In Debt But Not Indifferent

Chapter 58 and The Access Project's Medical Debt Resolution Program

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EXECUTIVE SUMMARY

In April of 2006, Massachusetts passed a major health reform law, Chapter 58. It was designed to achieve near universal coverage in the state by providing subsidies to help low and moderate income people obtain insurance and by requiring others to purchase coverage either through employment or on the individual market. Chapter 58 has made insurance coverage available to hundreds of thousands of previously uninsured state residents. Implementation of the law required the creation of new programs and products, as well as an array of changes to the regulations governing new and existing programs.

Reform occurred in the context of growing national awareness of the prevalence and consequences of unaffordable medical bills. Prior to implementation of Chapter 58, 21 percent of state residents under the age of 65 had medical bills they were paying off over time. Over half were insured, indicating that health insurance did not always protect Massachusetts residents financially when they got sick. A study comparing pre-reform (fall 2006) and post-reform (fall 2007) indicators showed that progress had been made, but there were still almost one in five state residents (18%) in the fall of 2007 paying off medical bills over time.[1]

In September of 2006, prior to implementation of Chapter 58, The Access Project (TAP) created the Medical Debt Resolution Program. The program has continued in operation throughout the period of health reform implementation. Its goals were to help people with medical debt resolve their unaffordable medical bills and to monitor the impact of Chapter 58 on people's ability to afford and access care. The program helped more than half of the people who called for help resolve over $1 million in medical bills. It also allowed TAP to identify issues related to health reform that still left people vulnerable to unaffordable bills. This report summarizes the findings.

FINDINGS

Affordability and Access Issues

Most Medical Debt Resolution clients had low incomes, and for many of them even relatively small medical bills were unaffordable and resulted in medical debt. TAP was able to refer many clients for help in enrolling in the state-subsidized Commonwealth Care insurance plans. However, for some, trying to pay off existing medical debt made it difficult to keep up with plan premiums and co-payments. A few higher income clients enrolled in the non-subsidized state-approved Commonwealth Choice plans; they also found the premiums difficult to afford.

Communication and Coordination Issues

Chapter 58 created a number of new programs that operate alongside existing public programs. While these programs are valuable, many clients in the Medical Debt Resolution program found it difficult to navigate through the complex system. The result was that people were often left with bills that one of these programs could have covered.

Insurance Problems

About 40 percent of program clients were insured when they incurred debt. Many incurred debt due to cost-sharing built into their plans, as well as uncovered services. The cumulative costs caused many clients, especially those with lower incomes, to choose between maintaining insurance coverage, paying off past debt, or getting needed care. Other clients suffered improper denial of insurance claims. The state's Office of Patient Protection, which provides an independent external review of insurance claims denials, provided relief for a number of clients. However, few were aware of the existence of this agency and of their right to an external review.

Safety Net Problems

Uncompensated Care Pool: Prior to the implementation of Chapter 58, many Medical Debt Resolution Program clients were able to resolve their bills through coverage under the state's Uncompensated Care Pool. However, many were not screened by their providers and only learned about the program through TAP. This was especially true of clients who had health insurance but were still eligible for Pool coverage. An important feature of the Pool was that it covered bills for up to six months prior to the time people applied for coverage; this was important because many Medical Debt Resolution Program clients were unaware of the Pool until months after they received care. For some insured people eligible for Pool coverage, even six months was insufficient because it took longer than that to resolve claims' issues with their insurers. Also, although the Pool provided coverage for hospital-related services and services provided at community health centers, it still left many clients with significant unpaid costs, such as ambulance or laboratory bills.

Health Safety Net: The Health Safety Net replaced the Uncompensated Care Pool under Chapter 58; as part of this change, many regulations were revised or altered. One change that created particular problems for Medical Debt Resolution Program clients involved retroactive coverage: people eligible for Commonwealth Care or MassHealth could only qualify for ten days of retroactive coverage under the Health Safety Net. Nineteen clients of the Medical Debt Resolution Program ended up with hospital debt because they didn't know to apply for coverage within ten days of receiving care.

Medical Hardship Program: This program helps cover expenses when unpaid medical bills comprise more than a certain percentage of a family's income. The Medical Hardship Program assumed increased importance because of the changes limiting retroactive coverage under the Health Safety Net; it helped some people pay for bills too old for coverage under the Health Safety Net. Application for the program must be initiated by a hospital or health center. However, some providers seemed unaware of the program. TAP advised two families to apply, and in both cases the client had to inform their providers about their eligibility for the program. Even when approved, some low-income clients had difficulty affording the percentage of income that constituted their hardship contribution.

