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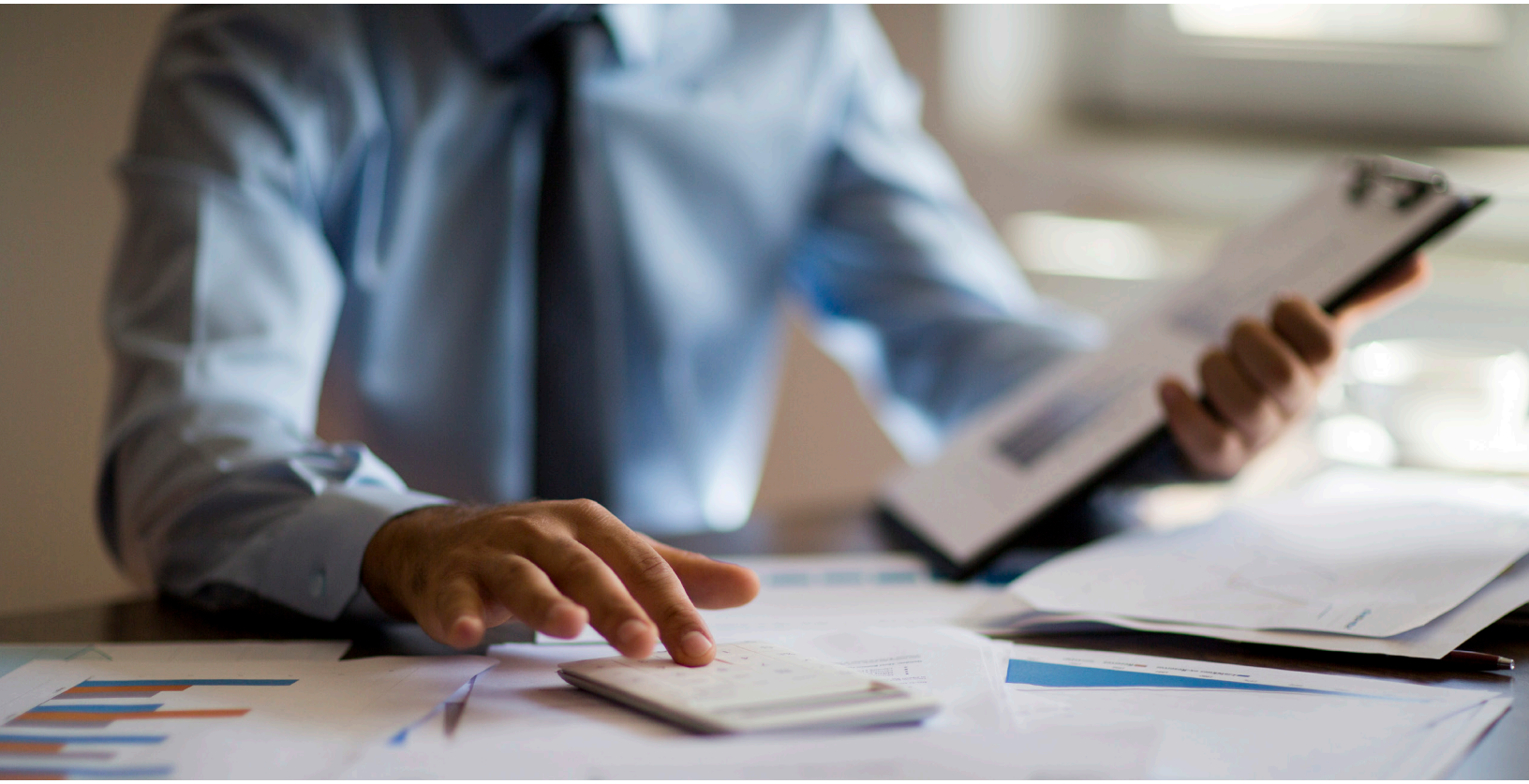

Seven Ways Stakeholders Can Help Alleviate Medical Debt Without Unintended Consequences

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On April 11th, Vice President Kamala Harris held a press conference to address the burden of medical debt on American families and announced several initiatives aimed at increasing consumers' access to credit and forgiving eligible medical debts.[1] The Administration proposed measures such as streamlining the process for veterans to apply for medical debt relief, curbing the use of medical debt in underwriting in federal credit programs, and increasing efforts to educate and support consumers in navigating medical debt.

