Six Ways to Reduce Medical Debt in Massachusetts

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Massachusetts' health reform initiative has made significant progress towards achieving universal health insurance coverage for all state residents; Massachusetts now has the lowest percentage of uninsured residents of any state in the country. However, data also indicate that some people in Massachusetts are still struggling with the costs of health care. In the fall of 2008, one in five Massachusetts residents had outstanding bills resulting from health care costs, and more than one in ten people said they had difficulty accessing care due to cost.[1]

The Access Project has undertaken several projects to better understand the financial impact of Massachusetts' health reform on consumers, focusing particularly on people's ability to afford and access needed care. These efforts have included:

• Working with individuals who owed medical debt to help them resolve their medical bills. Our Medical Debt Resolution Program has allowed us to provide customized assistance to more than three hundred Massachusetts residents.

• Training staff at more than one hundred Massachusetts organizations to help them develop capacity to assist clients with medical debt. These organizations have surfaced additional information about the causes and consequences of medical debt in the state.

• Conducting in-depth interviews with state residents who owed medical debt to learn more about the causes of the debt.

The Access Project has documented these initiatives in detail in a number of policy reports.[2]

Through this work, we have learned that many low-income people have benefited greatly from the subsidized Commonwealth Care insurance plans enacted as part of the state's health reform effort. However, we have also identified persistent problems, such as barriers that some populations experience when seeking needed care, as well as negative financial consequences resulting from inadequate coverage or unaffordable medical services.

Some of the groups still struggling with unaffordable health care costs include:

Lower income workers with offers of employer sponsored coverage and other low-income residents who are ineligible for state subsidized insurance plans: Lower-income workers who have an offer of insurance from their employers are ineligible for the state's subsidized health care plans. This is true even if they are otherwise income-eligible for the subsidized program and even if the offered insurance does not meet the state's minimum creditable coverage standards. While some of these workers obtain good coverage through employment, others are covered under plans that include high deductibles and out-of-pocket costs that are unaffordable for them.

In addition, others who are categorically ineligible for Commonwealth Care because they have access to other insurance, such as AmeriCorps volunteers and university students who are enrolled more than three quarters time, are frequently covered by highly inadequate insurance policies offered by their schools or programs. These policies often feature low caps on services and annual coverage caps that can leave people with high levels of debt if they become ill or injured.

People with incomes just over the limit for eligibility for Commonwealth Care who do not have access to other sources of insurance: This group must purchase private insurance in the non-group market to meet the state's mandate that residents have health insurance. While the Massachusetts Health Insurance Connector Authority markets private plans for people in this category, many still find the premiums and deductibles unaffordable. Those who do purchase policies may be forced to trade lower premiums for higher out-of-pocket costs, which may be difficult to pay if they become sick. Others may remain uninsured because they cannot afford to purchase health insurance, yet they may qualify for an exemption from paying the tax penalty under the Individual Mandate.

Many state residents struggle with ongoing health care costs, particularly those with chronic illnesses: The state's minimum creditable coverage standards limit deductibles and out-of-pocket costs for individuals and families, yet many still incur medical debt under their insurance plans due to cost-sharing. Even some of those covered under state subsidized plans avoid care because they find the costs of co-payments to be unaffordable. This is especially true for people with chronic illnesses who must see health care providers or use prescription medications on an on-going basis. For this group, even relatively low levels of debt ($1,000 or less) can have serious financial and access consequences. Many chronically ill people in employer-sponsored plans face similar issues. While the Health Safety Net provides some support for the underinsured, it does not cover the costs of co-payments, which, in recent years, have been increasing rapidly under private insurance policies.

Through our work, we have also identified some additional barriers to getting affordable care:

Provider billing and collections policies: Hospitals and other health care providers vary greatly in their willingness to negotiate with their patients for discounts and affordable payment plans. Some consumers have been able to negotiate manageable fees and affordable payment plans, while others have found providers unwilling to offer affordable payment agreements. Additionally, while providers generally do not report unpaid bills to credit reporting agencies, most sub-contract with third parties that do so. This practice can seriously damage patients' credit records and make it difficult for them to access loans, build assets, and even secure housing or employment.

System complexity: Massachusetts has a robust safety net with a multiplicity of programs. The state's health reform was built on top of these existing structures, all of which have varying eligibility criteria and program rules. This complexity leaves some consumers unaware of programs for which they may be eligible. Other people experience gaps in coverage as they move in and out of programs or between coverage types.

Changes in regulations resulting from heath reform have also reduced the amount of time programs will provide retroactive coverage; for example, people eligible for Commonwealth Care are offered only 10 days of retroactive coverage under the Health Safety Net. People often do not learn about programs that can provide financial assistance until it is too late for their bills to be covered.

In response to these identified problems, we make the following recommendations:

1) We urge the Connector to exercise its option to allow low-income workers whose employer sponsored health insurance plans are deemed unaffordable to enroll in the subsidized plans.[3] University students with coverage under the Qualifying Student Health Insurance Program (QSHIP) and AmeriCorps Volunteers should also be allowed to access these plans as long as individuals meet the program's other eligibility criteria.

Under Chapter 58, the Connector has the option to allow low-income workers to enroll in Commonwealth Care if their employer-sponsored health insurance plans are deemed unaffordable under state standards. It is also unfair that other individuals who would otherwise be eligible for Commonwealth Care, such as university students and AmeriCorps Volunteers, are excluded because of offers of insurance that are frequently inadequate. All low-income residents in the state should receive the same consumer protections and coverage options that are available to low-income adults currently covered by Commonwealth Care plans.

