Maryland
Hospital Association

House Bill 565 – Health Facilities – Hospitals – Medical Debt Protection

Position: *Oppose*
February 16, 2021
House Health & Government Operations 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 House Bill 565. 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)[1], 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 HB 565 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.

[1] Internal Revenue Service. (September 19, 2020). "Billing and Collections – Section 501(r)(6)".

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 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 HB 565 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 gave a series of concessions on behalf of hospitals even prior to the bill's introduction. MHA was, therefore, surprised to see that many of the points where we believe there was mutual agreement were not included in HB 565. We were disappointed that **despite the good faith effort to work through the language, the version that was introduced retained 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 deductible 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. House Bill 565 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.

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