIGURE I: **PLAINTIFF LAWYERS, 2009–2018**

Name	Location	Count of Cases
Law Office of John E. Lindner, P.A.	Maryland	301
Rosenthal, Gormly, Chtd.	District of Columbia	44
Peroutka, Miller, Klima & Peters, P.A.	Maryland	27
Herbert A. Thaler, Jr. Attorney At Law	Maryland	19
Bender & Radcliffe, P.A.	Maryland	17
Schrier Tolin & Wagman, LLC	Maryland	11
ARS National Services Inc.	California	7

Selected law firms. Plaintiff lawyer data available from 704 cases.

Johns Hopkins says it "monitors and evaluates the performance of all external collection agents that are contracted by the JHHSC and its affiliates," which includes JHH.[46] This evaluation requires at least annual audits of each collection agency. Collection agencies contracted by JHHSC play a major role in litigation because they forward their recommendations for filing suits to JHH, which are reviewed and authorized mainly by the hospital's associate director of collections. Interestingly, so-called "VIP accounts" follow a different process if judged delinquent, and the litigation brought against VIPs must be approved at the corporate senior director level of JHHSC before it can be initiated.[47] It is unclear how VIP status is determined by JHH.

JHH Debt Collection Practices: Wage and Property Garnishments

Since 2009, JHH has moved in court to target the wages or bank accounts of patients, with more than 400 garnishments ordered that sought $800,000 for medical debt.[48] Hospitals, like most creditors, cannot garnish wages without a court judgment asserting that an individual owes them money. Many of the judgments JHH obtains are called “affidavit judgments,” meaning the defendant in the suit did not answer the charges and did not show up in court for their trial. In Maryland, the ACLU has found that judges rule in the favor of debt collectors in 95% of cases, which is a troubling reality for patients pursued in court for medical debt.[49]

FIGURE J: **WAGE AND PROPERTY GARNISHMENTS BY JHH IN MARYLAND COURTS, 2009–2018**

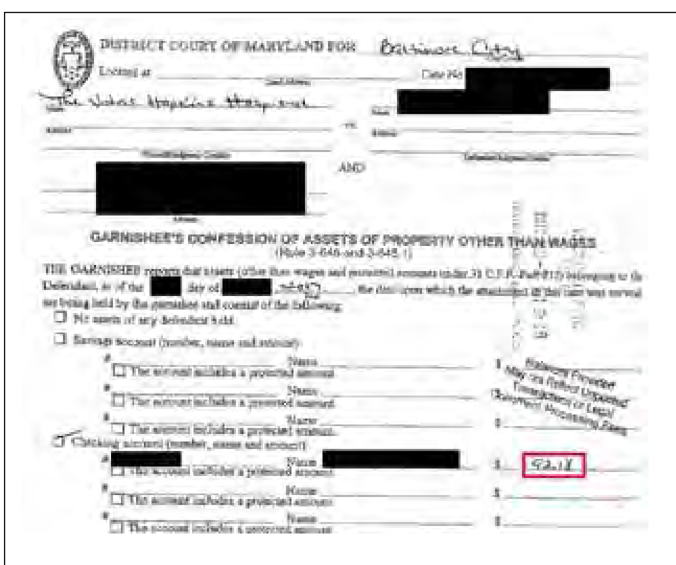
Garnishee Type	Number of Lawsuits	Total Garnishment Orders	Total Amount to be Garnished	Median Amount
Property Garnishee	79	86	$171,497	$1,466
Wage Garnishee	371	461	$661,744	$1,371
Total	450	547	$833,241	$1,419

There are two main types of garnishments creditors use in these cases. The first is a wage garnishment, in which a creditor legally can require an employer to turn over part of an individual’s wages to pay off debt. Federal law limits garnishments to 25% of a person’s disposable income,[50] or the “amount that [the person’s] income exceeds 30 times the federal minimum wage, whichever is *less*.”[51] Creditors may garnish wages until the debt is fully paid, or the debtor can stop garnishment actions by, for instance, filing for bankruptcy. Income from Social Security, workers’ compensation and public assistance benefits usually is protected from garnishment.[52]

The second type is a nonwage garnishment, also known as a bank levy, which grants creditors access to one's bank account to siphon funds. Bank accounts are considered property, and are exempt from the 25% protection.[53] Maryland law regarding wage garnishments—with varying degrees between counties—closely resembles federal law.[54] The IRS defines garnishments as an Extraordinary Collections Action (ECA), and requires that a hospital organization make "reasonable effort" to determine whether the patient is eligible for financial assistance from the hospital before requesting a wage or property garnishment.[55] It is JHH policy to pursue garnishments to recoup medical debt from former patients, including motor vehicles, bank accounts and wages.[56] This hospital policy to determine whether the judgment debtor has sufficient assets available seems to be at odds with what case files reveal about many patients' financial realities.

In 2017, JHH sued a patient who lived within a three-mile radius of the hospital for $280.13.[57] The patient, a 55-year-old female, had insurance that did not cover the entire amount billed by JHH for medical services provided. After obtaining a judgment, JHH moved to garnish the former patient's property. The defendant stated that she had $92.18 available in checking (Figure K), and JHH then requested to garnish all $92.18. (Figure L), clearing out her bank account. Beyond the ethical concerns this garnishment raises, JHH's action may have exposed this woman to bank overdraft and other account fees that may have further destabilized her financially.

FIGURE K: **GARNISHEE CONFESSION OF ASSETS**



DISTRICT COURT OF MARYLAND FOR Baltimore City

GARNISHEE'S CONFESSION OF ASSETS OF PROPERTY OTHER THAN WAGES

The account includes a protected amount

Checking account (number, name and amount)

$ 92.18

FIGURE L: **REQUEST FOR JUDGMENT—GARNISHMENT**

DISTRICT COURT OF MARYLAND FOR Baltimore City

The Johns Hopkins Hospital

Baltimore, MD 21202

REQUEST FOR JUDGMENT - GARNISHMENT

(Md. Rule 3-645 (g))

amount of $ 92.18

Garnishment details in the JHH lawsuits also shed light on the economic realities of working people pursued for medical debt. The top employer of patients sought for wage garnishment by JHH is Johns Hopkins itself—including the Johns Hopkins University (JHU), the JHH and other the affiliates of the Johns Hopkins Health Systems Corporation (JHHSC). One bank account with the Johns Hopkins Federal Credit Union also was garnished, in which JHH moved to garnish all $75 available in the patient's bank account.[58] Maryland court records reveal 44 instances in which a garnishment was ordered from a Johns Hopkins entity, accounting for approximately 10% of the garnishment cases since 2009. JHH sought $76,105 from Johns Hopkins employees since 2009, and was awarded $72,577 in total judgments from those

cases. The median amount sought per case was $1,178, and the minimum amount for which an employee was sued was $488.

Working people in low-wage industries, such as retail and food service, also are frequent targets of the hospital's garnishment actions. After the state of Maryland, the employers who received the most garnishment requests by JHH are Walmart and Amazon, private-sector employers criticized for paying employees low wages.[59] While JHH states that it only takes legal action against patients whom they deem have the ability to pay, the following examples show that JHH is pursuing low-wage and other marginalized workers in Maryland courts. Furthermore, the use of garnishments by a nonprofit institution like JHH makes the working people who are sued even more vulnerable, as their financial stress compounds and they may be less able to pay for such vital services as food, rent and utilities.

FIGURE M: **TOP FIVE EMPLOYERS WHO RECEIVED GARNISHMENT REQUESTS FROM JHH, 2009–2018**

Name of Employer	Count of Garnishment Requests
Johns Hopkins University	27
Johns Hopkins Hospital[60]	15
State of Maryland	17
Walmart	16
Amazon.com	10
Total:	*85*

In one example, a Walmart employee taking home $948.38 in biweekly pay was pursued aggressively by JHH in court. The defendant, a female who lives near the hospital, visited the JHH Emergency Room in January 2014 and was billed for an outstanding balance of $458.74. JHH then sued this patient in April 2015 for the outstanding balance claimed, and ultimately obtained a court order to garnish her wages at Walmart in October 2016 for $511, with the new amount reflecting post-judgment interest and court fees. The garnishment order obliges the patient to pay JHH $25 a month until the debt is satisfied. The case is still active, meaning this patient has not yet satisfied her debt.[61] At the rate of $25 a month, this patient will be indebted to JHH for an additional two years if she is able to pay every month. If the wage reported by the patient represented her household's sole source of income, under Maryland law she would qualify for charity care covering 80% up to 100% of her medical bill, depending on household size.[62]

In another example, a McDonald's employee received care at the JHH Emergency Room in 2014. The defendant, a white male Baltimore resident who lives near the hospital, was billed $1,990.44 with no adjustment, suggesting the patient either did not have insurance or, if he did, it did not cover the visit. In April 2016, a judgment was entered and in May 2016, JHH requested a garnishment of the McDonald's worker's wages to satisfy the debt, which now totals $2,081.98, including interest and court costs. JHH also filed for a property garnishment request in June 2018, likely seeking money from the patient's bank account. The case is still active, implying that JHH is still pursuing this patient for an ER visit in 2014.[63]

MEDICAL DEBT VICTIM SPEAKS OUT

ERIC SIMMONS*

Eric went to Johns Hopkins Hospital in 2013 for an ankle injury that ultimately caused him to lose his job at a bakery. Eric later got a more difficult job at Amazon. In 2014, Eric was sued for $524 for his hospital visit and had his Amazon wages garnished by Johns Hopkins Hospital for his medical debt.

"Stop lying, and tell the truth. I was never offered charity care. You withheld information from me, information that could have helped me and my family live more prosperously. Years later, we're still playing catch-up. We've finally paid off the debt to Hopkins, but I want to make sure this doesn't happen to anyone else."

*District Court of Maryland, Case No. 10100132652014.

JHH also pursued a patient earning $13.95 an hour from a nonprofit employer with a wage garnishment for medical debt. The patient, an African American male Baltimore resident who lives near the hospital, received medical care at JHH in June 2014. The patient was billed $2,100.86 and received no adjustment on the amount. JHH filed a lawsuit in November 2015, obtaining a judgment in March 2016, and then subsequently obtained a wage garnishment order from the court in June 2016. Two years later, JHH filed another garnishment request, which the employer answered, stating that the patient earns $13.95 an hour (earning $558 if he works 40 hours per week) and pays $303.74 per pay period for child support (Figure N). The case still is active, implying that JHH continues to pursue this patient for a debt incurred in 2014.[64] At the time of the initial lawsuit in 2015, the patient's wage rate indicates he would have qualified for 60% to 100% of charity care coverage depending on household size under Maryland law, assuming he worked 2,080 hours (full time) annually and had no other sources of household income.[65]

FIGURE N: **ANSWER TO WRIT OF GARNISHMENT OF WAGES**

ANSWER

(TO BE FILED WITHIN 30 DAYS FROM RECEIPT OF THE WRIT OF GARNISHMENT ON WAGES.)

The answer of the Garnishee/Employer to the Writ of Garnishment served in this case, reports as follows:

☐ The Defendant (specify name)_____ is not employed by this Employer, and the Employer req[redacted]ishment.

☒ The Defendant (specify name)[redacted]_____ is employed by this Employer, and the rate or basis of pay is $ 13.95 per hour.

☐ The Garnishee/Employer desires to contest the attachment and asserts the following defenses on the Garnishee's own behalf as well as any defenses that the Debtor could assert: _____

☐ The following prior liens exist:

Name and Address of Court	Case Number	Plaintiff's Name and Address	Date Attached	Amount of Attachment
Maryland Child Support	[redacted]		[redacted]18	132.50 per pay
Maryland Child Support	[redacted]		[redacted]18	171.25 per pay

HOPKINS EMPLOYEES BEWARE

JHH Targets Its Own Employees for Lawsuits and Garnishments

Our review of cases revealed that JHH moves to garnish the wages of Johns Hopkins University and JHH staff more than any other employers. In some cases it appears the defendants incurred hospital charges prior to becoming Johns Hopkins employees; in other cases, the debt is related to a defendant's out-of-pocket costs not covered by Johns Hopkins Employer Health Programs (EHP). Overall, it is not clear why Johns Hopkins employees are targeted so much by JHH for garnishments, but it simply may be because it is easier to collect money from its own or its affiliates' employees.

Several of the cases involved suing employees for hospitalization costs for a single year, even though the amount sought in litigation was greater than EHP's annual out-of-pocket maximums for individual coverage.[66] In other cases, individuals were pursued for small out-of-pocket amounts, only to have their wages garnished after they became JHH or JHU employees.

In one example, an African American woman in her 40s owed less than $200 for a 2009 ER visit mostly covered by her insurance. After filing suit, JHH's attorney let a year elapse without serving her,[67] but was able to get the case reinstated and then filed four summons renewals in an attempt to serve her over a three-year period. After serving her in early 2015, JHH obtained an affidavit judgment against her and eventually won a garnishment order instructing JHH to withhold her wages to cover the judgment amount, including more than $150 in court costs.[68]

In another case, a Latina woman employed by Johns Hopkins University asked the court to reconsider a garnishment order brought against her. In 2014, JHH had obtained a judgment for more than $2,300 stemming from hospitalization at JHH that was about 80% covered by insurance. The woman stated in her request letter that she'd had two major surgeries within four months and that she had temporarily lost her insurance and her pay while recuperating from back surgery. Her financial assistance application to JHH was denied, and JHH's attorney demanded payment of $650 per month in order to remove the garnishment order, according to her letter. Her request for reconsideration was denied by the court. About four months later, JHH filed an order of satisfaction, closing the case—suggesting she acceded to their demands.[69]

In other cases, it appears that some employees covered by Hopkins EHP do not realize the amounts they'll be charged for receiving medical treatment, as illustrated in Figure O.[70] Hospitalizations can result in thousands of dollars of medical debt, even for JHH employees, and these amounts would be especially difficult to repay for those earning less than $50,000. The irony is that a portion of these employees likely could qualify for some financial assistance, according to JHH's Financial Assistance Manual, if they were able to navigate the application system described later in the report (Appendix B). Financial or medical hardship assistance does not apply to patients that JHH has sued and obtained a judgment against.[71]

FIGURE O: **DEFENDANT NOTICE OF INTENTION TO DEFEND**

DISTRICT COURT OF MARYLAND

NOTICE OF INTENTION TO DEFEND

Case # [illegible] 2012

SEE NOTICE ON BACK OF COMPLAINT FORM FOR IMPORTANT INFORMATION

Explanation of defense:

JHH Takes Medicare and Medicaid Patients to Court

JHH also pursues Medicare and Medicaid beneficiaries in Maryland courts for alleged medical debt. This practice is in some cases forbidden.[72] In a review of more than 300 case files, the authors of this report identified four cases in which a JHH patient with Medicaid or Medicare was pursued in court for medical debt. The first case was filed in 2018 against a 75-year-old African American man and Baltimore resident with Medicare who lived near the hospital. The judge ruled in favor of the hospital, with a consent judgment against the patient to pay $100 a month, for a debt of $2,220.53 plus $74 in costs. Medicare covered some, but not all, of the patient's original bill.[73]

In a review of more than 300 case files, the authors of this report identified four cases in which a JHH patient with Medicaid or Medicare was pursued in court for medical debt.

The second case was filed against a woman and Baltimore resident in 2018 for a bill of $1,846.33 for one day of service at the hospital plus $74 in court costs. The patient answered the lawsuit stating she had "Amerigroup (Medicaid/Social Service) Insurance that should have covered this visit" (Figure P). The judge ruled in favor of the hospital with an affidavit judgment.[74]

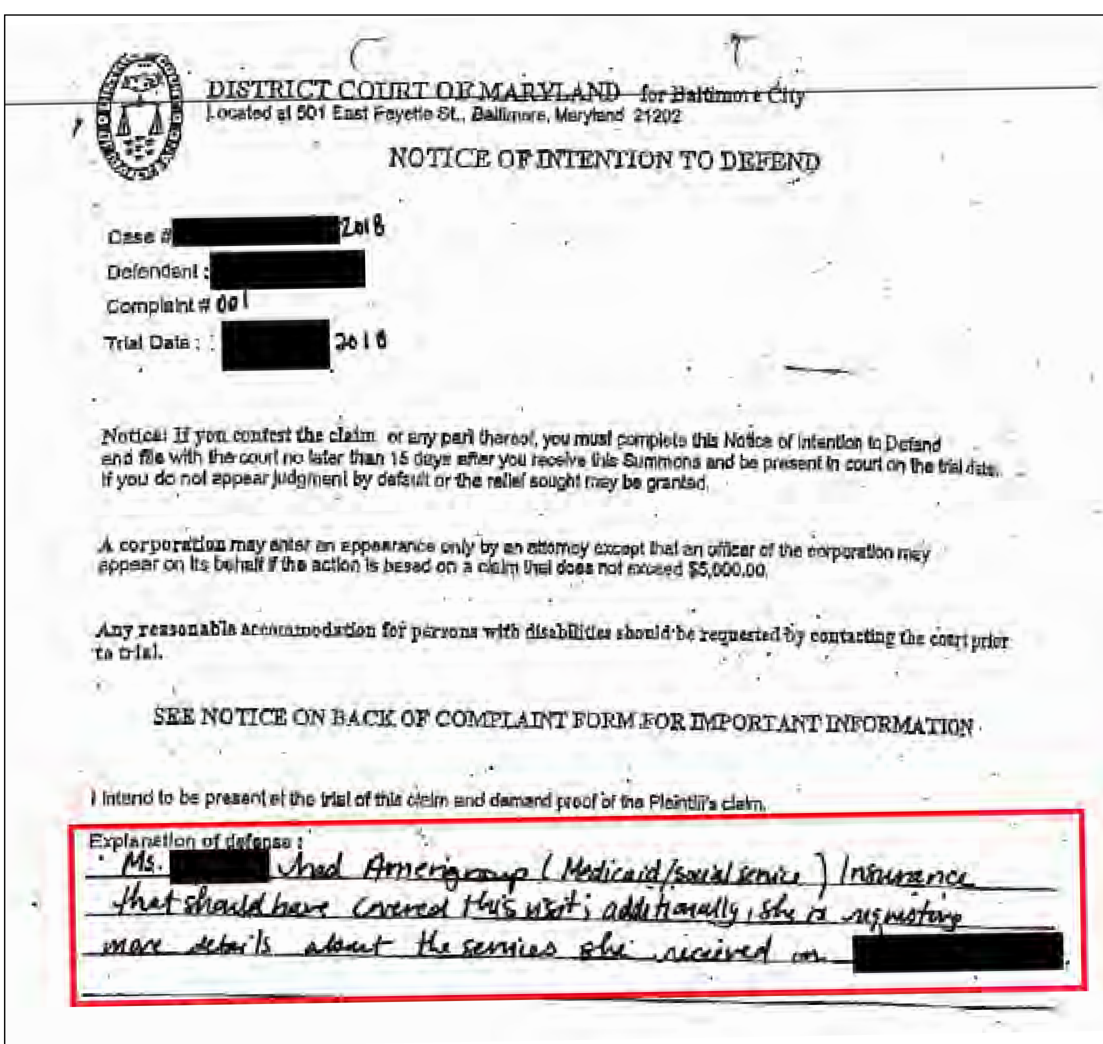
The third case was filed against a patient with Medicare, a 68-year-old African American woman and Baltimore resident residing near the hospital. The patient received care at JHH for 14 days between May and June of 2016. Medicare paid for some but not all of the charges, leaving the patient with the responsibility of paying a balance of $3,357. JHH filed a lawsuit against the patient in October 2017, and the judge ruled the case as a voluntary dismissal in November 2017.[75] The case file does not specify whether the case was dismissed with stipulated terms, which under Maryland law means the case could have been dismissed after an agreement like a payment plan or that the case can be reopened at any time by the plaintiff.[76]

The last example involves a case brought by JHH against a Baltimore resident and JHH employee who, in November 2014, took her 14-year-old daughter to the JHH emergency

room. It appears from the case file that the 14-year-old was covered by Medicaid at the time of the visit. The total bill was $1,174.21. In February 2017, the judge ruled against the patient and in June 2017, JHH sought a garnishment of the mother's wages from her employer, JHH. The garnishment seeks to recoup the outstanding balance of $1,162.21 plus an additional $111.68 in court costs and interest.[77] The case was satisfied in December 2017.

It is unclear why JHH has pursued patients with Medicaid and Medicare in court for medical debt. These four cases were identified within the sample of all of JHH's medical debt lawsuits reviewed for this report. It is possible there are even more patients with Medicare and Medicaid who have been pursued by JHH since 2009 for medical debt in cases outside of this report's sample size.

FIGURE P: **DEFENDANT NOTICE OF INTENTION TO DEFEND**



DISTRICT COURT OF MARYLAND for Baltimore City
Located at 501 East Fayette St., Baltimore, Maryland 21202

NOTICE OF INTENTION TO DEFEND

Case # [redacted] 2018
Defendant: [redacted]
Complaint # 001
Trial Date: [redacted] 2018

Notice: If you contest the claim or any part thereof, you must complete this Notice of Intention to Defend and file with the court no later than 15 days after you receive this Summons and be present in court on the trial date. If you do not appear judgment by default or the relief sought may be granted.

A corporation may enter an appearance only by an attorney except that an officer of the corporation may appear on its behalf if the action is based on a claim that does not exceed $5,000.00.

Any reasonable accommodation for persons with disabilities should be requested by contacting the court prior to trial.

SEE NOTICE ON BACK OF COMPLAINT FORM FOR IMPORTANT INFORMATION

I intend to be present at the trial of this claim and demand proof of the Plaintiff's claim.

Explanation of defense: Ms. [redacted] had Amerigroup (Medicaid/social service) Insurance that should have covered this visit; additionally, she is requesting more details about the services she received on [redacted]

It is possible there are even more patients with Medicare and Medicaid who have been pursued by JHH since 2009 for medical debt in cases outside of this report's sample size.

JHH Medical Debt Lawsuits Contribute to Bankruptcy Cases

Some former JHH patients even have filed for personal bankruptcy while being pursued by the hospital for debt. Since 2009, more than 40 cases filed by JHH have resulted in a bankruptcy status, meaning the defendant has filed for personal bankruptcy and the medical debt lawsuit has been stayed, or put on pause. These bankruptcies are not always solely due to being sued by JHH, but the medical debt likely is a contributing factor.[78] Filing for personal bankruptcy is a life-altering decision, as it lowers a patient's credit score, making it difficult for the patient to purchase a car, secure housing, get a loan, or even find and retain a job. The median amount of medical debt sought by JHH, for which patients' economic stability was destabilized, was $1,377.

FIGURE Q: **JHH MEDICAL DEBT LAWSUITS WITH BANKRUPTCY STATUS, 2009–2018**

	Total Lawsuits With Bankruptcy Status	Total Medical Debt Sued For	Median Claims of Medical Debt Sued For
No Garnishments	29	$64,637	$1,281
Property Garnishee	1	$5,000	$5,000
Wage Garnishee	13	$23,843	$1,377
Total	43	$93,480	$1,377

Bankruptcy cases involving JHH as a creditor also shed light on the economic realities of patients the hospital pursues in courts. For example, a former JHH patient, an African American female, is sued by JHH for $10,745.41 in alleged medical debt.[79] The patient ultimately filed for Chapter 7 bankruptcy,[80] which stays the medical debt lawsuit. In the Chapter 7 bankruptcy petition, the patient listed JHH and Johns Hopkins Bayview as creditors who have secured

claims for medical debt. The patient also stated she participated in the food stamp program and that she was facing eviction. Based on the information provided, the patient's stated income levels should have qualified her for charity care under Maryland law and JHH's own financial assistance policy, as she only took home $2,201.33 a month to support herself and two children, meaning she was earning below 200% of federal poverty levels if she was the sole source of household income.[81] Ultimately, the bankruptcy was discharged, wiping away her debts. But filing for bankruptcy deeply affects an individual's credit scores, and as a result this patient could have a more difficult time securing employment, housing and a job in the future in part because of JHH's pursuit of this medical debt. This case example also indicates that JHH is not making charity care as accessible as it should, especially since in recent years the hospital has been fully reimbursed.

MEDICAL DEBT VICTIM SPEAKS OUT

MARY SCOTT[82]

Mary went to the JHH ER for acute bronchitis in October 2016, lacking insurance and employed on modified compensation as a medical records clerk. JHH sued her in July 2017 for the ER visit and obtained a judgment against her two months later. Mary then began dealing with someone called "Ms. Smith" from "JH Law." She agreed to pay $100/month and did so for about five months with the help of her adult children.

In June 2018 Mary met someone who claimed they could help her file for bankruptcy. Unfortunately, after paying $400 to this person, Mary found out she was more or less swindled, as necessary paperwork and fees for the case were not submitted. Mary took it upon herself to file all the paperwork at the courthouse and eventually successfully declared bankruptcy in November 2018.[83] This has affected Mary's anxiety and well-being tremendously.

"They should really emphasize that charity care is available. Every patient should be informed. The way they go after people is aggressive, especially for those of us that are living paycheck to paycheck. Hopkins should find some compassion for its patients because their current practices can cause financial devastation."

Medical Debt Lawsuits Can Have an Outsized Impact on Patients' Lives While Making Almost No Difference to JHH's Finances

Between 2009 and 2018, JHH pursued patients in Maryland courts for medical debt claims that amount to less than one-tenth of 1% of the hospital's annual operating revenue (Figure R). However, as illustrated by review of the individual cases, medical debt lawsuits can disrupt the lives of working people in financially toxic ways, including wage and property garnishments, bankruptcies, creating a need to borrow at high interest rates and the risk of further financial marginalization.

FIGURE R: **JHH MEDICAL DEBT SUED FOR AS A % OF OPERATING REVENUE**

	Total Medical Debt Sued For	Operating Revenue[84]	Medical Debt Sued For as a % of Total Operating Revenue
FY 2011	$91,266.42	$1,730,277,000	0.01%
FY 2012	$307,574.18	$1,756,969,000	0.02%
FY 2013	$375,298.65	$1,948,222,000	0.02%
FY 2014	$395,468.68	$1,995,127,000	0.02%
FY 2015	$717,985.51	$2,096,729,000	0.03%
FY 2016	$807,156.91	$2,235,649,000	0.04%
FY 2017	$732,762.54	$2,339,516,000	0.03%
FY 2018	$975,325.04	$2,422,823,000	0.04%
Total	$4,402,838	$16,525,312,000	0.03% (Avg.)

In response to the 2008 Baltimore Sun investigation, Johns Hopkins offered a defense that the JHHS Corporation pursues less than 1% of bad debt through legal action.[85] However, analysis of recent JHH medical debt litigation shows the hospital is making smaller provisions for bad debt (both as percentage of revenue and as a dollar amount), while at the same time is increasing the number of lawsuits to get judgments (again as a percentage of bad debt and as a dollar amount). This means that JHH has been taking more people to court and suing to recover more of its bad debt in court. In 2015 and 2016, the hospital pursued more than 3% of medical debt in courts as a percentage of total bad debt reported, and nearly reached the 3% level in 2018.

FIGURE S: **JHH'S AUDITED FINANCIALS COMPARED WITH TOTAL MEDICAL DEBT CLAIMS IN MARYLAND**

	Net Patient Service Revenue	Provision for Bad Debt	Total Medical Debt Sued For (FY)	Total Claims as a Percentage of Provision for Bad Debt
FY 2011	$1,585,310,000	$38,243,000	$91,000	0.24%
FY 2012	$1,634,266,000	$34,930,000	$308,000	0.88%
FY 2013	$1,841,096,000	$59,693,000	$375,000	0.63%
FY 2014	$1,862,077,000	$58,044,000	$395,000	0.68%
FY 2015	$1,879,981,000	$19,830,000	$718,000	3.62%
FY 2016	$1,968,018,000	$25,774,000	$807,000	3.13%
FY 2017	$2,042,462,000	$40,121,000	$733,000	1.83%
FY 2018	$2,074,422,000	$33,103,000	$975,000	2.95%

These outpatient figures suggest that patients who were not admitted to the hospital had more difficulty paying for their medical care than those admitted.

JHH's financial reporting also provides insight into which patients have difficulty paying for medical care. Since 2010, JHH's bad debt has predominantly come from outpatient visits, accounting for approximately two-thirds of total bad debt reported by the hospital (Figure T).[86] Outpatient figures include ER visits. These outpatient figures suggest that patients who were not admitted to the hospital had more difficulty paying for their medical care than those admitted.

Charity care also has been provided on an overwhelmingly outpatient basis since 2010, with in-patient charity care spending averaging just 6.2% of total charity care spending, and outpatient charity care spending averaging 93.8% of total charity care spending between 2010 and 2018.[87] These inpatient and outpatient bad debt and charity care figures suggest that 1) JHH is resistant to providing charity care on an inpatient basis and 2) JHH prefers to stabilize but not admit ER patients that are presumed unlikely to pay their bills, a practice that is legal under the Emergency Medical Treatment and Labor Act (EMTALA),[88] but is an unethical and morally repugnant practice all the same.

FIGURE T: **JHH BAD DEBT PROVISIONS BY TYPE OF SERVICE**

Year	Bad Debts % Inpatient	Bad Debts % Outpatient	Charity Care % Inpatient	Charity Care % Outpatient
FY 2018	33.9%	66.1%	14.8%	85.2%
FY 2017	38.5%	61.5%	5.0%	95.0%
FY 2016	38.2%	61.8%	6.4%	93.6%
FY 2015	38.5%	61.5%	3.6%	96.4%
FY 2014	38.5%	61.5%	3.8%	96.2%
FY 2013	38.5%	61.5%	5.1%	94.9%
FY 2012	38.5%	61.5%	3.6%	96.4%
FY 2011	37.9%	62.1%	7.8%	92.2%
FY 2010	38.5%	61.5%	5.5%	94.5%

As noted elsewhere in this report, the amount of debt that JHH has sought in court from former patients is miniscule compared with the benefits JHH receives as a nonprofit institution. In 2017 alone, JHH received $164 million in tax exemptions and $25 million to provide charity care, $3.3 million of which was not even used.[89] The surplus charity care funding from 2017 nearly equals the $3.4 million sought in all of the medical debt cases JHH filed between 2015 and 2018. JHH also receives substantial philanthropic support. Between 2010 and 2018, Johns Hopkins Medicine, which oversees the JHHSC and Johns Hopkins University School of Medicine, received donor contributions totaling between $2.1 and $2.65 billion.[90] This raises the question why a multibillion-dollar institution with such generous taxpayer and philanthropic support still is in the business of aggressively pursuing patients for amounts that are less than pocket change to the institution.

JHH Financial Assistance is Difficult to Access

The process for receiving financial assistance at JHH is arduous and complicated, and should be made more accessible to patients. In order to apply for financial assistance at JHH, patients must submit a detailed Financial Assistance Application and a Patient Profile Questionnaire, available in Appendix A.[91] If an application is successfully completed and submitted, a JHH employee then determines whether the patient qualifies for assistance. In Maryland, there is a standardized financial assistance application for all acute care hospitals.[92] This uniform financial assistance application "may not require documentation that presents an undue barrier to a patient's receipt of financial assistance" under Maryland law.[93] It is up to the discretion of individual hospitals to decide what documentation to require from patients to support their financial assistance application, and JHH requires a shocking amount of information, including a copy of the patient's most recent tax return, last three pay stubs, Social Security award and determination letter if applicable, proof of monthly living expenses with copies of phone bills, utility bills and rent/mortgage payments, and proof of U.S. citizenship or lawful permanent residence status (Appendix A).

It is up to the discretion of individual hospitals to decide what documentation to require from patients to support their financial assistance application, and JHH requires a shocking amount of information...

As a nonprofit, JHH's financial assistance policies are regulated by the IRS. The IRS does not require any particular eligibility criteria for financial assistance, but only requires that the hospital's financial assistance policy specifies eligibility criteria.[94] In Maryland, state law requires hospitals, at minimum, to provide free medically necessary care for those below 200% of federal poverty line. There also are reduced-cost requirements for families between 200% and 500% of the federal poverty line,[95] as shown in Appendix B.[96]

JHHS hospitals are required to post notices of financial assistance availability at patient registration sites, the billing office and emergency department at each facility.[97] A site visit to JHH verified that one sign was located above the check-in desk in the Emergency Room

National

in the hospital, where security guards are present. The researchers who took this photo were discouraged from doing so, even though this is valuable public information. The same sign also is posted in the Admitting Office. The researchers also were told there is no onsite office for billing (where a patient could dispute a bill or ask for assistance), but that instead patients must call an offsite building called "Keswick," which only accepts phone calls and no in-person meetings.

The financial assistance signs in the hospital are not welcoming. They do not mention any of the Maryland legal requirements that those below 200% of the federal poverty line must receive free care, or that reduced cost care is available up to 500% of the federal poverty line, nor do they give any information about what those amounts are in actual dollars. For example, it's unlikely from reading this material that a family of three earning $62,340 might guess they are eligible for a 20% cost reduction, as shown in Appendix B. In fact, the first qualification for financial assistance listed on the sign is whether you "are a US citizen or permanent resident living in the U.S. for a minimum of one year."[98]

FIGURE U: **FINANCIAL ASSISTANCE SIGN IN JHH EMERGENCY ROOM**

The financial assistance signs in the hospital are not welcoming. They do not mention any of the Maryland legal requirements that those below 200% of the federal poverty line must receive free care, or that reduced cost care is available up to 500% of the federal poverty line, nor do they give any information about what those amounts are in actual dollars.

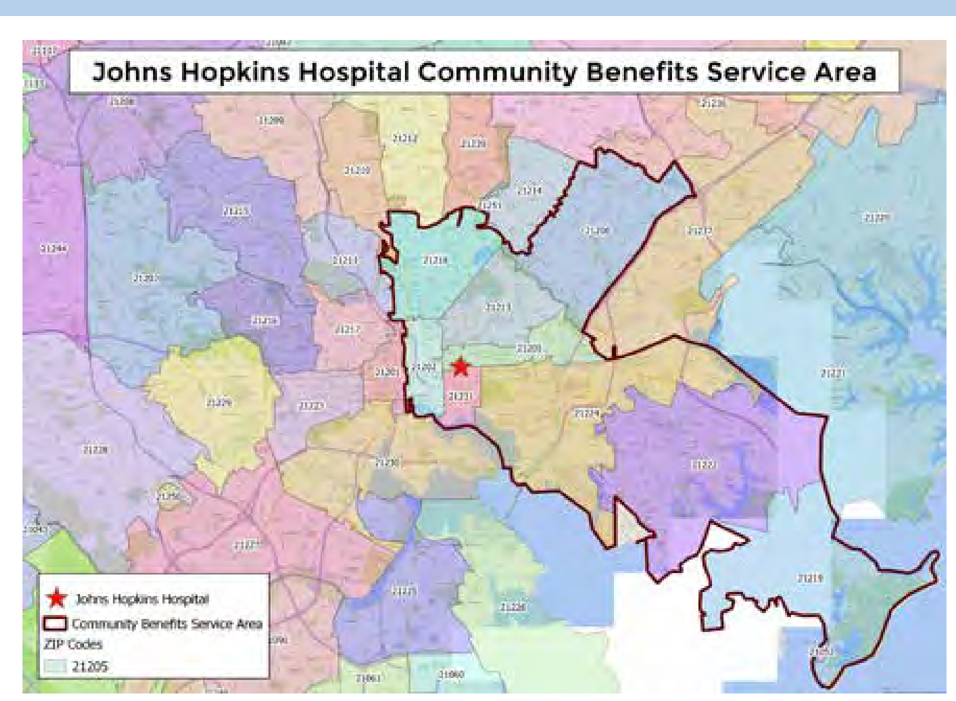
FIGURE V: **SIGN IN ADMITTING OFFICE**

UNDOCUMENTED PATIENTS NEED NOT APPLY

In the financial assistance signage (Figures U and V), U.S. citizenship or status as a permanent legal resident is listed as a requirement for financial assistance at JHH. But as of Jan. 1, 2015, patients who reside within JHH's Community Service Benefits Area, which is an area qualified and defined by the IRS, also are eligible regardless of documentation status (Figure W).[99] The CBSA is an identified area for health programming, but these rules also affect patients who receive care at the hospital. For patients at JHH who are not U.S. citizens or permanent legal residents for one year as of the date of their medical service, their address determines whether or not they will qualify for financial assistance from the hospital. This requirement is stricter than JHH's peers. The University of Maryland Medical Center, for example, does not withhold financial assistance on the basis of documentation status.[100] At Howard County General Hospital and Suburban Hospital, also affiliates of the JHHSC, financial counselors contact the U.S. consulate of patients who do not have U.S. citizenship to determine the patient's net worth.[101] Medical care at JHH would be more accessible to the Baltimore community if financial assistance qualifications were less arduous, and if those qualifications were communicated more clearly to patients.

The Access Partnership (TAP) is a Johns Hopkins Medicine program that provides access to primary and specialty care to those who are uninsured or underinsured and "do not have access to state or federal health insurance programs."[102] Presumably, this includes patients who are undocumented. Additional requirements for patients to qualify include a household income less than 200% of the federal poverty level and residence within specific zip codes in East Baltimore.[103] The program had an extremely modest cost of $113,203 to Johns Hopkins Hospital in 2017, according to the JHH Community Benefits Report.[104] While this program provides access to care to those who qualify, the program should be expanded to include all zip codes and all necessary care. For example, TAP does not cover prescriptions, dental services or routine vision care for qualifying patients.[105]

FIGURE W: **JHH COMMUNITY BENEFITS SERVICE AREA**



It’s Time for JHH to Stop Pursuing Medical Debt Cases

Johns Hopkins Hospital is not a welcoming institution for many, most notably its own neighbors. Its practice of suing neighbors for medical debt, which often includes years’-long pursuits, and aggressive tactics such as wage and property garnishments, targets working people and can push former patients into bankruptcy. JHH chooses to employ these punitive practices, all for a median claim amount of $1,438, even as the hospital receives more charity care dollars from the state of Maryland than it provides in benefits to the indigent. A key question is how JHH decides who are the 2% to 3% of debtors that it targets for legal action? The evidence reviewed in this report demonstrates that the answer cannot be simply, as JHH policy states, that it only sues patients who can afford to pay.

These practices...are deeply concerning and raise questions about whether JHH is the welcoming neighbor it should be to Baltimore residents who pass through the hospital’s doors for care.

Evidence also shows that Johns Hopkins employees and neighborhood residents, especially African American residents, are the most acutely affected by JHH’s medical debt litigation. These practices, in comparison with JHH’s requirement under Maryland law to provide charitable care, are deeply concerning and raise questions about whether JHH is the welcoming neighbor it should be to Baltimore residents who pass through the hospital’s doors for care. Does JHH effectively discourage working-class Baltimore residents from entering their doors with aggressive debt-collection tactics when those patients will struggle to pay? Does JHH raise unreasonable barriers to free or discounted care? And does JHH follow the letter of the Maryland law with respect to free and discounted care? Absent extensive reform of its financial assistance policies and practices, Johns Hopkins Hospital should stop suing people for medical debt completely. In addition, it should invest unused charity care dollars provided by the state for the direct benefit of its neighbors and the Baltimore community.

Appendix A: **JHH Financial Assistance Forms**

Johns Hopkins Hospital
Financial Assistance Application Requirements

If you or a family member is requesting a reduction on your bills, related to care provided by The Johns Hopkins Medical Institution and its affiliates, we would like to assist you with your request by conducting a reasonable assessment based on your current financial status. Please note that financial assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-residents of Maryland will only be considered based on special circumstances. We cannot guarantee that your financial status will justify a reduction on balances owed, but we will make every effort to work with you in trying to resolve your account(s).

In order to expedite your request, we will need you to provide us with all required information listed below.

If assistance is needed to complete the forms, please contact us at (443) 997-0148.

Please complete the attached forms and return them along with the documentation as indicated below.

Forms to include:

1. Maryland State Uniform Financial Assistance Application (attached)
2. Patient Profile Questionnaire (attached)
3. Medical Financial Hardship Application (attached), complete if medical expenses incurred over 12 months is greater than 25% of family income.

Documentation to include:

1. Copy of last year's tax returns. (If married and filed separately, please provide copies of both returns).
2. Copy of your last three (3) pay stubs, letter from employer or proof of unemployment status
3. Copy of social security award letter (if applicable)
4. Copy of the determination letter from Medical Assistance or Social Security.
5. Proof of monthly living expenses as recorded on your application such as copies of phone bills, BG&E bills, or rent/mortgage payments.
6. Copies of unpaid medical expenses.
7. Copy of all medical insurance cards.
8. Proof of U.S. citizenship such as an identification card, driver's license, birth certificate or lawful permanent residence status (green card).

PLEASE MAIL INFORMATION TO:
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211
ATTN: Financial Assistance Liaison

Johns Hopkins Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

Maryland State Uniform Financial Assistance Application

Information About You

Name ____
First Middle Last

Social Security Number ______-____-______ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address ______________________________________ Phone ______________

____

______________________________________ ______________
City State Zip code Country

Employer Name ______________________________________ Phone ______________

Work Address ______________________________________

____
City State Zip code

Household members:

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? ______________
If yes, what was the determination? ______________________________________

Do you receive any type of state or county assistance? Yes No

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: ______________________________

PATIENT NAME: ______________________________

PATIENT ADDRESS: ______________________________
(Include Zip Code)

MEDICAL RECORD # ______________________________

Date: ______________________________

Family Income for twelve (12) calendar months preceding date of this application: ______________

Medical Debt incurred at The Johns Hopkins Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of service	Amount owed
______________	____________________
______________	____________________
______________	____________________
______________	____________________

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

______________________________ Date: ________________
Applicant's signature

____
Relationship to Patient

For Internal Use: Reviewed By: ______________________________ Date: ____________

Income: ____________________ 25% of income= ________________

Medical Debt: ________________ Percentage of Allowance: __________

Reduction: ____________________

Balance Due: ____________________

Monthly Payment Amount: ______________ Length of Payment Plan: _______ months

PATIENT FINANCIAL SERVICES

PATIENT PROFILE QUESTIONAIRE

HOSPITAL NAME: ______________________________

PATIENT NAME: ______________________________

PATIENT ADDRESS: ______________________________ (Include zip code)

MEDICAL RECORD #: ______________________

1. What is the patient's age? ________
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the follow amounts? Yes or No

   Family Size:

   Individual: $2,500.00

   Two people: $3,000.00

   For each additional family member, add $100.00

   (Example: For a family of four, if you have total liquid assets of less than $3,200.00, you would answer, YES.)
8. Is patient a resident of the State of Maryland? Yes or No

   If not a Maryland resident, in what state does patient reside? ________
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does household have children in the free or reduced lunch program? Yes or No
12. Does household participate in low-income energy assistance program? Yes or No
13. Does patient receive SNAP/Food Stamps? Yes or No
14. Is the patient enrolled in Healthy Howard and referred to JHH? Yes or No
15. Does patient currently have:
    - Medical Assistance Pharmacy Only Yes or No
    - QMB coverage/SLMB coverage Yes or No
    - PAC coverage Yes or No
16. Is patient employed? Yes or No

    If no, date became unemployed. ________

    Eligible for COBRA health insurance coverage? Yes or No

Appendix B: **Maryland Financial Assistance Allowances**

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

Table for Determination of Financial Assistance Allowances
Effective 2/1/18

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$24,280**	$26,708	$29,136	$31,564	$33,992	$36,420
2	**$32,920**	$36,212	$39,504	$42,796	$46,088	$49,380
3	**$41,560**	$45,716	$49,872	$54,028	$58,184	$62,340
4	**$50,200**	$55,220	$60,240	$65,260	$70,280	$75,300
5	**$58,840**	$64,724	$70,608	$76,492	$82,376	$88,260
6	**$67,480**	$74,228	$80,976	$87,724	$94,472	$101,220
7	**$76,120**	$83,732	$91,344	$98,956	$106,568	$114,180
8*	**$84,760**	$93,236	$101,712	$110,188	$118,664	$127,140
**amt for each mbr	$8,640	$9,504	$10,368	$11,232	$12,096	$12,960
Allowance to Give	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines
** For family units with more than eight (8) members.

Table for Determination of Financial Assistance Allowances
Effective 2/1/18

# of Persons in Family	Income Level**		
# of Persons in Family	*300% of FPL	400% of FPL	500% of FPL
1	**$36,420**	$48,560	$60,700
2	**$49,380**	$65,840	$82,300
3	**$62,340**	$83,120	$103,900
4	**$75,300**	$100,400	$125,500
5	**$88,260**	$117,680	$147,100
6	**$101,220**	$134,960	$168,700
7	**$114,180**	$152,240	$190,300
8*	**$127,140**	$169,520	$211,900
Allowance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,960for each additional person at 300% of FPL, $17,280 at 400% at and $21,600 at 500% of FPL.

Source: Financial Assistance Policies Manual, General, Financial Assistance for JHH, JHBMC and JHBCC. Effective Date Feb. 1, 2017. https://hpo.johnshopkins.edu/enterprise/policies/1003/35770/appendix_169032.pdf

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AFL-CIO

www.aflcio.org

www.NationalNursesUnited.org

COALITION FOR A HUMANE HOPKINS

TestimonyFOR_SB514.Feb23-2021.pdf

Uploaded by: Guillemard, Claude

Position: FAV

To: Senate Finance Committee

From: Claude Guillemard, 9 Edgemoor Road, Timonium MD 21093

Re: Medical Debt Protection Act (HB565/SB514)

Date: February 23, 2021

I respectfully write to the Senate Finance Committee to express in the strongest terms my support of SB 514.

An employee at Johns Hopkins, I was shocked when I read the report (attached) on the hospital practice of suing low-income patients for less than $1000.

It turns out that the Hopkins hospital is not extending their 'charity care' to all eligible patients, as it should in exchange of the huge tax breaks they receive.

I have seen and participated in many events and actions to bring this issue to the administration in the past few years – but to no avail.

Only Maryland-wide legislation will help fix this issue of socio-economic discrimination: this practice is destroying families, neighbors, and even Hopkins employees themselves (some are sued by their own work place).

Please intervene in this pervasive issue so that our hospitals can truly serve everyone and support the Medical Debt Protection Act.

Thank you for your consideration.

Sincerely,

Claude Guillemard

410-842-5282

District 42B

PM SB0514 Testimony.docx.pdf

Uploaded by: Heflin, Malcolm

Position: FAV

PROGRESSIVE MARYLAND
P.O. Box 6988 Largo, MD 20792
www.ProgressiveMaryland.org
Contact@ProgressiveMaryland.org
Facebook.com/ProgressiveMaryland
@Progressive_MD

Testimony on Maryland HOUSE Bill SB0514:
Medical Debt Protection Act

TO: Senator Delores G. Kelley, Chair, and members of the Finance Committee
FROM: Malcolm Heflin, Progressive Maryland Lead Baltimore City Organizer, Baltimore City, District 46
DATE: Feb 23, 2021
POSITION: SUPPORT

Thank you for the opportunity to offer testimony on SB0514. Progressive Maryland is a grassroots, nonprofit organization with 9 chapters from Frederick to the Lower Shore and more than 100,000 members and supporters who live in nearly every legislative district in the state. In addition, there are dozens of affiliated community, faith, and labor organizations across the state that stand behind our work. Our mission is to improve the lives of working families in Maryland. Please note our strong SUPPORT FOR this bill.

Progressive Mayland has been tracking this issue since this effort started in 2019, and the need for reform has only grown more acute since the outbreak of the COVID-19 pandemic. Given that this disease disproportionately affects Black, Brown, immigrant, and other underserved people and communities, the fact that lawsuits to recover medical debt also affects them in large numbers is cause for immediate concern and alarm. We also want to ensure that anyone needs healthcare.

75% of people who contract COVID-19 will have at least one long-term effect. That's going to mean even more people requiring access to even more healthcare. This also means that this problem will only grow exponentially if we don't do anything to address this problem *now*.

And while we have tens of thousands of Marylanders who have to make the choice between healthcare and bills that month, hospitals in Maryland are given generous tax breaks and millions of dollars in charity care funding specifically to provide healthcare to low-income people. From 2014-2018, hospitals had $119,214,617 in unspent charity care funding, which is almost the exact amount of money they sought in medical debt lawsuits during the same time-period.

Progressive Maryland is proud to be a member of the End Medical Debt Maryland coalition with 43 other labor, faith, and community groups across the state representing over 350,000 Marylanders. We, along with our coalition partners, are dedicated to continuing the fight against medical debt and *for* our neighbors and communities, until struggles with medical debt is something we only read about in history books.

PROGRESSIVE MARYLAND

P.O. Box 6988 Largo, MD 20792
www.ProgressiveMaryland.org
Contact@ProgressiveMaryland.org
Facebook.com/ProgressiveMaryland
@Progressive_MD

We urge a FAVORABLE report on **SB0514**.

Respectfully,
Malcolm Heflin, Coalition Co-Lead
End Medical Debt Maryland
malcolm@progressivemaryland.org, 443-956-0001

###

End Medical Debt Maryland Coalition Partners

1199SEIU United Healthcare Workers East, Maryland Consumer Rights Coalition, Progressive Maryland, National Nurses United, Accessible Resources for Independence, Baltimore Women United, ATU Local 689, CASA in Action, Baltimore Teachers Union, CASH Campaign, Coalition Against Policing by Hopkins, Greater Baltimore DSA, Healthcare NOW of Maryland, Housing our Neighbors, IBEW Local 26, Lower Shore Progressive Caucus, Maryland Legislative Coalition, Maryland State AFL-CIO, Maryland Volunteer Lawyers Service, MD/DC Alliance for Retired Americans, Not Without Black Women, Peer Wellness & Recovery Services, Public Justice Center, SEIU 32BJ, Special Needs Navigator, Sunrise Baltimore, MICA Organizers and Activists, UFCW Local 1994 MCGEO, Maryland NAACP, Maryland Center on Economic Policy, UFCW Local 400, Metropolitan Washington Council AFL-CIO, Our Revolution Maryland, The Freedom Center, Independence Now, Integrated Living Opportunities, Disability Rights Maryland, Patient Providers LLC, Women's Democratic Club of Montgomery County, FreeState Justice, M.E.Action, IUOE Local 37, Maryland Professional Employees Council Local 6197, Marylanders for Patient's Rights, and unaffiliated community members

SB514 MVLS Testimony.pdf

Uploaded by: Hennen, Amy

Position: FAV

EXPANDING ACCESS TO JUSTICE FOR 40 YEARS

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MARYLAND SENATE FINANCE COMMITTEE
TESTIMONY OF MARYLAND VOLUNTEER LAWYERS SERVICE
IN SUPPORT TO SB0514: HEALTH FACILITIES—HOSPITALS – MEDICAL DEBT PROTECTION
WEDNESDAY, FEBRUARY 24, 2021

Chair Kelly and distinguished members of the Committee, thank you for the opportunity to testify in support to Senate Bill 514.

My name is Amy Hennen, and I am the Director of Advocacy at the Maryland Volunteer Lawyers Service (MVLS). MVLS is the oldest and largest provider of pro bono civil legal services to low-income Marylanders. Since MVLS' founding in 1981, our statewide panel of over 1,700 volunteer lawyers, has provided free legal services to over 100,000 Marylanders in a wide range of civil legal matters. In FY20, MVLS volunteer and staff lawyers provided legal services to 4,459 people across the state. Approximately 30% of our cases focus on consumer issues like foreclosure, tax sale, bankruptcy, and debt collection. For the reasons explained below, we respectfully request a favorable report on Senate Bill 514.

Medical debt is different from many other types of consumer debt -- people do not plan to get sick or get hurt. Medical bills often end in collections because of insurance or billing disputes. The consumer too often becomes responsible for medical debt because the hospital and insurer simply cannot resolve their disputes. Even when billing errors are corrected, the lengthy delays result in medical bills being sent to collections. The negative impact of medical debts on credit reports often creates additional hardships, including difficulty securing affordable credit, insurance, housing, and even employment.

MVLS assists Marylanders facing debt in several ways, including a courthouse clinic in Baltimore City as well as defending debt collection actions and representing Marylanders filing for bankruptcy throughout the state. In 2020, out of the 117 cases closed for bankruptcy, 30 percent of our clients stated that medical debt was a significant factor in filing bankruptcy.

Anne is a client that sought help from MVLS to resolve her numerous hospital bills. Her only income is from social security and is protected from garnishment. Anne's financial status would have made her a prime participant for the hospital's financial assistance programs especially since she is dealing with a permanent ongoing illness. However, she never knew that financial assistance was available because the hospital never informed her of it.

Her hospital bills were sent to collections and in the attempt to pay her overdue hospital bills, she fell behind on her other bills.

Another client that sought help from MVLS is Belinda who has stage 4 breast cancer. With her ongoing medical treatments and low source of income, Belinda became the subject of harassment from creditors. Many of the calls came from medical debt collectors, and Belinda began using credit cards to pay her hospital bills which resulted in $40,000 worth of debt.

Hospitals will likely say that people will not pay if they are not at risk of being sued or garnished. However, nearly everyone we meet at our courthouse clinic who is being sued for medical debt would qualify for financial assistance. From the data collected, the average consumer seen at these clinics is an African American woman earning less than half the Maryland median income. She is in her early 40s, does not have a college degree, and she is caring for at least one child or parent at home. She would be eligible for financial assistance.

Sadly, most individuals being sued for debt collection don't receive the type of legal assistance we provide at our courthouse clinic. Statistically people who do not dispute a bill or show up to the courthouse make up more than 80% of people sued in the state. That means they do not have the opportunity to contest the bill or the charges. This then means that the first interaction they have with the lawsuit is via a wage garnishment or bank attachment, taking 25% of their wages and possibly 100% of the contents of their bank account. Wage garnishments keep people in a cycle of poverty. They can easily mean someone cannot cover their rent payments, leading to eviction, and homelessness. This cycle creates a greater strain on state resources.

Reviewing patients for medical financial assistance prior to sending them to collections is necessary. My clients often choose to forego necessities like food and clothing to pay their medical debts. People should not have to decide between basic healthcare access and financial freedom. Consequently, we urge a favorable report on SB514.

Madam Chair and members of the Committee, thank you again for the opportunity to testify.

SB514 - Favorable - ORMD pdf.pdf

Uploaded by: Holt, Chrissy

Position: FAV

February 23, 2021

Maryland State Senate Finance Committee

SB 514: Health Facilities - Hospitals - Medical Debt Protection

Position: Favorable

Dear Chair Senator Kelley, Vice-Chair Senator Feldman, and Members of the Committee:

On behalf of Our Revolution Maryland, I am writing to express our strong support for SB 514.

This bill will protect low and middle-income households from punitive medical debt lawsuits. Medical debt is created when hospitals overcharge for products and procedures at rates that are not covered by insurance. Patients are charged for this overage and hospitals sells the debt as a revenue stream. Over thirty percent of the entire MD State Budget goes to healthcare, and hospitals receive ample Maryland tax subsidies for low and middle-income households. These hospitals should be challenged if they are billing the Maryland Budget again for losses so perhaps double dipping into Maryland tax dollars. All the while, Hospital Executives traumatize patients and their families for medical bills less than $1000. **When are patients or families given the list of costs per procedure and so they can make budgetary decisions in the medical moment? Or, before death? Is this life worth the $10,000 procedure knowing the medical debt can't be repaid? This process is cruel and inhuman in Maryland and America.**

This bill will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes and cars over medical debt. **This does not mean we support lawsuits for greater than $1000.** No one should have to choose between health and their home or car because they were sick. We can't deny COVID -19 has made this legislation even more necessary without universal healthcare. Without universal healthcare like single payer in the Healthy Maryland Program HB534 or Medicare for All, the global pandemic has documented the racism in the US Healthcare system, and the predatory behavior that pushes patients and families into medical debt, healthcare bankruptcy or even death, all of which happen in Maryland because of the lack of laws to protect patients and are unique to America.

We also can't deny that the potential of medical debt prevents sick people from seeking help. Without access to universal healthcare, how can we ask Maryland children go back into the

classrooms knowing that they might bring COVID-19 home from school that could cause medical debt, bankruptcy, or worse kill their family members? This is a cruel choice that politicians and Healthcare Executives are forcing families and children to make in a global pandemic in Maryland and across America.

We respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act with no changes. Thank you.

Sincerely,

Chrissy Holt
Our Revolution Maryland
chrissy@ourrevolutionmd.com

SB 514 Testimony VH.pdf

Uploaded by: Hsu, Valerie
Position: FAV

SB 514: The Medical Debt Protection Act
Position: **FAVORABLE**

To the Senate Finance Committee:

I am a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I strongly support the Medical Debt Protection Act (SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe passage of this bill ***with all provisions intact*** is essential for Maryland families.

SB 514 does not ask hospitals to forgive all debts; rather, it simply asks hospitals, the very institutions to which we entrust our lives, to be humane, reasonable, and compassionate in *how* they collect debts. Lawsuits, with their undue stress and accumulated extra costs, are a collections approach that is neither humane nor compassionate.

When I first learned about this predatory hospital practice, I was shocked. The very hospitals that we trust to care for us and our communities are in the regular practice of filing suits — an extreme measure — against already-struggling patients. To sue patients and their families during difficult seasons of their lives — because seasons that require lengthy hospital stays or that result in large medical bills are certainly difficult — feels akin to kicking someone while they are already down.

I was also horrified to learn that homes are often threatened in these lawsuits over outstanding medical bills. Housing and shelter are the most basic and fundamental human need; they are sources of stability and security for all of us. For homes to be threatened over unpaid medical bills, many of which are low in sum as the median amount per lawsuit is only $944, is essentially asking Marylanders to choose between their homes and their health.

Nobody *chooses* to be sick. You or someone you love has been confronted with unexpected medical bills at some point. For me, a standard wisdom tooth extraction in 2010 turned into a months-long ordeal requiring multiple surgeries and countless rounds of antibiotics. This experience underscored to me how lucky I was to have a solid support network, composed of caring friends, solid insurance coverage, and generous parents. Had only one of those elements not been in place, this single unexpected medical issue would have wrought long-lasting, debilitating effects on my life. Nobody deserves to be punished for being sick, for requiring healthcare.

I respectfully urge this committee to issue a favorable report on SB 514 because it will put in place simple mechanisms to prevent hospitals from enacting excessive cruelty on their patients through liens on homes, wage garnishments, and lawsuits over debts of $1000 and under.

Sincerely,

Valerie Hsu
Baltimore City, District 45

MAP - SB 514 - Medical Debt - Support.pdf
Uploaded by: Jefferson , Stacey
Position: FAV

Member Agencies:

Advocates for Children and Youth
Baltimore Jewish Council
Behavioral Health System Baltimore
CASH Campaign of Maryland
Catholic Charities
Episcopal Diocese of Maryland
Family League of Baltimore
Fuel Fund of Maryland
Health Care for the Homeless
Homeless Persons Representation Project
Job Opportunities Task Force
League of Women Voters of Maryland
Loyola University Maryland
Maryland Catholic Conference
Maryland Center on Economic Policy
Maryland Community Action Partnership
Maryland Family Network
Maryland Hunger Solutions
Paul's Place
Public Justice Center
St. Vincent de Paul of Baltimore
Welfare Advocates

Marylanders Against Poverty

Stacey Jefferson, Co-Chair
P: 410-637-1900 ext 8578
C: 443-813-9231
E: stacey.jefferson@bhsbaltimore.org

Julia Gross, Co-Chair
P: 410-528-0021x6029
E: jgross@mdhungersolutions.org

TESTIMONY IN SUPPORT OF SB 514

Health Facilities – Hospitals – Medical Debt Protection

Senate Finance Committee
February 25, 2021

Submitted by Stacey Jefferson and Julia Gross, Co-Chairs

Marylanders Against Poverty (MAP) strongly supports SB 514, which establishes reasonable protections for low-income and working Marylanders against destitution as a result of medical debt, creates reporting requirements to identify disparities in hospital collection processes and procedures, and allows for changes in financial circumstances to be considered within 240 days of care.

