UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT

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EXECUTIVE SUMMARY

A substantial body of research indicates that the uninsured are more likely than the insured to delay or forgo care because of cost, but even the insured may find cost a significant barrier to care. Recent research has documented that, in order to obtain medical care, many individuals are forced into debt, often with serious consequences for themselves and their families.

In one survey, 60 percent of uninsured respondents who received ambulatory care primarily at safety-net facilities said they needed help paying for their medical care, and nearly half (46%) said they owed money to the facility where they received care. The proportion with outstanding bills rose to about two-thirds for those who received care in emergency rooms. In another survey, more than a quarter of families in which one or more members were uninsured reported having to "change their way of life significantly" to pay medical bills, a figure that rose to nearly 40 percent when all family members were uninsured. A 2001 survey found that 10 percent of Medicare beneficiaries reported not being able to pay medical bills, and 12 percent said they had to change their way of life to pay bills.

The consequences of medical debt can be far-reaching. About 40 percent of those seeking help in restructuring their debt at a consumer credit counseling agency in Florida did so in part because of medical debts. Another study found that nearly half of personal bankruptcies result from health problems or large medical bills. In interviews with low-income consumers with medical debts, more than half said their medical debts made it harder for them to get medical care. Many also said the debts were a substantial obstacle to achieving self-sufficiency.

Currently, with rising health care costs, increased consumer cost-sharing, shrinking state revenues, cutbacks in public insurance programs, and growing numbers of uninsured, problems related to medical debt will inevitably worsen for both the insured and uninsured. It is thus important to understand what policies and factors exacerbate medical indebtedness, and to identify policies that might mitigate the problem.

This report examines whether federal and state laws and regulations and other factors that place financial requirements on health care providers may contribute to medical indebtedness. It also looks at whether these factors, and/or others, affect hospitals' actual practices related to billing and collections in ways that increase the likelihood of patients accruing medical debt.

Key Findings and Policy Recommendations

Federal and State Laws and Regulations

- Federal fraud and abuse laws and Medicare regulations and guidelines designed to prevent overbilling and the provision of unnecessary care may inadvertently inhibit providers from offering reduced-cost or free care and encourage providers to aggressively attempt to collect on both Medicare and uninsured patients' outstanding bills.

- The complexity of the rules and the difficulty in interpreting them may also lead some providers to standardize their fee-setting and collection practices across all payer groups, to the unintended detriment of the uninsured.

- Laws and regulations in some states add an additional policy overlay to the complex set of forces that affect provider billing practices, but state policies vary widely. Some states impose significant regulatory requirements, while others have no such regulations.

Hospital Billing and Collections Policies and Practices

- While most hospitals for which we were able to gather information have in-house programs to screen patients for eligibility for public insurance and charity care programs, it is not clear how effective these programs are in identifying patients eligible for assistance.

- These hospitals did not have formalized procedures for identifying and negotiating discounts with patients who are ineligible for public insurance programs but unlikely to be able to pay their full bill. Discounting or waiving of bills for these patients was rare, with decisions made on an ad hoc, case-by-case basis.

- A variety of financial factors may lead some hospitals to charge high fees and encourage aggressive collection efforts against uninsured and underinsured patients. These include the need or desire to:

  - target all revenue sources in a time of tight operating margins;
  - maintain high bond ratings to lower the cost of borrowing money for capital investments; and
  - establish charges as a basis for negotiating discounts with public and private insurers.

Policy Recommendations

- Establish clearer guidelines for the application to uninsured and underinsured patients of federal laws and regulations on billing and debt collection. Work with providers to address any concerns related to the regulations.

- Encourage states or hospitals to establish clear and standard criteria for eligibility for free or discounted care, and simplify application procedures.

- Establish state requirements on hospital publication and dissemination of free and reduced-cost care policies.

- Offer low-income, uninsured people the discounts that are provided to private and public insurers—for example, the rate paid by Medicaid.

- Discourage hospitals from initiating overly aggressive collection efforts against middle- and low-income uninsured consumers who are unlikely to be able to afford their care.

UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT

INTRODUCTION AND BACKGROUND

Many Americans face major challenges in paying for their medical care. A substantial body of research indicates that the uninsured are more likely than the insured to delay or forgo care because of cost, but even the insured may find cost a significant barrier to care. Recent research has also documented that in order to obtain medical care, many individuals are forced into debt, often with serious consequences for themselves and their families.

People without health insurance are most likely to experience financial hardship as a result of purchasing health care. A 2002 survey found that almost one of five families had problems paying medical bills, with the uninsured three times as likely as the insured to say they had problems (47% vs. 15%). Of those who had problems, the vast majority (86%) said the bills were a "very serious" or "somewhat serious" problem for their family. Over a quarter of those earning less than $25,000 per year said they had been contacted by a collection agency in the past year because of unpaid medical bills.[1] Another survey found that more than a quarter of families in which one or more members were uninsured reported having to "change their way of life significantly" to pay medical bills, a figure that rose to nearly 40 percent when all family members were uninsured.[2]

Hospitals do have some obligation to provide care regardless of people's ability to pay for it. The 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) requires all hospitals with emergency rooms that participate in Medicare to screen, and if necessary, stabilize any patient seeking care, and prohibits them from delaying treatment to inquire about patients' insurance status or other means of payment.[3] The purpose of EMTALA is to prevent "patient dumping," the practice of refusing to provide emergency care to patients unable to afford treatment.[4] However, EMTALA only requires that hospitals provide acute care, and it does not require that they provide the care for free or at a discount.

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[1] National Public Radio, Harvard University Kennedy School of Government, Henry J. Kaiser Family Foundation, *National Survey on Health Care,* Kaiser Family Foundation, 2002.

[2] L. Duchon et al., *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* The Commonwealth Fund, 2001.

[3] American College of Emergency Physicians, *EMTALA,* http://www.acep.org/1,393,0.html.

[4] J. A. Gordon, "The Hospital Emergency Department as a Social Welfare Institution," *Annals of Emergency Medicine,* March 1999: 321–325.

In fact, a 2000 study of uninsured people who received ambulatory care at safety-net hospitals and health centers—that is, facilities with a mission to serve all regardless of their ability to pay—found that many were in debt to the facilities. Among the nearly 7,000 uninsured respondents, 60 percent said they needed help paying for their medical care, and nearly half (46%) said they owed money to the facility where they received care. For those who received care in hospital emergency rooms, the proportion of both those who said they needed help to pay for care and those who owed money to the facility rose to about two-thirds. Among all respondents with unpaid bills, almost a quarter (24%) said the debt would deter them from seeking care at the facility in the future.[5]

While the financial burdens that result from obtaining health care fall most heavily on the uninsured, the cost of care can also be significant for people with insurance. A recent survey of Medicare beneficiaries in eight states found that nearly a quarter reported skipping doses of medicine or not filling prescriptions due to cost.[6] A 2001 survey found that while Medicare beneficiaries faced fewer financial barriers to care than those with private insurance, 10 percent reported not being able to pay medical bills, 12 percent said they had to change their way of life to pay bills, and 47 percent had out-of-pocket costs greater than $500 a year or 5 percent or more of their income.[7] Another study estimated that in 2000, Medicare beneficiaries paid an average of $3,142 for out-of-pocket expenses (uncovered medical services, prescription drugs, and supplemental insurance). For elderly beneficiaries in poor health with no supplemental insurance, the estimate for out-of-pocket expenses was $4,478.[8]

The consequences of medical debt can be far-reaching. A survey of clients at a consumer credit counseling agency in West Palm Beach, Florida, found that about 40 percent of those seeking help in restructuring their debt did so in part because of medical debt. Notably, three-quarters of the group with medical debt had health insurance when they incurred the debt.[9] Medical expenses also play a major role in causing people to file

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[5] D. Andrulis, L. Duchon, C. Pryor, N. Goodman, *Paying for Health Care When You're Uninsured: How Much Support Does the Safety Net Offer?,* The Access Project, January 2003.

