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February 21, 2024

The Honorable Pamela Beidle
Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: SB 705
Letter of Information

Dear Senator Beidle:

I am writing to share the results of a study Steve Ports Consulting conducted on behalf of the Health Care for All Coalition to assess the impact that previous major coverage expansions had on hospital uncompensated care while factoring in related hospital assessments to support those expansions.

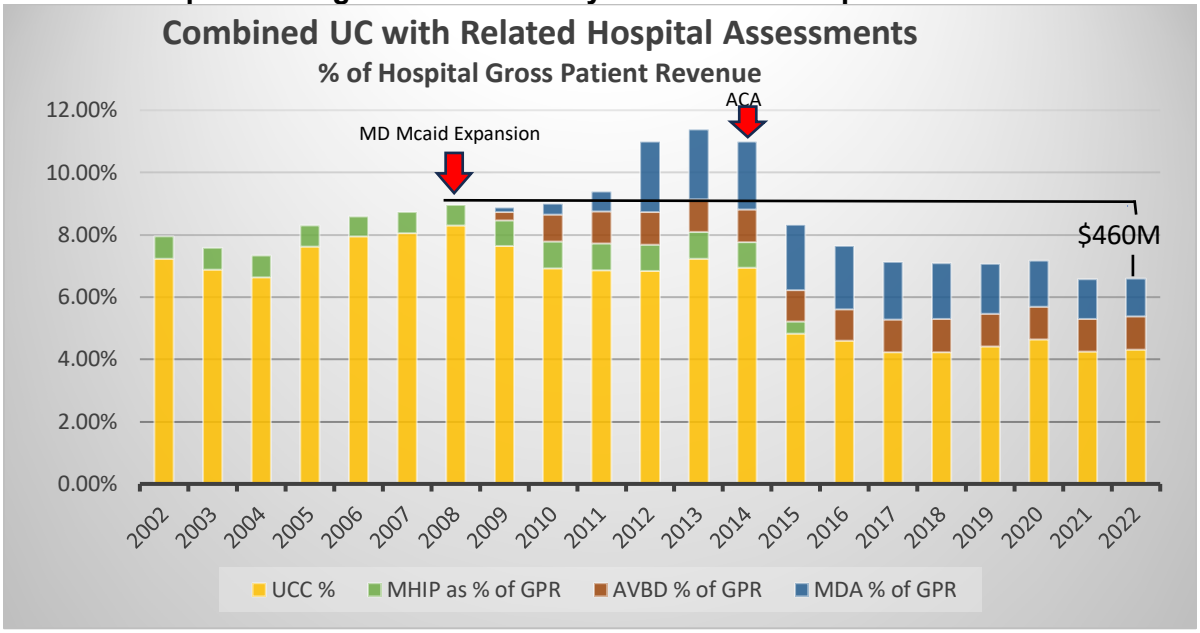
In short, the study found that there was at least $460 million in savings to hospital rates since the 2007 Medicaid expansion was adopted by the Maryland General Assembly. Those savings accrue to purchasers of hospital care such as public and private payers, consumers, and businesses, and provided the potential to reduce the growth in health insurance premiums and tax liability related to public payers.

As shown in Chart 1 below, it had been clear that hospital uncompensated care had declined since the 2007 Medicaid expansion and the Affordable Care Act, it was not as clear as to whether there were net savings to the system after considering the hospital assessments that were put in place to support these expansions. Our study found that there were net savings resulting from these expansions.

In chart 1, the yellow portion of the bars represents hospital uncompensated care which has declined significantly (from 8.29% of hospital revenue to 4.31%) since the 2007 Medicaid expansion. The other portions of the bars represent the former Maryland Health Insurance Plan

hospital assessment (MHIP in green), the Averted Bad Debt hospital assessment (AVBD in rust), and the Medicaid Deficit Assessment (MDA in blue).

Chart 1. Hospital Savings Since 2007 Maryland Medicaid Expansion



The savings found in this study represent a conservative estimate since it is possible that the Governor and the General Assembly would have considered a more limited Medicaid Deficit Assessment following the 2009 recession to support Medicaid through increased enrollment and reduced State revenues, even without the expansion policies.