For many Marylanders, an illness or medical emergency can lead to financial suffering, poverty and homelessness. Even after passage of the Affordable Care Act, medical bills frequently cause financial hardship and even destitution.[1,2] One need look no further than GoFundMe, which proclaims itself to be "the leader in online medical fundraising" with over 250,000 campaigns a year.[3] In Maryland, people are pushed into poverty and out of their homes as a result of medical debt. Lawsuits filed by Maryland hospitals against former patients for medical bills – some of which should have been paid by insurance companies – have led to wage and property garnishments that have pushed vulnerable Marylanders into poverty, at the same time that these hospitals saw billions in profits.

SB 514 would help to protect poor and working Marylanders against destitution as a result of medical debt. The bill would prevent homelessness and poverty by prohibiting hospitals from placing a lien on a patient's home, pursuing wage garnishment to collect medical debt from patients who are uninsured, or filing lawsuits to collect low-value debts that are often adjudicated in small claims court, where patients have fewer protections. SB 514 would help to ensure that insurance companies are pushed to pay for covered procedures – rather than pushing the costs to patients – by preventing hospitals from initiating medical debt collections lawsuits while health insurance appeals, applications for financial assistance, or requests to reconsider financial appeals are pending.

SB 514 balances the needs of hospitals and patients, requiring hospitals to offer patients monthly payment plans that limit payments to five percent of gross monthly income and cap interest rates at 1.5% per year. Additionally, SB 514 creates transparency in hospital procedures that may have a disparate impact by race, ethnicity, gender, or geography.

An illness or health emergency should not lead to financial ruin. **MAP appreciates your consideration, and strongly urges a favorable report on SB 514.**

Marylanders Against Poverty (MAP) *is a coalition of service providers, faith communities, and advocacy organizations advancing statewide public policies and programs necessary to alleviate the burdens faced by Marylanders living in or near poverty, and to address the underlying systemic causes of poverty.*

---

[1] Hamel L, Norton M, Pollitz K, Levitt L, Claxton G, Brodie M. The burden of medical debt: results from the Kaiser Family Foundation/New York Times Medical Bills Survey. Kaiser Family Foundation, 2016. Available at: https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/view/print.
[2] David U. Himmelstein, Robert M. Lawless, Deborah Thorne, Pamela Foohey, and Steffie Woolhandler, 2019: Medical Bankruptcy: Still Common Despite the Affordable Care Act
American Journal of Public Health 109, 431_433, https://doi.org/10.2105/AJPH.2018.304901
[3] GoFundMe. Get help with medical fundraising: with a free GoFundMe, you can get immediate help with medical bills. Available at: https://www.gofundme.com/start/medical-fundraising.

Chair Jones Testimony (SB565:SB514).pdf
Uploaded by: Jones, Councilman Julian
Position: FAV

Baltimore County Council Chair, Mr. Julian Jones

Testifying on the Medical Debt Protection Act, HB565/SB514

To the Health & Government Operations Committee / Senate Finance Committee,

My name is Mr. Julian Jones and I proudly serve as the Chairman of the Baltimore County Council. I support the Medical Debt Protection Act (SB565/SB514). This urgent legislation will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, cap interest rates at 1.5%, and prevent wage garnishments and liens on homes over medical debt.

The Medical Debt Protection Act will protect low and middle-income households from punitive medical debt lawsuits in Baltimore County and statewide. In Baltimore County, 40% of households can't afford to make ends meet according to the 2020 United Way's ALICE report. Over the past ten years, hospitals have filed 32,617 lawsuits against Baltimore County residents to collect on medical debts. The median amount owed was $928 and of these lawsuits, 9,016 resulted in wage or property garnishments.

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Julian Jones
Chairman, Baltimore County Council
Phone: (410) 887-3389
Email: council4@baltimorecountymd.gov

SB514 favorable testimony.pdf

Uploaded by: Kaey, Martin

Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Martin Kasey, and I'm a Baltimore resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing this bill is essential because getting sick or hurt shouldn't ruin someone's life and the future prospects for their family. This bill doesn't cancel debt, but simply prevents hospitals from collecting debts in a brutally violent manner, as though getting sick were the equivalent of betting one's house, savings and future wages on a losing horse. We already provide taxpayer dollars and tax breaks to nonprofit hospitals to help them provide care for low and middle income marylanders, but the lack of any protection for the most vulnerable patients allows hospitals to embezzle these charitable funds we give them and treat access to healthcare as a racket enforceable by violent means of extracting all of a patient's wealth as quickly as possible.

A few years ago I suffered a head injury from being thrown off my bicycle by a driver who went straight through a turn lane and never looked back. I was fortunate that Johns Hopkins premed students were present and came to my aid while I was delirious and bleeding profusely, but if I hadn't had good insurance at the time this would have been a curse; while I was just a block from Union Memorial Hospital, the idealistic students thought I would receive better care from Johns Hopkins, which practices a strict policy of violent predatory debt collection. The long ambulance ride, staples, CT scan and follow-up appointment would have wiped me out and I would still be paying for them five years later if I hadn't sprung for a good insurance policy. Because an insurance policy that actually insures against accidents is a luxury good in this country, I am forced to choose this protection from Maryland's nonprofit charitable medical predators over savings and major investments such as a car or house.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Martin Kasey
District 43
2805 N Calvert St
Baltimore, MD 21218
martin.kasey@gmail.com
(847)894-8495

SB514.pdf
Uploaded by: Kanneganti, Sandeep
Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**

To Chair Kelley and Members of the Senate Finance Committee,

My name is Sunny, and I'm a Halethorpe resident and a member of the End Medical Debt Maryland Coalition. I support SB0514, the Medical Debt Protection Act, and I ask the Committee to issue a favorable report.

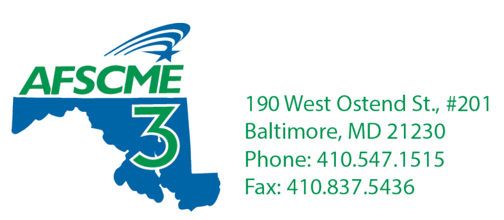
The Medical Debt Protection Act will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because both my family and myself have suffered due to medical expense and medical debt issues. What should be small or routine injuries and ailments become major stressors for us as healthcare costs grow and the fear of medical debt looms. Knowing thousands of others suffer like us just make this bill more urgent.

I respectfully urge this committee to issue a favorable report on SB0514: The Medical Debt Protection Act, with no amendments that water-down the bill.

Sincerely,

Sunny Kanneganti
GBDSA member, End Medical Debt Maryland Coalition
Halethorpe, MD

AFSCME_FAV_SB514.pdf
Uploaded by: Kilpatrick, Lance
Position: FAV



190 West Ostend St., #201
Baltimore, MD 21230
Phone: 410.547.1515
Fax: 410.837.5436

Patrick Moran - President

Testimony

SB 514 – Health Facilities - Hospitals - Medical Debt Protection

Finance

February 25, 2021

Support

AFSCME supports SB 514. This legislation would enhance protections for medical consumers by strengthening limits on hospital debt collection practices.

For years medical consumers have faced a terrifying prospect: getting needed medical services could very well send them into bankruptcy. The Affordable Care Act was supposed to address this issue but has had only limited success.

The State of Maryland has attempted to address this issue by providing financial support to all hospitals to ensure they provide free and low-cost care to patients who otherwise cannot afford care. Despite this mandate to provide care to low-income patients, Maryland hospitals often still go after former patients for medical debt - many of whom actually qualified for but did not receive free care - to collect on hospital bills under $5000.

The COVID-19 pandemic raises the issue of medical debt and potential bankruptcy to even more extreme concerns. Going after those least able to pay, particularly when they should be eligible for free care to begin with through existing State support, needs to end. HB 565 takes solid steps toward curbing this sad practice.

We ask a favorable reporting of SB 514.

Medical Debt Protection Act Testimony.pdf

Uploaded by: Klaitman, Jessica

Position: FAV

To the Senate Finance Committee,

My name is Jessica Klaitman. I am a Baltimore County resident and a member the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (SB514).

I am writing on behalf of Baltimore Women United, a diverse group that educates women on important issues, engages them as voters, constituents, candidates and donors, and plans major actions to further women's equality in Baltimore and throughout Maryland. I am also a social worker with over 20 years of experience.

Women are the center of family system. This does not just refer to women with minor children; women are responsible for and are the glue in many family configurations. When people are ill and need help, the whole family unit is impacted. The consequences of not passing this bill are dire: sick people refusing help because of fear of expense, getting sicker, and making others around them ill (especially dangerous in the COVID 19 environment); people losing their homes or cars because of medical bills that they cannot afford; families losing loved ones. In particular, when these circumstances befall women – who are most often responsible for childcare and elder care – families may become homeless, exacerbating numerous ills.

Hospitals have a fund of taxpayer money that they can draw upon for "charity cases." Hospitals do not have to sue patients. They are making that choice, and, in doing so, harming the people they are meant to help. They are harming women, children, elderly, families: the people of Maryland.

In the fall of 2020, I was faced with a medical emergency. In a few hours, I racked up nearly a thousand dollars of medical debt, with more to come before the medical issue was resolved. Even with the ability to pay, I was shocked by the costs. I deeply felt the privilege that allowed me to get medical care when I needed it, so I could remain alive and well for my 3 children, and to know that my family would not have to choose between feeding our children and paying my medical bills, or risk losing our home. Shouldn't every sick person have that dignity, that reassurance?

This bill would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. It will help the people of Maryland.

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Jessica Klaitman
Baltimore Women United
917-783-6783

WDC Testimony SB0514-FINAL.pdf

Uploaded by: Koravos, JoAnne

Position: FAV

MONTGOMERY COUNTY, MARYLAND
WOMEN'S DEMOCRATIC CLUB

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

Senate Bill SB0514 Health Facilities – Hospitals-Medical Debt Protection
Senate Finance Committee – February 25, 2021
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 2021 legislative session. WDC is one of the largest and most active Democratic Clubs in our County with hundreds of politically active women and men, including many elected officials.

Providing efficient, cost effective health care to all Marylanders is a legislative priority along with assuring fair access to underserved communities and the poor. Hospitals in Maryland should not be engaging in predatory practices, including lawsuits that put low-income patients in grave financial jeopardy to recover modest sums. Therefore, **WDC urges the passage of Senate Bill SB0514**.

This bill will among several other things prohibit hospitals from placing a lien on a patient's home or car, prohibit hospitals from pursuing wage or bank garnishment to collect medical debt if a patient is uninsured, require hospitals to offer monthly payment plans to patients, limit monthly payments to 5% of gross monthly income and cap interest rates at 1.5% per year. It will also prohibit hospitals from filing lawsuits to collect on low-value debts of $1,000 or less. Hospitals would also be required to report specific medical debt information to the Health Services Cost Review Commission on an annual basis, which must then make the reports public.

Medical debt is a major problem for Marylanders, especially those from low-income households and among communities of color. According to the National Consumer Law Center's *Maryland Debt Collection Fact Sheet*, 15% of Maryland residents report having medical debt, while 21% of those in communities of color report owing medical debts. Recognizing the high cost of hospital care, the state of Maryland already provides financial support to hospitals through the rate setting system to ensure hospitals provide free and low-cost care to patients. Despite this mandate Maryland hospitals sue patients, many of whom qualified for but didn't receive free care. Between 2009 and 2018 Maryland hospitals filed 145,746 lawsuits against former patients. In 36,370 cases patients had their wages garnished and their bank account wiped out or a lien put on their home or car. In 3,278 cases the hospital debt drove the patient o declare bankruptcy. The median debt owed: $944. While this debt is enormous for the patient, it's a pittance for hospitals.

Maryland is behind many other states in providing these protections to residents. It's time to eliminate predatory medical debt collection practices by Maryland hospitals.

We ask for your support for SB0514 and strongly urge a favorable Committee report.

Respectfully,

Diana Conway
President

SB514_Fav_FreeState Justice.pdf

Uploaded by: LaMaster, Jeremy

Position: FAV

2526 SAINT PAUL STREET
BALTIMORE, MD 21218
TEL (410) 625-LGBT (5428)
FAX (410) 625-7423
www.freestate-justice.org

Jeremy LaMaster (he/they)
Executive Director
jlamaster@freestate-justice.org

Bill: SB0514
Title: Health Facilities - Hospitals - Medical Debt Protection (Mental Health Access Initiative)
Date: February 25, 2021
Committee: Finance
Position: Favorable

To the Honorable Chair and Esteemed Members of the Finance Committee:

FreeState Justice is a statewide legal advocacy organization that seeks to improve the lives of low-income lesbian, gay, bisexual, transgender, and queer ("LGBTQ") Marylanders. FreeState Justice advocates for LGBTQ clients and community members in their attainment of safe, affirming, and accessible healthcare. LGBTQ Marylanders have unique medical needs that leave them vulnerable to health disparities, including medical debt.

Unique struggles our community faces include the expensive nature of hormonal therapy and costs associated with HIV/AIDS prevention and treatment. A 2013 study found that among low-income LGBTQ folks, almost 4 in 10 had medical debt and more than 4 in 10 reported postponing medical care due to costs. Routine medical care is necessary for transgender-related healthcare needs as well as HIV prevention.[1]

Additionally, anti-LGBTQ bias and structural, systemic oppression lead to a disproportionate incidence of mental health disorders in LGBTQ individuals. Research shows that lesbian, gay, and bisexual (LGB) youth are four times more likely, and questioning youth are three times more likely to attempt suicide than their straight peers.[2] Nearly half of young transgender people have seriously thought about taking their lives, and one-quarter report having made a suicide attempt.[3] Young people who experience family rejection based on their sexual orientation, including being subjected to conversion therapy, face severe health risks. Research

STAFF

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Director of Education & Outreach

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Venable LLP

Jessica P. Weber, Esq.
Brown, Goldstein & Levy, LLP

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[1] Center for American Progress. (2013). LGBT Communities and the Affordable Care Act: Findings from a National Survey.

[2] *CDC, "Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12."*

[3] *Arnold H. Grossman & Anthony R. D'Augelli, Transgender Youth and Life-Threatening Behaviors, 37(5) SUICIDE LIFE THREAT BEHAV. 527 (2007).*

reveals that LGB young adults who report higher levels of family rejection during adolescence are 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection.[4]

In addition to this disproportionate incidence, LGBTQ youth similarly lack access to quality and affirming mental health care, further exacerbated by poverty and racism. The COVID-19 pandemic has only entrenched these barriers to access.[5] Last year, The Trevor Project reported that overall, more than half (54%) of LGBTQ youth have reported wanting mental health services but were unable to obtain it within the past year.[6] That same report highlighted that the most common barrier was concerns incurring healthcare costs.[7]

In our 2016 state-wide needs assessment of LGBTQ Marylanders, healthcare access was one of the top priorities. Additionally, a recent national study on LGBTQ policy priorities including healthcare as the number one top priority.[8]

To this effect, SB0514, and protect low and middle-income households from punitive medical debt lawsuits that contribute to barriers in accessing healthcare for LGBTQ folks.

FreeState Justice strongly urges the Committee to issue a favorable report on SB0514.

Thank you for the opportunity to comment on this critical legislation, and please do not hesitate to contact us if we can be of further assistance.

Sincerely,

Jeremy LaMaster (he/they)
Executive Director

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[4] *Caitlyn Ryan et al., "Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults," 123 PEDIATRICS 346 (2009).*

[5] *Bowleg, L. (2020). We're Not All in This Together: On COVID-19, Intersectionality, and Structural Inequality. American Journal of Public Health, 110 (7), 969-970.*

6 Green, A.E., Price-Feeney, M. & Dorison, S. (2020). Breaking Barriers to Quality Mental Health Care for LGBTQ Youth. New York, New York: The Trevor Project.

7 Ibid

[8] *Whitman Insight Strategies. LGBTQ in America Survey. (2019). https://assets.documentcloud.org/documents/6175837/Withman-Insight-Strategies-LGBTQ-in-America.pdf*

Testimony Med Debt 2021.pdf
Uploaded by: Landers, Claire
Position: FAV

My name is Claire Landers. I have been a resident in Baltimore County for over 20 years. I am 58 years old and my husband is 59. At this stage of life, we recognize that should we become infected with Covid-19, we now face a greater risk of landing in the hospital, perhaps an ICU, for an extended period of time. We could become "long-haulers" whose ability to earn an our income is diminished.

It is terrifying to contemplate, but the pandemic has thrust all Marylanders into a new sense of vulnerability about our health: The prospect of accumulating overwhelming medical debt in fighting for our health, and even our lives, fuels that terror. Medical debt, even for those who have "good" private insurance, is the largest cause of bankruptcy in this country. SB514 can preemptively address an ongoing problem that will magnify in the months ahead.

Between 2009-2018, a number of primarily Baltimore-based hospitals, sued 32, 617 Baltimore County residents to collect unpaid hospital debt from former patients.[1] Many of these lawsuits were against patients that would have likely qualified for free or discounted medical care but did not receive charity or reduced-cost care from the hospital. **In my own backyard, 9,016 Baltimore County residents had their wages garnished, their bank account zeroed out, or a lien put against their home or car because they fell ill and couldn't pay their bill[2]. The median amount owed was $928[3].** Learning that shocked me and prompted to speak out to you, our legislative leaders.

Despite pursuing patients through lawsuits, many of the hospitals had a surplus from charity rate support levels and others turned down a large percentage of patients who applied for charity care.

SB514 contains reasonable provisions:

- **Require that hospitals provide income-based repayment plans before suing a patient;**
- **Stop the practice of putting a lien on a home or car to repay medical debt;**
- **Ban all lawsuits on medical debt that is $1000 or less**

The devastation caused by medical debt has been a fundamental and unacceptable reality for average Amercans for decades. That fact, in and of itself, should have all of us anticipating that medical debt, specifically, will have increased impact on the economic and personal well-being of Marylanders long past the pandemic.

Please support SB514. It is a reasonable constructive way to address Marylanders who have and will continue to suffer bodily and economically during a year of collective tragedy.

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[1] NNU, MCRC, AFL_CIO, Preying On Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits
[2] Ibid

[3]ibid

Favorable EMD Testimony .pdf
Uploaded by: Lent, Michael
Position: FAV

Medical Debt Protection Act / HB565
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Michael Lent, and I'm a Parkville resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing this bill is essential because people who are recovering from illness and already struggling to work should not have added barriers to becoming well and whole.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Michael Lent
District 08
2504 Creighton Ave Parkville MD 21234

SB514 testimony.pdf
Uploaded by: Lipscomb, Melinda
Position: FAV

To the Senate Finance Committee,

My name is Melinda and I'm a Rosedale resident and member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (SB514).

This bill would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. **I believe that the passing of this bill as is written is essential because** as a person with complex chronic illness I have been denied care due to outstanding medical debt, had to declare medical bankruptcy at 25 and due to loss of the ability to work and additional yearly medical debt cannot rebuild credit at 43. I also ended up with a precancerous condition because I have avoided seeking needed care due to the high cost knowing it will lead to debt for my retired parents who now care for me.

COVID19 has made this legislation even more necessary. Thousands of additional Marylanders will now have long-term complex health conditions and either lost work due to COVID19 or cannot work due to COVID19 causing Post-Covid disabling conditions. No one should have to choose between their health and their home.

The median debt for medical debt lawsuits is just $944. That is an added expense many working and middle-income families cannot afford – but hospitals that receive millions of dollars in tax breaks and grant funding can.

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Melinda Lipscomb
State Chapter Co-chair #MEAction Maryland
District 8 constituent
15 King Henry Cir., Rosedale, MD 21237
443-865-4770
melinda.advocate@meaction.net

Sherry Looney testimony Senate Bill 514.pdf

Uploaded by: Looney, Sherry

Position: FAV

To the Senate Finance Committee,

My name is Sherry Looney. I live in Berlin Maryland. I support Senate Bill 514, the Medical Debt Protection Act.

I had to file for bankruptcy several years ago, and I have worked hard since then to rebuild my credit. I pay my bills on time and check my credit report regularly. When I checked my report last year, I was shocked to find a collection from Atlantic General Hospital in Berlin. The amount was $85 and the charge was from 2013. I never got a bill for the charge, never got notice from my insurance that I owed a copay, and was never contacted by a collection agency. The only notice I got was the collection on my credit report. If I had known about the charge, I certainly would have paid it. Instead, I have to deal with getting it removed from my credit report. If hospitals deal with small bills like this so badly, I can only imagine how they must deal with large debts. Medical debt can really hurt people like me who are trying to rebuild our credit, and it's very unfair to have our credit suffer because the hospital mismanaged a bill. I urge you to pass Senate Bill 514 to help ensure that people with hospital debts are treated fairly.

Thank you.

SB 514 Med Debt Protection Act.docx.pdf

Uploaded by: MacMillan, Jackie

Position: FAV

Healthcare-NOW!
of Maryland

Testimony on SB 514
Medical Debt Protection Act

Position: Favorable
Healthcare-Now! of Maryland supports the 2021 Medical Debt Protection Act

To the Finance Committee:

My name is Richard Bruning, and I live in Baltimore City. I am testifying on behalf of Healthcare-Now! of Maryland (HCN-Md.) a grass-roots group working for universal health care through a single-payer (Medicare for All) system. HCN-Md. is a member of the End Medical Debt Maryland Coalition, and strongly supports the Medical Debt Protection Act (HB 565/SB 514).

It is unconscionable in the 21st century in the wealthiest country in the world that the concept of medical debt exists. In the time of COVID-19, the fear of medical debt should never factor into a person's decision to seek and receive the healthcare they need.

This bill shields low- and moderate-income families from some of the most punishing effects of medical debt lawsuits. The median debt for medical debt lawsuits is $944 and this legislation would prohibit lawsuits for $1,000 or less. Income-based repayment plans would be put in place. Barring wage garnishments and liens on homes would help protect the necessities Marylanders require to remain productive citizens.

The Medical Debt Protection Act is a critical step toward ensuring that people can seek and receive needed medical care without fear of financial catastrophe. These types of protections will be essential until the United States joins other wealthy nations in establishing universal, comprehensive healthcare.

We urge your passage of this important legislation.

Richard Bruning
barbruland@gmail.com
(410) 235-3504

4401 Roland Avenue
Unit 406
Baltimore, Md. 21210

Senate Medical Debt.pdf
Uploaded by: Marth, Eliza
Position: FAV

To the Senate Finance Committee

Hello there! My name is Eliza. I'm a City of Baltimore homeowner and a member of the End Medical Debt Coalition. I support the Medical Debt Protection Act (HB565/SB514).

I am writing to appeal to the most compassionate part of yourself. People are suffering from medical debt. Folks who cannot afford to pay less than a $1000 dollar bill certainly cannot afford a lien on their home or garnishment of their paychecks. The fact hospitals can do this seems to be a predatory practice that is kicking people when they are down, already in debt, already struggling. This is not the kind of community, the kind of state, country or world I want to live in.

No doubt we are living through difficult times. This bill is a light in the darkness, and I implore you all to be a part of that light, to be a part of that hope, to be a part of alleviating the suffering of people all over Maryland.

On this note, I urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Thank you for taking the time to consider my perspective. I have lit a candle of prayer for the committee.

With gratitude,
Eliza Marth
828-550-5242
Ekmarth@gmail.com

SB0514_DeclanMcKenna.pdf
Uploaded by: McKenna, Declan
Position: FAV

Medical Debt Protection Act / SB0514

Official Testimony

Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Declan McKenna, and I'm a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB0514).

I believe that passing of this bill is essential. I am 21 years old, and I am a student at the Maryland Institute College of Art. When I moved to Baltimore at 17, I was on my own, and had no economic support. I needed medical care for a variety of reasons. I suffer from chronic nosebleeds, needed skin surgery, and almost bled out in a park once. All of these situations resulted in extremely high medical bills, and as a student in college, paying my rent and tuition, I had no way to navigate this world. My bills went to collections, and to this day I have medical debt from every major hospital in Baltimore City. Despite essentially being a child, I was offered no assistance in navigating my debt, which is a complicated and scary process for anyone of any age.

Image description: Declan McKenna's face is shown, with a temporary tattoo listing the surgery costs for a "Nasal Endoscopy" covering his skin. The total cost for the treatment being $984.66

To help cope with the depression and self-hatred these bills gave me, I created a piece of art for one of my classes at school. I created temporary tattoos of my medical bills, of various surgeries and treatments, and plastered them over my body, showing the cost these hospitals have placed on my body. It is frightening to see a price tag on my face, because that is truly how much it costs to simply receive the care I need. This medical debt exists, and has left marks on my soul and my body.

It is painful to make a piece of art that says “I cannot afford to live in this body” on my skin, however that is how my medical debt makes me feel. There are nights where I have cried because I truly believe I will never be economically successful due to already having this debt. I feel guilty for getting the medical care I need. No one should feel this way. Everyone deserves to love their body, and not feel burdened by this predatory system. I urge you all to support the Medical Debt Protection Act, so that artists like me, children like I was, can worry less about getting the treatment they need.

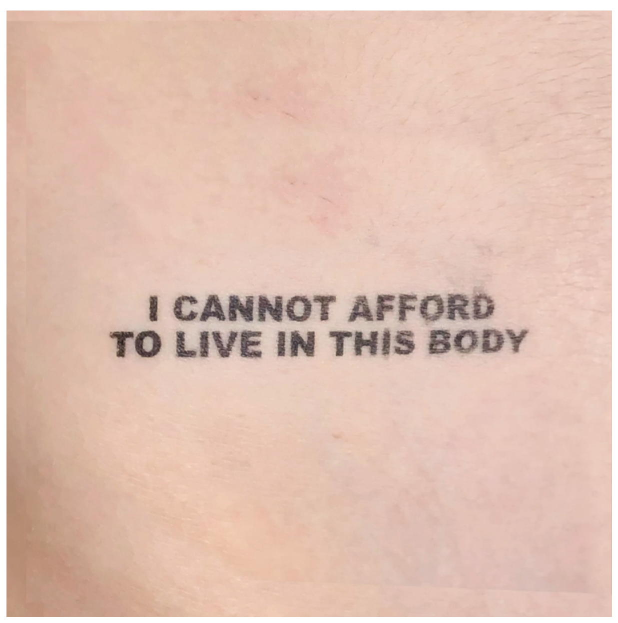


Image description: A patch of skin is shown, with the text “I cannot afford to live in this body” printed directly onto the body.

The full body is viewable at https://declanmckenna.com/medicaldebt.

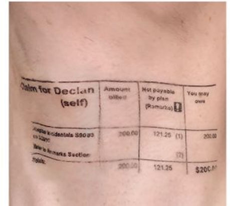
I respectfully urge this committee to issue a favorable report on SB0514, the Medical Debt Protection Act.

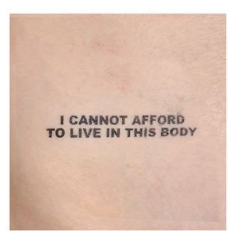
Sincerely,

Declan McKenna
Legislative District 45
415.299.9318, declanmckenna5@gmail.com

SB0514_DeclanMcKenna_Art.pdf
Uploaded by: McKenna, Declan
Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**





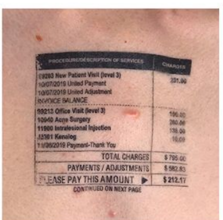


Image description: Declan McKenna's *Commerce* art series.
This work is also viewable at https://declanmckenna.com/medicaldebt.

Image description: Declan McKenna's face is shown, with a temporary tattoo listing the surgery costs for a "Nasal Endoscopy" covering his skin. The total cost for the treatment being $984.66

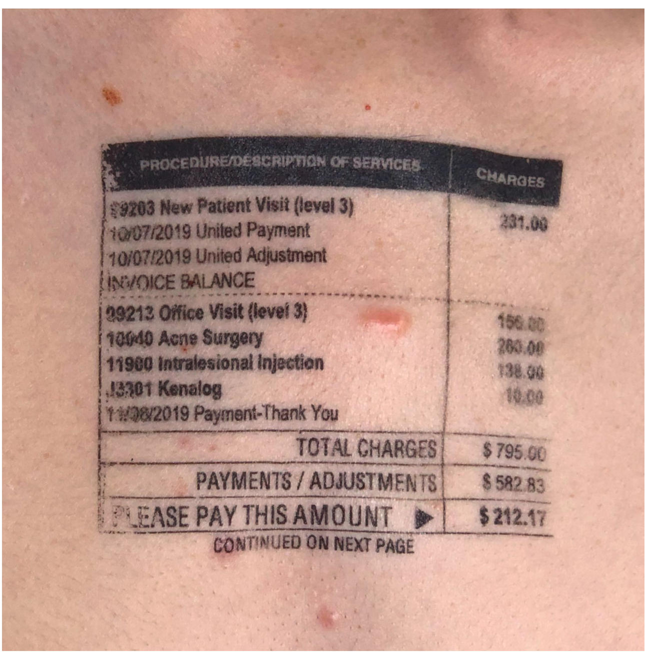


Image description: Declan McKenna's chest is shown, with a temporary tattoo for "Acne Surgery", with a total amount of $212.17 listed.

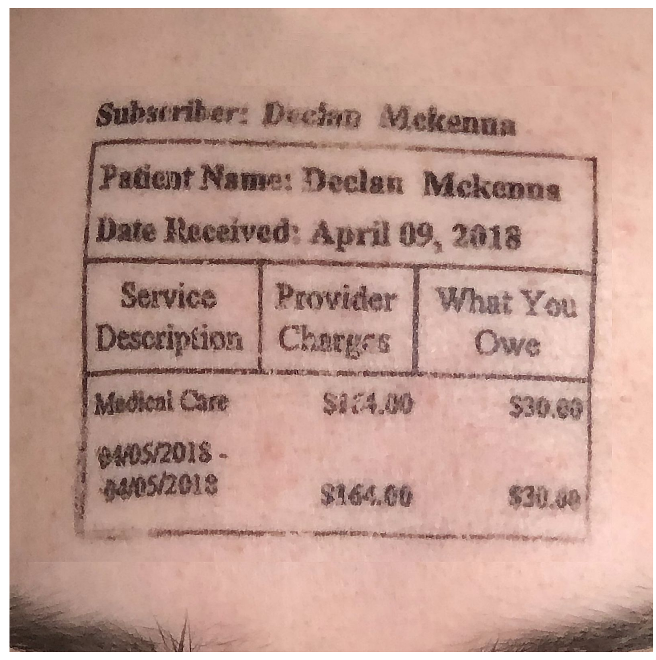


Image description: Declan McKenna's forehead is shown, with a medical bill listing $30.00 printed on his skin.

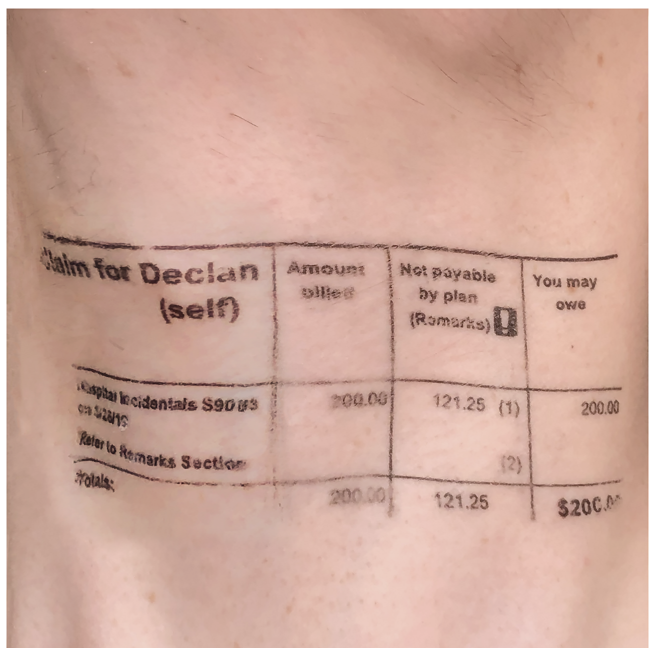


Image description: Declan McKenna's neck is shown, with an emergency medical treatment for $200.00 shown.

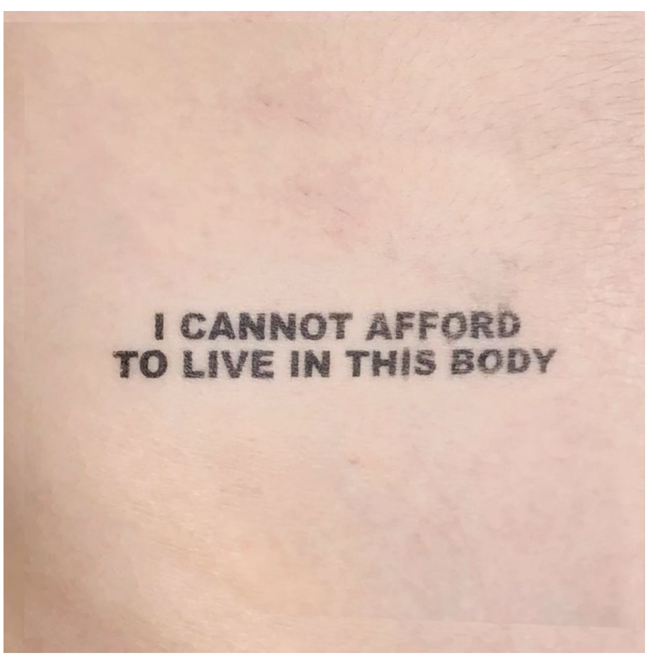


Image description: A patch of skin is shown, with the text "I cannot afford to live in this body" printed directly onto the body.

SB 514- Health Facilities - Hospitals - Medical De

Uploaded by: McKinney, Robin

Position: FAV

SB 514- Health Facilities - Hospitals - Medical Debt Protection
February 25, 2021
SUPPORT

Chairwomen Kelley, Vice-Chair and members of the committee, thank you for the opportunity to submit testimony in support of Senate Bill 565. This bill will ensure that hospital debt collection practices are not predatory for low to moderate income Marylanders.

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.**

Medical debt is fundamentally distinct from other types of debt because of the nature of medical emergencies and the absolute necessity to address adverse health conditions in order to continue basic living. 16% of all Marylanders have medical debt that has gone to collections, however for communities of color that statistic jumps to 20%[1]. As the pandemic rages on and continues to wreak havoc on the economy and the physical wellbeing of our citizens, it also continues to reveal the depth of inequalities present in our society. Medical debt was a heavy burden for low income earners and communities of color prior to COVID-19. Without deliberate action for these communities, the consequences of the pandemic will drive those inequalities much deeper. Many low income people will delay seeking out medical assistance which leads to greater medical and financial issues in the future.

When an individual's debt is in collections, they face a variety of challenges that drastically affect their quality of life. It can take years for an individual or a family to restabilize. During this time, children are negatively affected, housing becomes difficult to secure, and jobs are either more difficult to obtain or are harder to keep. **Predatory collection actions decrease the patient's ability to be accountable for their debts.** It makes it more difficult for them to pay their debts, because they will have to refocus their finances to more immediate needs. These practices put people into a cycle of debt that leads to bankruptcy, homelessness, and has an overall devastating financial impact that can take years to overcome.

SB 514 will address this issue by:

- Prohibiting hospitals from placing a lien on a patient's home or garnishing wages for a medical debt if a patient is uninsured and/or qualifies for free or reduced-cost care
- Prohibiting hospitals from filing lawsuits to collect on low-value debts of $1,000 or less
- Requiring hospitals to offer an affordable monthly payment plan at 5% of the patient's gross monthly income and with interest rates capped at 1.5% per year
- Prohibiting hospitals from filing an action against a patient until 180 days after nonpayment and after giving patients 45-day notice of the action
- Prohibiting hospitals from initiating medical debt collection lawsuits while health insurance appeals, applications for financial assistance, or requests to reconsider financial assistance are pending
- Prohibiting hospitals from making a claim against the estate of a deceased patient to collect debt owed

For these reasons, we encourage you to report favorable on SB 514.

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1 https://www.nclc.org/images/pdf/debt_collection/fact-sheets/Maryland.pdf

SB0514-FIN-FAV.pdf
Uploaded by: Mehu, Natasha
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB 514

February 23, 2021

TO: Members of the Senate Finance Committee

FROM: Natasha Mehu, Director of Government Relations

RE: SENATE BILL 514 – Health Facilities – Hospitals – Medical Debt Protection

POSITION: SUPPORT

Chair Kelley, Vice Chair Feldman, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 514.

SB 514 protects Marylanders from medical debt by expanding who is eligible for free and reduced cost medically necessary care, creating a payment plan for residents who may need it, limiting when a hospital can report debt to credit agencies, and requiring each hospital to report annually to the Commission the demographic background of residents whom the hospital has classified as having bad credit or filed an action against to collect debt.

SB 514 is a necessary step toward providing the public transparent information on medical debt and who is impacted by medical debt. Most importantly, this bill protects individuals with medical debt and puts in place safeguards to protect residents with low-income from accruing debt after seeking medically necessary care.

In Baltimore City, approximately 21% of residents live below the federal poverty line, with 7.5% of the population being under 65 years old without health insurance.[1] Data collected from the Baltimore City Community Health Survey shows that Baltimore City residents who live below the federal poverty line or lack health insurance use

[1] U.S. Census Bureau QuickFacts: Baltimore city, Maryland

hospital based emergency or urgent care at a higher percentage than residents above the federal poverty line or with insurance.[2]

The COVID-19 pandemic has widened economic and health disparities within Baltimore City, with Hispanic/Latino, African-American, and older adult communities disproportionately impacted. The pandemic has resulted in an estimated 41% of US adults delaying or avoiding medical care, with avoidance of emergency care and urgent care higher among unpaid caregivers, African-American adults, Hispanic adults, individuals with underlying medical conditions, individuals with disabilities, and young adults.[3] We know that avoidance of medical care for any reason can lead to delays in diagnosis and treatment; and in the worst cases, avoidance can lead to increased disease severity or death.

Altogether, seeking medical care should not exacerbate health or economic disparities. Of utmost importance, the inability to pay for medically necessary care and fear of accruing medical debt should not be a factor Marylanders' decision to seek or avoid needed medical care, especially during the COVID-19 pandemic.

We respectfully request a **favorable** report on Senate Bill 514.

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[2] https://health.baltimorecity.gov/sites/default/files/health/attachments/Baltimore%20City%20CHA%20-%20Final%209.20.17.pdf

[3] Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020 | MMWR (cdc.gov)

medicaldebtprotection.pdf
Uploaded by: Mostris, Nick
Position: FAV

Testimony to the Senate Finance Committee
SB514: Medical Debt Protection Act
Position: Favorable

February 25, 2021

The Honorable Delores Kelley, Chair
Finance Committtee
3 East, Miller Senate Office Building
Annapolis, MD 21401
cc: Members, Finance Committee

Honorable Chair Kelley and Members of the Committee:

I am writing to you in support of HB565/SB514, the Medical Debt Protection Act, which will take a huge step forward in protecting patients struggling with the burden of medical debt. My name is Nick Mostris and I am a life long resident of harford county and proud union member of IATSE local 19. I am writing in support of this legislation because I have seen first hand the devastating impact medical debt can have on a family.

My parents, John and Aristea Mostris, worked hard to move our family from New Jersey to Kingsville, Maryland so my two brothers and I could have a better life. My mother cut hair and my father worked as a cook but their dream was to open up a family diner. That didn't happen for them though.

In 1992, my father became very ill with no explanation. He was the hardest worker I knew and it was incredibly scary to see him getting weaker very quickly. We took him to the Emergency Room at Fallston General Hospital where he stayed for three days. They were unable to diagnose him and sent him back to work. Shortly after, he collapsed at work and we began to seek better medical treatment.

After two brain biopsies, my father was diagnosed with a disease called neurosarcoidosis. There was little known about the chronic and debilitating nature of this disease which affected his eyesight, and nervous system. He was too sick to work, sometimes too sick to stand, and was in and out of hospitals for experimental treatments.

My mother started working more to help pay all the bills. She often had to work two jobs while taking care of my brothers and I and managing my father's medical care. My mother worked incredibly hard and I know raising three sons on top of everything else wasn't easy for her.

The weight of my father's chronic illness and the uncertainty of his future weighed heavily on our family. We lost my father on June 15th in 2007 after fifteen years of fighting for his health, and his dignity. I deeply cherish every minute I had with my dad, even while he was ill. Even today I can hear his voice guiding and giving me advice.

Eventually, the bills started to come in from his hospital stays and from the experimental treatments. I saw the shock and stress of these bills take over my mom's every waking moment. My mom was always a fighter, she was the 5th of 6 girls who immigrated to America from Greece when she was a child. At this point in her life, she had been fighting to hold everything together for a very long time.

One of the hospitals, Fallston General where he stayed for just three days, filed a lawsuit to place a lien against the home my parents worked so hard for. I remember my mom telling me that she was too tired to fight the lien and deal with a lawyers and courtroom. Especially not for a hospital that had sent him back to work and didn't diagnose him.

Why is it right for hospitals to profit off the sick and dying? My mother worked literally her whole life to pay off medical debts. If not from my father, from her own health problems like spinal injuries she developed from working two jobs. She survived the last five years of her life working full time while receiving dialysis from kidney failure.

After she passed and my brothers and I began to sort through the estate, and by the time I finally got the attorney overseeing the lien to call me back, I was shocked. The original bill that had been $6,000 dollars, had now become over $26,000 dollars in interest, late fees, court fees and attorney fees. The lien had almost quadrupled in value in the ten years between my parents passing.

My brothers and I were blessed to be raised by our parents. Last year we are proud to say that we finally were able to pay off the lien after 22 years. Although, we had to sell the house they worked so hard for in order to do so.

I am writing to ask you to support HB565/SB514, the Medical Debt Protection Act, because this legislation would have prevented Fallston General, what is now UM Upper Chesapeake, from placing the lien on my parents home. No family deserves to go through what we did or lose their home because of medical debt.

I truly hope you find my story and stories like my own inspiring enough to help the hundreds of thousands of Marylanders who are crying and pleading for relief from medical debt. This bill is more important now than ever, for the countless number of families who have or who may lose a loved one during the pandemic and become burdened by medical debt. I respectfully request the Committee give this measure a favorable report.

Nick Mostris
Harford County District 7
Mostris99@gmail.com

FRANCA MULLER PAZ EMD Testimony HB565 & SB514 (1).

Uploaded by: Muller, Franca

Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**

To the *Senate Finance Committee*,

My name is Franca Muller Paz, and I'm a Baltimore City resident, a teacher and Building Representative of the Baltimore Teachers Union, and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect working class people and their families from punitive medical debt lawsuits. It will put a stop to medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because I know what it is like to feel like you can't go to the doctor.

Throughout my childhood my family didn't have health insurance. Because of which, we rarely went to the doctor, even why my dad, a construction worker, would regularly take on injuries at work. My father almost lost his eye in a welding accident. Yet instead of getting the sophisticated treatment he needed, relied on healing on his own. This is a decision which continues to affect his vision to today.

All families deserve the ability to go to the doctor. Getting medical treatment should be a right, not a privilege. While we continue to fight for a more robust health safety net like Medicare for All, our families cannot wait. Right now, we can relieve families of the tremendous burden of medical debt and ensure that more sick or injured people don't avoid the medical attention they deserve.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Franca Muller Paz
District 45 Resident of Baltimore City
Teacher & Building Representative
Baltimore Teachers Union
franca.muller@gmail.com
201-888-5618

Muniak SB0514 Legislative Testimony.pdf

Uploaded by: Muniak, Lindsey
Position: FAV

PROGRESSIVE MARYLAND

P.O. Box 6988 Largo, MD 20792
www.ProgressiveMaryland.org
Contact@ProgressiveMaryland.org
Facebook.com/ProgressiveMaryland
@Progressive_MD

Testimony on SB0514:
The Medical Debt Protection Act

To: Chair Kelley and Members of the Senate Finance Committee
From: Lindsey Muniak, Progressive Maryland Community Healthcare Organizer
Date: February 23, 2021
Position: Favorable

My name is Lindsey Muniak and I am a Baltimore City resident. I work with Progressive Maryland as a Community Healthcare Organizer, and I am an active member of the End Medical Debt Maryland coalition. I write today in **strong support of SB0514: The Medical Debt Protection Act,** and I urge the committee to move this legislation forward **in its current form**.

The rate at which Maryland hospitals sue their own patients over low-sum unpaid medical bills is staggering. Hospitals in the state filed a whopping 145,746 lawsuits against patients over the course of a single decade spanning from 2009–2018, and the median sum sought in these lawsuits was just $944. These same hospitals are granted enormous tax breaks by way of their status as nonprofit organizations and receive subsidies in exchange for offering basic community benefits. **That such powerful institutions pursue financially struggling patients with punitive lawsuits over low-sum debts is unconscionable**.

I spent my early 20s in and out of hospitals being treated for a serious medical condition. I was fortunate that the provisions of the Affordable Care Act allowed me to remain on my father's excellent insurance policy during this period. Had I not been covered by this plan, the financial consequences of this incredibly stressful and difficult time would have been disastrous for me.

I write to advocate for the many Marylanders who do not share my luck. Nobody should be forced into crushing debt because of a medical emergency. It is unacceptable that Maryland families risk losing their homes or having their wages garnished because they sought urgent and necessary medical care. The effects of the Covid-19 pandemic should make the critical need for this legislation clear.

It is time for Maryland hospitals to end these predatory practices. I respectfully ask the Committee to issue a favorable report on SB0514, the Medical Debt Protection Act.

Sincerely,

Lindsey Muniak
Community Healthcare Organizer, Progressive Maryland
Maryland Legislative District 40

SB0514_FAV_OAG HEAU.pdf
Uploaded by: O'Connor, Patricia
Position: FAV

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

Writer's Direct Fax No.
(410) 576-6571

Writer's Direct Email:
poconnor@oag.state.md.us

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WILLIAM D. GRUHN
Chief
Consumer Protection Division

Writer's Direct Dial No.
(410) 576-6515

February 25, 2021

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: The Office of the Attorney General, Health Education and Advocacy Unit

Re: Senate Bill 514 (Health Facilities - Hospitals - Medical Debt Protection): Support

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 514. This bill would simplify hospital legal compliance by expressly incorporating, into one state law, the federal law's minimum hospital debt protections plus enhanced state law protections needed because Maryland's care delivery system is increasingly hospital-centric. The enhanced protections also dovetail with and would fully effectuate the enhanced financial assistance policy protections enacted into Maryland law last session. We supported this bill last session because it was urgently needed then. We now consider the bill's protections to be essential in the economic devastation of the pandemic and its aftermath, especially for Marylanders in low income and minority communities who have been disproportionately impacted by the pandemic. Their vulnerabilities are documented in the Attorney General's COVID-19 Access to Justice Task Force report.[1]

The HEAU is familiar with patient harms caused by billing errors, improperly denied insurance claims, improper adverse reporting, and aggressive debt collection practices, including lawsuits and actions to enforce judgments, because we assist patients with hospital billing disputes. Without improved hospital debt protections, we foresee greater financial harm for an increasing number of patients related to the pandemic and its aftermath. Hospital patients have long struggled to find access to justice, equity and simple fairness because the needs of institutions –hospitals, debt collection businesses

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[1] https://www.marylandattorneygeneral.gov/Pages/A2JC/default.aspx

and courts- are often legally favored over the needs of individuals with temporarily acute or chronic medical conditions.

The affected patients frequently experience involuntary reductions in income and increases in medical spending that may be short-term, long-term, or sporadic. Their lives, in short, are in flux and full of uncertainty. These circumstances do not align well with current laws that impose short deadlines and high payment obligations, with punishing consequences for a consumer's inability to comply with a deadline or payment obligation.

We support the many ways this bill addresses the frequent misalignments between patients and hospital debt collection institutions. For instance, the bill makes clear that a hospital and any debt collector it hires are "jointly and severally responsible" for meeting the requirements of the bill. This would help to harmonize the legal and financial obligations and incentives of a hospital and any debt collector it hires. Both must act in accordance with the bill's prohibitions against adverse reporting or lawsuit initiation while health insurance appeals, applications for financial assistance, or requests to reconsider financial assistance are pending.

This provision also would prevent adverse reports or debt collection actions based on erroneous hospital bills like those described below. We have assisted patients with complaints about hospital billing errors which frequently occur and are hard to resolve quickly. Here are a few examples (potentially identifying information redacted):

"Billing copay was paid by check at the time of service. Amount paid was $25. Check was cashed by [hospital] which claims it has no record of check (copy of cashed check was presented to [hospital]). I paid $20 again to stop their collection per their request. I have paid twice (with proof) and the account has been sent to [debt collector] for collection (letter received)."

"[Patient] had multiple issues with [hospital] billing regarding when and how much she owed for her inpatient stay. They told her that her account balance was zero, but then sent her account to a collection agency."

"This service was paid by [HMO], based on an intra-hospital cooperative contract for [hospital] to provide surgery while I was a member of the HMO. [Hospital] billed a duplicate to [HMO] which retracted their payment for the duplicate billing as they had paid the original billing. [Hospital] applied the extra duplicated billing to my account. They agreed to hold the balance of $760.00 but turned me over to collections. They refuse to remove this from my account. I do not owe this amount. It was not an insurance payment. [Hospital] billing made an error and is trying to collect triple the payments and is harassing me. The contract for surgery was between [HMO and Hospital] and must be resolved between the two institutions."

We urge the committee to give this bill a favorable report.

cc: Sponsor

Kevinomalley.pdf
Uploaded by: O'Malley, Kevin
Position: FAV

Medical Debt Protection Act / HB565
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Kevin O'Malley and I'm a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because I am a practicing physician and I have a first-hand perspective on the factors that can lead someone to have a lot of medical debt. First, no one plans to get sick. And even if someone does plan, it is very easy for illness to far outpace any savings. Our insurance market does not provide adequate coverage. Many Marylanders ultimately face medical expenses that they cannot afford. Unlike discretionary or luxury spending, medical care is almost always never something that can be delayed without significant harm and cost (bodily and economic) down the line. I fear that many of the economic costs we bear as a medical system are the downstream effect of Maryland residents attempting to self-ration their own care due to cost concerns. If Marylanders had some kind of reassurance that they would not be at risk to become totally bankrupted by coming to the hospital then I think we, as a medical community, might have the ability to engage earlier along the course of a disease process – potentially saving life, limb and the cost of the often more expensive care required by conditions that were left unaddressed for too long.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Kevin O'Malley, MD
Baltimore City
Kevinomalley87@gmail.com

SB514_FAVORABLE_Marylanders for Patient Rights.pdf

Uploaded by: Palmisano, Anna

Position: FAV

Marylanders for Patient Rights

MARYLANDERS FOR PATIENT RIGHTS SUPPORTS SB 514

Feb. 23, 2021

Chair Delores Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401

Dear Chair Kelley,

On behalf of Marylanders for Patient Rights, a patient advocacy organization, I am writing in strong **SUPPORT OF SB 514** – Medical Debt Protection. The COVID-19 pandemic has challenged not only our healthcare and other essential workers, but also created extremely difficult conditions for hospital *patients*. The pandemic has prevented many hospital patients from accessing the comfort and support of family members and patient advocates.

The pandemic has also deepened the cracks in our healthcare system in terms of the ability of all patients to access healthcare and to pay down medical debt. Currently, many Maryland hospitals are filing lawsuits against patients for amounts typically $1000 or less. With the unemployment rate at a record high and patients losing their health care, the prospect of being overwhelmed by medical debt is very real and very frightening for many patients.

We have heard from patients who would actually rather avoid needed treatment from hospitals than burden themselves and their families with medical debt. As a microbiologist, I know that medical debt can contribute to a healthcare emergency, because the cycle of infection cannot be controlled without treating those with active COVID-19 infections.

SB 514 is a commonsense bill to address the problem of punitive medical debt for Marylanders. It will help to address healthcare disparities by: Requiring hospitals to develop a payment plan for those with outstanding debt that does not exceed 5% of the individual's monthly income; preventing hospitals from putting liens on family homes and from garnishing wages; and prohibiting hospitals from suing patients for medical debt under $1,000.

Other states have taken comparable action to ban wage garnishment (NC, PA, SC, TX) and to protect the family home for liens due to medical debt (AR, DC, FL, IA, KS, OK, PR, SD, TX). Maryland should follow their example. I encourage the committee to submit a **FAVORABLE report for SB 514** to protect vulnerable patients from punitive medical debt.

Sincerely,
Anna Palmisano
Anna Palmisano, Ph.D.,
Marylanders for Patient Rights
palmscience@verizon.net

Medical Debt Letter of Support_Councilman Patoka_S
Uploaded by: Patoka, Izzy
Position: FAV

County Council of Baltimore County
Court House, Towson, Maryland 21204

Izzy Patoka
Councilman, Second District
council2@baltimorecountymd.gov

Council Office: 410-887-3385
Fax: 410-887-5791

February 22, 2021

To the Health & Government Operations Committee / Senate Finance Committee,

My name is Councilman Izzy Patoka. I proudly serve the 2nd District Baltimore County, and I support the Medical Debt Protection Act (SB514). This urgent legislation will prohibit medical debt lawsuits for $1000 or less, require income-based repayment plans, cap interest rates at 1.5%, and prevent wage garnishments and liens on homes over medical debt.

The Medical Debt Protection Act will protect low and middle-income households from punitive medical debt lawsuits in Baltimore County and statewide. In Baltimore County, 40% of households can't afford to make ends meet according to the 2020 United Way's ALICE report. Over the past ten years, hospitals have filed 32,617 lawsuits against Baltimore County residents to collect on medical debts. The median amount owed was $928 and of these lawsuits, 9,016 resulted in wage or property garnishments.

I believe that the passing of this bill is essential to keep healthcare equitable, accessible, and affordable, without impacting a person's credit.

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Councilman Izzy Patoka
Baltimore County
410-887-3385

EndMedDebtfinancecommittee.pdf
Uploaded by: Pikler, Vanessa
Position: FAV

VANESSA PIKLER, PH.D

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Vanessa Pikler, PhD, and I am a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because I believe as a psychologist this bill has the potential to protect both the physical and mental health of generations of Marylanders. The import and long-term consequences of this can't be understated.

Because of the work that I do as a health psychologist, I know that just being diagnosed with a medical illness can be traumatic enough. Likewise, navigating medical procedures and the health care system can, and often is, highly stressful—and sometimes also traumatic. If one's wages are garnished or one loses one's home or car due to medical debt ***in addition*** to being ill, the likelihood of adverse mental and physical health outcomes significantly increase.

And that toll is not only exacted on the identified patient. Those patients have families—children. The research indicates that children who suffer adverse childhood events (or ACEs) are significantly more likely to develop future medical concerns and poor mental health outcomes themselves. Being homeless or having food scarcity (or having your parent have to choose between treatment for their illness or feeding or housing you) certainly constitutes the potentiality of ACEs.

The generational consequences of medical debt are exponential.
I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Vanessa Pikler, PhD
vanessa@vanessapiklerphd.com

600 Wyndhurst Ave., Suite 125B
Baltimore, MD 21210
410.246.4150
vanessa@vanessapiklerphd.com
www.vanessapiklerphd.com

SB0514_Medical_Debt_MLC_FAV.pdf
Uploaded by: Plante, Cecilia
Position: FAV

TESTIMONY FOR SB0514

HEALTH FACILITIES – HOSPITALS – MEDICAL DEBT PROTECTION

Bill Sponsor: Senator Feldman
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in favor of SB0514 on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of individuals and grassroots groups with members in every district in the state. We have over 30,000 members across the state.

Our members have been concerned over the ways that hospitals use their size as leverage to collect from those who are eligible for free or reduced-cost care. This is even more concerning that hospitals would collect interest and penalties on those bills.

Health care bills, and especially hospital bills can drive people into bankruptcy very quickly. It is hard enough for people who have few resources and have to work multiple jobs to make a living to fend off requests to pay from large organizations, even if they are in the right.

It is important for us to protect people from predatory practices and it is also important to understand the size of this problem to see if there is more that we need to do. This bill solves both of those problems. It requires reporting of hospital collections while also requiring hospitals to offer affordable payment plans and prohibiting them from filing lawsuits until payments are 180 days late and giving more notice to patients that a lawsuit is coming.

We should do everything we can to make sure that low-income people are not preyed upon and that they are able to keep their jobs and remain productive in the workforce, without the threat of bankruptcy hanging over their heads.

The Maryland Legislative Coalition supports this bill and we recommend a **FAVORABLE** report in Committee.

SB514 testimony.pdf
Uploaded by: Puglionesi, Alicia
Position: FAV

To the Senate Finance Committee,

My name is Alicia Puglionesi. I am a resident of Baltimore City and a PhD historian of medicine. I am writing to support the Medical Debt Protection Act SB514, which will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt.

Health care in the United States has long been treated as a consumer good, yet we also find it morally unacceptable that people should die when they are unable to pay for lifesaving treatment. To manage this contradiction, the state of Maryland provides ample public subsidies to hospitals to cover the costs of uncompensated care. However, these funds are often not utilized for their intended purpose, and patients eligible for charity care are instead sued for medical debt and their wages garnished.

These practices are built upon historical foundations of racist and classist policy in health care, an industry which has framed the costs of treatment as an individual responsibility while demanding public responsibility for hospital construction, capital expenses, medical training, and much more. When hospitals claim a right to public support, government must enforce their corresponding obligation to serve the public in an equitable way, as when the Medicare legislation of 1965 was used to end racial segregation in hospitals. Using Medicare funding to force compliance with Title VI of the Civil Rights Act was, however, an incomplete strategy. Black communities continued to receive disproportionately fewer medical resources as income, zip code, and type of insurance became a functional proxy for race. Lawsuits for medical debt correspond to this pattern of persistent racial and class disparity, especially in Baltimore City.

These are structural problems with structural, rather than individual, solutions. In order to access free or discounted care, vulnerable patients have long had to submit to invasive surveillance of their personal lives, and to bear the significant administrative burdens of research, paperwork, litigation, and extended payment plans. As documented in the health policy research of Pamela Herd and Donald Moynihan, such administrative burdens are a significant barrier to care that disproportionately impact minority groups, the poor, and the elderly. When disadvantaged people are unable to navigate the process of eligibility determination and enrollment in a labyrinth of assistance programs, they incur debts that further erode their ability to obtain payment assistance and to meet future health care needs. Sociologists Susan Starr Sered and Rushika Fernandopulle describe this as the "death spiral."

SB514 addresses these historical inequities in two ways. It will significantly reduce the number of Marylanders caught in the death spiral by preventing lawsuits, wage-garnishing, and liens on homes. Second, it enforces the disbursement of public funds for the public benefit, an automatic safeguard against cases where administrative burden has prevented patients from accessing programs meant to assist them. It is the role of racially and economically just policy to redistribute burdens from poor individuals onto well-resourced institutions. As a medical historian who teaches and writes frequently about these issues, I believe that this is a much-needed step towards more equitable health care in the state.

I respectfully urge this committee to issue a favorable report on SB514, the Medical Debt Protection Act.

