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PULSE

Gallup Poll Finds More Americans Than Ever Putting Off Medical Care Due to Cost

Findings from 2022 reveal that 38% of Americans say they put off medical payments due to rising costs of inflation.

A new Gallup poll found that the percentage of Americans postponing medical care payments due to cost rose in 2022.

Each year since 2001, Gallup has tracked the amount of Americans who delay medical care in the past 12 months due to cost.

This year's poll, which surveyed 1,020 people from Nov. 9 to Dec. 2, 2022, found that 38% of respondents reported having put off scheduled medical care payments due to cost, up 12% from the past two years.

The previous high point in these trends was at 33% in 2014 and 2019.

"The latest double-digit increase in delaying medical treatment came on the heels of two consecutive 26% readings during the COVID-19 pandemic that were the lowest since 2004," according to Gallup. An average 29% of U.S. adults reported putting off medical treatment because of cost between 2001 and 2021.

"Americans were more than twice as likely to report the delayed treatment in their family was for a serious rather than a nonserious condition in 2022," according to the poll.

The poll also found that 27% of respondents said that the delayed treatment in their family was for a condition that was considered to be "very" or "somewhat" serious, while 11% of those surveyed said the delayed treatment was for a condition considered to be "not very" or "not at all" serious.

The Gallup poll compared responses across economic status, age and gender.

Among different economic categories, 34% of respondents in the lower-income group (those with an annual household income under $40,000) said that they postponed medical care treatment for a very or somewhat serious condition, while 29% of respondents in the middle-income group (those with an annual household income between $40,000 to $100,000) said the same thing.

Conversely, only 18% of respondents in the upper-income group (those with an annual household income of $100,000 or more) said that they postponed medical care treatment for a very or somewhat serious condition.

Across age groups, 35% of respondents who are 18 to 49 years old said that they postponed medical care treatment for a very or somewhat serious condition, and 25% of respondents who are 50 to 65 years old also said the same.

Additionally, only 13% of respondents who are 65 and older have said that they postponed medical care treatment for a very or somewhat serious condition, according to the poll.

Finally, looking at gender differences in 2022, 32% of women and 20% of men reported putting off medical treatment—a 12-point increase from 2021 for women and a five-point increase for men.

The poll comes as the majority of U.S. adults noted that inflation has created a moderate hardship for them and that it's one of the most important issues in the last year.

Read the full report here.

CFPB Signals Fair Credit Reporting Act Rulemaking

The bureau's regulatory agenda says the rulemaking is in the pre-rule stage and could be a mechanism for the bureau to focus on medical debt.

The Consumer Financial Protection Bureau is considering whether to amend the Fair Credit Reporting Act and its implementing regulations.

The possible rule came up with little fanfare from the bureau on its rulemaking agenda—recently released for fall 2022—although CFPB Director Rohit Chopra said in a recent report on nationwide credit reporting agencies (CRAs) that the bureau will be "exploring new rules" related to credit reporting.

Going back to last June, Chopra said he is "rethinking the bureau's approach to regulations" by "seeking to move away from highly complicated rules that have long been a staple of consumer financial regulation and towards simpler and clearer rules."

Since then, the bureau under Chopra's leadership has issued advisory opinions and "Consumer Financial Protection Circulars," outside of the standard regulatory approach followed by the bureau under the Administrative Procedure Act, which ACA has long focused on in its advocacy.

The bureau's agenda for the FCRA rulemaking states, "Congress enacted the Fair Credit Reporting Act … to ensure fair and accurate credit reporting, promote efficiency in the banking system, and protect consumer privacy. The law and its implementing regulations (Regulation V) impose legal duties on consumer reporting agencies, data furnishers, and users of consumer reports, and furnishers of information to consumer reporting agencies. The [b]ureau is considering whether to amend Regulation V."

ACA's Take

ACA recently outlined in an amicus brief (PDF) some of the limitations the CFPB faces when seeking to legislate through regulations. The amicus brief also shows why credit reporting should not be a political issue decided at the whim of partisan lawmakers or regulators.