Hospital Charity Care

Hospitals and other providers can create charity care or financial assistance policies that exceed the standards set by the Health Safety Net. TAP found that many hospitals do not include information on such programs with the policies they are required to file with the state. Many providers were willing to provide discounts, affordable payment plans, or reduced cost care to patients in need. However, it often took effort to negotiate these arrangements because providers gave inconsistent information about their availability.

Medical Bills and Credit Reporting

A number of Medical Debt Resolution Program clients had medical bills from Massachusetts providers appear on their credit reports. In a few of these cases, people should have been eligible for coverage through the Uncompensated Care Pool or Health Safety Net at the time they received services. Poor credit ratings resulting from such bills can make it difficult for families to access affordable credit.

University Students and the Health Insurance Mandate

University students in the state have been mandated to purchase health insurance coverage since 1989, and are categorically ineligible for Commonwealth Care plans. If they do not have insurance from other sources, they must purchase it through their schools. These plans, called Qualifying Student Health Insurance Plans (QSHIP), are exempted from the minimum standards for insurance established under health reform. One-fifth of the people with private insurance who called the Medical Debt Resolution Program were covered by QSHIP plans. These plans often contained provisions that left students at serious financial risk, such as low annual and service caps.

RECOMMENDATIONS

- Initiate a public awareness campaign to inform Massachusetts residents and health care providers about the safety net resources available to people struggling with high healthcare costs and medical debt. Better integrate the Medical Hardship Program into the overall Health Safety Net.
- Clarify and publicize information about provider-based charity care and financial assistance programs that are available to help patients with unaffordable medical expenses.
- Extend the retroactive coverage period under the Health Safety Net for uninsured people who are eligible for state-subsidized plans to at least six months.
- Protect the financial security of low-income Massachusetts residents who are eligible for Commonwealth Care or the Medical Hardship Program.
- Monitor the quality of private insurance coverage.
- Increase public awareness about the Office of Patient Protection, which can help adjudicate claims that have been denied by insurance companies.
- Allow income-eligible college students to qualify for Commonwealth Care insurance products.
- Prohibit Massachusetts health care providers and collections agencies from reporting medical debt to credit bureaus.
- Conduct ongoing monitoring of the financial burden of health care costs and medical debt on Massachusetts residents.
- Build and support outreach capacity among providers and advocacy groups to help Massachusetts residents enroll in public programs and better navigate the health system.

While the findings in this report are based on the experiences of Medical Debt Resolution Program clients, we believe they suggest patterns and provide information that can help policy makers refine and improve implementation of the health reform legislation.

INTRODUCTION

In April of 2006, Massachusetts passed a major health reform law, Chapter 58. The law was designed to achieve near universal health insurance coverage for Massachusetts residents by providing subsidies to help low and moderate income people obtain insurance and by requiring others to purchase coverage, either through their employment or on the individual market (the individual insurance mandate).

A major achievement of health reform has been to make insurance coverage available to almost all Massachusetts residents, hundreds of thousands of whom were previously uninsured. For many, new insurance products have fulfilled the promise of being both affordable and comprehensive. Health plans subsidized by the state, called Commonwealth Care plans, have been especially helpful in allowing people to access affordable care without going into debt.

The Massachusetts health reform law represents an innovative approach to expanding health insurance coverage. Implementation required the creation of new programs and products, as well as an array of changes to the rules and regulations governing new and existing programs. Many of these changes were of necessity untested. This report, based on the experiences of people in the state who accrued debt because of unaffordable medical bills, highlights aspects of these changes that may still make it difficult for people to access affordable health care. It is hoped that this information will be used by policy makers to refine and improve the state's bold new initiative.

THE BURDEN OF HEALTHCARE EXPENSES

Health reform in Massachusetts occurred in the context of a growing national awareness of the prevalence and consequences of unaffordable medical bills for millions of Americans. A 2005 Commonwealth Fund report estimated that 1 in 5 adults under the age of 65 had medical debt or medical bills being paid off over time; among these people, almost two-thirds (62%) were insured when they sought the care that resulted in medical debt.[2] Medical debt creates major barriers to accessing care for both the insured and uninsured: 28 percent of the privately insured with medical bill problems postponed care and 30 percent skipped a test or treatment due to cost, figures similar to those for people without insurance.[3] Other studies have shown that medical debt and medical bill problems create serious long term financial problems, such as housing problems, exhaustion of savings to pay for care, or inability to obtain credit.