Sincerely,
Alicia Puglionesi
43rd District

Phone: 610.764.8905
Email: puglionesi@gmail.com

SB514.pdf
Uploaded by: Rachel, Strodel
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Rachel Strodel, and I'm a second-year medical student at Johns Hopkins, Baltimore resident (46th district) and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing this bill is essential because as a future doctor, I believe that everyone has a right to healthcare that won't put them at risk of falling into or continuing in poverty. Johns Hopkins Hospital (JHH)—the very hospital where I am training—receives funding from the federal government to cover care when people are unable to pay, and has yet continued to sue patients even when that funding exceeds the cost of charity care. From a report by the National Nurses Union (NNU) called Taking our Neighbors to Court: "In 2017 alone, JHH received $164.4 million in tax exemptions and $25 million in rate support to provide charity care, $3.3 million of which was in excess of charity care provided." This same report highlighted how 88% of those sued were Black or Latinx, which demonstrates how this practice is racist and exacerbates existing disparities. One of the most disturbing parts of this report is the fact that JHH employees represented 10% of wage garnishments, meaning that Johns Hopkins was disproportionately suing their own employees for medical debt, ostensibly because it would be easier to get those wages back.

In medical school we learn that health is not mainly determined directly by random chance or by genetics, but by the structures, policies, practices, and systems that determine your environment and social sphere. By suing patients for medical debt, Hospitals are making our state sicker and sicker. You have the power to end this and I urge you to do so.

Please issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Rachel Strodel
District 46
330 S Collington Ave
Baltimore, MD 21231
Rstrode3@jhmi.edu
978-866-4994

SB514_ARakochi.pdf
Uploaded by: Rakochi, Adrian
Position: FAV

Medical Debt Protection Act / SB0514
Official Testimony
Position: **FAVORABLE**

To Chair Kelley and Members of the Senate Finance Committee,

My name is Adrian Rakochi and I'm a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support SB0514, the Medical Debt Protection Act, and I ask the Committee to issue a favorable report.

The Medical Debt Protection Act will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because healthcare is essential and one's health and well-being should not be dictated by their wealth. As Co-Chair of Democratic Socialist of America's Health Justice Committee, our chapter believes that healthcare is a human right and our organization, which has 800+ members across the Baltimore Metro area, is a member of the End Medical Debt Maryland Coalition.

I have personal reasons to be in support of this bill as well. I had an acute illness requiring a hospital stay in early 2020. At the same time, I was laid off from my job. And I consider myself lucky for this, because it meant I was eligible for Medicaid. When I looked at the bill, it was nearly $100,000. I have never seen that much money in my life. Owing that much money profoundly changes the character and quality of a person's life for years and while I am grateful for my health now, I am almost equally as grateful to have been spared years of indebtedness. It is unfair to hold regular people prisoner to a debt that represents such a small portion of hospital income.

I respectfully urge this committee to issue a favorable report on SB0514: The Medical Debt Protection Act, with no amendments that water-down the bill.

Sincerely,

Adrian Rakochi
Co-Chair of the Health Justice Committee of Greater Baltimore DSA
adrianrakochi@gmail.com
586-258-9134

TestimonySB0514.pdf
Uploaded by: Roos, Suzanne
Position: FAV

To the Senate Finance Committee:

My name is Suzanne Roos. I am a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I strongly support the Medical Debt Protection Act (HB565/SB514). This bill will protect low and middle-income households from punitive lawsuits for medical debts. It will make certain that hospitals provide refunds of overpayments to patients found to have been eligible for reduced-cost care at the time that they incurred their bills. In addition to that, it will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt.

I feel strongly about this issue, for when I was a child, my family was forced into bankruptcy due to my father's medical bills. I spent most of my childhood in poverty, growing up with my parents in a crowded one-room apartment and wondering how I would ever be able to afford college. Despite years of working 50-hour weeks, my mother only dug our family out of the ranks of the working poor after my father's death when she remarried my stepfather.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, The Medical Debt Protection Act.

Sincerely,

Suzanne Roos
Maryland State Senate District 43
2902 N. Calvert St.
Baltimore MD 21218
sroos@jhu.edu

SB514 testimony from MD PPC (1).pdf

Uploaded by: Saxton, Stephanie
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To Chair Kelley and Members of the Senate Finance Committee,

We are the Maryland Poor People's campaign, a grassroots anti-poverty organization with committees in every Maryland region representing over 10,000 poor and impacted Marylanders. We support SB514, the Medical Debt Protection Act, and I ask the Committee to issue a favorable report.

Organizers of the Poor People's campaign have spoken with a number of Baltimore city residents impacted by medical debt lawsuits. These stories reflect the worst cases of greed and suffering. Baltimoreans have lost their homes over a small debt for broken bones, sick children, and cancer treatment. These stories exist across the state. The Medical Debt Protection Act will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt.

I respectfully urge this committee to issue a favorable report on SB514: The Medical Debt Protection Act, with no amendments that water-down the bill.

Sincerely,
Maryland PPC

Tri-Chair of the Maryland Poor People's Campaign,
Part of the National Poor People's Campaign for a National Moral Revival

testimony2021sb514ltr.pdf

Uploaded by: Schneiderman, Franz

Position: FAV

Auto Consumer Alliance
13900 Laurel Lakes Avenue, Suite 100
Laurel, MD 20707

Testimony to the Senate Finance Committee Committee
SB 514 – Health Facilities – Hospitals –
Medical Debt Protection
Position: Favorable

February 25, 2021

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Building
Annapolis, MD 21401
cc: Members, Senate Finance Committee

Honorable Chair Kelley and Members of the Committee:

I'm a consumer advocate and Executive Director of Consumer Auto, a group that brings together consumer-friendly auto dealers and consumer advocates to work for safety, transparency, and fair treatment for Maryland drivers and car buyers.

We strongly support S**B 514** because it would provide important relief to thousands of Maryland families facing financial devastation as a result of large and often unmanageable medical bills and debts.

As someone who has worked in consumer advocacy in Maryland for the last decade, I am well aware of the huge burden the high cost of medical care often puts on low- and middle-income families. Sadly, as is well known, an unexpected serious illness or emergency surgery can often cause financial ruin or bankruptcy, even for a middle-income family or individual who has reasonably good private medical insurance.

Still I was startled by the extent of the problems caused to families by medical debt lawsuits documented in the 2020 report "Preying on Patients." As the report showed, over the last decade hospitals have filed more than 145,000 medical debt lawsuits resulting in more than 37,000 families having their wages garnished, more than 4,400 liens on Maryland homes and 3,278 bankruptcy filings. For each of the tens of thousands of Marylanders hit hard by these cases, medical lawsuits have produced deeply painful financial problems that will impact their lives for many years to come.

SB 514 would provide much-needed relief for many of the families who will face similar woes in the coming years. By prohibiting lawsuits for debts less than $1,000, it would dramatically ease the number of lawsuits and require hospitals to find ways to handle these debts that are less devastating to indebted patients. By preventing hospitals from putting liens on people's homes or garnishing their wages as a result of medical debt, it will prevent families from losing the ability to pay their bills and meet their basic needs or losing all of their assets as a result of such debts. And, perhaps most importantly, by requiring hospitals to develop manageable repayment plans, it will prevent medical misfortune from becoming a financial fiasco for many families.

Auto Consumer Alliance
13900 Laurel Lakes Avenue, Suite 100
Laurel, MD 20707

No one should lose his or her home or the ability to meet their basic needs as a result of medical misfortune. And in this time when the pandemic is visiting terrible and unpredictable medical disaster on so many – and making millions more vulnerable by costing them their jobs and the health insurance that often comes with them – it is more important than ever for Maryland to act to protect health care consumers against financial devastation.

We support SB 514 and ask you to give it a FAVORABLE report.

Sincerely,

Franz Schneiderman
Consumer Auto

SB 514_MDCEP_FAV.pdf
Uploaded by: Schumitz, Kali
Position: FAV

FEBRUARY 25, 2021

Reasonable Regulations of Medical Debt Would Improve Economic Security for Marylanders

Position Statement Supporting Senate Bill 514

Given before the Finance Committee

Medical bills burden too many Maryland households with financial insecurity, debt collections that damage credit history, and bankruptcy. Senate Bill 514 would protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1,000 or less, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. **For these reasons, the Maryland Center on Economic Policy supports Senate Bill 514.**

National surveys and other research show that medical debt can and does affect people across different levels of income, education and other indicators[i]. However, even relatively minor illness can threaten the financial security of low-income households, whether they have insurance or not. Co-pays and medical bills that aren't covered by insurance, and lost income or employment from time-off work, can become insurmountable obstacles for those already living paycheck to paycheck.

The median debt for medical debt lawsuits is just $944. That is an added expense many working and middle-income families cannot afford – but hospitals that receive millions of dollars in tax breaks and grant funding can. Prohibiting lawsuits for these small amounts and instead putting the focus instead on reasonable repayment plans is a more appropriate way to address the needs of all parties.

In addition, garnishing someone's wages for medical debt is counterproductive. When a working person's wages are seized, it becomes harder to afford necessities like rent, food, and transportation. When families have less to spend on necessities, that also affects local small businesses and the broader community.

Finally, it is all the more important, as Marylanders continue to deal with both the health and economic effects of the COVID-19 pandemic, that people know they can get the medical care they need without putting their family's future financial security at risk.

For these reasons, the Maryland Center on Economic Policy respectfully requests that the Finance Committee give a favorable report to Senate Bill 514.

Equity Impact Analysis: Senate Bill 514

Bill summary

The Medical Debt Protection Act would protect people with medical debt by:

- Mandating hospitals to develop a repayment plan that does not exceed 5% of the individual's monthly income – and capping interest rates at 1.5%
- Prohibiting hospitals from putting liens on homes and from garnishing wages
- Banning hospitals from suing for medical debt $1,000 and under
- Requiring a hospital to provide a refund of certain amounts collected from a patient or the guarantor of a patient who was found eligible for reduced-cost care on the date of service

Background

An estimated 1 in 4 Americans have past due medical bills, according to national surveys. The median debt for medical debt lawsuits is just $944. That is an added expense many working and middle-income families cannot afford – but hospitals that receive millions of dollars in tax breaks and grant funding can.

Equity Implications

Discriminatory policies that created barriers to opportunity and barriers to accessing health care have led to racial inequities in income, wealth, and health. As a result, Black Americans are more likely to have medical debt, with about 1 in 3 having a past due medical bill[ii].

Marylanders of color are also less likely to have health insurance, particularly low-income immigrant Marylanders who might not be eligible for Medicaid or subsidies.

Reducing the frequency of medical debt lawsuits, preventing wage garnishments, and requiring reasonable repayment plans would make it easier for Marylanders to access and afford needed medical care.

Impact

Senate Bill 514 would likely **improve racial and economic equity** in Maryland.

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[i] Singlecare, "2021 Medical Debt Statistics," January 2021. https://www.singlecare.com/blog/medical-debt-statistics/

[ii] Signe-Mary McKernan, Steven Brown, Genevieve M. Kenney; Urban Institutre; "Past-due medical debt a problem, especially for black Americans"; March 2017 https://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans

SB514 test 022321.pdf

Uploaded by: SHAFER, CHARLES

Position: FAV

February 23, 2021
From: Charles Shafer
To Senator Delores G. Kelley (chair), Senator Brian J. Feldman and the members of the Senate Finance Committee.

This testimony supports the Medical Debt Protection Act (SB514).

I am a Baltimore City resident and recently retired professor of law at the University of Baltimore Law School (teaching , Consumer Law and Debtor Creditor Law. While others have detailed for you the statistics regarding the consequences of medical debt collection, I'd like to give you a brief discussion the ways in which these areas of the law are, sadly, implicated in this legislation.

In these courses we often deal with people or businesses that bought something they really couldn't afford, in transactions they didn't understand, or for something they absolutely didn't need. Yet the law provides them with many protections. And rightly so.

Rather we are dealing with people who desperately needed help, at a time when they weren't able to carefully understand legal details, who are then confronted with threats or institution of law suits they are equipped to deal with. In short we are not talking about wealthy people who purchased a deluxe wide screen television.

Instead, this bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. Often fear of these lawsuits can caused frightened or unrepresented people to make payments that they and their families cannot legitimately afford or lose property that they severely need.

Thus, based on my familiarity with the protections afforded in standard consumer transactions, challenges facing people in these types of situations, and the dangerous effects of submitting them to the usual debt collection practices, I urge you to pass this bill.

Thank you for considering this extremely important legislation.

Respectfully submitted.

Charles Shafer.

2021.02.24 testimony - SB 514 - Health Facilitie

Uploaded by: Stephen, David

Position: FAV

Metropolitan Washington Council, AFL-CIO

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SB 514 - Health Facilities - Hospitals - Medical Debt Protection

Senate Finance Committee
February 24, 2021
SUPPORT

To: Chairman Feldman and Senate Finance Committee:

On behalf of our 150,000 union members affiliated with the Council throughout Metropolitan Washington D.C., including about 110,000 residents in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties, we thank you for the opportunity to provide written testimony in support of House Bill 565. This bill is important to the quality of life for working people in Maryland and is especially needed in this time of economic uncertainty.

The workers we represent include skilled tradesmen, healthcare workers, transit operators, grocery store workers, and school personnel, among many others. We believe that the passage of this bill is essential because no one should have to choose between their health and their finances. The illnesses we do not prevent now will cost us all more in the end.

This bill would prohibit liens on homes, the garnishment of wages, and require finding reasonable alternatives to lawsuits for debt under $1,000, all current practices that significantly negatively affect the quality of life for working people. The median for medical debt lawsuits is $944, which might not seem burdensome but, in many cases, makes workers' ability to pay their rent or mortgage or even to buy food an unnecessary challenge and a financial injustice. We also know that the patients who are most likely to be sued are essential workers. Garnishing the wages of essential workers, especially during a pandemic, is patently ridiculous and unacceptable.

Finally, by mandating hospitals to develop a repayment plan that does not exceed 5% of the individual's monthly income, we can end this nightmare and make our healthcare laws work for and protect working people.

We respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

In Solidarity, Dyana Forester

Testimony-SB514-Medical Debt.pdf
Uploaded by: Stevenson, Christopher
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

Madam Chair and Members of the Senate Finance Committee:

My name is Ricarra Jones. I am the Political Director of 1199SEIU United Healthcare Workers East. Our union represents 10,000 frontline healthcare in Maryland alone. We are in favor of the Medical Debt Protection Act / SB514 and we ask the Committee to vote yes on this urgent legislation. Some of the most important elements of the bill include prohibiting medical debt lawsuits for $1000 or less, and prohibiting liens on houses and wage garnishments for unpaid medical bills.

1199SEIU members work at hospitals that are among the top offenders statewide for suing patients, including but not limited to Johns Hopkins Hospital and Greater Baltimore Medical Center. Our members have seen firsthand how damaging it is to patients who avoid seeking healthcare because they know they can't afford it, then patients end up in the hospital and incur medical debt because they were not able to get care early on. This is a problem that has been made even more severe during the COVID19 pandemic. Furthermore, we are learning now that many patients experience long-term, chronic effects from COVID19, which will require low and middle income patients to either take on more medical debt or avoid healthcare.

One of the most disturbing debt-collection practices hospitals are pursuing is garnishing wages over medical debt. The patients most likely to be sued and have their wages garnished are essential workers. Garnishing essential workers' wages, especially during a pandemic, is unacceptable. Even more disturbing is hospitals like Johns Hopkins suing their own workers for medical debt, including some of our members who work in environmental services. Hospitals create an almost inescapable cycle of poverty by underpaying their workers and providing inadequate healthcare benefits, all while encouraging workers to receive healthcare at their facility. Then, they turn around and sue those same workers and garnish their paychecks when they can't afford healthcare due to their already low wages.

We can no longer allow patients to be financially punished for getting sick – during COVID19 and beyond. It is critical that we pass the Medical Debt Protection Act this session. 1199SEIU urges the committee to **issue a favorable report on SB514** that includes the ban on lawsuits for $1000 or less, and the prohibition of wage garnishments and liens on homes. Thank you.

Respectfully,
Ricarra Jones, Political Director
1199SEIU United Healthcare Workers East
ricarra.jones@1199.org, 443-844-6513

SB514 Testimony 2021-02-23 Walsh, Michael.pdf

Uploaded by: Walsh, Michael
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Michael Walsh. I'm a resident of Shady Side, a two-time cancer survivor, and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that passing of this bill is essential because anyone that needs the basic human right of health care should NOT be subjected to exorbitant costs to receive it! Whether it be the care we need to receive on a regular basis to live a healthy life, or the extraordinary and emergency care we need to survive a health crisis like a cancer diagnosis or COVID-19 in the middle of our global pandemic, the last thing that should be of concern is how to afford healthcare. And it especially shouldn't be a priority of the hospitals that receive millions of dollars in profits to be chasing down such minor amounts of medical debt, the median value of which is $944! Nobody should threaten your home with a lien or garnish your wages to take food and housing out of their hands, all over such a small amount relative to what the hospital has to work with! How can the hospitals that promise to "do no harm" actively work to do that through these means?!

As I mentioned I am a two-time cancer survivor. My first diagnosis came in 2012 and a whirlwind of actions started up in order to determine a treatment plan. Scans and tests determined a surgical excision would be appropriate, and in the interest of stopping it in its tracks we moved very quickly. At the time I had health insurance through my employer, and I could only assume my coverage would be sufficient that I wouldn't go into debt from my first fight with cancer. Those hopes were crushed when, after a successful surgery and post-op tests that showed the cancer had not metastasized to any lymph nodes (yet), I was faced with over $8000 in bills! I didn't know what to do, so forced to make a quick decision and no support from my insurer or the hospital, I took out a personal loan at a high interest rate but that would allow me to pay over an extended period of time. Adding a major monthly payment on top of rent, transportation, food, and student loans was not the plan and the fact that there were no better options for me was disheartening to say the least.

Fast-forward six years and I got the news a second time that nobody wants to receive even once - a tumor in my lung and in my neck. Not only had my previous cancer returned, I was diagnosed with a rare cancer called Ewing Sarcoma. The difference this time - I was no longer employed. Imagine receiving that news, and the first thing that pops into your head is "How am I going to pay for this so I don't die?! That was me, and I was hopeless. Fortunately with the assistance of a healthcare worker much more familiar with the options available through the health insurance marketplace, I was able to enroll in a Medicaid program that would

cover most of the even more expensive treatment I would then go on to receive over the next 2+ years. I learned the cost of each treatment after my first one was going to be well over $10K each time, so knowing I would need at least 14 total treatments and multiple surgeries, you can imagine the dread I felt wondering if my life was worth being saved and that I would not lose the financial coverage I was able to receive. These are the things that NO ONE should have to contemplate in the middle of a health crisis. My life has been changed forever now that I must monitor for any cancerous activity on a very frequent basis - those scans and tests are not cheap either and now that I am no longer eligible for Medicaid I could easily be loaded down with debt again if something were to come up. Again I ask you - is that what you or your loved ones should have to contemplate? Whether they are worth receiving the care and treatment they need, or whether a hospital will overload them with debt and force them to make decisions about their well-being or their financial security? For hospitals to go after people and families for these costs is unfathomable, and I only hope that if I am met with a cancer diagnosis again, I will not have to fear the collectors when I can't afford to save my own life.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Michael Walsh
MD-05
410-353-2756 | walsh2.michael@gmail.com

SB514 - Warman Testimony.pdf
Uploaded by: Warman, Christopher
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the Senate Finance Committee,

My name is Christopher Warman, and I'm a Baltimore resident and a member of the End Medical Debt Maryland coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for debts under $1,000, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. I believe that the passing of this bill is essential because forcing patients to choose between their health and the financial future of themselves and their families is unjust, unnecessary, and cruel.

In the summer of 2018, I lost my grandmother to colorectal cancer. She was always the type to avoid a doctor and put off caring for herself, so I dropped everything to be with her when I received a call informing me she had been admitted to MedStar Franklin Square Hospital. Her cancer was mature and incurable and the tumor in her colon had torn open her internal tissue, poisoning her bloodstream and abruptly shutting her body down. It was surely incredibly painful and terrifying. And yet when the doctors proposed a surgical procedure to remove the tumor and repair the tissue—a surgery they said could lead to several months to a year more of her life—she fiercely refused. She kept saying to me, "I can't leave that for you."

I did not understand at the time, but I have since realized my grandmother was terrified of leaving behind a medical debt that would likely fall due to her grandchildren, named as beneficiaries in her will. My grandmother raised all of us, she cared deeply for us. She had saved and diligently paid life insurance policies for years to ensure she would leave something to help us when she passed away. Fairly, she did not want that money getting swept up by medical debt. Despite being on death's door, she was forgoing potentially life-saving care for the sake of avoiding debt.

When I think about medical debt lawsuits, I think of the thousands of people who are forced to make that terrible calculation every year in Maryland, forgoing even basic care because they know a hospital may take a quarter of their paycheck or their savings account or their home if they cannot pay. And yet from 2014-2018, hospitals underspent their state-provided charity care funds by almost the same amount as the total they sought from the medical debt lawsuits they brought against their patients. Enough is enough. It is time for the state legislature to end these practices and provide long-overdue relief to Maryland's patients and their families.

I respectfully urge this committee to issue a favorable report on HB565/SB514, the Medical Debt Protection Act.

Sincerely,

Christopher Warman
43rd District
cwarman.baltimore@gmail.com

MCRC Report - Gonzales Maryland Poll October 2020
Uploaded by: White, Marceline
Position: FAV

GONZALES MARYLAND POLL

October 2020

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Christmas Toy Drive

Gonzales Research has joined forces with Amigos of Baltimore County on a Toy Drive for the immigrant community for this upcoming Christmas.

We are asking for your support!

We are collecting the following items:

- Toys for the children from infant through 10 years old.
- Pampers – all sizes
- Candy
- Zip lock bags
- Formula
- Crayons
- Coloring Books

If you are able to let us drop a box at a business or an office location please let us know. We are also asking for donations, you can directly make donations by going to our website at: https://www.amigosbaltimorecounty.org

CONTACT:

Alejandra (Ally) Ivanovich, Executive Director
Amigos of Baltimore County
410-900-0920

Background and Methodology

Patrick E. Gonzales graduated magna cum laude from the University of Baltimore with a degree in political science.

His career in the field of public opinion research began in the mid-1980s as an analyst with *Mason-Dixon Opinion Research*. During this time, Mr. Gonzales helped develop, craft and implement election surveys and exit polls for television and radio in the Baltimore-Washington D.C. metro area.

Mr. Gonzales has polled and analyzed well over a thousand elections in Maryland and across the country since that time. Furthermore, he and his associates have conducted numerous market research projects, crafting message development plans and generating strategy blueprints for businesses and organizations throughout the state.

Over his 35 years conducting public opinion polls, Patrick Gonzales has been widely recognized by his peers for his ability to conduct unbiased surveys, and analyze the results in an impartial, evenhanded manner.

Mr. Gonzales appears frequently on radio and television in the Baltimore-D.C. region as a guest commentator.

Elizabeth Gonzales Byers has joined *Gonzales Research* as Director of Marketing and Social Media. She can be contacted at elizabeth@gonzalesresearch.com

This poll was conducted by ***Gonzales Research & Media Services*** from October 19th through October 24th, 2020. A total of 820 registered voters in Maryland, who indicated that they are likely to vote in the 2020 general election, were queried by live telephone interviews, utilizing both landline (38%) and cell phone (62%) numbers. A cross-section of interviews was conducted throughout the state, reflecting general election voting patterns.

The margin of error (MOE), per accepted statistical standards, is a range of plus or minus 3.5 percentage points. If the entire population was surveyed, there is a 95% probability that the true numbers would fall within this range.

Gonzales Poll – October 2020 Results

Medical Debt

Among Maryland voters, 12% indicate that they or someone in their household have medical bills or debt that they are unable to repay in the next 12 months.

A profile of Marylanders with medical bills and debt they are unable to repay:

Unable to repay Medical Debt	**Yes**	**No**
Democrat	15%	85%
Republican	7%	93%
Unaffiliated	11%	89%
African American	21%	79%
White	7%	93%
Women	13%	87%
Men	11%	89%
18 to 39 yrs. old	13%	87%
40 to 49 yrs. old	14%	86%
50 to 59 yrs. old	13%	86%
60 and older	9%	91%
Baltimore Metro	14%	86%
Washington Metro	11%	89%
Rural Maryland	9%	90%

Source of Medical Debt

Among those with medical bills and debt they are unable to pay, 58% say the debt derived from an outpatient visit, 14% say the bills resulted from a hospital stay, 25% say both outpatient visits and hospital stays, and 3% give no response.

Medical Debt – Payment Source

We then asked respondents, "*If you had a $500 medical debt to pay today, where would the money come from: would you pay it from funds you have, would you put it on a credit card or borrow it, or would you not pay it*?"

Statewide, 70% say the money to pay the debt would come from existing funds, 18% say from a credit card or they would borrow money, and 8% say they would not pay the debt.

Among those respondents indicating earlier that they were "unable to repay medical bills," 47% say they would use a credit card/borrow the money, only 17% say they would use existing funds, and 34% say they could not repay it.

A profile of payment sources for Marylanders with medical bills:

Pay $500 in Medical Bills	**Existing Funds**	**Credit Card**	**Not Pay**
Democrat	66%	20%	10%
Republican	77%	15%	5%
Unaffiliated	72%	17%	9%
African American	53%	28%	17%
White	79%	13%	5%
Women	69%	19%	9%
Men	72%	17%	8%
18 to 39 yrs. old	74%	16%	5%
40 to 49 yrs. old	66%	21%	10%
50 to 59 yrs. old	69%	18%	9%
60 and older	72%	17%	9%
Baltimore Metro	67%	19%	10%
Washington Metro	68%	22%	7%
Rural Maryland	80%	11%	7%

Surprise Medical Billing – Level of Concern

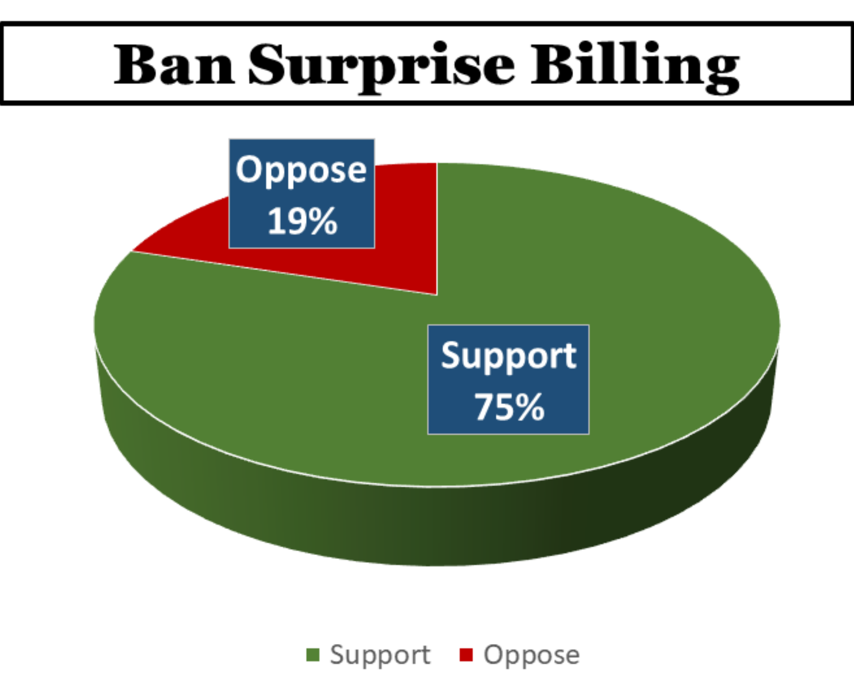
Among Marylanders, 35% are worried (12% "very worried and 23% "somewhat worried") that they, over the next 12 months, will receive a surprise medical bill - that is, a bill for services from a doctor that wasn't included in their health insurance plan, while 65% are not worried about getting a surprise bill.

Within the group "unable to repay medical bills," 80% are worried (36% "very worried and 44% "somewhat worried") that they will receive a surprise medical bill over the next 12 months.

Legislation to Ban Surprise Medical Billing

Seventy-five percent of voters would support a law to ban surprise billing, 19% are opposed to such legislation, with 6% offering no opinion.

By party, 76% of Democrats, 70% of Republicans, and 81% of independents support a law to ban surprise medical billing.



Delayed/Avoided Medical Care in Past Year

Seventeen percent of Free State respondents say that they, over the past year, have delayed or avoided medical care because of concerns about the costs, while 83% say they have not.

Among those "unable to pay medical bills", however, 53% say they have delayed care over a concern of the costs.

A profile of Marylanders who have delayed medical care because of cost concerns:

Delayed/Avoided Care	Yes	No
Democrat	18%	82%
Republican	14%	86%
Unaffiliated	19%	80%
African American	24%	75%
White	12%	87%
Women	18%	82%
Men	16%	84%
18 to 39 yrs. old	12%	87%
40 to 49 yrs. old	22%	78%
50 to 59 yrs. old	17%	83%
60 and older	16%	84%
Baltimore Metro	19%	81%
Washington Metro	17%	82%
Rural Maryland	11%	89%

Aware Hospitals Provide Free Care For Low-Income Patients

Overall, 29% of respondents say they were not aware that hospitals provide free care and reduced-cost care for low-income patients, while 70% say they were aware of this.

Fifty percent of African Americans responded that they were **not** aware that hospitals provide free care and reduced-cost care for low-income patients.

Aware Hospitals Sue To Collect Debt

Fifty-seven percent say they knew that many hospitals sue their former patients to collect debt that is less than $5,000, while 43% did not know this.

A profile of those aware hospitals sue for debt:

Aware Hospitals Sue Patients	Yes	No
Democrat	53%	47%
Republican	64%	36%
Unaffiliated	60%	40%
African American	47%	53%
White	64%	36%
Women	53%	47%
Men	63%	37%
18 to 39 yrs. old	60%	40%
40 to 49 yrs. old	55%	45%
50 to 59 yrs. old	58%	42%
60 and older	57%	43%
Baltimore Metro	62%	38%
Washington Metro	49%	51%
Rural Maryland	61%	39%

Zero Out Bank Accounts To Collect Debt

Among Marylanders, 92% say that hospitals should **not** be able to zero out a patient's bank account to collect a debt, while only 7% believe that it is okay for hospitals to recover debt in this manner.

Huge majority of residents across the board do not believe zeroing out one's bank account to collect a debt for medical bills is appropriate.

Property Lien To Collect Debt

Eighty-eight percent of Free State voters do **not** believe it is acceptable for hospitals to put a lien on personal property such as a car or home to collect a debt for medical bills.

A profile:

OK To Put a Lien on Property	Yes	No
Democrat	7%	90%
Republican	15%	83%
Unaffiliated	6%	89%
African American	2%	95%
White	12%	85%
Women	9%	88%
Men	10%	87%
18 to 39 yrs. old	7%	89%
40 to 49 yrs. old	9%	89%
50 to 59 yrs. old	9%	90%
60 and older	12%	84%
Baltimore Metro	8%	88%
Washington Metro	9%	89%
Rural Maryland	12%	85%

Garnish Wages To Collect Debt

Further, 79% say that hospitals should **not** be able to garnish a person's wages to collect a debt for medically necessary care, while only 19% of Marylanders believe that it is okay for hospitals to recover a debt from patients by seizing their income.

By party, 83% of Democrats, 70% of Republicans, and 81% of independents say garnishing wages to collect a medical debt is unreasonable.

By race, 91% of African Americans and 74% of whites express the opinion that it is unacceptable for hospitals to collect a medical debt by snatching the income of their former patients.

Legislation To Prohibit Zero Out Bank Accounts

Sixty-seven percent of Maryland voters would support legislation to prohibit hospitals from zeroing out a bank account to collect a medical debt, while 31% would oppose such legislation.

A profile of voters on legislation to prohibit hospitals from zeroing out a bank account to collect a medical debt:

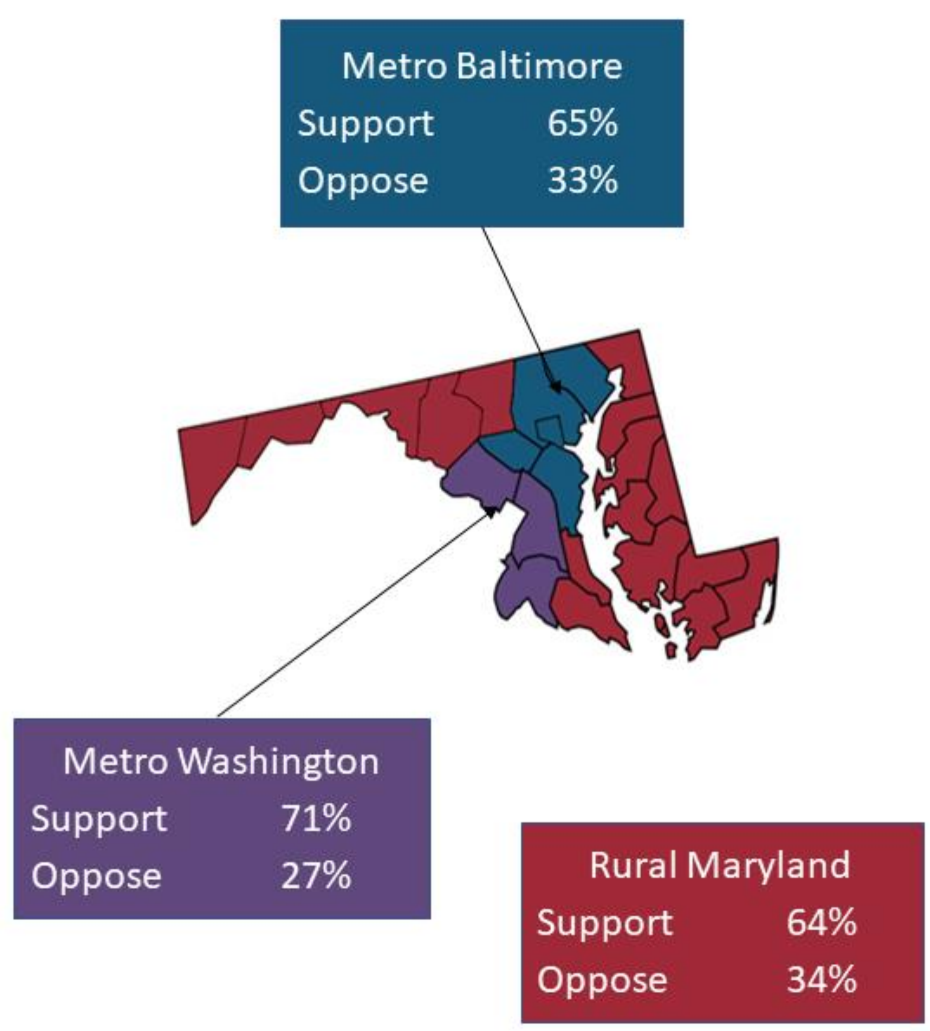
Prohibit Zeroing Out Account	Support	Oppose
Democrat	77%	21%
Republican	46%	52%
Unaffiliated	71%	26%
African American	73%	25%
White	65%	34%
Women	69%	31%
Men	65%	32%
18 to 39 yrs. old	76%	22%
40 to 49 yrs. old	68%	32%
50 to 59 yrs. old	66%	32%
60 and older	62%	37%
Baltimore Metro	65%	33%
Washington Metro	71%	27%
Rural Maryland	64%	34%

Legislation To Prohibit Placing Property Lien

Fifty-nine percent of respondents would support legislation to prohibit hospitals from putting a lien on one's car or home to collect a medical debt, while 39% would oppose legislation to prohibit hospitals from putting a lien on personal property to recover a medical debt.

By race, 64% of African Americans and 57% of white voters would support legislation prohibiting hospitals from putting a lien on one's car or home to collect a bill.

Legislation to Prohibit Zeroing Out by Region



Debt Ceiling

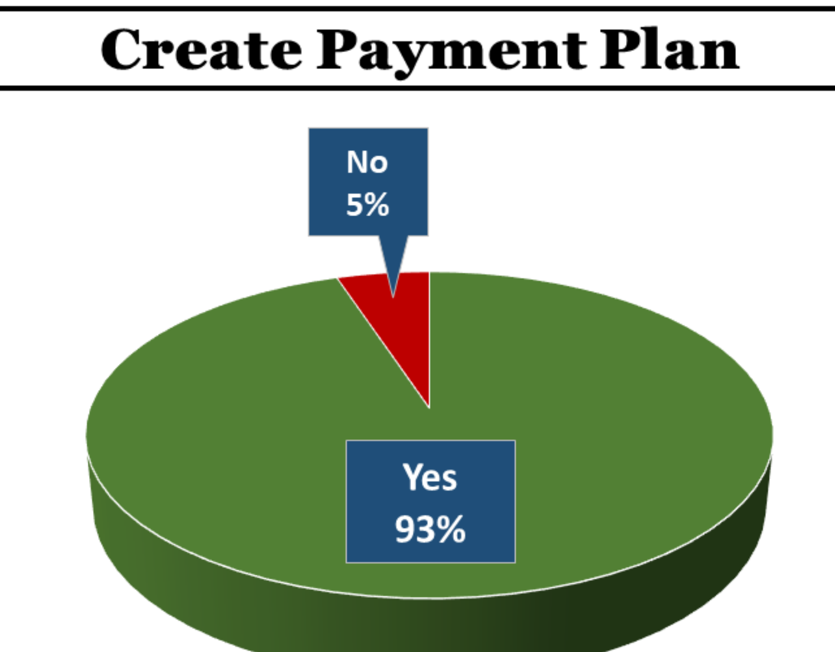
We asked respondents whether they would support or oppose prohibiting hospitals from suing former patients for debts ranging from five thousand dollars down to $250. The results:

Proscribe Hospitals From Suing Patients

Debt Amount	Support	Oppose
$5,000	61%	34%
$2,500	63%	33%
$1,000	64%	32%
$500	65%	31%
$250	65%	30%

Create Payment Plan

An overwhelming 93% of Maryland voters think that before a hospital can file a lawsuit or send a debt to collection, the hospital should be required to create a payment plan based on income for former patients to pay off the debt.



Appendix A: Data Tables

QUESTION: Medical Bills/Debt *Do you or someone in your household currently have medical bills or debt that you are unable to repay in the next 12 months?*

UNABLE TO PAY MEDICAL BILLS	Number	Percent
Yes	97	11.8 %
No	720	87.8 %
No answer	3	0.4 %
Total	820	100.0 %

N=820	UNABLE TO PAY MEDICAL BILLS		
	Yes	No	No answer
PARTY			
Democrat	64 14.8%	366 84.5%	3 0.7%
Republican	18 7.3%	229 92.7%	0 0.0%
Unaffiliated	15 10.7%	125 89.3%	0 0.0%

N=820	UNABLE TO PAY MEDICAL BILLS		
	Yes	No	No answer
RACE			
African American	47 21.3%	173 78.3%	1 0.5%
White	39 7.2%	500 92.6%	1 0.2%
Other/ Refused	11 18.6%	47 79.7%	1 1.7%

N=820	UNABLE TO PAY MEDICAL BILLS		
	Yes	No	No answer
GENDER			
Female	56 12.9%	376 86.4%	3 0.7%
Male	41 10.6%	344 89.4%	0 0.0%

N=820	UNABLE TO PAY MEDICAL BILLS		
	Yes	No	No answer
AGE			
18 to 39	21 12.5%	146 86.9%	1 0.6%
40 to 49	26 14.0%	160 86.0%	0 0.0%
50 to 59	28 13.4%	180 86.1%	1 0.5%
60 and older	22 8.6%	234 91.1%	1 0.4%

N=820	UNABLE TO PAY MEDICAL BILLS		
	Yes	No	No answer
REGION			
Baltimore Metro	51 14.4%	304 85.6%	0 0.0%
Washington Metro	29 10.4%	249 88.9%	2 0.7%
Rural Maryland	17 9.2%	167 90.3%	1 0.5%

QUESTION: Medical Bills/Debt - Source *Are your medical bills from an outpatient visit or from a hospital stay?*

MEDICAL BILL SOURCE	Number	Percent
Outpatient visit	56	57.7 %
Hospital stay	14	14.4 %
Both	24	24.7 %
Other	0	0.0 %
No answer	3	3.1 %
Total	97	100.0 %

N=820	MEDICAL BILL SOURCE			
	Outpatient visit	Hospital stay	Both	No answer
PARTY				
Democrat	38 59.4%	10 15.6%	15 23.4%	1 1.6%
Republican	9 50.0%	2 11.1%	6 33.3%	1 5.6%
Unaffiliated	9 60.0%	2 13.3%	3 20.0%	1 6.7%

N=820	MEDICAL BILL SOURCE			
	Outpatient visit	Hospital stay	Both	No answer
RACE				
African American	31 66.0%	6 12.8%	9 19.1%	1 2.1%
White	18 46.2%	6 15.4%	13 33.3%	2 5.1%
Other/ Refused	7 63.6%	2 18.2%	2 18.2%	0 0.0%

N=820	MEDICAL BILL SOURCE			
	Outpatient visit	Hospital stay	Both	No answer
GENDER				
Female	34 60.7%	7 12.5%	15 26.8%	0 0.0%
Male	22 53.7%	7 17.1%	9 22.0%	3 7.3%

N=820	MEDICAL BILL SOURCE			
	Outpatient visit	Hospital stay	Both	No answer
AGE				
18 to 39	7 33.3%	5 23.8%	8 38.1%	1 4.8%
40 to 49	13 50.0%	4 15.4%	7 26.9%	2 7.7%
50 to 59	20 71.4%	2 7.1%	6 21.4%	0 0.0%
60 and older	16 72.7%	3 13.6%	3 13.6%	0 0.0%

N=820	MEDICAL BILL SOURCE			
	Outpatient visit	Hospital stay	Both	No answer
REGION				
Baltimore Metro	34 66.7%	6 11.8%	11 21.6%	0 0.0%
Washington Metro	13 44.8%	5 17.2%	10 34.5%	1 3.4%
Rural Maryland	9 52.9%	3 17.6%	3 17.6%	2 11.8%

QUESTION: $500 Medical Debt – Payment Source *If you had a $500 medical debt to pay today, where would the money come from: would you pay it from funds you have, would you put it on a credit card or borrow it, or would you not pay it?*

PAY MEDICAL BILLS	Number	Percent
Existing funds	576	70.2 %
Credit card/borrow	147	17.9 %
Not pay	68	8.3 %
No answer	29	3.5 %
Total	820	100.0 %

N=820	PAY MEDICAL BILLS			
	Existing funds	Credit card/ borrow	Not pay	No answer
UNABLE TO PAY MEDICAL BILLS				
Yes	17 17.5%	46 47.4%	33 34.0%	1 1.0%
No	556 77.2%	101 14.0%	35 4.9%	28 3.9%
No answer	3 100.0%	0 0.0%	0 0.0%	0 0.0%

N=820	PAY MEDICAL BILLS			
	Existing funds	Credit card/ borrow	Not pay	No answer
PARTY				
Democrat	285 65.8%	87 20.1%	44 10.2%	17 3.9%
Republican	190 76.9%	36 14.6%	11 4.5%	10 4.0%
Unaffiliated	101 72.1%	24 17.1%	13 9.3%	2 1.4%

N=820	PAY MEDICAL BILLS			
	Existing funds	Credit card/ borrow	Not pay	No answer
RACE				
African American	118 53.4%	61 27.6%	37 16.7%	5 2.3%
White	425 78.7%	68 12.6%	25 4.6%	22 4.1%
Other/ Refused	33 55.9%	18 30.5%	6 10.2%	2 3.4%

N=820	PAY MEDICAL BILLS			
	Existing funds	Credit card/ borrow	Not pay	No answer
GENDER				
Female	300 69.0%	82 18.9%	38 8.7%	15 3.4%
Male	276 71.7%	65 16.9%	30 7.8%	14 3.6%

N=820	PAY MEDICAL BILLS			
	Existing funds	Credit card/ borrow	Not pay	No answer
AGE				
18 to 39	124 73.8%	27 16.1%	9 5.4%	8 4.8%
40 to 49	123 66.1%	39 21.0%	18 9.7%	6 3.2%
50 to 59	145 69.4%	38 18.2%	19 9.1%	7 3.3%
60 and older	184 71.6%	43 16.7%	22 8.6%	8 3.1%

N=820	PAY MEDICAL BILLS			
	Existing funds	Credit card/ borrow	Not pay	No answer
REGION				
Baltimore Metro	238 67.0%	66 18.6%	35 9.9%	16 4.5%
Washington Metro	190 67.9%	61 21.8%	20 7.1%	9 3.2%
Rural Maryland	148 80.0%	20 10.8%	13 7.0%	4 2.2%

QUESTION: Surprise Billing – Level of Concern *Over the next 12 months, how worried are you about receiving a surprise medical bill; that is, a doctor providing you services without your knowledge the services weren't covered by insurance: very worried, somewhat worried, or not worried?*

SURPRISE MEDICAL BILLING - LEVEL OF CONCERN	Number	Percent
Very Worried	97	11.8 %
Somewhat Worried	191	23.3 %
Not Worried	531	64.8 %
No answer	1	0.1 %
Total	820	100.0 %

N=820	SURPRISE MEDICAL BILLING - LEVEL OF CONCERN			
	Very Worried	Somewhat Worried	Not Worried	No answer
UNABLE TO PAY MEDICAL BILLS				
Yes	35 36.1%	43 44.3%	19 19.6%	0 0.0%
No	61 8.5%	147 20.4%	511 71.0%	1 0.1%
No answer	1 33.3%	1 33.3%	1 33.3%	0 0.0%

N=820	SURPRISE MEDICAL BILLING - LEVEL OF CONCERN			
	Very Worried	Somewhat Worried	Not Worried	No answer
PARTY				
Democrat	50 11.5%	103 23.8%	280 64.7%	0 0.0%
Republican	31 12.6%	52 21.1%	164 66.4%	0 0.0%
Unaffiliated	16 11.4%	36 25.7%	87 62.1%	1 0.7%

N=820

	SURPRISE MEDICAL BILLING - LEVEL OF CONCERN			
	Very Worried	Somewhat Worried	Not Worried	No answer
RACE				
African American	30 13.6%	52 23.5%	139 62.9%	0 0.0%
White	56 10.4%	127 23.5%	356 65.9%	1 0.2%
Other/ Refused	11 18.6%	12 20.3%	36 61.0%	0 0.0%

N=820

	SURPRISE MEDICAL BILLING - LEVEL OF CONCERN			
	Very Worried	Somewhat Worried	Not Worried	No answer
GENDER				
Female	53 12.2%	102 23.4%	279 64.1%	1 0.2%
Male	44 11.4%	89 23.1%	252 65.5%	0 0.0%

N=820

	SURPRISE MEDICAL BILLING - LEVEL OF CONCERN			
	Very Worried	Somewhat Worried	Not Worried	No answer
AGE				
18 to 39	14 8.3%	43 25.6%	110 65.5%	1 0.6%
40 to 49	16 8.6%	41 22.0%	129 69.4%	0 0.0%
50 to 59	29 13.9%	48 23.0%	132 63.2%	0 0.0%
60 and older	38 14.8%	59 23.0%	160 62.3%	0 0.0%

N=820	SURPRISE MEDICAL BILLING - LEVEL OF CONCERN			
	Very Worried	Somewhat Worried	Not Worried	No answer
REGION				
Baltimore Metro	40 11.3%	92 25.9%	223 62.8%	0 0.0%
Washington Metro	32 11.4%	52 18.6%	195 69.6%	1 0.4%
Rural Maryland	25 13.5%	47 25.4%	113 61.1%	0 0.0%

QUESTION: Ban Surprise Billing *Would you support or oppose legislation to ban surprise billing?*

BAN SURPRISE MEDICAL BILLING	Number	Percent
Support	615	75.0 %
Oppose	153	18.7 %
No answer	52	6.3 %
Total	820	100.0 %

N=820	BAN SURPRISE MEDICAL BILLING		
	Support	Oppose	No answer
PARTY			
Democrat	329 76.0%	64 14.8%	40 9.2%
Republican	172 69.6%	69 27.9%	6 2.4%
Unaffiliated	114 81.4%	20 14.3%	6 4.3%

N=820	BAN SURPRISE MEDICAL BILLING		
	Support	Oppose	No answer
RACE			
African American	174 78.7%	35 15.8%	12 5.4%
White	396 73.3%	108 20.0%	36 6.7%
Other/ Refused	45 76.3%	10 16.9%	4 6.8%

N=820	BAN SURPRISE MEDICAL BILLING		
	Support	Oppose	No answer
GENDER			
Female	319 73.3%	82 18.9%	34 7.8%
Male	296 76.9%	71 18.4%	18 4.7%

N=820	BAN SURPRISE MEDICAL BILLING		
	Support	Oppose	No answer
AGE			
18 to 39	124 73.8%	32 19.0%	12 7.1%
40 to 49	128 68.8%	44 23.7%	14 7.5%
50 to 59	170 81.3%	30 14.4%	9 4.3%
60 and older	193 75.1%	47 18.3%	17 6.6%

N=820	BAN SURPRISE MEDICAL BILLING		
	Support	Oppose	No answer
REGION			
Baltimore Metro	265 74.6%	67 18.9%	23 6.5%
Washington Metro	219 78.2%	41 14.6%	20 7.1%
Rural Maryland	131 70.8%	45 24.3%	9 4.9%

QUESTION: Delayed/Avoided Medical Care *In the last year, have you delayed or avoided medical care because of concerns about the costs, or not?*

AVOIDED MEDICAL CARE	Number	Percent
Yes	138	16.8 %
No	680	82.9 %
No answer	2	0.2 %
Total	820	100.0 %

N=820	AVOIDED MEDICAL CARE		
	Yes	No	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	51 52.6%	46 47.4%	0 0.0%
No	87 12.1%	631 87.6%	2 0.3%
No answer	0 0.0%	3 100.0%	0 0.0%

N=820	AVOIDED MEDICAL CARE		
	Yes	No	No answer
PARTY			
Democrat	76 17.6%	356 82.2%	1 0.2%
Republican	35 14.2%	212 85.8%	0 0.0%
Unaffiliated	27 19.3%	112 80.0%	1 0.7%

N=820	AVOIDED MEDICAL CARE		
	Yes	No	No answer
RACE			
African American	54 24.4%	166 75.1%	1 0.5%
White	67 12.4%	472 87.4%	1 0.2%
Other/ Refused	17 28.8%	42 71.2%	0 0.0%

N=820	AVOIDED MEDICAL CARE		
	Yes	No	No answer
GENDER			
Female	76 17.5%	358 82.3%	1 0.2%
Male	62 16.1%	322 83.6%	1 0.3%

N=820	AVOIDED MEDICAL CARE		
	Yes	No	No answer
AGE			
18 to 39	20 11.9%	147 87.5%	1 0.6%
40 to 49	41 22.0%	145 78.0%	0 0.0%
50 to 59	35 16.7%	173 82.8%	1 0.5%
60 and older	42 16.3%	215 83.7%	0 0.0%

N=820	AVOIDED MEDICAL CARE		
	Yes	No	No answer
REGION			
Baltimore Metro	69 19.4%	286 80.6%	0 0.0%
Washington Metro	48 17.1%	230 82.1%	2 0.7%
Rural Maryland	21 11.4%	164 88.6%	0 0.0%

QUESTION: Aware of Free Care *Were you aware that hospitals provide free and reduced care for low-income patients, or not?*

AWARE OF FREE CARE	Number	Percent
Yes	577	70.4 %
No	240	29.3 %
No answer	3	0.4 %
Total	820	100.0 %

N=820	AWARE OF FREE CARE		
	Yes	No	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	58	38	1
	59.8%	39.2%	1.0%
No	518	200	2
	71.9%	27.8%	0.3%
No answer	1	2	0
	33.3%	66.7%	0.0%

N=820	AWARE OF FREE CARE		
	Yes	No	No answer
PARTY			
Democrat	268	164	1
	61.9%	37.9%	0.2%
Republican	207	39	1
	83.8%	15.8%	0.4%
Unaffiliated	102	37	1
	72.9%	26.4%	0.7%

N=820	AWARE OF FREE CARE		
	Yes	No	No answer
RACE			
African American	109 49.3%	111 50.2%	1 0.5%
White	424 78.5%	114 21.1%	2 0.4%
Other/ Refused	44 74.6%	15 25.4%	0 0.0%

N=820	AWARE OF FREE CARE		
	Yes	No	No answer
GENDER			
Female	301 69.2%	132 30.3%	2 0.5%
Male	276 71.7%	108 28.1%	1 0.3%

N=820	AWARE OF FREE CARE		
	Yes	No	No answer
AGE			
18 to 39	112 66.7%	55 32.7%	1 0.6%
40 to 49	140 75.3%	46 24.7%	0 0.0%
50 to 59	141 67.5%	68 32.5%	0 0.0%
60 and older	184 71.6%	71 27.6%	2 0.8%

N=820	AWARE OF FREE CARE		
	Yes	No	No answer
REGION			
Baltimore Metro	246 69.3%	108 30.4%	1 0.3%
Washington Metro	188 67.1%	91 32.5%	1 0.4%
Rural Maryland	143 77.3%	41 22.2%	1 0.5%

QUESTION: Aware Hospitals Sue *Did you know that many hospitals sue their former patients to collect hospital debt that is less than five thousand dollars, or not?*

AWARE HOSPITALS SUE	Number	Percent
Yes	471	57.4 %
No	349	42.6 %
Total	820	100.0 %

N=820	AWARE HOSPITALS SUE	
	Yes	No
PARTY		
Democrat	228 52.7%	205 47.3%
Republican	159 64.4%	88 35.6%
Unaffiliated	84 60.0%	56 40.0%

N=820	AWARE HOSPITALS SUE	
	Yes	No
RACE		
African American	103 46.6%	118 53.4%
White	345 63.9%	195 36.1%
Other/ Refused	23 39.0%	36 61.0%

N=820	AWARE HOSPITALS SUE	
	Yes	No
GENDER		
Female	230 52.9%	205 47.1%
Male	241 62.6%	144 37.4%

N=820	AWARE HOSPITALS SUE	
	Yes	No
AGE		
18 to 39	100 59.5%	68 40.5%
40 to 49	102 54.8%	84 45.2%
50 to 59	122 58.4%	87 41.6%
60 and older	147 57.2%	110 42.8%

N=820	AWARE HOSPITALS SUE	
	Yes	No
REGION		
Baltimore Metro	221 62.3%	134 37.7%
Washington Metro	137 48.9%	143 51.1%
Rural Maryland	113 61.1%	72 38.9%

QUESTION: Zero Out Bank Account *Do you believe hospitals should be able to zero out a person's bank account to collect a debt for medically necessary care, or not?*

HOSPITALS SHOULD BE ALLOWED TO ZERO OUT	Number	Percent
Yes	57	7.0 %
No	754	92.0 %
No answer	9	1.1 %
Total	820	100.0 %

N=820	HOSPITALS SHOULD BE ALLOWED TO ZERO OUT		
	Yes	No	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	0	97	0
	0.0%	100.0%	0.0%
No	57	654	9
	7.9%	90.8%	1.3%
No answer	0	3	0
	0.0%	100.0%	0.0%

N=820	HOSPITALS SHOULD BE ALLOWED TO ZERO OUT		
	Yes	No	No answer
PARTY			
Democrat	21	407	5
	4.8%	94.0%	1.2%
Republican	28	218	1
	11.3%	88.3%	0.4%
Unaffiliated	8	129	3
	5.7%	92.1%	2.1%

N=820	HOSPITALS SHOULD BE ALLOWED TO ZERO OUT		
	Yes	No	No answer
RACE			
African American	6 2.7%	212 95.9%	3 1.4%
White	40 7.4%	496 91.9%	4 0.7%
Other/ Refused	11 18.6%	46 78.0%	2 3.4%

N=820	HOSPITALS SHOULD BE ALLOWED TO ZERO OUT		
	Yes	No	No answer
GENDER			
Female	31 7.1%	402 92.4%	2 0.5%
Male	26 6.8%	352 91.4%	7 1.8%

N=820	HOSPITALS SHOULD BE ALLOWED TO ZERO OUT		
	Yes	No	No answer
AGE			
18 to 39	7 4.2%	158 94.0%	3 1.8%
40 to 49	16 8.6%	170 91.4%	0 0.0%
50 to 59	11 5.3%	196 93.8%	2 1.0%
60 and older	23 8.9%	230 89.5%	4 1.6%

N=820	HOSPITALS SHOULD BE ALLOWED TO ZERO OUT		
	Yes	No	No answer
REGION			
Baltimore Metro	20 5.6%	330 93.0%	5 1.4%
Washington Metro	18 6.4%	260 92.9%	2 0.7%
Rural Maryland	19 10.3%	164 88.6%	2 1.1%

QUESTION: Place Property Lien *Do you believe hospitals should be able to put a lien on your car, home, or other property to collect a debt for medically necessary care, or not?*

HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN	Number	Percent
Yes	77	9.4 %
No	719	87.7 %
No answer	24	2.9 %
Total	820	100.0 %

N=820	HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN		
	Yes	No	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	0 0.0%	97 100.0%	0 0.0%
No	77 10.7%	619 86.0%	24 3.3%
No answer	0 0.0%	3 100.0%	0 0.0%

N=820	HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN		
	Yes	No	No answer
PARTY			
Democrat	31 7.2%	391 90.3%	11 2.5%
Republican	38 15.4%	204 82.6%	5 2.0%
Unaffiliated	8 5.7%	124 88.6%	8 5.7%

N=820	HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN		
	Yes	No	No answer
RACE			
African American	4 1.8%	210 95.0%	7 3.2%
White	67 12.4%	459 85.0%	14 2.6%
Other/ Refused	6 10.2%	50 84.7%	3 5.1%

N=820	HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN		
	Yes	No	No answer
GENDER			
Female	39 9.0%	383 88.0%	13 3.0%
Male	38 9.9%	336 87.3%	11 2.9%

N=820	HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN		
	Yes	No	No answer
AGE			
18 to 39	11 6.5%	150 89.3%	7 4.2%
40 to 49	17 9.1%	165 88.7%	4 2.2%
50 to 59	18 8.6%	188 90.0%	3 1.4%
60 and older	31 12.1%	216 84.0%	10 3.9%

N=820	HOSPITALS SHOULD BE ALLOWED TO PLACE LIEN		
	Yes	No	No answer
REGION			
Baltimore Metro	29 8.2%	313 88.2%	13 3.7%
Washington Metro	25 8.9%	248 88.6%	7 2.5%
Rural Maryland	23 12.4%	158 85.4%	4 2.2%

QUESTION: Garnish Wages *Do you believe hospitals should be able to garnish a person's wages to collect a debt for medically necessary care, or not?*

HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES	Number	Percent
Yes	154	18.8 %
No	647	78.9 %
No answer	19	2.3 %
Total	820	100.0 %

N=820	HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES		
	Yes	No	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	0	97	0
	0.0%	100.0%	0.0%
No	154	547	19
	21.4%	76.0%	2.6%
No answer	0	3	0
	0.0%	100.0%	0.0%

N=820	HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES		
	Yes	No	No answer
PARTY			
Democrat	62	361	10
	14.3%	83.4%	2.3%
Republican	70	172	5
	28.3%	69.6%	2.0%
Unaffiliated	22	114	4
	15.7%	81.4%	2.9%

