Maryland
Hospital Association

House Bill 1782 – Health Insurance – Health Care Access Program – Establishment (Maryland Health Care Access Act of 2018)

Position: *Support with Amendments*

Bill Summary
HB 1782 would require the State Health Services Cost Review Commission, for fiscal year 2019, to assess on each hospital a uniform, broad-based, and reasonable fee to support the Health Care Access Program established by the Maryland Health Benefit Exchange; require a carrier to pay a certain assessment on certain premiums beginning January 1, 2019; require certain health insurance entities to pay an additional assessment; require, beginning January 1, 2019, an individual to maintain certain coverage for certain individuals; etc.

MHA Position
Maryland's hospitals support broad-based, continuous health coverage, an essential pillar of the state's unique agreement with the federal government. Hospitals therefore appreciate the state's efforts to develop a reinsurance program, and apply for a waiver of section 1332 of the Affordable Care Act to develop a long-term solution to market stabilization. We hope that a waiver will establish a mechanism to maintain and bolster coverage. Through this means, Maryland will be able to leverage federal funds, decreasing the pressure on the state and alleviating the burden on individual Marylanders' monthly insurance premiums.

HB 1782, however, includes an additional provision, which carries the risk of unintended consequences that could threaten the important gains on health care cost control and quality improvement that Marylanders have seen over the past five years under the All-Payer Model. Specifically, any addition to health care costs, whether it's called a tax, a fee, or an assessment, diminishes hospitals' ability to invest in care delivery transformation, an essential catalyst for meaningful improvements, and adds pressure on the state's ability to meet the measures of the All-Payer Model.

The state is at a critical juncture in negotiating the terms of the next phase of the model, which could begin as early as January 2019. Under that model, there will be an even greater emphasis on controlling costs in all health care settings, not just hospitals. This will necessitate an even greater investment on the part of hospitals to innovate, develop new partnerships, and proactively care for communities. All of this takes resources, and any new costs, fees, or assessments, would make continuing this good work all the more challenging.

The model has proven to reduce cost and improve quality for all payers, including the commercial insurance market. Since 2014:

- Inpatient admissions are down 8 percent
- Readmissions are down 13 percent
- Hospital-acquired conditions are down nearly 50 percent
- Average annual hospital rate increases average a below-inflation 1.8 percent

Under the model, commercial payers:

- Have seen $250 million in shared savings returned to them
- Enjoy the second-lowest in the nation per member, per month commercial spending cost
- Have saved $170 million through reductions in uncompensated care
- Pay 107 percent of the cost of care compared to 140 percent nationally

Hospitals stand ready to continue their work to hold health care costs down and improve quality for all Marylanders and are eager to build on the gains realized thus far under the All-Payer Model. Inherent in this proposal is the assumption that the All-Payer Model will continue. Any new costs added to the system, or funds diverted from the resources needed to meet the goals of the model, actually increase the risk that the model will fail and seriously undermine the work to ensure all Marylanders have not just access to affordable coverage, but true access to affordable care.

We respectfully request further consideration to review the cost estimates and estimates of covered lives in the forthcoming actuarial report, and look forward to working with all stakeholders on a long-term plan for a stable insurance market where insurance carriers can provide affordable coverage so that hospitals may continue to deliver lower-cost, higher-quality care.

MHA proposes the following initial amendments:
Pg.3, line 28-35 strike entire section and Pg. 4, line 1-6 strike entire section