Prior to health reform, some assumed that because of Massachusetts' robust safety net system, medical debt was not a significant problem in the state. However, a study sponsored by the Blue Cross Blue Shield of Massachusetts Foundation in the fall of 2006, before healthcare reform was implemented, found that rates of medical debt in the state mirrored national averages: 21 percent of Massachusetts residents under the age of 65 had medical bills they were paying off over time. Of these, 54 percent had health insurance.[4] These data clearly showed that prior to reform, unaffordable healthcare expenses were a problem for significant portions of Massachusetts residents and that health insurance did not always provide financial protection when people got sick.

THE IMPACT OF HEALTH REFORM

Health reform has had a major impact on residents in the state. As of April 2008, 355,000 previously uninsured people had gained coverage (177, 000 in Commonwealth Care; 55,000 in MassHealth; and 123,000 in private coverage).[5] A 2008 Urban Institute report that compared the Massachusetts healthcare landscape between the fall of 2006 and the fall of 2007, before and during implementation of health reform, found that that the uninsured rate among low income adults (incomes under 300 percent of poverty) fell from 13 percent to 7 percent in this time period. It also found that, among this population, the percent paying off medical bills over time fell from 27 percent to 23 percent.

However, while health reform has resulted in significant gains, the report showed that medical debt is not a thing of the past in Massachusetts. The Urban Institute found that almost one in five state residents (18%) were paying off medical bills in the fall of 2007.[6] Also, despite important progress, health access problems remained. While the Urban Institute reported that the percentage of people forgoing care because of cost dropped from 17 to 11 percent, this still represents more than one in ten adults ages 18 to 64 (11%) who did not get needed care in the past year because of cost.

THE IMPLEMENTATION OF CHAPTER 58

Implementation of the Massachusetts Health Reform law, Chapter 58, required major changes in the Massachusetts safety net and in rules and regulations affecting both private health insurance and public programs. To achieve its goal of near universal coverage, the state created subsidized health plans to help lower-income residents obtain insurance. A newly created Connector Authority established rules regarding income eligibility for these health plans and their cost sharing and benefit packages. The Connector Authority also set minimum standards for coverage that qualified as insurance under the individual mandate, and set standards for determining who qualifies for an exemption from the insurance mandate because of lack of affordable health insurance.

Other state agencies have also had to adjust their regulations to support the new requirements. For example, prior to reform, the state's Uncompensated Care Pool reimbursed hospitals and community health centers for a portion of the uncompensated care they provided. Under reform, the expectation was that use of the Uncompensated Care Pool would decline as insurance rates rose, and that the money in the Pool could be shifted to provide subsidies for insurance coverage. The Uncompensated Care Pool was replaced by the Health Safety Net on October 1, 2007, after the Division of Health Care Finance and Policy established new rules regarding eligibility, coverage, and payment.

All of these rules and regulations were new and without real precedent. For example, the Connector Authority and state agencies applied various frameworks to determine how much residents at varying levels of income could afford to pay for health care, but these determinations were of necessity best guesses that need to be tried out, monitored, and refined.

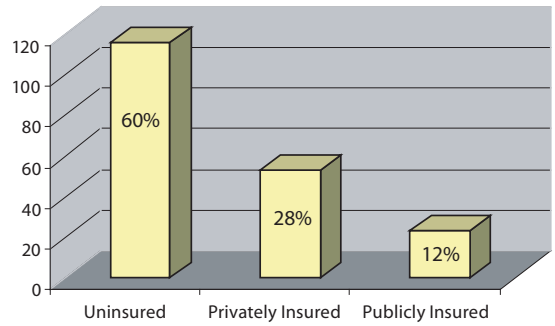
THE MEDICAL DEBT RESOLUTION PROGRAM

In September of 2006, prior to implementation of Chapter 58, TAP created the Medical Debt Resolution Program. The program had two objectives. The first was to help people with medical debt resolve their unaffordable medical bills. The second was to monitor the impact of Chapter 58 on people's ability to afford and access health care.

The program began serving clients in September of 2006 and has continued in operation through 2008, thus spanning the period in which the state's health reform law was implemented. Between September 2006 and April 2008, the program served 187 people. To help people resolve their medical debt, TAP staff provided individuals with information on how to appeal insurance claims, coached them on negotiating with medical providers to reduce their bills to manageable levels and, when appropriate, referred people for legal assistance or help applying for public programs.