N=820	HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES		
	Yes	No	No answer
RACE			
African American	14 6.3%	202 91.4%	5 2.3%
White	129 23.9%	398 73.7%	13 2.4%
Other/ Refused	11 18.6%	47 79.7%	1 1.7%

N=820	HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES		
	Yes	No	No answer
GENDER			
Female	74 17.0%	351 80.7%	10 2.3%
Male	80 20.8%	296 76.9%	9 2.3%

N=820	HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES		
	Yes	No	No answer
AGE			
18 to 39	26 15.5%	136 81.0%	6 3.6%
40 to 49	36 19.4%	147 79.0%	3 1.6%
50 to 59	44 21.1%	162 77.5%	3 1.4%
60 and older	48 18.7%	202 78.6%	7 2.7%

N=820	HOSPITALS SHOULD BE ALLOWED TO GARNISH WAGES		
	Yes	No	No answer
REGION			
Baltimore Metro	60 16.9%	289 81.4%	6 1.7%
Washington Metro	49 17.5%	224 80.0%	7 2.5%
Rural Maryland	45 24.3%	134 72.4%	6 3.2%

QUESTION: Prohibit Zeroing Out Bank Account *Would you support or oppose legislation to prohibit hospitals from zeroing out a bank account to collect hospital bills?*

PROHIBIT ZEROING OUT	Number	Percent
Support	549	67.0 %
Oppose	257	31.3 %
No answer	14	1.7 %
Total	820	100.0 %

PROHIBIT

N=820	PROHIBIT ZEROING OUT		
	Support	Oppose	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	82	15	0
	84.5%	15.5%	0.0%
No	464	242	14
	64.4%	33.6%	1.9%
No answer	3	0	0
	100.0%	0.0%	0.0%

N=820	PROHIBIT ZEROING OUT		
	Support	Oppose	No answer
PARTY			
Democrat	335	92	6
	77.4%	21.2%	1.4%
Republican	114	128	5
	46.2%	51.8%	2.0%
Unaffiliated	100	37	3
	71.4%	26.4%	2.1%

N=820	PROHIBIT ZEROING OUT		
	Support	Oppose	No answer
RACE			
African American	161 72.9%	56 25.3%	4 1.8%
White	351 65.0%	182 33.7%	7 1.3%
Other/ Refused	37 62.7%	19 32.2%	3 5.1%

N=820	PROHIBIT ZEROING OUT		
	Support	Oppose	No answer
GENDER			
Female	298 68.5%	133 30.6%	4 0.9%
Male	251 65.2%	124 32.2%	10 2.6%

N=820	PROHIBIT ZEROING OUT		
	Support	Oppose	No answer
AGE			
18 to 39	127 75.6%	37 22.0%	4 2.4%
40 to 49	126 67.7%	59 31.7%	1 0.5%
50 to 59	138 66.0%	67 32.1%	4 1.9%
60 and older	158 61.5%	94 36.6%	5 1.9%

N=820	PROHIBIT ZEROING OUT		
	Support	Oppose	No answer
REGION			
Baltimore Metro	230 64.8%	119 33.5%	6 1.7%
Washington Metro	200 71.4%	76 27.1%	4 1.4%
Rural Maryland	119 64.3%	62 33.5%	4 2.2%

QUESTION: Prohibit Placing Property Lien *Would you support or oppose legislation to prohibit hospitals from putting a lien on your car or home to collect hospital bills?*

PROHIBIT PUTTING LIEN ON PROPERTY	Number	Percent
Support	485	59.1 %
Oppose	320	39.0 %
No answer	15	1.8 %
Total	820	100.0 %

N=820	PROHIBIT PUTTING LIEN ON PROPERTY		
	Support	Oppose	No answer
UNABLE TO PAY MEDICAL BILLS			
Yes	66	31	0
	68.0%	32.0%	0.0%
No	417	288	15
	57.9%	40.0%	2.1%
No answer	2	1	0
	66.7%	33.3%	0.0%

N=820	PROHIBIT PUTTING LIEN ON PROPERTY		
	Support	Oppose	No answer
PARTY			
Democrat	305	122	6
	70.4%	28.2%	1.4%
Republican	92	150	5
	37.2%	60.7%	2.0%
Unaffiliated	88	48	4
	62.9%	34.3%	2.9%

N=820	PROHIBIT PUTTING LIEN ON PROPERTY		
	Support	Oppose	No answer
RACE			
African American	142 64.3%	75 33.9%	4 1.8%
White	310 57.4%	222 41.1%	8 1.5%
Other/ Refused	33 55.9%	23 39.0%	3 5.1%

N=820	PROHIBIT PUTTING LIEN ON PROPERTY		
	Support	Oppose	No answer
GENDER			
Female	259 59.5%	172 39.5%	4 0.9%
Male	226 58.7%	148 38.4%	11 2.9%

N=820	PROHIBIT PUTTING LIEN ON PROPERTY		
	Support	Oppose	No answer
AGE			
18 to 39	112 66.7%	51 30.4%	5 3.0%
40 to 49	106 57.0%	80 43.0%	0 0.0%
50 to 59	125 59.8%	77 36.8%	7 3.3%
60 and older	142 55.3%	112 43.6%	3 1.2%

N=820	PROHIBIT PUTTING LIEN ON PROPERTY		
	Support	Oppose	No answer
REGION			
Baltimore Metro	213 60.0%	135 38.0%	7 2.0%
Washington Metro	175 62.5%	102 36.4%	3 1.1%
Rural Maryland	97 52.4%	83 44.9%	5 2.7%

QUESTION: Suing Patients – Debt Under $5,000 *Would you support or oppose prohibiting hospitals from suing former patients for debts under $5,000?*

PROHIBIT - SUE FOR UNDER $5,000	Number	Percent
Support	501	61.1 %
Oppose	282	34.4 %
No answer	37	4.5 %
Total	820	100.0 %

N=820	PROHIBIT - SUE FOR UNDER $5,000		
	Support	Oppose	No answer
PARTY			
Democrat	306 70.7%	114 26.3%	13 3.0%
Republican	121 49.0%	112 45.3%	14 5.7%
Unaffiliated	74 52.9%	56 40.0%	10 7.1%

N=820	PROHIBIT - SUE FOR UNDER $5,000		
	Support	Oppose	No answer
RACE			
African American	145 65.6%	67 30.3%	9 4.1%
White	323 59.8%	191 35.4%	26 4.8%
Other/ Refused	33 55.9%	24 40.7%	2 3.4%

N=820	PROHIBIT - SUE FOR UNDER $5,000		
	Support	Oppose	No answer
GENDER			
Female	275 63.2%	141 32.4%	19 4.4%
Male	226 58.7%	141 36.6%	18 4.7%

N=820	PROHIBIT - SUE FOR UNDER $5,000		
	Support	Oppose	No answer
AGE			
18 to 39	111 66.1%	48 28.6%	9 5.4%
40 to 49	112 60.2%	63 33.9%	11 5.9%
50 to 59	130 62.2%	73 34.9%	6 2.9%
60 and older	148 57.6%	98 38.1%	11 4.3%

N=820	PROHIBIT - SUE FOR UNDER $5,000		
	Support	Oppose	No answer
REGION			
Baltimore Metro	216 60.8%	119 33.5%	20 5.6%
Washington Metro	176 62.9%	95 33.9%	9 3.2%
Rural Maryland	109 58.9%	68 36.8%	8 4.3%

QUESTION: Suing Patients – Debt Under $2,500 *Would you support or oppose prohibiting hospitals from suing former patients for debts under $2,500?*

PROHIBIT - SUE FOR UNDER $2,500	Number	Percent
Support	516	62.9 %
Oppose	270	32.9 %
No answer	34	4.1 %
Total	820	100.0 %

N=820	PROHIBIT - SUE FOR UNDER $2,500		
	Support	Oppose	No answer
PARTY			
Democrat	313	108	12
	72.3%	24.9%	2.8%
Republican	129	106	12
	52.2%	42.9%	4.9%
Unaffiliated	74	56	10
	52.9%	40.0%	7.1%

N=820	PROHIBIT - SUE FOR UNDER $2,500		
	Support	Oppose	No answer
RACE			
African	149	64	8
American	67.4%	29.0%	3.6%
White	332	185	23
	61.5%	34.3%	4.3%
Other/	35	21	3
Refused	59.3%	35.6%	5.1%

N=820	PROHIBIT - SUE FOR UNDER $2,500		
	Support	Oppose	No answer
GENDER			
Female	277 63.7%	140 32.2%	18 4.1%
Male	239 62.1%	130 33.8%	16 4.2%

N=820	PROHIBIT - SUE FOR UNDER $2,500		
	Support	Oppose	No answer
AGE			
18 to 39	117 69.6%	43 25.6%	8 4.8%
40 to 49	117 62.9%	61 32.8%	8 4.3%
50 to 59	131 62.7%	71 34.0%	7 3.3%
60 and older	151 58.8%	95 37.0%	11 4.3%

N=820	PROHIBIT - SUE FOR UNDER $2,500		
	Support	Oppose	No answer
REGION			
Baltimore Metro	222 62.5%	117 33.0%	16 4.5%
Washington Metro	182 65.0%	89 31.8%	9 3.2%
Rural Maryland	112 60.5%	64 34.6%	9 4.9%

QUESTION: Suing Patients – Debt Under $1,000 *Would you support or oppose prohibiting hospitals from suing former patients for debts under $1,000?*

PROHIBIT - SUE FOR UNDER $1,000	Number	Percent
Support	524	63.9 %
Oppose	258	31.5 %
No answer	38	4.6 %
Total	820	100.0 %

N=820	PROHIBIT - SUE FOR UNDER $1,000		
	Support	Oppose	No answer
PARTY			
Democrat	315 72.7%	102 23.6%	16 3.7%
Republican	131 53.0%	104 42.1%	12 4.9%
Unaffiliated	78 55.7%	52 37.1%	10 7.1%

N=820	PROHIBIT - SUE FOR UNDER $1,000		
	Support	Oppose	No answer
RACE			
African American	154 69.7%	58 26.2%	9 4.1%
White	332 61.5%	181 33.5%	27 5.0%
Other/ Refused	38 64.4%	19 32.2%	2 3.4%

N=820	PROHIBIT - SUE FOR UNDER $1,000		
	Support	Oppose	No answer
GENDER			
Female	285 65.5%	129 29.7%	21 4.8%
Male	239 62.1%	129 33.5%	17 4.4%

N=820	PROHIBIT - SUE FOR UNDER $1,000		
	Support	Oppose	No answer
AGE			
18 to 39	117 69.6%	43 25.6%	8 4.8%
40 to 49	122 65.6%	56 30.1%	8 4.3%
50 to 59	135 64.6%	69 33.0%	5 2.4%
60 and older	150 58.4%	90 35.0%	17 6.6%

N=820	PROHIBIT - SUE FOR UNDER $1,000		
	Support	Oppose	No answer
REGION			
Baltimore Metro	229 64.5%	108 30.4%	18 5.1%
Washington Metro	182 65.0%	86 30.7%	12 4.3%
Rural Maryland	113 61.1%	64 34.6%	8 4.3%

QUESTION: Suing Patients – Debt Under $500 *Would you support or oppose prohibiting hospitals from suing former patients for debts under $500?*

PROHIBIT - SUE FOR UNDER $500	Number	Percent
Support	532	64.9 %
Oppose	256	31.2 %
No answer	32	3.9 %
Total	820	100.0 %

N=820	PROHIBIT - SUE FOR UNDER $500		
	Support	Oppose	No answer
PARTY			
Democrat	313 72.3%	106 24.5%	14 3.2%
Republican	134 54.3%	102 41.3%	11 4.5%
Unaffiliated	85 60.7%	48 34.3%	7 5.0%

N=820	PROHIBIT - SUE FOR UNDER $500		
	Support	Oppose	No answer
RACE			
African American	155 70.1%	58 26.2%	8 3.6%
White	339 62.8%	179 33.1%	22 4.1%
Other/ Refused	38 64.4%	19 32.2%	2 3.4%

N=820	PROHIBIT - SUE FOR UNDER $500		
	Support	Oppose	No answer
GENDER			
Female	286 65.7%	131 30.1%	18 4.1%
Male	246 63.9%	125 32.5%	14 3.6%

N=820	PROHIBIT - SUE FOR UNDER $500		
	Support	Oppose	No answer
AGE			
18 to 39	117 69.6%	43 25.6%	8 4.8%
40 to 49	126 67.7%	54 29.0%	6 3.2%
50 to 59	135 64.6%	69 33.0%	5 2.4%
60 and older	154 59.9%	90 35.0%	13 5.1%

N=820	PROHIBIT - SUE FOR UNDER $500		
	Support	Oppose	No answer
REGION			
Baltimore Metro	231 65.1%	109 30.7%	15 4.2%
Washington Metro	185 66.1%	85 30.4%	10 3.6%
Rural Maryland	116 62.7%	62 33.5%	7 3.8%

QUESTION: Suing Patients – Debt Under $250 *Would you support or oppose prohibiting hospitals from suing former patients for debts under $250?*

PROHIBIT - SUE FOR UNDER $250	Number	Percent
Support	536	65.4 %
Oppose	243	29.6 %
No answer	41	5.0 %
Total	820	100.0 %

N=820	PROHIBIT - SUE FOR UNDER $250		
	Support	Oppose	No answer
PARTY			
Democrat	319 73.7%	95 21.9%	19 4.4%
Republican	128 51.8%	105 42.5%	14 5.7%
Unaffiliated	89 63.6%	43 30.7%	8 5.7%

N=820	PROHIBIT - SUE FOR UNDER $250		
	Support	Oppose	No answer
RACE			
African American	160 72.4%	52 23.5%	9 4.1%
White	340 63.0%	170 31.5%	30 5.6%
Other/ Refused	36 61.0%	21 35.6%	2 3.4%

N=820	PROHIBIT - SUE FOR UNDER $250		
	Support	Oppose	No answer
GENDER			
Female	282 64.8%	133 30.6%	20 4.6%
Male	254 66.0%	110 28.6%	21 5.5%

N=820	PROHIBIT - SUE FOR UNDER $250		
	Support	Oppose	No answer
AGE			
18 to 39	124 73.8%	36 21.4%	8 4.8%
40 to 49	125 67.2%	52 28.0%	9 4.8%
50 to 59	137 65.6%	64 30.6%	8 3.8%
60 and older	150 58.4%	91 35.4%	16 6.2%

N=820	PROHIBIT - SUE FOR UNDER $250		
	Support	Oppose	No answer
REGION			
Baltimore Metro	233 65.6%	100 28.2%	22 6.2%
Washington Metro	195 69.6%	77 27.5%	8 2.9%
Rural Maryland	108 58.4%	66 35.7%	11 5.9%

QUESTION: Create Payment Plan *Before they can file a lawsuit or send a debt to collections, do you think hospitals should be required to create a payment plan based on income for former patients to pay off the debt, or not?*

CREATE PAYMENT PLAN	Number	Percent
Yes	763	93.0 %
No	40	4.9 %
No answer	17	2.1 %
Total	820	100.0 %

N=820	CREATE PAYMENT PLAN		
	Yes	No	No answer
PARTY			
Democrat	404 93.3%	21 4.8%	8 1.8%
Republican	230 93.1%	11 4.5%	6 2.4%
Unaffiliated	129 92.1%	8 5.7%	3 2.1%

N=820	CREATE PAYMENT PLAN		
	Yes	No	No answer
RACE			
African American	204 92.3%	11 5.0%	6 2.7%
White	505 93.5%	25 4.6%	10 1.9%
Other/ Refused	54 91.5%	4 6.8%	1 1.7%

N=820	CREATE PAYMENT PLAN		
	Yes	No	No answer
GENDER			
Female	406 93.3%	20 4.6%	9 2.1%
Male	357 92.7%	20 5.2%	8 2.1%

N=820	CREATE PAYMENT PLAN		
	Yes	No	No answer
AGE			
18 to 39	157 93.5%	7 4.2%	4 2.4%
40 to 49	173 93.0%	7 3.8%	6 3.2%
50 to 59	195 93.3%	11 5.3%	3 1.4%
60 and older	238 92.6%	15 5.8%	4 1.6%

N=820	CREATE PAYMENT PLAN		
	Yes	No	No answer
REGION			
Baltimore Metro	329 92.7%	18 5.1%	8 2.3%
Washington Metro	262 93.6%	14 5.0%	4 1.4%
Rural Maryland	172 93.0%	8 4.3%	5 2.7%

Appendix B: Maryland Poll Sample Demographics

PARTY	Number	Percent
Democrat	433	52.8 %
Republican	247	30.1 %
Unaffiliated	140	17.1 %
Total	820	100.0 %

RACE	Number	Percent
African American	221	27.0 %
White	540	65.9 %
Other/Refused	59	7.2 %
Total	820	100.0 %

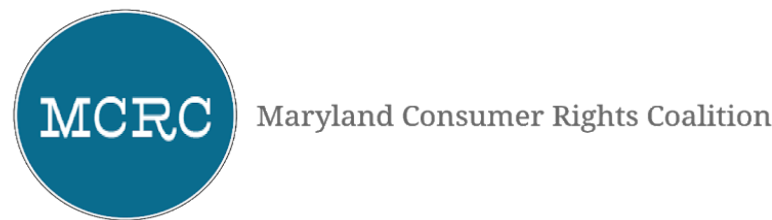
GENDER	Number	Percent
Female	435	53.0 %
Male	385	47.0 %
Total	820	100.0 %

AGE	Number	Percent
18 to 39	168	20.5 %
40 to 49	186	22.7 %
50 to 59	209	25.5 %
60 and older	257	31.3 %
Total	820	100.0 %

AGE GROUP	Number	Percent
Under 50	354	43.2 %
50 or older	466	56.8 %
Total	820	100.0 %

REGION	Number	Percent
Baltimore Metro	355	43.3 %
Washington Metro	280	34.1 %
Rural Maryland	185	22.6 %
Total	820	100.0 %

MCRC SB514 Health Facilities-Hospitals-Medical Deb
Uploaded by: White, Marceline
Position: FAV



Testimony to the Senate Finance Committee
SB514: Health Facilities-Hospitals-Medical Debt Protection
Position: Favorable

February 25, 2021

The Honorable Delores E. Kelley, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401
cc: Members, Senate Finance Committee

Honorable Chair Kelley and Members of the Committee:

The Maryland Consumer Rights Coalition (MCRC) is a statewide coalition of individuals and organizations that advances financial justice and economic inclusion for Maryland consumers through research, education, direct service, and advocacy. Our 8,500 supporters include consumer advocates, practitioners, and low-income and working families throughout Maryland.

We're here today in strong support of SB514 and thank Sen. Feldman for sponsoring this bill.

Healthcare & Medical Debt Nationally

Nationally, healthcare is a growing concern for many Americans. A 2019 report found that about 7 million more adults are without health insurance since the number started rising in 2016[1]. Nearly 1 in 6 Americans was contacted by a debt collector in the past year over a health care bill[2].

Nationally, healthcare and medical debt have a disparate impact on Black Americans. A 2016 study of older adults found that older African-Americans had 2.6 times higher odds of medical debt and only about 40% of that disparity is explained by insurance, health status, and income[3]. In addition, African-Americans were more likely to be contacted by a debt collection agency and to have to borrow money rather than draw on savings to pay the medical debt.

Medical Debt in Maryland

Medical debt is also a major problem for Maryland residents, especially those from low-income households and among communities of color. 15% of Maryland residents report having medical debt, while 21% of those in communities of color report owing medical debts.[4]

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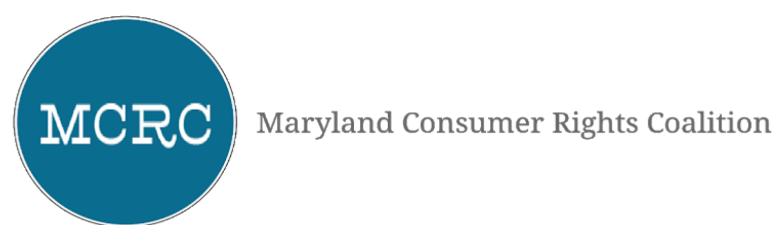
[1] "GoFundMe CEO: One-Third of Site's Donations are to Cover Medical Costs" Time magazine, Jan. 30, 2019.
[2] NCLC, Don't Add Insult to Injury, November 2019
[3] NCBI, 2016
[4] NCLC, Maryland Debt Collection Fact Sheet



In an October 2020 survey commissioned by MCRC, 12 % of Maryland voters survey have or have a family member with a medical bill they are unable to pay[5]. Three times as many African-American residents are unable to pay a medical compared to white residents[6].

Hospital Debt & Lawsuits in Maryland

Hospital care, in particular, is a major driver of healthcare costs and medical debt in Maryland. An average hospital stay lasts four days and costs, on average, $14,200. In fact, hospital care makes up 37% of health care services in Maryland, the highest percentage of all health care costs.[7]

Although hospitals have financial assistance policies in place and last year with the passage of HB1420, the General Assembly expanded eligibility for financial assistance, the current system is leaving too many behind. Charity care provided by Maryland hospitals has plummeted by 36%, or $168 million, from 2009 to 2018.

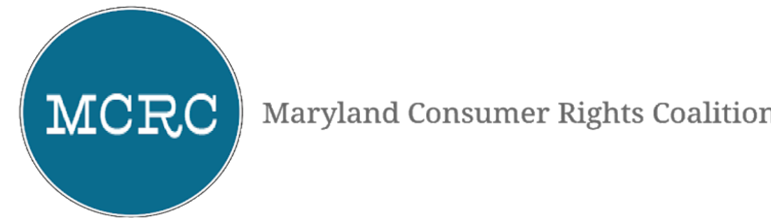
At the same time that charity care has plummeted, hospitals have sued former patients for medical debts of $5000 or less at an alarming rate. Over the past 10 years, Maryland hospitals filed 145,746 lawsuits for medical debt, resulting in 37,370 wage garnishments, 4,432 property liens, and 3,278 bankruptcies due to medical debt[8]. Many of these lawsuits were against patients that would have likely qualified for free or discounted medical care.

COVID-19

We are in a time of twin crises of COVID-19 pandemic and an economic recession. Thousands of Marylanders have lost their jobs, reduced their hours, or had to close their business. Many continue to wait on unemployment. Nationally, more than 12 million people have lost their employer-tied health insurance. At the same time, essential workers continue to be at risk on the frontlines of this crisis. The brunt of job loss and the vulnerability of exposure fall disproportionately on Black and Brown communities who have experienced greater job loss, comprise a large segment of the essential workforce, and have higher rates of contracting COVID-19 than other Marylanders.

While the immediate danger from the pandemic may wane, the longer-term consequences will continue. Experts now predict that up to 10% of COVID-survivors will experience long-term disabilities including chronic fatigue and dysautonomia. Many others who survive do so with severely damaged heart or lungs. These chronic conditions will require long-term medical treatment that is not covered by the COVID protections in federal law while at the same time, these health conditions make it more difficult for individuals to continue to work full-time[9]. And it will take several years, at best, for the economy to recover. Under no circumstance does it make sense for hospitals to continue to garnish wages, place liens on homes, zero out bank accounts, or pursue lawsuits against individuals who are seeking medical care.

[5] Gonzales poll, October 2020
[6] ibid
[7] MHCC, Health Care Costs in Maryland
[8] Preying on Patients, NNU, 2020
[9] COVID Long-Haulers Struggle, NPR February 2021



- **Public Health**

COVID-19 safeguards call for social distancing. To garnish wages, wipe out bank accounts, or place a lien against a home will increase housing insecurity for former patients. Some may lose housing altogether, while others will need to move into a family member's home, thereby increasing public health risks.

Many individuals who may need medical care for non-COVID issues, may not seek treatment because of their concerns regarding medical debt. In fact, in an October poll, of the survey respondents who said they or a family member had a medical bill they were unable to pay, 53% say they have already delayed care because of a concern for costs[10]. This troubling trend is likely to accelerate as many workers who had health insurance tied to their employment have lost health insurance. A national study estimates that 7.7 million workers have lost employer-sponsored health insurance which means that many more may avoid care.

Finally, the evidence is emerging that many who survive COVID-19 do so with new chronic lung and heart problems. Others suffer from COVID long-haulers disease, a form of dysautonomia. These individuals will need long-term care and will need to be able to afford that care.

- **Economic Rights**

As noted this is an economic rights issue. Medical debt differs from other consumer debt in a number of important ways. First of all, debt that is accrued by seeking medical treatment is not a choice like other products and services. It is often incurred involuntarily and, in emergency situations, there are not opportunities to make informed choices. Moreover, even when a patient with insurance chooses an in-network facility, the patient has no control over whether or not they are treated by an in-network physician. Pricing is opaque and confusing and problems with medical errors abound.

The solutions to collect on a debt are punitive and lead to a vicious cycle of poverty. Many of those sued in Maryland for hospital debt work as staff at the hospitals that sue them, at Walmart or Target. Many are hard-working, low-wage individuals. Individuals who can not afford $1000 hospital debt, cannot afford to have their wages garnished, nor can they afford to have their savings taken by a hospital, nor to have a lien on their home. In fact, these solutions are likely to worsen an individual's health as financial stress is linked to poor physical and mental health problems.

- **Racial Equity**

As research shows, these lawsuits fall hardest on low-income communities and many fall hardest on Black neighborhoods and other communities of color. Our October 2020 Gonzales poll found that 45% of African-American respondents would have to use credit or could not afford a $500 medical bill. And as noted earlier, there is evidence of higher collection efforts in majority Black communities than in white

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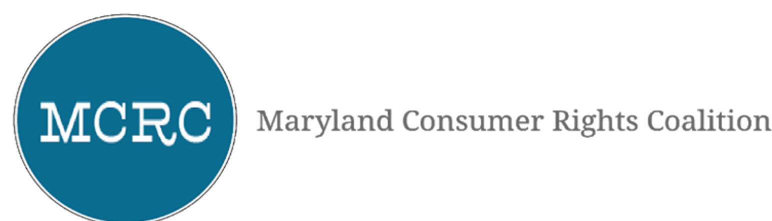
[10] Gonzales poll, October 2020



communities. And just as disturbingly, our poll found that more than 50% of African-American households were not aware of any hospital financial assistance policies. There are already social disparities in health and health outcomes. Hospitals lawsuits and debt collection practices also exacerbate and deepen these existing inequalities and widen the racial wealth gap.

Why SB514 is needed
This bill expands consumer protections for patients who have hospital medical debt. It increases transparency, provides an income-based repayment plan for patients, provides redress if patients qualify for financial assistance but didn't receive it, and eliminates or lessens the most punitive aspects of these debt collection practices.

Many of the solutions in SB514 are not new. Washington and Oregon state have passed legislation related to medical debt issues. A number of states have introduced legislation this year.

Four states do not garnish wages for any debts, nine states do not place liens on first homes, and Delaware does not garnish bank accounts. Moreover one-third of Maryland hospitals do not sue their patients for medical debt. Other Maryland hospitals can follow suit. In fact, the amount of medical debt sought in these lawsuits is 0.18 % of operating revenue and 4.2 % of net income.

As research from health economists from Boston University shows, this bill will not harm hospitals' bottom line. New research shows the effect of a prohibition on medical debt of $1000 or less would cost $7000, on average ,per hospital.

Finally, this bill does not eliminate the ability of hospitals to pursue the debt. Once they have exhausted a financial payment plan, the hospital can pursue debt collection. The consumer will receive multiple calls, texts, social messages each day about the debt and their credit will be lowered. Both are significant incentives to pay the debt owed.

For all these reasons, we support SB514 and urge a favorable report.

Best,

Marceline White
Executive Director

Medical Debt Testimony.pdf

Uploaded by: Whitley, Cherquira

Position: FAV

Medical Debt Testimony

My name is Cherquira Whitley and I am a resident of Montgomery county Maryland and I support the Medical Debt. Protection Act (HB565/SB514). This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for 1,000 or under based repayment plans, prevent wage garnishments and liens on homes from medical debt. I believe passing of this bill is essential because a family should never face choosing their health over money. Here is my own personal experience with this issue.

On February 12, 2017 my adult autistic son was experiencing a meltdown that was putting his life and others at risk. I made the decision to place him in a safe environment while getting his medication readjusted. At this moment, I felt that this was a wise decision (to seek professional help for violent aggressive behavior that is very common with individuals with autism). At this time, my son was insured by Kaiser Permanente and was being treated by one of their doctors. After sitting in the emergency room for 12 hours, he was finally admitted to" Shady Grove Adventist Behavioral Health" units on February 13th at 3am. He was evaluated by Kaisers doctors and was released shortly after, on February 13th. On that same day at 1pm, I received a call from one of the hospitals social worker and was told that he was being discharged. The social worker (Jessica) was very rude and told me that they did not know what to do with him. She responded by replying that they would put him in cab or I can come pick him up (my son is a severely autistic adult) . I responded by picking him up from the facility. When I arrived, I was told by the health care team that they could do nothing for him and Kaiser Permanente was not going to cover his treatment or stay. At this time, my son was clearly mentally unstable and was refusing to leave the facility. Further, I did not know what else to do. I felt that I had no other choice but to bring him home, even though he was showing that he was not stable. I immediately asked to speak to someone about the poor decision and I was directed to speak to Dr. Brown. As I was speaking to him about my concerns, he took what I was saying with a grain of salt. After being dismissed by the doctor, security workers proceeded by forcefully bringing my son outside with no shoes or socks, dressed in sweatpants, a t-shirt and continued to carry him out in 32 degree weather, while he cried and fought the workers. During this poor treatment of my son, I was disgusted in the way this problem was handled. I felt hopeless, scared and hurt for my son. While he was being literally thrown out of the hospital (because we could not afford him to stay). While this was going on, security were stopped by head of security. This man clearly saw that this was inhumane treatment and it was dangerous to take him home while in this condition. My son was welcomed back in the hospital, while given a patient advocate. Through his advocate (Natalie), we pushed for insurance to review his case and to treat him for his violent aggressive behavior. He then was readmitted, reevaluated and treated for a week. Overall, my testimony demonstrates that hospitals will choose money over a person's right to be properly medically treated. As a human being, no one should be treated poorly or not treated at all because they cannot afford to cover medical expenses. In closure, this is why I believe this bill should be passed.

My name is Cherquira Whitley and I am a resident of, Montgomery county Maryland and I support the Medical Debt. Protection Act (HB565/SB514). This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt

lawsuits for 1,000 or under based repayment plans, prevent wage garnishments and liens on homes from medical debt. I believe passing of this bill is essential because a family should never face choosing their health over money. Here is my own personal experience with this issue.

On February 12, 2017 my adult autistic son was experiencing a meltdown that was putting his life and others at risk. I made the decision to place him in a safe environment while getting his medication readjusted. At this moment, I felt that this was a wise decision (to seek professional help for violent aggressive behavior that is very common with individuals with autism). At this time, my son was insured by Kaiser Permanente and was being treated by one of their doctors. After sitting in the emergency room for 12 hours, he was finally admitted to" Shady Grove Adventist Behavioral Health" units on February 13th at 3am. He was evaluated by Kaiser's doctors and was released shortly after, on February 13th. On that same day at 1pm, I received a call from one of the hospital's social workers and was told that he was being discharged. The social worker (Jessica) was very rude and told me that they did not know what to do with him. She responded by replying that they would put him in a cab or I can come pick him up (my son is a severely autistic adult) . I responded by picking him up from the facility. When I arrived, I was told by the health care team that they could do nothing for him and Kaiser Permanente was not going to cover his treatment or stay. At this time, my son was clearly mentally unstable and was refusing to leave the facility. Further, I did not know what else to do. I felt that I had no other choice but to bring him home, even though he was showing that he was not stable. I immediately asked to speak to someone about the poor decision and I was directed to speak to Dr. Brown. As I was speaking to him about my concerns, he took what I was saying with a grain of salt. After being dismissed by the doctor, security workers proceeded by forcefully bringing my son outside with no shoes or socks, dressed in sweatpants, a t-shirt and continued to carry him out in 32 degree weather, while he cried and fought the workers. During this poor treatment of my son, I was disgusted in the way this problem was handled. I felt hopeless, scared and hurt for my son. While he was being literally thrown out of the hospital (because we could not afford him to stay). While this was going on, security were stopped by head of security. This man clearly saw that this was inhumane treatment and it was dangerous to take him home while in this condition. My son was welcomed back in the hospital, while given a patient advocate. Through his advocate (Natalie), we pushed for insurance to review his case and to treat him for his violent aggressive behavior. He then was readmitted, reevaluated and treated for a week. Overall, my testimony demonstrates that hospitals will choose money over a person's right to be properly medically treated. As a human being, no one should be treated poorly or not treated at all because they cannot afford to cover medical expenses. In closure, this is why I believe this bill should be passed.

Medical Debt Protection Act _ SB514 Testimony.pdf

Uploaded by: Willinger, Lior
Position: FAV

Medical Debt Protection Act / SB514
Official Testimony
Position: **FAVORABLE**

To the *Senate Finance Committee*,

My name is Lior Willinger, and I'm a Baltimore City resident and a member of the End Medical Debt Maryland Coalition. I support the Medical Debt Protection Act (HB565/SB514).

This bill will protect low and middle-income households from punitive medical debt lawsuits. It will prohibit medical debt lawsuits for $1000 or under, require income-based repayment plans, and prevent wage garnishments and liens on homes over medical debt. Passing this bill is essential because I strongly believe that access to healthcare is a human right. Without medical debt protection, patients are vulnerable to be coerced into exchanging their basic needs of income and housing for medical attention. In effect, this bill helps mitigate the ever-looming crisis of homelessness. So many Marylanders, including myself, are struggling with finances and health. When hospitals receive millions of dollars in tax breaks and funding to provide charity, legislation should ensure that the money goes to where it was intended-- to help lower income patients. This is the moment to be proactive to save lives from drowning tied to the weight of insurmountable financial burden. I plead you to kindly offer a life vest to protect your constituents.

I respectfully urge this committee to issue a favorable report on the HB565/SB514, the Medical Debt Protection Act.

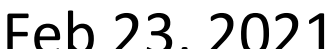
Sincerely,

Lior Willinger
District 45
liorpiano@gmail.com

Wilson Medical Debt Protectn Act SENATE 02.23.2021

Uploaded by: Wilson, Anne

Position: FAV



Feb 23, 2021

Testimony on HB0514

Health Facilities - Hospitals - Medical Debt Protection

Senate Finance Committee

Position: Favorable

I'm writing to you today as an elder ally of Sunrise Movement Baltimore, a youth-led movement to stop climate change and create millions of good jobs in the process. As an organization, we are also a member of the End Medical Debt Maryland Coalition.

I am writing to urge your support for the Medical Debt Protection Act (HB565/SB514). While medical debt might seem like an issue that is far afield from the climate crisis, the reality is these two problems are breathing down each other's necks.

TIme and time again, our country, our state and our cities have chosen to place profits over people. The COVID pandemic has laid bare the structural economic inequities we have accepted for too long, along with the ways our policies around health care and paying for it -- who pays for it, and how -- reinforce and compound harms to those who already have least access to resources: low-income residents and communities.

These are often the same folks who will be hit first, worst and hardest by the effects of climate change. Structural economic injustices, like a system that allows a hospital to sue low-income patients for amounts owed of less than $1,000, are a symptom of a society that is also not prepared for the health and economic challenges of climate change, which have already begun to hit Americans across the country and right here in Baltimore. The recent deep freeze and massive power failures in Texas are just one more instance of the effects of climate change -- a jet stream destabilized by Arctic warming allowing unusually cold air to reach a part of the country that would "normally" be out of reach -- compounded by failures of government to invest properly in the best interests of the people of Texas and require corporations to do the same in the operations of their businesses.

Addressing this unjust medical debt problem now would correct an unethical practice that we have tolerated for too long, and would set a precedent for sound policies in the future that will help us weather challenges ahead.

I believe that the passing of this bill is essential because I do not want to live in a community where large health care institutions, including some with reputations for being among the best in the world, are given a pass on wrongly penalizing low-income patients, when systems have

been set up to assist with covering the cost of providing low-income patients' health care, expenses which none of us choose to take on.

I respectfully urge the Committee to issue a favorable report on the Medical Debt Protection Act. Thank you.

Sincerely,

Anne C.A. Wilson
Hub coordinator, Sunrise Movement Baltimore
221 Stony Run Lane, Apt H-2, Baltimore, MD 21210 (District 43)
410-294-8074
annecawilson@gmail.com

20210225Testimony in Support of SB514.pdf

Uploaded by: Wilson, Michael

Position: FAV

Testimony in Support of SB514
Health Facilities – Hospitals – Medical Debt Protection
February 25, 2021

To: Hon. Delores Kelley, Chair, and members of the Senate Finance Committee
From: Michael Wilson, Executive Assistant to the President
United Food and Commercial Workers Union, Local 400

Chair Kelley and members of the Senate Finance Committee, I appreciate the chance to share my testimony on behalf of our over 10,000 members in Maryland, working on the front lines of the ongoing pandemic in grocery, retail, food distribution, law enforcement, and health care.

We strongly support SB 514 and urge you to vote it favorably. The ongoing pandemic has had profound impacts on our members and all working people. It has also exacerbated many problems working people face during normal times. Medical debt was a crisis before COVID-19 and it is even more of one now.

This bill would take simple, common sense, steps to protect working families from often predatory debt collection practices. It will mandate reasonable repayment plans and interest rates so that people are not forced into a debt spiral by onerous payments and interest rates that force them to pay back far more than they ever owed. It will stop hospitals from putting liens on homes or garnishing wages, unnecessary steps that only lead people further into debt and financial chaos. It will ban hospitals from suing for medical debt that is under $1000, ensuring that debts that are not significant to hospital systems do not become expensive and anxiety inducing court cases for already struggling families.

Together, these provisions protect Maryland's working families and their health by making sure they do not have to choose between a hospital visit and potentially losing their home or paycheck. Many of these debts are small to the hospital systems pursuing them but can mean the difference between food on the table or a mortgage payment made for working families. Hospital systems, which receive millions in tax breaks, can absorb the cost of these debts much more easily than families can.

Our members range from part time grocery workers who may not have affordable health insurance, to nurses who are doing their best to provide quality care in often difficult circumstances. All of them know that fear of medical debt stops people from seeking care and can lead people into an inescapable financial spiral once they have it.

For the health of our members and all Marylanders, we urge you to vote favorably on SB 514.
Thank you.

SB0514 - Health Facilities - Hospitals - Medical D
Uploaded by: Wivell, Brian
Position: FAV

AMALGAMATED TRANSIT UNION
LOCAL 689

2701 Whitney Place, Forestville, Maryland 20747-3457
Telephone 301-568-6899 Facsimile 301-568-0692
www.atulocal689.org

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2nd Vice President

Statement of the Amalgamated Transit Union (ATU) Local 689

SB0514 - Health Facilities - Hospitals - Medical Debt Protection
February 25th, 2021

TO: The Honorable Chair Delores G. Kelley and Members of the Committee
FROM: Brian Wivell, Political & Communications Director, ATU Local 689

At the Amalgamated Transit Union Local 689 we represent over 13,000 workers and retirees performing many skilled transportation crafts for the Washington Metropolitan Area Transit Authority (WMATA), MetroAccess, DASH, and DC Streetcar among others.

We encourage all Senators to support this bill. Medical debt has a devastating effect on society. As one of the few industrialized countries to not guarantee healthcare as a human right, we have incentivized the creation of a parallel industry that seeks to exploit those in already unfortunate situations. It cannot be emphasized enough how bizarre the American medical system appears to those living in other countries. In 2019, the Los Angeles Times wrote a piece entitled, "Americans' struggles with medical bills are a foreign concept in other countries."

Despite fighting hard for all of our members to have high quality healthcare plans, many members and their families still hold medical debt. We recognize that medical debt is not a voluntary debt. There can be no comparison to business loans, student loans, or credit cards. Medical debt occurs when the American healthcare system's failure is so acute that it requires someone to put themselves into further financial hardship just to receive the potentially life saving care that they require.

The very least we can do at this moment, during the middle of a global pandemic, is provide certain protections to those with medical debt. HB0565 will help protect medical debt holders from unscrupulous industry practices.

SB 514 Testimony JW.pdf
Uploaded by: Woller, John
Position: FAV

SB 514: The Medical Debt Protection Act
Position: **FAVORABLE**

To: Senator Delores Kelly and members of the Senate Finance Committee
From: John A. Woller, MD
Date: February 25, 2021

I am a Baltimore City resident and an internal medicine physician at the Johns Hopkins Hospital. I strongly support the Medical Debt Protection Act (SB 514).

This bill takes a small yet important step toward a future in which my patients are no longer punished for being sick. SB 514 prohibits lawsuits for debts of $1000 and under, limits the amount of wages hospitals like my own are allowed to seize, and ensures income-based payment plans for my patients. The provisions of this bill will not significantly impact the financial status of large hospital systems, but it will make a difference for individuals who are already suffering from multiple medical problems and a financial system that is rigged against them.

Many of my patients' lives have been significantly disrupted and completely altered by medical debt, when they did nothing wrong other than get sick. I support SB 514 because I do not want them to have to deal with the added stress and anxiety of court dates, wage garnishments, and seizure of property. Such stressors have been shown to contribute to adverse health outcomes, feeding a cruel cycle of illness and financial consequence, ultimately resulting in shorter life expectancy for those experiencing bankruptcy.

I respectfully urge this committee to issue a favorable report on SB 514 because it will put in place simple mechanisms to prevent hospitals from enacting excessive duress on my patients through liens on homes, wage garnishments, and lawsuits over debts of $1000 and under.

Respectfully,

John A. Woller, MD
Assistant Professor of Medicine
The Johns Hopkins Hospital

3b-SB514-FIN-HSCRC-LOIWA.pdf
Uploaded by: Office of Governmental Affairs, Maryland Department of Health
Position: FWA

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Director
Payment Reform & Provider Alignment

Gerard J. Schmith
Director
Revenue & Regulation Compliance

William Henderson
Director
Medical Economics & Data Analytics

February 25, 2021

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

RE: Senate Bill 514 – Health Facilities – Hospitals – Medical Debt Protection – Letter of Information with Amendments

Dear Chair Kelley:

The Health Services Cost Review Commission (HSCRC) submits this letter of information with amendments for Senate Bill 514 (SB 514) titled, "Health Facilities - Hospitals - Medical Debt Protection." The HSCRC supports protecting consumers from unnecessary financial hardship through the Commission's financial assistance and uncompensated care policies.

Uncompensated Care (UCC) Fund Sustainability
The HSCRC has worked hard to develop policies to ensure the long-term sustainability of hospital UCC funding. UCC is care that is provided by the hospital for which no compensation is received. The Maryland Health Model's unique hospital payment system ensures equitable funding for uncompensated care by payer type and equitable funding between hospitals for UCC. Equitable distribution of UCC funding is important because some hospitals face larger volumes of uncompensated care than other hospitals. The HSCRC's policies ensure all payers share the cost of uncompensated care and hospitals with high volumes of low-income patients are not at a financial disadvantage.

In developing UCC funding policies, HSCRC carefully balances policies to ensure that hospitals provide financial assistance to patients who need it while limiting incentives for hospitals to charge the UCC fund for care provided to patients who can reasonably pay for those services.[1] HSCRC's financial assistance policies require hospitals to provide free and reduced care to certain patients. At the same time, hospitals are required to make a "reasonable collection effort" before determining that charges that are unpaid by a patient who does not qualify for financial assistance are bad debt that can qualify for UCC funding.[2] The goal of this policy is to ensure that UCC funding is sustainable.

[1] 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/. To achieve the balance described above, HSCRC blends "actual" UCC and "predicted" UCC to calculate hospital UCC rates. HSCRC Accounting and Budget Manual Section 100, page 39.
[2] HSCRC Accounting and Budget Manual Section 100, page 39.

SB 514 restricts hospitals from filing an action to collect debts less than $1,000 and debts owed by patients that were uninsured at the time services were provided. Similarly, the bill does not allow hospitals to "file an action to collect a debt owed on a hospital bill by a patient until the hospital determines whether the patient is eligible for free or reduced–cost care." HSCRC agrees that patients who do not have insurance and cannot afford to pay their hospital bills should be protected from extended bill collection efforts. However, these provisions, as currently drafted, potentially restrict hospitals' ability to collect bills owed by patients who are not eligible for financial assistance or who do not respond to the hospital's attempts to determine the patient's eligibility for financial assistance. HSCRC believes it is important that hospitals engage in "reasonable collection efforts" to support the sustainability of the UCC fund by minimizing total UCC.[3] HSCRC does not have data to evaluate the possible impact of these provisions of SB 514 on the sustainability of the UCC fund. Without data to evaluate how much additional bad debt will be charged to the UCC fund because of these policies, HSCRC cannot evaluate whether these policies will impact the sustainability of the fund.

Cost and Charges

SB 514 prohibits hospitals from "collecting additional fees in an amount that exceeds the *cost* of the hospital services for which the medical debt is owed in a bill for a patient who is eligible for free or reduced-cost care." The use of the word "cost" in this provision of the bill does not reflect the requirements of the hospital all-payer rate setting system in Maryland. Acute general hospitals in Maryland must charge patients (and insurers) the rate set by the HSCRC. Health General § 19-212 states that aggregate rates set by the HSCRC for a facility must be reasonably related to the aggregate costs of the facility. Under Maryland's rate setting system, hospital rates are the same for all payers, including Medicare, Medicaid, private insurance, and uninsured patients.[4] The HSCRC requests that the Committee amend this bill to replace the reference to "cost of the hospital service" with a reference to the HSCRC approved charge (see AMENDMENT 1 below). This amendment eliminates any interpretation that this bill allows hospitals to charge amounts that are different than the rates set through Maryland's unique all-payer rate system.

Similarly, this bill requires hospitals to report on the cost of hospital services "provided to patients but not collected by the hospital for patients covered by insurance and patients without insurance". The HSCRC collects the amount of unreimbursed charges, not costs, for services to HSCRC, broken out by insured and uninsured patients. As noted above, under the Maryland Health Model, the HSCRC sets the charges for

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[3] It is reasonable to assume that many individuals who are uninsured may not be able to afford certain health care services. However, this bill does not distinguish between people who are uninsured because they cannot afford insurance (or, in the case of certain immigrant populations, do not qualify for affordable coverage options) and individuals who are self-insured (i.e., have the wealth to not require insurance from a third party).

[4] Other States have large differentials between payers. For example, a 2019 study found that relative prices for private insurance may be 150 percent to 400 percent higher than Medicare rates in 25 states (not including Maryland). White, C., Whaley, C. "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely Findings from an Employer-Led Transparency Initiative." Rand, 2019. Available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.pdf. Rates charged to uninsured patients may be even higher. See Sherry A. Glied, Benjamin Zhu, Ougni Chakraborty, and Aggie Tang, "Who Will Pay for COVID-19 Hospital Care: Looking at Payers Across States", The Commonwealth Fund, August 18, 2020. Available at: https://www.commonwealthfund.org/blog/2020/who-will-pay-covid-19-hospital-care-looking-payers-across-states

services at all hospitals for all payers, including self-pay and uninsured individuals. HSCRC urges the Committee to adopt an amendment to align this reporting requirement with Maryland's All-Payer rate setting system by requiring the collection of data on charges, rather than costs. AMENDMENT NO. 2, provided below, adjusts that reporting requirement for hospitals to collect data on charges.

Alternative income determination regulations.
SB 514 requires HSCRC to develop regulations that contain standards for determining patient income for patients applying for free or reduced care who do not submit tax documentation to hospitals. The HSCRC agrees that patients should have alternatives for verifying their income. However, the HSCRC does not have expertise in income-based eligibility determination processes and practices. If this bill passes as written, HSCRC plans to contract with an expert to support the Commission in drafting these regulations. This contract is the reason for HSCRC's $50,000 fiscal note for this bill. The HSCRC proposes AMENDMENT NO. 3 to remove the language that assigns this role to HSCRC. Adopting this amendment would reduce HSCRC's fiscal note to zero.

HSCRC reporting
The bill as currently drafted requires HSCRC to submit an annual medical debt collection report to the legislature "based on special audit procedure requirements for hospitals related to medical debt". HSCRC requests flexibility to use data collected through other processes for this report, including processes that would allow HSCRC to report data more promptly than would be possible using the special audit procedures process. AMENDMENT NO. 4 is offered to allow for this flexibility.

The Commission urges the Committee to consider the amendments suggested in this letter when considering this consumer protection bill. If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 443.462.8632 or tequila.terry1@maryland.gov or Megan Renfrew, Associate Director of External Affairs, at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Tequila Terry
Principal Deputy Director

HSCRC Proposed Amendments to SB 514

AMENDMENT NO. 1

On page 5, in line 1, strike "cost of the hospital service" and substitute "**APPROVED CHARGE FOR THE HOSPITAL SERVICE AS ESTABLISHED BY THE COMMISSION**".

AMENDMENT NO. 2

On page 3, in line 24, strike "costs of" and substitute "**CHARGES FOR**"

AMENDMENT NO. 3

On page 6, strike beginning with "determine" in line 15 down through "regulations" in line 18 and substitute "**CONSIDER OTHER CREDIBLE AND VERIFIABLE DOCUMENTATION PROVIDED BY THE PATIENT TO DETERMINE THAT PATIENT'S ADJUSTED GROSS MONTHLY INCOME**".

AMENDMENT NO. 4

On page 13, strike beginning with "that" in line 11 down through "debt" in line 12.

SB 514- Health Facilities – Hospitals – Medical De

Uploaded by: Witten, Jennifer

Position: UNF

Senate Bill 514 – Health Facilities – Hospitals – Medical Debt Protection

Position: ***Oppose***
February 25, 2021
Senate Finance Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 514. Maryland hospitals have only one core mission: to provide the best patient care possible in the state. Hospitals believe every person should receive the care they need without financial worry. Maryland hospitals make every effort to inform patients about available financial assistance, including free or reduced-cost care. That includes helping patients enroll in Medicaid or other insurance options and set up reasonable payment options when needed.

Maryland Leads in Consumer Protections
Hospitals' financial assistance and billing collections practices are governed by extensive state and federal laws. Just last year, this legislature strengthened the state's already-robust hospital financial assistance laws by passing HB 1420, Chapter 420, Hospitals – Financial Assistance Policies and Bill Collection. These comprehensive reforms took effect Oct. 1, 2020, and hospitals worked diligently during the COVID-19 pandemic to ensure timely implementation. As seen in the attached slides, hospitals routinely engage patients throughout the financial assistance and billing process. In addition, federal law addresses nearly every aspect of financial aid and billing practices. Established by the Internal Revenue Code §501(r)[i], these laws set thresholds for free and reduced-cost care; define notice requirements for financial assistance and collections; create application period timelines; and outline actions hospitals may take to pursue outstanding bills.

Extensive Overhaul Threatens Maryland's Unique Model
The complex and comprehensive reforms included in SB 514 are based on model legislation that does not account for Maryland's all-payer system. In Maryland, every patient has access to every hospital, regardless of ability to pay, because uncompensated care is equitably funding in the system among all hospitals and all payers. We agree patients who cannot afford to pay should not. As the Health Services Cost Review Commission (HSCRC) points out, we must balance our efforts to make reasonable attempts to collect. Otherwise, hospital rates increase due to increased uncompensated care—straining Maryland's agreement with the federal government and raising prices for all health plans and patients. Maryland's unique fixed budget system keeps hospitals from growing volume to cover uncollectable accounts, further focusing the need for hospitals to reasonably collect on bills. Any proposed overhaul would need to be considered against the impact on our system.

For these reasons, after this bill was introduced last session, the hospital field evaluated our process over the summer and identified best practices for the field. As part of this endeavor, MHA surveyed members

6820 Deerpath Road, Elkridge, MD 21075 ▪ 410-379-6200 ▪ www.mhaonline.org

about hospital billing and collection practices, held focus groups, and engaged a dedicated work group to consider these reforms. This process considered each of the reforms included in SB 514 for operational feasibility, interactions with the new financial assistance requirements, and, most importantly, impact on the Total Cost of Care Model, as noted by HSCRC. MHA briefed this committee on many of those findings, including existing laws and best practices last November.

These efforts culminated in a series of in-depth conversations with bill sponsors and proponents to identify potential agreement ahead of this legislative session. Working with hospital members, MHA offered alternative language to add consumer protections and payment plan requirements established by HSCRC and strengthen insurance appeal notification and aligned notices with existing financial hardship laws. MHA was, therefore, surprised to see that many of the points where we believe there was mutual agreement were unfortunately not included in SB 514. **The bill as introduced retains the provisions that were identified as longstanding and major concerns.**

Maryland Must Address the Real Cause of Outstanding Bills: High-Deductible Health Plans

The direct relationship between a rise in outstanding bills and an increase in high-deductible health plans is well established. Quite simply, **high-deductible health plans leave many people functionally uninsured.** The increasing individual financial obligations for health insurance results in avoided preventive care, and unexpected burdens when individuals obtain health services. This is because insurers have thinned coverage, shifting the burden of health costs onto consumers.

> *Over the past decade, premiums and deductibles have risen faster than worker's wages nationally. In Maryland, premiums have increased 24% from 2013-2019 and remain over the national average. Deductibles increased 55.6% in employer-sponsored plans: In 2013, the average deductible was $1,075. In 2019, that number had jumped by nearly $600 to $1,673.*

Individuals in these plans often do not understand that their coverage only kicks in after the several thousand-dollar deductibles is met. True reform in medical debt must bring insurers to the table with solutions to protect and educate consumers when choosing coverage for health services in lieu of comprehensive health insurance coverage.

A Connecticut Task Force, created by the Legislature issued a February 2020 report that explored how rising out-of-pocket costs create and exacerbate health disparities, particularly among economically vulnerable individuals and those with chronic conditions. The report noted “substantial and compelling evidence regarding the connection between consumers’ inability to meet high deductibles (and other cost sharing obligations) and medical debt, and its downstream financial and health consequences.” The Task Force identified **consumer literacy** around health care and health insurance as a factor in consumers choosing plans that are economically dominated or are not right for their situation. They outlined several recommendations to support this finding. **They also recommended cost-sharing reforms, including phasing out high deductibles and coinsurance and making carriers responsible for paying cost shares to providers and collecting those payments**. The report found:

In light of the evidence regarding the relationships between high deductibles and medical debts, many Task Force members viewed this proposal as an opportunity to preserve the provider-patient relationships (particularly among smaller provider groups) that are harmed by debt collection activities and avoidance of care, which can also impact patient and population health. Some Task Force members also predicted that the additional certainty of receiving payments for services would lead to more providers joining carriers' networks and thereby improving access to care.

This reform has been considered in other states as well.

We ask this committee to consider new approaches to the health care billing process as part of true reform we have seen succeed in other states.

Maryland hospitals give every patient the ability to seek financial assistance and fair payment options to pay medical debt owed. Senate Bill 514 as introduced does not take into account the laws, resources, and steps hospitals take to work with every patient. Nor does it balance the need for changes in provider processes with the need to address the impact of insurance practices.

For these reasons, we urge an ***unfavorable*** report.

For more information, please contact:
Jennifer Witten, Vice President, Government Affairs
Jwitten@mhaonline.org

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[i] www.irs.gov/charities-non-profits/billing-and-collections-section-501r6

Financial Assistance

Hospital practices to assist patients with financial assistance

Assist with Obtaining Needed Documents

- ID
- Death/Birth Certificate
- EOBs
- Itemized Bills
- Home visits for screening and pick up of documents

Tracking down family/next of kin

- Research online
- Call payers
- Review previous admissions
- Checking social media profiles

Checking State, Federal, & Credit Agency data bases

- Vital Records
- IRS
- Work Number
- Experian/credit reporting
- DSS Inquiries

Contracting with vendors and state caseworkers to assist patients

- DSS Caseworker
- DECO/Medical Assistance Vendor Partners
- Navigators

Enhancements to Financial Assistance Process in Response to Passage of HB1420 in 2020

- Increased financial eligibility threshold to 500% of FPL
  - Most hospitals already included up to 400% of FPL
- Excluding certain assets such as
  - Any resource excluded for Medicaid Eligibility determination
    - MAGI (under 65 and not disabled) qualifications do not count assets
  - Retirement Plans
  - First $10,000
- Developed plain language financial assistance summaries in multiple languages
- Developed consumer complaint and appeal process (HSCRC & HEAU)
- Preparation for Annual Financial Assistance Report

Assistance Starts At Patient Admission

- Hospitals counsel patients on assistance options and provide information on how to get help with financial assistance.
- Information provided in multiple ways; directly to patient at registration, included in discharge packets, posters in hospital, posted on website, mailed with billing statements, etc.

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

Adventist HealthCare is committed to meeting the health care needs of our community through the ministry of physical, mental and spiritual healing. All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance.

Availability of Financial Assistance: You may be able to get financial assistance if you do not have insurance, are underinsured, or if it would be a financial hardship to pay in full your expected out-of-pocket expenses for emergency and other medically necessary care that Adventist HealthCare provides.

Eligibility: Adventist HealthCare provides financial assistance based upon need. To determine need, we review your household income and compare it to the Federal Poverty Level guidelines set by the U.S. Department of Health and Human Services. We also review the amount of charges for which you are responsible.

If you and/or the party responsible for payment has combined income equal to or below 200 percent of the federal poverty guidelines, you will have no financial responsibility for the care that Adventist HealthCare provides. If you fall between 200 percent and 600 percent of the guidelines, you may qualify for discounted rates for our care.

> Out of work
> Working but not able to afford health insurance
> Single Parent
> Disabled
> Pregnant
> Have children
> 65 years of age or older
> Limited time to apply

The Eligibility Experts
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We are dedicated to helping the uninsured.

Financial Assistance
(866) 285-0041

Financial Assistance

FAP Plain Language Summary

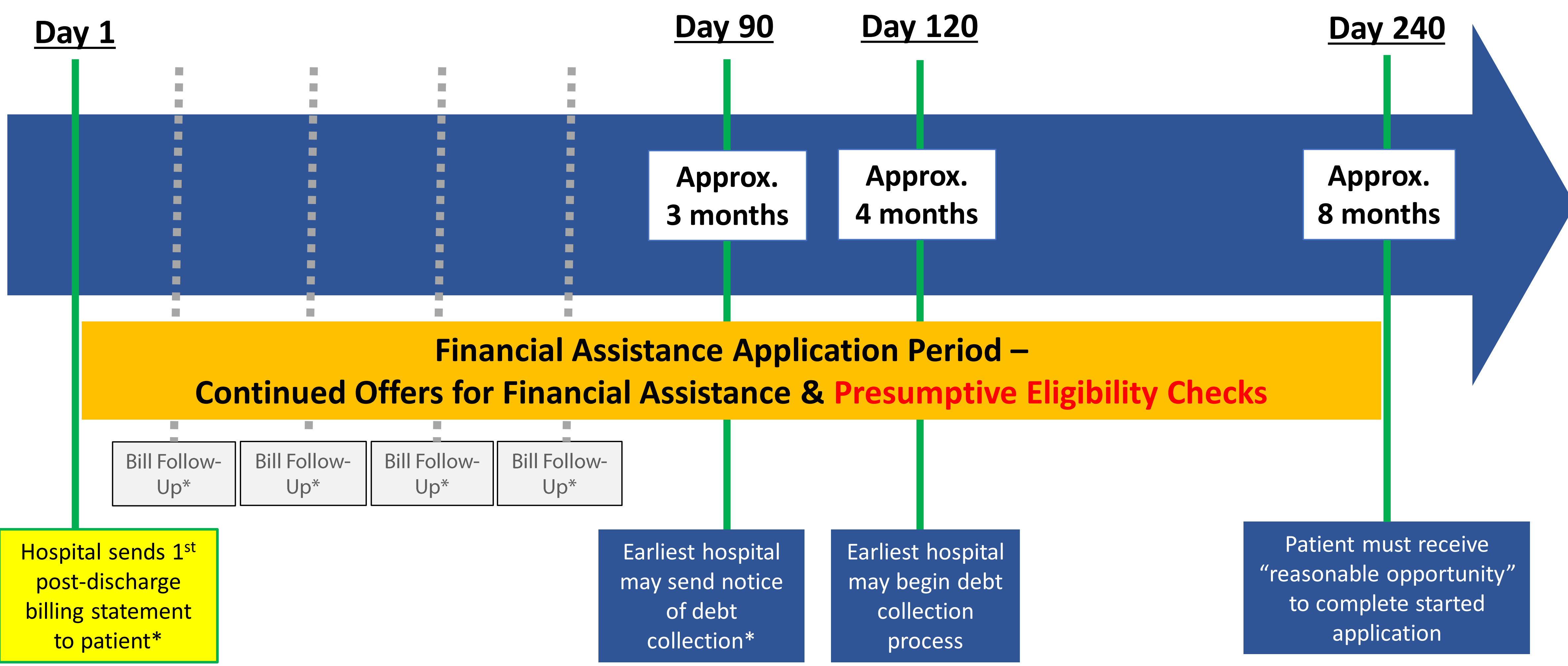
Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get **free** or **lower cost** services.

