STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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HEALTH SERVICES COST REVIEW COMMISSION
4160 PATTERSON AVENUE · BALTIMORE, MARYLAND 21215
Phone: 410-764-2605 Fax: 410-358-6217
Toll Free: 1-888-287-3229
www.hscrc.state.md.us

Robert Murray
Executive Director

Stephen Ports
Principal Deputy Director
Policy & Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Charlotte Thompson
Deputy Director
Research and Methodology

March 16, 2010

NOTICE OF SPECIAL COMMISSION SESSION

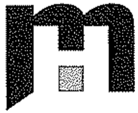
Notice is hereby given that the Health Services Cost Review Commission will be holding a special session on April 6, 2010 from 9:00 a.m. – 11:30 a.m. for the purpose of reconsidering action taken by the Commission on March 3, 2010. The issue to be addressed at the special session will be: how should the Commission fund any residual budget cuts following the adoption of the Fiscal Year 2011 Update Factor.

Any person or entity desiring to comment on this issue may submit written comments to the Commission's office by March 26, 2010. The Commission will also entertain comments relating to the above issue during the Special Commission Session. Any written comments should be addressed to: Dennis Phelps, Associate Director, Audit and Compliance, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215.

The Commission will allow for a full discussion of the issue at the special session in light of the comments received before making a decision.

HEALTH SERVICES COST REVIEW COMMISSION

*Written comments attached



Maryland
Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

To be sent via e-mail; original to follow

March 26, 2010

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Dr. ~~Young~~: Don

On behalf of Maryland's hospitals, the Maryland Hospital Association appreciates the Health Services Cost Review Commission's (HSCRC) willingness to revisit its March 3 policy decision and urges the Commission to reconsider its stated preference for implementing the proposed $123 million in hospital Medicaid budget cuts. As you know, there is widespread agreement among hospitals, payors, the Administration, and the HSCRC that an assessment is the most efficient way to address the state's current budget shortfall. At issue is how to apply the assessment.

At your March 3 meeting, the Commission stated its preference to build half of the assessment into rates and to have hospitals remit the other half back to the state. Hospitals strongly urge the Commission, for this FY 2011 assessment, to build all of the needed Medicaid assessment into hospital rates. The reasons:

- **Any rate increase would be temporary.** Hospital rates would only increase until the Medicaid savings target is achieved. Rates would then be adjusted downward accordingly.

- **It takes best advantage of federal funds.** Of the $123 million increase in rates, about $60 million would be paid for by the federal government. The federal Medicare program would absorb about $47 million of the increase, and the federal government's share of Medicaid would absorb about $13 million of the increase. At a time when state dollars are dear, we shouldn't leave federal dollars on the table.

- **It saves jobs and protects access to care at a time when hospitals' financial condition is poor.** Placing a portion of the assessment, at this time, on hospitals jeopardizes jobs across the state because the current condition of Maryland hospitals' finances is so serious. As some of the largest employers in the state, Maryland's hospitals employ 88,000 people with payroll and benefits over $5 billion annually. Every hospital job in Maryland creates two additional jobs in the state, for a total contribution of $24 billion in hospital-related economic activity in Maryland. But that economic activity is jeopardized by hospitals' poor financial condition. The projected average operating margin for the fiscal year ending June 30, 2010 for the hospital field is 1 percent, well below the 2.75 percent operating margin target set by the HSCRC to ensure hospitals can adequately meet the needs of their patients and

- more -

communities. This year's Commission-approved 1.77 percent update, once $100 million in averted uncompensated care hospital cuts and $27 million in Board of Public Works hospital cuts are taken into account, translated into only an effective 0.8 percent rate increase for hospitals. This is well below the actual rate of inflation and has squeezed hospital finances considerably. Recent snowstorm costs to hospitals across the state--which total over $60 million--have added to the financial difficulties. Some, but only a small portion, of those losses may be reimbursed through federal disaster relief funds, but that won't occur for the next twelve to eighteen months. Given these current financial challenges, hospitals have few choices but to address a potential cut of this magnitude through job losses. So far this year, many hospitals curtailed hiring and froze wages. If half the assessment is placed on hospitals, this would translate into some 900-1,200 jobs likely lost across the state. And any hospital assessment is an even greater burden for our most vulnerable hospitals and systems, like Dimensions Healthcare System and Bon Secours Baltimore Health System, that serve large numbers of low income Medicaid patients and for whom the assessment would have an even greater impact.

Hospitals are willing to help hold the state harmless for its share of the impact of any rate increase due to the assessment on the Medicaid program. But because of the impact of an assessment and other HSCRC policy decisions on jobs and the economy, now is not the time to have hospitals absorb a $61 million cut, which alone is equivalent to a hospital update reduction of 0.5 percentage points. This, on the heels of insurance companies' proposal to freeze the FY 2011 update for hospitals, is neither reasonable nor sensible.

We strongly urge the Commission to revise its March 3 decision by building all of the needed assessment this year into rates.

Sincerely,

Carmela Coyle
President & CEO

March 25, 2010

The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **Comment Letter Re Handling of Proposed $123 Million Medicaid Payment Reduction in HSCRC Approved Rates**

Dear Members of the Commission:

We are writing on behalf of the Johns Hopkins Health System (JHHS), MedStar Health (MedStar) and the University of Maryland Medical System (UMMS). Together, our three system's represent 22 of Maryland's hospitals and over 50% of Maryland hospital revenues. In total, our health systems employ over 60,000 Marylanders and have a major economic impact on the State's economy.

As you know, the Department of Health and Mental Hygiene (DHMH) is moving forward with a $123 million reduction to hospital payments in fiscal 2011. DHMH has recommended that this payment cut be handled as an "assessment" to Maryland hospitals (i.e. Maryland hospitals would be billed and would pay this amount to DHMH in fiscal 2011). We agree that the "assessment approach" is the most efficient way to administer this budget reduction due to the significant opportunity for DHMH to obtain substantial federal matching funds.

The HSCRC has proposed that only 50% (or $61.5 million) of the proposed $123 million budget cut be included in HSCRC approved rates. The Commission has also indicated that the Maryland hospital industry concurs with the HSCRC's 50% approach. This statement is not accurate. **Our three hospital systems, and many other Maryland hospitals, strongly recommend that 100% of the proposed budget cut be included in HSCRC approved rates.**

Our recommendation is based on the following key factors:

1. ***First***, the HSCRC's 50% funding proposal will have a very direct and immediate negative impact on employment at Maryland's hospitals. Specifically, we estimate that approximately 1,000 jobs could be lost in

the coming months if the HSCRC proposal is implemented. This is not the time to increase unemployment in Maryland.

2. ***Second***, the full (100%) funding in rates of the $123 million Medicaid cut will bring additional federal funds to Maryland's hospitals. Specifically, the federal government (Medicare and the federal portion of Medicaid) will fund approximately 48% of the $123 million payment cut or $59 million. However, the HSCRC's 50% funding proposal will result in $30 million less federal funding to Maryland's hospitals and a corresponding loss of jobs.

3. ***Third,*** our 100% funding proposal will have a small (less than 1%) and **temporary** impact on Maryland's Medicare waiver cushion (which we believe currently exceeds 10%).

4. ***Fourth,*** the funding in rates of the entire $123 million is a temporary action and will be removed from rates as soon as the economy improves. As a result, this will not be a permanent increase to hospital rates. Past Medicaid budget cuts have proven to be temporary in nature.