Three in five (59%) people who sought help through this program were uninsured when they incurred debt. Before Chapter 58, there were few coverage options for them. The uninsured had to rely solely on coverage through the state's Uncompensated Care Pool, which was a pale substitute for real insurance; those covered by the Uncompensated Care Pool continued to lack a medical home, so they still sought care in hospital emergency rooms. While the Uncompensated Care Pool covered acute care hospital bills, patients were still often left with costly doctor, ambulance, and laboratory bills that sometimes ended up on their credit reports. Thus many of the program's clients avoided, delayed, or discontinued necessary care.

Fig.1
Insurance Status of Program Clients at Time of Incurring Debt*

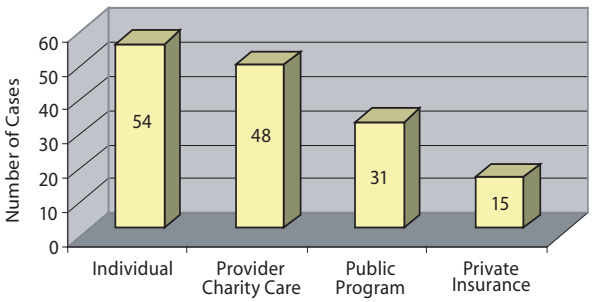


*Among those who reported their insurance status at the time of incurring medical debt.

The changes that resulted from Chapter 58 helped relieve these debt problems for many of the program's clients. Almost all of the uninsured people who sought TAP's help with their medical debt now have insurance coverage, most of them through Commonwealth Care or MassHealth, the state's Medicaid program. The increase in insurance coverage helped many of them—particularly those with low incomes—avoid medical debt and improve access to care.

The people who contacted TAP for help had an aggregate medical debt of over $2 million. The program helped more than half of these people resolve more than $1 million in medical bills. The bulk of this amount, $926,000, was paid by private insurers and public programs, or by providers in the form of discounts or charity care. Individuals paid $103,000 in renegotiated payment plans or lump sum payments. Most of the other cases are in process and many should be resolved in the future.

Fig. 2
Who Paid Medical Debt Among Clients Who Resolved Medical Debt



*More than one payer per case possible.

MONITORING CHAPTER 58 THROUGH THE MEDICAL DEBT RESOLUTION PROGRAM

The creation of new public programs and private insurance products under Chapter 58 with a bevy of new rules has produced some unanticipated concerns and gaps in coverage. The experiences of Medical Debt Resolution Program clients suggest that some of the new regulations make it more difficult for people to resolve their medical bill problems. For example, rules related to retroactive coverage under Commonwealth Care eliminated coverage that previously would have been provided under the Uncompensated Care Pool. Likewise, transitions between public programs or private insurance plans were not seamless for many who found themselves unexpectedly uninsured. Many others had trouble enrolling in programs for which they were eligible. Also, some people continued to experience problems due to inadequate private insurance coverage. When people fell into these gaps, medical debt and healthcare access problems were often the result.

Working with clients allowed TAP to learn more about the effect of the insurance mandate and these newly created rules and regulation. By focusing on those with medical debt, TAP hoped to identify issues such as coverage gaps, program regulations, and program design that caused people to accrue debt and possibly to delay seeking needed care. Although the program's client population was clearly not representative of the entire population of people in the state with medical debt, clear patterns of problems emerged.

METHODOLOGY

Medical Debt Resolution Program clients came from all parts of the Commonwealth, from Yarmouth Port to Pittsfield. Most clients resided in the Boston metro area, but 20 or more came from each part of the state (Western, North Central, and Southern). The vast majority were adults between the ages of 19 and 64, although a few were older adults on Medicare, as well as a few families who incurred medical debt because of healthcare services received by their children. The program accepted people who had debt from any kind of medical provider (hospital, doctor, dentist, ambulance company, lab, etc.), regardless of their income level or insurance status.

To recruit clients, TAP established partnerships with Health Care for All (HCFA) and Health Law Advocates (HLA). These groups referred medical debt cases to the Medical Debt Resolution Program, which in turn referred people who needed assistance applying for public programs to HCFA and those with legal problems to HLA. Since the program's inception, TAP has expanded its network, receiving referrals from additional organizations, most notably Community Partners and the Greater Boston Interfaith Organization. Other clients learned about the program through word of mouth, press coverage, or internet searches.

TAP collected standardized information from all clients, including contact and demographic information, income and family size, insurance status, the reasons they sought care, and any consequences they experienced as a result of the debt. TAP did not begin collecting information about the race and ethnicity of clients until mid-2007. Among those whose race and ethnicity were known, slightly more than half were white, with the remaining clients comprised of a mixture of African-Americans, Latinos, Asians, and those of mixed race.

