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Past-Due Medical Debt Impacting Americans

More than one in seven non-elderly adults live in families with past-due medical debt, according to findings from the Urban Institute.

A new report from the Urban Institute sheds light on Americans' struggle with medical debt, revealing that more than one in seven non-elderly adults have unpaid medical debt.

The report also reveals that low-income families are most affected by medical debt. According to data from the Urban Institute's Health Reform Monitoring Survey (HRMS) from June 2022, nearly two-thirds of individuals with past-due medical debt have earnings below 250% of the federal poverty line.

About three-quarters of impacted persons owe at least some debt to hospitals, which account for a larger portion of past-due medical debt, according to the report. More specifically, 45% of affected adults owed debt to hospitals and some other providers, whereas 28% of affected adults owed debt only to hospitals.

More key findings include:

- Adults with past-due hospital bills generally have much higher total amounts of debt than those with past-due bills only owed to non-hospital providers.
- Most adults (60.9%) with past-due hospital bills reported that a collection agency contacted them about the debt, but much smaller shares reported that the hospital filed a lawsuit against them (5.2%), garnished their wages (3.9%), or seized funds from a bank account (1.9%).
- Though about one-third (35.7%) of adults with past-due hospital bills reported working out a payment plan, only about one-fifth (21.7%) received discounted care.

Before seeking to collect patient financial responsibility, nonprofit hospitals are required by federal law to develop financial assistance plans and offer charity care to qualified patients. The Urban Institute notes that nonprofit hospitals determine their own criteria for eligibility for charity treatment, and that many patients who would probably be eligible under hospital regulations do not receive it.

Additionally, federal regulations governing medical financial assistance do not apply to public and for-profit hospitals. These hospitals are free to employ their own collection tactics, such as hiring a collection agency, suing patients directly, or garnishing wages.

Recently, more aggressive medical debt collection practices have come under scrutiny from state lawmakers. For instance, New York changed its civil practice legislation last year to forbid health care providers from garnishing wages or recording liens against a patient's primary residence in order to recover medical debt.

Additionally, the Biden administration has also recognized the issue of medical debt and pledged to protect consumers through a number of initiatives, including obtaining information from more than 2,000 providers to assess medical debt collection practices and provide financial help options.

"In their efforts to protect patients from medical debt, policymakers have increasingly focused on the role of hospital billing and collection practices, with particular scrutiny directed toward nonprofit hospitals' provision of charity care. Understanding the experiences of people with past-due bills owed to hospitals and other providers can shed light on the potential for new consumer protections to alleviate debt burdens," according to the Urban Institute report.

The Urban Institute's analysis draws on data from the June 2022 round of the HRMS, a nationally representative, internet-based survey of adults ages 18 to 64 that provides timely information on health insurance coverage, health care access and affordability, and other health topics. Approximately 9,500 adults participated in the June 2022 HRMS.

Read the full report here.

From the Web: 'How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them'

Report from ProPublica reveals doctors from Cigna, one of the nation's largest insurance companies, spend an average of 1.2 seconds on each insurance claim, often swiftly denying them en masse.

Recent findings from ProPublica reveal that doctors from Cigna, one of the U.S.'s largest insurers, are rejecting patients' claims without opening their files, confirmed through internal documents and former company executives.

"The company has built a system that allows its doctors to instantly reject a claim on medical grounds without opening the patient file, leaving people with unexpected bills," ProPublica says. "Over a period of two months last year, Cigna doctors denied over 300,000 requests for payments using this method, spending an average of 1.2 seconds on each case, the documents show."

According to insurance laws and regulations in many states, company doctors must examine claims before health insurers deny them on medical grounds. In order to decide whether to approve or deny claims, medical directors are expected to analyze coverage regulations, review patient data, and exercise their clinical judgment, according to authorities, a procedure that aids in preventing biased denials.

However, the Cigna review system appears to largely bypass those important steps.