The Health Care for All Coalition asked Steve Ports Consulting to conduct this analysis to understand the impact that prior health care expansions has had on hospital costs to answer the question as to whether such strategies can work to both improve access to a full array of health care services for individuals who do not have coverage and at the same time provide savings to the system. The findings of this study found that it has worked in the past to accomplish both of those goals.

Attached please find a copy of the full study. I will be happy to discuss the findings of the study at your convenience.

Sincerely,

Stephen M. Ports

Steve Ports
Steve Ports Consulting

Analysis of Hospital Uncompensated Care, Related Hospital Assessments, and Health Care Expansion

Steve Ports Consulting, December 2023

Executive Summary

The purpose of this study is to examine the trends in hospital uncompensated care in Maryland over the past 20 years to assess the impact that several health coverage expansion policies have had on those trends, and to determine whether there have been savings for purchasers of hospital care through a reduction in hospital uncompensated care inclusive of related hospital assessments.

Maryland's unique hospital payment system is predicated on meeting the total cost of care requirements of an agreement with Medicare by achieving cost savings to Medicare and improved quality outcomes. Assessments in hospital rates increase hospital costs to all payers/purchasers of hospital care in Maryland, which can negatively impact Maryland's performance on the total cost of care requirements. However, if those assessments ultimately result in net savings to Medicare and all payers/purchasers, it can help to achieve the goals of the system and at the same time allow for the availability of comprehensive health care coverage to more Marylanders rather than those individuals depending on emergency care in a hospital.

An analysis of trends since Maryland's expansion of Medicaid coverage in 2007 found that the combined percentage of uncompensated care in Maryland hospital rates and related hospital rate assessments has been reduced equating to at least $460 million in savings. These savings have provided the potential to reduce the growth in premiums to premium payers, out-of-pocket costs to consumers, as well as provide fiscal benefits to public payers that are supported by their respective tax bases.

Methodology

This study uses the Health Services Cost Review Commission's (HSCRC) annual disclosure reports for each fiscal year 2002-2020 to determine the actual amount of uncompensated care reported by all Maryland hospitals each year and the percentage of gross patient revenue for regulated and unregulated services that uncompensated care represents. We then reviewed legislation and annual reports of the HSCRC to determine the dollar amount of health care coverage and expansion related hospital assessments that were in hospital rates each year during the same period.

In **Chart 2** we summed the total amount of uncompensated care in each fiscal year of the study and added the amount of related coverage/expansion assessments in rates for each year. That total is the combined uncompensated care and related assessments amount. This amount was divided by total hospital revenue in each year to determine the percentage of hospital revenue that UCC and related assessments represented in those years. The last year prior to

implementation of the 2007 Medicaid expansion legislation was 2008. In 2008, hospital uncompensated care and related assessments (only the Maryland Health Insurance Plan assessment was applicable at that time) represented 8.96% of gross patient revenue. The last year of available HSCRC disclosure data available is FY 2022. The combined amount of hospital uncompensated care plus assessments in FY 2022 represented 6.6% of gross patient revenue. The difference between FY 2008 and FY 2022 is -2.36%.

To ensure that hospital inflation (cost, utilization, demographic changes, etc.) and the growth of related hospital assessments is considered in determining the amount of savings, we applied the 2.36% combined uncompensated care and related assessment percentage difference to FY 2022 revenue – $19.5 billion x 2.36% = $460 million. The result shows that if the combined uncompensated care and related assessments remained at 8.96% in FY 2022, the amount in hospital rates would have been $460 million more.

Hospital Uncompensated Care in Maryland

Under Maryland's unique all-payer total cost of care model, the Health Services Cost Review Commission sets rates for services provided by Maryland hospitals and all payers pay the same rates for the same service at a Maryland hospital. The rates, of course, differ by hospital for the same service to recognize the uniqueness and reasonable cost related to each hospital.

To recognize the burden of hospitals to cover the costs of care for patients who cannot or do not pay for their services, the Commission includes an amount in rates to cover all or a portion of the costs associated with uncompensated care. As a result, there are no public hospitals in Maryland and there is no incentive for hospitals to deny care based on a patient's ability to pay.

Uncompensated Care (UCC) is hospital care provided for which no compensation is received, typically a combination of charity care and bad debt. Charity care services are those Commission regulated services rendered for which payment is not anticipated. Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill.