ACA also outlined similar concerns in a letter to the CFPB (PDF) in response to an NCLC request to the bureau to engage in a medical debt credit reporting rulemaking.

If the CFPB were allowed to engage in rulemaking here, it must do so in compliance with the Administrative Procedure Act and provide impacted entities with an opportunity to voice their concerns as well as follow the Regulatory Flexibility Act, which requires a cost-benefit analysis of proposed rules and collecting input from small businesses—all actions the bureau has skirted recently in other proposed rules.

ACA continues to advocate that the CFPB's actions taken outside of the rulemaking process will have negative consequences for the accounts receivable management industry.

ACA is following Chopra's plans in the medical debt collection space, and we expect the agency may continue to move forward in this area, particularly after the National Consumer Law Center proposed a petition for rulemaking on medical debt, ACA's lobbyist and shareholder at Brownstein Hyatt Farber Schreck Leah Dempsey reports in the latest issue of *Collector* magazine.

Nacha Urges Health Care Providers to Use ACH Network

Health care EFT payments were on the rise in 2022, and Nacha is continuing its outreach to get dentists and health care providers to use the network.

A new blog post from Nacha is urging health care providers to look to the national automated clearing house (ACH) network as the primary means to receive claim payments. New Nacha figures show that there were more than 452 million health care claims paid by ACH in 2022, up from 6.1% in 2021.

"Healthcare practices work hard and should receive claim payments fast and efficiently. ACH makes that happen," said Brad Smith, senior director of industry engagement and advocacy at Nacha, who leads the team encouraging the use of ACH.

According to the blog post, there's a lot of money at stake. In 2022, $2.1 trillion in health care claim payments was processed through the ACH Network—an increase of 7.4% from 2021.

There's been a special focus on encouraging dental offices to use the ACH network, which have historically been slower to accept ACH claim payments than the rest of the medical community, according to Smith.

"Among some dental practices, there's a hurdle to enrolling for EFTs by ACH, particularly small offices with limited staff," Smith said. "Virtual credit cards are newer, and there's sometimes a misunderstanding among dentists that they must accept them, when they don't."

Nacha's corporate credit or debit (CCD) format was adopted by the Department of Health and Human Services as the Healthcare Electronic Funds Transfer (EFT) standard in January 2012, which must be used for electronic

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NEWS & NOTES

Health Care Bankruptcies Grew by 84% in 2022

The number of health care bankruptcies increased by 84% from 2021 to 2022, driven by rising costs, workforce shortages and high interest rates, according to a report from Gibbins Advisors.

There were 46 total large bankruptcies in the health care sector in 2022, compared to 25 in 2021. This growth marked a return to 2019 and 2020 levels, when 51 and 45 health care bankruptcies occurred, respectively, according to the report.

Across the board in 2022, there were 31 bankruptcies with liabilities between $10 million and $50 million, up from nine in 2019. Eight bankruptcies in 2022 had liabilities between $50 million and $100 million, two cases were in the $100 million to $500 million range, and five cases had liabilities over $500 million.

Read the full report here.

2022 Brought Major Workforce Challenges to Medical Groups

A survey from the American Medical Group Association (AMGA) found that ongoing workforce challenges in the medical sector have led to declining staff ratios and higher labor expenses for medical groups in 2022.

The AMGA survey gathered data from more than 24,000 health care providers across 5,600 U.S. clinics.

Among the challenges faced, AMGA found that medical groups saw an 11.3% decrease in clinical staffing full-time equivalents on a per-provider basis compared to pre-pandemic levels, and overall staffing expenses increased by 15% due to these staffing shortages.

"This situation will force medical groups to optimize, and hopefully leverage, technology to automate their processes," said Rose Wagner, consulting chief operations officer of AMGA. "They have had to learn how to operate as efficiently as possible, to work with the staff they have, while also managing higher labor costs. This trend is unlikely to change for the foreseeable future."

Read the full release here.