[6] D. Safran et al., "Prescription Drug Coverage and Seniors: How Well Are States Closing the Gap?" *Health Affairs* Web Exclusive, July 31, 2002.

[7] K. Davis, C. Schoen, M. Doty, K. Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive, October 9, 2002.

[8] S. Maxwell, M. Moon, M. Segal, *Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries,* The Commonwealth Fund, December 2000. Estimates were based on data from 1999 Medicare Trustees Reports and the Medicare Current Beneficiary Survey.

[9] Unpublished data, The Access Project.

for bankruptcy. One study found that nearly half of personal bankruptcies result from health problems or large medical bills.[10]

More than half of low-income uninsured and insured consumers with medical debts interviewed in three sites said their medical debts made it harder for them to get medical care. They reported that providers discouraged them from seeking additional services by requiring cash payment up front, flatly refusing care, or encouraging them to seek new providers. Many respondents expressed a strong desire to pay off their debt and tried to negotiate payment plans, but found that the terms of the plans hospitals offered were very difficult to maintain, given inflexible hospital collection practices and their own tenuous financial circumstances. Many also experienced a great deal of stress and anxiety, as well as feelings of hopelessness, embarrassment, and shame because of their medical debt. Respondents said the debt was a substantial obstacle to achieving self-sufficiency because of a reduced ability to access credit, save money, or pay for the daily necessities of life. Many felt frustration and anger at being financially penalized for a medical event over which they had little or no control.[11]

In the current environment, with rising health care costs, increased consumer cost-sharing, shrinking state revenues leading to cutbacks in Medicaid and other public insurance programs, and growing numbers of uninsured, problems related to medical debt will inevitably worsen for both the insured and uninsured. In January 2002, a third of working adults with employer-sponsored insurance said that, compared with the previous year, they were faced with higher deductibles or copayments or their benefits had been reduced; one-quarter said they had significantly higher premiums.[12] For Medicare beneficiaries, it is projected that the average beneficiary liability (which includes premium payments, copayments, and deductibles) will grow from $1,636 per year in 2000 to $1,903 in 2005.[13] In addition, some recent studies indicate that safety-net facilities, which treat large numbers of uninsured people, have already begun to pursue patients with outstanding bills more aggressively. A 2002 survey of safety-net providers in five cities found that some hospitals had begun sending bills to uninsured patients, often for large

[10] M. B. Jacoby, T. A. Sullivan, E. Warren, "Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts," *NYU Law Review* 76, May 2001: 375.

[11] D. Gurewich, R. Seifert, J. Prottas, *The Consequences of Medical Debt: Evidence from Three Communities,* The Access Project, February 2003.

[12] J. Edwards, M. Doty, C. Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey,* The Commonwealth Fund, August 2002.

[13] S. Maxwell et al., December 2000.

sums, and using collection agencies to collect on delinquent accounts. In two of the cities, all of the community health centers had taken steps to improve their collection of fees.[14]

STUDY METHODOLOGY

The enormous burdens that medical debt places on individuals and families make it important to understand whether some public or private policies exacerbate medical indebtedness and to identify policies that might mitigate the problem. This report presents the findings of a study that investigated these issues. The research examined federal and state laws and regulations that place financial requirements on health care providers generally and may affect their billing and collections policies. It also investigates whether nongovernmental financial requirements that particularly affect hospitals, such as those of bond rating agencies, financing authorities, and private insurers, may lead to practices that increase the likelihood that hospital patients will accrue medical debt. In addition, hospital administrators were interviewed to learn whether these factors, and/or others, affect their actual billing and collections policies and practices in ways that contribute to the problem of medical debt.

To study these issues, the authors reviewed existing literature, statutes, and regulations and interviewed key informants such as hospital finance experts, Medicare officials, staff at Medicare rights organizations, medical billers, medical bill auditors, and hospital administrators. Because of the limited scope of the project, the findings are necessarily preliminary. However, they do indicate a number of policies and practices that may contribute to the problem of medical debt. The report also suggests a number of policy options that might help to alleviate the problem and highlights areas where further research is needed.

FEDERAL LAWS AND REGULATIONS

A number of federal fraud and abuse statutes and Medicare regulations affect provider billing behavior, with consequences for program beneficiaries and the uninsured. These include rules that prohibit providers from routinely and consistently waiving the collection of fees for Medicare beneficiaries, require providers to make "reasonable" collection efforts before reimbursing them for bad debt, and encourage providers to set uniform fee schedules across payer groups. The purpose of these regulations is to control program costs and prevent cost shifting to non–Medicare patients by preventing unnecessary utilization of Medicare services and overbilling of the program.

[14] S. Felt-Lisk, M. McHugh, E. Howell, "Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?" *Health Affairs* 21 (September/October 2002): 277–282.

Preventing providers from engaging in fraudulent activities that might financially burden the Medicare program and cause beneficiaries to undergo unnecessary procedures is, of course, a legitimate function of program regulation. However, the rules are complex, apply differently to different types of providers, and allow for a variety of exceptions. The rules may leave some Medicare beneficiaries with significant bills that can contribute to indebtedness. In addition, requirements encouraging uniform fee schedules and standard debt collection practices, while designed to prevent overbilling of Medicare, may have unintended effects that contribute to indebtedness among uninsured patients.[15]

Prohibitions on Waiving Coinsurance, Copayments, and Deductibles for Medicare Beneficiaries

Federal anti-kickback statutes prohibit providers from routinely waiving Medicare beneficiary fees, such as deductibles, coinsurance, or copayments.[16] One rationale for the prohibition is "the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program."[17] The concern is that not collecting such fees or attempting to recover them might result in the costs being shifted to individuals not covered by Medicare.

