Draft Staff Recommendation for Adjustment to the Payer Differential

November 14, 2018

Health Services Cost Review Commission
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This is a draft recommendation. Comments on the draft policy may be submitted by email to madeline.jackson@maryland.gov and are due by Wednesday, November 21, 2018.

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DRAFT RECOMMENDATION

Staff is presenting this draft recommendation to increase the public-payer differential from 6.0 percent to 7.7 percent, effective July 1, 2019. Given recent trends of increasing bad-debt write-offs in commercial coverage, it is most equitable that the differential be increased 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to ensure that these costs are not shifted to Medicare and Medicaid. This change accounts for the changes in business practices of private Maryland payers that have resulted in higher bad debt costs.

The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue.

This report presents analyses and the staff recommendation to adjust the public-payer differential in order to correct for excess bad-debt write-offs from commercial coverage, which is shifting costs onto Medicare and Medicaid. This adjustment will result in a more equitable distribution of uncompensated care costs and adjust the differential for payers who are averting more bad debt. The HSCRC staff is recommending an effective date of July 1, 2019 to allow for implementation by the Medicare intermediary and other payers. This differential change is not intended to supplant the work of providers to generate savings to Medicare under the All-Payer and Total Cost of Care Model Agreements with CMS, but rather to more accurately and fairly adjust for current trends in uncompensated care resulting from plan design changes of private payers.

BACKGROUND AND HISTORY

The Maryland Health Services Cost Review Commission ("HSCRC," or "Commission") is a state agency with unique regulatory authority. Legally, the HSCRC is authorized to set the rates that Maryland hospitals may charge. These rates form the basis for which all payers in Maryland pay for the provision of hospital services. The federal government granted Maryland the authority to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system administered by the HSCRC. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost-shifting among payers, while also appropriately accounting for certain differences among payers.

At the inception of the first Medicare waiver in 1977, a payer differential was established based on business practices of payers that helped to avert bad debt to hospitals such as prompt payment and insuring high-risk individuals. It is referred to as a differential rather than a discount, because the differential in payments is built into hospitals' rate structures.

Initially, the HSCRC allowed some private carriers to pay Maryland hospitals four percent less than a hospital's approved rates, with an additional reduction available contingent upon compliance with HSCRC prompt pay regulations. This four percent reduction program, known as Substantial, Available and Affordable Coverage (SAAC), encouraged the provision of health care coverage to high-risk individuals, thereby averting bad debt and reducing uncompensated care at Maryland hospitals. The HSCRC adopted specific requirements for a non-governmental payer to be eligible for the SAAC program. For example, in order to obtain the SAAC discount, a payer was required to provide annually, at a minimum, an open enrollment period of 60 days, comprised of two 30-day periods at least five months apart. Such open enrollment, required to be advertised to the public, would allow for individuals or families to purchase health insurance coverage, without a medical exam or medical screening (referred to as medical underwriting), at a standard, affordable price. The SAAC program and the provision of health insurance to those that may not otherwise have afforded health insurance helped to avert bad debt or non-payment to hospitals.

In 1999, however, the HSCRC decided to examine whether the SAAC policy was achieving its intended purposes in light of numerous complaints regarding changing payer practices. Among the complaints, it was reported that the coverage provided under these SAAC plans was not substantial. For example, many of the policies offered lacked substantial, or any, prescription drug coverage. There were also complaints about availability indicating the gradual shortening of open enrollment timeframes. Furthermore, the employer market became increasingly self-insured, and the SAAC differential was being passed on to the self-insured employers as an administrative benefit, rather than being used to lower the cost of coverage to high-risk individuals. Upon examination, the HSCRC determined that the cost of the SAAC discount greatly outweighed the hospital savings generated by the open enrollment program and the provision of health insurance afforded to high risk individuals. In 2001, recognizing

shortcomings of the SAAC program, the legislature required SAAC providers to contribute 37.5 percent of the value of the differential to a Short-Term Prescription Drug Subsidy Plan. The SAAC program was finally discontinued in 2003.