Learn More

For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse-newsletters-archive

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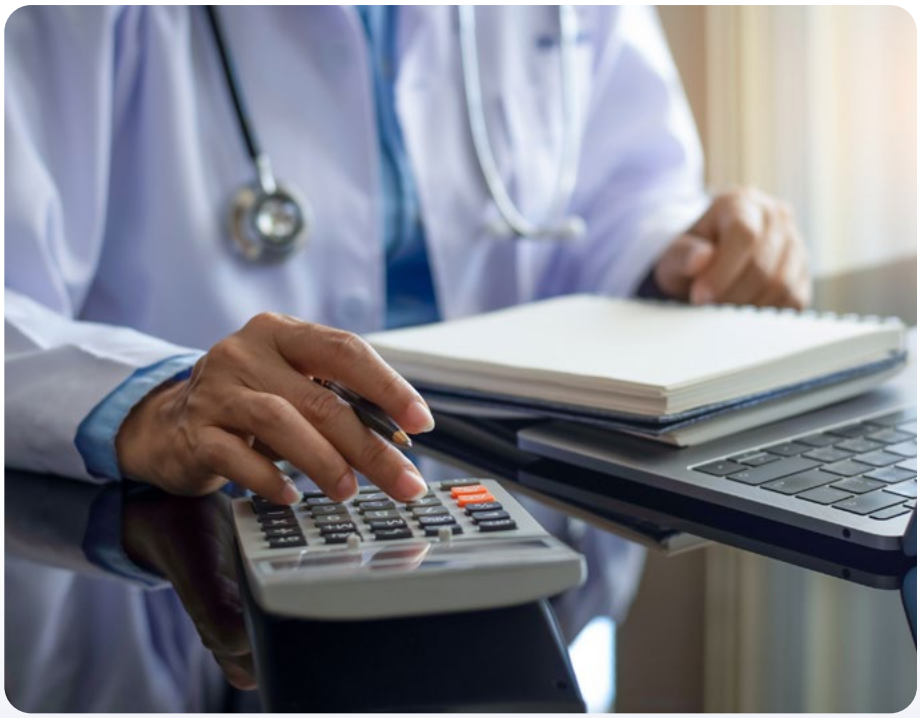
claims payment initiation by all health plans that conduct health care EFTs.

"Nacha's mission is twofold," said Smith. "We want to make it clear to providers that medical and dental plans must offer ACH claim payments if requested, and we want to show providers the benefits of having those payments safely and quickly paid electronically by ACH."

Nacha continues to promote outreach to dentists and dental offices in 2023, including at the Chicago Dental Society Midwinter Meeting in February, where they will have a booth to promote their resources available to dentists and help them get started accepting ACH payments, as well as sharing success stories from dentists who already use the network.

Read the post here.



DATAWATCH

65% of Beneficiaries Uninsured After Medicaid Disenrollment

An issue brief from the Kaiser Family Foundation (KFF) found that in the year that followed a disenrollment from Medicaid and the Children's Health Insurance Program (CHIP), roughly two-thirds (65%) of people had a period of uninsurance while just 35% were continuously enrolled in coverage.

Additionally, 17% of individuals were uninsured for the full year, 16% were uninsured for some of the year and had another source of coverage at one point, and a third of beneficiaries were uninsured after disenrollment but eventually re-enrolled in Medicaid or CHIP before the end of the year, known as churning.

KFF researchers used pre-pandemic data from 2016 to 2019 from the Medical Expenditure Panel Survey (MEPS) to assess the number of people who enrolled in and retained other coverage during the 12 months after Medicaid or CHIP disenrollment.

The Families First Coronavirus Response Act (FFCRA) required Medicaid to keep beneficiaries continuously enrolled in the program during the COVID-19 pandemic. However, the continuous enrollment provision ends on March 31, 2023, and states must resume Medicaid eligibility determinations.

As a result of this interruption, KFF researchers project that 5 million to 14 million people will lose Medicaid coverage when the continuous enrollment provision ends.

Health Insurance Changes in the 12 Months Following Disenrollment from Medicaid/CHIP, 2016-2019

Source: KFF analysis of the Medical Expenditure Panel Survey Household Component (MEPS-HC), Panels 21-23, Agency for Healthcare Research and Quality (AHRQ). https://bit.ly/40cvuWO

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