The vast majority of the people referred through HLA, HCFA, and Community Partners had already received assistance in enrolling in public health coverage programs. Individuals who came to TAP through other sources were more likely to be uninsured. Clients were largely self-selected; most contacted TAP or its referral partners on their own initiative. In addition, a number of people who contacted the program did not respond to follow-up phone calls, emails, or letters, so those who continued to work with the program were perhaps better able to advocate on their own behalf to resolve their medical bills than others with medical debt.

FINDINGS

The sections below describe some of the key problems issues experienced by clients of the Medical Debt Resolution Program. Some issues reflected the situation prior to the implementation of health reform, while others resulted from the changes resulting from the implementation.

AFFORDABILITY AND ACCESS ISSUES

A key issue for the Connector Authority in implementing the insurance mandate was determining how much money people could actually afford to pay for coverage and care, which includes health insurance premiums and out-of-pocket costs such as deductibles, co-payments, and co-insurance.

The Medical Debt Resolution Program showed that for many, even relatively small medical bills could result in debts that people were unable to pay. The median amount of money owed by clients of the Medical Debt Resolution Program was $3,000. Almost one-fifth of the clients owed $1,000 or less, and one in ten owed less than $600. Not surprisingly, most people seeking help had low incomes. About one in five had no income (a few of these were non-working students living off of student loans). Almost two-thirds earned less than 200 percent of the Federal Poverty Level (FPL) and more than 80 percent earned less than 300 percent of the FPL. While some clients accrued debt because of catastrophic medical events, most accumulated debt as a result of treatment for routine illnesses or because they had chronic illnesses that necessitated ongoing care.

Fig. 4
Income Level of Program Participants

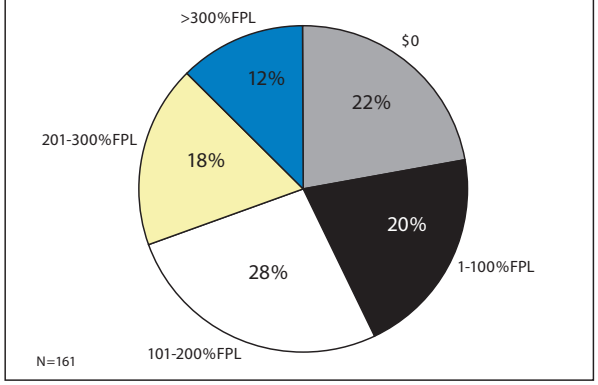
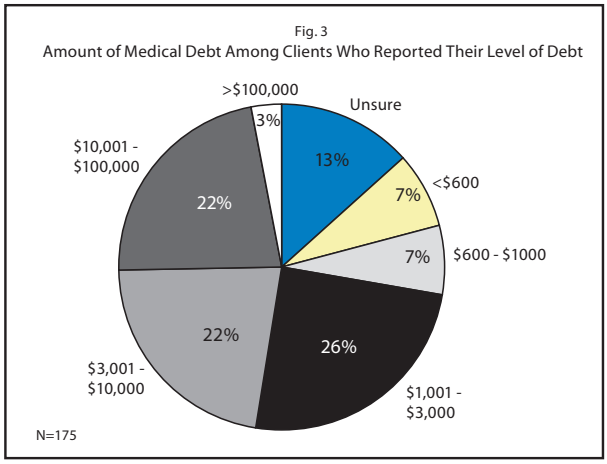


Fig. 3
Amount of Medical Debt Among Clients Who Reported Their Level of Debt



Many clients said they had delayed or foregone needed care because of their debt, out of fear that they would incur additional unaffordable bills. In addition, most people experienced great stress and anxiety because of their debt; they were anxious to pay off their bills and comply with the new law but simply didn't have the resources to do so. For many, the burden of paying off existing bills also made it difficult for them to afford health insurance premiums or pay the required co-payments when they needed care.

Commonwealth Care allows premium-paying members to file a premium hardship waiver under circumstances of extreme financial hardship that meet certain limited criteria. These criteria include, for instance, eviction, homelessness, shut-off of an essential utility, and un-reimbursed medical expenses incurred while on Commonwealth Care that exceed 7.5 percent of family income. Medical bills incurred prior to enrollment in Commonwealth Care do not count towards fulfilling these criteria. Despite this significant limitation, the premium hardship waiver is a key provision that has helped some enrollees maintain their subsidized coverage in tough times. People who have private insurance through an employer or Commonwealth Choice have no such remedy, however. A number of TAP's clients did not purchase or lost their insurance coverage due to financial strains that made them unable to afford insurance premiums.