Please Note:

- We treat all patients needing emergency care, no matter what they are able to pay.
- Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. See the list of physicians who provide emergency and other medically necessary care in the hospital facility whose services are not covered under this policy. You can call **410-821-4140** or **877-632-4909** (toll free), or email CBOService@umm.edu if you have questions.
- You will never be charged for emergency and other medically necessary care more than **amounts generally billed** to patients who are not eligible for financial assistance under the financial assistance policy. Rates are set by the State of Maryland.

Timeline of Financial Assistance Availability



* Denotes when the financial assistance policy information sheet must be given to patient.

High Deductible Health Plan Task Force

Final Report

February 24, 2020

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Executive Summary

In the 2019 budget, Governor Lamont and the Connecticut Legislature asked for a Task Force to look at how health insurance plans with high deductibles (HDHPs) were affecting consumers. (A deductible is money that the consumer has to pay for their health care before the insurance will begin to pay for care.)

The Task Force heard from many experts about issues with high deductibles. Deductibles which are too high can lead people to avoid necessary care because they cannot afford to pay for it. Some people avoid care even when it will be completely paid for by the insurance company. Some do not understand or trust that their care will be paid for by the insurance company, and some do not want to pay for follow up care that may be necessary. Insurance companies use deductibles to lower monthly premiums by shifting more of the costs directly to consumers. Both premiums and deductibles have grown over the years because the price of medical care has gone up a lot.

The Task Force heard how high deductibles prevent people from getting health care that they need even when they have health insurance. At the same time, deductibles do help some people to save money, especially people who are able to put money into a Health Savings Account, which is one the best tax shelters in the tax code. The Internal Revenue Service has put forth rules on which HDHPs allow people to put money into an HSA. Not all HDHPs qualify.

The Task Force heard about how high deductibles lead to medical debt, especially for people who do not have a lot of money to begin with. Medical debt is a problem for both consumers and providers. Consumers tend to avoid going back to doctors when they owe money and are not able to pay. Providers have to choose between serving the needs of the patient who owes them money, and making sure they can stay in business to serve all of their patients.

The Task Force considered many possible changes to HDHPs that could address some of the problems that high deductibles contribute to. Those changes are described in this report, as well as what the Task Force thinks about each change. The possible changes fall into five basic categories:

1. Helping people understand their insurance better
2. Changing how deductibles work
3. Making HSAs work for more people
4. Helping people pay for health care
5. Bringing health care prices down

A majority of the Task Force adopted many of the recommendations that had been considered, while several other proposals were rejected. None of the recommendations had unanimous support from the Task Force membership.. In general, Task Force members looked favorably on efforts to teach consumers about their health plans, while at the same time noting that the complexity of health insurance is itself an issue. The Task Force further supported reforms to

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encourage people who qualify for HSAs to fund them, and to encourage the state to consider funding the HSAs of people who qualify but do not have the income to fund their own. Task Force members also recognized that a main cause for the growth of HDHPs is the growth of the underlying health care costs, and expressed its support for existing efforts to identify a Healthcare Affordability Standard and a Health Care Cost Benchmark. Finally, Task Force members supported certain cost sharing reforms intended to mitigate consumer and provider concerns that necessary or high-value care is cost-prohibitive due to a high deductible.

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Introduction

On June 26, 2019, Governor Lamont signed Public Act 19-117. Section 247 of the Act created a High Deductible Health Plan Task Force (the Task Force) "to study the structure of high deductible health plans and the impact of such plans on enrollees in this state." The Task Force was further directed to report to the General Assembly's Insurance and Real Estate Committee its recommendations concerning:

1) Measures to ensure access to affordable health care services under high deductible health plans;
2) The financial impact that high deductible health plans have on enrollees and their families;
3) The use of health savings accounts, and the impact that alternative payment structures would have on such accounts, including, but not limited to, the status of such accounts under the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;
4) Measures to ensure that each cost-sharing payment due under a high deductible health plan and paid by an enrollee at the time of service accurately reflects the enrollee's cost-sharing obligation for such service under such plan;
5) Measures to ensure the prompt payment of a refund to an enrollee for any cost-sharing payments under a high deductible health plan that exceeds the enrollee's cost-sharing obligation under such plan;
6) Measures to enhance enrollee knowledge regarding how enrollee payments are applied to deductibles under high deductible health plans; and
7) Payment models where a physician can receive reimbursement from a health carrier for services provided to enrollees.

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Task Force Membership

The following members were appointed to the Task Force by their respective appointing authorities:

- Ted Doolittle, Healthcare Advocate (Chair)[1]
- Dr. Daniel Freess, CT College of Emergency Physicians
- Cassandra Murphy, CT Coalition of Taft-Hartley Health Funds
- Dr. Greg Shangold, CT State Medical Society
- Dr. Andrew Lim, Bristol Hospital
- Robert Krzys, Esq.
- Susan Halpin, CT Association of Health Plans
- Janice Perkins, ConnectiCare
- Patrick McCabe, Yale New Haven Health System
- Dr. Andrew Wormser, CT Medical Group
- Joseph McDonagh, McDonagh Insurance
- Seth Powers, The Center for Children with Special Needs

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[1] Sean King, senior Staff Attorney for the Office of the Healthcare Advocate, temporarily served on the task force as the Healthcare Advocate's designee for the December 4, 2019 meeting.

Background

Definition of High Deductible Health Plan

High deductible health plans (HDHPs) are health insurance designs that, in exchange for lower premiums, require members to absorb greater initial out-of-pocket expenditures for medical services (other than "preventive" services) before the insurer begins to cover expenses. HDHPs formally originated in 2003, upon enactment of Section 223 the Internal Revenue Code (the Code). For calendar year 2020, the Code defines an HDHP as a health plan with: 1) a deductible of at least $1400 for an individual or $2800 for a family; and 2) a maximum out-of-pocket limit that does not exceed $6900 for an individual or $13,800 for a family.[2] In addition, the Code requires that an HDHP apply the deductible to all health care expenses. However, the Code provides for an exception for pre-deductible coverage with respect to preventive care services (safe harbor).

The safe harbor for preventive care benefits is limited to those services defined as preventive care under section 1861 of the Social Security Act, as well as services identified as preventive by the Secretary of the Treasury.[3] By way of Internal Revenue Service (IRS) Notice 2019-45, the Secretary recently expanded the list of preventive care services that fall within the Code's safe harbor provision.

Accordingly, the current list of preventive care services that may be covered without regard to a deductible include:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals or routine prenatal and well-child care;[4]
- Tobacco cessation programs;[5]
- Obesity weight-loss programs;[6]
- Various screening services (as listed in the Appendix to IRS Notice 2004-23);[7]
- Any treatment that is incidental or ancillary to the preventive care services listed above;[8]

[2] IRS Bulletin 2019-22. CT insurance statutes have incorporated the IRS's definition of an HDHP by reference to the Code. See Conn. Gen. Stats. § 38a-493(f). In addition to the IRS limits on out-of-pocket maximums applicable to HDHPs in 2020, federal law also limits out-of-pocket maximums under all group health plans at $8150 for self-only coverage and $16,300 for other than self-only coverage. See 42 U.S.C § 300gg-6.
[3] 26 U.S.C. § 223(c)(2)(C).
[4] IRS Notice 2004-23.
[5] Id.
[6] Id.
[7] Id.
[8] IRS Notice 2004-50.

- Evidence-based items or service that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); [9]
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;[10]
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;[11]
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration;[12]
- Medications prescribed to an individual who has developed risk factors for a disease that has not manifested or to prevent recurrence of a disease from which the individual has recovered;[13]
- High value services and Items used to prevent exacerbation of certain chronic conditions, as listed in the Appendix to IRS Notice 2019-45.[14]

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[9] IRS Notice 2013-57 and 42 U.S.C. § 300gg-13. A listing of the recommendations published by the USPSTF is available online at: https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations
[10] Id.
[11] Id.
[12] Id.
[13] IRS Notice 2004-50
[14] IRS Notice 2019-45, Appendix A provides the following chart:

Preventive Care for Specified Conditions	**For Individuals Diagnosed with**
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders

It should be noted that the Secretary's identification of services that are subject to the Code's safe harbor does not result in a requirement that plans provide pre-deductible coverage for the identified services.[15]

<u>Health Savings Accounts</u>

Health Savings Accounts (HSAs) were also established under Section 223 of the Code. HSAs are essentially non-taxable trust accounts that are established, funded and distributed in connection with a beneficiary's enrollment in an HDHP (as defined by the Code).

Contributions to HSAs, up to prescribed limits, are deducted from an individual's gross income. For calendar year 2020, the contribution limits are $3550 for individual coverage and $7100 for family coverage.[16] For individuals over age 55, an additional $1000 in "catch-up" contributions may be deposited in an HSA and deducted from gross income. The Code does not place any limitations on who may contribute to an individual's eligible HSA. As a common example, many employers contribute to their employees' HSAs where the employees are enrolled in an HDHP offered under the employers' group health plan.

Just as contributions to HSAs are deductible from gross income, distributions from HSAs are also tax-free, so long as the distribution is used exclusively for paying qualified medical expenses of an account beneficiary.[17] HSAs offer a third benefit as well, in that any interest or other earnings that accumulate to the account, which can feature investment option similar to other tax-sheltered retirement accounts such as 401(k)s or Individual Retirement Accounts, are also tax exempt. In addition, HSAs are portable and balances remain accessible to the account holder even after an account holder changes health plans. After age 65, HSA funds may be withdrawn without penalty for any non-medical purpose, though unlike qualified medical expense withdrawals, such non-medical withdrawals after 65 are subject to normal income tax. In this way, HSAs can be an attractive tool for individuals who wish to build a savings fund to pay for their medical care, or to pay other expenses after they become eligible for Medicare coverage.

Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

[15] See IRS Notice 2019-45.
[16] IRS Bulletin 2019-22.
[17] Interest paid on the balance of an HSA is also not taxable and can be distributed to pay for qualified expenses.

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Purpose of HDHPs

HDHPs were initially created as a method of attempting to control health care costs. Conceptually, the higher deductibles influence members of HDHPs to make wiser health care decisions because they have "skin in the game." Thus, in theory, members of HDHPs would "shop" for services on the basis of quality and cost. In doing so, members would elect to forego more low value services (potentially higher cost with lower health outcomes) and seek out higher value care (potentially lower cost with greater health outcomes). In return, members of HDHPs would be rewarded with a lower monthly premium and the tax benefits associated with an HSA, from which they could meet their higher deductible obligation.

As discussed further herein, the benefits of HDHPs and HSAs have not manifested as expected for every member of such plans. For example, information regarding provider cost and quality is not readily available, making it difficult for members to engage as "smart shoppers." In addition, not all HDHP members have the resources to contribute adequately to an HSA and take advantage of the associated tax benefits.

Some Health Plans with High Deductibles are not HSA-Compatible

As indicated above, the definition an HDHP under the Code is confined to those health plans with a minimum deductible and maximum total out-of-pocket responsibility, as well as limitations on the services that can be covered without regard to the deductible. However, as HDHPs have evolved, insurers have introduced plans that incorporate high deductibles, but do not qualify as HSA-eligible HDHPs under the Code – either because their out-of-pocket maximum exceeds the threshold established by the Code, or because the plan covers certain ineligible services without regard to the deductible. In such cases where the "high deductible health plan" does not conform to the Code's definition of an HSA-eligible HDHP, the plan's members are not eligible to receive tax benefits for contributions to an HSA. However, such non-compatible high deductible plans do have the flexibility to offer consumers pre-deductible coverage of more services (*i.e.*, services not subject to the IRS safe harbor). For example, some of the products currently offered on the Access Health CT insurance exchange incorporate such additional pre-deductible benefits into their product designs, and thus are not HSA-compatible.

Regulation of High Deductible Health Plans

Of interest to the Task Force was the limitation on the state's ability to regulate health coverage provided under what is at times called a "self-insured" or "ERISA" plan. In self-insured plans, an employer assumes the risk and maintains the capital reserve from which the claims of its enrolled employees and their family members are paid, and a third party performs the administrative functions of enrolling employees and providers, adjusting and paying claims, and

so on. The third party administrator, sometimes called a TPA, may be a traditional insurance company providing administrative services only, or it may be a separate specialized contractor.

Approximately 65% of Connecticut residents who have health coverage through an employer currently receive that coverage through a self-funded plan.[18] While self-funding has traditionally been the domain of larger employers, self-funding plans have made strong inroads into the small group market in recent years.

Due to a provision of the federal Employee Retirement Income Security Act of 1974 (ERISA), federal law preempts states from regulating self-insured plans. Only Congress and Federal agencies can regulate self-insured plans. This places a majority of health coverage in Connecticut out of the reach of state regulation.

In contrast, fully insured health plans, by which an insurance company rather than the employer maintains the capital reserve from which the medical claims are paid, are regulated by the laws of the state in which they are written, as well as by applicable federal laws such as the Affordable Care Act (ACA). The Task Force is mindful that as a smaller segment of the market, fully insured plans are more price sensitive, and accordingly, certain legislative changes could potentially lead to other downstream impacts such as premium increases and dropped coverage.

The Task Force recognizes that the findings and recommendations presented herein will be primarily addressed to the smaller fully insured market in CT. However, Task Force also considered that it would be appropriate for its members, as well as elected officials, private individuals, or the General Assembly as a body, to recommend certain changes that are within the federal rather than the state purview to the state's Congressional delegation.

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[18] See https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/

Summary of Meetings and Evidence

The Task Force convened on August 22, 2019. Additional informational and business meetings were held on October 16, November 6, November 20, December 4 and December 18, 2019, and on January 9, January 17, January 28 and February 5, 2020.

At its October meeting, preliminary discussions among Task Force members initially identified access to care as a primary issue to be addressed by high deductible health plan (HDHP) reforms. At the time, Task Force members perceived and later received evidence that high deductibles present barriers to care, in that out-of-pocket deductible costs can deter patients who need health care services from seeking or obtaining those services from their providers. This deferment of care can result in consequences to an individual's health and wellness. Task Force members further posited that high deductibles can result in medical debts that patients are unable to pay, which too often lead to other negative financial impacts, such as credit collections, litigation and bankruptcy. Task Force members also acknowledged the relationship between deductibles and premiums and that both are a reflection of underlying healthcare costs, with an understanding that the cost of healthcare and the price of healthcare are not necessarily synonymous. The Task Force recognized the need to be mindful of unintended consequences that may accompany any of its recommendations, if implemented by policymakers, in that some reforms could result in the negative indirect impacts of raising out-of-pocket costs to consumers or limiting consumer choices. As a further example, policymakers should also be mindful that as a result of the Silver loading workaround to the federal government's recent attempts to stop paying the Cost Sharing Reduction subsidies, higher premiums can result in a positive impact on federal premium tax credit subsidies, which in turn makes insurance cheaper for lower-income customers who receive subsidies to buy insurance through the Exchange.

The task force received a series of presentations, which sought to articulate for the Task Force the benefits and challenges associated with HDHPs.[19] The presenters included Dr. Victor G. Villagra, Associate Director of the UCONN Health Disparities Institute,[20] Lynn Quincy, Director of Altarum's Health Care Value Hub,[21] Kevin McKechnie, Executive Director of the American Bankers Association HSA Council,[22] James Stirling, Stirling Benefits, Inc.,[23] Dr. A. Mark Fendrick,

[19] The information presented was not independently validated by the Task Force and represented the opinions of the presenters.

[20] Dr. Villagra's bio and additional information regarding UCONN's Health Disparities Institute may be found at: https://health.uconn.edu/health-disparities/

[21] Ms. Quincy's bio and additional information regarding the Healthcare Value Hub may be found at: https://altarum.org/solution/altarums-healthcare-value-hub

[22] Mr. McKechnie's bio and additional information regarding the HSA Council may be found at: https://www.aba.com/authors/kevin-mckechnie

[23] Mr. Stirling's bio and additional information regarding Stirling Benefits, Inc. may be found at: https://www.stirlingbenefits.com/about-us/

Director of the University of Michigan Center for Value-Based Insurance Design,[24] Ann Lopes, Product Carrier Manager for Access Health CT, Sabrina Corlette, J.D., Co-Director Georgetown University Center on Health Insurance Reforms[25] and Paul Lombardo, Director of the Life and Health Division of the Connecticut Insurance Department.[26] The Task Force also received several oral and written comments from various members of the public.

Dr. Victor Villagra – Health Disparities Institute[27]

Dr. Villagra presented some of his research regarding HDHPs. According to his research, a substantial proportion of Connecticut residents lack the health insurance literacy needed to make effective decisions regarding plan selection and to understand their plan's benefits. The research further exposes significant racial, economic, education-level and other disparities among healthcare consumers when it comes to selecting the "just right" plan and understanding their coverage. Dr. Villagra also highlighted several impacts of high deductibles on plan participants, including increased medical debts, avoidance of medically necessary services and increased administrative costs for providers. Specifically, there is substantial evidence that members of HDHPs underutilize high value medical and mental health procedures such as vaccinations, maintenance medications and preventive care visits. Additional findings demonstrate that:

- Nearly a quarter of insured individuals experience medical debt
- Of those individuals, 43%-67% have exhausted their savings to pay bills
- 43% have been impacted by a reduced credit rating
- 16% have been subjected to collections activity
- 18% have delayed education or career plans
- Up to 62% of bankruptcies are related to medical debt
- Providers' accounts receivables have grown over time in terms of amounts and duration

With respect to these financial burdens, Dr. Villagra highlighted the number of times that providers have sued their patients in small claims court (for less than $5000). Between 2011 and 2016, providers filed 85,136 small claims actions seeking recovery of debt totaling over $110 million, most of the time without any appearance from the defending patient.[28] Dr.

[24] Dr. Fendrick's bio and additional information regarding the Center for Value-Based Insurance Design may be found at: https://sph.umich.edu/faculty-profiles/fendrick-a.html
[25] Ms. Corlette's bio and additional information regarding the Center on Health Insurance Reforms may be found at: https://chir.georgetown.edu/faculty_sabrina_corlette/
[26] Additional information regarding the CT Insurance Department's Life & Health Division may be found at: https://portal.ct.gov/CID/About-Us/The-Life--Health-Division
[27] Dr. Villagra's presentation materials are included in Appendix A.
[28] Dr. Villagra's presentation identified an outlier hospital that accounted for nearly half of all of the lawsuits studied as part of his research.

Villagra emphasized the ethical dilemma that providers face when deciding to subject their patients to collections and litigation.

Finally, Dr. Villagra posited that reforms must ultimately address the root cause of the negative outcomes identified in his research, namely the unsustainable growth in the underlying prices of healthcare services. Among his suggestions, policymakers interested in addressing these impacts should explore:

- Establishing public-private partnerships with a goal of improving health insurance literacy, particularly among marginalized groups
- Enacting regulations to gradually phase out high deductibles and coinsurance from health insurance plan designs
- Promoting performance-based regulations to set goals for improvement on Consumer Report Card data points
- Facilitating new entrants who can offer simpler plan alternatives within the health insurance market
- Improving transparency regarding provider charges and billing practices
- Reforming judicial procedures to protect individuals from unfair medical debt collection and litigation practices

Lynn Quincy – Altarum Healthcare Value Hub[29]

Lynn Quincy presented further evidence of the negative impacts that HDHPs have on plan participants. In addition, Ms. Quincy explained that the benefits of HDHPs, which include lower premiums and opportunities for tax savings through HSAs, are substantially outweighed by the negative financial and health impacts of medical debt and avoidance of necessary care. In particular, HDHPs do not accomplish one of their intended purposes of motivating plan participants to become "smart shoppers" who will seek out the highest value services. Additional research affirms that poor healthcare literacy, as well as lack of cost and quality transparency, are major contributors to inefficient use of health insurance plans.

Predictably, the financial impacts of HDHPs fall most heavily on individuals and families with income less than 250% of the federal poverty level. More than 60% of the tax benefits available to members of HDHPs with HSAs accrue to families earning more than $100,000 annually.

In Connecticut, the health consequences of HDHPs is substantial. More than half of adults have reported delaying or avoiding healthcare procedures due to the cost. Over ten percent of individuals reported problems accessing mental health care. More than one in four individuals reported leaving a prescription unfilled or skipping doses of medications.

[29] Lynn Quincy's presentation materials are included in Appendix B.

Regarding financial impacts, ten percent of adults have reported being contacted by a collections agency, and another sixteen percent have used up all of their savings or shifted their medical debt to their consumer credit accounts. Six percent have reported being unable to pay for other necessities in order to accommodate payments toward their medical debts.

Some of the solutions proposed by Ms. Quincy include:

- Utilize copayments rather than coinsurance to distribute the costs of care between member and insurer
- Tie cost-sharing to family income – i.e., create affordability standards
- Implement Value Based Insurance Design (VBID)

Regarding VBID, the most consumer-friendly designs will focus on high value care, simplify cost-sharing and ensure benefits are based on evidence. However, current research on VBID indicates that positive responses to lower cost-sharing incentives are less than predicted, and little research exists as to whether higher cost-sharing has the intended impact of limiting just low-value services or instead reduces utilization indiscriminately.

As for the need for healthcare and insurance to be affordable, there is no current consensus on how "affordability" should be defined. However, there is substantial evidence that affordability is negatively impacted by wasteful healthcare spending. Specifically, up to one third of healthcare spending is wasted on low-value care,[30] excessive unit costs, unnecessary administrative costs and fraud, among other things. Recommendations for reducing unit costs include increasing quality, cost and price transparency, aligning prices with costs and eliminating cost outliers.

Kevin McKechnie - HSA Council[31]

Mr. McKechnie explained that not all HDHPs are created equal. True HDHPs and HSAs are the creation of the IRS, and are distinguished from "health plans with high deductibles," which may look like a true HDHP but don't have the applicable cost sharing or first dollar coverage limitations to meet the definition of an HDHP under the IRS code, and therefore are not HSA-compatible. HSAs come with the triple benefit of tax-free contributions, capital gains and distributions (if used for qualified healthcare costs). In addition to actual provider charges, qualified healthcare expenses include COBRA premiums, Medicare premiums and qualified long term care insurance premiums.

One of Mr. McKechnie's interests is to help States understand the relationships between coverage mandates and IRS limitations of first dollar coverage for HSA-compatible HDHPs. As

[30] Ms. Quincy acknowledged that the practice of "defensive medicine" plays a role in the overutilization of some lower-value services.
[31] Mr. McKechnie's presentation materials are included in Appendix C.

an example of a failed experiment, he discussed Maryland's mandate to provide parity for male reproductive services. The mandate was found to be inconsistent with IRS rules, and ultimately disqualified several hundred thousands of Maryland residents from utilizing an HSA and paying for their healthcare with pre-tax dollars, or contributing to their HSAs on a pre-tax basis.

Mr. McKechnie acknowledged that HSAs are not appropriate for everyone. HSAs require account holders to be somewhat active participants in managing their accounts. In addition, individuals must be financially able to contribute, and most participants do contribute or receive contributions from their employer. Nonetheless, he cautioned against the concept that a state might mandate that all HDHPs be HSA compatible. Consumers prefer choice.

HSA contributions typically come from the account holder or their employer; however, there are no restrictions on who can contribute. A state government or other funding source can also fund an individual's HSA. However, ACA rules currently limit the ability to use premium tax credit dollars or cost sharing reduction dollars to fund an HSA.

The IRS recently updated its rules to expand the list of items that can be subject to first-dollar coverage under an HDHP with an HSA.[32] However, there is no federal requirement that plans must cover those items without a deductible.

Minimum deductibles under an HSA-compatible HDHP are $1400 for individuals for 2020, and average deductibles are approximately $1650. Compared to HSA-compatible HDHPs, deductibles for "health plans with high deductibles," have grown three times faster. One of the primary mechanisms that plans use to keep premiums low is to increase deductibles. In other words, "the first healthcare dollar is the most expensive dollar to insure."

Mr. McKechnie's reform recommendations largely would require Congressional action. Presently, he has expressed support for HR 3796, which would allow Medicare eligible HSA holders to continue to make tax-free contributions. Because there is no political consensus on how to reform the ACA or expand Medicare, he believes the most expedient option to address some of the issues related to HDHPs is to expand the availability of pre-tax dollars to be spent on healthcare. He also expressed favor for innovations such as expanding use of HSA dollars on over-the-counter drugs and allowing for spouses to make catch-up contributions above ordinary annual contribution limits. He also expressed favor for the concept of establishing HSA-compatibility on the basis of metal-tiering level, rather than the size of a deductible.

Mr. McKechnie offered some feedback on other reform ideas, including a proposal that the deductible portion of a healthcare expense be paid by the member to the insurer, rather than the healthcare provider, and that the insurer instead of the member would pay the healthcare provider directly for such expenses. He explained that such a payment likely would not be a qualified healthcare expense, because once the insurer paid the charge and sought

[32] See fn 14, *supra*.

reimbursement from the member, the amount would represent a consumer debt to the insurer, as opposed to a healthcare expense owed to the provider.

Under another scenario, Mr. McKechnie addressed a concept where an individual moves from one HDHP to another HSA-compatible HDHP. He explained that IRS rules would permit the latter plan to credit the individual for deductible costs incurred under a prior plan earlier in the year. However, he stated that it must be an optional benefit for the plan to offer – if a State were to mandate such a credit, the plan would no longer conform to IRS rules and therefore would lose its HSA compatibility. As an additional cautionary statement, he indicated that individuals who switch plans must be mindful not to exceed their annual contribution limits under the IRS rules.

James Stirling – Stirling Benefits, Inc.[33]

Stirling Benefits, Inc. provides third party administrator services for self-funded or level-funded employers. In general, Mr. Stirling agrees with the observations and research that concludes that HDHPs have not improved access to care or contributed to improvements in health. His primary thesis is that the players in the health benefits market have incentives that are misaligned with the goals of cost containment and population health improvement.

Carriers and brokers operate under high volume and low margins, as the ACA's Medical Loss Ratio (MLR) rules, which require healthcare plans to spend 80%-85% of the premiums they collect on medical claims, cap their allowable profits from premiums. Thus, insurer profits can only increase when premium collections increase, which in turn incentivizes inflation of the underlying costs of care. Another unintended consequence of the MLR rules is the tendency of incentivizing lower-risk, lower-cost business to move out of the fully insured market and into the self-insured market, which is not subject to the same MLR rules, thereby destabilizing the fully insured market that must bear an increasing amount of risk year-to-year.

In his experience in working with employers, about 2% of the employee population under a health plan will incur about 50% of the expenses. The next 20% of employees will incur another 25%. This represents a population that has emerging or chronic conditions with expenses typically in the range of $10,000-$30,000 annually. That leaves about 75% of employees who incur less than a few thousand per year, including many who never use the plan at all. Under a high deductible plan, many of these employees feel that they are effectively uninsured since they would never have the occasion of meeting their deductible in a given year. Those employees for whom HDHPs work are those who can establish an HSA and adequately fund it.

Employers who endeavor to control premium costs are typically compelled to raise deductibles as an offset. In addition, employers who are paying close attention to their margins will

[33] Mr. Stirling's presentation materials are included in Appendix D.

frequently change carriers from year to year, despite the potential continuity of care disruptions that may occur due to changes in networks. This dynamic precludes the possibility of carriers establishing a longer-term relationship with an employer group, which in turn disincentivizes carriers from taking a longer-term approach to employee health and wellness. In addition, wellness programs are designed more for carriers to evaluate group risk rather than to foster improvements in health outcomes. Carriers also do not share their claims data with employers, which would allow the employers to better assess any changes in the associated costs of their employee health plans.

As for recommendations, Mr. Stirling noted that employers are trending away from increasing deductibles as they view higher deductibles as an impediment to improving the health and productivity of their workforces. He would like to see policies that help employers to incentivize employees to improve health, such as placing primary care and other higher value services in front of the deductible, *i.e.* allowing plans to pay for such services before the patient satisfies her deductible. He would also utilize employee health information for positive discrimination, as allowed by the ACA. For example, an employee with an emerging health issue would be treated more favorably than other employees by having certain services paid for by the plan. He would also recommend greater disclosures of data to the employer, including vendor fees, prescription rebates, group claims experience and provider fees. He further supports certain VBID principles, including narrow networks, but understands the complications and unintended consequences that might flow from some strategies.

Dr. A. Mark Fendrick - University of Michigan, Center for Value Based Insurance Design[34]

Dr. Fendrick is the Director at the Center for Value Based Insurance Design (VBID) at the University of Michigan. He is the architect behind the concept of VBID and a nationally recognized expert on the development, implementation and evaluation of innovative health plan designs. Through his research, Dr. Fendrick has found that scientific innovation will continue to drive up total spending on health care, but that spending can be offset by identifying, measuring and reducing the utilization of low value services. This requires conversations to shift from the cost of care in isolation, and focus on reallocating costs from low value services to higher value services. There is enough money in the US health care system to pay for what is needed, it just needs to be spent differently.

Dr. Fendrick reported on the growth of deductibles and their impact on consumer demand for services. The downward pressure on demand for services that is generated by deductibles and other consumer-facing levers has had no impact on costs because consumers don't care about systemic costs; they only care about what a service is costing them individually. As of last year, 40% of Americans had less than $400 in the bank and don't have the cash flow to meet a high

[34] Dr. Fendrick's presentation materials are included in Appendix E.

deductible. This goes beyond requiring consumers to have “skin in the game.” Rising cost shares are worsening health disparities and adversely affecting overall population health. He characterized the relationship of raising deductibles for the sake of lowering premiums as “a tax on the sick.” However, the alternative equitable approach of raising premiums for all is ineffective because over 50% of consumers don’t utilize their benefits at all in any given year. The more optimal approach is to not raise deductibles or premiums any further, but address the substantial amount of money that is being spent on services that don’t make individuals any healthier.

VBID principles have been introduced into the Medicare program with bipartisan support. Among the strategies that Dr. Fendrick favors are more generous pre-deductible coverage for highly valued “secondary” preventive services that may be even more important to a patient’s health than current “primary” preventive services. If consumers don’t have the money to follow up preventive diagnoses with secondary prevention services, the former is rendered ineffective. IRS Notice 2019-45, which expanded pre-deductible coverage for chronic conditions under HSA-eligible plans, was a step in the right direction, but doesn’t go as far as patients need. The Chronic Disease Management Act of 2019 (bipartisan and bicameral) would markedly expand the IRS list even further.

A corresponding strategy would be to reduce spending on low-value care, including certain diagnostic testing, imaging services and branded drugs. As an example, Dr. Fenrick referenced one study that showed 60 of the most commonly used drug classes could be covered, cost-neutrally, without a deductible by reducing spending on low value services by one percent. Cost shares could still be used to incentivize lower utilization, but those higher cost shares would be applied to low-value services to deter overuse, rather than the current system of applying cost shares on a broader category based on the type of service or place of service.

If existing dollars can be properly reallocated in this way toward high-value services and away from low-value services, the results would be flatter premiums and cost shares and improved patient health. Systems need to become more aggressive in identifying which services are low-value compared to those that are higher value. In response to task force member questions, Dr. Fendrick could not give any opinion on whether or to what extent providers should be indemnified for poor patient outcomes when lower patient utilization of low value services yields the poor outcome, but he did stress that VBID strategies should incorporate increased patient accountability. Patients don’t need to get every service they ask for, but also shouldn’t have to foreclose on their house to get cancer therapy.

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Ann Lopes – Access Health CT, Product Manager[35]

Ann Lopes is the Product Carrier Manager for Access Health Connecticut (AHCT), Connecticut's ACA Marketplace for individuals and small employers. She provided an overview of the products offered through AHCT. The Marketplace is the only place where individuals can qualify for the ACA's advanced premium tax credits (APTCs) and cost sharing reductions (CSR) subsidies. Connecticut has approximately 3.3 million insured residents. Just over one half, about 1.7 million are presumed to be insured by large group and self-insured plans. Another substantial segment of Connecticut residents, about 1.4 million, are insured under government programs including Medicare, Medicaid and Veteran's Affairs, which leaves a small group and individual market of only approximately 230,000 people. In the group market, employers have been shifting the burden of increasing premium costs from the employer share (*i.e.*, employer-paid premiums) to the employee share (*i.e*., patient-paid premiums, deductibles and other patient responsibility) over the last decade.

AHCT requires its participating insurers, Anthem and ConnectiCare, to develop standardized plans as part of their product portfolios. Standardized plans provide for a prescribed measure of the various cost sharing terms for the particular plans, thus allowing consumers to compare plans with similar coverage. Ms. Lopes provided examples of some standardized plan terms. Each plan must comply with federal actuarial value (AV) requirements.

For 2020, the two insurers that participate in the Marketplace have offered a total of two individual plans that are true HDHPs, *i.e.*, HSA compatible plans. The Connecticut Insurance Department reviewed and approved five other individual plans available outside of the Exchange that were identified as HSA compatible, although these may not all be marketed by the submitting carriers. Additional HSA compatible HDHPs are offered through the small group market. In order to qualify as HSA compatible, a plan must comply with IRS requirements, including minimum deductible and maximum out-of-pocket limits, as well as limitations on services that are exempted from applying to the plan's deductible. Cost Sharing Reduction (CSR) plans do not qualify as HSA compatible. Ms. Lopes explained that these limitations make it difficult to design a bronze level plan with a lot of services that would not be subject to the plan's deductible; however, there is one HSA compatible bronze level HDHP that is offered as standardized plan. This plan has not been changed for a number of years. There are not Silver level HSA plans available.

Presently, there are no current offerings on the Exchange without a deductible, unless an individual is between 138%-150% FPL and chooses a Silver plan (with a $900 out-of-pocket max). Based on the information included in the Individual rate filings for 2020 plans submitted in July of 2019, approximately 22,600 individuals in CT were projected by the carriers to be

[35] Ms. Lopes' presentation materials are included in Appendix F.

enrolled in HSA compatible (individual) plans, of which about 15,000-16,000 were on-exchange. Ms. Lopes did not have details (until February 2020) as to how many of those enrollees are subsidized, but a total of about 70% of all enrollees on AHCT get subsidies. She further explained that AHCT has no way of knowing how many individuals on HSA-compatible plans actually open or contribute to HSAs. However, carriers offering plans through AHCT do offer information to enrollees as to how they can set up an HSA account.

Ms. Lopes further discussed consumer education and health literacy initiatives. AHCT recently launched its “choose.use.be well” campaign to help enrollees access and use primary care services. Other education initiatives include healthy chats, in-home events, canvassing, and navigator assistance programs.

Ms. Lopes also reviewed snapshots of the AHCT enrollment portal to highlight plan enrollment and decision-support tools. Some features of these tools help enrollees analyze their current providers and medication costs to forecast their anticipated costs and coverage under various plan options. The tools also include information about network participation, formulary inclusion and total cost estimates that combine premium and cost shares for the identified providers and drugs. Actual plan documents are also available for review for further comparison if desired. In addition, enrollees can link directly to a carrier’s provider search tool. The portal also provides enrollees with a checklist of items they will need in order to complete their enrollments. The portal has another search tool to help identify brokers and navigators to assist with plan selection and enrollment.

Ms. Lopes provided analysis of some of the ideas discussed by task force. She noted that on November 15, 2019, the federal government announced new rules intended to increase price transparency for hospitals and insurers to help consumers identify actual costs for services. Regarding proposals to offer only HSA-compatible plans, such strategies would be contrary to AHCT’s stated mission. With respect to manufacturer coupons, last year’s federal payment notice stated that carriers did not have to apply coupons to a member’s out of pocket max; however, the federal Department of Labor and IRS indicated that this topic would be revisited in the 2021 payment notice.

AHCT’s product design committee has looked into offering VBID features, and further discussion on VBID will come up for the 2021 plan year. One recent modification to the standard plan differentiates site of service cost sharing as a VBID component. Carriers also must be mindful of mental health parity (*i.e.*, federal and state rules requiring parity between medical and mental health coverage) when adjustments to certain cost share can create a disparity, which must be rejected.

Ms. Lopes reiterated the Task Force’s concerns that reforms have to avoid unintended consequences like negating HSA-compatibility.

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Sabrina Corlette, J.D. – Georgetown University Center for Healthcare Reforms[36]

Ms. Corlette observed that the high price of care has been the driver of the high cost of insurance for decades. At end of the day, states have to get at the prices of the providers and the prescription drugs in order to rein in insurance costs. She repeated the findings of other presenters that there is strong evidence that high deductibles, in general, cause delayed or foregone care.

Connecticut has an advantage with respect to its ability to impact costs through plan design, in that its state-run exchange can access data that federal exchange states aren't able to access. Ms. Corlette reviewed what some other states are doing with benefit designs, including standardized plans, prescription cost sharing structures and mandates. She is not aware of any states that have extended standardization into their group markets. There are tradeoffs to standardization. On one hand, you can require pre-deductible coverage of certain services, but because of AV ratings, you would have to raise cost sharing somewhere else. Many states have been wrestling with these tradeoffs. Some states use pre-deductible coverage as a marketing tool to get more people covered or retain enrollment. Washington D.C. and California we offered as examples. Ms. Corlette was not familiar with health outcome data in states where individuals have greater pre-deductible coverage, however, she opined that not much clinical science actually goes into some of the decisions as to what services become pre-deductible.

With respect to prescription drugs, plans have explored changing formulary designs and cost sharing. Some states have limited prescription cost sharing or imposed monthly or annual caps. Some cap specialty drugs. NY bans specialty tiers altogether.

Ms. Corlette also discussed community benefit requirements and federally mandated community needs assessments conducted by non-profit hospitals. There has been an uptick in attention from policymakers at the state level, focusing on bad debt collection practices. Many bad debts are incurred by insured individuals. Approaches to addressing bad debts include hospital spending floors on community benefits (*e.g.*, Illinois imposes a floor equal to the hospital's property tax relief) and limitations on debt collection practices. States also are imposing reporting and transparency requirements, including more frequent or more detailed reporting (such as top salaries). States have also explored conditioning mergers and Certificate of Need (CON) approval on expanding community benefits.

With respect to consumer education, Ms. Corlette opined that decision-support tools are effective, but has not found great data to support that conclusion. She noted, however, that the tools must be available at time of enrollment to be most effective. Most state based exchanges have such tools, and some have been made fairly sophisticated, incorporating

[36] Ms. Corlette's presentation materials are included in Appendix G.

estimated utilization metrics to inform analysis. She noted that visual tools are also important and helpful in improving consumer literacy with respect to many general concepts like cost shares, metal tier levels and how claims are paid and cost shares are applied. She noted that state-based marketplaces spend a substantial amount of resources on navigator funding and advertising, and that CT has increased its funding for navigators. However, navigators don't assist in plan selection. Broker commissions are relatively low for marketplace plans, which can disincentivize brokers from spending time with individuals exploring those plans.

Overall, she has found that consumer satisfaction with exchange products is relatively high – but about 80% don't really use it. She suggested that it would be better to know what the rate of satisfaction is for high-utilizers.

<u>Paul Lombardo – Connecticut Insurance Department</u>

Paul Lombardo is the Director of the Life and Health Division of the Connecticut Insurance Department. He presented an assessment of a few of the recommendations that the Task Force had been considering during its deliberations. First he addressed a concept whereby coverage would be required, pre-deductible, for some or all of the 14 items added to the IRS's safe harbor pursuant to IRS Notice 2019-45. Presently, pre-deductible coverage of those items is optional. If some or all of the items were required to be covered pre-deductible, it would likely increase premiums, although the amount of the increase could not be calculated without further information. It would also create a potential impact on the AV calculator. Whenever you change cost sharing, it can move a given plan outside of a particular metal tier. In addition, carriers would have to recalculate parity to ensure compliance with mental health parity rules.

Regarding a second proposal, Mr. Lombardo noted that mandating pre-deductible coverage of mental/behavioral health and substance abuse benefits would require federal input with respect to HSA-compatible plans. Including first-dollar coverage of such items is unequivocally beyond the IRS safe harbor parameters. With respect to non-HSA plans, this proposal would have similar results as with the mandate of the 14 new safe harbor items. The additional pre-deductible coverage would likely increase premiums, affect AV calculator and require new parity calculations. Mr. Lombardo also recognized that this proposal raised an issue related to "reverse-parity," which prohibits plans from offering first dollar coverage of just mental health services without also establishing comparable coverage for medical services.

In response to Task Force member questions, Mr. Lombardo noted that the mandated coverages discussed above may have the potential for improving health benefits, but because health insurance premium rates are only approved for one year it would be difficult to predict or compare those downstream health benefits with present costs of mandating those coverages. In other words, the premium rate filings cannot capture the potential health savings

beyond the one year rate review period. Rates are reviewed from an actuarial perspective through a well-defined, transparent and public process, which largely occurs from July through September. Rate filings include data regarding utilization, trend and other information. Mr. Lombardo was not aware of any other state that allows for a multi-year rate review process.

Regarding a proposal whereby insurers pay providers the deductible portion of covered charges, and then collect the deductible from members, Mr. Lombardo noted that it might raise issues regarding tax qualified status of HSA-compatible plans. In addition, he posited that carriers' administrative structures are not currently set up to collect deductibles, and that it would potentially increase premiums because if plans paid all the deductible amounts and then had to seek reimbursement from their members, plans would likely end up paying more claim dollars due to uncollectible debts. He is not aware of any similar recommendations being contemplated by the National Association of Insurance Commissioners (NAIC).

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Public Comments

Throughout the sessions, The Task Force was presented with both written and in-person testimony from individuals who have experienced the negative effects of HDHPs. These stories of unaffordable medical care, unpredictability of health care costs, and an ever-increasing financial burden on consumers and businesses went beyond the academic presentations and provided the necessary contextual realities that many Connecticut residents face when it comes to health care and HDHPs.

Lynne Ide, Director of Program & Policy for the Universal Health Care Foundation of Connecticut provided oral and written testimony. She stated deductible costs have increased 162% over the past ten years, and that HDHPs have the effect of leaving many people functionally uninsured. In 2018, a research poll found that 43% of Connecticut residents delayed or avoided necessary care due to the cost. Another study found that HDHPs have yielded 13% reductions in per-employee health care spending, which was almost entirely attributable to underutilization.

Colleen Brunetti provided oral testimony as a patient with a rare disorder that requires her to incur over $250,000 annually just in medication expenses. Her spouse's health plan has an HDHP with an individual out-of-pocket maximum of over $8,000, which she is guaranteed to meet every year. She has had some relief from this financial burden in the past through the use of a copayment assistance card. Recently, however, her health plan stopped applying copayment assistance to her cost share accumulators. She urged the task force to examine this emerging practice by the insurers.

Senator Matt Lesser addressed the task force to express his gratitude for their time and effort in tackling this issue of high deductibles.

Dr. Larry Deutch, former Hartford City Councilman, testified from the perspective of a local government official, a physician and a healthcare consumer. He observed that over the long term, HDHPs have not proven to be a cost benefit to the city. He has seen employees and patients avoid care due to costs, which has negatively impacted overall health of workers, reduced productivity and increased other costs such as workers' compensation. HDHPs have not otherwise had the intended impacts of making consumers more cost-conscious. He further expressed that this trend has had a discriminatory impact on lower-income populations.

Jill Zorn, of the United Health Care Foundation of Connecticut provided testimony that HDHPs do not protect individuals' physical or financial health. She highlighted the attention that Danbury Hospital received as a result of Dr. Villagra's presentation to the Task Force regarding its medical debt collection practices. She further highlighted a consumer story of a professional counsellor who could not access the care she needed because of her high deductible. Other health care professionals have reported that high deductibles are the biggest reasons (up to 30% of patients) for cancellations, no-shows and premature termination of the physician-patient relationship. Other patients cut back on regular therapy. Occurrences are higher in the

early months of the year right after deductibles typically reset. She ended by acknowledging that everyone is going to have to give a little if the task force is going to have an impact on the lives of individuals.

Paula Haney testified that she is a physical therapist, Arthritis Foundation volunteer, and has a child with a diagnosis. Her patients have to be able to navigate options to find what works best. Those with chronic illness don't always understand that low premium = high deductible, which may not be their best option. That deductible might get eaten up in the first month of coverage. Nearly 44% of CT residents have less than $1000 in savings. Thus, people go without necessary services or meds in order to pay household expenses. She suggests that preventive services and maintenance services be pre-deductible.

Jessica Black shared her personal experience as an individual with an HDHP. She was in a car accident in Michigan while she was a student. Medical bills started rolling in. She had a $6,000 deductible for in-network providers. Very few of her medical bills would be covered by health insurance because she was living in Michigan. Michigan's no-fault law required her to use her own auto policy, which did not have medical coverage. Prior to moving there, she had asked about out of state coverage, and was told she would have no problem. After the accident, she was told she should have purchased out of state coverage. Her father pays $600 per month for her coverage. She only received about $3,000 from a settlement with the other driver. She was left paying the balance out of her own pocket. She offered this story as another example of how HDHPs do not work for Connecticut residents.

Tom Lally works with the Connecticut Education Association as an insurance specialist. He works with local unions to negotiate the benefits portions of contracts. More than half of Boards of Education have HDHPs, all with HSAs (unless a member has VA benefits or TRICARE). Some have no deductible funding but share a higher portion of premiums. About 90% of employers contribute to an HSA, which reduces claims costs, thereby reducing trend. His organization assists members in understanding their plans and educating them on how to use the plan. For example, he counsels members who are over 65 and still working on the benefits of postponing Medicare and continuing to fund HSAs through their employer. He gives 90-120 minute presentations at the contract ratification stage of contract negotiations. He covers a lot of material. He believes the ACA excise tax was the driving force behind introduction and increase in deductibles. When it was first introduced, high deductibles were relatively low, and the premium differential between non-deductible plans and HSA plans was about 30%-35%, which was sufficient to fund the HSA. The excise tax led plans to hedge bets against the tax, and the trend for copay plans began to outpace high deductible plans, such that the cost of doing business increased, and the premium differential has narrowed significantly. In fact, most plans now also include post-deductible exposure. As a final comment, Mr. Lally thinks that the Insurance Department should be a participant in the Task Force's work, particularly to address what can't be done with respect to self-insured plans.

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Dr. Victor Villagra, one of the previous Task Force presenters, offered additional public comment suggesting four metrics to accompany proposed Task Force recommendations. With respect to tracking health insurance literacy, he states that annual surveys are a feasible and inexpensive way to follow disparities. He further stated that tracking of small claims initiated by providers would be a good proxy for the ebbs and flows of medical debt and the impacts that HDHPs are having on consumers. Next, he suggested that tracking and publicizing consumer satisfaction scores collected by the Insurance Department would lead to recommendations for improvement in mediocre performances by insurer. Finally, Dr. Villagra expressed a need to establish a baseline for the number of dominated plans made available through the Exchange. (A "dominated plan" is the term for a plan that is always more expensive than at least one other available plan, regardless of the individual's level of utilization of medical services. By definition, a dominated plan from the financial perspective is never the right choice for the consumer.) Without further study, there is no way to know the volume of dominated plans purchased or the economic burden of those purchases. The Health Disparities Institute is available to assist as needed.

Additional written testimony submitted by members of the public is attached as Appendix H.

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Findings of the HDHP Task Force

Based on all of the information received and discussed, the Task Force makes the following findings:

1) Although the reasons for healthcare cost growth are complex and multifactorial, the Task Force finds that healthcare costs are increasing at an unsustainable rate.

The Task Force received substantial evidence regarding the growth of healthcare costs over the last decade or more, all of which demonstrated that healthcare cost increases are outpacing increases in income and are consuming a greater and greater proportion of household resources.[37] For example, government spending on Medicaid and Medicare, per enrollee, have risen 12% and 21%, respectively, since 2008, and private health insurance spending has increased by over 50% during the same time span.[38] Presently, per capita spending on health care in the United States is more than double that of nearly every other wealthy nation.[39]

Due to the complexity of the underlying drivers of health care cost growth, the Task Force does not make any findings as to the causation of cost growth. However, the Task Force acknowledges that the state Office of Health Strategy (OHS) is already leading a coalition of stakeholders who are exploring the establishment of a health care affordability standard and a health care cost growth benchmark in order to address this issue. The Task Force supports OHS's ongoing efforts in that regard.

2) Health insurance premiums and all-in consumer costs are most heavily influenced by the underlying prices of health care services, which may or may not reflect the actual costs of the services.

The Task Force received substantial and largely undisputed evidence that health insurers set premiums, deductibles and other out-of-pocket costs primarily as a reflection of both the prices that the insurer must pay for covered services and the number of times those services are

[37] See, e.g., Appendix I, "The Burden of Health Care Costs for Working Families" published by the Leonard Davis Institute of Health Economics. See also "The Self-Sufficiency Standard for Connecticut 2019" available from the Office of Health Strategy at: https://portal.ct.gov/-/media/OHS/Affordability-Standard-Advisory/Self-Sufficiency-Standard/CT2019_SSS_Web_20191014.pdf?la=en; "What's likely to drive medical cost trend in 2019?" available from PwC's Health Research Institute at https://www.pwc.com/us/en/industries/health-industries/library/hri-survey-2018.html (highlighting that prices, rather than utilization, have driven trend and that those increases are influenced by expanded access points, provider mergers and physician consolidations)

[38] See Appendix G (Corlette)

[39] See Appendix I "Americans' Struggles with medical bills are a foreign concept in other countries," Los Angeles Times, September 12, 2019.

utilized by plan members.[40] Likewise, medical loss ratio (MLR) requirements compel insurers to spend a minimum percentage (80%-85%) of the premiums they collect on member health care expenses.[41] The Connecticut Insurance Department also subjects health insurance premium rates to rigorous actuarial review and approval to ensure that rates are not insufficient, excessive or unfairly discriminatory. As a result, insurers are limited in their ability to increase profit margins or expand other overhead expenses merely by increasing premiums or cost sharing obligations on products subject to regulatory approval.

Instead, the prices of covered services, which must consume at least 80%-85% of premium revenues, comprise the largest driver of health insurance premium and cost share increases. As reflected in the insurers' annual rate filings with the Insurance Department, where premiums have increased, insurers' profit margins generally remain narrow and consistent from year-to-year while the trend factors of price and utilization are more volatile.[42]

3) In order to minimize premium increases, insurers have introduced benefit designs that include increased deductibles and other cost shares.

Increasing a health plan's deductible can be effective at keeping the plan's premiums lower as underlying prices rise. As Dr. Fendrick observed, however, the shifting of costs away from premiums and onto cost-shares can be viewed as a "tax on the sick," in that healthier individuals will enjoy the benefits of the lower premiums while those who need to utilize services during the plan year will incur significantly greater total out-of-pocket expenses.

4) HSAs can be effective at offsetting the cost burdens of a high deductible when an HSA-compatible HDHP participant can reserve the resources to fund the HSA.

As mentioned herein, when an HDHP is HSA-compatible under IRS rules, consumers can take advantage of the three tax advantages of HSAs (tax-exempt contributions, tax-exempt earnings and tax-exempt distributions) to pay for their deductibles and other health care expenses.

In addition, employers who offer HSA-compatible plans to their employees may contribute funding toward the employee's HSA, which further reduces individual cost burdens on the

[40] Using actuarial methodologies, insurers combine prices and utilization of covered services into a factor known as "trend."

[41] See 45 C.F.R. § 158.210.

[42] Connecticut insurers' individual and small group plan rate filings can be obtained from the Insurance Department at: https://www.catalog.state.ct.us/cid/portalApps/RateFilingDefault.aspx. As reflected in the rate filings, risk and profit margins generally fall in the 1%-4% range year over year. Some Task Force members observed that notwithstanding these narrow profit margins, insurers' net earnings, in terms of absolute dollars, have grown substantially over the past several years, potentially reflecting greater profitability in other business areas such as the self-insured ASO (administrative services only) or non-health (e.g., life insurance) markets.

employee. About one quarter of employers, including half of large employers (> 200 employees), offer HSA-compatible HDHPs to their employees.[43] Over the past decade, employee participation in HSA-compatible HDHPs has risen from approximately 6% of covered workers to 23% of covered workers.[44] Up to three quarters of employees covered under their employer's HSA-compatible HDHP receive a contribution from the employer.[45] In 2019, the average annual employer contribution to its employees' HSAs was $572 for single coverage and $1062 for family coverage.[46]

HSA-compatible HDHPs have also experienced slower premium and deductible growth compared with other types of health plans, including non-HSA compatible HDHPs, which further moderates consumers' out-of-pocket cost burdens. As of 2019, the average annual premium for HSA-compatible HDHPs was $6211 for single coverage and $18,433 for family coverage, with employers covering approximately 75%-85% of those premiums. In addition, the average annual deductible for HSA-compatible HDHPs in 2019 was $2476 for single coverage and $4673 for family coverage.[47] This represents an increase of 25% and 29%, respectively, over the past decade. By comparison, deductibles under non-HSA compatible health plans have more than doubled over the same time period.[48]

5) <u>HSA-compatible HDHPs are most effective when members can reserve funds and utilize an associated Health Savings Account.</u>

In order to realize the most benefits of an HSA-compatible HDHP, consumers must have the resources available to direct funds into their HSA. Accordingly, HSA-compatible HDHPs typically work better for higher-income, higher-asset families who can afford to pay into the HSA, or who receive a substantial employer contribution, in order to meet the high deductible. The same plans are experienced as underinsurance or lack of insurance by moderate- and lower-income families.

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[43] See Kaiser Family Foundation 2019 Employer Health Benefits Survey, as referenced by Mr. McKechnie during his presentation, available at https://www.kff.org/report-section/ehbs-2019-section-8-high-deductible-health-plans-with-savings-option/

[44] Id.

[45] Id. Note that a disproportionate number of employees who receive employer contributions are employed by larger employers, as approximately half of smaller employers offer no contribution to their employees' HSAs.

[46] See id. As noted in the survey, the overall average HSA contributions include the portion of covered workers whose employer contribution to the HSA is zero. When only firms that contribute to employee HSAs are included in the calculation, the average employer contribution for covered workers is $768 for single coverage and $1,433 for family coverage.

[47] Id.

[48] Id. See also Appendix C (McKechnie)

6) Funding for HSAs can come from account holders, employers or any other public or private source, including a state or federal entity, as long as total contributions are within the applicable annual limits set by the IRS.

The Task Force notes that IRS rules apparently permit anyone, including public and private entities, to contribute to an individual's HSA. Although the traditional funding sources are primarily individuals and their employers, other sources such as state and local governments, foundations, charities and other entities could also make contributions within the IRS' annual limits.

7) Non-HSA HDHPs have some advantages over HSA-compatible HDHPs.

Although HSA-compatible HDHPs come with the advantages described above, non-HSA HDHPs can offer certain benefits that are not available under HSA-compatible HDHPs. Primarily, non-HSA plans have greater flexibility to cover additional services on a pre-deductible basis that are not included on the IRS's safe harbor list. For example, a non-HSA plan design might include 100% coverage for regular breast cancer screening by ultrasound, though this would be prohibited for an HSA-compatible plan. In this way, non-HSA HDHPs can offer consumers additional choices in the marketplace when shopping for coverage.

8) High deductibles can present an impediment to medically necessary care when consumers delay or avoid care due to lack of resources to meet their deductible.

The Task Force received substantial evidence from the presenters that some individuals with high deductibles will delay or forego care because they don't have the resources to meet their high deductibles and other out-of-pocket expenses. Providers have observed that patients tend to schedule fewer appointments and procedures, and cancel or fail to show for appointments at a higher rate, at the beginning of a calendar year, as compared with the end of the year. As a further barrier to care, some providers will refuse to see patients who have presented for a scheduled appointment unless the patient pre-pays for his or her out-of-pocket cost obligation.

9) For a certain segment of the population, high deductibles can lead to incidences of medical debt, which in turn can lead to bankruptcies, collections activities and other household stressors, including negative effects on physical and mental health on individuals.

The Task Force received substantial and compelling evidence regarding the connection between consumers' inability to meet high deductibles (and other cost sharing obligations) and medical debt, and its downstream financial and health consequences. In particular, the research presented by Dr. Villagra and the UConn Health Disparities Institute (HDI) elucidated the

prevalence of medical debt and medical debt collection activities through small claims litigation. The Task Force adopts the following findings of Dr. Villagra and the HDI's research:

- Nearly a quarter of insured individuals experience medical debt
- Of those individuals, 43%-67% have exhausted their savings to pay bills
- 16% have been subjected to collections activity
- Up to 62% of bankruptcies are related to medical debt[49]
- Between 2011 and 2015, providers in Connecticut filed 85,136 small claims actions and obtained judgments totaling over $110 million, most of the time without any appearance from the defending patient

These consequences of medical debt and medical debt collection activities further impact individual and social health outcomes. As noted by Dr. Fendrick, rising out-of-pocket costs create and exacerbate health disparities, particularly among economically vulnerable individuals and those with chronic conditions.

10) <u>Plan complexity, pricing opacity and various cost sharing mechanisms result in consumer inability to predict and budget for their annual health care costs.</u>

The research of Dr. Villagra and the Health Disparities Institute was particularly insightful with respect to health care and health insurance literacy among consumers. More than one-third of consumers lack a sufficient understanding of some of the basic features of their health plans, including annual deductibles, annual out-of-pocket limits and formularies. [50] Furthermore, when these data are examined in relation to consumer ethnicity and race, disparities in health care literacy begin to emerge, reflecting a greater negative impact on communities of color imposed by the complexity of the health care and health insurance system.

As a result of suboptimal health care and health insurance literacy, consumers who lack adequate knowledge or assistance frequently select health care plans that are not best suited to meet their individual health care needs, either by over-insuring or underinsuring themselves. Unfortunately, this phenomenon is sometimes exacerbated by the availability of too many consumer choices, resulting in information overload and causing consumers to disengage from plan comparison activity.

