KHI/10-04 • May 2010

Issue Brief

KANSAS HEALTH INSTITUTE

Medical Debt: Consequences and Policy Options

M. Suzanne Cleveland, J.D.

More Information

This *Issue Brief* and related information can be found at www.khi.org/underinsurance.

Selecting the footnotes imbedded in the text of this *Issue Brief* will take you to source information at other websites. Most source information is in PDF format.

Introduction

Medical debt is a serious problem for many Americans. According to a recent study,[1] in 2007 over 60 percent of personal bankruptcies in the U.S. were linked to medical debt — an increase of 50 percent in medical debt-related bankruptcies since 2001. Many states have enacted laws that have the potential to reduce the prevalence or minimize the impact of medical debt, and the recently passed Patient Protection and Affordable Care Act[2] and Health Care and Education Reconciliation Act[3] aim to reduce out-of-pocket spending on medical care and ensure that more Americans have health insurance that adequately covers their needs.

Still, medical debt remains a concern. While no panacea has been identified, policymakers may want to consider a comprehensive approach to both prevent and resolve medical debt.

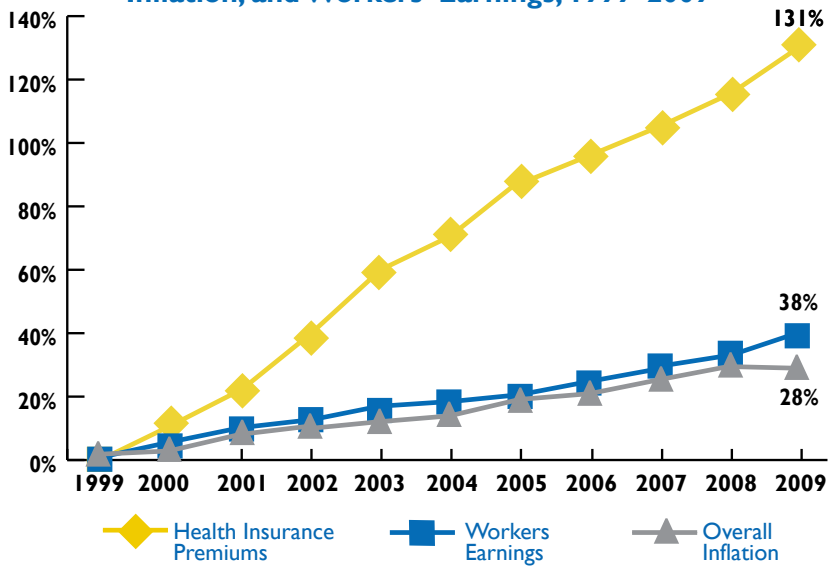
BACKGROUND

Medical debt can impact both the uninsured and those with inadequate insurance — the so-called "underinsured." Individuals who are uninsured or underinsured may postpone needed medical care due to lack of coverage or worry about costs.[4] Not only does this behavior negatively affect health, but it also may have economic consequences. For many chronic illnesses, prevention or early-stage disease management is less costly than late-stage disease management and acute or emergency care. Medical debt also presents challenges for hospitals and providers left with revenue shortfalls. These inefficiencies can result in greater overall costs to the health care system.

A variety of factors contribute to and can exacerbate medical debt. Some of these factors include:

- Uninsurance — According to the most current data, 12.4 percent of the Kansas population is uninsured.

Figure 1. **Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999–2009**



Note: Due to a change in methods, the cumulative changes in the average family premium are somewhat different from those reported in previous versions of the Kaiser/HRET Survey of Employer-Sponsored Health Benefits. See the Survey Design and Methods Section for more information, available at http://www.kff.org/insurance/7936/index.cfm.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2009. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999–2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999–2009 (April to April).