YVONNE is a 48-year old woman who could not afford the $91 per month premium contribution for her employer-sponsored health insurance plan. Although her income was less than 300 percent of the poverty level, she was categorically ineligible for Commonwealth Care because her employer paid more than one third of the insurance premium. Yvonne successfully applied to the Connector Authority for an affordability waiver from the individual mandate, in order to avoid the tax penalty. Although she had partial Health Safety Net coverage, the $1000 annual deductible made it difficult to access care. Yvonne's choices were to pay for on-going care or continue monthly payments for a $150 hospital bill for services received in September 2007. Yvonne ultimately chose to pay her past bill so it wouldn't go to collections. She also put off needed care, postponing treatment for a cavity despite her struggles with periodontal disease and canceling an appointment for a mammogram.

A few clients in the Medical Debt Resolution Program have enrolled in Connector-approved non-subsidized plans, called Commonwealth Choice plans. Some had incomes that exceeded eligibility levels for Commonwealth Care plans, while others were categorically ineligible for Commonwealth Care, such as those who had student health insurance. The Commonwealth Choice plans are available at three tiers of coverage—Gold plans have higher premiums with lower levels of cost sharing, while Bronze plans have lower premiums with higher levels of cost sharing. (Silver plan coverage falls between these two tiers.) The clients who bought these plans expressed frustration with their options. Two families that bought Bronze plans said that although the premiums were more affordable, the cost sharing was a barrier to care. Another client borrowed money to pay the premiums for a Bronze plan. The program's clients who purchased Gold plans said it was very difficult to afford the premiums, especially on a sustained basis.

JOHN AND JUDY are in their 60s but not yet eligible for Medicare. After their retirement, they became uninsured. They knew they needed good coverage because Judy was recovering from breast cancer and chemotherapy treatments. They thus purchased a Commonwealth Choice Gold family plan with premiums at $1,400 per month, which consumed nearly half of their $3,000 monthly income.

DEBBIE suffers from a chronic seizure disorder, which landed her in the Emergency Room multiple times over a three-year period. She paid over $12,000 in medical bills in cash and with her credit card, but still owed another $23,000. She was on monthly payment plans at more than ten providers. Debbie was eligible for partial free care under the state's Uncompensated Care Pool, which helped cover a small portion of her hospital bills. In August of 2007 she purchased a non-subsidized Commonwealth Choice plan, which cost $212 per month. To afford the first month's premium, she borrowed money from her mother. Even with help, however, Debbie overdrew her checking account as a result of the additional monthly expense. Debbie told TAP, "Of course I have delayed seeking medical care, either hospital or doctor visits, because of my medical debt and lack of insurance coverage. The reason is simple: I can't afford to get myself in any more debt."

MONA was uninsured when she had to visit a hospital emergency room several times in 2006 and 2007 because of heart troubles. When Commonwealth Care became available, she enrolled in a subsidized plan with a premium of $37 per month. However, Mona was still coping with medical debt for bills from the hospital, doctors, and an ambulance company that were related to her emergency room visits. The cost of premiums plus co-payments for on-going treatment left no money to pay her past debt. Some of the bills went to collections and landed on her credit report. Mona needs heart surgery very soon, but she is worried that things will only get worse after her premiums and co-payments increase in July, 2008.

In March of 2008, the state set new premiums and co-payments for Commonwealth Care plans, and increased the premiums and reduced some of the benefits in the Commonwealth Choice plans. These changes went into effect in July of 2008. It is too early to tell the impact of these changes, but it will be important to track whether they reduce people's access to care, result in medical debt, or force people to drop coverage altogether.

COMMUNICATION AND COORDINATION ISSUES

Chapter 58 created a number of new programs that operate alongside previously existing public programs. MassHealth continues to provide coverage to categorically eligible low-income people. Others may be eligible for subsidized health insurance plans or required to buy non-subsidized but approved plans. Still others may be required to purchase plans offered through their employment. In addition to or in place of insurance, state residents may also be able to get free or discounted care through the Health Safety Net. This program covers hospital and community health center bills for some people who don't have insurance and provides assistance to some with inadequate insurance. While all of these programs are necessary and valuable, many clients in the Medical Debt Resolution program found it difficult to navigate through this complex system. The result was that people were often left with bills that one of these programs could have covered.

Some problems stemmed from the fact that people apply to MassHealth and to the Health Safety Net using the same form—the Medical Benefit Request (MBR). Some clients did not apply for the Health Safety Net because they thought they were being asked to apply for MassHealth and knew that they weren't eligible; they thus failed to apply for anything. Others were confused about which of the programs they had qualified for, what services were covered, and what the cost sharing would be.