These problems are further exacerbated by the lack of access to specific pricing information with respect to health care services, which vary by plan, provider, setting, network status and

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[49] This particular finding is consistent with the findings of other researchers. See http://medicaldebthub.com/2019/03/podcast-authors-of-end-medical-debt-discuss-the-problem-and-their-solutions/

[50] See Appendix A (Villagra). Dr. Villagra further emphasized that while his research characterized the issue in terms of consumer literacy and understanding of the terms of their healthcare plans, the primary issue is the plans are too complex and should be simplified as a means of improving consumer comprehension.

several other factors. In the absence of such pricing information, particularly at the point of plan selection, consumers are unable to compare accurately the suitability of plan choices, even if they fully understand the plan's cost sharing structure and other features.

11) Improvements in healthcare literacy would positively impact consumers' ability to select plans that best fit their needs and to utilize their selected plan efficiently.

The Task Force finds that consumers may benefit from efforts to improve population healthcare literacy in order to improve consumer plan selection efforts and help consumers optimize the use of the plans they select. The Task Force acknowledges the efforts of Access Health CT to improve consumer literacy via initiatives such as Healthy Chats, and improvements in its online plan selection tools. While the Task Force encourages Access Health CT to continue to build upon those efforts, it also finds that more support is needed to assist consumers with plan selection and utilization both at the time of enrollment and throughout the term of the contract.

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Recommendations Supported by the Task Force

The Task Force was presented with a number of proposals for possible reforms that would potentially address some of the issues related to HDHPs, as described in this report. The reform ideas discussed by the Task Force were generated from a number of sources including the formal presentations, written materials distributed to members and from Task Force member discussion. Many of the proposals were adopted as recommendations for the General Assembly to consider for further action. The following section of this report provides a summary of the proposals supported by the Task Force, including a synopsis of the Task Force's discussions regarding each recommendation.

1. Healthcare Literacy and Education

The Task Force received evidence that consumer literacy around healthcare and health insurance is a significant factor when consumers choose plans that are economically dominated or are not right for their situation, and also when consumers become dissatisfied with plans that have, or are perceived to have, high deductibles and cost sharing. In addressing healthcare literacy, the Task Force makes several specific recommendations. An overarching recommendation is that the state should consider piloting multiple initiatives in consumer literacy in order to see which initiative or initiatives are especially effective at improving consumer choice and satisfaction. Members of the Task Force cautioned, however, that efforts to improve consumer literacy might be economically inefficient if they add significantly to the costs of care.

Establish public-private partnerships to improve health insurance literacy. (6)[51]

A majority of the members of the Task Force supported this recommendation. The lessons that consumers learn about their health coverage are often lessons learned after an expense has been incurred. Information from the UConn Health Disparities Institute suggests that there is an opportunity to prevent these expensive lessons through partnership between the state and educational, social service, and community organizations. While the Task Force is supportive of this recommendation, it does not identify specific partnerships for recommendation, and notes that multiple programs may need to be piloted and measured for sufficient outcomes to ensure a positive return on investment of resources.

Explore expanding access to health plan navigators. (1), (6)

A majority of the members of the Task Force supported this recommendation. The Navigators provide assistance to individuals before and up to the point of enrollment; however, Navigators are not able to recommend that a consumer choose a particular health plan. The state should

[51] The numbers in parentheses refer to the seven statutory charges of the High Deductible Health Plan Task Force, found in Public Act 19-117 §§ 247(b)(1) through (b)(7).

examine whether there is an opportunity to provide additional effective consumer health literacy interventions through the Navigator program.

Improve transparency regarding provider billing and reimbursement practices and claims experiences. (1), (2), (4), (6)

A majority of the members of the Task Force supported this recommendation. However, the Task Force is also aware of the state's ongoing efforts to increase transparency in healthcare costs, including but not limited to the All-Payer Claims Database and HealthscoreCT cost estimator. Carriers also have improved the tools available to their customers in this regard. The Task Force encourages the state and the carriers to continue and expand these efforts.

Improve information presented to consumers regarding total costs of healthcare coverage both on and off the Exchange. (2), (6)

A majority of the members of the Task Force supported this recommendation. The Task Force is aware that Access Health CT is continually working to provide consumers with additional information that can assist in making health coverage choices. For example, upgraded planning tools help consumers understand a health plan's potential annual fixed costs (premiums) and annual maximum costs (deductible plus out-of-pocket max). These tools could be enhanced to also provide additional metrics, such as the likelihood of a household of *n* size experiencing a major medical event, or an individualized prediction of annual health expenditures under a particular plan based on prior claims data. Information from the HDI suggests that more work can be done here, and the Task Force encourages improvement in this area.

Increase public awareness of the availability of pre-deductible preventive services. (1), (2)

A majority of the members of the Task Force supported this recommendation. The Task Force received evidence from several presenters that the presence of high deductibles served as an obstacle to consumers seeking even preventative care that would be covered pre-deductible under the ACA. The reasons for this are myriad, including: consumers may not trust that their procedures will be billed or adjusted appropriately; providers may not be able to state ahead of time whether a procedure is preventive or diagnostic; and consumers fear that preventive services may lead to expensive diagnostic follow-up which hits the deductible. The Task Force feels that improvement in consumer education about the availability and scope of preventive services will have a positive effect on uptake of these higher-value services.

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2. Cost Sharing Reforms

The Task Force considered several proposals that contemplated reforms to the way that insurers could utilize deductibles and other cost sharing to spread risk, reduce premiums, address underlying costs and otherwise address the negative impacts felt by consumers.

Shift HDHPs toward VBIDs with an emphasis on high-value care. (1), (2)

A majority of the members of the Task Force supported this recommendation. Regarding this proposal, the Task Force endorses a shift towards VBID (value-based insurance designs), which may include designs that increase cost shares on low-value services and decrease cost shares on high value services.

Healthcare Affordability. (1), (2)

A majority of the members of the Task Force supported this recommendation. The Task Force considered the concept of tying cost-sharing to affordability, and ultimately concluded that it would defer to the work of the Office of Health Strategy with respect to the development of a healthcare affordability standard.[52]

Consider allowing for pro-rating deductible for new enrollees in the middle of plan year. (1), (2), (4)

A majority of the members of the Task Force supported this recommendation. The Task Force considered a requirement that health plans must pro-rate deductibles for members who enroll in the middle of the plan year. While some members of the Task Force generally endorsed this concept as a matter of fairness, Task Force members also recognized the difficulties of administering such a requirement, including its impact on the rate setting process, as well as unanswered questions regarding the compatibility of such a requirement with IRS rules regarding HSAs.

Consider allowing for deductible credits for enrollees who switch from plan to plan during a plan year. (1), (2), (4)

A majority of the members of the Task Force supported this recommendation. The Task Force also discussed this concept on general fairness principles, acknowledging the financial burden of consumers having to meet two full deductibles within the same year when they switch from one plan to another – typically in connection with a job change. Similar to the concerns

[52] See Appendix J.

regarding pro-rating of deductibles, however, Task Force members recognized similar concerns regarding administration and impact on HSAs. In addition, this proposal was further complicated by the fact that not all plans are on a calendar year renewal, which would result in further logistical obstacles and other complex issues with implementation. Also problematic is the mixing or overlapping of markets. The Task Force further noted that such a proposal would have to also consider credits toward maximum out-of-pocket limits.

Make carriers responsible for paying deductibles to providers and collecting those payments from their insureds. (7)

A majority of the members of the Task Force supported this recommendation. The Task Force engaged in substantial debate regarding a proposal that would shift the risks and administrative burdens (including costs) of collecting deductibles from providers onto insurers. The Task force recognizes that any additional cost share shift from deductibles onto copayments or coinsurance would be equally detrimental to the doctor-patient relationship. In light of the evidence regarding the relationships between high deductibles and medical debts, many Task Force members viewed this proposal as an opportunity to preserve the provider-patient relationships (particularly among smaller provider groups) that are harmed by debt collection activities and avoidance of care, which can also impact patient and population health. Some Task Force members also predicted that the additional certainty of receiving payments for services would lead to more providers joining carriers' networks and thereby improving access to care.

Other Task Force members raised concerns that implementation of this proposal may result in greater premiums due to the increased administrative burdens on carriers to set up systems for tracking and collecting cost shares. Other task force members cited these burdens are already reflected in provider administrative burdens. It also was not clear to the Task Force whether or to what extent this burden shift would translate into reductions in provider prices for the cost of services. Task Force members also raised concerns about unintended consequences. For example, Task Force members were concerned about whether unpaid deductibles could lead to disenrollment, and how carriers would establish proper accounting of the cost shares among its actuarial and other reportable calculations such as minimum loss ratios (MLR). Another open question concerned the impact of such a cost shift on HSA-compatible plans and whether the result would destroy the tax benefits of the HSA. Regarding this issue, the Task Force was presented with legal memoranda from the law firms of Husch Blackwell and the Groom Law Group,[53] presenting competing opinions regarding the effect of this proposed shift on HSA utilization and compliance. In order to resolve this conflict, a final opinion would be required from the IRS itself. A majority of members of the Task Force strongly support this proposal, while a minority expressed fierce opposition.

[53] See Appendix K

Recommend to expand the Chronic Disease Management Act of 2019 to include Mental Health and Substance Abuse services.

A majority of the members of the Task Force supported this recommendation. The Federal Chronic Disease Management Act of 2019 expanded the covered services that were eligible as pre-deductible interventions. This recommendation reflects the value in supporting mental health services and the significant challenges that arise when mental health care is delayed or avoided due to costs to the consumer. The Task Force received feedback from the CT Department of Insurance that this may create reverse-parity issues that would need to be further explored by regulators.

For non-HSA eligible HDHPs that would not require an expansion of the Chronic Disease Management Act of 2019, the Task Force recommends including Mental Health and Substance Abuse services as pre-deductible services and subject to co-payment.

3. Health Savings Accounts

In light of the substantial evidence regarding the advantages of HSAs, the Task Force considered several proposals that could potentially increase access to HSAs and the appurtenant tax benefits, particularly among lower-income consumers. The Task Force acknowledges, however, that HSAs are a creature of Federal law and regulation, and fundamental reforms to HSAs or qualified HDHPs would require Federal action. Nevertheless, the state may take some more limited actions to improve HSA-qualified HDHPs without Federal action. In addition, the state may wish to recommend some potential reforms to members of its Congressional delegation or other Federal regulators. These are the potential reforms that the Task Force has considered:

Allow enrollees in Medicare Part A to continue contributing to HSAs. (3)

A majority of the members of the Task Force supported this recommendation. As noted, this proposal would require Federal action in order to implement, which the state may recommend to Connecticut's congressional delegation.
At the present time, individuals who have enrolled in Medicare Part A are not eligible to contribute to HSAs. Individuals who have not enrolled because they have creditable employer-sponsored coverage through a qualified HDHP can continue to contribute to the HSA after age 65. Changing this policy would enable enrollees in Part A to contribute pre-tax dollars through an HSA for qualified medical expenses, including payment of long-term care premiums.

Allow spouses to make HSA catch-up contributions above current allowable limits. (3)

A majority of the members of the Task Force supported this recommendation. As above, this would require Federal action, but it would expand consumer access to pre-tax dollars in order to make payments toward medical expenses.

Allow consumers who are in an HSA to direct any state tax refund to their HSA instead of another personal bank account, and if possible allow them to exclude the refund amounts paid into their HSA from their federal income for the next year. (2), (3)

A majority of the members of the Task Force supported this recommendation. HSAs are ordinary deposit accounts which receive special tax treatment from the IRS. The Task Force is not aware of any impediment to individuals directing their tax refund dollars to an HSA so long as their total annual contribution remains below the IRS limit. Nudging HSA-qualified consumers toward contributing to their HSA may encourage those consumers to use their HDHPs. The Task Force notes that this may already be permissible, as people who get refunds *via* direct deposit maybe already can choose for the money to go to an HSA. If this is already permissible, the Task Force would recommend having the Department of Revenue Services (DRS) publicize this option at the point of filing.[54]

When considering measures to provide healthcare coverage cost relief to consumers, or to otherwise create market-based incentives to drive healthcare costs down, consider alternatives that use state, federal, AHCT, or private funding to give consumers direct individual control over their healthcare dollars by funding individual HSAs, in addition to more traditional subsidization or cost-shifting strategies, such as reinsurance, cost-sharing reductions, or others. (1), (2), (3)

A majority of the members of the Task Force supported this recommendation. The State should adopt a policy of examining, for any future funding stream related to health coverage, whether direct contribution to HSAs would be an efficient and effective form of relief for CT consumers. Members of the Task Force noted that it is helpful for consumers to have funded their HSAs earlier in the year to overcome the problem of a high deductible being an impediment to seeking treatment.

[54] The Task Force further notes that if this option is available, individuals will need to be mindful, or reminded, that deposits from all sources cannot exceed the IRS's annual limits without incurring a tax penalty.

4. Financial relief

In addition to other financial reforms discussed above, the Task Force considered several concepts for providing further financial relief to consumers enrolled in HDHPs under current market conditions.

Support the existing initiative at the Office of Health Strategy as it pertains to a healthcare affordability standard. (2)

A majority of the members of the Task Force supported this recommendation. The Task Force noted with approval an existing initiative at OHS to identify a Healthcare Affordability standard, and recommends that the state continue to support those existing efforts. At the same time, members of the Task Force noted that health care costs and/or prices are complex, that consumers have very different health care needs and abilities to pay for treatment and insurance, and that a one-size-fits-all approach may not serve to identify when health care costs have exceeded a uniform Affordability Standard.

The Task Force is cautiously supportive of provisions to protect consumers from medical debt collection practices, such as defenses regarding the lack of transparency in the calculation of the medical debt, or a right for consumers to receive an itemized medical bill that is accessible to a layperson, prior to judgment. (2)

A majority of the members of the Task Force supported this recommendation.

5. Cost & Quality Control

The final group of proposals considered by the Task Force centered around establishing mechanisms for slowing the rate of cost growth and improving the quality of delivered services. Given that one of the Task Force's primary findings is that healthcare costs are increasing at an unsustainable rate, the Task Force explored several cost growth containment concepts for recommendation to the General Assembly.

Implement Value Based Insurance Designs (VBIDs). (1), (2)

Establish means for evaluation low- vs. high-value care. (1), (2), (6)

A majority of the members of the Task Force supported this recommendation. As noted in connection with its Cost Sharing Reform Recommendations, the Task Force views VBIDs favorably and notes that implementation of such product designs will require further exploration of which services may be deemed low-value vs. high-value, and under what circumstances those designations may apply.

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Encourage all fully-insured non-HSA eligible HDHP plans in the state to cover as many as possible of the new optional IRS list of covered services/chronic conditions, and urge insurers to include pre-deductible coverage of the IRS list in HSA-eligible plans. (1)

A majority of the members of the Task Force supported this recommendation. The Task Force recognizes that the IRS safe harbor list is largely, if not entirely, comprised of services that are very high in terms of value or return on investment. Accordingly, the Task Force recommends that HDHPs be encouraged to voluntarily cover safe harbor items pre-deductible whenever possible, and within any further limitations under IRS guidelines, as part of a broader effort to implement VBIDs. In addition, the Task Force recommends that a mechanism be put into place to attempt to capture the health outcomes as a result of such coverage, which can be compared to the increased costs that may be imposed through increased premiums or cost shares (if any). Since covering these new services is optional, it is appropriate for the Task Force to encourage carriers to consider offering plans that do cover these new services.

Promote performance-based goals for improvement within certain data points reported on the Consumer Report Card. (2)

A majority of the members of the Task Force supported this recommendation. In general, the Task Force recommends that any reforms intended to have a particular impact should be accompanied by appropriate tools to measure and report on the actual impact to determine whether the intended result was obtained.

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Reform Proposals Rejected by the Task Force

As discussed above, the Task Force considered a number of reform ideas that it did not support. The following section summarizes the Task Force's discussions regarding each of the rejected proposals, and reasons therefore.

Documented advice given by Customer Service Representatives (CSRs) over the phone to consumers should take precedence over plan terms inconsistent with specific verbal representations. (4), (6)

A majority of the members of the Task Force rejected this recommendation. This proposal arose from the experiences of staff at the state Office of the Healthcare Advocate (OHA) who hear complaints from consumers who sought answers regarding how their plans work and were misinformed about coverage and benefits by insurers' CSRs. Although Task Force members acknowledged that consumers should not have to bear the consequences of such misinformation, the Task Force was concerned about unintended consequences, particularly the likelihood that carriers would respond by limiting the assistance that CSRs would provide in response to consumer inquiries, thereby leading to even poorer customer service experiences. Task Force members further recognized that plans already must provide a rigorous appeals process to consumers, which can resolve such disputes, and that consumers also have the ability to avail themselves of the services of OHA, which has among its core mission assisting consumers in navigating their health plans. The Task Force therefore did not endorse this proposal.

Provide and promote incentives to encourage members to seek care early in the plan year, such as insurers allowing providers to waive collection of copay/coinsurance for primary care sought in first quarter of plan year. (1), (2)

A majority of the members of the Task Force rejected this recommendation. This proposal was generated in response to evidence that was presented on the tendency of individuals to schedule appointments for the end of the year, after their deductible has been met. However, Task Force members acknowledged that asking individuals to come in early may not be the solution, as it could result in tipping the scale too far in the opposite direction.

Explore redefining HSA eligibility on the basis of metal tiering levels rather than size of deductibles and out-of-pocket maximums. (3)

A majority of the members of the Task Force rejected this recommendation. As with other proposals that have to do with HSA eligibility , this would require Federal action, but it would expand consumer access to pre-tax dollars in order to make payments toward medical

expenses because more plans would qualify as HSA-compatible based on metal tiering, as opposed to deductible and out-of-pocket limits.

Require AHCT to explore, and if legally permissible, require only HSA-eligible HDHP plans. (3)

A majority of the members of the Task Force rejected this recommendation. The Task Force considered recommending that the only high deductible plans on the AHCT exchange be HSA-qualified HDHPs. However, because Federal requirements for HSA-qualified HDHPs are very narrow, the Task Force did not feel there was enough space within the Federal requirements to design an HSA-qualified plan that is appreciably different from the existing offerings. In addition, this proposal has the potential to dramatically reduce consumer choice, in that non-HSA-compatible plans that offer pre-deductible coverage beyond the IRS safe harbor would be unavailable, although the Task Force did receive some evidence that excessive consumer choice in the complex world of health insurance is also detrimental to consumers' ability to engage in "just right" plan selection. Overall, the Task Force did not support this recommendation.

Endorse using federal or any other new state or private subsidy money to fund HSAs for subsidized enrollees, and possibly go as high as possible up the income ladder with HSA funding. (2), (3)

A majority of the members of the Task Force rejected this recommendation. It was suggested that the state should consider the impact of applying health care funding dollars directly to the HSAs of consumers in qualified HDHPs. A growing body of research shows that, in general, direct cash payments to consumers are highly effective in relieving the effects of poverty and financial distress, when compared to non-fungible services having the same cost to the state. Directly funding the HSAs of consumers, starting with subsidy-eligible enrollees and proceeding as far up the income ladder as possible, could be an efficient way to relieve CT consumers of a portion of their health care costs.

In-network rate negotiation protection: If high deductible enrollees can show that their carrier's negotiated rate is above a localized benchmark (say 60th percentile of commercial plan payments) for that service, procedure, or drug, limit the patients' liability to the provider to the amounts up to the benchmark. The provider can collect the balance directly from the insurer who negotiated the rate. (1), (2), (7)

A majority of the members of the Task Force rejected this recommendation. Some members felt strongly that this proposal is a matter of fairness to consumers, who must count on their carriers to negotiate good prices. Particularly in high deductible health plans, the consumer pays the full rate that has been negotiated between the carrier and the provider, but the consumer has not negotiated that rate and in many cases has not even seen the rate prior to

treatment. Where the negotiated rate is above the benchmark the carrier should bear the cost for failing to negotiate it down.

Others on the Task Force pointed out that providers negotiate rates in the context of a total package of services that they provide, and that a provider or insurer may want to incentivize the provision of a particular service in a particular provider for myriad reasons. Members also expressed concern that the additional payments by the carriers would eventually be passed on to consumers in the form of higher premiums. Others also felt that it would be more appropriate to compel the provider to accept the benchmark rate. There is also a practical question of how the benchmark rate is to be determined for a particular location.

Establish rules aligning prices of healthcare services with actual costs. (2)

A majority of the members of the Task Force rejected this recommendation. The Task Force ultimately rejected this concept on the basis that it assumed without sufficient evidence that prices don't align with costs, and fails to account for the variety of costs that are considered in the overall delivery of care, which include provider services, other fixed costs, cost shifts due to governmental reimbursement rates, administrative burdens of payment and collection activities, and investments in capital, programs and innovations. The Task Force further contemplated that this issue would be explored further pursuant to the Governor's executive order.

Address defensive medicine. (1)

A majority of the members of the Task Force rejected this recommendation. Members of the Task Force felt that this recommendation was outside of the scope of its charge, and at best was one of the myriad complexities discussed under Finding #1 (regarding underlying costs of care).

Address high cost of training clinicians and physicians. (1), (2)

A majority of the members of the Task Force rejected this recommendation. Members of the Task Force felt that this recommendation was outside of the scope of its charge, and at best was one of the myriad complexities discussed under Finding #1 (regarding underlying costs of care).

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Require copays and, possibly, coupons, to count towards deductibles and out-of-pocket maximums for non-HSA plans.

A majority of the members of the Task Force rejected this recommendation, as it presented numerous administrative complications regarding the tracking of coupons, and overall impact of coupons on efforts to get individuals to use less expensive (higher-value) drugs more efficiently. In this context, it was noted that the United States is one of only two countries that allows advertising of drugs on TV.

Facilitate new entrants into the health insurance marketplace.

A majority of the members of the Task Force rejected this recommendation. The Task Force generally supported the idea of new entrants into the health insurance market but several members expressed concerns if the new entry is a public option. Those concerns arose from past experience with under reimbursement by government payers and the resulting cost-shifting onto other commercial payers. Others felt that this recommendation does not present a solution to HDHPs or underlying health care costs, and in any event, endorsement of this recommendation or a public option would be outside of the scope of the Task Force's charge.

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Conclusion

The members of the High Deductible Health Plan Task Force wish to thank the General Assembly for this opportunity to study the healthcare and health insurance landscape in Connecticut, particularly as it relates to HDHPs. We hope that the research, evidence, ideas and recommendations offered in this report will be a useful resource to policymakers as they continue to wrestle with the healthcare access and coverage challenges faced by our state and its communities.

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Appendix A

UCONN HEALTH | Bioscience Connecticut Health Disparities Institute

High Deductible Plans A Product Assessment from the Consumer Perspective

High Deductible Plan Task Force
August 6, 2019

Victor G. Villagra, MD
Associate Director
UCONN Health Disparities Institute

UCONN HEALTH | Bioscience Connecticut Health Disparities Institute

UCONN Health Disparities Institute
Health Insurance Advance Initiative

A five-year project aimed at enhancing the value of health insurance for all CT citizens but especially for people at the highest risk of experiencing healthcare inequities

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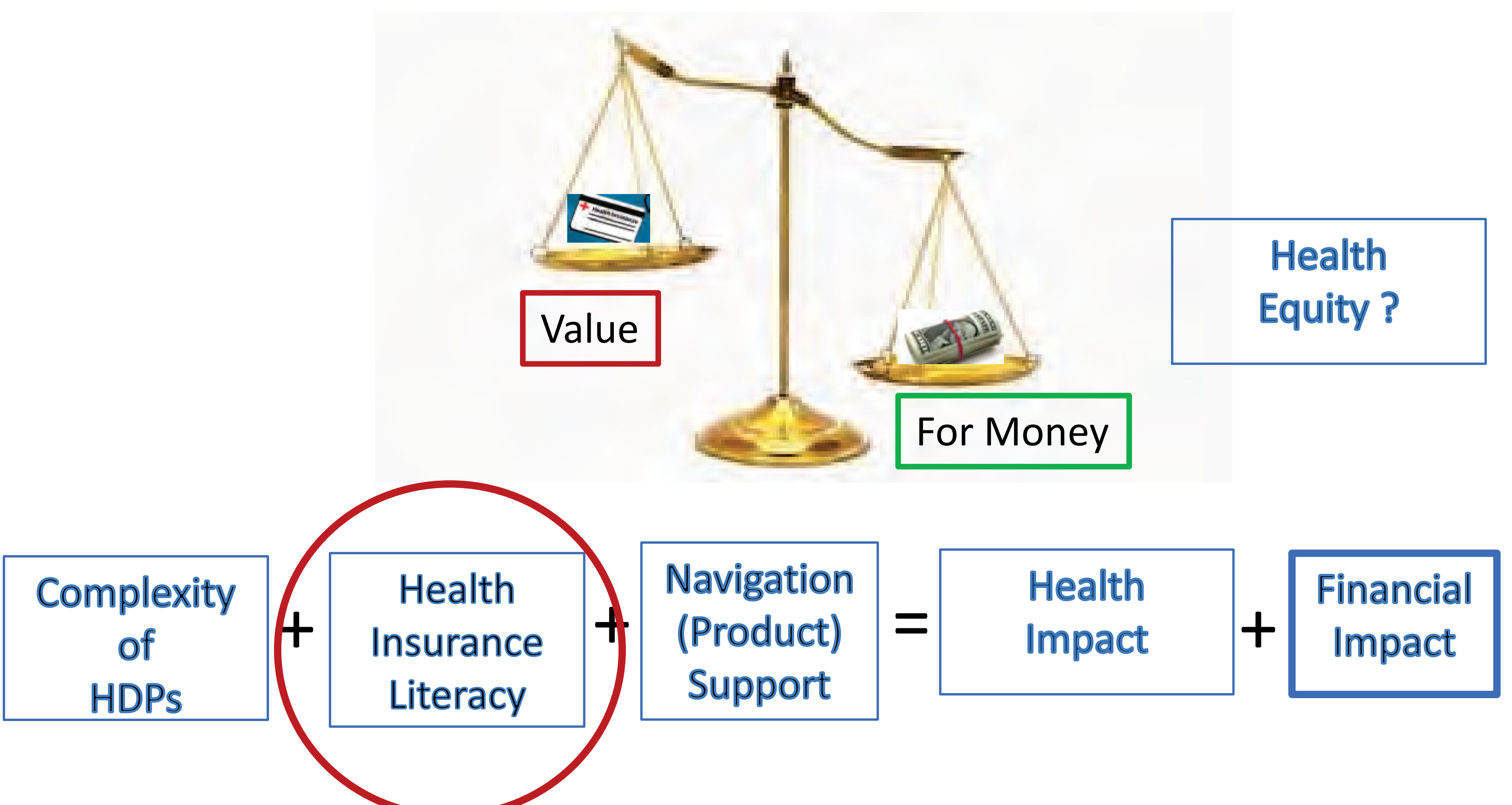
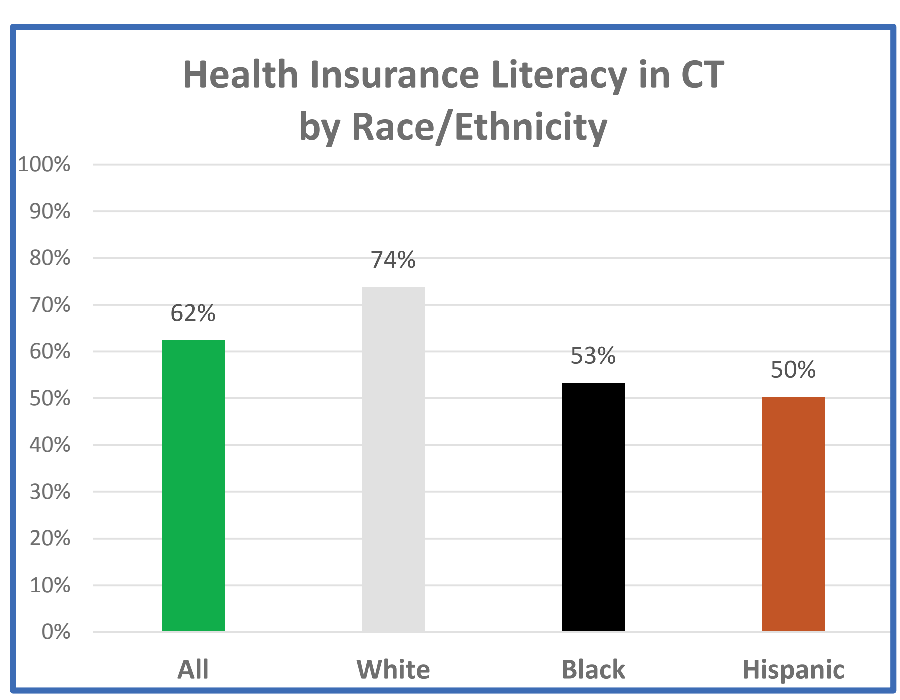
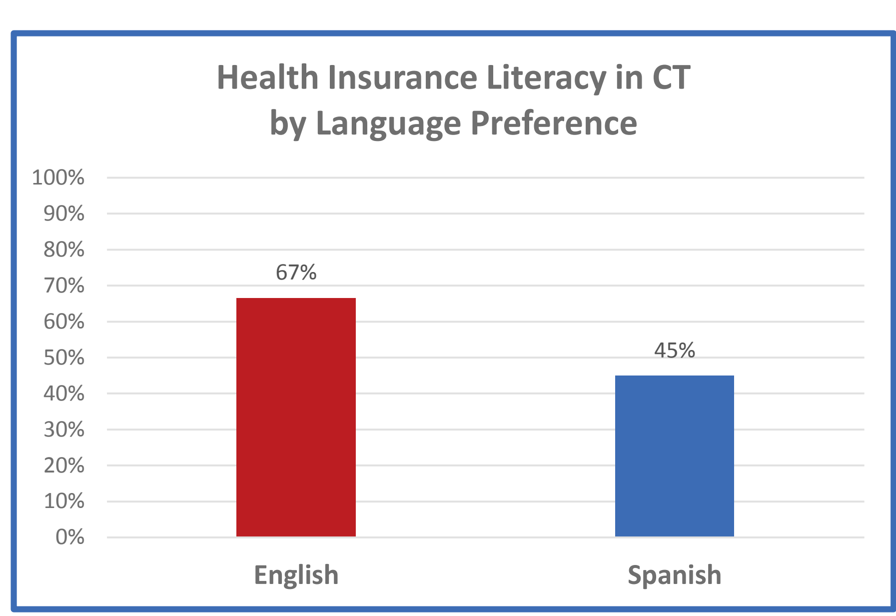


1. Health Insurance Literacy: Consumer Understanding of Basic Features of HDPs

Survey: Statewide, % correct answers to 13 basic concepts





Reference: Am J Manag Care. 2019;25(3):294-e298

UCONN HEALTH | Bioscience Connecticut
Health Disparities Institute

1. Health Insurance Literacy in Connecticut by Race/Ethnicity and Language Preference

HIL question	All	White	Black	Hispanic	English	Spanish
Premium definition	75%	88%	66%	61%	80%	56%
Premium Payment	94%	98%	94%	88%	96%	84%
Annual Deductible	64%	**85%**	**44%**	**42%**	**72%**	**29%**
Hospital Bill Amount	31%	44%	25%	15%	37%	7%
Annual Out of Pocket Limit	**55%**	**70%**	**42%**	**39%**	**60%**	**31%**
Copay	78%	89%	71%	63%	83%	54%
Health Insurance Formulary	36%	44%	27%	29%	37%	30%
Provider Network	73%	**89%**	**60%**	**57%**	**79%**	**49%**
Inpatient Care	45%	47%	34%	51%	44%	50%
Appeal Definition	68%	80%	63%	51%	74%	44%
Appeal True or False	83%	91%	75%	76%	85%	77%
Information Source	58%	72%	48%	41%	64%	32%
Less Choice HMO vs PPO	51%	61%	44%	40%	53%	41%
Percent correct of all 13 HIL	62.4%	73.8%	53.3%	50.3%	66.5%	44.9%

Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference

Am J Manag Care. 2019;25(3):294-e298

Percentage of Correct Answers by Race, Ethnicity and Education Levels

	Whites	Blacks	Hispanic
High School	49	17	16
Bachelor's Degree	74	43	41

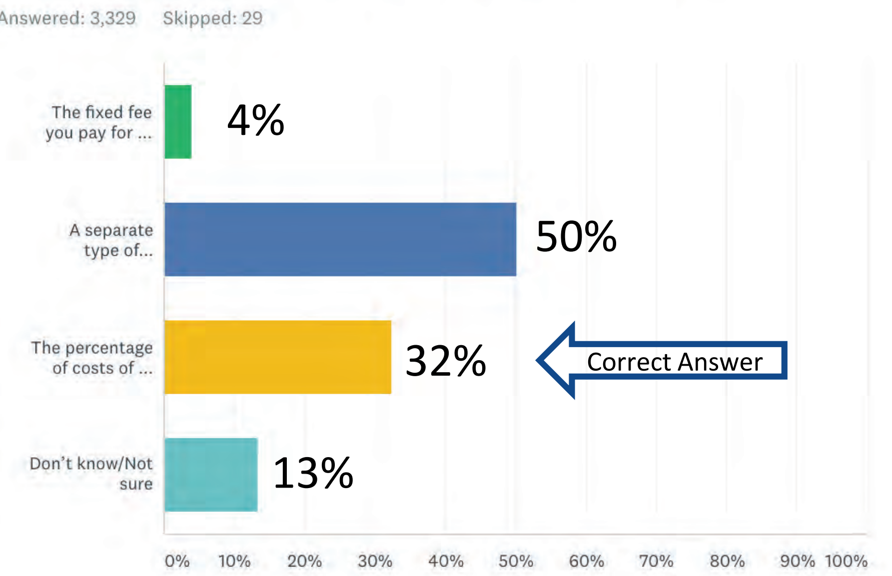
Figure 1: Health Disparities Institute, 2016

UCONN HEALTH

Bioscience Connecticut

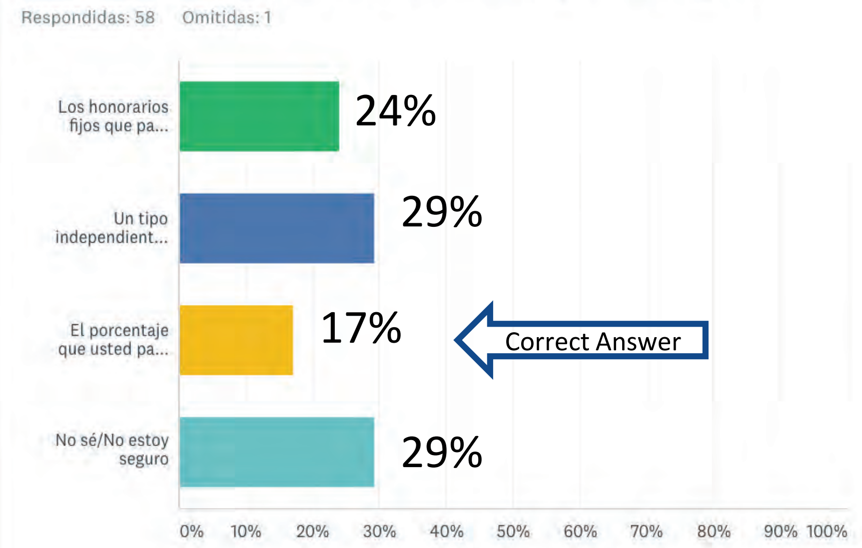
Health Disparities Institute

HDI-AHCT Insurance Literacy Survey (2018)



QUIZ STATISTICS			
Percent Correct 32%	Average Score 0.3/1.0 (32%)	Standard Deviation 0.47	Difficulty 1/12

ANSWER CHOICES	SCORE	RESPONSES	
The fixed fee you pay for a doctor visit or other health care service.	0/1	4.06%	135
A separate type of insurance to cover additional services.	0/1	50.20%	1,671
✓ The percentage of costs of a covered health care service you pay.	1/1	32.41%	1,079
Don't know/Not sure	0/1	13.34%	444
TOTAL			3,329



ESTADÍSTICAS DEL TEST			
Porcentaje de correctas 17%	Puntuación promedio 0,2/1,0 (17%)	Desviación estándar 0,38	Dificultad 3/12

OPCIONES DE RESPUESTA	PUNTUACIÓN	RESPUESTAS	
Los honorarios fijos que paga por una visita al médico o a otro servicio de atención médica.	0/1	24,14%	14
Un tipo independiente de seguro para cubrir servicios adicionales.	0/1	29,31%	17
✓ El porcentaje que usted paga de los costos de un servicio de atención médica cubierto.	1/1	17,24%	10
No sé/No estoy seguro	0/1	29,31%	17
TOTAL			58

HDI-AHCT Insurance Literacy Survey (2018)

English Version: 3 hardest concepts

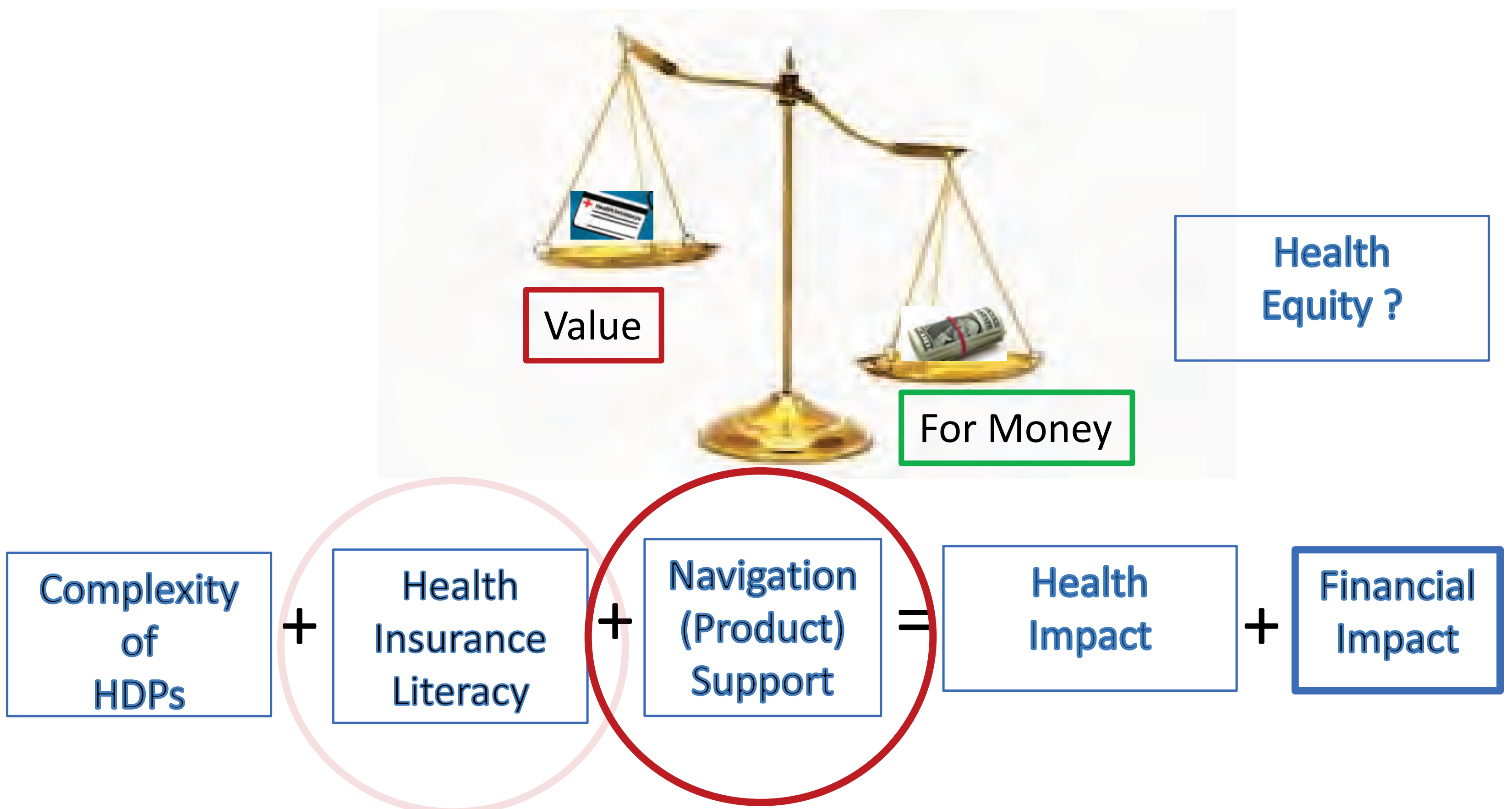
- “Coinsurance”
- “Formulary”
- “Bronze vs Silver vs Gold”

Spanish Version: 3 hardest questions:

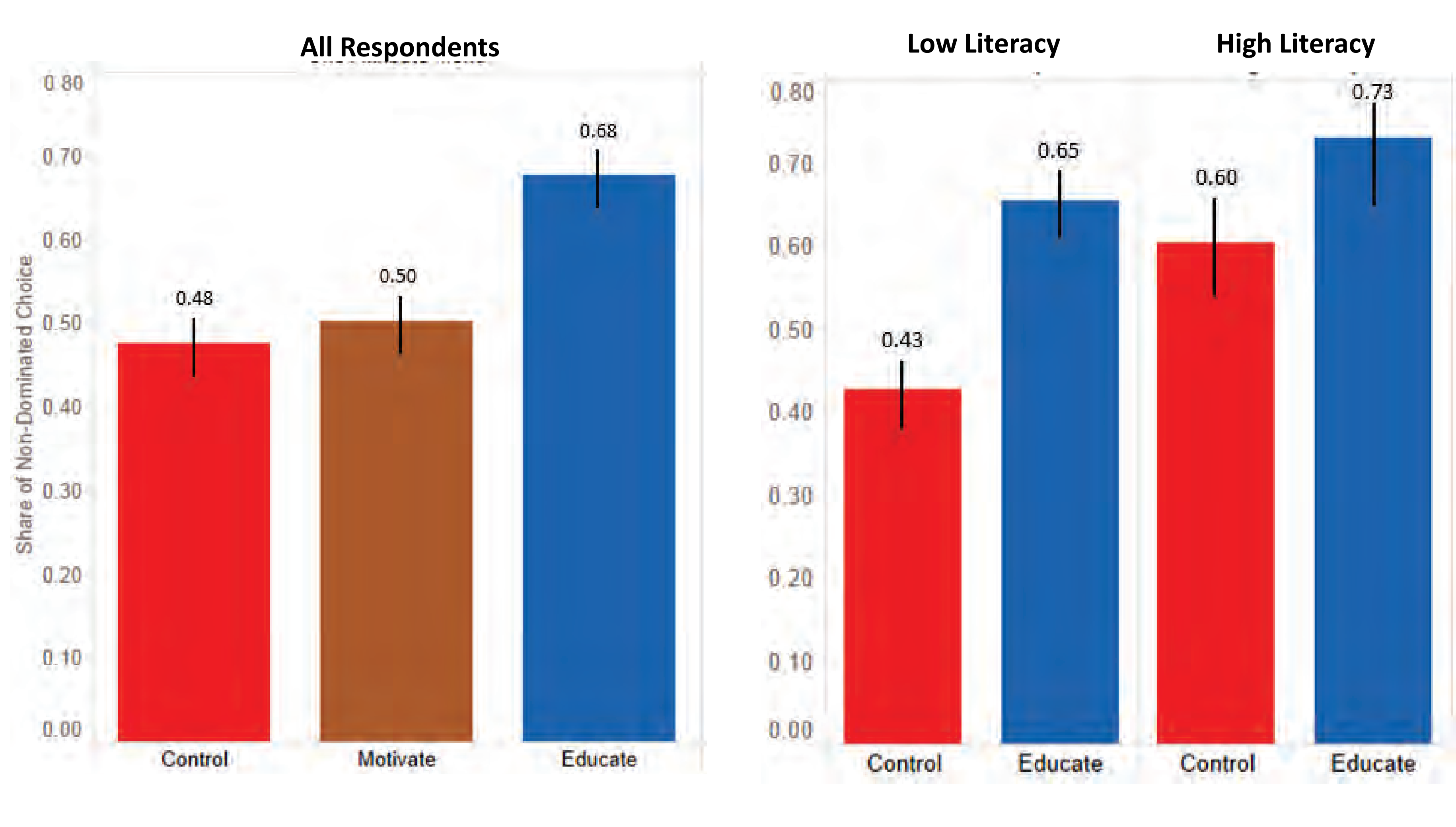
- “HSA”
- “Formulary”
- ”Coinsurance”

UCONN Health Disparities Institute
Health Insurance Advance Initiative

A five-year project aimed at enhancing the value of health insurance for all CT citizens but especially for people at the highest risk of experiencing healthcare inequities



Choosing a "just right" health insurance: Literacy and search motivation matter



Source: George Loewenstein, Carnegie Mellon University

HDI Pilot Health Insurance Literacy Educational Program

	HIL question (13)	% Pre	% Post
1	Premium Definition	40.2	54.6
2	Premium Payment	48.5	59.9
3	Annual Deductible	30.3	49.2
4	Hospital Bill Amount	17.4	23.5
5	Annual Out of Pocket Limit	37.1	56.1
6	Copay	47.0	66.7
7	Health Insurance Formulary	15.9	20.5
8	Provider Network	43.2	62.1
9	Inpatient Care	27.3	30.3
10	Appeal Definition	53.8	61.4
11	Appeal True or False	62.9	72.0
12	Information Source	52.3	72.0
13	Less Choice	22.7	62.1

HIL Education= Palliative measure to mitigate the negative impacts of HDP complexity

CT Insurance Department Consumer Report Card (product support)

Q5) In the last 12 months, how often did the written materials or Internet provide the information you needed about how your health plan works?

2019

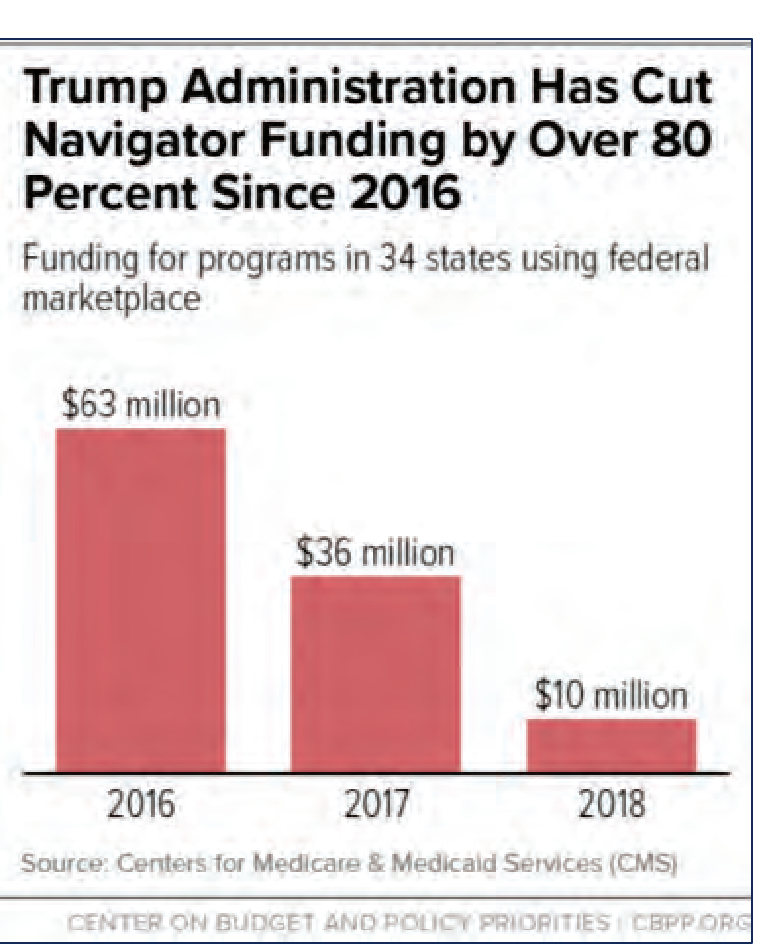
	Aetna Health	Anthem	ConnectiCare	Harvard	Oxford
Never	0.0%	1.5%	7.6%	0.0%	4.0%
Sometimes	40.0%	40.0%	0.0%	22.2%	31.0%
Usually	60.0%	38.5%	46.2%	48.1%	45.0%
Always	0.0%	20.0%	46.2%	29.7%	20.0%

Q6) In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

Never	0.0%	1.5%	8.3%	0.0%	3.0%
Sometimes	0.0%	18.8%	8.3%	22.7%	9.0%
Usually	33.3%	36.2%	41.7%	40.9%	29.0%
Always	66.7%	43.5%	41.7%	36.4%	59.0%

Source:\https://ct.gov/cid/cwp/view.asp?a=4903&Q=587026

Navigation Support: Regressive Federal Policy



Year
2016
Number of Navigators
0
1
2
3
4

Year
2018
Number of Navigators
0
1
2

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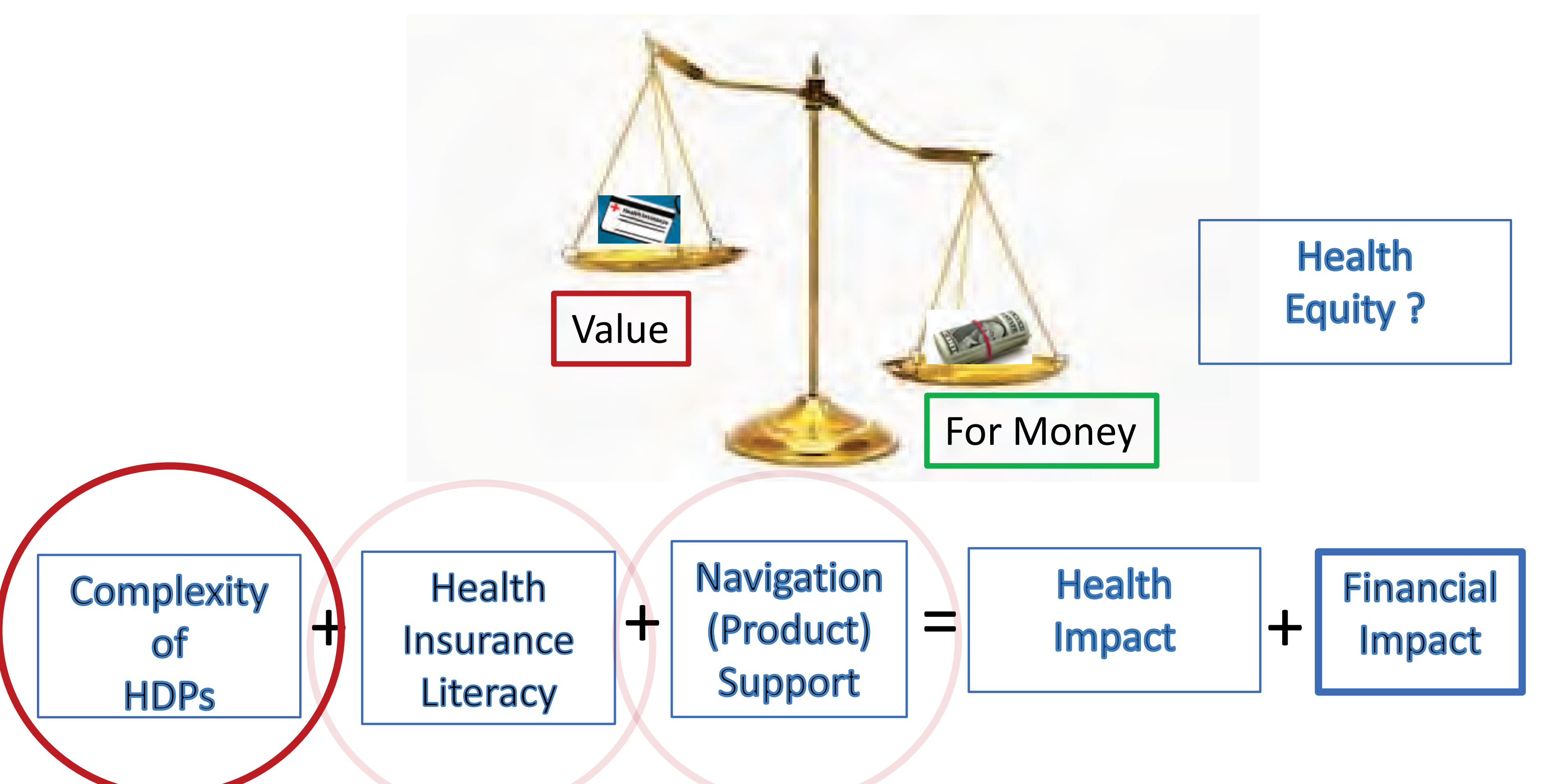
UCONN Health Disparities Institute
Health Insurance Advance Initiative

A five-year project aimed at enhancing the value of health insurance for all CT citizens but especially for people at the highest risk of experiencing healthcare inequities



Elements of HDP Excessive Complexity

- Large number of plan choices: Information overload → disconnect.
- Confusing rules, exceptions, jargon: Claims denials →provider and patient hassle, administrative cost.
- Deductibles: Growing consumer financial burden →Medical debt
- Co-insurance: intractable because prices of service and product are unknown → Surprise medical bills.
- Inefficient presentation (menu) of plan choices → 24% excess spending over optimal choice.
- Coverage uncertainty → Forgone care including preventive services.
- Misleading plan naming (e.g.: Bronze, Silver, Gold): marketing ≠ information.

Readability of a HDP Materials

- A typical subscriber agreement (SA) is over 100 pages long.
- A typical Bronze PPO plan in CT had a Flesch-Kinkaid Reading Ease score of 30.7 corresponding to a **16.5 grade level** (10-12 is roughly high school)

Non-Intuitive Plan Choice Menu

Which health plan option would *you* choose?

Assume the plans have identical coverage and provider network and covers all costs after the deductible has been met.

Option	Annual Deductible	Monthly Premium
A	$1,000	$72
B	$750	$110
C	$500	$118
D	$350	$163

Bhargava, S., Loewenstein, G. & Sydnor, J. (2017). **Choose to Lose: Health Plan Choices from a Menu with Dominated Options.** *Quarterly Journal of Economics, 132(3): 1319-1372.*

Circle the correct answer: A B C D

Better Plan Information

Which health plan option would *you* choose?

Assume the plans have identical coverage and provider network and covers all costs after the deductible has been met.

Option	Annual Deductible	Monthly Premium	Annual Premium
A	$1,000	$72	$864
B	$750	$110	$1,320
C	$500	$118	$1,416
D	$350	$163	$1,956

To save $250

Pay $464

Bhargava, S., Loewenstein, G. & Sydnor, J. (2017). **Choose to Lose: Health Plan Choices from a Menu with Dominated Options.** *Quarterly Journal of Economics, 132(3): 1319-1372.*

Circle the correct answer: A B C D

In a real world experiment more than 50% of employees chose a "wrong plan"

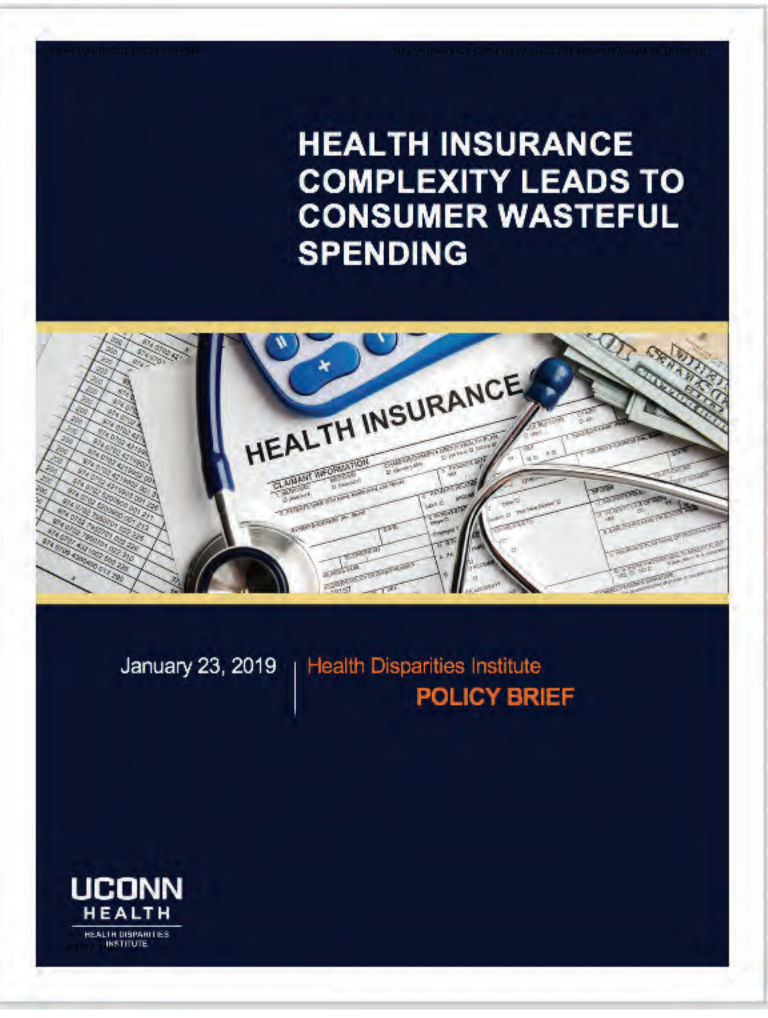
Misleading (unwittingly) Naming of Plan Choices

Naming convention	Over-insured	Just right	Under-insured
Metal	43%	24%	33%
Medical need	19%	53%	28%
Neutral name	37%	40%	23%
Recommended	34%	47%	19%

Selection based on medical need yielded the highest proportion of just right choices. It is estimated that "guided" by metal naming consumers overspend an average of $888/year (Ref).