"Medical directors do not see any patient records or put their medical judgment to use, said former company employees familiar with the system," according to the ProPublica article. "Instead, a computer does the work. A Cigna algorithm flags mismatches between diagnoses and what the company considers acceptable tests and procedures for those ailments. Company doctors then sign off on the denials in batches, according to interviews with former employees who spoke on condition of anonymity."

Although Cigna established its review method more than 10 years ago, insurance executives claim that comparable processes have been in use across the industry in various forms.

In a response to ProPublica, Cigna claims its review system was created to "accelerate payment of claims for certain routine screenings. This allows us to automatically approve claims when they are submitted with correct diagnosis codes."

When questioned if its PXDX review procedure permits Cigna doctors to deny claims without inspecting them, the insurance company said that the statement was "incorrect." However, former Cigna doctors confirmed that the review system was used to quickly reject claims.

Though the creator of Cigna's review system, Dr. Alan Muney, claims the system is an efficient way to save money and "was designed to prevent claims for care that Cigna considered unneeded or even harmful to the patient," two unnamed former Cigna doctors said the system was unfair to patients and that the claims "automatically routed for denial lacked such basic information as race and gender."

Further research from ProPublica found that one Cigna doctor rejected 121,000 claims in the first two months of 2022, according to a scorecard provided in the article.

Ultimately, findings like these open the door for further regulation of insurance processes. Medicare and Medicaid currently have a system that automatically prevents improper payment of claims that are wrongly coded, and ensures it does not reject payment on medical grounds.

"It's hard to imagine that spending only seconds to review medical records complies with the law," said Dave Jones, California's former insurance commissioner. "At a minimum, I believe it warrants an investigation."

Read the article here.

NEWS & NOTES

Providers Billing Outpatient Visits at Increasingly Higher Levels

A new analysis from Peterson-KFF Health System Tracker found that outpatient visits are being billed at higher levels, leading to an increase in health care spending and concerns about upcoding, which refers to using billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided, according to HHS.gov.

Health care providers can bill outpatient evaluation and management claims at five different levels, determining a visit's complexity, with Level 1 being the lowest and Level 5 being the most complex. The findings suggest that patients are paying higher out-of-pocket costs due to these increases in coding, which might suggest providers are encouraged to bill for more complex cases.

"Overall, our findings demonstrate that regardless of the driving factors, increasing billing at higher levels for outpatient care has led to substantial increases in outpatient visit spending at the health system level," researchers concluded. "For consumers who bear the marginal costs of more expensive services—those with co-insurance or deductibles—this trend impacts out-of-pocket costs in addition to overall health system costs."

Read the full analysis here.

Hospital Margins Beginning to Return to Normal Since Pre-Pandemic

According to a new report from Kaufman Hall, hospital finances are seeing signs of stability after years of unpredictable ups and downs during the COVID-19 pandemic.

The median year-to-date operating margin index for hospitals was -1.1% last month, down slightly compared to the -0.8% index in January 2023. Kaufman Hall said hospital operating margins took a small dip; however, February was the eighth month in which changes to month-to-month margins decreased relative to the last three years.

Read the report here.

Learn More

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

Colorado Legislation on Medical Debt Advances

The legislation focuses on limiting medical debt credit reporting.

Colorado Assembly bill (HB 23-1126) on the inclusion of medical debt information on consumers' credit reports is advancing in the state legislature, The state Senate approved the bill March 31, and sent it back to the Assembly for approval. At press time, if it advances out of the Assembly with approval of the Senate's changes, the bill would next be sent to the governor.

HB 23-1126 is being considered in Colorado's legislature along with a bill in the Senate Health & Human Services Committee that would cap interest rates on medical debt, establish payment plan requirements for medical debt, and prohibit collection on medical debt during appeal proceedings, among other changes, ACA International previously reported.

Overall, the Assembly bill from Democratic sponsors State Rep. Naquetta Ricks and State Rep. Tony Exum seeks to prohibit medical debt information on credit reports and "prohibits a debt collector or collection agency, when attempting to collect debt that the debt collector or collection agency knows or should know is medical debt or to obtain information about a consumer in relation to an attempt to collect medical debt from making a false or misleading representation that the medical debt will be included in a consumer report or factored into a consumer's credit score."