This followed an announcement made in March by Equifax, Experian, and TransUnion outlining changes to medical debt practices that will be implemented by July including:

- Immediately erasing paid medical debts from consumers' credit reports
- New unpaid medical debt won't be added to credit reports until a year after the debt was sent to collections
- Removing unpaid medical debts less than $500 from credit reports[2]

These actions have their merits, but there are other ways to alleviate the burden of medical debt on American families. A review of existing efforts in this area follows below, as well as balanced solutions to help further alleviate medical debt in the U.S.

Background

The Kaiser Family Foundation (KFF) recently reported that approximately 23 million people in the U.S. owe medical debt with 11 million owing more than $2,000 and 3 million who owe more than $10,000. The study suggests that in 2019 Americans had collective medical debt totaling at least $195 billion.[3]

Medical debt doesn't just affect people who are uninsured. "Self-pay" patients who pay directly for their medical care often have insurance that requires them to pay a greater share of their care than they can afford – a state sometimes referred to as being underinsured.

Medical debt arises when patients do not pay for medical care they have received– often because they are financially unable to do so. A KFF report found many U.S. households do not have enough money to pay a typical health plan deductible and lower-income families with employer-sponsored health coverage spend a tenth of their income on health care.[4] Medical charges can be difficult to estimate in advance or completely unexpected, adding to the challenge for patients and families whose attention is often focused on recovery, comforting a family member, or grieving the loss of a loved one. In addition, self-pay patients often encounter medical charges as much as 3.6 times higher than those that insurance plans negotiate.[5]

Medical debt negatively impacts consumers by reducing their access to credit and employment and subjecting them to sometimes aggressive collection efforts, liens, and bankruptcy. Medical debt also causes patients to forego needed care, which not only negatively impacts their health but can also cause them to require more costly care later.[6] Medical debt also disproportionally hurts marginalized groups such as Black Americans and people with disabilities because they hold more medical debt (16% and 15% respectively) than other groups.[3]

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Recent Efforts

In addition to the Biden Administration and credit agencies' actions described above, various recent developments highlight noteworthy efforts to address medical debt in the U.S. including:

The No Surprises Act.

As its name implies, the No Surprises Act protects patients from unexpected "surprise" medical bills. Surprise bills most commonly occur when a patient receives emergency services from providers who are outside the patient's insurance network.[7] This law took effect January 1st 2022, and some legislative details are still being settled.

Hospital Price Transparency Rules.

These regulations require hospitals to publish price information for the services they provide online in a consumer-friendly format.[7] Although they took effect January 1st 2021, hospital compliance with the requirements has been complicated and inconsistent.[8,9]

State Laws.

In recent years, individual states have passed laws that aim to address medical debt in several ways including:

- Limiting the amount that self-pay patients can be billed for certain services.[10,11,12]
- Prohibiting "copay accumulator" practices and requiring insurers to apply drug manufacturer payments toward patients' out-of-pocket cost sharing limits.[13]
- Requiring nonprofit hospitals to provide additional reporting about their community benefit spending.[14]
- Implementing minimum requirements regarding the amount nonprofit hospitals must spend for community benefit.[15]

Private Nonprofits.

Several nonprofits have emerged to help consumers avoid or eliminate medical debts. For example, one such group focuses on helping patients navigate hospitals' financial assistance policies[16], and another uses donated funds to purchase and forgive patients' medical debt from hospitals or collection agencies.[17] In addition, a recent report found that some hospitals spend tens or even hundreds of millions of dollars more on charity care and community investment compared to the value of their tax-exempt status.[18]

Medical Debt Collection Best Practices.