There are two types of charity care: (1) free care and (2) reduced-cost care. State law and regulation dictate the minimum eligibility requirements of hospitals for both free and reduced-cost care. Specifically:

1. Free care is care for which the patient is not responsible for any out-of-pocket expenses for hospital care. Hospitals are required statutorily to provide free care to patients with a household income less than 200% of the federal poverty level (FPL).

2. Reduced-cost care is care for which the patient is only responsible for a portion of out-of-pocket expenses and is required for patients with household income between 200 and 300% of the FPL. Reduced-cost care is also required for patients that have a financial hardship, as defined in law, and have household incomes below 500% of the FPL.

The other type of hospital uncompensated care is bad debt, which is for Commission regulated services rendered for which payment is anticipated and credit is extended to the patient, but the payment is not made. There are various exceptions to this definition such as denials from payers are not considered bad debt for the purposes of HSCRC's uncompensated care policy.

The Commission's uncompensated care methodology in determining the amount of uncompensated care to include in rates also incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents the cost of uncompensated care from rising too quickly and increasing hospital costs to consumers.

Table 1 below identifies the various payers/purchasers of hospitals services, the percentage of charges that each payer/purchaser represents, and how those payers/purchasers derive the resources to make those payments. Medicare is the largest payer of hospital services in Maryland representing 42% of hospital charges.

Table 1. Payer Breakdown, % of Hospital Charges, and Source of Revenue to Make Hospital Payments

Payer/Purchaser of Hospital Care in Maryland	% of Total Hospital Charges	Who Pays and the Source of Revenue
Medicare	42%	Federal Gov't derived from Federal tax base, out of pocket costs
Medicaid	20%	State General Funds and Federal Gov't (generally shared 50/50) derived from each tax base, hospital assessments
Commercial	35%	Commercial Insurers derived from premiums on employers and individuals, out of pocket costs
Self Pay/Miscellaneous	2%	Patients, e.g., international medical tourists, that do not have traditional medical coverage

Source: HSCRC Annual Reporting Schedule RE

Table 2 shows that In FY 2022, hospital uncompensated care represented 4.3% of hospital revenue. This means that in FY 2022 hospital rates were increased to all payers by 4.3% to pay for the cost of hospital uncompensated care in the State. The largest source of hospital uncompensated care results from charity care provided to patients. This population typically does not have health care coverage and meets the State and hospital income requirements to be eligible for free or reduced cost care. The remaining uncompensated results from bad debt associated with individuals with commercial insurance, Medicare, or Medicaid coverage.

Table 2. Share of Uncompensated Care by Payer

Bad Debt or Charity Care Associated with Payer/Purchaser	UCC as a Share of Total Hospital Charges	% of Total UCC
Medicare	0.63%	15%
Medicaid	0.60%	14%
Commercial	1.08%	25%
Charity Care/Self Pay	2.02%	47%
Total	4.33%	100%

Source: HSCRC case-mix write-off data set

Major Health Care Expansions in Maryland and US over the Past 20 Years

This study is intended to determine whether two major health insurance reform initiatives implemented in Maryland had an impact on hospital uncompensated care in Maryland. While there are many factors that impact uncompensated care, general trends can help understand whether those reform provisions altered uncompensated care trends. We will examine two major reforms, one of which was Maryland specific and the other represented a broad-based national reform.

Maryland Medicaid Expansion - Chapter 7 of 2007

In 2007, the Governor and the Maryland General Assembly enacted Chapter 7, The Working Families and Small Business Health Coverage Act (The 2007 Act), which expanded access to health care coverage for Maryland residents in the following ways:

- Beginning in FY 2009, expanded Medicaid eligibility to parents and caretaker relatives with household income up to 116% of the FPL, an increase from 46% of the FPL;

- Contingent on available funding, incrementally expanded the Primary Adult Care (PAC) program benefit over three years, to be phased in from FY 2010 through FY 2013. PAC offered limited benefits to childless adults with household income up to 116% of the FPL.

• Established a Small Employer Health Insurance Premium Subsidy Program, to be administered by the Maryland Health Care Commission.

The legislation also required the Commission to implement a uniform assessment on hospital rates that reflects the aggregate reduction in hospital uncompensated care realized from the expansion of the Medicaid/PAC programs under the Act.