2) When considering the affordability of available coverage, we urge the Connector to consider out-of-pocket costs (deductibles, co-payments, co-insurance, and uncovered services) in addition to insurance premiums. Under the Massachusetts Individual Insurance Mandate, the state can waive the tax penalty for not having health insurance for individuals who do not have access to affordable coverage. Currently, the Connector only considers the cost of monthly premiums when defining insurance affordability. Out-of-pocket costs that people incur when they get sick—deductibles, co-insurance, co-payments, and bills for uncovered services—are not included in affordability calculations. Out-of-pocket costs can leave people with medical debt and also act as a deterrent for who need to seek medical services.

We urge legislators to adopt S.549/H.1102: An Act Relative to Health Care Affordability, which will improve the current affordability standard by considering out-of-pocket costs in addition to monthly insurance premiums.

3) We recommend that The Division of Health Care Finance and Policy update regulations for the Health Safety Net (HSN) program to reimburse eligible medical expenses incurred due to co-payments required by private health insurance plans. Under the Free Care Pool, which predated the Health Safety Net, acute care hospitals and community health centers could receive reimbursement for co-payments incurred by eligible patients. Under current regulations, co-payments are excluded from reimbursement by this program. As we have noted, even co-payments as low as $15 or $20 for medical appointments can add up very quickly and become unaffordable for some people who need regular medical care. The Access Project and our partners have also increasingly seen clients with high co-payments, ranging from $100 to $600 under some plans. Because these costs are categorized as co-payments, rather than a one-time annual deductible, they can be incurred multiple times in a given year. Allowing the Health Safety Net to reimburse providers for co-payments would provide needed assistance to lower and middle income clients, especially those with chronic illnesses who incur these costs on a regular basis.

4) Massachusetts residents need more support in navigating complicated health care bureaucracies. We urge the state to make a permanent commitment to supporting health care outreach and enrollment.

In Fiscal Years 2007 through 2009, the state dedicated $3.5 million annually to outreach and enrollment grants for non-profit agencies across the state. These grants were nearly eliminated for Fiscal Year 2010 due to dwindling tax revenues during the economic downturn. However, advocates organized to promote reinstating the grants and the legislature ultimately approved $2.5 million. Even with these resources, it is still evident that many Massachusetts residents are slipping through the cracks in the system due to confusion and misunderstanding.

We urge legislators to adopt S.873/HD1232: An Act Strengthening Health Reform. This bill would make the Health Care Reform Outreach and Education Unit a permanent program and create an advisory council to help make the program more effective.

We also recommend that the state support training for non-profit organizations that work with clients to strengthen finances, build assets, and secure access to care, to educate them about health insurance and how to assist their clients who have medical debt.

5) We urge the state to adopt additional measures that would simplify the health care safety net, such as making Health Safety Net retroactive coverage consistent for all eligible patients. We recommend that the state adjust the application and appeals processes for Commonwealth Care and MassHealth to make them consistent with one another.

These measures are also included in S 873/HD1232: An Act Strengthening Health Reform. Adoption of this legislation would help to streamline the state's safety net programs and simplify the process by which residents receive the financial support for which they are eligible.

6) Medical providers and their agents should be prohibited from reporting a patient's medical debt to a credit reporting agency unless specifically approved by an institution's board of directors. For any medical bills that have been reported to credit bureaus, debts that have been completely paid off should be removed from patients' credit reports.

Medical debt is fundamentally different than other forms of consumer debt because it is generally involuntary. It is particularly unfair that health care expenses can continue to damage people's credit records even when paid in full, either by the patient or a third-party payor.

Congress is currently considering legislation to automatically remove medical debts with zero balances from people's credit records (HR 3421: The Medical Debt Relief Act of 2009). We urge state policymakers to consider supporting a similar measure in Massachusetts.

The Massachusetts Attorney General outlined recommended hospital debt collection practices as part of its 2009 Community Benefit Guidelines for Non-Profit Hospitals.[4] Many of these practices would provide additional protections for patients. For example, the guidelines recommend that hospitals or their agents not begin collection activities without first informing patients of the availability of financial counseling services and giving low-income patients the opportunity to set up reasonable payment plans. They also recommend that hospitals and their agents not report patients' medical debts to credit reporting agencies or sell patient debts unless these actions are specifically approved by hospitals' boards of directors. We urge state policy makers to consider these guidelines as the blueprint for new state regulations governing medical providers' billing and collection practices.

ENDNOTES

1 Long, Sharon K. and Paul B. Masi. “Access and Affordability: an Update on Health Reform in Massachusetts, Fall 2008,” Health Affairs 28 no. 4 (2009): w578-w587.

2 These projects have been described in detail in three studies: Pryor, Carol and Andrew Cohen. “Consumers’ Experience in Massachusetts: Lessons for National Reform,” Focus on Health Reform, The Henry J. Kaiser Family Foundation, September 2009; Cohen, Andrew and Carol Pryor. In Debt but Not Indifferent: Chapter 58 and The Access Project’s Medical Debt Resolution Program, The Access Project, September 2009; and Rukavina, Mark, Carol Pryor, Stephen D’Amato, and Stacey Beberman. Not Making the Grade, The Access Project, May 2007.

3 Section 3 (a)(4) of Chapter 58.

4 The Attorney General’s Guidelines for Non-Profit Hospitals, Massachusetts Attorney General Martha Coakley, 2009.