Routinely waiving beneficiary fees may also violate section 1128A(a)(5) of the federal Social Security Act, which prohibits offering inducements to beneficiaries in order to influence their selection of a provider for Medicare or Medicaid services, or section 1128B(b) (the anti-kickback statute), which makes it a criminal offense to knowingly or willfully solicit or pay anything of value to influence the referral of federal health care program business. The intention of these provisions is to prevent providers from soliciting business, for example by routinely waiving Medicare patient fees, because it might result in the provision of unnecessary services and thus unnecessary costs to a federal health care

[15] Another significant driver of medical indebtedness may be simple non-compliance with laws and regulations intended to protect patients from excessive costs, and thus prevent indebtedness. For example, the Medicaid Act and regulations require participating providers to accept Medicaid reimbursements as payment in full, and prohibit them from billing patients for any remaining charges. (See 42 U.S.C. §1396a(a)(25)(c) and 42 C.F.R.§447.15.) However, cases in which providers accept Medicaid reimbursement and bill Medicaid patients for services are documented, as are cases in which states fail to enforce the full payment requirements. In addition, some providers who have made billing errors that result in denials of Medicaid reimbursement then bill patients for the entire bill, even though federal Medicaid transmittals have made clear that this is not allowed. (Personal conversation, Jane Perkins, National Health Law Program, March 3, 2003.) Noncompliance with existing laws and regulations may contribute quite significantly to medical indebtedness. However, this topic is beyond the scope of this section, which focuses on federal health care program policies, often designed for other purposes, that may have the unintended effects of increasing indebtedness for program beneficiaries and/or the uninsured.

[16] 42 U.S.C. §1320a-7b(b)

[17] *Medicare Provider Reimbursement Manual Part I,* Chapter 3, Section 304, Centers for Medicare and Medicaid Services, http://www.cms.gov/manuals/pub151/PUB_15_1.asp.

program. The Medicare carrier's manual lists examples of unallowable waivers; they include physicians giving unsolicited advice to non-indigent beneficiaries that they do not have to pay the fees and charging Medicare beneficiaries higher prices than others for similar services (e.g., to offset the waiver).[18]

The manual also says that routinely waiving the fees constitutes a reduction in providers' usual and customary charges, because their actual charges effectively become the full charges minus the patient fees.[19] If providers are found to be engaging in such practices, Medicare may reduce their usual charges for all of their Medicare patients by the amount of the waived fees.

The prohibition on waivers of Medicare fees may cause financial hardship for some Medicare beneficiaries, particularly those who have low incomes but do not qualify for Medicaid, and in this way contribute to medical indebtedness.[20] This is especially true in the current climate in which all insurers, including Medicare, are shifting an increasing portion of medical costs to patients.

There are exceptions to the prohibition on waiving fees. For example, the Office of the Inspector General (OIG) of the Department of Health and Human Services ruled that hospitals that receive Medicare payments under the prospective payment system (PPS) can waive fees for inpatient services, as long as they do not later claim payment for the waived fees as bad debt under Medicare or otherwise shift the cost onto Medicare, a state health care program, other payers, or individuals. The rationale for this exception is that, since hospitals receive a predetermined payment under PPS regardless of costs or charges, such waivers do not cause financial harm to the Medicare program. In addition, such waivers are not expected to significantly increase utilization of services because of hospital peer review requirements, the relatively fixed level of patient demand for hospital inpatient services, and the undesirability of overnight hospital stays from a patient's

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[18] *Medicare Carriers Manual Part 3,* Chapter 5, Section 5220, Centers for Medicare and Medicaid Services, http://www.cms.gov/manuals/14_car/3b5213.asp#_1_6.

[19] Ibid.

[20] Some low-income Medicare beneficiaries may qualify for Medicaid ("dual eligibles") or Medicare buy-in programs to assist them in paying the patient share of Medicare costs. The buy-in programs include Qualified Medicaid Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI). People with incomes below 100 percent of the federal poverty level (FPL) are eligible as QMBs, between 100 percent and 120 percent of the FPL as SLMBs, and between 120 percent and 135 percent of the FPL as QIs. (See "List and Definition of Medicare/Medicaid Dual Eligibles," Centers for Medicare and Medicaid Services, http://cms.hhs.gov/dualeligibles/bbadedef.asp.) In 2003, 100 percent of the FPL for a family of one is $8,980; 135 percent of FPL is $12,123. (See "The 2003 HHS Poverty Guidelines," U.S. Department of Health and Human Services, http://aspe.os.dhhs.gov/poverty/03poverty.htm.) Nationally, underenrollment in these programs has been a problem. (See "Making Health Care Affordable for People with Low Incomes," *Medicare Facts and Faces,* Medicare Rights Center, Fall 2000.)

perspective.[21] The OIG also created an exception for some local government health care providers that primarily serve an extremely indigent population, such as county hospital outpatient departments, because "such health care providers, typically, have no need to engage in sophisticated marketing strategies to induce more business."[22] However, the OIG did not allow exceptions for other cost-based fee-for-service health care providers.[23]

As the above examples indicate, the application of the statute to particular situations is often a matter of interpretation that requires a case-by-case analysis. This complexity can understandably leave providers confused about when the prohibition does and does not apply, and thus hesitant to ever waive fees.

The clearest exception to the prohibition is one that allows providers to waive fees based on a particular patient's indigence. It is the provider's responsibility to document indigence. According to Medicare guidelines, providers may consider as indigent Medicare beneficiaries who have been found eligible for Medicaid, or they may apply their customary methods for determining indigence as follows:

1. The physician, not the patient, must determine indigence—a patient's signed declaration of inability to pay is not sufficient.
2. The provider should take into account a patient's total resources, liabilities, income, and expenses, as well as any extenuating circumstances.
3. The provider must determine that no source other than the patient is legally responsible for the patient's bill.
4. The provider must include in the patient's file documentation of how indigence was determined, as well as backup information to substantiate the determination.[24]

According to the national office of the Centers for Medicare and Medicaid Services (CMS), a patient's indigence must be determined at each visit in which a coinsurance amount or deductible would apply, although it might be reasonable for a provider to use the same determination when the visits are within days of each other.[25] According to the New England Medicare intermediary, indigence would need to be

[21] Office of Inspector General, Department of Health and Human Services, 42 CFR Part 1001, RIN 0991-AA49, *Medicare and State Health Care Programs: Fraud and Abuse; OIG Kickback Provisions, Final Rule,* July 29, 1991.

[22] Ibid.

[23] Ibid.

[24] *Medicare Provider Reimbursement Manual Part I,* Chapter 3, Section 312, Centers for Medicare and Medicaid Services, http://www.cms.gov/manuals/pub151/PUB_15_1.asp.