The SAAC program was eventually replaced by the Maryland Health Insurance Program (MHIP), a program that subsidized high-risk individuals who could not obtain medically underwritten coverage or had to pay higher rates to obtain coverage. MHIP was funded through an assessment of the aggregate value of the SAAC discount, or 0.08128 of Net Patient Revenue. In FY 2009 the assessment on hospital rates was increased to one percent of Net Patient Revenue. The MHIP program was discontinued in 2014 after the implementation of the Affordable Care Act which increased availability of coverage for high-risk individuals and expanded Medicaid eligibility. The assessment to pay for the program was also rescinded and savings were generated to all payers in the system.

All payers were still allowed to pay Maryland hospitals two percent less than the hospitals' approved rates if the HSCRC requirements for prompt payment were met, and 2.25 percent less if they provided current financing equivalent to payment upon admission. The two percent reduction is currently made available to all payers other than Medicare.

ASSESSMENT OF CHANGING BUSINESS PRACTICES

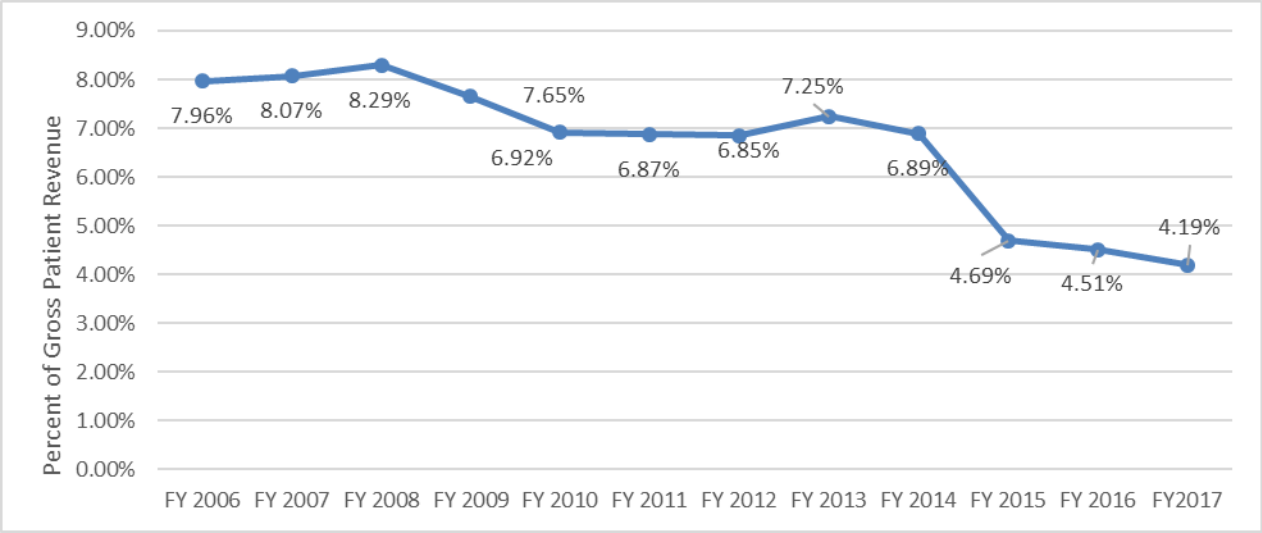
While expansion of coverage under the Affordable Care Act has contributed to a large increase in averted bad debt at hospitals and a subsequent decline in uncompensated care, rising deductibles and coinsurance have resulted in increased levels of uncompensated care for privately covered beneficiaries. The following section provides information on uncompensated care trends, health care coverage, and more detailed information on plan design trends for private payers in Maryland.

Uncompensated Care Trends

The share of hospital revenues attributed to uncompensated care has been declining in Maryland. This decline aligns with the increase in insurance coverage due to the 2007 Maryland Medicaid expansion and the expansion of Medicaid in 2014 under the Affordable Care Act (ACA). Uncompensated care, as a percentage of total patient revenue, has been reduced from 7.25 percent in 2013 (pre-ACA Medicaid Expansion) to 4.19 percent in 2017, a 3.06 percentage point reduction or a 42.2 percent decrease in uncompensated care. The HSCRC adjusts hospital rates overall to reflect state-wide levels of uncompensated care, based on state-wide averages derived from hospitals' most recent annual reports filed with the Commission. When the ACA provided a significant expansion of Medicaid in CY 2014, the HSCRC began reducing hospitals' rates on July 1, 2014 and July 1, 2015, before information was available from annual reports. While there was a lag in removing uncompensated care from rates, at the same time, there was an increase in Medicaid utilization resulting from the expansion. As a result, hospitals were overfunded for uncompensated care, but underfunded for utilization resulting from the expansion. This was resolved through a hospital specific adjustment for Medicaid expansion and a return to using annual reports and the source of uncompensated care for making the state-wide

uncompensated care adjustment beginning July 1, 2016. All payers received the benefit of the 3.06 percentage point reduction in uncompensated care through hospital revenue reductions.