5. ***Fifth,*** Maryland's hospitals are experiencing very difficult economic conditions. Unlike the health insurance industry (which currently has margins in the 3-6% range), our operating margins are declining to razor thin levels of approximately 1%. In addition, Maryland's hospitals are non-profit organizations whose operating income benefits the residents of Maryland. However, many insurance companies doing business in Maryland are publicly traded companies with headquarters and operations located outside of Maryland. In addition, insurance company profits largely benefit shareholders (via capital gains and dividends) who are not residents of Maryland.

6. ***Sixth,*** the recent snow storms have had a very negative financial impact on Maryland's hospitals. As the healthcare and social safety net for Maryland during periods of economic difficulty and natural disasters, our hospitals never closed during the storms. In total, we estimate that Maryland's hospitals incurred losses in excess of $60 million from the storms.

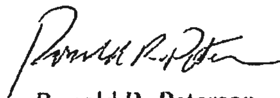
7. ***Seventh***, in other states (which do not operate under an all-payor waiver system), the impact of Medicaid cuts is usually passed on to private payors through individual hospital negotiations. Our proposal would accomplish

the same result here in Maryland. You should also note that the resulting increase to the private payors would almost certainly be less than the increases in hospital reimbursement they are facing in other states.

8. And finally, the HSCRC's 50% proposal will result in additional pressure on financially vulnerable hospitals in Prince George's County and Baltimore City.

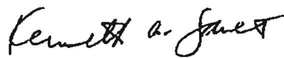
In conclusion, we urgently request your support in funding 100% of the proposed Medicaid budget reduction in HSCRC approved rates. If you have any further questions or need additional input, we are available to meet with you at your convenience and look forward to your public hearing on April 6th.

Sincerely,



Ronald R. Peterson
President
Johns Hopkins Health System

Robert A. Chrencik
President and Chief Executive Officer
University of Maryland Medical System



Kenneth A. Samet
President and Chief Executive Officer
MedStar Health

cc: Secretary John M. Colmers
Carmela Coyle

Hal Cohen, Inc.
Health Care Consulting
17 Warren Road, 13B
Baltimore, Maryland 21208
(410) 602-1696; Fax (410) 602-1678; e-mail JandHCohen@aol.com

March 26, 2010

Via e-mail

Dennis Phelps
Associate Director, Audit and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Special Session on funding of residual budget cuts

Dear Dennis:

I am writing this letter on behalf of CareFirst Blue Cross Blue Shield and Kaiser Permanente. However, as discussed by both Commissioners and myself, the levies being discussed that would be allocated to CareFirst and Kaiser Permanente would actually be paid by their members. In the case of CareFirst, over half the levy would be directly paid by its ASO (non-risk) accounts through higher hospital payment rates. Others would pay, eventually, through higher premiums.

The issue before the Commission is what percent of the residual budget cuts should be borne by hospitals and what percent should be borne by payers and their members. The hospitals have asked that the full 100% be borne by the insurers and their members. The payers have never suggested that 100% be borne by the hospitals. Rather, they have suggested that the dollars be split 50/50 between hospitals and payers/patients. CareFirst and Kaiser Permanente repeat the call for a 50/50 split. That 50/50 split can either be done prospectively for the "residual budget cuts following the adoption of the Fiscal Year 2011 Update Factor" as noted in the Notice of the Special Commission Session (the position supported by CareFirst and Kaiser Permanente) or it can be done 50/50 over the sum of the budget cuts for FY 2010 and FY 2011 as approved by the HSCRC at its March 3, 2010 regular session.

The amount of the residual budget cuts for FY 2011 is unknown because it depends on the Commission's decision regarding the update for the next rate year and the increase in rates associated with rising uncompensated care. However, for convenience the full budget savings amount of $123,000,000 has been used in most correspondence and examples. We follow that precedent.

Given that hospital revenue is approximately $13 billion, one half of $123 million represents less than 0.5% of hospital revenue. Asking hospitals to absorb 0.5% as their share of responding to the current budget crisis is very low and, as John Folkemer of

Medicaid has noted, is much less than the other segments of the provider community have to absorb.

CareFirst and Kaiser Permanente believe strongly that the hospitals need to absorb a decent share of the budget savings. Unless the hospitals have significant "skin in the game" they will have no incentive whatever to bring their considerable political strength in Annapolis to fight for reducing such budget shortfalls over the next few years. All we have seen suggests that the budget crisis is not a one-time or, counting last year, a two-time happening. The Commission should make a policy decision to fund any future residual budget cuts equitably between hospitals and payers (50/50) so long as such cuts continue to occur. Most importantly, health insurance is increasingly unaffordable and it is inappropriate to have the full effect of the budget cuts increase hospital charges. The hospitals' proposal would cause hospital rates to increase by about 1.1%.

In correspondence and testimony before the legislature, hospitals have argued that the 50% funding proposal will:

1. Lead hospitals to cut approximately 1,000 jobs.
2. Reduce federal funding and therefore result in more job loss.
3. Only reduce the waiver test on a temporary basis by less than 1%.
4. Be temporary in nature and go out of rates when the budget crisis is past.
5. Impact hospitals which are currently experiencing margins of approximately 1%, unlike the health insurance industry.
6. The recent snow storms have had a negative effect on Maryland's hospitals.
7. In other states the impact of Medicaid cuts are usually passed on to private payers.
8. The HSCRC's 50% proposal could result in the closure of vulnerable hospitals, with Prince George's and Bon Secours being mentioned.

This letter only briefly responds to these points. I may well comment further at the public hearing.

1. Lead hospitals to cut approximately 1,000 jobs.

The hospitals are acting as if the only way to respond to the unfunded assessment is to cut the number of jobs. According to the AHA, the average cost per employee at a Maryland hospital was $69,980 in 2008. Clearly, it will be more than that in 2011, in excess of $72,000. Thus, cutting 1,000 average jobs would save much more than the $61,500,000 in savings assigned to hospitals. Throughout the economy, workers are taking pay cuts to absorb the increase in their health insurance premiums. The hospitals' proposal is tantamount to saying all the burden should be borne by workers who have health insurance but do not work in hospitals. (Baltimore City is proposing to have its employees pay part of their drug premiums as a way to avoid 350 layoffs. Baltimore Sun, March 20, p.3.) There are various other ways for hospitals to save money. See discussion of point 5, below.

2. Reduce federal funding and therefore result in more job loss.

Maryland has a very favorable Federal Waiver. But to get any federal dollars, Marylanders have to spend more money. Health insurance is unaffordable to Marylanders and the Commission should not act so as to increase federal dollars at the expense of insured or charge paying Marylanders.

3. Only reduce the waiver test on a temporary basis by less than 1%.

CareFirst and Kaiser Permanente believe the waiver is an excellent deal for Marylanders, but maximizing federal dollars is not the purpose. Having uniform incentives and equitable payment for reasonable costs is the purpose. (Hospitals continue to say that the effect on other payers is less than 1%, but in fact, it is more than 1% because none of the $123 million can be paid for by state Medicaid dollars and the need to mark up the needed dollars for uncompensated care and Commission approved discounts.)

4. Be temporary in nature and go out of rates when the budget crisis is past.

Yes, this is temporary, though we do not know how long it will last. The temporary nature of the problem argues as much for hospitals paying a share temporarily as for payers, their members and patients, paying a share temporarily. It is of interest that the hospitals suggest they will reply to this temporary burden by cutting jobs not by short term adjustments.