CORINNE had a high-deductible Health Savings Account plan through her employer with a $5,000 deductible and 50 percent co-insurance. A series of routine medical visits for a family member and her own emergency surgery resulted in almost $8,000 in hospital and doctors' bills. Staff in the hospital's billing department told her that she needed to apply to MassHealth in order to receive financial assistance. However, knowing that she was ineligible for the program, Corinne did not apply. Hospital staff did not explain to her that she needed to receive a rejection from MassHealth before she could qualify for the hospital-based financial assistance program. When TAP staff clarified this policy, Corinne immediately applied for public programs. However, by then it was too late; the period for which these programs provided retroactive coverage had been exceeded. After rejection from the public programs, she was finally able to apply for financial assistance from the hospital.

JANE, who applied for the state's subsidized health plan, received a letter telling her she had qualified for both Commonwealth Care and the Health Safety Net. The letter told her that if she received care under the Health Safety Net, she would have to pay a $1,900 deductible. Thinking this deductible applied to her health plan, she did not see a doctor because she thought she would have to pay the deductible first, which she could not afford.

INSURANCE PROBLEMS

While Chapter 58 greatly expanded the number of people with health insurance in the state, it is important to recognize that insurance by itself does not always guarantee access to care and protect people financially when they get sick. In fact, 40 percent of clients in the Medical Debt Resolution program were insured when they incurred debt, including 28 percent who had private coverage.

Many of those with private insurance coverage incurred debt due to the cost sharing built into their plans (deductibles, co-payments, and co-insurance). Uncovered services were also a problem for many, especially when added to other out-of-pocket expenses. The cumulative cost of co-payments, premiums, and past debt caused many individuals, especially those with lower incomes, to face difficult choices; they had to decide whether to maintain insurance coverage, pay off past debt, or get needed care that required unaffordable co-payments. Coping with both past debt and ongoing co-payments was a problem for a number of newly insured clients, even those who were eligible for fully subsidized Commonwealth Care plans.

NANCY is a middle-aged woman who enrolled in the state's subsidized health plan, and is now very glad to have health insurance without a monthly premium. However, she has still finds it difficult to keep up with the co-payments for her frequent doctors' visits. Nancy borrows money from her children to cover those costs. She also had a past ambulance bill from when she was uninsured (the Uncompensated Care Pool did not pay for ambulance bills). Unable to afford the $1,000 bill, even after a 50 percent discount, it ended up in collections and hurt her credit.

Other clients in the Medical Debt Resolution Program suffered improper denial of claims from their insurers. Many states, including Massachusetts, have an external review program that adjudicates claims for people who think they have been unfairly denied coverage by their insurers. The Office of Patient Protection provides this service in Massachusetts. The Office of Patient Protection provided relief to a number of clients whose insurers improperly denied a claim, which saved thousands of dollars in some cases. However, very few people were aware of their right to external review.

AMY underwent surgery to remove a cyst on her vocal cords. Although she had insurance through her university, this medical care left her with over $10,000 in medical debt. Citing a $2,000 annual cap on "outpatient miscellaneous expenses," the insurance company denied coverage for the $10,000 hospital bill. Amy filed two internal appeals, but the insurance company denied both of them. A year after receiving care, she still had not received the official claims denial paperwork and the hospital sent the bills to collections. Upon advice from TAP, Amy appealed the denial to the Office of Patient Protection, which adjudicated the claim in her favor. The insurance company finally paid $8,000 of the claim and the hospital wrote off the remainder.

Unfortunately, the Office of Patient Protection can only take cases where the insurer is subject to state laws. Employers that self-insure are exempt from state insurance regulation by a federal law called the Employee Retirement Income Security Act (ERISA). A number of clients in the Medical Debt Resolution Program worked for employers who were self-insured. They would have benefited from external review, but the Office of Patient Protection was not allowed to review their cases.

An important achievement of health reform was establishing Minimum Creditable Coverage (MCC) standards for private health insurance. The Connector Authority set these standards to ensure that the individual mandate would not force people to buy inadequate insurance that left them vulnerable when they got sick. The MCC standards take effect on January 1, 2009, so they have yet to be implemented or tested. It remains to be seen how well MCC standards ensure that everyone has access to adequate coverage through their employers and on the individual market.

Some insured clients had insurance through their employment that will not meet MCC. These clients were particularly at risk of facing unaffordable out-of-pocket costs.