Another means of funding the State costs associated with the Medicaid expansion was the revenue generated through the Transportation and State Investment Act of 2007 which increased the cigarette tax from $1.00 to $2.00 per pack of 11-20 cigarettes. This Act was passed in conjunction with Chapter 7 with the intent of supporting the expansion and generated between $70 and $130 million for the State General Fund. According to an Abell Foundation study "following the $1.00 per pack cigarette tax increase in 2008, smoking by Maryland adults decreased by 26 percent among current smokers between 2011 and 2016. Among Maryland high school students there was a 47 percent reduction in students who reported smoking a cigarette in the preceding 30 days, as well as a decline in frequent smoking between 2007 and 2015."[1]

The Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, referred to as the Affordable Care Act (ACA) is the comprehensive health care reform law enacted in March 2010, although its major provisions went into effect in 2014. By 2016, the uninsured share of the population nationally had roughly halved, with estimates ranging from 20 to 24 million additional people covered.

One of the primary goals of the legislation was to make affordable health insurance available to more people in the United States. As such the law provides consumers with subsidies that lower costs for households with incomes between 100% and 400% of the federal poverty level and expands the Medicaid program to cover all adults with income below 138% of the federal poverty level. Not all states have expanded their Medicaid programs.

The provisions of the law that are relevant to this study include:

- Guaranteed issue - prohibits insurers from denying coverage to individuals due to preexisting conditions.

- Medicaid Expansion - expanded Medicaid eligibility starting in 2014. All U.S. citizens and legal residents with income up to 138% of the federal poverty level, including adults without dependent children, would qualify for coverage in any state that participated in the Medicaid program. The federal government was to pay 100% of the increased cost

[1] *Public Health Policy in Maryland: Lessons from Recent Alcohol and Cigarette Tax Polices,* The Abell Foundation, February 2018, Volume 31, Number 2.

in 2014, 2015 and 2016; 95% in 2017, 94% in 2018, and phasing out to 90% in subsequent years.

- Created Health Insurance Exchanges - mandated that health insurance exchanges be provided for each state. The exchanges are regulated, largely online marketplaces, administered by either federal or state governments, where individuals, families and small businesses can purchase private insurance plans. Exchanges first offered insurance for 2014.

- Employer Mandate - businesses that employ 50 or more people but do not offer health insurance to their full-time employees are assessed an additional tax if the government has subsidized a full-time employee's healthcare through tax deductions or other means.

- Premium Subsidies - individuals whose household incomes are between 100% and 400% of the FPL are eligible to receive federal subsidies for premiums for policies purchased on an ACA exchange, provided they are not eligible for Medicare, Medicaid, the Children's Health Insurance Program, or other forms of public assistance health coverage, and do not have access to affordable coverage