5. Impact hospitals which are currently experiencing margins of approximately 1%, unlike the health insurance industry.

Hospitals claim that their total operating margins are approximately 1%. That may well be the case. They also note that the Commission has a target of 2.75% operating margins. Interestingly, the hospitals never mention that the Commission also has a cost target of being 3-6% below the nation. The current estimate is that hospital costs in Maryland are at the national average. Profits are to be earned not granted – otherwise we just have cost based reimbursement and no incentive for efficiency. If Maryland hospital costs were only 3% below the nation (well above what we have suggested as the appropriate target), at current revenues hospital profits would be 4%. Clearly, there is plenty of margin for hospital cost reductions**.** Further, there has been reference to high profit margins for health insurance companies, though national insurance company margins are irrelevant. For example, the underwriting gain (loss) for CareFirst for 2008 was (0.3) and for 2009 was 0.1% with a two year loss of 0.1%. Over half of CareFirst's business is ASO which means they would immediately realize the 1.1% increase in hospital charges. In respect to the CareFirst's Fully Insured Business, their premiums have been set for the next year , so that the immediate impact of the recommended increase would further reduce the above mentioned margins and over time factor into account premiums further impacting the issue around affordability.

6. The recent snow storms have had a negative effect on Maryland's hospitals.

The state is actually seeking federal dollars under the stimulus bill to finance hospital snow related losses. However, all sorts of businesses suffered losses from the snow including governments who had to pay for the clean up and who, like other

businesses that still provide insurance, would be assessed their share of all the costs of the budget shortfall under the hospitals' request.

7. In other states the impact of Medicaid cuts are usually passed on to private payers. The intent of the waiver is not to produce the same lack of fiscal constraint that occurs in many other hospital markets resulting in overly high costs. Further, nationally many hospitals, especially independent hospitals in relatively competitive markets are unable to shift their government shortfalls – at least not totally. For example, many such hospitals have negative operating profits, the vast bulk of hospitals nationally are not investment grade and several such hospitals are going into bankruptcy.

8. The HSCRC's 50% proposal could result in the closure of vulnerable hospitals, with Prince George's and Bon Secours being mentioned.

The small share of the burden, which is based on revenue and not on Medicaid share, will not cause the closure of either Prince George's or Bon Secours hospitals. The Commission and the State and Local governments have given tens of millions of dollars over the years to both hospitals – which, I am sure, would have been closed long ago were it not for the waiver – and to threaten the HSCRC with causing their closure is disingenuous.

Thank you for your consideration. I look forward to testifying and answering any questions regarding this issue at the hearing on March 26.

Yours truly,

Hal Cohen
Consultant

Cc: Bob Murray
John Hamper
Debra Collins
Laurie Kuiper
Jessica Boutin
Jack Keane

Calvert Memorial Hospital
Tradition. Quality. Progress.

March 26, 2010

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Dr. Young:

Calvert Memorial Hospital appreciates the Health Services Cost Review Commission's (HSCRC) willingness to revisit its March 3 policy decision and urges the Commission to reconsider its stated preference for implementing the proposed $123 million in hospital Medicaid budget cuts. As you know, there is widespread agreement among hospitals, payers, the Administration and the HSCRC that an assessment is the most efficient way to address the state's current budget shortfall. At issue is how to apply the assessment.

At your March 3 meeting, the Commission stated its preference to build half of the assessment into rates and to have hospitals remit the other half back to the state. Hospitals strongly urge the Commission, for this FY 2011 assessment, to build all of the needed Medicaid assessment into hospital rates. The reasons:

- **Any rate increase would be temporary.** Hospital rates would only increase until the Medicaid savings target is achieved. Rates would then be adjusted downward accordingly.

- **It takes best advantage of federal funds.** Of the $123 million increase in rates, about $60 million would be paid for by the federal government. The federal Medicare program would absorb about $47 million of the increase, and the federal government's share of Medicaid would absorb about $13 million of the increase. At a time when state dollars are dear, we shouldn't leave federal dollars on the table.

- **It saves jobs and protects access to care at a time when hospitals' financial condition is poor.** Placing a portion of the assessment, at this time, on hospitals jeopardizes jobs across the state because the current condition of Maryland hospitals' finances is so serious. As some of the largest employers in the state, Maryland hospitals employ 88,000 people with payroll and benefits of nearly $5 billion annually. Every hospital job in Maryland creates two additional jobs in the state, for a total contribution of $24 billion in hospital-related economic activity in Maryland. But that economic activity is jeopardized by hospitals' poor financial condition. The projected average operating margin for the fiscal year ending June 30, 2010 for the hospital field is 1 percent, well below the 2.75 percent operating

margin target set by the HSCRC to ensure hospitals can adequately meet the needs of their patients and communities. This year's Commission-approved 1.77 percent update, once $100 million in averted uncompensated care hospital cuts and $27 million in Board of Public Works hospital cuts are taken into account, translated into only an effective 0.8 percent rate increase for hospitals. This is well below the actual rate of inflation and has squeezed hospital finances considerably. Recent snowstorm costs to hospitals across the state – which total over $60 million – have added to the financial difficulties. Some, but only a small portion, of those losses may be reimbursed through federal disaster relief funds, but that won't occur for the next twelve to eighteen months. Given these current financial challenges, hospitals have few choices but to address a potential cut of this magnitude through job losses. So far this year, many hospitals curtailed hiring and froze wages. If half the assessment is placed on hospitals, this would translate into some 900-1,200 jobs likely lost across the state. And any hospital assessment is an even greater burden for our most vulnerable hospitals and systems, like Dimensions Healthcare System and Bons Secours Baltimore Health System, that serve large numbers of low income Medicaid patients and for whom the assessment would have an even greater impact.

Hospitals are willing to help hold the state harmless for its share of the impact of any rate increase due to the assessment on the Medicaid program. But because of the impact of an assessment and other HSCRC policy decisions on jobs and the economy, now is not the time to have hospitals absorb a $61 million cut, which alone is equivalent to a hospital update reduction of 0.5 percentage points. This, on the heels of insurance companies' proposal to freeze the FY2011 update for hospitals, is neither reasonable nor sensible.

We strongly urge the Commission to revise its March 3 decision by building all of the needed assessment this year into rates.

Sincerely,

JAMES J. XINIS
President & CEO

British American
AUTO CARE, INC.

9577 Berger Road
Columbia, MD 21046-1514

Testimony Before the Health Services Cost Review Commission
In Support of the 50/50 Assessment Approach

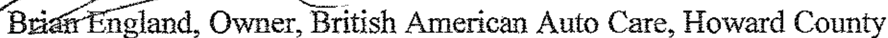
Mr. Chairman, Members of the Commission, My name is Brian England and I own British American Auto Care in Columbia, Maryland. I am here as a small business owner to support the 50/50 assessment approach proposed by the Health Services Cost Review Commission to address the $123 million hospital Medicaid provider assessment included in the Governor's Fiscal 2011 budget.

British American Auto Care has provided award winning automobile services for over 30 years. Like many Maryland business owners, I am fortunate enough to be able to provide full health insurance to my 18 employees, but escalating costs are making this very difficult. Small employers such as British American Auto Care don't have the same negotiating power as big companies. The insurance overhead I pay is much higher than at larger companies. Some of my fellow businesses that provide health insurance pay for the hospitalization of employees whose employers cannot, or will not, offer benefits.

Without the 50/50 assessment, I would be placed in a very difficult financial situation. Incorporating the entire $123 million in proposed cuts in the hospital rates paid by payers would open the door for the imposition of hidden taxes. These taxes stand to be in excess of $200 per hospital admission, a cost that would directly impact Maryland citizens and small business owners alike. Absorbing the financial burden of hidden taxes would adversely affect my hiring practices, forcing me to restrict hiring or even release current employees in order to accommodate rising health care costs.