Figure 1. Actual Uncompensated Care Percentage of Gross Patient Revenue FY2006-FY2017

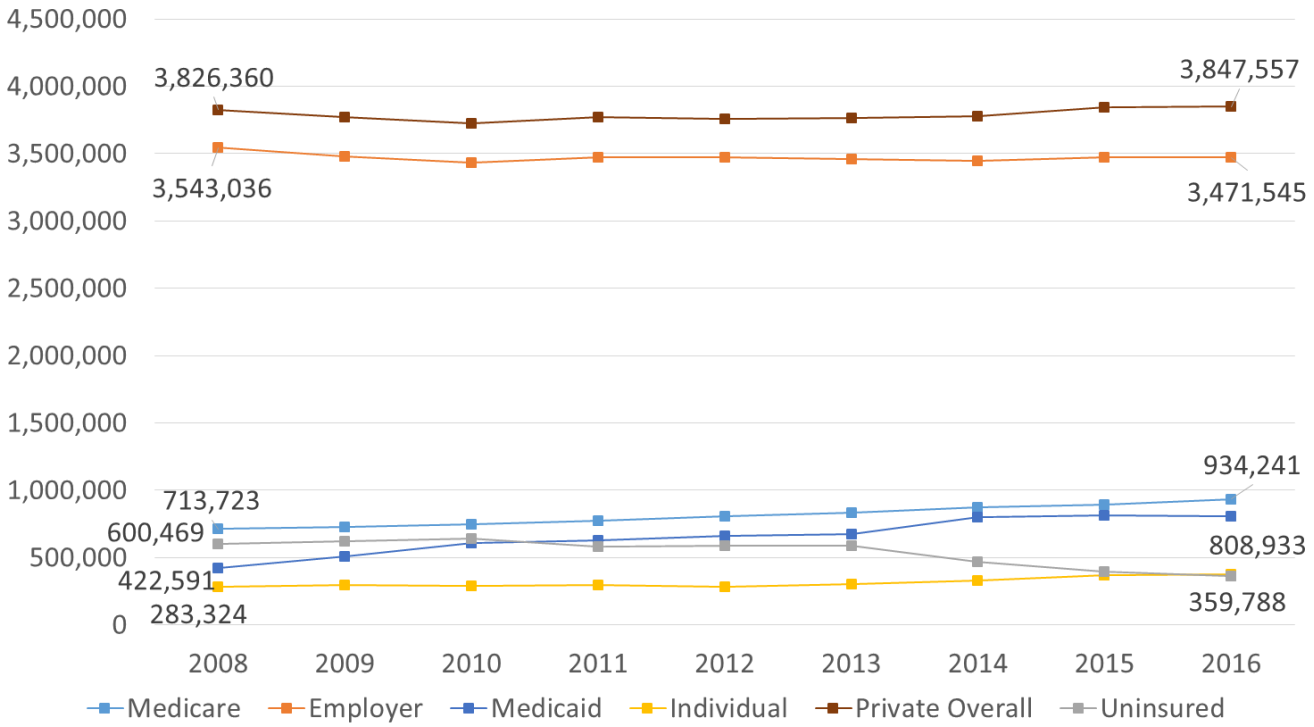


Source: HSCRC Historical Financial Data

Changes in Payer Enrollment

The uncompensated care reduction resulted from an overall increase in health insurance coverage, mainly from the ACA Medicaid expansion. Figure 2 shows the trend of enrollment for Medicaid, individual insurance, employer-sponsored insurance, and aggregate private insurance (aggregate of individual, small group, and large group enrollees), as well as the trend for uninsured individuals, between 2008 and 2016.