[25] U. Randall, Special Assistant, Provider Billing Group, Centers for Medicare and Medicaid Services, Baltimore, Maryland, September 6, 2002 (e-mail).

redocumented only when there is a change in the patient's status.[26] In either case, these guidelines in effect require providers to gather documentation in order to prove that they should not be paid. Whether providers in fact perceive these requirements as a barrier to waiving fees for low-income or financially strapped Medicare beneficiaries, or use them as a justification to not waive fees, is a subject for further research. However, a variety of cases in which providers have appealed Medicare intermediary decisions related to improper documentation of indigence suggest, at a minimum, that conflicting interpretations of the guidelines occur.[27]

It should be noted that other Medicare provisions may also leave beneficiaries with high out-of-pocket expenses. For example, Medicare pays durable medical equipment suppliers who "take assignment"—that is accept the Medicare-approved fee scale as coverage in full—for 80 percent of the Medicare-approved coverage amount, while beneficiaries pay the remaining 20 percent. However, registered Medicare suppliers that do not take assignment can charge individuals whatever price they want for the equipment. These suppliers do not have balance-billing limits, and beneficiaries are responsible for any amounts above the Medicare-approved coverage amount, which can often be substantial. The number of suppliers that take assignment has been shrinking; in 1999, only 38 percent took assignment, compared with 45 percent in 1996.[28] Moreover, according to a survey of their clients by the Medicare Rights Center, only slightly more than a third of beneficiaries knew the difference between suppliers that do and do not take assignment, and 60 percent of those who used suppliers that did not take assignment had difficulties paying for their medical equipment.[29]

Medicare Debt Collection and Fee-Setting Requirements That May Have Unintended Consequences for Uninsured Patients

Medicare has requirements related to providers' efforts to collect unpaid fees from program beneficiaries. It also has fee-setting requirements to prevent overbilling of the program. While these policies are designed to protect the Medicare program from unnecessary costs, they may have unintended consequences for uninsured patients that increase their likelihood of accruing medical debt.

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[26] Letter from S. Kimball, Education and Outreach, National Heritage Insurance Company, Biddeford ME, September 18, 2002.

[27] For examples, see the following decisions: Peachtree Rehabilitation Center v. Mutual of Omaha Insurance Company, Case Number 94-2203, Provider Reimbursement Review Board, November 24, 1998; Hoag Memorial Hospital Presbyterian v. Blue Cross and Blue Shield Association/United Government Services, LLC-CA, Case Number 96-1240, Provider Reimbursement Review Board, August 2, 2002.

[28] Office of Inspector General: Department of Health and Human Services, *Balance Billing for Medical Equipment and Supplies,* January 2001.

[29] Medicare Rights Center, "Getting Affordable Durable Medical Equipment," *Medicare Facts and Faces,* New York, Summer 2001.

Debt collection requirements. Related to the prohibition on routine waivers of fees, Medicare also requires that providers make "reasonable efforts" to collect these fees before it will reimburse them for the unrecovered costs.[30] As with the prohibition on waiving Medicare copayments and deductibles, the rationale for this requirement is to ensure that providers do not shift the costs of uncollected Medicare fees to others not covered by the program.[31]

To be considered a reasonable effort, "the provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill to the beneficiary and other actions, such as subsequent billings, collection letters, phone calls, and personal contacts in order to constitute a genuine, rather than a token, collection effort." In addition, when a provider uses a collection agency, Medicare expects that "all uncollected patient charges of like amount and for patients in like circumstances to be referred to the agency without regard to class of patient."[32]

The intent of this regulation is to ensure that providers are as aggressive in collecting outstanding fees from Medicare beneficiaries as they are for other patients. The question arises, however, whether providers can be *less* aggressive in their efforts to collect from the uninsured. While Medicare expects similar collection procedures across payer types, according to CMS it is unlikely that any penalty or legal action would result from relaxing the efforts for non-Medicare, and especially uninsured, patients.[33] However, uncertainty about the application of the regulations affecting collections may encourage providers to apply the same procedures to all clients, regardless of whether they are insured. Providers have in fact appealed decisions related to reimbursement for uncollected bad debt in a number of cases, sometimes with particular reference to the requirement that they pursue similar collection efforts against Medicare and non-Medicare patients, an indication that confusion over the regulations does exist.[34] (See the section below on Hospital Billing and Collections Procedures for a discussion of hospitals' collections policies.)

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[30] 42 CFR §413.80(e)

[31] *Medicare Provider Reimbursement Manual Part I,* Chapter 3, Section 304, Centers for Medicare and Medicaid Services, http://www.cms.gov/manuals/pub151/PUB_15_1.asp.

[32] *Medicare Provider Reimbursement Manual Part I,* Chapter 3, Section 310, Centers for Medicare and Medicaid Services, http://www.cms.gov/manuals/pub151/PUB_15_1.asp.

[33] U. Randall, September 6, 2002.

[34] See for example Metro Physical Therapy and Rehabilitation, Inc. v. Blue Cross and Blue Shield Association/United Government Services, Case Numbers 00-3147 and 00-3150, Provider Reimbursement Review Board, August 28, 2002. In this case, the Review Board found the provider in violation of the requirement to pursue similar collection efforts because it sent bills of working patients to collections but did not send bills of non-working patients, a category that included most of its Medicare beneficiaries.

Uniform fee schedules. Federal law also prohibits providers from billing Medicare beneficiaries at a higher or different fee schedule rate than non-Medicare patients. Providers may be excluded from Medicare and other federal and state health programs if they have "submitted or caused to be submitted bills . . . containing charges . . . furnished substantially in excess of such individual's or entity's usual charges for such services."[35] (Many managed care contracts also stipulate that the provider must charge the "usual" fee for services rendered to members.)[36]

According to HCPro, a company that provides information on regulatory compliance for the health care industry, implementing multiple fee schedules can put providers at risk of violating the law. It advises that "because mistakes can be costly in terms of lost revenue and possible violations, one fee schedule for all patients, with provisions for financial hardship cases, is usually the safest course."[37]

Setting uniform prices is not the same as receiving uniform reimbursements. While providers may charge everyone the same, they then generally negotiate discounted reimbursement rates with various insurers or, in the case of Medicare, receive payment according to a set fee schedule. However, the need for a uniform fee schedule means that uninsured patients would presumably be billed at full charges. It is not clear whether the statute prevents providers from also negotiating discounts with these patients, although some providers seem to believe this to be the case. In a recently announced program to reduce rates for the uninsured at its hospitals, the Hospital Corporation of America (HCA, Inc.) said the program was subject to a ruling by the Centers for Medicare and Medicaid Services that the discounts would not adversely impact the hospitals' Medicare reimbursements.[38] Tenet Healthcare Corporation, announcing a similar program, claimed that "current regulations require hospitals to bill these patients at gross-charge rates."[39]

Even if Medicare rules allow such discounts, it is unclear whether hospital and other provider billing procedures allow for such discounting on any formalized basis. Rather, it is likely that uninsured patients, unless they are prescreened and found eligible for public or charity care programs, are billed at full charges and only receive discounts if they initiate negotiations with providers. Such practices can leave uninsured patients with very high bills, since they have no insurance coverage and may be expected to pay more

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[35] Section 1128b of the Social Security Act (42 U.S.C. §1320a-7).

[36] J. Campbell, *Are Separate Fee Schedules a Compliance Problem?,* HCPro's complianceinfo.com, www.complianceinfo.com/resources/hot_topics/content.cfm?content_id=15743.

[37] Ibid.

[38] K. Russell, "HCA to Cut Rates for Uninsured," *Tennessean.com,* March 12, 2003.