With the recent passage of federal health care reform, allowing hidden taxes to be imposed on payers by Maryland hospitals is a step in the wrong direction. In order for small businesses to thrive and grow, we need the 50/50 assessment approach to allow us to continue to provide quality, affordable coverage to our employees.

Sincerely,



Brian England, Owner, British American Auto Care, Howard County

410•381•2700
301•596•2240
410•381•6491 fax
www.britishamericanauto.com

AARP Maryland
200 St. Paul Place
Suite 2510
Baltimore, MD 21202

T 1-866-542-8163
F 410-837-0269
TTY 1-877-434-7598
www.aarp.org/md

"20-10 Vision: Together We Can"

Testimony of Rawle Andrews Jr., Esq. of AARP
Before the Health Services Cost Review Commission

Honorable Donald A. Young, Chairman
HSCRC Special Session
April 6, 2010

Good morning Chairman Young and Members of the Commission, my name is Rawle Andrews Jr., and I am the Senior State Director of AARP in Maryland. On behalf of the AARP's 850,000 members across the state of Maryland, I thank you for your leadership in convening this special session to address the Commission's recent unanimous vote on the apportionment of reduction in hospital reimbursement rates resulting from any Medicaid cuts in the FY 2011 budget. I am also pleased to convey AARP's support for the Commission's 50%-50% assessment methodology in response to the proposed Medicaid budget cuts for FY 2011.

Since its inception, AARP has championed the rights of older Americans, including Marylanders 50 and older. Our Association's two primary mandates are the protection and promotion of the *health care* and *financial security* needs for our nearly 40 million members and their families nationwide. At a time when all Marylanders are struggling or digging a little deeper to make ends meet, the ever escalating cost of health care directly impacts the daily living needs of older Marylanders acutely as they struggle to get by on fixed incomes, maintain or find gainful employment, and/or care for even older parents or minor children.

By any measure, even asking patients and their families to shoulder the full burden of these deep budget cuts through a stealth, $200 hospital admission tax is unreasonable and unworkable for at least three (3) reasons. *First*, according to a recent, multi-disciplinary study in *The American Journal of Medicine* over 60% of all bankruptcies filed in America today arise out

of or are related to medical debt, and nearly 80% of American debtors in bankruptcy actually have some level of health insurance (i.e., patients already lack the funds to cover existing care).[1] *Second,* the Commission's 50%-50% methodology is a proven system that is already known to providers and patients because it was implemented in response to budget cuts during FY 2010. *Third,* the imposition of any hidden hospital admission tax to offset state budget cuts runs counter to the promise of expanded health care coverage and choices provided in the recently enacted federal Patient Protection and Affordable Care Act of 2010. No good cause exists to abandon a system that already is working in Maryland.

Absent the Commission's 50%-50% assessment methodology to fund any residual cuts following the adoption of the FY 2011 budget, older Marylanders and their families will fall even further behind the health and wellness curve, which at the end of the day will only serve to increase health care costs beyond current levels. It is for these, among other reasons, that AARP supports the Commission's decision that any reductions in hospital reimbursement resulting from Medicaid budget cuts in FY 2011 be funded by a uniform broad based assessment to be shared equally between hospitals and payers.

Thank you.

Respectfully submitted,

Rawle Andrews Jr.
Senior State Director
AARP Maryland
O: 410-895-7601; F: 410-837-0269 E: RAndrews@aarp.org

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[1] D. Himmelstein, D. Thorne, E. Warren & S. Woolhandler, *Medical Bankruptcy in the United States 2007: Results of a National Study,* The American Journal of Medicine, Vol. XX, No. X (2009 ed.), a copy of which is attached hereto.

CLINICAL RESEARCH STUDY

THE AMERICAN JOURNAL of MEDICINE®

Medical Bankruptcy in the United States, 2007: Results of a National Study

David U. Himmelstein, MD,[a] Deborah Thorne, PhD,[b] Elizabeth Warren, JD,[c] Steffie Woolhandler, MD, MPH[a]

[a]Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass; [b]Department of Sociology, Ohio University, Athens; and [c]Harvard Law School, Cambridge, Mass.

ABSTRACT

BACKGROUND: Our 2001 study in 5 states found that medical problems contributed to at least 46.2% of all bankruptcies. Since then, health costs and the numbers of un- and underinsured have increased, and bankruptcy laws have tightened.

METHODS: We surveyed a random national sample of 2314 bankruptcy filers in 2007, abstracted their court records, and interviewed 1032 of them. We designated bankruptcies as "medical" based on debtors' stated reasons for filing, income loss due to illness, and the magnitude of their medical debts.

RESULTS: Using a conservative definition, 62.1% of all bankruptcies in 2007 were medical; 92% of these medical debtors had medical debts over $5000, or 10% of pretax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance. Using identical definitions in 2001 and 2007, the share of bankruptcies attributable to medical problems rose by 49.6%. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001.

CONCLUSIONS: Illness and medical bills contribute to a large and increasing share of US bankruptcies.
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KEYWORDS: Bankruptcy; Health care costs; Health economics

As recently as 1981, only 8% of families filing for bankruptcy did so in the aftermath of a serious medical problem.[1] By contrast, our 2001 study in 5 states found that illness or medical bills contributed to about half of bankruptcies.[2]

Since then, the number of un- and underinsured Americans has grown;[3] health costs have increased; and Congress tightened the bankruptcy laws.[4]

Here we report the first-ever national random-sample survey of bankruptcy filers.

Funding: Supported by Grant #56590 from the Robert Wood Johnson Foundation, Princeton, NJ.

Conflict of Interest: None.

Authorship: All authors had access to the data and a role in writing the manuscript.

Requests for reprints should be addressed to David U. Himmelstein, MD, Department of Medicine, Cambridge Hospital/Harvard Medical School, 1493 Cambridge Street, Cambridge, MA 02139.

E-mail address: dhimmelstein@challiance.org

0002-9343/$ -see front matter © 2009 Elsevier Inc. All rights reserved.
doi:10.1016/j.amjmed.2009.04.012

METHODS

We used 3 data sources: questionnaires mailed to debtors immediately after bankruptcy filing; court records; and telephone interviews with a sub-sample of debtors.

Sample Design

Between January 25 and April 11, 2007, we obtained from Automated Access to Court Electronic Records, a list of all 118,308 bankruptcy petitions filed in the US. We excluded filings in Guam and Puerto Rico, nonpersonal bankruptcies, and cases missing a name or address. Within 2 weeks of their filings, we mailed introductory letters to 5251 randomly selected debtors; 275 were returned as undeliverable. We then mailed self-administered questionnaires to the 4976 debtors with valid addresses; 2314 (46.5%) were completed and returned; 124 were returned incomplete (2.5%) and 83 (1.7%) declined to participate; 2455 (49.3% of those with valid addresses) did not respond.

We compared court records (described below) of respondents with a random sample of 99 nonrespondents. Nonre-

spondents resembled respondents in income, assets, debts, net worth, market value of homes, and history of prior bankruptcy.

Questionnaire

Introductory letters described the study and offered debtors the option of obtaining a Spanish-language version of the questionnaire. The questionnaire and $2 were mailed a few days later. Nonrespondents received replacement questionnaires, another $2, and were invited to respond via telephone or on-line. Subsequently, we offered nonrespondents $50 to complete the questionnaire.

The questionnaire asked about demographics, health insurance and gaps in coverage, occupation, employment, housing, and efforts to cope financially before filing. It also asked about specific reasons for filing for bankruptcy; the range of out-of-pocket medical expense (none, $1-$999, $1000-$5000, or >$5000); loss of work-related income; and borrowing to pay medical bills. Finally, it asked respondents if, for $50, they would be willing to complete a follow-up interview.