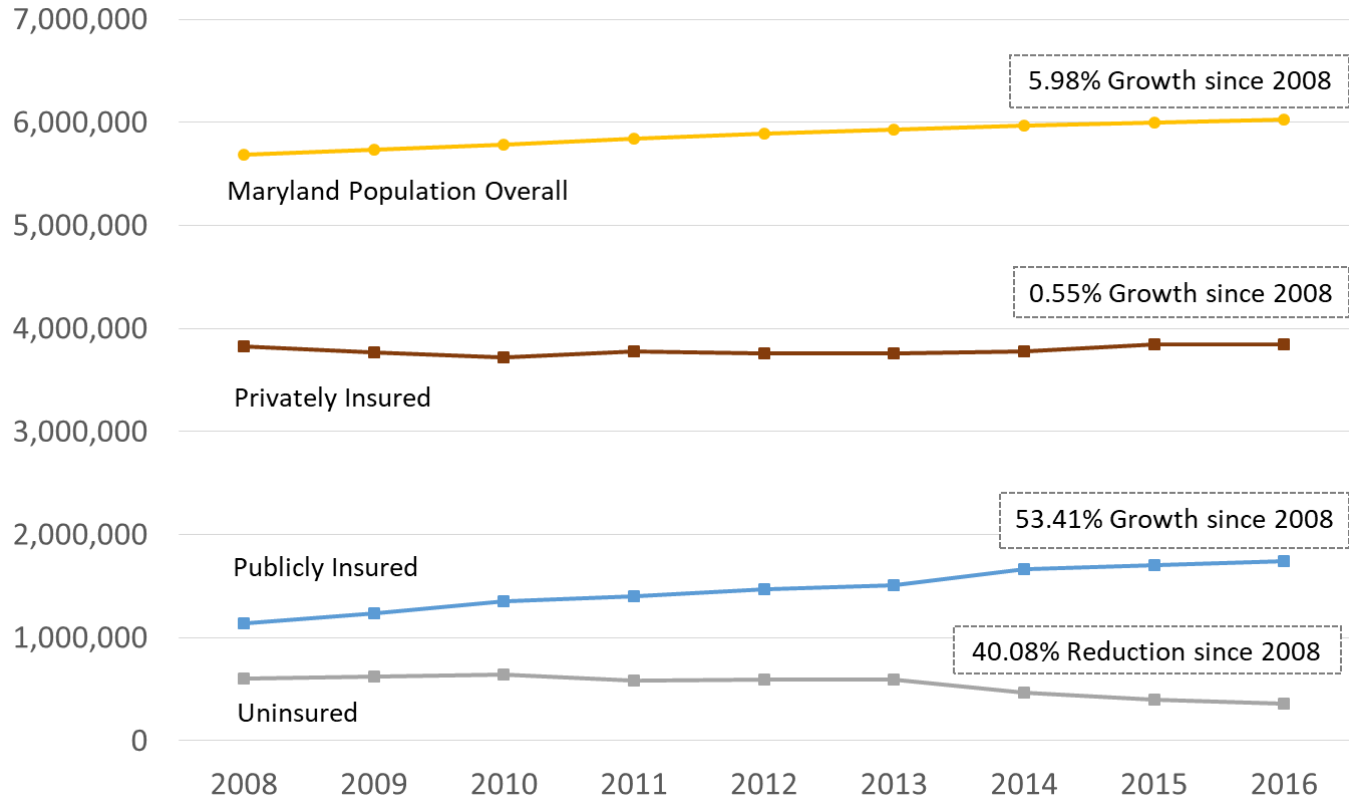
Figure 2. Maryland Health Insurance Coverage by Payer type and Uninsured, CY2008-CY2016.



Source: SHADAC Analysis of the American Community Survey (ACS). http://statehealthcompare.shadac.org/trend/11/health-insurance-coverage-type-by-total#0/1/5/1,2,3,4,5,6,7,8,15/21 and Maryland Department of Health, Office of Healthcare Financing, Accessed June 2018.