[39] "Tenet Pledges Fair Treatment, Discount Prices for Uninsured," http://www.etenet.com/GeneralInfo/News/Article.asp?ID=7776, January 28, 2003.

for the same service than the amount paid by other payers. (See the section on Hospital Billing and Collections Procedures for more information.)

Moreover, as uninsured patients are almost the only people expected to pay full charges, any Medicare rules that encourage providers to raise prices may negatively affect the uninsured. For example, Tenet Healthcare Corporation was recently found to have aggressively raised prices to take advantage of a loophole in Medicare rules that used charges as a basis for calculating supplemental Medicare payments for outliers (expensive cases that exceed normal fixed rates).[40] Although Tenet's goal was to maximize Medicare reimbursements, aggressive price increases would result in increased charges for the uninsured as well.

STATE LAWS AND REGULATIONS

A preliminary review of laws and regulations affecting provider billing and collection practices in four states indicates that state laws vary substantially. In Colorado, for example, a statute enacted in 1985 prohibits providers from waiving deductibles and copayments for commercially insured patients; its goal is to make consumers cost-conscious purchasers of health care.[41] An exception is made for charity care, but only in cases where the provider determines that the services are needed for the immediate health and welfare of the patient and, on a case-by-case basis, that payment would create a substantial financial hardship to the patient. The law states that any providers who waive copayments or deductibles for more than a quarter of their patients in a given year are deemed to be in violation of the statute.

Massachusetts imposes significant regulatory requirements on hospitals in connection with the state uncompensated care pool, which reimburses hospitals for a portion of their charity care. Hospitals are required to file their credit and collection policies with state authorities.[42] They must specify their collection procedures, how they collect financial information from patients, and how they calculate patient deductibles. Hospitals are also required to provide detailed policies that have been approved by their governing boards on how they classify emergency patients and how they notify patients regarding free care. The goal of these regulations is to ensure that hospitals make reasonable efforts to notify people about the availability of free care, and that they apply standard criteria in determining who is eligible. Hospitals that fail to meet these requirements may be denied reimbursements from the uncompensated care pool.

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[40] R. Rundle, A. Wilde Mathews, "Tenet Reaped Outsize Gains from Flaw in Medicare System," *Wall Street Journal,* November 11, 2002.

[41] C.R.S. 18-12-119.

[42] 114.6 CMR 10.09.

Florida also has enacted a variety of regulatory requirements, such as an income-related "bad debt threshold" that regulates how hospitals claim bad-debt disproportionate share hospital (DSH) reimbursement, and a "Deceptive Insurance Practices" law that governs reporting of discounts, among other things.[43, 44]

At the other end of the spectrum, according to the Counsel of the Illinois Hospital Association, Illinois has no state regulatory requirements related to patient billing. While the state tracks levels of charity care for use in distributing DSH money, no substantive regulation of provider billing practices exists.[45]

It should also be noted that nonprofit hospitals, as tax-exempt charitable institutions, have an obligation to provide some form of community benefits, or unreimbursed goods and services, to their surrounding communities. These benefits may include the provision of free or "charity" care to patients unable to pay. In the past, hospitals have generally been free to decide what level of community benefits they will provide. More recently, some states have enacted laws, regulations, or guidelines requiring that hospitals provide free care, although the existence and nature of such requirements vary by state.[46] However, the obligation to provide community benefits generally does not require hospitals to provide free care to any particular individual.

This preliminary review makes it clear that a full understanding of the factors that contribute to medical indebtedness in a community requires knowledge of the particular laws and regulations of the state in which it is located.

HOSPITAL POLICIES AND PRACTICES

The previous sections outline governmental policies that influence provider practices regarding billing and collections. However, regulations are always subject to interpretation, so it is important to know how they affect health care providers' actual day-to-day practices, especially with respect to low-income and uninsured patients. In addition, providers' billing and collections practices are of course influenced by a variety of private policies and financial factors. This section investigates these topics.

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[43] The Medicaid program permits states to make additional payments to hospitals that serve a "disproportionate share" of Medicaid beneficiaries and low-income patients. It is up to each state, subject to broad federal guidelines and descriptions, to define how a hospital qualifies for DSH payments and how these payments are distributed.

[44] K. Reep, Vice President, Financial Services, Florida Hospital Association. Interviewed August 28, 2002.

[45] J. T. Bomher, Vice President and Associate General Counsel, Illinois Hospital Association. Interviewed August 14, 2002.

[46] N. Seto, B. K. Weiskopf, *Community Benefits: The Need for Action, an Opportunity for Healthcare Change,* The Access Project, 2000.

While previous sections discussed the impact of various legal requirements on health care providers generally, this section focuses on hospitals in particular because, as large institutions with large budgets, they may be most strongly affected by governmental policies and other financial considerations. In addition, as hospital-related services often result in charges that are higher than charges for services provided elsewhere, such as in private physicians' offices, hospital billing and collections practices may contribute significantly to patients' likelihood of accruing large medical debts.

Hospital Billing and Collections Procedures

Hospitals are often reluctant to share information about their billing and collections procedures. Although repeated efforts were made to arrange interviews with CEOs, CFOs, and patient accounts staff at nearly 30 hospitals, only four hospital administrators, all at public hospitals, ultimately agreed to provide information for this report. The small number of interviews limits the generalizability of the findings. However, the research does provide a preliminary look at hospital policies and practices that affect patients' likelihood of accruing medical debt and suggests some directions for further research.

Determining eligibility for public and charity care programs. The four hospitals for which we have information have systems to screen uninsured patients for eligibility for Medicaid and other public insurance programs. These eligibility units are generally in-house. Administrators reported that the hospitals used similar procedures to determine whether patients qualified for hospital charity care programs, with eligibility generally based on whether patients' incomes fall below a certain percentage of the federal poverty level.

Other research, however, raises questions about how effective these programs are in identifying eligible patients. A survey of uninsured patients who received ambulatory care in local safety-net hospitals in 18 states found that 66 percent of respondents who used urban/suburban hospitals, and 79 percent who used rural hospitals, reported needing help paying their medical bills. However, of these respondents, only 14 percent of urban respondents and 39 percent of rural respondents said staff "always" offered to find out if financial assistance was available. Sixty-three percent of urban respondents and 49 percent of rural respondents said staff "never" offered such assistance.[47] Further research is needed to determine how consistently hospital screening procedures are implemented and whether significant numbers of patients are not appropriately screened.

Billing and collections process for self-pay patients. The billing and collections process for "self-pay" patients—both uninsured patients who are responsible for paying their

[47] D. Andrulis et al., January 2003.

entire bill and insured patients who are responsible for paying a deductible or copayment—was similar at the hospitals for which we have information. All patients who owe money are expected to pay their bills in full. If patients are not identified as qualifying for public programs or charity care, hospitals do not have standard mechanisms for distinguishing among patients in terms of the size of their bills and their ability to pay them, or for informing patients of their ability to negotiate discounts when appropriate.