"The bill defines 'medical debt' as ~~any obligation or alleged obligation of a consumer to pay any amount whatsoever arising from the receipt of health-care goods or services.~~ debt arising from health-care services or health-care goods, including products, devices, durable medical equipment, and prescription medications."

Note: The strike-through text was removed in the last round of amendments.

Discussion during a March 14 hearing before the Senate Committee on Business, Labor & Technology focused on the definition of medical debt in the bill and ensuring it is consistent in the Senate and Assembly proposals.

Concerns of industry stakeholders included how the proposal will separate medical debt and credit card debt on a credit report if a consumer uses their credit card to pay for a health care expense.

In the Senate, the Health and Human Services Committee also previously heard support of an amendment to align the definition of medical debt in both bills and concern about the assignment of providers as plaintiffs in a debt collection lawsuit, when it should be the collection agency they are working with.

ACA International and the Associated Collection Agencies Inc. state unit representing Colorado, Wyoming and New Mexico continue to work with a health care coalition on advocacy related to the proposed changes in these bills.

DATAWATCH

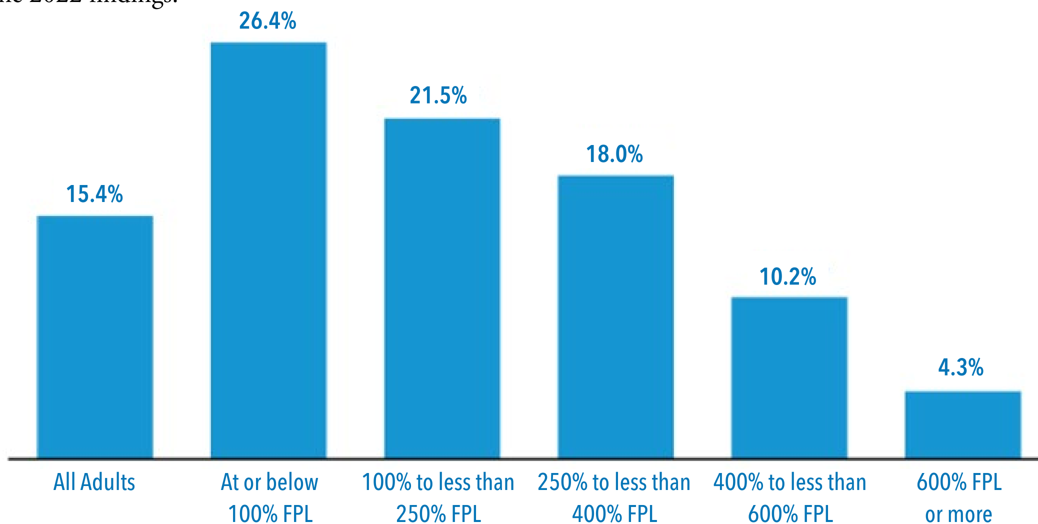
Americans Living Under the Poverty Line Facing Unpaid Medical Debt

A study conducted on Americans' medical debt last month by the Urban Institute found that more than one in seven non-elderly adults have unpaid medical debt.

Of those adults, nearly two-thirds have incomes below 250% of the federal poverty line.

"The concentration of past-due medical debt among families with low incomes and the large share who owe a portion of that debt to hospitals suggests that expanded access to hospital charity care and stronger consumer protections could complement health insurance coverage expansions and other efforts to mitigate the impact of unaffordable medical bills," according to the Urban Institute.

Findings below show the breakdown of adults aged 18 to 64 reporting past-due medical debt overall and by family income from the survey's June 2022 findings.



Source: The Urban Institute's Health Reform Monitoring Survey https://urbn.is/3M5KC3Y

is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

Communications Department
ACA International
3200 Courthouse Lane
Eagan, MN 55121
comm@acainternational.org

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