Behavioral science & policy | volume 3 issue 1 2017

HDPs: Complexity + low literacy + poor product support



- Creates consumer confusion and promote poor buying choices.
- Companies respond with more disclosures that further confuse and obfuscate consumers
- Calls for more effective regulatory oversight

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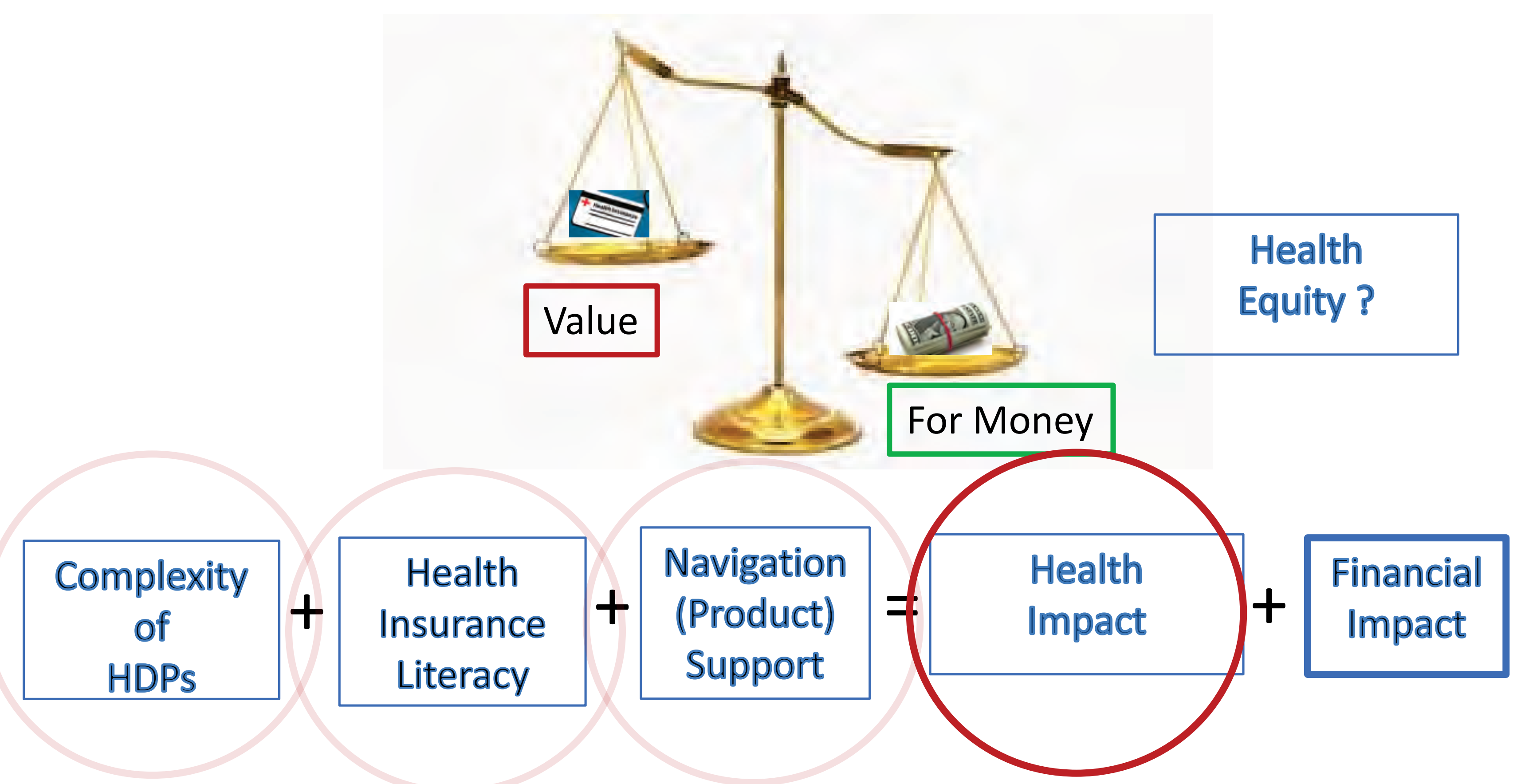

HDPs are associated with reduced utilization of services,[1]

Q: What types of services are affected by HDPs that can have a negative impact on health status?

- Vaccinations. [2]
- Prescription drugs. [3,,4,5,6]
- Mental health visits.[7]
- Preventive and primary care. [8,9,10,11,12]
- Inpatient and outpatient care. [13,14]
- Decreased adherence to medications.[15,16,17]
- Increased rates of uncontrolled hypertension and hypercholesterolemia. [18]

Source: Evidence and references adapted from the original Kaiser Family Foundation report. References listed in the Appendix

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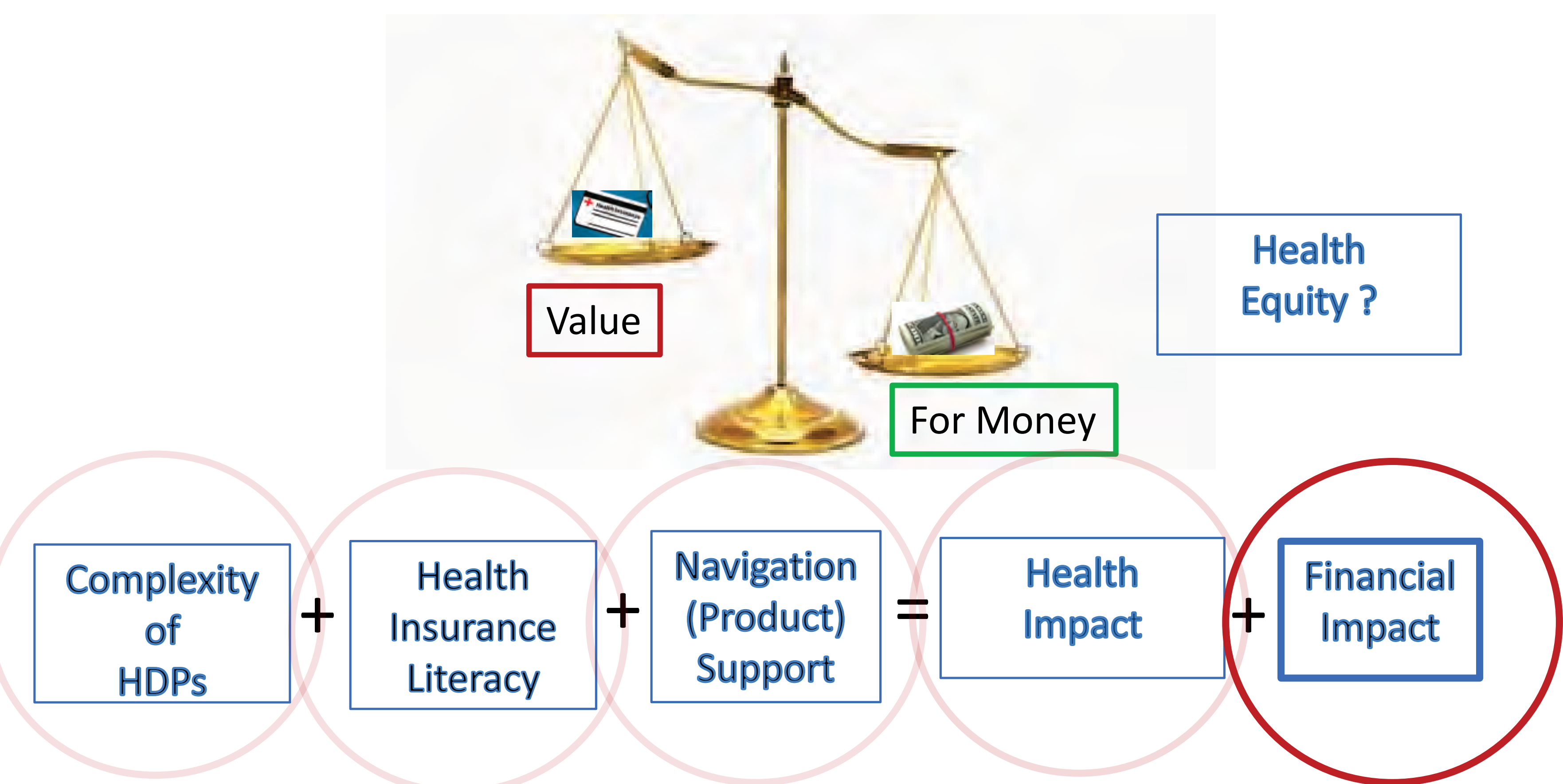
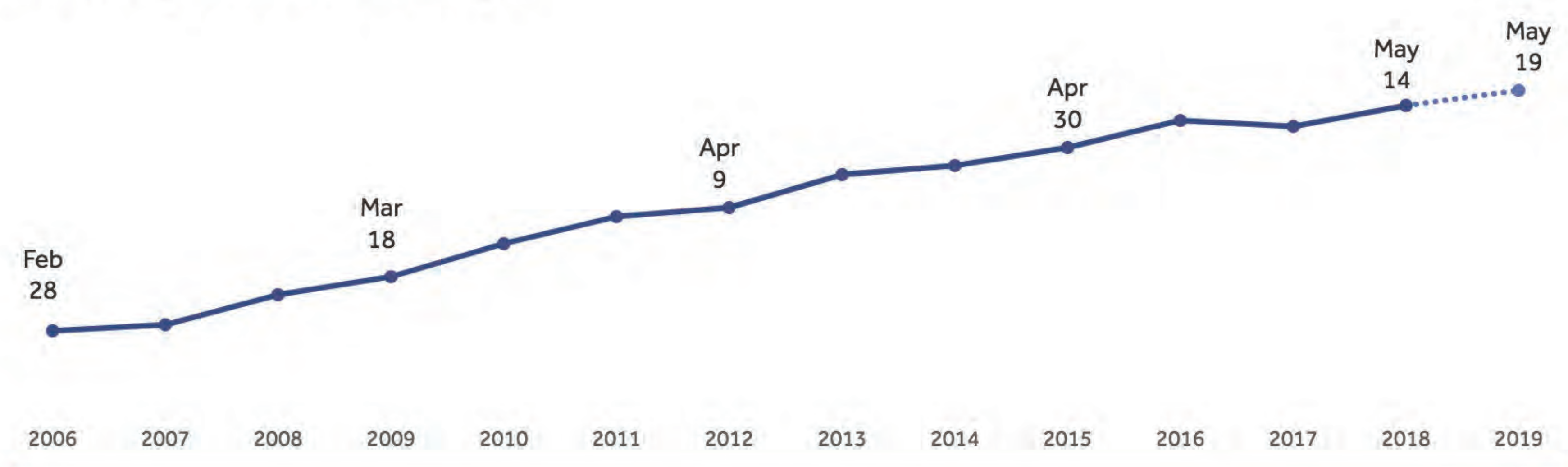
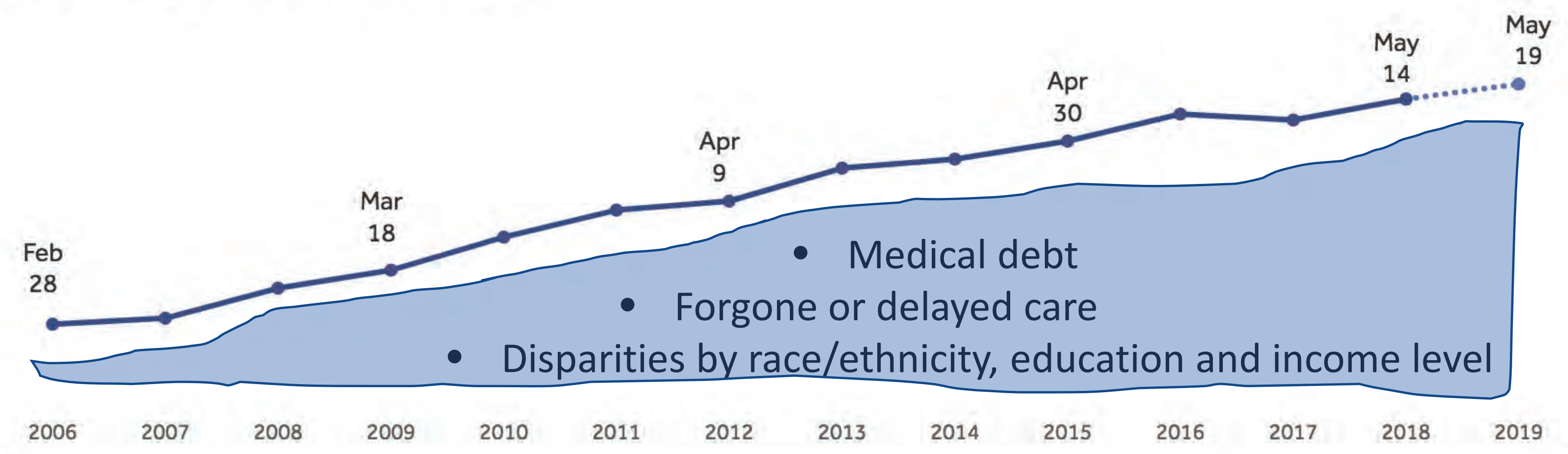


HDPs Deductible Relief Day



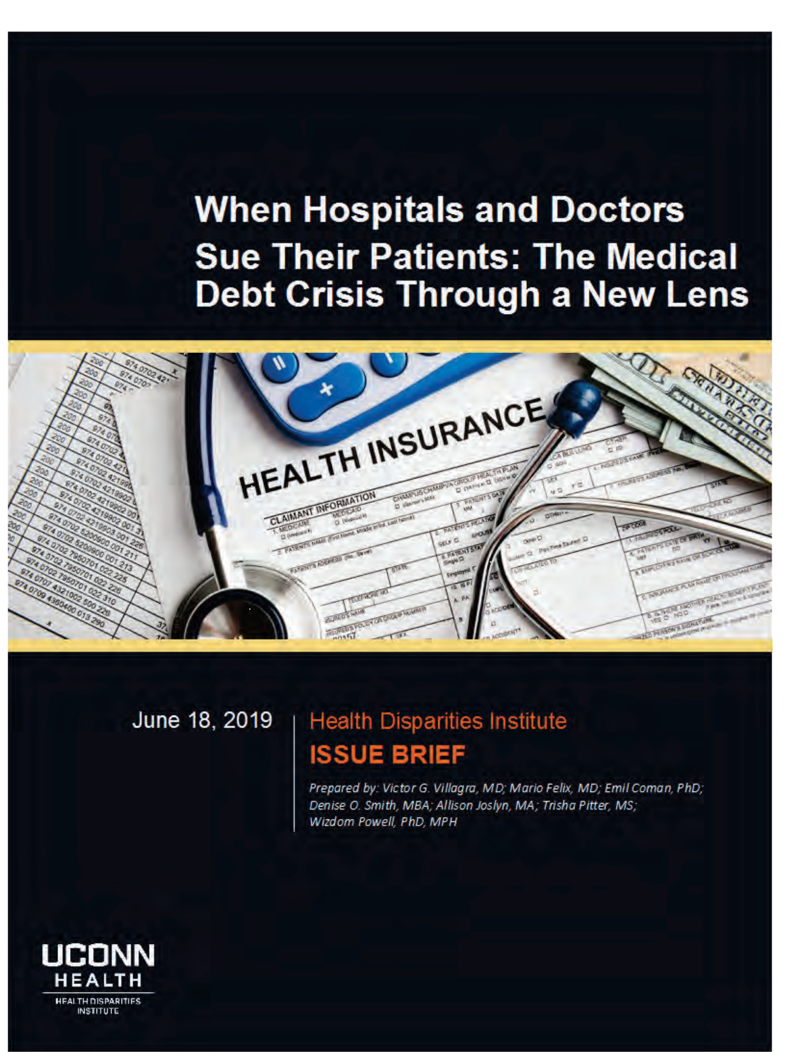
HDPs Deductible Relief Day



HDPs → Medical Debt

- Among adults 43% have problems with medical bills or medical debt
- Among the insured 23% percent still had medical debt, compared to 31% of uninsured people.
- Among those with medical debt
  - 43%-67% have used up all their savings to pay their bills
  - 43% had received a lower credit rating as a result of their debt
  - 16% are contacted by collection agencies
  - 18% delay education or career plans.
- Personal bankruptcies: Depending on methodology between 2% (KFF) and 62% (Health Affairs 2009) are healthcare related.

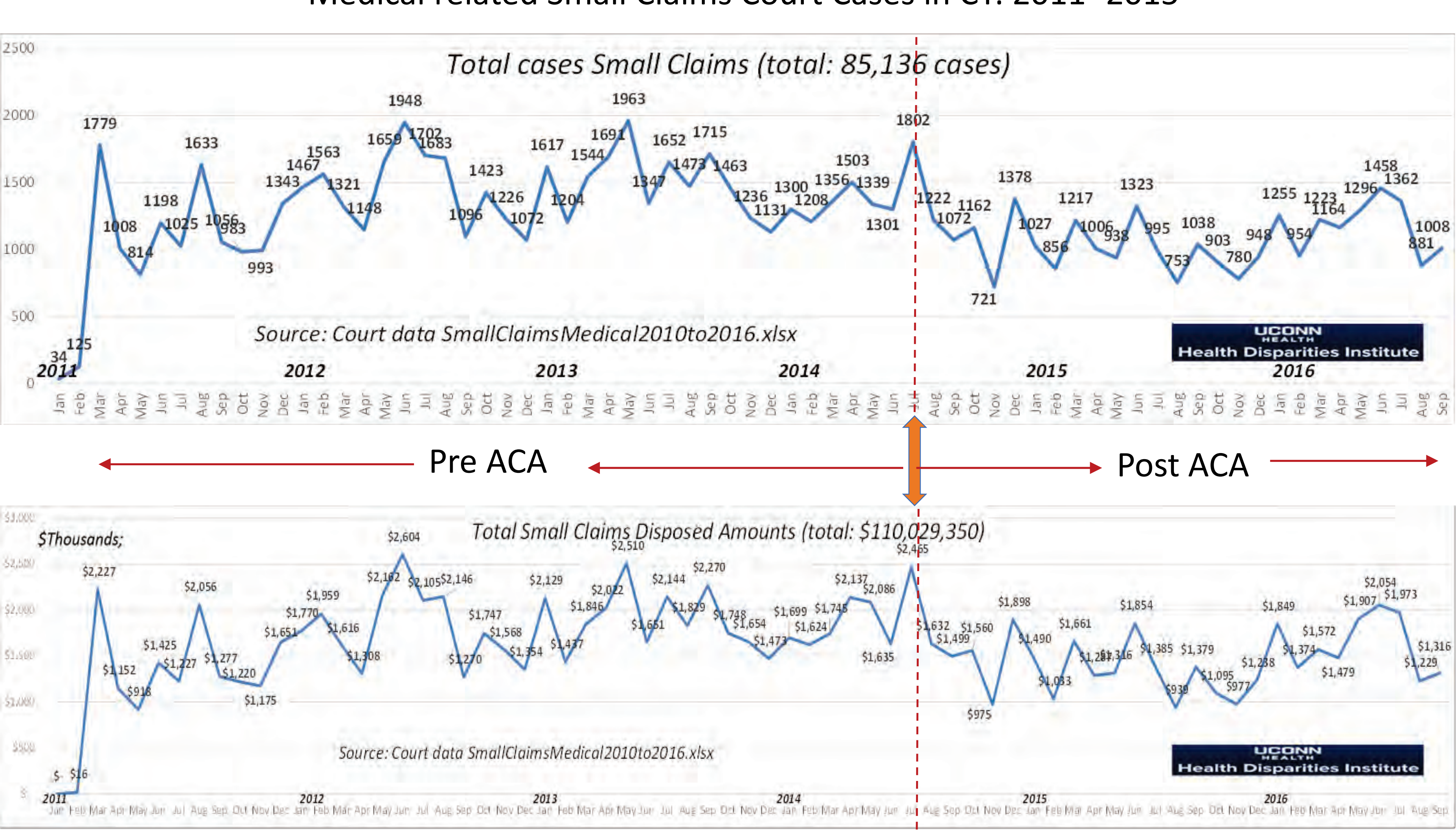
Medical Debt: A Silent Crisis in Connecticut



- Unpaid debt carries a social stigma
- Medical debt is difficult to measure
- HDP and medical debt are causally linked
- HDI obtained data from the CT Judicial System
- Small Claims only (≤ $5,000)
- Unlike other debt (mortgages, credit card, car loans, etc.) medical debt is never voluntary
- A window into the magnitude of medical debt in CT

Connecticut Hospitals and Doctors Sue Their Patients

Medical related Small Claims Court Cases in CT: 2011- 2015



When Connecticut Hospitals and Doctors Sue Patients: Outcomes?

Small-Claims Dockets Disposed: 2011 through 2015
Hospital & non-Hospital Medical Collections

Percentage of Dockets
80%
70%
60%
50%
40%
30%
20%
10%
0%

$70
$60
$50
$40
$30
$20
$10
$0
Millions

Number of Dockets
Damages Awarded

Judgment for Plaintiff after Default w/o Hearing in Damages: 68% of Dockets, $62 Million in Damages

Stipulated Judgment for Plaintiff: 23% of Dockets, $22 Million in Damages

Judgment for Defendant after Hearing: 0.1% (.001) of Dockets, $0 in Damages

99.9% in favor of plaintiffs

Judgment for Plaintiff after Default w/o Hearing in Damages	Stipulated Judgment for Plaintiff	Judgment for Plaintiff after Default and Hearing in Damages	Judgment for Plaintiff after Hearing	Judgment for Plaintiff	Other	Judgment for Defendant after Hearing	Judgment for Defendant
68%	23%	7%	1%	1%	0.1%	0.1%	0.05%

While these figures do not represent the number of unique defendants or the actual amount of debt recovered or attempted to recover, they do expose the magnitude of the medical debt problem and raise important questions that have received relatively little attention by the medical community, policy makers or the public at large.

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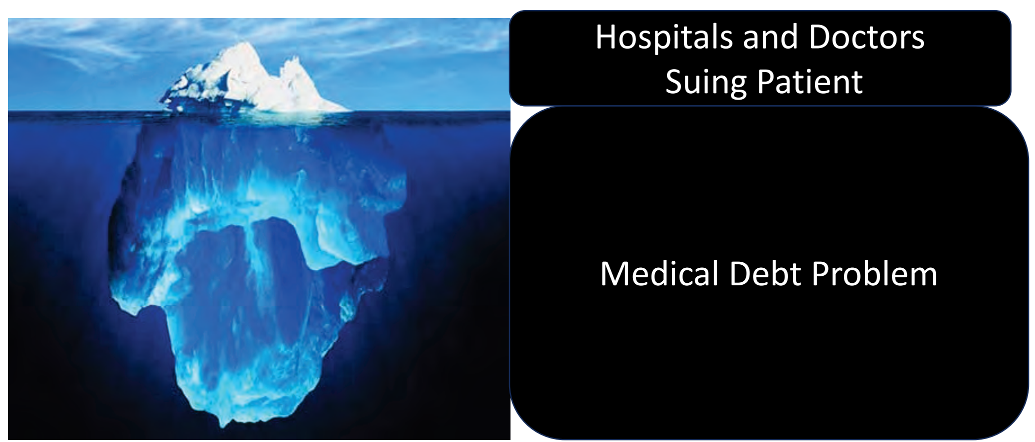
Medical Debt ≠ Being Sued



What is the impact of debt and law suits on patients' mental health, physical health and social stigma?

What is the impact of law suits on the patient-provider relationship?

- Trust
- Continuity of care
- Quality of care
- Physician agency *("I am on your side")*

Providers faced with a medical malpractice law suit have expressed a range of emotions including anxiety, fear, frustration, remorse, self-doubt, shame, betrayal and anger.

Source; Rehm SJ, Borden BL. The emotional impact of a malpractice suit on physicians: Maintaining resilience. *Cleve Clin J Med*. 2016;83(3):177-178. doi:10.3949/ccjm.83a.16004

The Provider Perspective: Ethical Dilemma

- Primary care is a low margin operation, even a "loss leader"* segment of the healthcare delivery system
- Since the advent of High Deductible Plans "accounts receivables" have been growing (duration and amount)

> *"I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."* Excerpt of physicians' Hyppocratic Oath

- Providers face dual responsibility to care for their patients and to protect the financial integrity of their practices: Ethical dilemma
- Difference between small practices and corporate ownership of medical practices.

A **loss leader** is a product or service that is offered at a price that is not profitable, but it is sold to attract new customers or to sell additional products and services to those customers.

Hospitals Suing Patients in Other States

St. Joseph Missouri:

- Heartland Hospital sued this uninsured patient, a truck driver making $30,000/yr.

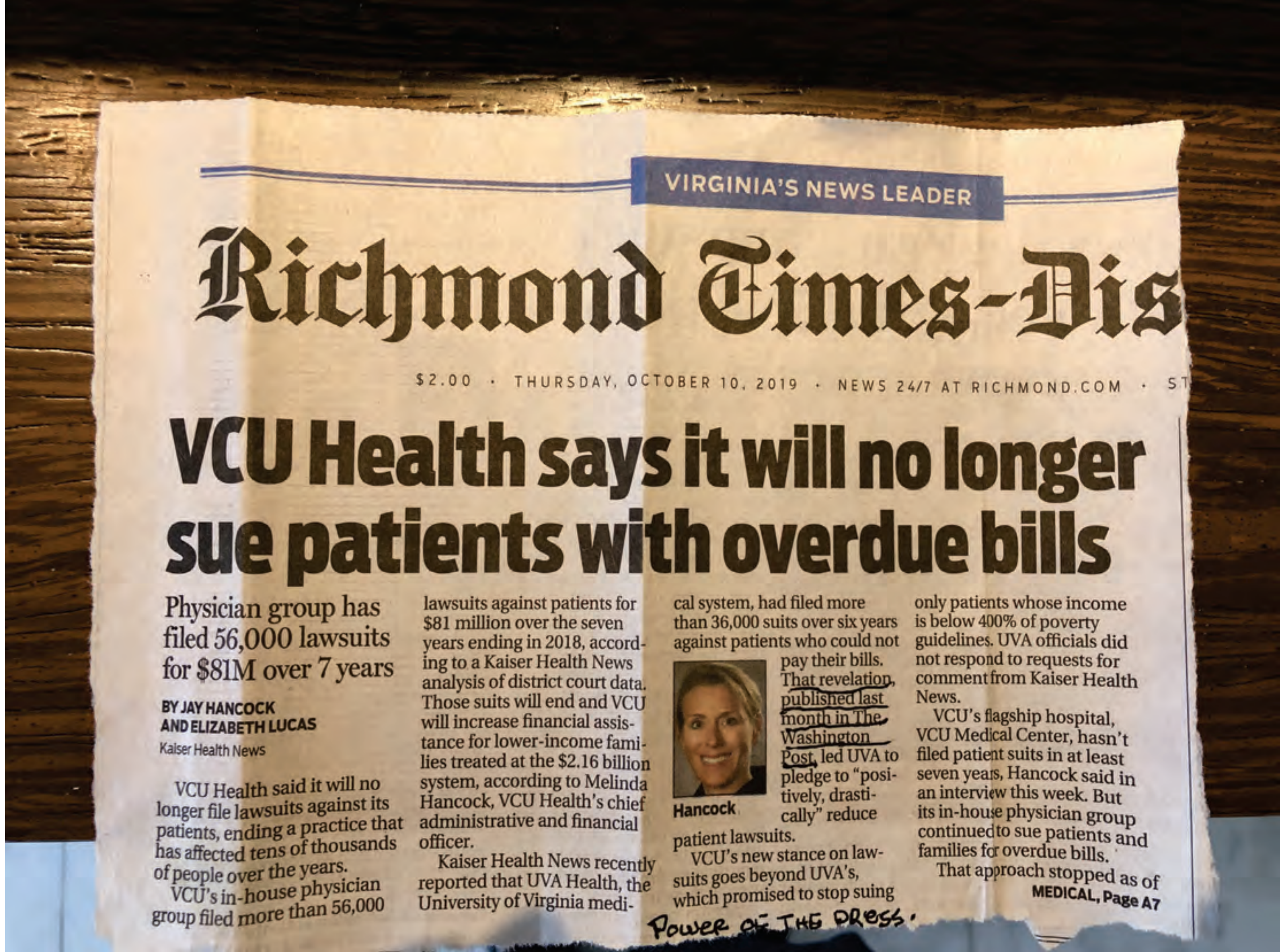
- Seized 10% of his paychecks

  and 25% of his wife's wages
- Charged 9% interest
- Placed lien on the patient's home

Virginia Hospitals: 2017

- 36% of hospitals sued 20,054 patients.
- And garnished wages from 9,232 patient s in 2017.
- Five hospitals accounted for over half of all lawsuits
- All but one of those were nonprofits.
- Mary Washington sued the most patients, according to the researchers.
- 300 summons for 1 day, most are "no-shows"

News From Virginia



VIRGINIA'S NEWS LEADER

Richmond Times-Dis

$2.00 · THURSDAY, OCTOBER 10, 2019 · NEWS 24/7 AT RICHMOND.COM · ST

VCU Health says it will no longer sue patients with overdue bills

Physician group has filed 56,000 lawsuits for $81M over 7 years

BY JAY HANCOCK AND ELIZABETH LUCAS
Kaiser Health News

VCU Health said it will no longer file lawsuits against its patients, ending a practice that has affected tens of thousands of people over the years.

VCU's in-house physician group filed more than 56,000 lawsuits against patients for $81 million over the seven years ending in 2018, according to a Kaiser Health News analysis of district court data. Those suits will end and VCU will increase financial assistance for lower-income families treated at the $2.16 billion system, according to Melinda Hancock, VCU Health's chief administrative and financial officer.

Kaiser Health News recently reported that UVA Health, the University of Virginia medical system, had filed more than 36,000 suits over six years against patients who could not pay their bills. That revelation, published last month in The Washington Post, led UVA to pledge to "positively, drastically" reduce patient lawsuits.

Hancock

VCU's new stance on lawsuits goes beyond UVA's, which promised to stop suing only patients whose income is below 400% of poverty guidelines. UVA officials did not respond to requests for comment from Kaiser Health News.

VCU's flagship hospital, VCU Medical Center, hasn't filed patient suits in at least seven years, Hancock said in an interview this week. But its in-house physician group continued to sue patients and families for overdue bills.

That approach stopped as of

MEDICAL, Page A7

Power of the press.

Connecticut Hospitals Suing Patient

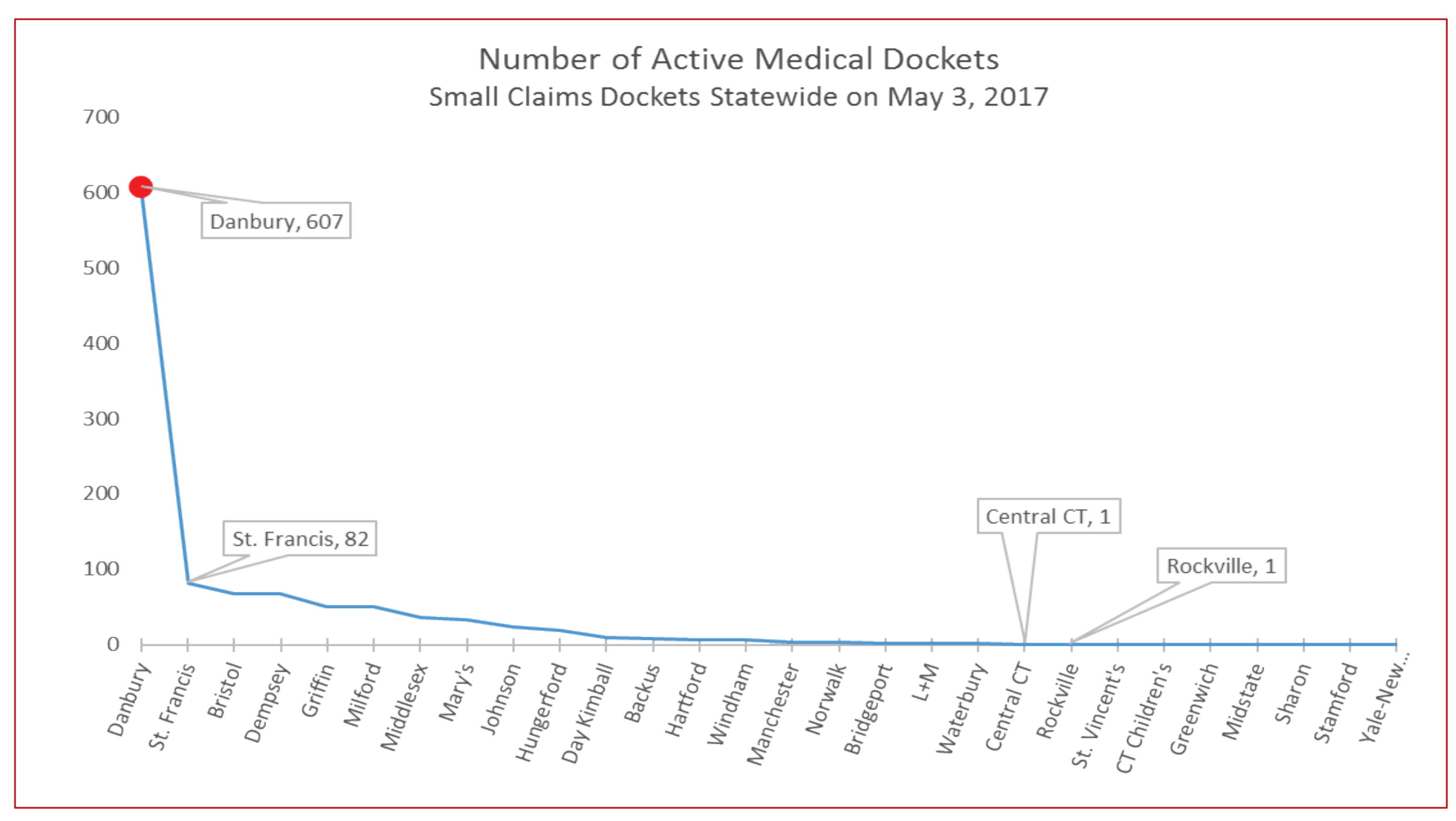
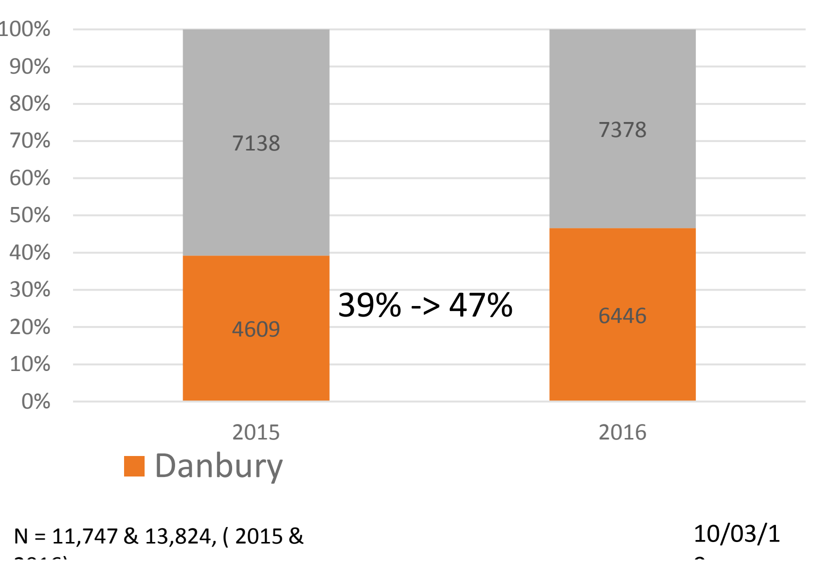


Chart shows that on May 3rd, 2017, Danbury Hospital had 607 total active dockets in small claims courts throughout Connecticut. This was a significantly higher number of dockets compared to the other 28 short-term acute care hospitals in CT

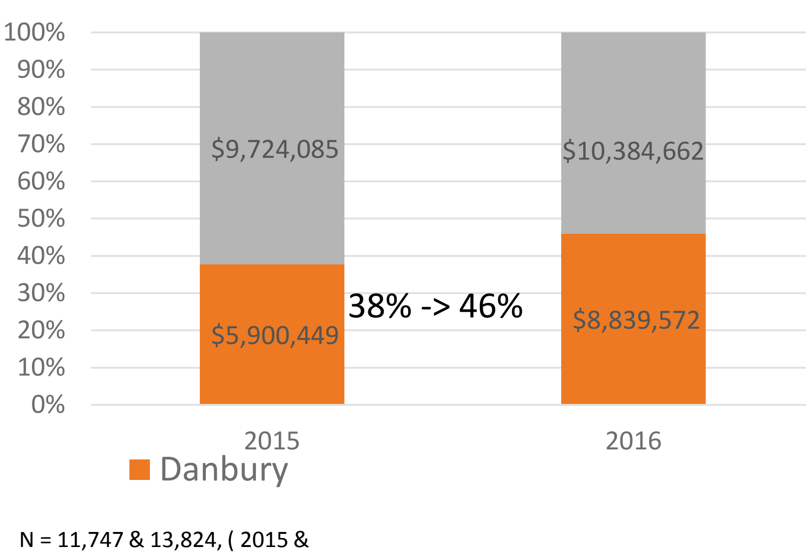
Danbury Hospital Small Claims Lawsuits Against Patients for Medical Debt vs. All Other Hospitals in Connecticut

Total number of cases 2015-2016



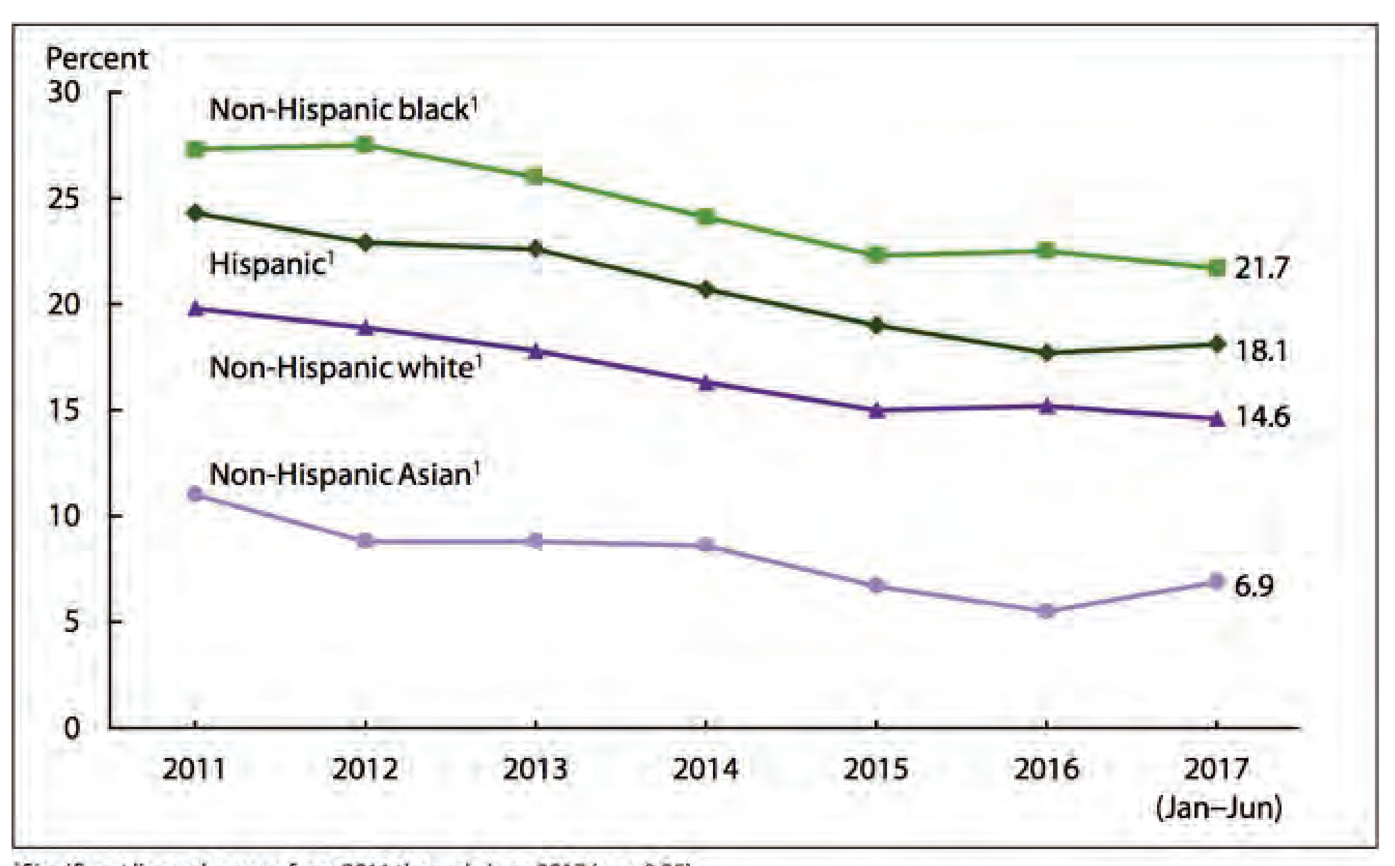
N = 11,747 & 13,824, (2015 & 2016)

Total dollars awarded 2015-2016



N = 11,747 & 13,824, (2015 & 2016)

Racial/Ethnic disparities in medical debt



[1]Significant linear decrease from 2011 through June 2017 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2011–2017.

Policy considerations to mitigate HDPs-related healthcare inequities

- **Public Education:** Private-public partnership for statewide health insurance literacy campaign.
- **Workforce Development**: State and private funding for health insurance navigators training and deployment in underserved communities.
- **Regulatory** (Performance-based regulation): Aggressive goals for year-to-year improvement in CID Consumer Report Card scores.
- **Legislative:** Elimination of co-insurance and gradual phase-out of deductible features from all non-ERISA plans.
- **Simpler plan alternatives**: New entrants (e.g.: public option)

Policy considerations to mitigate HDPs-related healthcare inequities

POLICY BRIEF | October 2015

Enhancing the Value of Health Insurance by Making it Simpler

Victor G. Villagra, MD | Health Disparities Institute, University of Connecticut Health Center

Policy considerations to mitigate HDPs-related healthcare inequities

- **Administrative (for medical debt)**:
  - Transparent and standardized (understandable) hospital and provider billing statements
  - Judicial system administrative reforms to protect consumers against unfair medical debt collection practices and litigation
- **Legal framework** to control healthcare pricing practices

UCONN HEALTH | Bioscience Connecticut Health Disparities Institute

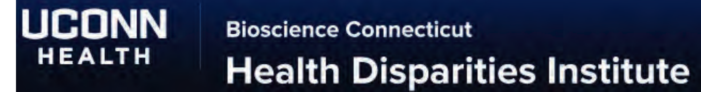
Health Insurance Advance Project

A five-year initiative (2016-2020) aimed at enhancing the value of health insurance for all CT citizens but especially for people at the highest risk of experiencing healthcare inequities

From a consumer point of view our research posits that HDPs meet customary criteria for A DEFECTIVE PRODUCT

Rationale: when used as designed and marketed HDPs

- Are often unreliable
- Widen healthcare disparities [19,20,21]
- Can lead to health and financial harms
- Affect a substantial portion of Connecticut citizens, specially racial/ethnic minorities.



Thank you

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(for slide 37)

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(for slide 37)

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High Deductible Plans Widen Disparities

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Appendix B

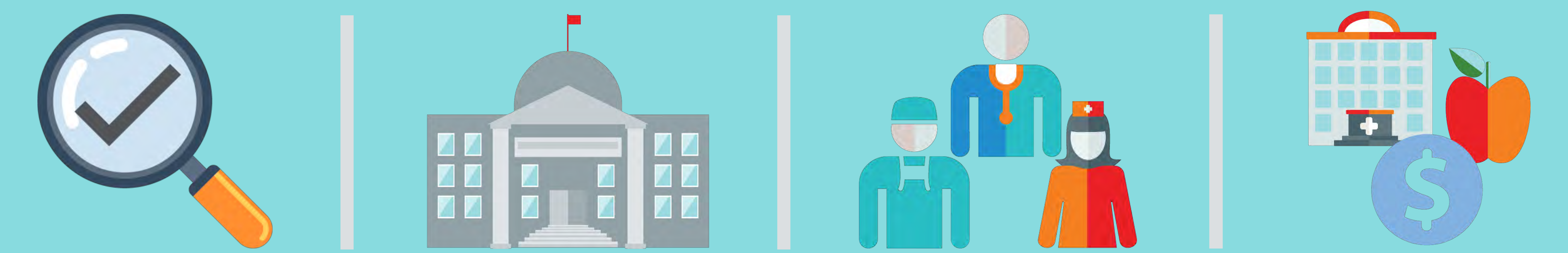
High Deductible Health Plans

What does the evidence say?

Lynn Quincy, Nov. 6, 2019

@HealthValueHub

HealthcareValueHub.org



Altarum

A 450-employee, nonprofit health services research organization that creates and implements solutions to advance health among vulnerable and publicly insured populations.

What is the Healthcare Value Hub?

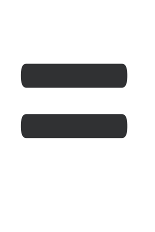
With support from the Robert Wood Johnson Foundation:

- The Healthcare Value Hub reviews evidence to identify the policies and practices that work best to reduce healthcare spending, improve affordability for consumers, improve outcomes and reduce disparities.
- We provide FREE resources to help YOU work on these healthcare value issues.
- We support and connect consumer advocates across the U.S., providing comprehensive fact-based information to help them advocate for change, and connect them to researchers and other resources.

Guide to Jargon

High Deductible Health Plan (HDHP)

Health Savings Account (HSA)



Consumer Directed Healthcare (CDHC)

HSA-Qualified Plan (Individual Deductible> $1,350)

Also Health Reimbursement Account (HRA)

Plus consumer shopping tools

HDHPs – The Bottom Line

HDHP Benefits:

Lower Premiums
~HSA Savings Opportunity

HDHP Consumer Harm:

Not getting needed care
Affordability Burdens

What HDHPs DON'T Do: Drive Value in the Marketplace

ALTARUM HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 11 | APRIL 2016

Rethinking Consumerism in Healthcare Benefit Design

High healthcare costs are a concern for consumers and payers alike. Insurance premiums have risen faster than wages and the economy in general for nearly two decades (see Figure 1). High levels of health spending crowd out other important spending. For households, this means lower wages and less money for competing priorities. For state and national governments, it means less to spend on education, infrastructure and other public needs.

SUMMARY

For decades, rising healthcare costs have strained household, employer and government budgets. A strategy often proposed to address these high costs is to give consumers more "skin in the game," through high-deductible health plans. When accompanied by shopping aids, these plans are sometimes called consumer-directed health plans. But a wealth of evidence suggests that high-deductible health plans are not leading to better value in our healthcare system. What's more, unaffordable cost sharing causes considerable consumer harm. Instead, efforts to address high prices and promote high-value care must have a strong provider-directed component, because providers direct treatment plans and steer almost all of our healthcare spending. Our country needs to rethink the role of the consumer in healthcare to be fair, patient-centric and evidence-based. Consumers should be empowered with timely, accurate and actionable information to help make decisions about their care and not have their choices curtailed due to unaffordable cost sharing.

There is consensus that we can cut back on waste in the system (including prices that are too high) in order to reduce spending without harming our health outcomes.

An oft-used strategy to address high healthcare costs are insurance products called high-deductible health plans, or more generally, consumer-directed healthcare. Nearly half of Americans with employer-provided insurance were required to meet an individual deductible of more than $1,000 in 2015, and many plans go much higher, with deductibles in the $5,000-$6,500 range.[1] The basic idea is that by requiring consumers to pay substantial cost sharing these plan designs will incentivize consumers to extract better value from the healthcare marketplace, helping to stem the tide of rising healthcare costs and reducing the use of low-value care.

There's just one problem—we have little evidence to suggest that these high-deductible plan designs work. To control spending and bring better value to our healthcare system, we need a new vision for what the consumer's role should be.

The Theory Behind Consumer-Directed Healthcare and High-Deductible Health Plans

Whether described as a high-deductible health plan or consumer-directed healthcare—either paired with a tax advantaged account like an HRA or an HSA[2] or not—the theory is the same: If consumers face the consequences of their health spending they will spend their dollars more wisely. With up to 30 percent of healthcare spending classified as "waste" by the Institute of Medicine,[3] the goal is for consumers to cut out unnecessary or "wasteful" spending and put downward pressure on prices.

Compared to more generous coverage, HDHP lower premiums BUT:

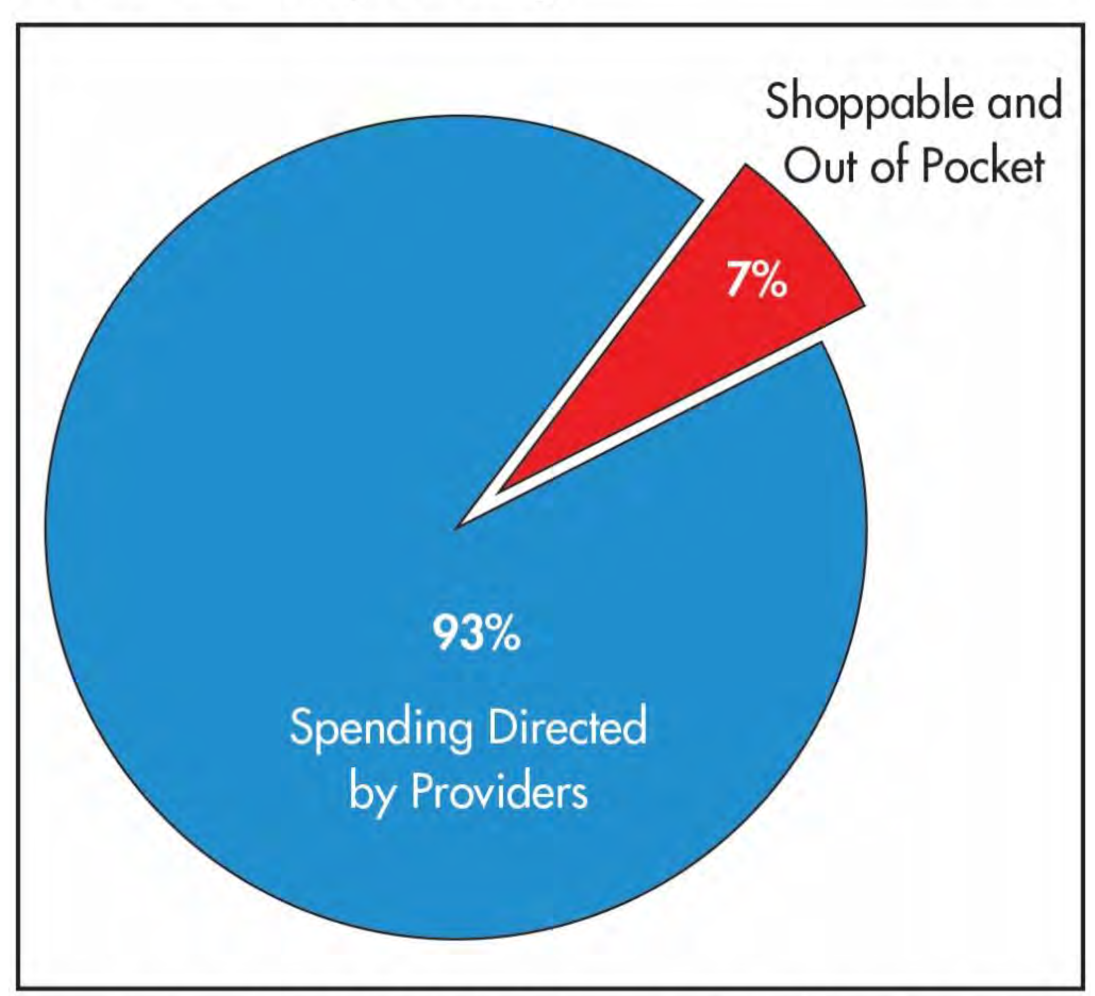
- Patients reduce both necessary and unnecessary care
- Patients don't price shop
- Patients don't shop based on quality

First Author	Journal	Findings
Mary E. Reed	*Health Affairs*, 2012	Survey of beneficiaries: fewer than one in five understood that their plan exempted preventive office visits, medical tests, and screenings from their deductible.
Neeraj Sood	*RAND Forum for Health Economics and Policy,* 2013	Claims data analysis across CDHP and non –CDHPs: no evidence that, within CDHP plans, consumers with lower expected medical expenses exhibited more price shopping or that consumers exhibited more price shopping before reaching the deductible
Rachel O. Reid	*American Journal of Managed Care, 2017*	Using a before/after: no change in spending on 26 commonly used, low-value services
Zarek C. Brot-Goldberg	*Quarterly Journal of Economics*, 2017	Using a before/after: spending reductions are entirely due to outright reductions in quantity. We find no evidence of consumers learning to price shop after two years in high-deductible coverage. Consumers reduce quantities across the spectrum of health care services, including potentially valuable care (e.g. preventive services) and potentially wasteful care (e.g. imaging services).
Rejender Agarwal	*Health Affairs,* 2017	Systematic review: HDHPs associated with a significant reduction in preventive care in seven of twelve studies and a significant reduction in office visits in six of eleven studies—which in turn led to a reduction in both appropriate and inappropriate care.

Other evidence suggests WHY consumers don’t shop based on price or quality:

- Care is rarely labeled as high-value or low-value
- Patients rarely know the price of a service and providers are often unable to help
- Patients rarely know quality or likely outcomes between two treatments.
- Consumers don’t view healthcare as a commodity.

Most Healthcare Dollars Are Directed by Physicians

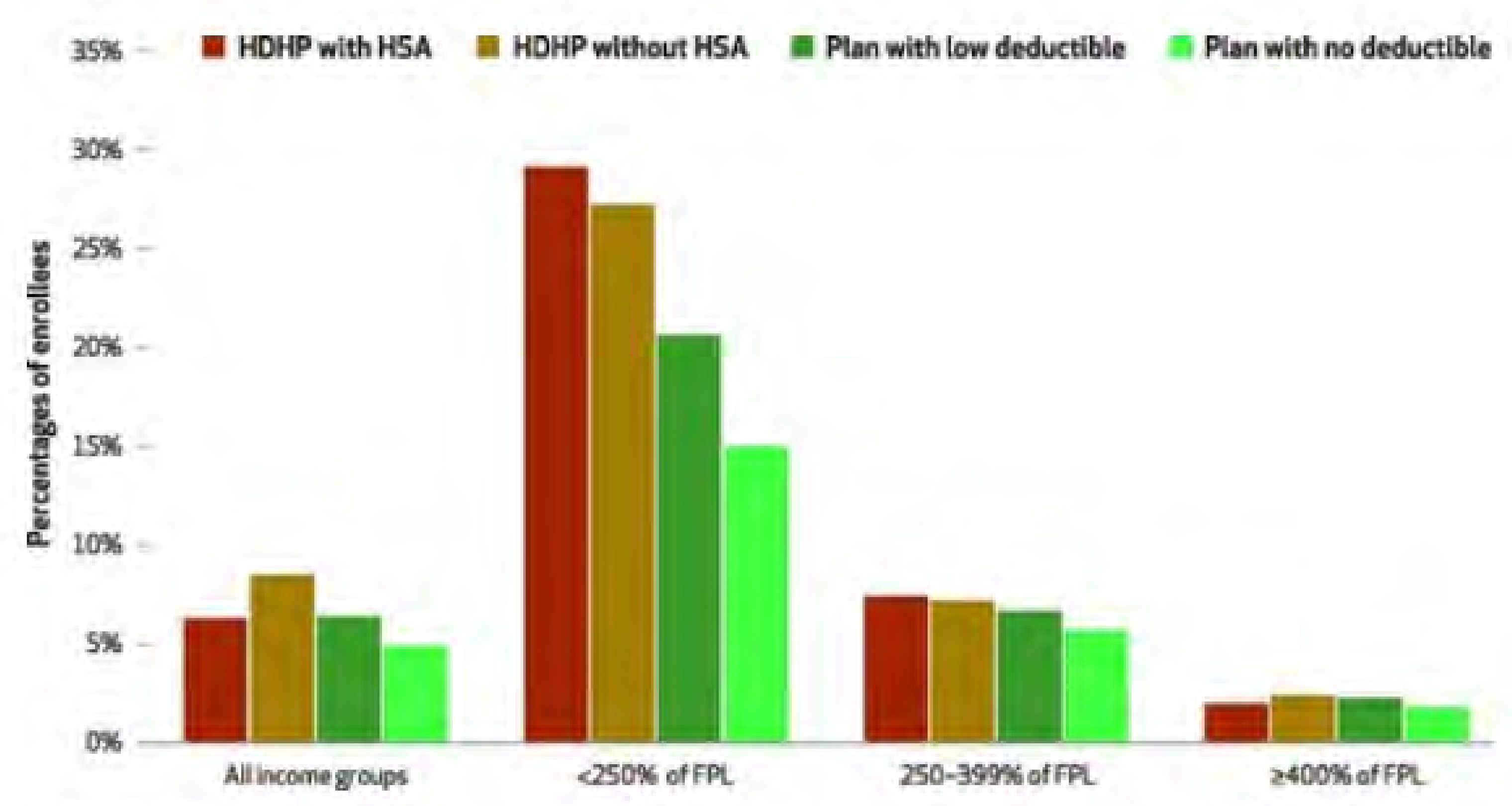


Source: Healthcare Value Hub, Rethinking Consumerism in Healthcare Benefit Design, *Research Brief No. 11 (April 2011). Adapted from Health Care Cost Institute,* Spending on Shoppable Services in Health Care, *(March 2016).*

High Deductible Health Plans Cause Consumer Harm

First Author	Journal	Findings
J. Frank Wharam	*J Clin Oncol.*, 2018	Women with breast cancer who had switched to HDHPs before being diagnosed experienced delays in every aspect of the care process: diagnostic imaging, biopsies, early-stage diagnoses, and chemotherapy treatments.
J. Frank Wharam	*Health Affairs*, 2019	A similar study design: finds delays occurred regardless of income status, although delays were longer for women with lower income levels.
Alison A. Galbraith	*Health Affairs*, 2011	Survey: Almost half (48 percent) of the families with chronic conditions in high-deductible plans reported health care-related financial burden, compared to a fifth of families (21 percent) in traditional plans. Almost twice as many lower-income families in high-deductible plans spent more than 3 percent of income on health care expenses as lower-income families in traditional plans (53 percent versus 29 percent).
Zhiyuan_Zheng	*Journal of Oncology Practice*, 2019	Survey: High-deductible health plans linked to delayed, forgone care among cancer survivors, especially if no HSA; the percentage of delayed or forgone care appeared similar for cancer survivors who had an HDHP with an HSA vs. those with an Low Deductible plan

Exhibit 1 Percentage of nonelderly adults with employer-sponsored insurance facing health care burden exceeding 20 percent of family income, by income and deductible level, 2011–13



Source: Salam Abdus, Thomas M. Selden, and Patricia Keenan. "The Financial Burdens Of High-Deductible Plans," *Health Affairs*, December 2016

About Health Savings Accounts

- HSAs are tax-advantaged savings accounts designed to pay medical expenses.
- HSAs must be paired with HDHPs meeting specific IRS criteria.
- Only one-third of individuals with a high-deductible health plan also have a health savings account
- The U.S. Treasury finds that more than 60 percent of all HSA tax benefits accrue to families earning more than $100,000 annually

Source: https://www.healthcarevaluehub.org/improving-value/browse-strategy/health-savings-accounts

2018 Poll of Connecticut Adults

DATA BRIEF NO. 2 | OCTOBER 2018

Connecticut Residents Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines

Nationally, consumer worry about healthcare affordability is well documented but now—for the first time—a new survey reveals how affordability concerns and ideas for action play out in Connecticut.

A survey of over 900 Connecticut adults conducted from Jan. 31-Feb. 9, 2018, found that:

- 50% experienced healthcare affordability burdens in the past year;
- Even more are worried about affording healthcare in the future; and
- Across party lines, most express strong support for policymakers to address these problems.

A Range of Healthcare Affordability Burdens

Connecticut is a top ranked state in terms of household income—in 2016, census data show median household income was $73,433.[1] Nonetheless, like many Americans, Connecticut residents currently experience hardship due to high healthcare costs.

These affordability burdens take many forms. All told, 50% of adults in Connecticut experienced one or more of the following three healthcare affordability problems in the prior 12 months.

1.) **Being Uninsured Due to High Premium Costs.** 50% of uninsured cite "too expensive" as the major reason for not having coverage.

2.) **Delaying Or Foregoing Healthcare Due To Cost.** Nearly half (43%) of Connecticut adults encountered one or more cost related barriers to getting care in the past year. In descending order of frequency, they report:

- 33%—Delayed going to the doctor or having a procedure done
- 24%—Avoided going altogether to the doctor or having a procedure done
- 22%—Skipped a recommended medical test or treatment
- 15%—Did not filled a prescription
- 13%—Cut pills in half or skipped doses of medicine
- 11%—Had problems getting mental healthcare

Moreover, cost was far and away the most frequently cited reason for not getting needed medical care, exceeding a host of other barriers like transportation, difficulty getting an appointment, lack of childcare and other reasons.