- Out-of-pocket costs — A recent study revealed that 6.7 percent of privately insured Kansas adults reported paying more than 10 percent of their 2004 annual income on out-of-pocket medical costs.[5]
- Health insurance premiums — Nationwide, health insurance premiums have risen dramatically in the past decade (See Figure 1).[6]
- Cost of care — For many years, the cost of medical care has been steadily increasing.[7]

States have attempted to address medical debt through a variety of legislation, including laws requiring transparency of medical costs and laws calling for free or discounted care, among others. Because medical debt is handled the same way that other debt is handled, federal bankruptcy and credit laws apply to medical debtors. This brief explores the various approaches states have taken to combat medical debt as well as federal laws applicable to medical debt situations.

REDUCING COSTS

One policy option for reducing the frequency of medical debt is legislatively limiting the amount uninsured or low-income patients can be charged for medical services. Hospitals that are not-for-profit, and therefore receive a favorable federal tax status, are required, as a condition of that benefit, to provide free or discounted care (often referred to as "charity care") to vulnerable populations. Some states add additional or more stringent duties as a condition of favorable state tax status such as Mississippi,[8] where not-for-profit hospitals must dedicate one ward to the provision of charity care. Still others, like Rhode Island,[9] require as a condition of hospital licensure in the state a prescribed threshold of free or discounted care.

Due to the way the health care payment system is currently structured, hospitals sometimes charge patients without insurance more than those with insurance because insurance companies are able to negotiate lower rates for care. In response to this, a few states have enacted laws that limit the amount hospitals may charge the uninsured, particularly those who are low-income. For example, both New Jersey[10] and Nevada[11] limit the way that some hospitals charge low-income uninsured patients. A bill[12] was introduced in the Kansas Legislature in the 2010 legislative session that would set a hospital allowable charge limit for both uninsured and underinsured low-income patients. The bill did not pass.

While the laws described above may reduce the accrual of medical debt for patients, they also potentially limit the amount of revenue a hospital generates. Hospitals that treat a large population of Medicaid, Medicare and low-income patients are provided a type of payment from both the state and federal government called "Disproportionate Share Hospital" or

"DSH" payments. The purpose of DSH payments is to compensate hospitals for the low reimbursement and higher operating costs incurred for treating this population. However, even with these payments and, in the case of not-for-profit hospitals, favorable tax status, hospitals report concern over the cost of this uncompensated or poorly compensated care.[13]

The relationship between efforts to prevent medical debt and the burden of uncompensated care is not unique to hospitals. While the most significant medical expenses typically occur in a hospital setting, patients can also accrue medical debt through care from private providers in clinical settings. For patients in need, data show that some private providers are also offering free or reduced care. Estimates in 2008[14, 15] ranged from 7.8 to 48.9 in billions of dollars of free care attributable to private providers. Still, state legislation limiting charge amounts and requiring the provision of free care appears to be largely targeted at hospitals.

INCREASING TRANSPARENCY

Many states that require the administration of free or discounted care also stipulate that notice of the availability of this care be provided to a patient prior to admission or treatment. In California,[16] if requested, a written estimate of the amount a patient can expect to pay must be provided before care is administered. Other states require that average charge information be made publicly available for consumers to use in choosing a hospital or provider. Minnesota,[17] for example, utilizes a web-based approach to publicizing such data. A bill[18] introduced in the 2010 Kansas legislative session would have required providers to give, upon request, notice of estimated treatment costs to patients. The bill did not pass.

PREVENTING ABUSIVE DEBT COLLECTION PRACTICES

For those dealing with debt collections, federal fair collection practice laws are applicable. This area of law — creditor/debtor law — is largely controlled by federal legislation, unless states enact laws that add even greater consumer protection. Currently, federal laws do not differentiate between medical debt and other forms of debt. As such, medical debtors are covered by the same laws and policies as other debtors. The Fair Debt Collection Practices Act[19] bars abusive practices by debt collectors. California[20] strengthens this provision by applying this law to not only debt collectors, but the original creditor (such as the hospital or provider seeking payment). Kansas law [21] (statute 60-2310) provides an additional consumer protection — wages cannot be garnished if it is a debtor's illness that has prevented work at his or her "regular trade." This exclusion lasts for up to two months following recovery from the illness.