Analysis

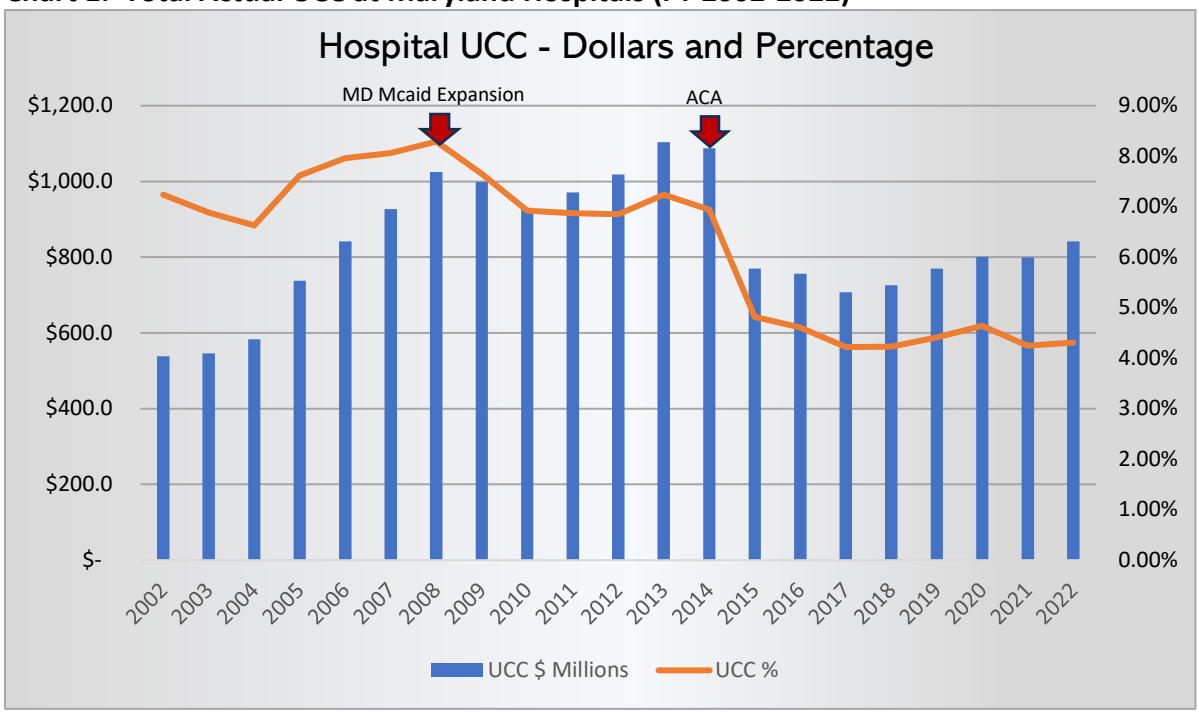
Hospital UCC Amount in Maryland and Percentage of Hospital Gross Patient Revenue

For the purposes of this study, we have obtained the actual amount of uncompensated care and the percentage of revenue that hospital uncompensated care represented beginning in FY 2002. It is important, however, to distinguish between experienced uncompensated care and the amount placed in rates. While these percentages will be similar, Commission policies have changed over the years that can slightly alter the amount put in rates from the actual uncompensated care experienced by all hospitals.

In addition, these percentages may also differ slightly from other HSCRC reports in that this study includes uncompensated care at freestanding medical facilities such as University of Maryland – Bowie, Laurel, and Queen Anne's.

Chart 1 below shows the amount of UCC that hospitals have experienced in millions of dollars, and the percentage of patient revenue that it represents, dating back to 2002.

Chart 1. Total Actual UCC at Maryland Hospitals (FY 2002-2022)



Source: HSCRC Disclosure Reports 2002-2022

Chart 1 shows that, following the major health care reforms reviewed in the study, the total amount of uncompensated care experienced by Maryland hospitals declined from $1.025 billion in 2008 to $707 million in 2017 and $842 million in 2022. Following the implementation periods of each reform, uncompensated care resumed growth due to many factors including growth in hospital revenues, hospital utilization, population changes, and the impact of the economy on employment and coverage.

To better understand the impact of uncompensated care on rates in the context of normal revenue growth, HSCRC typically considers uncompensated care as a percentage of hospital regulated gross patient revenue. **Chart 1** also shows a clear decline in hospital uncompensated care from a high of 8.29% in FY 2008, prior to the first reform, to a low of 4.25% in 2021. HSCRC has indicated that the slight uptick in the percent of uncompensated care between 2021 and 2022 was driven by the increase in Emergency Department utilization as the COVID-19 Pandemic gradually phased out. It is possible that uncompensated care could increase in FY 2024 as Medicaid has not made redeterminations over the course of the pandemic and has now begun to "unwind" the prior determinations.

As for the impact of the pandemic, HSCRC has indicated that the downward trend in uncompensated care in 2021 was driven in part by significant statewide declines in hospital utilization, with declines in ED utilization being the largest driver.

UCC Analysis Inclusive of Related Assessments

It is important to note that some of the major coverage expansions in Maryland over the past 20 years have been partially supported by offsets in hospital uncompensated care in the form of hospital rate assessments. They have also been supported by a federal match on Medicaid expansion and subsidies for some of the coverage obtained through the Maryland Health Benefit Exchange. To determine the true savings from the expansions it is important to take the rate offsets or hospital assessments into account. For the Medicaid-related expansions, these assessments partially reduced the financial pressure on Medicaid to provide more services to more enrollees.