CLINICAL SIGNIFICANCE

- 62.1% of all bankruptcies have a medical cause.
- Most medical debtors were well educated and middle class; three quarters had health insurance.
- The share of bankruptcies attributable to medical problems rose by 50% between 2001 and 2007.

Court Records

We obtained the public bankruptcy court records of respondents and the sample of nonrespondents from the federal court's electronic filing system. Research assistants (mainly law students) abstracted each record.

The court records included the chapter of filing, income, assets, and debts outstanding at the time of filing. These records indicate the creditor to whom money is owed, but not why the debt was incurred.

Telephone Interviews

There were 2314 debtors who completed questionnaires, 2007 of whom were willing to be interviewed. By February 2008, research assistants had completed telephone interviews (in English or Spanish) with 1032 of them; 69 debtors no longer wished to be interviewed. We were unable to reach 906.

Interviewers collected additional detail about employment, finances, housing, borrowing to pay medical bills, and whether medical bills or income loss due to illness had contributed to their bankruptcy (questions we used to verify written questionnaire responses from the entire sample of 2314 debtors).

The 1032 telephone interviews identified 639 patients (debtors or dependents) whose health problems contributed to bankruptcy; details about medical expenses, health insurance, and diagnoses were obtained. Two physicians grouped diagnoses into 14 categories.

Telephone survey participants resembled other respondents on most financial and demographic characteristics. They were slightly older and better educated.

Data Analysis

We used data from the questionnaires and court records to analyze demographics, health insurance coverage at the time of filing, and gaps in coverage.

The questionnaires were the basis for our 2001-2007 time trend analysis. For this analysis, we replicated the most conservative definition employed in the 2001 study, which designated as "medically bankrupt" debtors citing illness or medical bills as a specific reason for bankruptcy; OR reporting uncovered medical bills >$1000 in the past 2 years; OR who lost at least 2 weeks of work-related income due to illness/injury; OR who mortgaged a home to pay medical bills. Debtors who gave no answers regarding reasons for their bankruptcy were excluded from analyses.

For all other analyses (ie, those not reporting time trends) we adopted a definition of medical bankruptcy that utilizes the more detailed 2007 data. We altered the 2001 criteria to include debtors who had been forced to quit work due to illness or injury. We also reconsidered the question of how large out-of-pocket medical expenses should be before those debts should be considered contributors to the family's bankruptcy. Although we needed to use the threshold of $1000 in out-of-pocket medical bills for consistency in the time trend analyses, we adopted a more conservative threshold—$5000 or 10% of household income—for all other analyses. Adopting these more conservative criteria reduced the estimate of the proportion of bankruptcies due to illness or medical bills by 7 percentage points.

To arrive at nationally representative estimates, we weighted the data to adjust for the slight underrepresentation of respondents who filed under Chapter 13 (bankruptcies with repayment plans). In calculating mean out-of-pocket medical expenses from our telephone interviews, we trimmed outliers at $100,000.

Chi-squared and 2-tailed t tests were used for univariate analyses. We used forward stepwise logistic regression analysis on the 2007 cohort to assess predictors of medical bankruptcy and predictors of home loss or foreclosure among homeowners. Finally, we performed logistic regression using the combined 2001 and 2007 cohorts to examine whether the odds of a bankruptcy being medical were higher in 2007 than in 2001, after controlling for demographics, income, and insurance status. SAS Version 9.1 (SAS Institute Inc., Cary, NC) was used for all analyses.

Table 1 Demographic Characteristics of 2314 Bankruptcy Filers and Comparison of Medical and Nonmedical Filers, 2007*

	All Bankruptcies	Medical Bankruptcies	Nonmedical Bankruptcies	*P* Value Medical vs Nonmedical Bankruptcies
Mean age	44.4 years	44.9 years	43.3 years	.01
Debtor or spouse/partner male	44.5%	44.9%	44.3%	NS
Married	43.9%	46.3%	40.1%	.02
Mean family size—debtors + dependents	2.71	2.79	2.63	.02
Attended college	61.9%	60.3%	65.8%	.02
Homeowner or lost home within 5 years	66.7%	66.4%	67.8%	NS
Current homeowner	52.3%	52.0%	53.2%	NS
Occupational prestige score >20	87.3%	86.1%	89.8%	.01
Mean (median) monthly household income at time of bankruptcy filing	$2676 ($2299)	$2586 ($2225)	$2851 ($2478)	.002
Debtor or spouse/partner currently employed	79.2%	75.5%	85.0%	.001
Debtor or spouse/partner active duty military or veteran	19.4%	20.1%	18.4%	NS
Market value of home (mean)	$147,776	$141,861	$159,145	.03
Mean net worth (assets—debts)	−$41,474	−$44,622	−$37,650	NS

*Bankruptcies meeting at least one of the following criteria: illness, injury or medical bills listed as specific reason for filing OR uncovered medical bills >$5000 or >10% of annual family income OR, lost ≥2 weeks of work-related income due to illness/injury, OR depleted home equity to pay medical bills.

Human subject committees at Harvard Law School and The Cambridge Health Alliance approved the project.

RESULTS

The demographic characteristics of our sample are shown in **Table 1**. Most debtors were middle aged, middle class (by occupational prestige),[5] and had gone to college. Their modest incomes reflect the financial setbacks common in the peri-bankruptcy period. Two thirds were homeowners.

Compared with other debtors, medical debtors had slightly lower incomes, educational attainment, and occupational prestige scores; more were married and fewer were employed (reflecting more disability). Medical debtors were older and had larger families. Although similar proportions were homeowners, medical debtors' homes had 11% lower market value. The average net worth was similar (and negative) for medical and nonmedical debtors (−$44,622 vs −$37,650, $P > .05$).

Medical Causes of Bankruptcy

Illness or medical bills contributed to 62.1% of all bankruptcies in 2007 (**Table 2**).

Unaffordable medical bills and income shortfalls due to illness were common; 57.1% of the entire sample (92% of the medically bankrupt) had high medical bills, proportions that did not vary by insurance status; 5.7% of homeowners had mortgaged their homes to pay medical bills; 40.3% of the entire sample had lost income due to illness; 95% of the lost-income debtors also had high medical bills.

Data from the detailed telephone survey yielded confirmatory results. When asked about problems that contributed very much or somewhat to their bankruptcy, 41.8% of interviewees specifically identified a health problem, 54.9% cited medical or drug costs, and 37.8% blamed income loss due to illness. Overall, 68.8% cited at least one of these medical causes. An additional 6.8% had recently borrowed money to pay medical bills.

Insurance Status of Debtors and Dependents

Less than one quarter of debtors—whether medical or nonmedical—were uninsured when they filed for bankruptcy; an additional 7% had uninsured family members (**Table 3**). Medically bankrupted families, however, had more often experienced a lapse in coverage during the 2 years before filing (40.0% vs 34.1%, $P = .005$).

Table 2 Medical Causes of Bankruptcy, 2007*

	Percent of All Bankruptcies
Debtor said medical bills were reason for bankruptcy	29.0%
Medical bills >$5000 or >10% of annual family income	34.7%
Mortgaged home to pay medical bills	5.7%
Medical bill problems (any of above 3)	57.1%
Debtor or spouse lost ≥2 weeks of income due to illness or became completely disabled	38.2%
Debtor or spouse lost ≥2 weeks of income to care for ill family member	6.8%
Income loss due to illness (either of above 2)	40.3%
Debtor said medical problem of self or spouse was reason for bankruptcy	32.1%
Debtor said medical problem of other family member was reason for bankruptcy	10.8%
Any of above	62.1%

*Percentage based on recent homeowners rather than all debtors.