REGULATING BANKRUPTCY

For those in the most serious medical debt situations, bankruptcy may be the only viable option for discharging one's financial obligation to repay debt. Bankruptcy is also largely controlled by federal law, though states vary in what each allows the bankruptcy filer to keep in the form of exemptions (exemptions are the assets one is allowed to keep after filing for bankruptcy). Kansas law[22] (Statute 60-2301) is fairly generous in this regard, allowing individuals filing bankruptcy to keep their homes and up to 160 acres of land, if the homestead happens to be a farm. Other state laws, such as the one in Alabama,[23] only allow bankruptcy filers to keep up to $5,000 of the value of their homes. Although some federal bills have proposed looking

CURRENT HEALTH INSURANCE PRACTICES

Rescission is the cancellation of a health insurance policy, even after premium payments have been made, if an insured individual allegedly made a mistake on his or her application. Under the new federal health reform law, insurers may only rescind policies if it is discovered that an applicant intentionally and knowingly misrepresented his or her health information at the time he or she applied for the policy.

Pre-existing condition exclusion is the period of time that a person waits before receiving coverage for services related to an illness he or she had at the time of enrollment in the plan.

Lifetime limit is the dollar amount placed on an insurance policy such that if the policyholder reaches that limit, the insurer of the policy will pay no further benefits.

Annual limit is the dollar amount placed on an insurance policy such that if the policyholder reaches that limit within one plan year's time, the insurer will pay no further benefits.

at specific protections for medical debt bankruptcies versus other bankruptcies,[24] a challenge with this approach is the difficulty of distinguishing between situations when a bankruptcy is solely due to medical debt, and when other factors played contributing roles.

REPAIRING CREDIT SCORE

Though state and federal laws exist for those patients dealing with debt collections and bankruptcies, a major challenge for medical debtors — poor credit rating — remains largely unsolved. A poor credit score can have long-lasting and far-reaching consequences for someone trying to rebuild financial stability. Some lawmakers have argued that those with medical debt should be treated differently than other types of debtors because of the unique circumstances that can lead to medical debt. It can also be argued that medical debt can be a sign of financial mismanagement and therefore should impact credit score. A few federal bills[25,26] have been introduced in past sessions looking at preserving the credit score of those whose debt is solely medical — but again the question arises, when is medical debt the root cause of a person's financial trouble and when it is one of several causes? A Kansas bill[27] introduced in the 2010 legislative session would prevent a provider from reporting to a credit agency a consumer's failure to pay. This bill did not pass.

REFORMING THE SYSTEM

The federal health reform law is intended to improve the availability and adequacy of health insurance coverage. The reform law sets minimum creditable coverage standards, meaning many health insurance plans will be required to cover a certain set of benchmark services. In addition, the law requires first-dollar coverage for proven preventative services, which means there will be no cost-sharing required of plan participants, and the law will limit, for some populations, the amount of out-of-pocket money spent on health care. Medical debt tends to more frequently affect uninsured and underinsured individuals. Increased availability of health insurance and minimum-creditable coverage standards expanding the adequacy of coverage could help to reduce instances of medical debt by reducing the rates of uninsurance and underinsurance. Additionally, curbing health insurance practices such as rescission, pre-existing condition exclusions, and lifetime or annual limits (see sidebar on page 3) will allow more individuals access to adequate health insurance policies.

CONCLUSION

The negative impact of medical debt on patients and of uncompensated care costs on providers and hospitals has been documented. Over half of U.S. bankruptcies are attributable, at least in part, to medical bills and many providers are feeling the squeeze of administering discounted care. The federal health reform bill seeks to lower overall health care costs and increase rates of insurance, which may help reduce the frequency of medical debt. For those patients with existing medical debt, post-accrual tactics such as credit score preservation may be more helpful. As federal and state lawmakers search for policy solutions, it is important that both the patient and provider sides of the equation are considered, as medical debt impacts not only the individuals with outstanding balances, but also everyone who participates in the health care system.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

KANSAS HEALTH INSTITUTE
212 SW Eighth Avenue, Suite 300
Topeka, Kansas 66603-3936
Telephone (785) 233-5443
Fax (785) 233-1168
www.khi.org

KHI/10-04 • May 2010