In 2020, the Healthcare Financial Management Association (HFMA) established "voluntary best practices for the fair resolution of patients' medical bills." These guidelines have informed hospitals' and debt collectors' policies and influenced their approach to the collection of medical debts.[19]

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Solutions

Solutions to alleviate medical debt are most effective when they avoid mandatory price controls because lower reimbursement can discourage providers from supplying services, which restricts access and impacts health outcomes.[20] Solutions should also avoid unintentionally incentivizing more patients to default on medical debt, as some evidence suggests debt relief policies can do.[21]

Following are proposals designed to alleviate medical debt while minimizing the risk of unintended consequences.

Encourage providers to charge "self-pay" patients less when it aligns with providers' interests.

As explained above, self-pay patients are often charged prices that exacerbate their medical debt. In some cases, these inflated charges are due to complexities in the system that can be overcome with thoughtful policy design.

1. CMS should adopt the reforms recommended by an Alliance comprised of 560 hospitals and convened by HFMA.

The recommended changes would make it feasible and rational for hospitals to voluntarily base the prices they charge self-pay patients on their cost to provide care, rather than often arbitrary and inflated "chargemaster" rates. This change would bring relief to self-pay patients and support price transparency.[22]

2. Payers and providers should make sure insured patients aren't charged more when they're paying the tab.

When insured patients are responsible for paying for their medical care due to cost sharing arrangements like unmet deductibles, occasionally they are not charged the lower rate their insurance negotiated with the provider but are charged the higher self-pay rate. Some but not all insurers contractually require providers to only charge patients their negotiated price regardless of whether the insurer or the patient is paying the bill. More payers and providers should adopt this model, as it does not cost a provider more to provide services simply because the patient is paying the bill. This best practice can be encouraged by requiring nonprofit hospitals to report related policies on their IRS 990 form or a schedule thereto.

Afford patients and families more resources and time to deal with difficult medical issues.

The following policies would provide patients and families with more resources to pay for care and avoid medical debt, as well as allow families to focus on terminally ill loved ones before confronting medical bills.

3. Increase Health Savings Account (HSA) contribution limits.

Although out-of-pocket maximums this year are $14,100 for employer-sponsored plans and $17,400 for exchange plans, the annual limitation on deductible HSA contributions is only $7,300 for families.[23,24] Allowing patients to set aside more tax-free income will help patients save for future medical expenses.

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4. Update expectations related to nonprofit hospital charity care, community benefit spending, and Community Health Needs Assessments. This might take the form of:

- » Encouraging data-matching and automation for hospital charity care eligibility determinations;
- » Requiring nonprofit hospitals to account for medical debt burden and mitigation plans in Community Health Needs Assessments; or
- » Requiring detailed public reporting of information like the number and amount of medical bills paid using a credit card and medical debt collection activities and methods by ZIP code, race, ethnicity, and other demographic characteristics.

5. Provide greater support to help interested states adopt auto-enrollment policies for people already eligible for Medicaid, Children's Health Insurance Program (CHIP), and marketplace insurance plans.

Individuals with consistent health insurance coverage are less likely to file for bankruptcy due to medical bills.[25] Support could take the form of increased flexibility or technical assistance.

6. Create a one-stop federal website and mobile app to educate patients about how they can get the care they need at the best price.

Video tutorials and consumer hotlines may assist patients in navigating the complex health industry and be a preventative approach to reducing the burden of medical debt.

7. Allow patients and families to pause collection activity for up to 180 days when a patient is discharged from the hospital for hospice care.

This flexibility would allow patients and families to focus on compassionate care and quality of life without the added anxiety of often-overwhelming hospital bills.

Conclusion

Although various efforts have been made to address the problem, medical debt remains a serious challenge for patients and families in the U.S. Common policy approaches often miss the mark or even worsen the problem by restricting access to care or disincentivizing financial responsibility. By making it more feasible and rational for providers to charge self-pay patients less when it aligns with providers' interests, and by affording patients and families more resources and more time to deal with difficult medical issues, we can begin to alleviate medical debt without unintended consequences. There is progress to be made in this arena, and our experts are ready to be a part of the solution.

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