Table 3 Health Insurance Status of Debtor Households With and Without Medical Causes of Bankruptcy

	Medical Bankruptcy	Nonmedical Bankruptcy	*P* Value
Debtor or a dependent uninsured at time of bankruptcy filing	30.8%	30.7%	.93
Debtor or a dependent had a lapse in coverage during 2 years before bankruptcy filing	40.0%	34.1%	.005

In multivariate analysis, being uninsured at filing did not predict a medical cause of bankruptcy, while a gap in coverage did (odds ratio [OR] = 1.35, *P* = .002). Other predictors included: older age (OR = 1.016/year, *P* = .0001), married (OR = 1.59, *P* = .0001), female (OR = 1.34, *P* = .002), larger household (OR = 1.97/household member, *P* = .01), and lower income quartile (OR = 1.30, *P* = .0001).

Medical debtors' court records identified more debt owed directly to doctors and hospitals than did nonmedical debtors', a mean of $4988 vs $256, respectively (*P* <.0001). Medical debtors with coverage gaps owed providers a mean of $8338, vs $2740 (*P* <.0001) for medical debtors with continuous coverage. Nonmedical debtors had few medical debts, averaging under $300 regardless of insurance status. (Medical debts financed through credit cards or other borrowing, or owed to collection agencies are not included because they cannot be identified through court records.)

Patients Whose Illness Contributed to Bankruptcy

Telephone interviews identified 639 patients whose illness contributed to bankruptcy: the debtor or spouse in 77.9% of cases; a child in 14.6%; and a parent, sibling or other adult in 7.5%. At illness onset, 77.9% were insured: 60.3% had private insurance as their primary coverage; 10.2% had Medicare; 5.4% had Medicaid; and 2% had Veterans Affairs/military coverage. Few of the uninsured lacked coverage because of a preexisting condition (2,8%) or belief that coverage was unnecessary (0.3%); nearly all cited economic reasons.

By the time of bankruptcy, the proportion of patients with private coverage had fallen to 54.1%, while the percentage with Medicare and Medicaid had increased to 16.4% and 9.9%, respectively. The proportion whose employers contributed to coverage decreased from 43.2% to 36.6%.

Out-of-pocket medical costs averaged $17,943 for all medically bankrupt families: $26,971 for uninsured patients, $17,749 for those with private insurance at the outset, $14,633 for those with Medicaid, $12,021 for those with Medicare, and $6545 for those with Veterans Affairs/military coverage. For patients who initially had private coverage but lost it, the family's out-of-pocket expenses averaged $22,568.

Among common diagnoses, nonstroke neurologic illnesses such as multiple sclerosis were associated with the highest out-of-pocket expenditures (mean $34,167), followed by diabetes ($26,971), injuries ($25,096), stroke ($23,380), mental illnesses ($23,178), and heart disease ($21,955).

Hospital bills were the largest single out-of-pocket expense for 48.0% of patients, prescription drugs for 18.6%, doctors' bills for 15.1%, and premiums for 4.1%. The remainder cited expenses such as medical equipment and nursing homes. While hospital costs loomed largest for all diagnostic groups, for about one third of patients with pulmonary, cardiac, or psychiatric illnesses, prescription drugs were the largest expense.

Our telephone interviews indicated the severity of job problems caused by illness. In 37.9% of patients' families, someone had lost or quit a job because of the medical event; 24.4% had been fired, and 37.1% subsequently regained employment. In 19.9% of families suffering a job loss, the job loser was a caregiver.

Changes in Medical Bankruptcy, 2001 to 2007

In our 2007 study, 69.1% of the debtors met the legacy definition of medical bankruptcy employed in our 2001 study, a 22.9 percentage point absolute increase (49.6% relative increase) from 2001, when 46.2% met this definition (*P* <.0001). (Inflation, which might edge families over our $1000 medical debt threshold, did not account for this change. An analysis that used all criteria except the size of medical debts found a 48.7% relative increase. An analysis limited to the 5 states in our 2001 study yielded virtually identical findings.

In multivariate analysis, a medical cause of bankruptcy was more likely in 2007 than in 2001 (OR = 2.38, *P* <.0001) (**Table 4**).

DISCUSSION

In 2007, before the current economic downturn, an American family filed for bankruptcy in the aftermath of illness every 90 seconds; three quarters of them were insured.

Since 2001, the proportion of all bankruptcies attributable to medical problems has increased by 50%. Nearly two thirds of all bankruptcies are now linked to illness.

How did medical problems propel so many middle-class, insured Americans toward bankruptcy? For 92% of the medically bankrupt, high medical bills directly contributed to their bankruptcy. Many families with continuous coverage found themselves under-insured, responsible for thousands of dollars in out-of-pocket costs. Others had private coverage but lost it when they became too sick to work. Nationally, a quarter of firms cancel coverage immediately when an employee suffers a disabling illness; another quar-

Table 4 Multivariate Predictors of Medical Causes of Bankruptcy, 2001 and 2007 Combined

	Odds Ratio	95% Confidence Interval	*P* Value
Age	1.02	1.01–1.02	.0001
Married	1.32	1.13–1.55	.0006
Own home now or in past 5 years	1.10	0.93–1.30	NS
All family members insured at time of filing	1.23	1.03–1.46	.02
Gap in health insurance coverage for any family member within past 2 years	1.64	1.38–1.94	.0001
Income quartile	.99	.82–1.07	NS
Attended college	1.02	.87–1.18	NS
Year of bankruptcy filing, 2007 vs 2001	2.38	2.05–2.77	.0001

ter do so within a year.[6] Income loss due to illness also was common, but nearly always coupled with high medical bills.

The present study and our 2001 analysis provide the only data on large cohorts of bankruptcy filers derived from in-depth surveys. As with any survey, we depend on respondents' candor. However, we also had independent checks—from court records filed under penalty of perjury—on many responses. Because questionnaires and court records were available for our entire sample, we used them for most calculations. The lowest plausible estimate of the medical bankruptcy rate from these sources is 44.4%—the proportion who directly said that either illness or medical bills were a reason for bankruptcy. But many others gave reasons such as "aggressive collection efforts" or "lost income due to illness" and had large medical debts. Indeed, detailed telephone interview data available for 1032 debtors revealed an even higher rate of medical bankruptcy than our 62.1% estimate—at least 68.8% of all filers.

Our current methods address concerns expressed about our previous survey. We assembled a random, national sample and asked far more detailed questions. In addition, we adopted more stringent criteria for medical bankruptcy. Adopting an even more stringent threshold for medical debts (eg, eliminating those with medical debts below 10% of family income) would reduce our estimate by <1%.

Teasing causation from cross-sectional data is challenging. Multiple factors push families into bankruptcy. Yet, our data clearly establish that illness and medical bills play an important role in a large and growing proportion of bankruptcies.

Changes in the Law

Between our 2001 and 2007 surveys, Congress enacted the Bankruptcy Abuse Prevention and Consumer Protection Act (BAPCPA), which instituted an income screen and procedural barriers that made filing more difficult and expensive. The number of filings spiked in mid-2005 in anticipation of the new law, then plummeted. Since then, filings have increased each quarter. They are likely to exceed one million households in 2008, representing about 2.7 million people.

BAPCPA's effects appear nonselective. Current filers differ from past ones mainly in having struggled longer with their debts.[7] New restrictions fall equally on medical and nonmedical bankruptcies, with no preferences for medical debts or sick debtors. It is implausible to ascribe the growing predominance of medical causes of bankruptcy to BAPCPA.