While there is little increase overall in privately insured beneficiaries (small and large employers and individual combined), there was an increase of 92,688 people (32.7 percent) enrolled in the individual market. Employer coverage has decreased by 71,491 people, or 2.0 percent. Since 2008, Medicaid enrollment has increased by 386,342 people (91.4 percent overall), with a sharp uptick in Maryland's Medicaid enrollment in 2014 as Maryland Medicaid expanded eligibility under the ACA. As a result of the ACA, the uninsured population has decreased by 240,681 people, or 40.1 percent. Over the same time period, aggregated private health coverage (individual and employer) has only increased by 21,197 people (0.6 percent), significantly less than the population growth rate (0.66 percent average and 5.98 percent growth since 2008) and the 606,860 people newly enrolled in public coverage from Medicare and Medicaid, a 53.4 percent increase. (Figure 3).

Figure 3. Maryland Population Growth and Health Care Coverage, CY2008-CY2016



Private Insurance through the Maryland Health Benefit Exchange

While the uninsured rate in Maryland dropped precipitously between 2012 and 2015 (during the ACA expansion), it appears that this decrease can be attributed more closely to increases in Medicaid enrollment than a large uptake on the individual exchanges. CY2016 estimates of Maryland's marketplace enrollment among potential enrollees show that only 35 percent of eligible enrollees have signed up.[1] A Department of Legislative Services report from 2017 notes that the largest drops in the uninsured rate were for Marylanders at 0-138 percent and 139-200 percent brackets of the federal poverty guidelines (FPG); higher income Marylanders (201-400 percent FPG), who could enroll in private insurance on the exchanges, did not have the same magnitude decrease in their uninsured rates.[1]

Although Maryland already had a subsidized high risk product available to individuals prior to the ACA expansion with the Maryland Health Insurance Plan ("MHIP"), many other existing

[1]Maryland Department of Legislative Services. Assessing the Impact of Health Care Reform In Maryland. January 2017. http://mgaleg.maryland.gov/pubs/legislegal/2017-impact-health-care-reform.pdf

individual policies offered by private carriers were required to expand their benefits under the ACA. CareFirst and Kaiser Permanente provided most of the new individual policies. These policies resulted in losses due to low risk individuals enrolling at a level less than projected, and federal subsidies and premiums not adequately covering costs. During the 2018 legislative session, the State legislature passed legislation to provide relief for insurers providing these products. As a result, a reinsurance program will be established to provide stability in the individual markets and cover some of the losses from the adverse selection noted above.

Private Insurance Offered by Employers

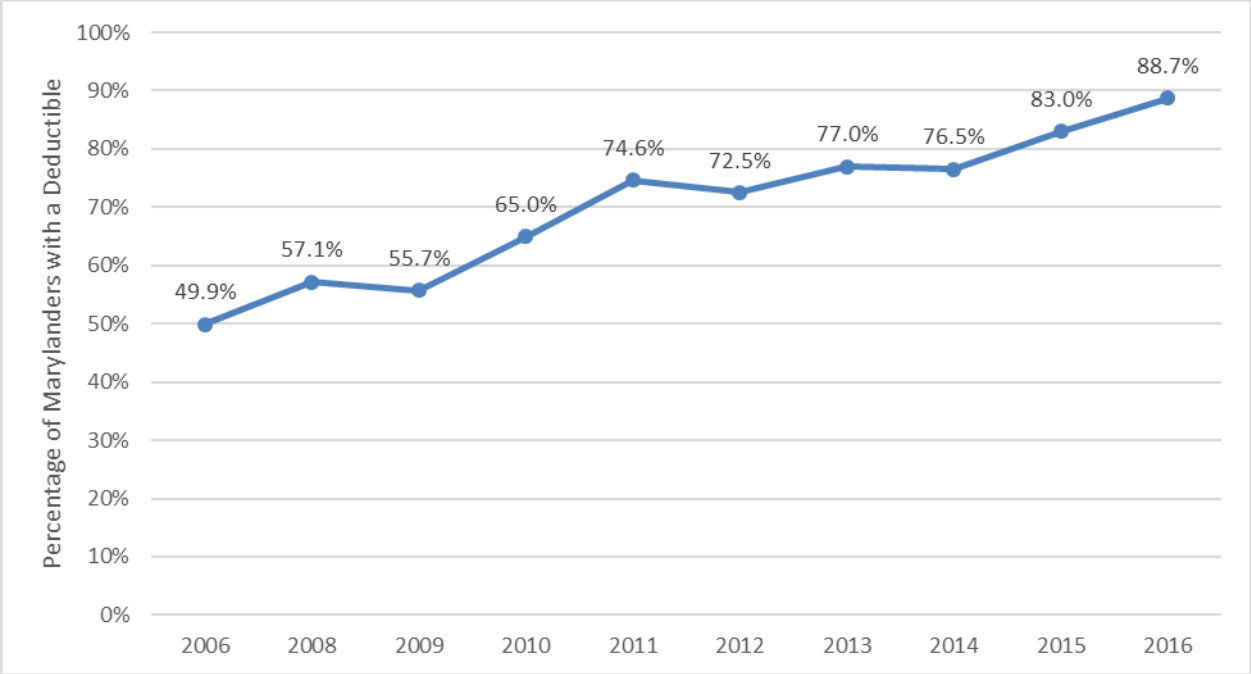
Overall, uptake of employer-sponsored health insurance plans has also dropped in Maryland. Between 2012 and 2015, employee uptake with small group insurance dropped from 72.4 percent to 64.8 percent, and dropped from 78.0 percent to 74.0 percent for large group employers.[1] Medicaid expansion and individual market options may be contributing to this decline.