To recognize the expected shift from uncompensated care that results from coverage expansion, the General Assembly passed several laws to create hospital assessments to be implemented through the HSCRC that is paid primarily by purchasers of hospital care (i.e., insurers, the State and federal government, out of pocket costs to consumers, etc.). These assessments apply to all payers and are transferred to Medicaid to pay for services to Medicaid enrollees. Below are those assessments.

- *Maryland Health Insurance Program (MHIP) and Substantial, Accessible, and Affordable Coverage Program (SAAC)* – For decades the HSCRC provided a subsidy to commercial insurers known as SAAC to provide open enrollment to the "uninsurable" population as a mechanism to expand coverage throughout the State with the goal of reducing hospital uncompensated care. Following the passage of Chapter 153 of the Laws of 2002, the SAAC program was replaced by the Maryland Health Insurance Program (MHIP) in 2003. The initial assessment was equivalent to the value of the SAAC subsidies or 0.8128%. Chapter 397 of the Laws of 2011 changed the assessment to the amount need to support the operations of MHIP but was to be established at no less than 0.8128% of hospital patient revenue. MHIP expired when the Health Benefit Exchange began. A portion of the balance of the assessment was transferred to the Exchange and the remaining balance was transferred to the HSCRC to support infrastructure for care transformation (Maryland Health Information Exchange - CRISP, etc.).

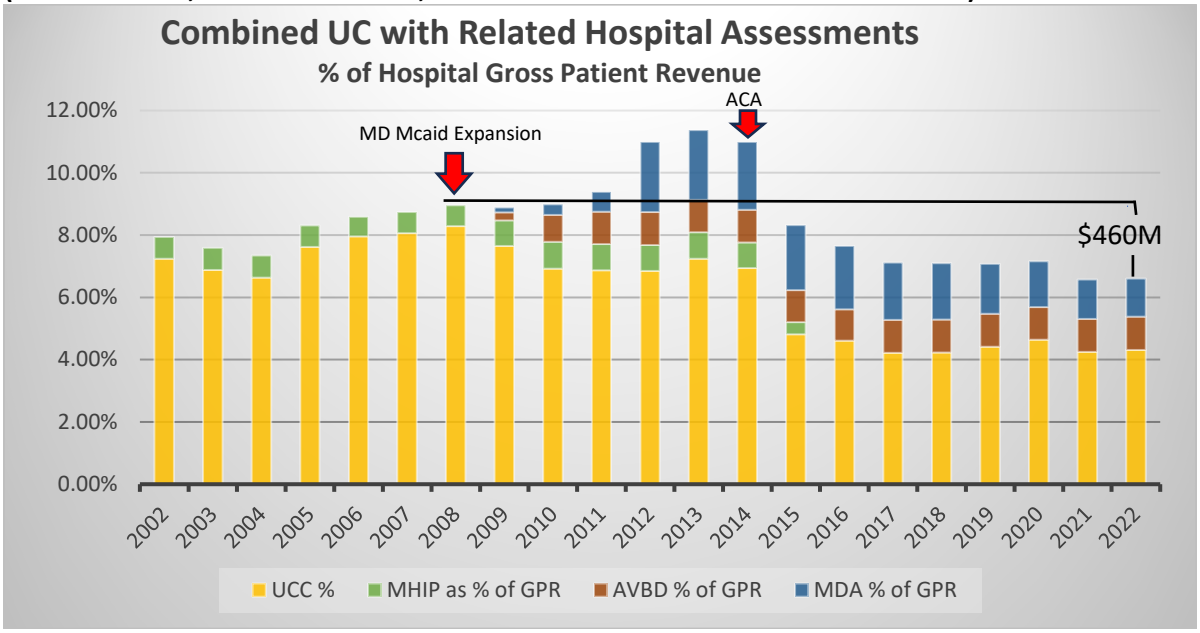
- *Averted Bad Debt (AVBD) Assessment* – As indicated above, Chapter 7 of the Laws of 2007 established an offset in rates for the amount that the Maryland Medicaid expansion reduced uncompensated care in rates. Under Chapter 7, new Medicaid enrollees would receive full coverage rather than receiving free or reduced cost care at the time of hospital or ED visit, resulting in hospital uncompensated care. The averted bad debt assessment increases hospital rates to all payers proportionately, and the yield for the assessment is transferred to the Medicaid program to pay for care for services for Medicaid enrollees which is typically matched 50% by the federal government.