If bills are not paid, hospital staff members send subsequent bills and/or try to contact patients by phone. If the bills are still not paid, they are then turned over to a collection agency. After the bills are in collections, they are treated the same as other types of debt—no special allowance is made for debts accrued for medical reasons. (The fact that bills are often sent to independent or out-of-house collection agencies probably exacerbates the tendency to follow standard debt collection procedures without regard to the type of debt or a patient's unique financial circumstances.) Policies vary as to how long collections agencies attempt to collect payments. Some stop after a set amount of time (e.g., one year), others stop after they attempt to contact the patient a set number of times. In one state, a state hospital sends all bills over $5,000 to the state's attorney general, who never stops trying to collect.

Administrators said their hospitals rarely take legal action against patients who cannot or do not pay, although other research suggests that hospital practices vary widely in this regard. For example, a recent report on the charity care and collections practices at Yale–New Haven Hospital found that in state fiscal year 2002, the hospital was lead plaintiff in 426 civil lawsuits, almost all of which concerned collections or foreclosure lawsuits against individuals, compared with 93 lawsuits at a similarly sized local hospital. Yale–New Haven Hospital also frequently engaged in aggressive collections measures, such as wage garnishment, seizure of bank accounts, and property liens. In 2001, the hospital filed 134 new property liens in New Haven, almost 20 times the number filed by the city's other hospital.[48]

The hospital administrators with whom we spoke said their institutions are willing to set up payment plans for patients who request them. However, most also said that they rarely offer to waive or discount patients' bills and do not have specific policies for doing so. Some, but not all, cited Medicare guidelines, anti-kickback regulations, and managed care contracts as influencing their discounting policies, or as reasons for not offering

[48] G. Rollins, *Uncharitable Care: Yale-New Haven Hospital's Charity Care and Collections Practices,* Connecticut Center for a New Economy, January 2003. See also L. Lagnado, "Twenty Years and Still Paying," *Wall Street Journal,* March 13, 2003, and L. Lagnado, "Full Price: A Young Woman, An Appendectomy, and a $19,000 Debt," *Wall Street Journal,* March 17, 2003.

discounts. When discounts are offered, it is generally on a case-by-case basis. Given the lack of a formalized process and case-by-case decision-making, it is unclear how patients with unaffordable medical bills would come to the attention of hospital administrators with the authority to reduce or waive charges.

Information from medical bill auditors—people who review patients' medical bills for errors and negotiate with providers for discounts—reinforces these findings.[49] Auditors suggest that hospital billing clerks are generally authorized to offer only negligible discounts, and that patients often need to contact supervisors or even CFOs to achieve more substantial savings. Obtaining such discounts thus requires that patients take the initiative in researching charges and requesting discounts; it is not part of hospitals' standard operating procedures.[50]

Financial Factors Affecting Hospital Billing and Collections Practices

Hospitals' billing and collections practices are, of course, influenced not only by federal and state laws and regulations, but also by a variety of private policies and financial factors. Our research identified three general financial concerns that might affect hospitals' billing and collections practices for self-pay patients, including those with low-incomes and no insurance. Interviews with health care finance experts, a review of the literature in journals such as *Health Affairs* and *Modern Healthcare*, and published reports by Moody's Investors Services (a bond rating agency), MBIA, Inc. (a health care revenue bond insurance agency), and the Health Insurance Association of America (an association of private insurers) indicated that hospitals may be influenced by the need or desire to

- maintain operating viability;
- maintain favorable bond and borrowing ratings; and
- define full charges as a benchmark for negotiating discounts and fees with insurers.

Operating viability. A common measure of a hospital's overall operating viability is its annual operating margin (total net revenue less total operating expenses divided by total net revenue). Operating margin essentially measures the profitability of a hospital, or how well operating revenues cover operating expenses. Most hospital financial analysts

[49] Confidential communications.

[50] See for example P. Palmer, "Shock Treatment: Don't Let Your Hospital Bills Make You Sick," *Modern Maturity,* May/June 2001.

characterize today's hospital sector as barely "breaking even"—the median operating margin for nonprofit hospitals in 2000 was 0.79 percent.[51]

Given such tight margins, hospitals are attempting to maximize every source of revenue, including the relatively small portion that comes from self-pay patients. (Self-pay in this context refers to all patients who are responsible for paying some portion of their bill, whether because they lack insurance; their insurance does not cover some services; or their insurance requires payment of significant deductibles, coinsurance, or copayments.) While self-pay patients account for only 3 to 4 percent of hospitals' health care expenditures, they represent 16 percent of outstanding accounts receivable.[52] In a recent survey reported on by the Healthcare Financial Management Association, hospital-based patient financial services professionals identified boosting collections for self-pay patients as a major goal.[53]

Information is not available on whether the costs of attempting to collect from low-income uninsured and underinsured patients in fact exceed recovered revenues. However, some of the health care finance experts we interviewed suggested that, even if this were the case, some hospitals might still view aggressive collection efforts as economically rational by discouraging uninsured patients from using the facility. This factor may be especially important in the current health care environment, in which hospital profit margins have generally been declining and many hospitals are concerned about their survival.

Interviewees conceded that few CFOs would knowingly endorse an operating practice that yielded no return or a negative return, but said that cost-benefit analyses of billing and collection procedures for self-pay patients may be a low priority, because third-party payers represent a much larger proportion of revenue than self-pay patients. However, as self-pay revenue becomes increasingly important, hospitals will probably start paying more attention to the cost efficiencies of their self-pay collection procedures.[54]

Bond and borrowing ratings. Along with paying for daily operating expenses, hospitals need to fund capital investments. The average hospital, whether nonprofit or for-profit,

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[51] B. Wexler, *Not-for-Profit Healthcare: 2001 Outlook and Medians,* Moody's Investors Services, Municipal Credit Research. September 2001. As an example, a hospital that generated $126 in revenue and $125 in expenses in a single operating year would have an annual operating margin of .79% ($126 – $125 / $126).

[52] M. C. Jaklevic, "No Room for Patience: As Patient's Out-of-Pocket Responsibilities Rise, and Every Dollar of Revenue Becomes More Important, Hospitals Are Paying Attention," *Modern Healthcare,* July 22, 2002.

[53] Ibid.

[54] Ibid.

makes an investment in infrastructure every two or three years. All hospitals finance some portion of their capital investments through debt, and the cost of borrowing money is very sensitive to bond ratings. Several financial ratios are taken into consideration in setting a hospital's overall bond rating (Moody's Investors Services lists 15).[55] All of them, in one form or another, attempt to measure the financial condition of a hospital—that is, how well it can cover all of its liabilities, not just its annual operating expenses. Hospital finance experts identified three ratios as especially important in determining bond ratings: annual debt service coverage, cash on hand (the number of days a hospital could pay its cash operating expenses from existing cash balances in the absence of any cash inflows), and the debt-to-capitalization ratio. Operating margin may also be weighed relatively heavily.

Although accounts receivable is considered one of the less critical ratios in determining bond ratings, its corollary, cash on hand, is uniformly considered to be very important. This means that the more cash a hospital is able to collect, the better its rating is likely to be.[56] The impact of collecting certain additional amounts of cash is of course dependent on a hospital's overall cash operating expenses and will vary by hospital. However, financial ratios can be quite sensitive to relatively small changes in operating performance, which can translate into substantially different bond ratings.