Of the various types of medical bills, the ones most frequently associated with an affordability barrier were dental care, doctor bills and prescription drugs, likely reflecting the frequency with which

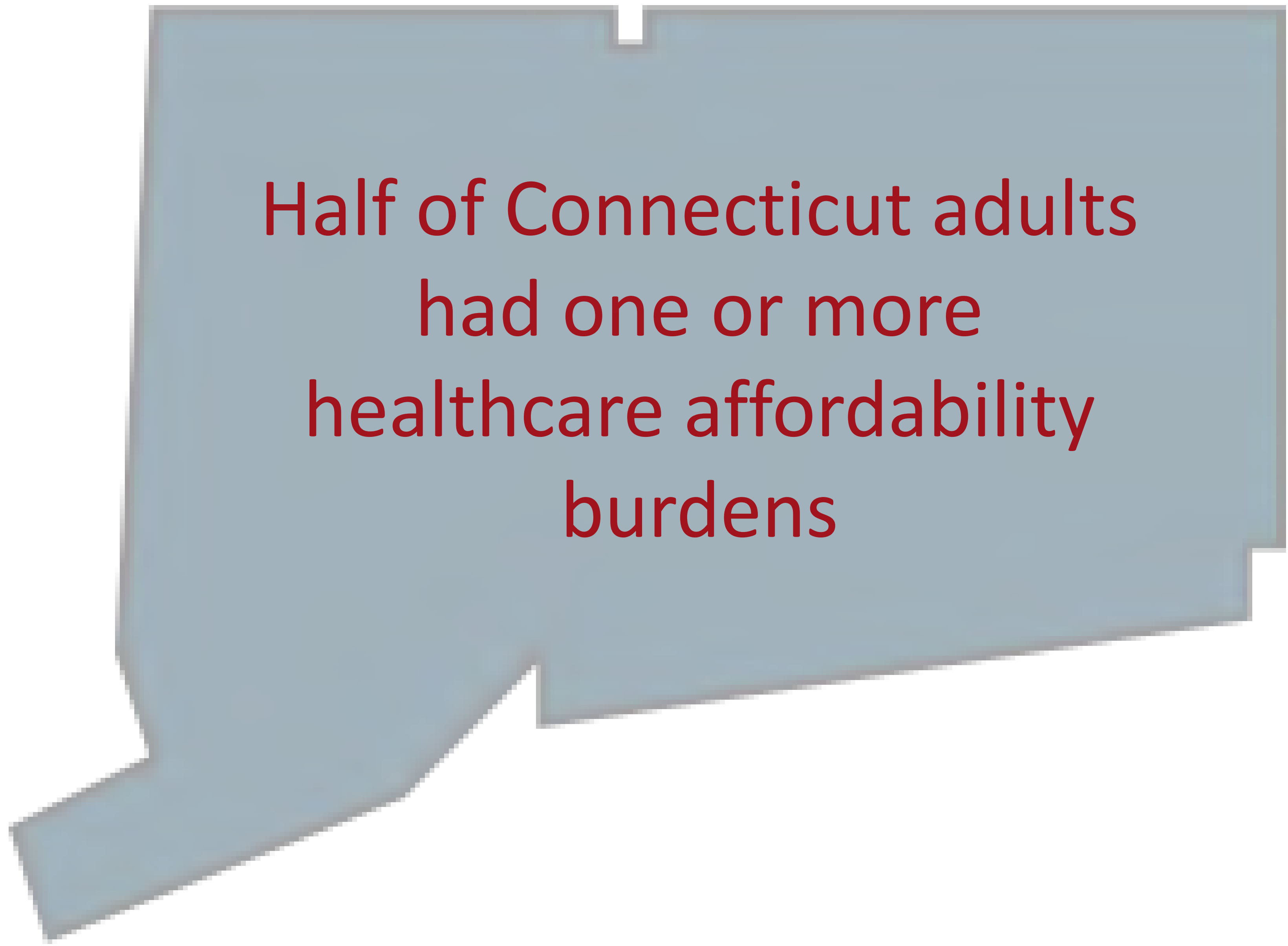
Results from Altarum's Consumer Healthcare Experience State Survey

Altarum's Consumer Healthcare Experience State Survey (CHESS):

- designed to elicit respondents' unbiased views on a wide range of health system issues
- a web panel from *Dynata* of ~1,000 residents 18 and older
- fielded Jan. 31-Feb. 9, 2018
- English language only

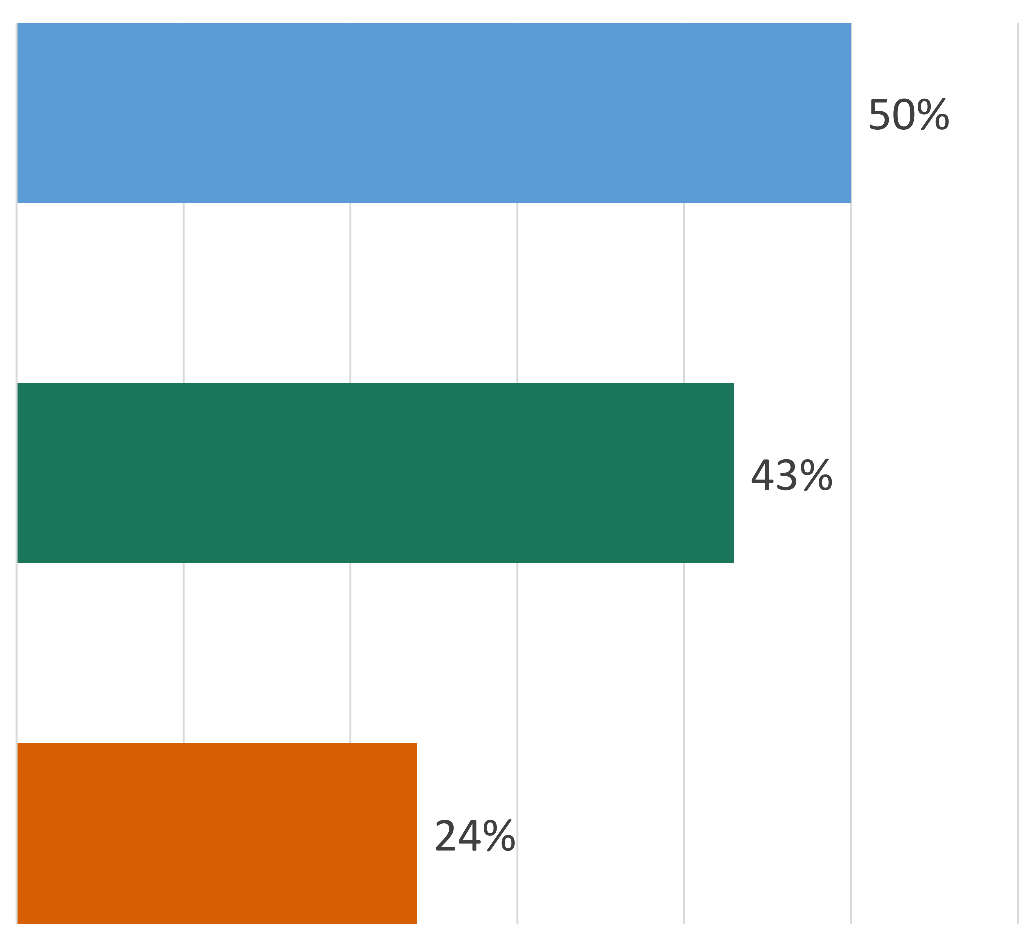
More methodology and demographics available at:
HealthcareValueHub.org/CT-2018-Healthcare-Survey

High Healthcare Affordability Burdens in Connecticut



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub’s Consumer Healthcare Experience State Survey (CHESS)

Healthcare Affordability Burdens: *Percent of Connecticut Adults*



Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

2018 Poll of Connecticut Adults

Cost Barrier to Care: Detail

- **33%** - Delayed going to the doctor/having a procedure done
- **24%** - Avoiding going to doctor/having procedure done
- **22%** - Skipped recommended medical test or treatment
- **15%** - Did not fill a prescription
- **13%** - Cut pills in half/skipped doses of medicine
- **11%** - Had problems getting mental health care

Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

2018 Poll of Connecticut Adults

Struggled to Pay Medical Bills: Detail

- **10%** - Contacted by a collection agency
- **9%** - Used up all or most of their savings
- **7%** - Racked up large amounts of credit card debt
- **6%** - Placed on a long-term payment plan
- **6%** - Unable to pay for basic necessities (food, heat, or housing)
- **4%** - Borrowed money/got a loan/another mortgage on home

Source: 2018 Poll of Connecticut Adults, Ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey

Healthcare affordability burdens hit lower income families the hardest….

Percent of Adults with Any Healthcare Affordability Burden in Past Year, by Household Income

Household Income	Percent
Less than $40,000	53%
$40,001-$74,999	51%
More than $75,000	36%

Source: 2018 Poll of Connecticut adults, ages 18+, Altarum Healthcare Value Hub's Consumer Healthcare Experience State Survey (CHESS)

QUESTIONS about HDHP evidence?

Solutions

Addressing Healthcare Affordability In 4 ~~Easy~~ Steps

1) Smart, affordable cost-sharing
2) Address wasteful spending
3) Address prevention “failures”
4) Address excess healthcare prices

Smart, Affordable Cost-sharing

Reminder

- There are numerous ways to divide the cost of needed medical care between the health plan and the beneficiary.
- Cost-sharing design decisions affect how this spending is distributed across the enrolled population and only affect total spending at the margins.

Smart, Affordable Cost-sharing

Goal: avoid creating barriers to care while still discouraging low-value care; make cost-sharing designs understandable

- Use copays, not coinsurance; tie cost-sharing levels to family income
- Value Based Insurance Design

Value-based Insurance Design: “clinically nuanced benefit design”

Lower cost-sharing for high value services

Higher cost-sharing for low value services

Considerations for consumer-friendly VBID

- Focus on High Value Care
- Ensure Benefits are Based on Evidence
- Prioritize – overly complex cost-sharing doesn’t help patients
- Don’t Confuse VBID with Wellness Programs

VBID: What Does The Evidence Say?

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EASY EXPLAINER | NO. 3 | JULY 2016

Value-Based Insurance Design: Potential Strategy for Lower Costs, Increased Quality

Health insurance plans have long included various forms of consumer cost sharing, in the form of deductibles, copays and coinsurance. Value-based insurance design (VBID) introduces a new twist by aligning the amount of cost sharing with the relative value of care: reducing or eliminating cost sharing for high-value care while increasing cost sharing for low-value care. By reducing financial barriers, the goal is to incentivize consumers to make better healthcare treatment decisions.

VBID was originally conceived as a way to encourage patients with chronic conditions, such as diabetes, to adhere to long-term treatment plans. Insurers have since expanded VBID to encourage the use of preventive services and other types of high-value care. The Affordable Care Act (ACA) embraced this concept by requiring that key preventive services be provided with no patient cost sharing. More recently, HHS announced a Medicare Advantage VBID trial in seven states starting in 2017.

By reducing patient cost sharing—providing a "carrot"—insurers hope to incentivize the use of high-value care, ultimately leading to better health outcomes and lower costs. Ideally any savings associated with having healthier beneficiaries would then be passed onto consumers in the form of lower premiums. In contrast, by increasing cost sharing—providing a "stick"—VBID may be used to discourage the use of healthcare that is deemed low value. Here, the target is not patient health, but rather preventing wasteful spending on services that are either over-used or not considered cost effective. An example of low-value care would be prescribing an antibiotic for a viral sinus infection or performing an MRI for back pain that has not been given time to heal.

What Does the Evidence Say?

Surprisingly, the response to lower cost-sharing incentives under VBID is not as strong as originally predicted. An analysis of thirteen studies found an average three percent increase in treatment adherence among patients with chronic conditions. These results indicate that factors other than, or in addition to, cost continue to prevent many consumers from using the high-value care that VBID aims to promote. In many cases, consumers may simply lack the information, expertise or motivation to change their behavior. Because of this, the benefits of VBID "carrots" have largely accrued to consumers who are already relatively health conscious and treatment compliant.

Perhaps for these reasons, the evidence is mixed on the effect of VBID on health outcomes. Although some studies show health improvements, others found improved treatment adherence did not necessarily lead to better clinical outcomes.

Early but promising research shows that employing VBID as one piece of a larger and more comprehensive strategy can encourage healthy behavior. Studies indicate that plans are more effective at boosting treatment compliance when they provide more generous benefits, target high-risk patients, include wellness programs and employ mail-order pharmacies.

The other side of VBID—providing a "stick" to discourage lower value care—is rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known

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- Surprisingly, response to lower cost-sharing incentives under VBID is not as strong as predicted.
- Because of this, the benefits of VBID “carrots” have largely accrued to patients who are already relatively health conscious and treatment compliant.
- VBID “sticks” (to discourage lower value care) are rarely implemented and for the most part unstudied. While it is well understood that higher cost-sharing discourages the use of care, it is not yet known whether patients will respond in the nuanced way that VBID intends, as opposed to reducing the use of care indiscriminately.

What does it MEAN to make cost-sharing affordable?

RESEARCH BRIEF NO. 16 | JANUARY 2017

Making Healthcare Affordable: Finding a Common Approach to Measure Progress

Healthcare affordability is a long-standing, top-of-mind worry for consumers.[1] Surveys show that up to one-third of Americans report postponing needed care due to cost, two-thirds of insured Americans report difficult affording deductibles and one-quarter report difficultly affording out-of-pocket copayment or coinsurance obligations.[2] The incoming administration has promised to broaden healthcare access, *make healthcare more affordable* and improve the quality of the care available to all Americans.[3]

SUMMARY

Healthcare affordability is a long-standing, top-of-mind worry for consumers and as many as one-third report affordability problems. For decades, state and federal policymakers have promised to make healthcare affordable–with some successes–but we know surprisingly little about the affordability thresholds that would provide widespread access to both coverage and healthcare services.

Going forward, we need to agree on the most important aspects of evidence-based, consumer-friendly affordability standards. Important criteria include: the standard should include all healthcare-related expenses (premiums and cost-sharing), thresholds must slide with income and family size, must reflect an accurate assessment of families' financial liquidity and different incomes, and be harmonized across coverage programs (employer, Medicaid, CHIP, Medicare).

But what does it mean to make healthcare affordable or even more affordable? These considerations are particularly urgent as "consumerism" is increasingly embraced—promoting high deductibles and increased consumer cost sharing.

Surprisingly, there is no standard definition of affordability in healthcare that can be readily used for policy purposes.[4] Instead, there is a patchwork of inconsistent program standards and a diversity of opinions on what constitutes affordability. Yet clear standards are important to realizing policy goals. For example, in 1965, the Office of Economic Opportunity adopted poverty thresholds as a working definition of poverty in order to operationalize President Johnson's War on Poverty.[5] While there are valid criticisms of federal poverty levels (FPL), this measure lended clarity to the policymaking process and evaluation of outcomes.

Creating healthcare affordability standards may seem like an inherently subjective exercise—what seems affordable to some may not seem affordable to others of similar means—but evidence and experts suggest that it is both possible and useful to explore this question. This Research Brief explores the background on health affordability and suggests evidence-based criteria for defining an affordability standard in healthcare.

Components of an Affordability Standard

There are some basic, common-sense criteria that give direction to an affordability standard but stop short of being definitive.

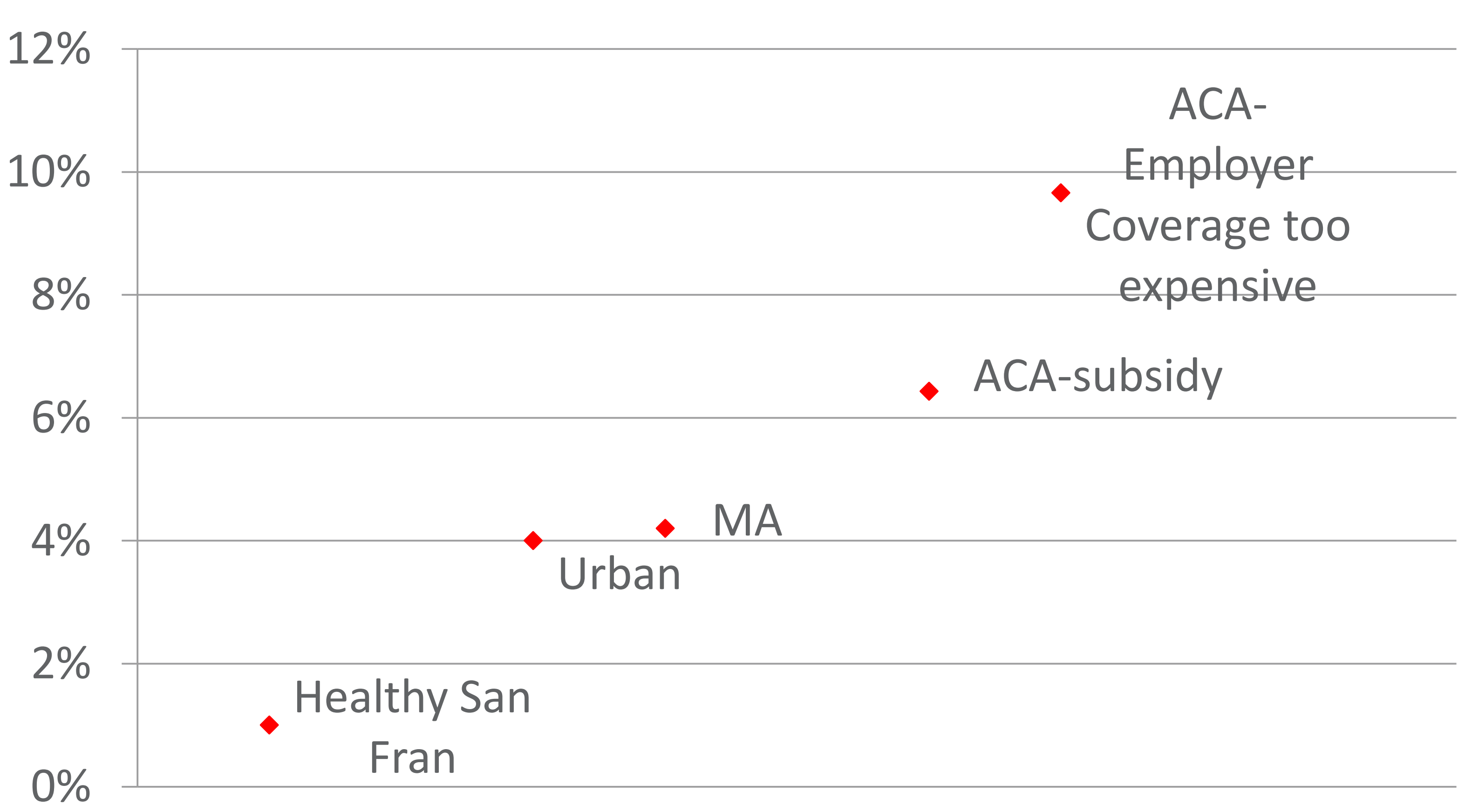
Goal: Remove financial barriers to care

The first step to establishing an affordability standard is to determine the goal towards which we strive. In the past, policymakers have often prioritized increasing

Hub finds lack of harmonization across programs with respect to affordability thresholds

- IRS Tax Deductibility Threshold
- Medicaid
- CHIP
- Massachusetts (Romneycare)
- Healthy San Francisco
- ACA
- Urban Institute estimates for more generous ACA thresholds

Affordability of Premium Alone: Not Harmonized Across Programs



Defining a Healthcare Affordability Standard

- Goal: No financial barriers to care
- Consider a “Total Cost” concept. What percent of income can a household devote to:
    - Cost of coverage (premiums)
    - Cost-sharing for covered services
    - Cost of needed services not included in the benefit package
- Standard slides with income and family size

Address Inadvertent, Surprise Out-of-Network Bills

- Get patients out of the middle – prohibit balance billing and include a mechanism to resolve provider payment
- Stronger network adequacy transparency provisions – at point of insurance shopping, show likelihood of getting a Surprise Bill
- Better consumer assistance

More Info: https://www.healthcarevalluehub.org/improving-value/browse-strategy/surprise-medical-bills

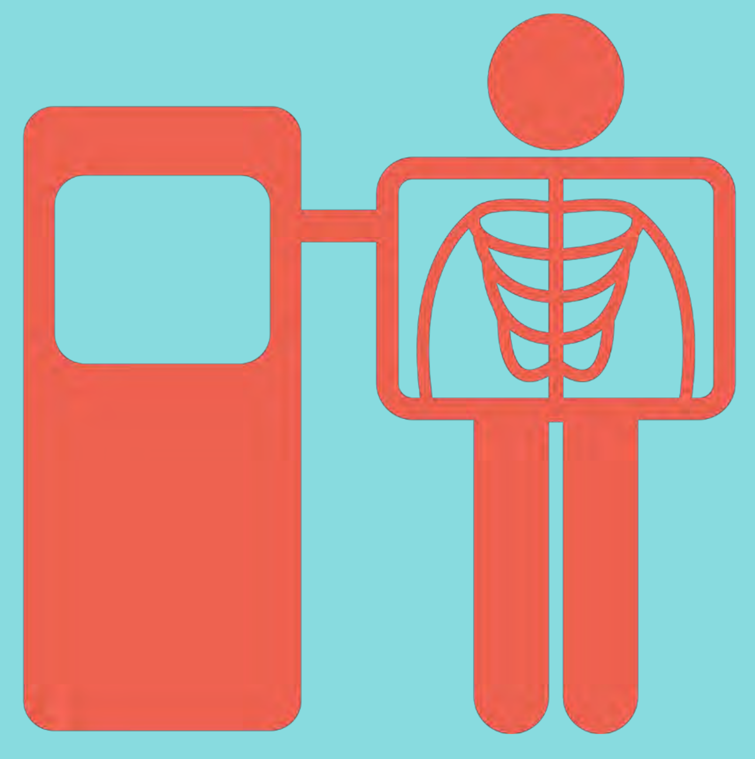
Short-term Health Plans
aka skimpy health plans

- Premiums savings stems from less coverage, not duration of the policy
- Exempt from ACA consumer protections:
  - have annual and life-time caps
  - likely don’t cover minimum essential services like maternity and mental health; cost-sharing obligations can > $20,000
  - can exclude pre-existing conditions
  - not subject to MLR minimum: 80% of premium dollar spent on medical care

How are states protecting consumers?

- Prohibit sale of Short-term plans (MA, NJ, NY, CA)
- Enact term limits (MD-90 days)
- Enact state limits on renewal
- Benefit mandates to place a floor under the coverage offered by ST plans (CT)

Address Wasteful Spending



One-Third of Healthcare Spending is Wasted

Average Healthcare Spending per Person (2016)
$11,193

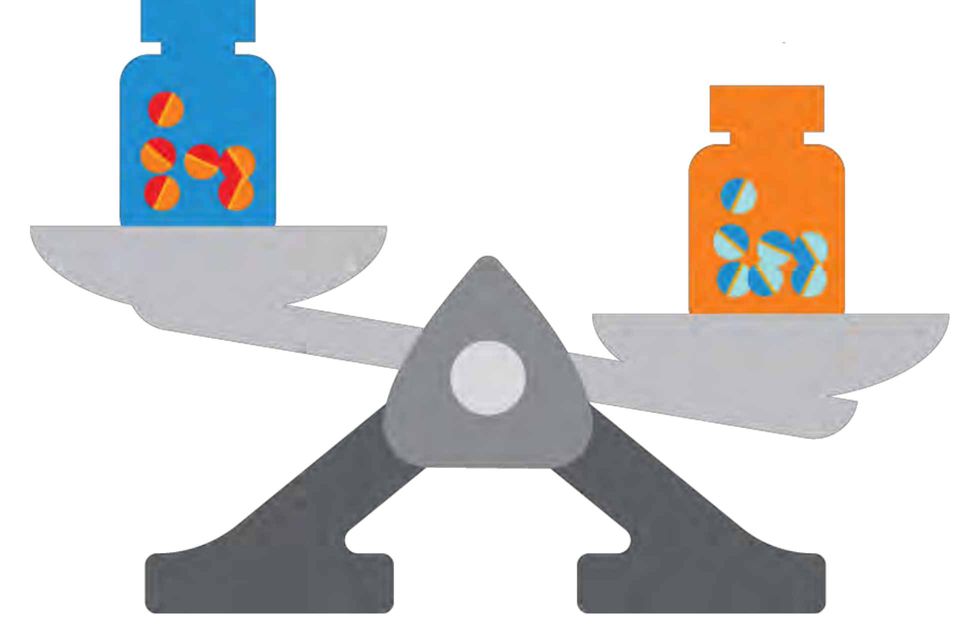
Wasted Spending
$3,431

Necessary Spending

Category	Share	Details
Low-Value Care	14% of spending	**Unnecessary Services** — *Examples: Duplicate Tests, Choosing Wisely Services*; **Inefficient Care Delivery** — *Example: Test Results Not Shared*
Administrative Waste	8% of spending	*Example: Billing Errors*
Pricing Failures	4% of spending	*Example: Excessive Profits*
Fraud	3% of spending	*Example: False Claims*
Prevention Failures	2% of spending	*Example: Missed Flu Shot*

Insufficient Comparative Effectiveness Research Undercuts Efforts

Up to 50% of our care may be provided without evidence of effectiveness



Some care is not ambiguous; tagged as low- or no-value in most cases

Diagnostic Testing and Imaging Before Low-Risk Surgery

19.2 million unneeded pre-surgery tests and imaging services

$9.5 billion in avoidable spending

Vitamin D Screening Tests

6.3 million non-clinically indicated Vitamin D tests

$800 million in avoidable spending

Prostate-Specific Antigen Testing for Men 75+

>1 million Medicare beneficiaries 75 and older receive a PSA test

$44 million in avoidable Medicare spending

Imaging for Low-Back Pain within 6 Weeks of Onset

1.6 million unnecessary imaging services for low-back pain

$500 million in avoidable spending

Branded Drug Use when Chemically Equivalent Generics are Available

$14.7 billion spent unnecessarily on branded drugs

Source: Center for Value-based Insurance Design

Many, many other services have been identified as low or no-value.

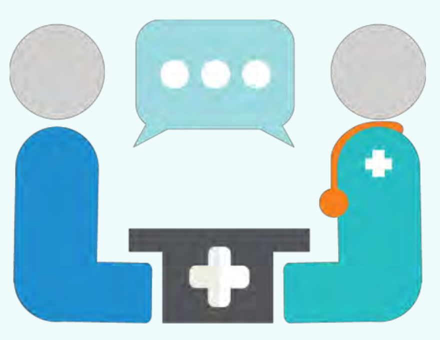
GETTING UTILIZATION RIGHT: STRATEGIES

Provider Payment Reform

GET INCENTIVES RIGHT

Non-Financial Provider Incentives

ALSO POWERFUL



Patient Shared Decision-Making should be the

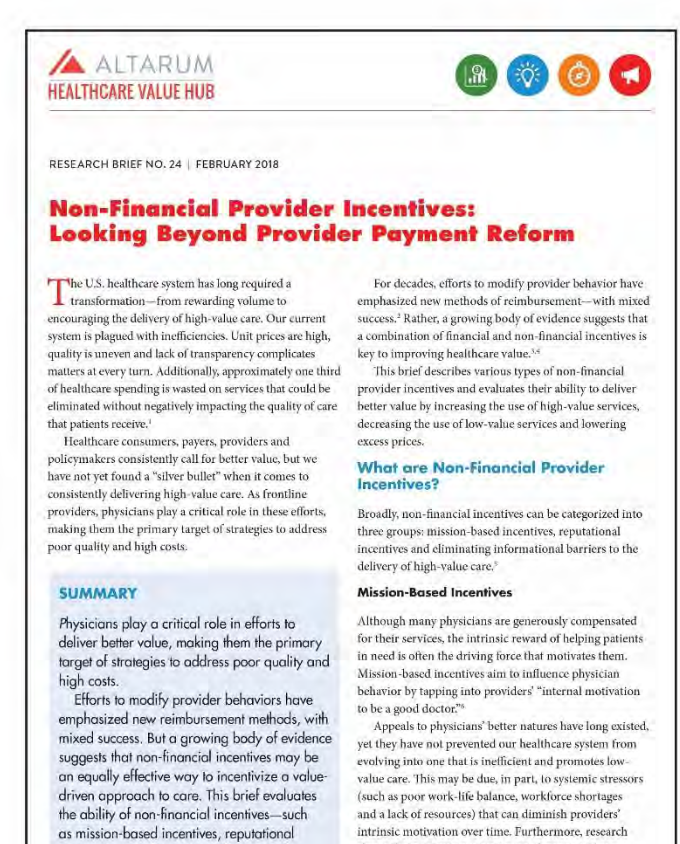
STANDARD OF CARE

Insurance Benefit Design but

KEEP IT SIMPLE

Financial incentives are not our only provider tool….

- Non-financial incentives:
  - Peer comparisons
  - Peer recognition
  - Eliminate barriers
  - Institutional support and leadership



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RESEARCH BRIEF NO. 24 | FEBRUARY 2018

Non-Financial Provider Incentives: Looking Beyond Provider Payment Reform

The U.S. healthcare system has long required a transformation—from rewarding volume to encouraging the delivery of high-value care. Our current system is plagued with inefficiencies. Unit prices are high, quality is uneven and lack of transparency complicates matters at every turn. Additionally, approximately one third of healthcare spending is wasted on services that could be eliminated without negatively impacting the quality of care that patients receive.[1]

Healthcare consumers, payers, providers and policymakers consistently call for better value, but we have not yet found a "silver bullet" when it comes to consistently delivering high-value care. As frontline providers, physicians play a critical role in these efforts, making them the primary target of strategies to address poor quality and high costs.

SUMMARY

Physicians play a critical role in efforts to deliver better value, making them the primary target of strategies to address poor quality and high costs.

Efforts to modify provider behaviors have emphasized new reimbursement methods, with mixed success. But a growing body of evidence suggests that non-financial incentives may be an equally effective way to incentivize a value-driven approach to care. This brief evaluates the ability of non-financial incentives—such as mission-based incentives, reputational incentives and eliminating informational barriers—to deliver better healthcare value.

For decades, efforts to modify provider behavior have emphasized new methods of reimbursement—with mixed success.[2] Rather, a growing body of evidence suggests that a combination of financial and non-financial incentives is key to improving healthcare value.[3,4]

This brief describes various types of non-financial provider incentives and evaluates their ability to deliver better value by increasing the use of high-value services, decreasing the use of low-value services and lowering excess prices.

What are Non-Financial Provider Incentives?

Broadly, non-financial incentives can be categorized into three groups: mission-based incentives, reputational incentives and eliminating informational barriers to the delivery of high-value care.[5]

Mission-Based Incentives

Although many physicians are generously compensated for their services, the intrinsic reward of helping patients in need is often the driving force that motivates them. Mission-based incentives aim to influence physician behavior by tapping into providers' "internal motivation to be a good doctor."[6]

Appeals to physicians' better natures have long existed, yet they have not prevented our healthcare system from evolving into one that is inefficient and promotes low-value care. This may be due, in part, to systemic stressors (such as poor work-life balance, workforce shortages and a lack of resources) that can diminish providers' intrinsic motivation over time. Furthermore, research shows that intrinsic motivation can be overridden by other incentives, such as financial gain and loss.[7] Despite these challenges, evidence suggests that mission-

Address “Prevention Failures”

LOW-VALUE CARE .VS HIGH-VALUE CARE

LOW-VALUE CARE

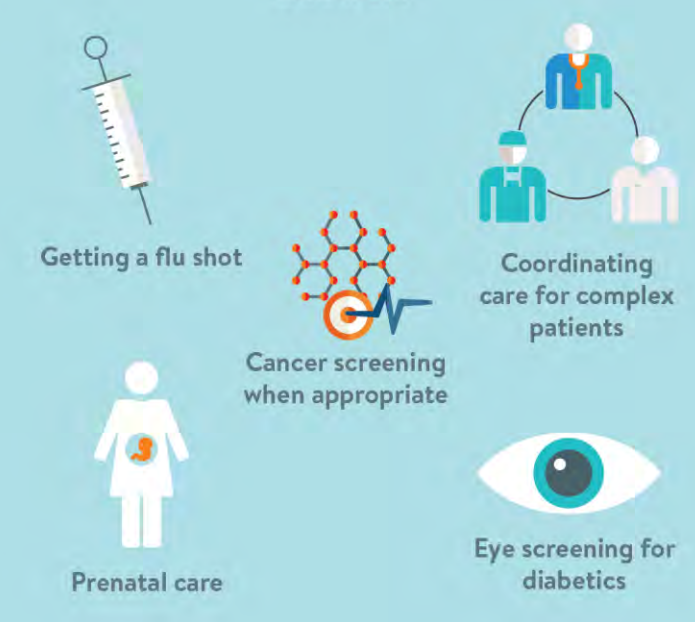
EXAMPLES

- Unneeded diagnostic testing
- Bloodwork for low-risk surgery
- Unneeded imaging
- Use of branded drugs when generics are available
- Elective/unwarranted C-sections

Spending wasted on low-value care is estimated to be more than $340 billion each year.

HIGH-VALUE CARE

EXAMPLES



- Getting a flu shot
- Cancer screening when appropriate
- Coordinating care for complex patients
- Prenatal care
- Eye screening for diabetics

Providing more high-value care could avoid costly care later, saving more than $55 billion each year.

For details on the strategies, go to:
HealthcareValueHub.org/low-vs-high-value-care

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Fraud	3% of spending	*Example: False Claims*
Prevention Failures	2% of spending	*Example: Missed Flu Shot*

SOCIAL DETERMINANTS OF HEALTH
Unhealthy Food Options
MARKET
WINE
BEER
SALE
Lack of Transportation Options
NOT IN SERVICE
Quality of Education
Economic Instability
FORECLOSURE
SCHOOL
Substandard Housing
PARK
CLOSED
Public Safety
Inadequate Parks/Playgrounds
The conditions where you live, work and play impact your health outcomes.
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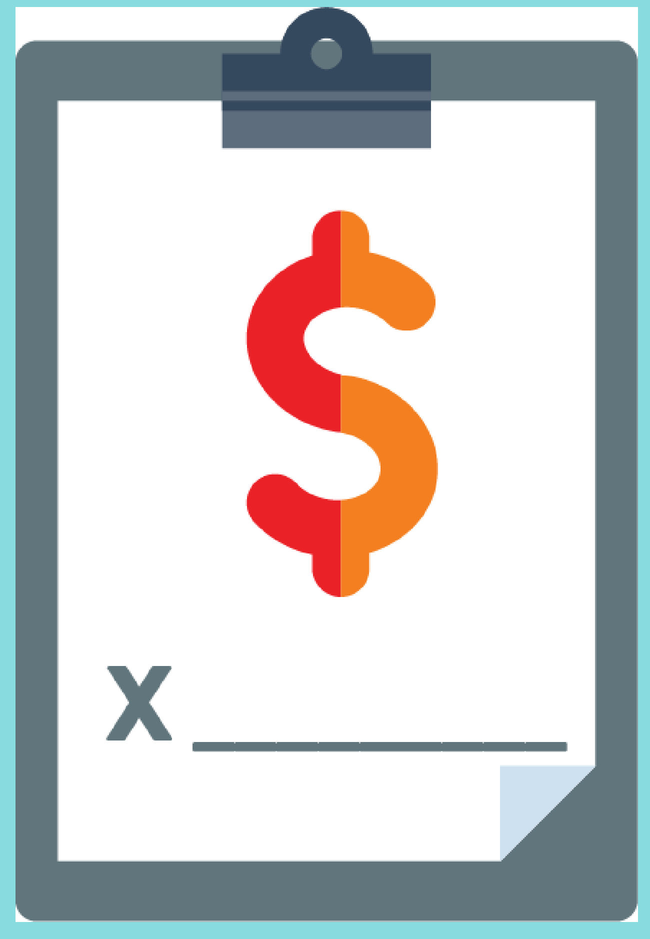
Addressing Personal and Social Determinants of Health

- Assess community needs and capacity to address needs
- Collect better data to track disparities and support targeted interventions
- Place-based, Accountable Health Structures, plus variations
  - Environmental nudges
  - Social-medical models of care
- Address financing silos

Addressing High Unit Prices



UNREASONABLE PRICES: STRATEGIES

Price Transparency to expose

HIGH PRICES

Anti-trust, CON/DON, foster competition to address

MONOPOLY POWER

Reference pricing, rate setting, price regulation to address

PRICING OUTLIERS

Global Budgets to cap

OVERALL SPENDING

Neither Paid Amount nor Charge Provide an Accurate Picture of the Underlying Cost

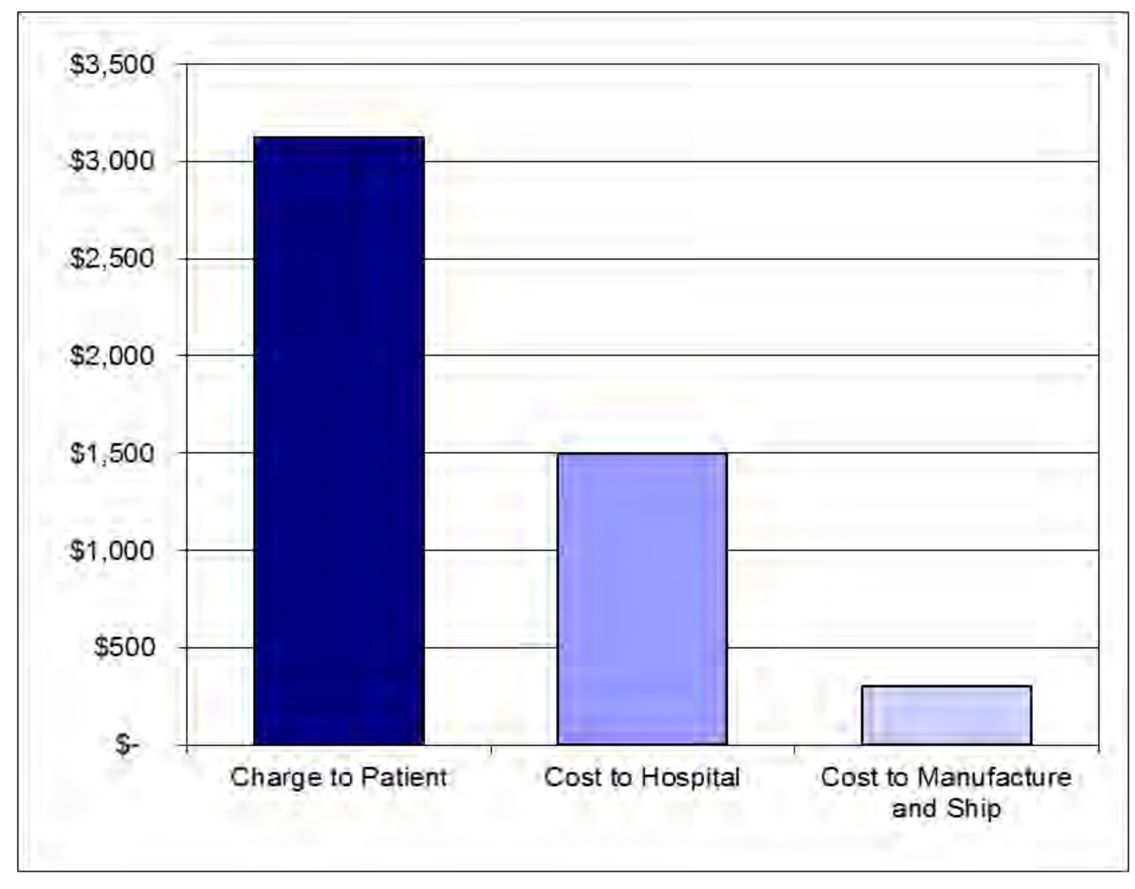
For the most part,

we have no idea what

the underlying cost of

inputs is.

Dose of Drug Flebogamma



Source: Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us," Time, March 4, 2013

Which Price Concept(s) Should We Make Transparent?

Listed Charges (Charge-master)

Negotiated Charges (varies by payer)

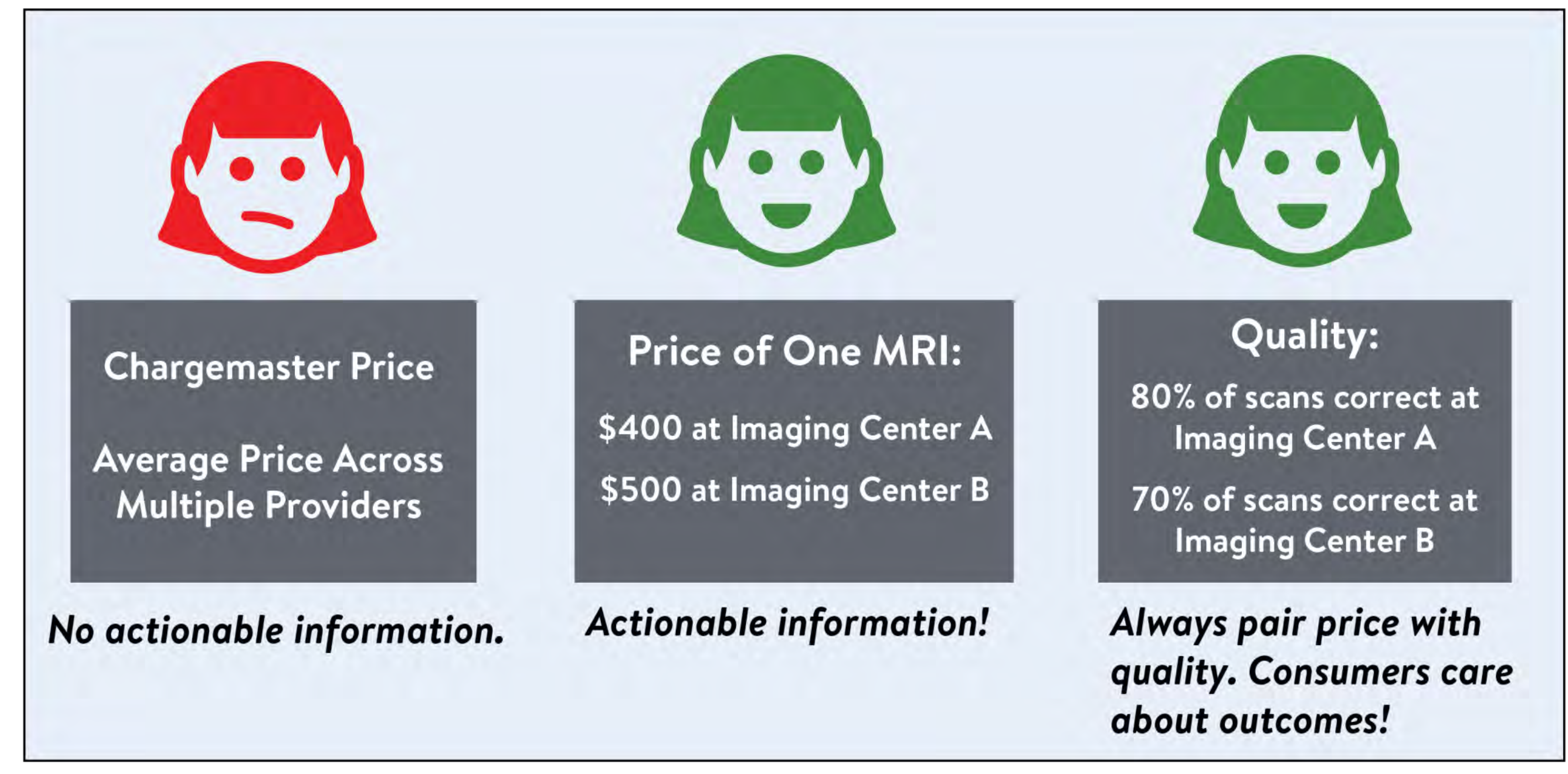
The fair price?

Medicare Payments

Patient OOP (varies by insurer)

Cost to produce the good or service

Healthcare Price Transparency...



...can help consumers budget and plan, but it is unlikely to drive value in the marketplace – especially when hospital markets lack competition

What is a State Health System Oversight Entity?

An entity empowered to look systematically across various types of health and social spending, with tools and authority to identify where the state needs to be more efficient in terms of value for each dollar spent, including addressing quality short-comings and affordability problems for residents.

Important roles can include:

- Leadership/legislative recommendations
- Data stewardship and infrastructure
- Convener
- Innovator
- Regulator/enforcer

Health System Oversight: A Scan

RESEARCH BRIEF NO. 20 | NOVEMBER 2017

Health System Oversight by States: An Environmental Scan

The high cost and uneven quality of healthcare have profound negative impacts on the health and financial security of American families. Unaffordable prices can lead consumers to delay or forgo needed medical care and cause painful budgetary tradeoffs, medical debt and bankruptcy.[1] Moreover, the quality of care that patients receive does not uniformly reflect our high healthcare spending.

States are under financial pressure to prioritize and promote health system efficiency to manage their budgets, attract employers and to address the healthcare affordability concerns of their residents.[2] While all states have well-defined roles for certain segments of their health system—such as Medicaid, state employee coverage, healthcare delivered within the criminal justice system, and public health and safety-net coverage—relatively few states take a comprehensive, systematic approach to ensure that all consumers get value for the money they spend.

But there are exceptions: a few states such as Vermont, Colorado, Pennsylvania and others have oversight agencies focused on lowering spending, while increasing quality and access for their residents. This report compares state approaches to comprehensive health system oversight. Through this exercise, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

SUMMARY

It's hard to imagine robust progress on healthcare value issues without an overarching entity whose role is to look at the big picture. And yet, to date, only a few states have a centralized oversight agency that focuses on reducing healthcare costs, improving quality, bringing spending in line with overall economic growth and implementing new innovations for better value.

This report is a comparison of broad healthcare oversight authorities in seven states. We found significant variation in the responsibilities and powers these entities hold. Common roles include recommending strategies to combat rising health-care costs and monitoring aspects of healthcare quality. Less common roles include regulating health insurance rates, piloting new innovations and implementing global budgets.

By comparing these roles, we hope to help states more effectively leverage this approach to reduce healthcare spending and improve quality.

Why is an Oversight Authority Needed?

While there will always be a federal and private payer role, there are myriad reasons why much of the activity to successfully address poor healthcare value needs to occur at the state level.[3]

For one, our fragmented health system typically limits the ability of any one payer or stakeholder to incentivize the provider practice changes that will lead to lower costs.[4] States are well positioned to serve as a convener and support the multi-payer coordination that is critical for meaningful progress on healthcare value.

Further, broad access to coverage and getting to better healthcare value are inseparable, intertwined policy objectives. State efforts to ensure access to coverage will be eased if the costs of care are more reasonable. In addition, efforts to improve the value we get for our healthcare dollar—such as provider payment reform—are universally premised on a population having coverage.

Moreover, state governments are uniquely positioned to invest in "upstream" approaches that lead to healthier communities. Research shows that just 10-20 percent

NEW: in addition to tracking the value of health spending over time, include an accounting mechanism to recognize future savings from current year investments

HealthcareValueHub.org/state-accountability

All Payer Claims Datasets (APCD) Support Success

ALTARUM
HEALTHCARE VALUE HUB

RESEARCH BRIEF NO. 8 | September 2015

All-Payer Claims Databases: Unlocking Data to Improve Health Care Value

Every year, billions of lines of health care data are generated when health care services are billed and paid by insurers. These claims data contain a wealth of information about what services are being provided and what they cost. But these data are often locked up in proprietary datasets owned by insurers or aggregators that often deny access or charge high prices.

All-payer claims databases (APCDs)[1] are used to unlock this data by collecting health care claims and other data into databases that can be used by a wide variety of stakeholders to monitor and report on provider costs and the use of health care services. Armed with this information, policymakers, regulators, payers and other key stakeholders can begin to address unwarranted variation in prices, health care waste and other consumer harms.

SUMMARY

Meaningful health system improvements are hindered when systematic information about prices, quality and utilization levels are not available. All-payer claims databases (APCDs) are an important tool for revealing spending flows within a state and measuring progress over time. To fully realize their value, implementation of an APCD requires broad stakeholder engagement, sufficient funding, participation by consumer representatives and extensive data access so that the data can be used for a variety of public purposes. APCDs are a necessary step to building health care transparency in states.

What are All-Payer Claims Databases?

APCDs are large-scale databases created by states that contain diverse types of health care data (see Exhibit 1).[2] APCDs usually contain data from medical claims with associated eligibility and provider files. APCDs may also include HMO encounter data and/or pharmacy and dental claims.[3] All-payer claims databases differ from insurers' proprietary claims databases in that APCDs bring together data from multiple payers and are assembled and managed in the public interest.

When the data includes Medicaid and Medicare claims as well as fully insured and self-insured commercial claims we call it an *all-payer* claims database. When it includes only some of these payers it is referred to as a *multi-payer* claims database. Generally, APCDs are created through state legislation, although in some circumstances they are created by voluntary data reporting arrangements.

Who Finds This Information Useful and Why?

All-payer claims databases are beneficial for a wide range of stakeholders, including policymakers, consumers, payers and researchers, and have been touted as a key part of health system transformation because they increase health care spending transparency and help inform decision making.

Consumers can benefit from the increased price transparency that APCDs provide, particularly when the data is used to create a consumer-friendly website that enables them to compare cost information for specific procedures across providers. More importantly, they benefit indirectly when the data in the APCD is used by other stakeholders to reduce pricing variation or improve quality.

Policymakers and regulators can use APCD data for a wide variety of purposes. A key use is to understand the health pricing

"APCDs are a necessary step to building healthcare transparency in states."

- With APCD, learn:
  - Total spending with price, utilization, location, payer and service sector components
- When claims data is combined with other data streams, learn:
  - Affordability for consumers
  - Outcomes, including medical harm
  - Patient experience
  - Disparities
- Critical to measure progress towards state goals

QUESTIONS about:

Smart, affordable cost-sharing?
Wasteful spending?
Prevention “failures”?
Excess healthcare prices ?

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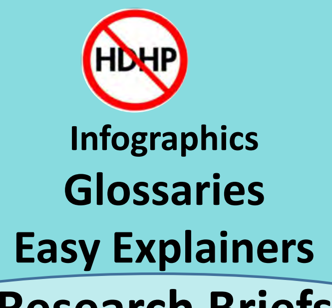

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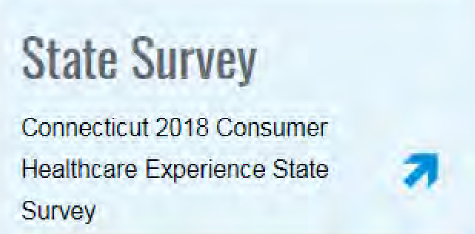
State News

Connecticut

Connecticut has explored many approaches to improving healthcare value for consumers over the past several years. The state created an all-payer claims database in 2012 and passed a comprehensive law prohibiting certain out-of-network billing practices and establishing a "certificate of need" process for insurance companies to acquire physician groups in 2015. The law also requires health insurance companies to submit an annual report to the Connecticut Health Insurance Exchange that lists the billed and allowed amounts paid to each healthcare provider in the insurer's network for certain diagnoses and procedures, and the corresponding out-of-pocket costs. The state launched an Office of Health Strategy in 2018 to implement comprehensive, data-driven strategies that promote equal access to high-quality healthcare, control costs and ensure better health for Connecticut residents. Among other responsibilities, the office will oversee the state's four-year State Innovation Model grant to test multi-payer healthcare payment and service delivery models to improve health system performance, increase quality of care and decrease costs.

As of 2019, Connecticut is one of the few states that has comprehensive protections from surprise medical bills. However, high drug costs remain a significant consumer concern. The state has passed several pieces of drug pricing legislation to address these concerns, including laws that require pharmaceutical companies to disclose and explain drug price hikes; force pharmacy benefit managers to report how much they collect in rebates and how much they keep; and protect pharmacists from "gag clauses" that prohibit them from disclosing specified information to people purchasing certain drugs.



Final Questions?

Contact Lynn at Lynn.Quincy@Altarum.org or any member of the Hub team with follow-up questions.

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Uploaded by: Bennardi, Maryland Department of Health /Office of Governmen
Position: INFO

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

February 25, 2021

The Honorable Delores G. Kelley
Chair
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 514 – Health Facilities – Hospitals – Medical Debt Protection – Letter of Information

Dear Chair Kelley and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of information for SB 514 – Health Facilities – Hospitals – Medical Debt Protection.

SB 514 modifies requirements surrounding hospital collection of bad debt. Specific requirements under this legislation involve restrictions on the threshold for debt collection and interest charged, payment plans and screening for financial assistance eligibility, and timeframes for debt collection activities.

Maryland Medicaid participants are not financially responsible for payments on health care services received. Therefore, the provisions of SB 514 would not affect the Medicaid-enrolled population. However, if enacted, there would be an indeterminate fiscal impact on the Medicaid program, due to Maryland's unique, all-payer approach to uncompensated care for acute care hospitals.

During the annual update factor process that determines all-payer hospital global budgets for the upcoming fiscal year (FY), the Health Services Cost Review Commission (HSCRC) prospectively calculates the cost of uncompensated care, forming a statewide pool. The calculation takes into account actual statewide uncompensated care (UCC) for the prior year, as well as a logistic regression model that includes area deprivation index (ADI), payer type and site of care for each hospital. The per-hospital regression outputs statewide probabilities for the various combinations of site of care, payer type and ADI, and those in turn are used to predict UCC for each hospital. Services delivered to commercial patients in the emergency department most greatly influence the predicted UCC rate, as they have the highest probability of uncompensated care.

Under SB 514, as written, the uncompensated care pool would likely increase, thereby increasing the amount owed by payers of health care - including Medicaid - according to the payer mix of hospital utilization in that year. Medicaid is typically about 20 percent of the hospital revenues.

I hope this information is useful. If you would like to discuss this further, please do not hesitate to contact me at webster.ye@maryland.gov / (410) 260-3190 or Heather Shek, Director of Governmental Affairs at heather.shek@maryland.gov and at the same phone number.

Sincerely,

Webster Ye
Assistant Secretary, Health Policy

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Position: INFO

Letter of Information to the Senate Finance Committee

SB514: Health Facilities-Hospitals-Medical Debt Protection

Position: Informational

February 23, 2021

The Honorable Delores E. Kelley, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD 21401

cc: Members, Senate Finance Committee

Chair Kelley and Members of the Committee:

Every year, Maryland hospitals sue Maryland residents for $20 to $30 million in unpaid medical bills. We have produced a report that projects the impact of a policy that would limit the ability of Maryland hospitals to file medical-debt lawsuits below various thresholds. To do so, we analyze a dataset of medical-debt lawsuits filed in Maryland on behalf of hospitals from 2009 through 2018.

The typical medical-debt lawsuit filed by hospitals in Maryland involves relatively small dollar amounts. Roughly half of these lawsuits are below $1,000. Lawsuits primarily affect low-income residents: there are three times as many lawsuits per capita filed against residents in the lowest-income regions of Maryland as compared to the highest-income regions.

In our analysis of existing lawsuits, a threshold of $1,000 would avoid 6,974 lawsuits per year, totaling about $3.6 million sought by all Maryland hospitals. However, the impact on hospitals' revenue would not be that full dollar amount, since hospitals do not collect the full amount sought. We estimate that a $1,000 threshold on lawsuits would lead to a total revenue loss per hospital of $7,046 per year. A higher threshold of $5,000 would prevent 12,357 lawsuits per year and about $14 million in complaint amounts across all hospitals. Again, the actual consequences on hospitals' revenue of the $5,000 threshold would be smaller: about $27,000 per hospital per year.

A threshold on lawsuits might also change patients' behavior: some patients may stop paying bills if they know that the hospital will not be allowed to sue them. There are many reasons, however, that patients would still pay their hospital bills, even without the threat of a lawsuit. Hospitals could require prepayment for non-emergency care or take collection activities such as reporting non-payment to credit bureaus. Moreover, many people view deliberate non-payment as morally wrong. The last section of our report assesses the degree to which the estimates above might be affected by changes in patients' willingness to pay their bills. Our estimates are uncertain, in that it is difficult to

estimate how the threat of lawsuits affects bill-paying behavior. At a threshold of $1,000, we examine two alternative scenarios. If 50 percent of patients respond to the policy by no longer paying bills below the threshold, then a $1,000 threshold would lead to a revenue loss per hospital of about $750,000 per year. On the other hand, if only 5 percent of patients stop paying their bills, the impact would be only $76,000 per hospital per year.

Sincerely,

Keith Ericson
Associate Professor of Markets, Public Policy & Law
Questrom School of Business
Boston University

Tal Gross
Associate Professor of Markets, Public Policy & Law
Questrom School of Business
Boston University

SB 514 LOI MIA.pdf
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LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

JAY COON
Deputy Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2408 Fax: 410-468-2020
Email: Michael.paddy@maryland.gov
www.insurance.maryland.gov

**TESTIMONY OF
THE
MARYLAND INSURANCE ADMINISTRATION
BEFORE THE
SENATE FINANCE COMMITTEE**

FEBRUARY 25, 2021

SENATE BILL 514 - HEALTH FACILITIES - HOSPITALS - MEDICAL DEBT PROTECTION

POSITION: LETTER OF INFORMATION

Thank you for the opportunity to provide written comments regarding Senate Bill 514. While Senate Bill 514 does not amend the Insurance Article, there are references to insurance coverage and the Maryland Insurance Administration (MIA). Specifically, § 19-214.2(i) of the bill requires that at least 45 days before filing an action against a patient to collect on a hospital debt, a hospital must provide a notice to the patient that includes, among other things, "an explanation of the patient's right to appeal to the patient's insurance carrier, the Maryland Insurance Administration, or the hospital for any denied reimbursement or access to free or reduced-cost care, and the need to inform the hospital if an appeal is in process."

The MIA is concerned that the language in § 19-214.2(i)(2)(iii)(7) as drafted may confuse patients as to what the MIA's role and authority is. The language implies that a consumer may appeal to the MIA for "access to free or reduced-cost care," which is not accurate. This could lead to increased calls in the Life and Health Complaints Unit from confused consumers who mistakenly believe they received a notice indicating that the MIA can help them obtain access to free care. The MIA would recommend amending this language to distinguish between the MIA's role (i.e., investigating consumer complaints about reimbursement denials from insurance carriers) and a hospital's role (i.e., providing access to free or reduced-cost care).

Additionally, § 19-214.2(f)(4) of the bill states that if a hospital is informed that an appeal or review of a health insurance decision is pending, Senate Bill 514 requires a hospital to wait to report a debt to a consumer reporting agency or send the case to a debt collector until 60 days after the appeal is complete. The bill does not differentiate between "appeals" and "grievances" (i.e., disputes over medical necessity determinations), and does not explain that in most cases, a

consumer must exhaust the carrier's internal appeal process before filing a complaint with the MIA. Furthermore, the notice provision of the bill does not address the fact that there are various time limitations on the consumer's right to request reimbursement from the insurance carrier and right to file a complaint with the MIA. Conceivably, a consumer could receive a notice from the hospital of their right to appeal to the carrier or the MIA after the deadline to exercise those rights has expired, resulting in consumer confusion and frustration. The bill should be amended to clarify the patient's rights with respect to the MIA.

While the MIA does not have a policy position on Senate Bill 514, the MIA believes that the bill should be reviewed by the Committee to clarify the role of the MIA, differences between appeals and grievances and that a consumer must exhaust a carrier's internal appeal process before filing a complaint with the MIA.