Conversely, there is ample evidence that the financial burden of illness is increasing. The number of under-insured increased from 15.6 million in 2003 to 25.2 million in 2007.[3] Of low- and middle-income households with credit card balances, 29% use credit card borrowing to pay off medical expenses over time.[8] Collection agencies contacted 37.2 million Americans about medical bills in 2003.[9] Between 2005 and 2007, the proportion of nonelderly adults reporting medical debts or problems paying medical bills rose from 34% to 41%.[10]

Adding to Other Studies

We have reviewed elsewhere the older studies on medical bankruptcy.[2,11] Most rely exclusively on court records where many medical debts are invisible, disguised as credit card debt or mortgages. In our cohort, most medical debtors had charged unaffordable medical care to credit cards.

Similarly, debts turned over to collection agencies by doctors or hospitals may be unrecognizable on court records. Moreover, income loss due to illness cannot be identified. In short, even though such studies find substantial rates of medical bankruptcy,[12,13] estimates based solely on court records understate medical bankruptcies.[9]

Population-based studies also are problematic because many debtors are unwilling to admit to filing. Thus, a study based on the Panel Survey of Income Dynamics could identify only 74 bankruptcies (0.4% of respondents), half the actual filing rate among the national population from which the sample was drawn.[13]

A few studies employed novel methods to analyze medical bankruptcy. One found a high bankruptcy filing rate in a cohort of patients with serious neurologic injuries.[14] A survey of cancer patients documented a 3% bankruptcy rate; 7% had taken a second mortgage to pay for treatments.[15] A questionnaire-based study found medical contributors to 61% of Utah bankruptcies; 58% of families seeking help at bankruptcy clinics in upstate New York reported outstanding medical debts.[16]

Medical impoverishment, although common in poor nations,[17,18] is almost unheard of in wealthy countries other than the US.[19] Most provide a stronger safety net of disability income support. All have some form of national health insurance.

The US health care financing system is broken, and not only for the poor and uninsured. Middle-class families fre-

quently collapse under the strain of a health care system that treats physical wounds, but often inflicts fiscal ones.

ACKNOWLEDGMENTS

Additional support came from Harvard Law School and the American Association of Retired Persons. Professors Melissa Jacoby, Robert Lawless, Angela Littwin, Katherine Porter, John Pottow, and Teresa Sullivan played key roles in the Consumer Bankruptcy Project.

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Testimony Before the Health Services Cost Review Commission
In Support of the 50/50 Assessment Approach

Mr. Chairman, Members of the Commission, My name is Mark Derbyshire and I own Park Moving and Storage in Harford County, Maryland. I am here to support the 50/50 assessment approach, as proposed by the Health Services Cost Review Commission, to resolve the $123 million proposed cuts in Governor O'Malley's FY 2011 budget.

Park Moving and Storage is a family business which has provided reliable moving and storage services for over 50 years. Like many Maryland business owners, I am fortunate enough to be able to provide full health insurance to my employees, but escalating costs are making this very difficult.

Without the 50/50 assessment, my business, employees and customers would be shouldering the burden of paying for the $123 million budget cuts. I already subsidize the health care of competitors who don't provide health care coverage. Now, I'll be forced to subsidize Governor O'Malley's proposed budget cuts. Businesses and families are being hit hard by the economic downturn. There is no way we can pay for the budget cuts through the hidden hospital admission tax that the hospitals are proposing. The extra $200 that will be added to every hospital admission is unacceptable. I would be placed in a very difficult financial situation as I continue to provide employer sponsored health care to my employees.

Allowing hidden taxes to be imposed on payers alone is counter to the goals of the federal government in the recent passage of national health care reform. I support the 50/50 assessment approach because it is vital to the continued growth and success of Maryland small businesses.

Health Care for All!
Maryland Citizens' Health Initiative
2600 St. Paul Street
Baltimore, MD 21218
(410) 235-9000 (voice) ~~ (410) 235-8963 (fax)
glenn@healthcareforall.com (e-mail) http://www.healthcareforall.com

Statement of Glenn E. Schneider, Member, Board of Directors
to the Maryland Health Services Cost Review Commission
March 26, 2010

On proposals to fund residual budget cuts to hospitals

The Maryland Health Care for All! Coalition is made up of 1,200 health care, business, faith, labor, and community groups from around the state that have endorsed the Initiative's Health Care for All Plan. Our Coalition strongly believes that all Marylanders should have access to quality, and affordable health care.

Over the past ten years, thousands of citizens have testified at our numerous public town meetings. Groups representing key interests in the state, including advocates for mental health, disabilities, children, health centers, the poor, and substance abuse treatment have provided input. And leaders from the business, labor, government and the health care community have told us what they need. Our input today is based on what we've heard from thousands of organizations, representing hundreds of thousands of Marylanders.

Thank you for the opportunity to comment on how the Commission should fund residual budget cuts that impact hospitals. As we understand it, the Commission has outlined the following proposals:

I. Imposition of Medicaid Day Limits
We oppose this proposal. Day limits were meant to be a short-term cost cutting mechanism. MHA made it a legislative priority in 2008 to end day limits. The Commission's own study found that while saving Medicaid money, imposition of day limits also increased the amount of uncompensated care AND presented a short-term cash-flow problem for the hospital system. Like the Commission, we care about the financial stability of Maryland hospitals and for that reason alone, we oppose day limits.

II. Add 100% of cuts to hospital rates
We oppose this proposal. The Commission estimates that passing along cuts of this magnitude via the hospital rate setting process would add $200 to each hospital admission. Holding the hospitals "harmless," in this case, means that substantial new costs will be passed along solely to those who purchase and use insurance (e.g., employers, employees, and their families). Given the tough economic times, this additional tax will make premiums more expensive, will drive deductibles higher, will push employers to reduce services or drop coverage all-together, and will increase the ranks of the uninsured. In the absence of its effects on health coverage, adding costs of this nature may force an employer to eliminate jobs or reduce wages. Given exciting developments on the national front, this is not the time to increase the number of uninsured people in Maryland.

III. Assess hospitals for the entire amount
We oppose this proposal. If the Commission could guarantee that assessing hospitals for the entire amount of cuts would not effect the quality of care provided, appropriate staffing, and financial stability of the system, we would be all for this method. But we do not think that is likely. Absorbing $123 million in cuts will not be easy to do no matter who/what entity takes on that burden.

IV. Share the cost of cuts 50/50 (patients/hospitals)

We support this approach with reservations. While we regret that the Governor and Maryland General Assembly found it necessary to cut health care in order to balance the budget, we think that the Commission should do its best to fairly distribute the impact of those cuts. In order to preserve both the quality and the affordability of our health care system, sharing the costs 50/50 with hospitals is likely the best possible approach. However, if the Commission could show that hospitals could take on more of the burden without impacting the quality of care provided, appropriate staffing, and financial stability of the system, we'd support a 60/40 split or some other split where hospitals take on more of the costs than patients.

As you consider our comments please know that we value our partnership with Maryland hospitals. In recent years, we have worked closely with the Maryland Hospital Association (MHA) and its members to increase access to health care. Working hand-in-hand with our Coalition members, MHA, and others, we have successfully advocated for laws that expanded health care coverage in Maryland to over 100,000 uninsured Marylanders, bringing Maryland from 44th in the nation in health care for adults to 16th.

Thank you for the opportunity to present our written comments to the Commission. And thank you for all you do to keep Maryland healthy.