In order to maintain high bond ratings, therefore, hospitals have a strong incentive to maximize revenue from all sources, including self-pay and/or uninsured patients, and thus to institute vigorous collection policies that may include the uninsured.

Negotiating discounts and fees with insurers. Hospitals may view the uninsured as one of the few groups left to whom they can apply full charges, in order to set benchmarks for negotiating discounted rates with other payers. Moreover, private insurers sometimes insist on the price charged to the lowest-paying customers. If providers bill all uninsured patients at less than full charges, insurers might demand that their payments be similarly reduced.[57]

Like Medicare, private insurers consider waiving of copayments and deductibles as fraud.[58] (Also like Medicare, they allow these fees to be waived for indigent patients on a case-by-case basis.) If providers discount or waive fees, insurers may consider the

[55] Wexler, September 2001.
[56] Ibid.
[57] Personal conversation, T. Musco, Director of Research and Statistics, Health Insurance Association of America, August 2, 2002.
[58] T. Musco, K. Fyffe, *Health Insurers' Anti-Fraud Programs,* Health Insurance Association of America, 1999.

discounted fee as the amount for which they are liable; in the most extreme case, if a patient pays nothing, the insurer may decide that it also owes nothing.[59] As is the case for Medicare beneficiaries, these prohibitions may result in financial hardship for low-income privately insured patients.

AREAS OF FURTHER RESEARCH

Given the limited scope of this study, its findings are necessarily preliminary. There is much room for further research to learn to what extent the findings can be generalized, and also to delineate with greater specificity whether and how the various factors that may contribute to medical debt actually influence providers' policies and practices. Some areas for further research include the following:

- How do health care providers interpret the various laws and regulations that may bear on their billing and collections practices? How, specifically, do these laws and regulations affect their billing and collections policies? Do they have similar effects on the underinsured and the uninsured?
- In their actual practices, do providers find Medicare and private insurer requirements for documenting patient indigence in order to waive copayments and deductibles a significant barrier to offering such waivers?
- How effective are providers' procedures in identifying, referring, and enrolling patients who are eligible for public programs or charity care? Are patients who receive care in different venues (e.g., inpatient vs. emergency rooms) equally likely to receive information about financial assistance programs? Are certain groups of patients, such as those with limited English proficiency, less likely to be screened?
- Do providers, and particularly hospitals, view federal law and Medicare regulations on fee-setting as an obstacle to offering discounts to uninsured patients? Do they have any formal mechanisms for negotiating discounts with uninsured patients who do not qualify for public programs, but lack the financial resources to pay their full bill? How do they identify such patients?
- How aggressively do providers pursue collections efforts against low-income uninsured and underinsured people? Are such efforts cost-effective, or do they in fact result in net losses? If these collection efforts are not profitable, do providers have other reasons for instituting them?

[59] R. Tuten, *Ask the Expert Archive, Week of September 5, 2002,* HCPro's complianceinfo.com, www.complianceinfo.com/news/asktheexpert/autoask-arc.cfm?content_id23765.

- Will current trends toward increased consumer cost-sharing (e.g., through catastrophic insurance policies and increased copayments) significantly increase the exposure of both the insured and the uninsured to the risks of indebtedness?

POLICY RESPONSES

Because our results are preliminary, suggestions about policy responses to alleviate the burdens of medical debt are also preliminary. However, the findings suggest some possible approaches.

1. Establish clearer guidelines for the application to uninsured and underinsured patients of federal laws and regulations affecting billing and debt collection practices. Work with providers to address any concerns they have related to the regulations. Do the same with respect to state laws and regulations.

As our discussion indicated, uncertainty exists over the application of the various rules and regulations that apply to billing and debt collection, and many providers may simply charge everyone the same amount and apply standard collection procedures to "play it safe" and avoid running afoul of the laws. Clarification of how these regulations actually apply to uninsured patients might make it easier for providers to offer them free or reduced-cost care. In addition, revisions of some policies might be called for, such as simplifying the process for documenting indigence of Medicare beneficiaries.

2. Encourage the state or hospitals to establish clear and standard criteria for eligibility for free or discounted care and simplify application procedures, so that patients who are eligible are not billed or pursued by collection agencies.

Such an approach has been implemented in Oregon.[60] Initially, consumer groups advocated for standardization of eligibility criteria and notification procedures in selected cities. These local efforts ultimately led the Oregon Association of Hospitals and Health Systems to release a model charity care policy for all Oregon hospitals that includes a common application process, sliding fee scale, written materials in appropriate languages, and continuing education of health care employees about the policies.

Advocacy for state funds to support implementation of standardized and simplified procedures might be part of such a policy proposal.

[60] T. Loew, "A Statewide Plan to Publicize Care for Uninsured Patients Is Modeled After Local Hospitals," *Statesman Journal,* Salem, Oregon, June 13, 2001.

3. As part of, or independent of, a statewide policy on free care, establish state requirements on hospital publication and dissemination of free and reduced-cost care policies.

The Oregon initiative, for example, resulted from a year-long study by consumer groups that showed that local hospitals were so secretive about their charity care policies that poor people rarely knew they existed. Access Project research in Palm Beach County, Florida, also found that many hospitals were reluctant to provide their policies related to charity care.

In Alexandria, Virginia, where a regional grassroots organization used the results of a survey of local uninsured residents to request that a local hospital forgive patient debts, the process revealed that 60 of 80 indebted patients should not have been in debt in the first place because they were eligible for partial or total free care. The negotiations resulted in the elimination (not forgiveness) of $200,000 in outstanding payments.[61]

A survey of the uninsured found that information about public insurance and charity care programs does make a difference—the more often staff offered to find out about financial assistance programs for respondents, the less likely they were to have outstanding bills at the facility.[62] Massachusetts is one state where clear requirements regarding the publication of free care policies exist; its regulations might serve as a model for other states.

4. Offer low-income uninsured people the discounts that are provided to private and public insurers, for example, the rate paid by Medicaid.

This approach highlights the fact that those who can least afford it are often the ones who are asked to pay the most—a situation that we believe is not widely known, and one that seems obviously unfair. It also mirrors initiatives that some states are currently undertaking to allow people without prescription drug coverage to purchase medications at Medicaid rates.

A related policy approach would require hospitals that provide services to uninsured patients to collect no more than the cost of services, rather than full charges, for

[61] Silvia Portillo, Program Coordinator, Healthy Community Program, Tenants' and Workers' Support Committee, Alexandria, Virginia, January 24, 2003.

[62] D. Andrulis et al., January 2003.

individuals with incomes below a specified percentage of the federal poverty level or whose total annual medical bills exceed a specified percentage of their income.[63]

5. Discourage hospitals from initiating overly aggressive collection efforts against middle- and low-income uninsured consumers who are unlikely to be able to afford the full cost of their care.