Commercial Insurance Plan Design Changes

In recent years, private payers have changed plan benefit design to help address growing healthcare costs, as well as address the plan design requirements for individual policies offered under the ACA guidelines. Plans in Maryland, and nationally, are increasingly reliant on beneficiaries to cover larger portions of their care. The share of privately insured Marylanders with a deductible has increased from 49.9 percent in 2006 to 88.7 percent as of 2016. Enrollment in high-deductible health plans has also increased: 44 percent of privately insured Marylanders are now enrolled in a plan with deductibles of at least $1,300 for an individual and $2,600 for a family.[2] Furthermore, average deductibles in Maryland have increased at a rate far outpacing the Consumer Price Index (CPI) for both urban consumers (CPI-U) and medical care (CPI-MC).

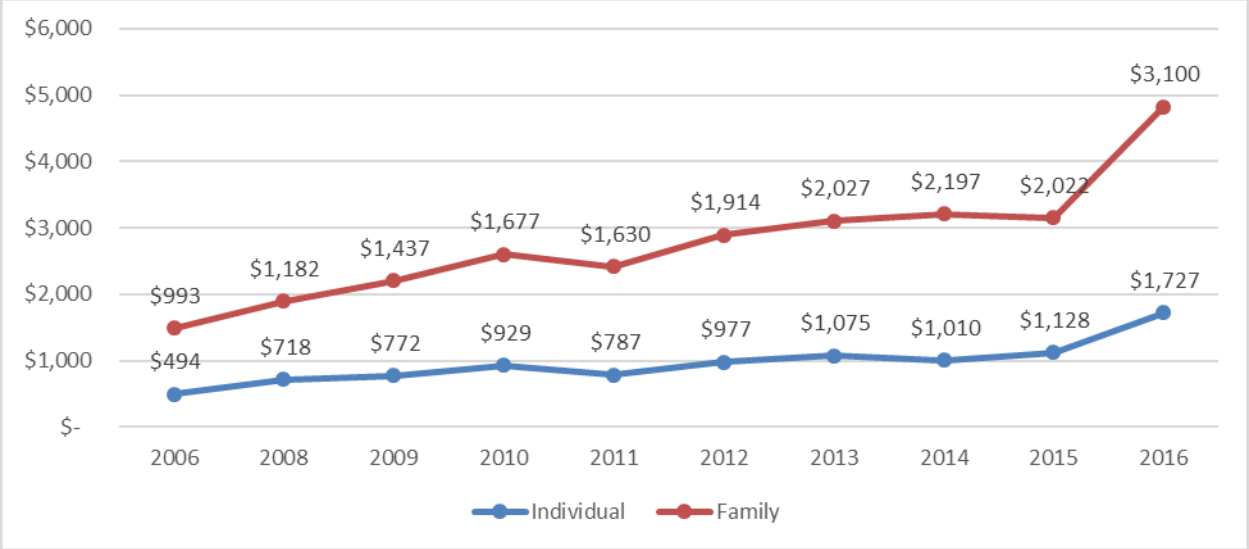
Figure 4. Percent of Maryland private-sector employees enrolled in a health insurance plan with deductible (CY2002-CY2016)

[2] Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017 https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

Figure 5. Maryland Average Deductibles for Private Insurance, Unadjusted (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

While the plan design changes are aimed at encouraging individual attention to cost levels, the HSCRC staff does not believe it is equitable to have the related uncompensated care allocated to all payers. Deductibles have increased three-fold since 2006, and twice as many Marylanders are

exposed to the rapidly increasing cost burden imposed by deductibles, thereby increasing the level of private payer uncompensated care at hospitals.