To be sent via e-mail; original to follow

March 26, 2010

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Dr. Young:

On behalf of Peninsula Regional Medical Center, we appreciate the Health Services Cost Review Commission's (HSCRC) willingness to revisit its March 3 policy decision and urge the Commission to reconsider its stated preference for implementing the proposed $123 million in hospital Medicaid budget cuts. As you know, there is widespread agreement among hospitals, payers, the Administration and the HSCRC that an assessment is the most efficient way to address the state's current budget shortfall. At issue is how to apply the assessment.

At your March 3 meeting, the Commission stated its preference to build half of the assessment into rates and to have hospitals remit the other half back to the state. Hospitals strongly urge the Commission, for this FY 2011 assessment, to build all of the needed Medicaid assessment into hospital rates.

Placing a portion of the assessment at this time on hospitals jeopardizes jobs across the Delmarva region. As the largest single employer in the Delmarva Region who employs approximately 3,400 people, we are an economic engine for this region. Our projected average operating margin for the fiscal year ending June 30, 2010 for the hospital is .50%, less than 1%, well below the 2.75 percent operating margin target set by the HSCRC designed to ensure we can adequately meet the needs of our patients and communities. This year's Commission-approved 1.77 percent update, once $100 million in averted uncompensated care hospital cuts and $27 million in Board of Public Works hospital cuts are taken into account, translated into only an effective 0.8 percent rate increase for hospitals. This is well below the actual rate of inflation and has squeezed hospital finances considerably. Recent snowstorms, through both additional costs and reduced volumes, have added to our financial difficulties. Given these current financial challenges, we have few choices but to address a potential cut of this magnitude through job restructuring, hiring restrictions and minimal market basket adjustments.

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Further, because of the impact of an assessment and other HSCRC policy decisions on jobs and the economy, now is not the time to have hospitals absorb a $61 million cut, which alone is equivalent to a hospital update reduction of 0.5 percentage points. This, on the heels of insurance companies' proposal to freeze the FY2011 update for hospitals, is neither reasonable nor sensible.

I strongly urge the Commission to revise its March 3 decision by building all of the needed assessment this year into rates.

Sincerely,

Dr. Peggy Naleppa, M.S., M.B.A., FACHE
President/CEO, Peninsula Regional Health System

To be sent via e-mail; original to follow

March 26, 2010

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Dr. Young:

On behalf of Maryland's hospitals, the Maryland Hospital Association appreciates the Health Services Cost Review Commission's (HSCRC) willingness to revisit its March 3 policy decision and urges the Commission to reconsider its stated preference for implementing the proposed $123 million in hospital Medicaid budget cuts. As you know, there is widespread agreement among hospitals, payers, the Administration and the HSCRC that an assessment is the most efficient way to address the state's current budget shortfall. At issue is how to apply the assessment.

At your March 3 meeting, the Commission stated its preference to build half of the assessment into rates and to have hospitals remit the other half back to the state. Hospitals strongly urge the Commission, for this FY 2011 assessment, to build all of the needed Medicaid assessment into hospital rates. The reasons:

- **Any rate increase would be temporary.** Hospital rates would only increase until the Medicaid savings target is achieved. Rates would then be adjusted downward accordingly.

- **It takes best advantage of federal funds.** Of the $123 million increase in rates, about $60 million would be paid for by the federal government. The federal Medicare program would absorb about $47 million of the increase, and the federal government's share of Medicaid would absorb about $13 million of the increase. At a time when state dollars are dear, we shouldn't leave federal dollars on the table.

- **It saves jobs and protects access to care at a time when hospitals' financial condition is poor.** Placing a portion of the assessment, at this time, on hospitals jeopardizes jobs across the state because the current condition of Maryland hospitals' finances is so serious. As some of the largest employers in the state, Maryland hospitals employ 88,000 people with payroll and benefits of nearly $5 billion annually. Every hospital job in Maryland creates two additional jobs in the state, for a total contribution of $24 billion in hospital-related economic activity in Maryland. But that economic activity is jeopardized by hospitals' poor financial condition. The projected average operating margin for the fiscal year ending June

30, 2010 for the hospital field is 1 percent, well below the 2.75 percent operating margin target set by the HSCRC to ensure hospitals can adequately meet the needs of their patients and communities. This year's Commission-approved 1.77 percent update, once $100 million in averted uncompensated care hospital cuts and $27 million in Board of Public Works hospital cuts are taken into account, translated into only an effective 0.8 percent rate increase for hospitals. This is well below the actual rate of inflation and has squeezed hospital finances considerably. Recent snowstorm costs to hospitals across the state – which total over $60 million – have added to the financial difficulties. Some, but only a small portion, of those losses may be reimbursed through federal disaster relief funds, but that won't occur for the next twelve to eighteen months. Given these current financial challenges, hospitals have few choices but to address a potential cut of this magnitude through job losses. So far this year, many hospitals curtailed hiring and froze wages. If half the assessment is placed on hospitals, this would translate into some 900-1,200 jobs likely lost across the state. And any hospital assessment is an even greater burden for our most vulnerable hospitals and systems, like Dimensions Healthcare System and Bons Secours Baltimore Health System, that serve large numbers of low income Medicaid patients and for whom the assessment would have an even greater impact.

Hospitals are willing to help hold the state harmless for its share of the impact of any rate increase due to the assessment on the Medicaid program. But because of the impact of an assessment and other HSCRC policy decisions on jobs and the economy, now is not the time to have hospitals absorb a $61 million cut, which alone is equivalent to a hospital update reduction of 0.5 percentage points. This, on the heels of insurance companies' proposal to freeze the FY2011 update for hospitals, is neither reasonable nor sensible.

We strongly urge the Commission to revise its March 3 decision by building all of the needed assessment this year into rates.

Sincerely,

Laurie Beyer
Senor Vice President & CFO

Proposed $123 Million Reduction
To Medicaid Hospital Payments

April 6th Public Hearing
Discussion Questions

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1. Who are the top five (5) commercial health insurance companies doing business in Maryland based on health care premiums generated in Maryland?

    - Are they for-profit or non-profit organizations?
    - Are their headquarters in Maryland or some other state?
    - If for-profit, who benefits from their annual profits (is it shareholders, executives, the public, etc)?
    - What are their operating and total profit margins for the past 3 years?
    - Is it likely that local company executives have stock options tied to share price/profitability?

2. For the top five (5) commercial insurers, how much have they raised premiums in Maryland's large group, small group and individual insurance markets (on average) over the past three (3) years?

    - How do these premium increases compare to the average annual rate increases granted to Maryland hospitals by the HSCRC?
    - Is there a relationship between hospital rate increases and insurance premium rate increases?
    - If the premium increases are large, how are they justified?

3. If the $123 million Medicaid cut is included in rates, how will it impact:

    - Commercial insurance premiums
    - Commercial insurance company profit margins
    - Jobs in Maryland
    - The Medicare Waiver

4. If the $123 cut is not included in rates, how will it impact:

    - Hospital profit margins
    - Jobs in Maryland

5. How much money did Maryland hospitals lose due to the snow storms in December and February?

    - Will any of these losses be recovered in rates or through federal disaster relief?

6. Is it true that major insurance companies operating in Maryland are planning to deny claims/days of care during the storms due to a lack of medical necessity (since hospitals could not discharge patients due to the extraordinary amounts of snow)?

   - If this is true, it is very unfair to hospitals and the HSCRC should take a position on this issue and communicate it to the Maryland Insurance Commissioner. How would the MIA likely react to appeals related to such denials?

   - The insurance companies should explain their position to the HSCRC on this issue.

Requested by Commissioner Hall on March 30, 2010