Legislation recently introduced in some states, while not enacted, suggest some possible policy approaches:

Limit Disproportionate Share Hospital (DSH) payments for written-off bad debts to only those debts on which all collection activity has ceased, thus discouraging hospitals from continuing to attempt to collect on bills that patients are unlikely to be able to pay.[64]

Structure DSH payments to hospitals for uncompensated care so that they give more weight to free care, as opposed to bad debt, giving hospitals an incentive to establish patients' free-care eligibility and offer free services.[65]

Prevent hospitals from foreclosing on people's homes or attaching their wages or bank accounts if they are complying with established installment plans based on their income.[66]

Prohibit hospitals from charging interest on medical debt.[67]

CONCLUSION

Lack of health insurance, with its attendant consequences for access to health care and health status, is widely recognized as a long-term and growing problem in the United States. The problem of debt resulting from unaffordable medical bills is less well known, although its consequences are in some ways more far-reaching. Medically related debt affects both the insured and the uninsured, deters individuals from seeking future care, and can undermine the overall financial security of individuals and families. Moreover, it is a

[63] Legislation introduced, but not enacted, in Illinois and Connecticut would have implemented this approach. See Illinois General Assembly, SB 552, introduced February 18, 2003, and Connecticut General Assembly, Committee Bill Number 568, *An Act Concerning Hospital Billing Practice,* introduced in 2003.

[64] See bill introduced on April 9, 2003, in the Connecticut General Assembly, Senate Bill Number 683, *An Act Concerning Payment Rates to Hospitals Serving a Disproportionate Share of Indigent Patients*.

[65] Ibid.

[66] Connecticut General Assembly, Committee Bill Number 568, *An Act Concerning Hospital Billing Practice,* introduced in 2003.

[67] Ibid.

problem that will inevitably worsen as more people become uninsured due to rising health insurance premiums and restrictions on Medicaid eligibility, and as those with insurance face growing out-of-pocket costs due to increased copayments, deductibles, and premiums and reduced benefits.

In this environment, identifying policies that exacerbate the problem of medically related debt, as well as those that can potentially mitigate it, are crucial tasks. This study represents a first step in identifying such policies and in suggesting areas that would benefit from additional research.

OTHER COMMONWEALTH FUND PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling its toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org.** Other items are available from the authors and/or publishers.

#649 *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (May 2003). Sara R. Collins, Cathy Schoen, and Katie Tenney. This issue brief reports that young adults are far more likely to be uninsured than older adults. The authors point to targeted policy options that could extend coverage to more young adults and help others keep it; for example, requiring private insurers to extend dependent coverage to unmarried adults through age 23.

#634 *Creating Consensus on Coverage Choices* (April 23, 2003). Karen Davis and Cathy Schoen, The Commonwealth Fund. *Health Affairs* Web Exclusive (*In the Literature* summary). In this article, the authors propose an innovative framework to provide automatic, affordable health insurance to nearly all Americans. The approach would combine tax credits for private insurance with public program expansions. It would also promote insurance efficiencies through automatic enrollment, use of information technology, and group coverage. The framework could be phased in gradually over time and modified along the way. Article available online only at http://www.healthaffairs.org/WebExclusives/2203Davis.pdf/.

#631 *Health Insurance Spending Among Cancer Patients* (April 9, 2003). Kenneth E. Thorpe and David Howard, Emory University. *Health Affairs* Web Exclusive (*In the Literature* summary). In this article, the authors find that the amount that uninsured cancer patients spent on their care over a typical six-month period is just over half that spent by cancer patients with private insurance. Lower spending among uninsured cancer patients is partly, if not completely, due to lower use of health services—including hospital admissions, physician visits, and emergency room visits. Article available online only at http://www.healthaffairs.org/WebExclusives/2203Thorpe.pdf/.

#627 *State Medicaid Prescription Drug Expenditures for Medicare–Medicaid Dual Eligibles* (April 2003). Stacy Berg Dale and James M. Verdier, Mathematica Policy Research, Inc. This issue brief reports that Medicaid prescription drug coverage for approximately 6 million "dual eligibles"—low-income seniors and persons with disabilities who are covered by both Medicaid and Medicare—accounts for nearly half of all Medicaid spending on prescription drugs, including both federal and state shares of Medicaid prescription costs.

#626 *On the Edge: Low-Wage Workers and Their Health Insurance Coverage* (April 2003). Sara R. Collins, Cathy Schoen, Diane Colasanto, and Deirdre A. Downey. In this issue brief, the authors note that although employees of small companies are particularly unlikely to have health coverage through their jobs, low-wage workers in firms of all sizes have less access than their higher-earning counterparts.

#622 *Time for Change: The Hidden Cost of a Fragmented Health Insurance System* (March 2003). Karen Davis, The Commonwealth Fund. In invited testimony before the Senate Special Committee on Aging, Fund president Karen Davis detailed the failure of the U.S. health care system to meet the objectives of ensuring access to needed medical care and protecting Americans from the financial burden of costly medical bills. Calling the system "costly, complex, and

confusing," Davis said the solution requires automatic and affordable health insurance coverage for all Americans and shared responsibility for financing coverage.

#592 *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English* (February 2003). Michelle M. Doty, The Commonwealth Fund. This study reports that, based on survey findings, Hispanics who speak Spanish primarily are in poorer health, are less likely to have a regular doctor, and are more likely to lack insurance and rely on public or community clinics for their health care, compared with Hispanics who speak English primarily, non-Hispanic whites, and African Americans.

#566 *Approaching Universal Coverage: Minnesota's Health Insurance Programs* (February 2003). Deborah Chollet and Lori Achman, Mathematica Policy Research, Inc. In 2001, Minnesota had the highest rate of health insurance coverage among the nonelderly—95 percent. While a high rate of private insurance is an important factor, the state also operates five public programs that collectively cover nearly all adults and children without private coverage. This report reviews the eligibility rules, covered services, and funding for each of these programs and attempts to identify lessons for policymakers across the country.

#621 *What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs* (January 2003). Dahlia K. Remler and Sherry A. Glied. *American Journal of Public Health,* vol. 93, no. 1 (*In the Literature* summary). In this article, the authors report that public health insurance programs that enroll people with little effort on the part of the individual have the highest rates of participation. They recommend introducing automatic enrollment to programs to improve participation among eligible individuals.

#598 *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations* (January 2003). Sharon Silow-Carroll, Economic and Social Research Institute. RIte Care, Rhode Island's managed care program for Medicaid beneficiaries, Children's Health Insurance Program enrollees, and certain uninsured populations, has made quality improvement a central goal. This report examines the state's initiatives aimed at improving care for pregnant women, children, and others, including efforts focused on preventive and primary care, financial incentives, and research and evaluation.

#596 *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times* (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

#585 *Small But Significant Steps to Help the Uninsured* (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

#586 *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (December 2002). Leighton Ku and Donna Cohen Ross, Center on Budget and Policy Priorities. This report examines why many low-income adults lose their health coverage, what the effects of losing coverage are, and which strategies can help people retain their insurance.