Hospital Bad Debt Share by Payer

As a result of the trends noted above, HSCRC staff is concerned that public payers are unduly burdened with the bad debts of private payers. Until recently, HSCRC did not have reliable data to evaluate the impact of increased bad debts for these changing plan designs. The HSCRC used a regression adjustment to estimate predicted bad debt levels for hospitals. Medicaid payer percentages were used to estimate expected charity levels, but with the expansion of Medicaid under the ACA, the relationships used in the regression were no longer valid. Since 2015, HSCRC collected actual write-offs at the account level and matched the write-offs to the case-mix data. Upon collection of this data, HSCRC was able to create new and more accurate estimates of predicted uncompensated care. Staff also evaluated differences in write-offs of patient balances for insured patients. The HSCRC has now collected and analyzed several years of actual write-off data. The data below show a consistent pattern: commercial payer write-off rates are significantly higher than Medicare and Medicaid write-off rates.

Table 1. Maryland Bad Debt to Hospitals, by Payer (FY2015-CY2017)

	Medicare and Medicaid	Commercial	Difference
FY 2015	2.2%	3.6%	1.4%
FY 2016	2.1%	3.8%	1.7%
FY 2017	1.8%	3.6%	1.9%
Change	**-0.5%**	**0.0%**	

According to FY 2017 write-off data, commercial payers' bad-debt write-off rate (3.6 percent) is much higher than the combined rate for Medicare and Medicaid (1.8 percent). If these percentages were applied to FY 2019 revenues, they would translate to approximately $100 million more in write-offs for commercial payers than for Medicare and Medicaid. Of this $100 million, approximately $67 million would be allocated to Medicare and Medicaid through uncompensated care payments funded through hospital rates.

Proposed Change in the Differential

The HSCRC staff believes that this allocation should be corrected through an increase in the differential by 1.7 percentage points in CY 2019. This increase would result in:

- A lower cost to Medicare of approximately $40 million;
- A lower cost to Medicaid of approximately $27 million; and
- An increase in overall commercial payer costs of $67 million, or 0.4 percent, assuming commercial costs reflect approximately one-third of total hospital costs.

The adjustment in the differential is being made to change the allocation of uncompensated care to Medicaid and Medicare. When it is implemented, it will have a revenue neutral effect on

hospitals, providing neither more nor less net revenue for each hospital through the formulaic adjustment that is made each year to the mark up for uncompensated care and payer differential. Private payers will see an increase in hospital payments of approximately 1.2 percent (which represents an overall increase of approximately 0.4 percent), while Medicare and Medicaid will see a corresponding decrease in their net payments of 0.7 percent as a result of the higher differential afforded.

This adjustment will ensure more equitable cost allocation going forward, consistent with the HSCRC's statutory mandate.

RECOMMENDATION

Based on the assessment above, staff recommends the following, effective July 1, 2019:

1) Increase the differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients. This adjustment will be made through the hospital mark-up adjustment, which will provide a net revenue neutral result for hospitals.
2) To assure that the savings from the differential adjustment is not used to justify an increase to rates in a future rate year, the staff recommends that the cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates. Furthermore, the savings associated with the increased differential should not supplant hospital savings needed to meet the annual savings goals required by the TCOC contract.
3) Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
4) The Commission should develop and adopt policies that prioritize the use of the All-Payer rate reductions and the Medicare Performance Adjustment as a means to account for costs and savings to the system. The success of the TCOC Model is dependent on improving care and health, reducing avoidable utilization, and providing efficient and effective quality health care services. To this end, the Commission should not use changes to the differential to meet Medicare total cost of care performance requirements.
5) It is the intent of the Commission to make this a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract, to correct for cost inequities and to avoid future changes to the public-payer differential to assure stability of the system and to preserve the all-payer nature of the Maryland Model.