- *Medicaid Deficit Assessment* - Following the 2009 "Great Recession", small assessments were added to hospital rates to reduce deficits in the Medicaid budget. In 2011, the Maryland General Assembly through the Budget Reconciliation and Financing Act (BRFA) initiated the Medicaid Deficit Assessment as we know it today. At the time, the State faced a significant gap between ongoing general fund spending and revenues. Federal stimulus funds provided through the American Recovery and Reinvestment Act of 2009 had been integral to the State's ability to meet its health care obligations during the two years following the 2009 economic downturn, but those funds went away in FY 2012. The federal funds covered $670 million of the Medicaid budget shortfall through a temporary enhancement in the federal Medicaid match. The loss of these funds in FY 2012, coupled with a sluggish recovery from the national recession, left a sizable gap between ongoing general fund spending and revenues. Thus, the General Assembly adopted a Budget Reconciliation and Financing Act (BRFA) provision to require the HSCRC to include policies to support Medicaid in the amount of $389.8 million beginning in FY 2012. Subsequent BRFAs have reduced that amount over time. The Commission set a policy that the first $56 million of the Medicaid Deficit Assessment amount will be paid directly from the profit margins of hospitals and the remaining will be included in the rates paid by purchasers of hospital care.

  All payers pay this assessment which is transferred to the Medicaid program. When those funds are expended for care, Medicaid receives a federal match of 50% of eligible costs.

The primary purpose of this study is to determine whether there have been savings for purchasers of hospital care through a reduction in uncompensated care in rates inclusive of related assessments since the implementation of the major health care reform initiatives. To take into account the growth in hospital revenue, one must look at the trends in uncompensated care and related assessments on a percentage of hospital revenue basis.

Chart 2. Combined Uncompensated care (UCC) and Related Assessments as % of Hospital Revenue (Includes MHIP, Averted Bad Debt, and Medicaid Deficit Assessment % in Rates)



Note: This chart shows the Medicaid Deficit Assessment (MDA) amount in rates paid by all payers. Hospitals pay an additional $56 million each year on top of this amount for the total amount transferred to Medicaid.
Source: HSCRC Disclosure Reports and HSCRC Annual Reports 2002-2022

Chart 2 demonstrates that the percentage of hospital revenue the combination of uncompensated care in rates plus the MHIP, AVBD and Medicaid Deficit Assessments has declined since the implementation of the 2007 Maryland Medicaid expansion. The combination of uncompensated care and assessments has declined from its highest of 11.38% of hospital gross patient revenue in FY 2013 (prior to the ACA) to 6.6% in FY 2022. There was a slight uptick in FY2020 which could represent a byproduct of utilization changes caused by the pandemic.

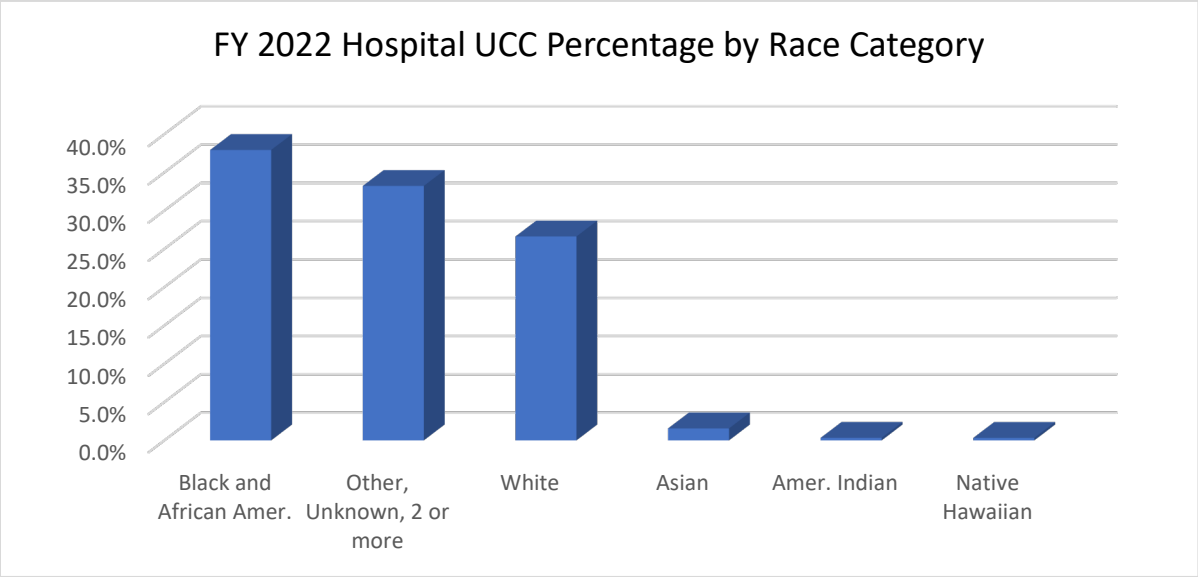
However, immediately following the 2007 Maryland Medicaid expansion, while the uncompensated care percentage of hospital gross patient revenue declined, the total percentage with related assessments increased significantly. This was primarily due to the use of the Medicaid Deficit Assessment as a budget mechanism to assist the State and Medicaid navigate through the difficult budget revenue situation caused by the recession of 2009. The sum of the percentage of UCC and assessments increased from 8.96% in FY2008, prior to the assessments, to the high of 11.38% in FY2013 prior to the ACA. Since that time, the combined percentage has declined.

As shown in **Chart 2**, if the combined uncompensated care and related assessment percentage remained at 8.96%, the percentage prior to the expansion policies, the combined percentage would have been $1.749 billion rather than $1.288 billion – a reduction of over $460 million.

Composition of Hospital Uncompensated Care by Race

The analysis above has led us to the question of what is the composition of the remaining hospital uncompensated care in Maryland? As part of its case-mix data set, the HSCRC has been collecting write-off or uncompensated care data regarding the race and ethnicity of patients.

Chart 3. FY 2022 Hospital Uncompensated Care Composition by Race Category



Source: HSCRC case-mix write-off data set

As indicated in **Chart 3**, in FY 2022, 38% of hospital charity care or bad debt patients have identified themselves as Black or African American; 33% have identified as other, unknown, or two or more races; and 26.6% as White. Those identifying themselves as Asian, American Indian, and Native Hawaiian combined represent under 3% of hospital charity care and bad debt.

Conclusion

While we cannot assume that the major health care reforms outlined in the study are the only factors impacting hospital uncompensated care, the trends above show that they certainly represent an impact. The estimated savings from this report is a conservative estimate since it is possible that the Governor and the General Assembly would have considered a more limited Medicaid Deficit Assessment following the 2009 recession to support Medicaid through increased enrollment and reduced State revenues, even without the expansion policies discussed in this paper.

Many studies have shown how better access to health care and the availability of full coverage can help improve the health care outcomes of individuals as well as the health of the population. To the extent that these reforms have done that, it is a clear benefit to those who were previously unable to obtain coverage. This study poses the question as to whether the

amount purchasers of hospital care pay for uncompensated care through hospital rates inclusive or related assessments has been impacted from these policies as well. This study shows that the combination of the reduced hospital uncompensated care from expanded coverage and rate increases from related assessments on all payers to financially support Medicaid initially increased hospital rates, but since the implementation of the ACA has declined precipitously. It is important to note that any increase in hospital rates today could negatively impact HSCRC's Total Cost of Care Model savings requirements if such policies do not accrue net savings.

As shown in **Chart 2** above, when looking at total percentage of uncompensated care in hospital rates and associated assessments between 2008, before the Maryland Medicaid expansion, and 2022 there is a savings of at least $460 million during that period. This represents savings to purchasers of hospital care such as public and private payers, consumers, and businesses. These savings provided the potential to reduce the growth in premiums to premium payers, and out-of-pocket costs to consumers, as well as provide fiscal benefits to public payers that are supported by their respective tax bases.

This study also provides a cursory look at the racial composition of the remaining uncompensated care. We found that those patients identifying themselves as Black or African American make up the largest portion of hospital uncompensated care (38%). However, the second largest category are those who have reported as other, unknown, or two or more races. To better understand the racial and ethnic composition of hospital uncompensated care, further analysis would be necessary regarding the reliability and usability of the data.