ERIC has a chronic illness; the costs of treatment exceeded the $4,000 annual cap on out-patient services under his employer-sponsored insurance. He was eligible for partial free care under the state's Uncompensated Care Pool, which was very helpful in covering his expenses. Still, he had to pay $560 on his bills and owed more than $800 to an ambulance company. With an income just over $20,000 per year, Eric was not eligible for the state's subsidized insurance plan and was required by the state insurance mandate to purchase his employer-sponsored insurance. The cost of his daily medications, $22 per week for insurance premiums, and accumulated debt drained his savings. Eric now lives precariously on the edge of financial insolvency.

It is interesting to note that among Medical Debt Resolution Program clients who were uninsured when they accrued medical debt, a quarter thought they had insurance coverage (either public or private) at the time they sought medical care and were unaware that their insurance had been terminated, or they were in a waiting period to receive coverage through an employer or the state.

CHRISTIN had a new job with a six-month waiting period before she could get coverage under her employer's health insurance plan. Less than one month before the waiting period would have ended, she experienced severe abdominal pain from kidney stones. The treatment left her with $6,500 in hospital bills. Although she earned more than $50,000 per year, because of student loan obligations and the need to provide financial support for her disabled mother, she could not afford the $200 per month payment plan which the hospital offered her, even though it included a 25 percent discount in the overall bill.

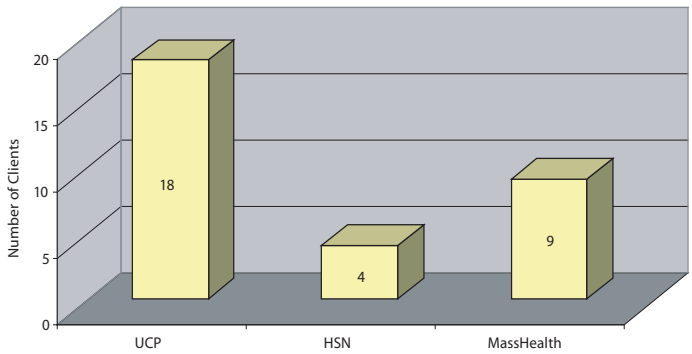
A special category of insurance problems relates to college students who obtain insurance through their schools. For information, see "University Students and the Health Insurance Mandate" later in this report.

THE SAFETY NET

While Chapter 58 was designed to achieve universal health insurance coverage, there was recognition that not everyone would obtain coverage and that some people would still require safety net programs to provide additional support. The main components of the state's safety net system are the Health Safety Net (formerly the Uncompensated Care Pool) and hospital charity care.

These programs proved invaluable for many Medical Debt Resolution Program clients. Thirty-one clients received help from the Health Safety Net, Uncompensated Care Pool, or MassHealth to pay their bills, and forty-eight clients received charity care, either through formal hospital-based charity care programs or through discounts offered by hospitals and other healthcare providers. However, a number of clients had difficulty learning about these programs or found that they were not eligible.

Fig. 5
Public Programs That Paid Past Medical Bills*



*Among clients for whom public programs paid past medical bills.

Uncompensated Care Pool:

Prior to the implementation of Chapter 58, the Uncompensated Care Pool was a crucial component of the state's healthcare safety net. The Uncompensated Care Pool reimbursed hospitals and community health centers for a portion of the uncompensated care that they provided to patients who met certain eligibility requirements. Many consumers who contacted the Medical Debt Resolution Program were able to resolve their bills because of eligibility for this program. However, many were not screened by their providers; instead they only learned about it through TAP or its partners. This was especially true of clients who had health insurance but were still eligible for the Uncompensated Care Pool.

One crucial feature of the Uncompensated Care Pool was that it covered bills for up to six months prior to the time that people applied for coverage. As many of the Medical Debt Resolution Program clients were unaware of the Uncompensated Care Pool until months after they received care, they were only able to receive coverage for their bills because of this six-month retroactive window. For some clients even the six-month window was not sufficient, such as those experiencing delays in payment resulting from slow claims processing by insurance companies or public programs. Even though, for patients deemed eligible for the Uncompensated Care Pool, hospitals were prohibited from attempting to collect on bills accrued before eligibility was established, many of TAP's clients still faced collection actions on these bills.

ANNIE is an AmeriCorps fellow who earned $13,000 per year. Although she was insured through the program, her plan only paid for $150 of a $1,400 bill she incurred after seeking preventive care at a hospital in 2005. Given Annie's income level, she should have been eligible for the Uncompensated Care Pool, which would have covered the remainder of the bill. However, she didn't receive a bill in the mail until eight months after receiving services, well beyond the Uncompensated Care Pool's six-month period of retroactive coverage. Two years later, she has still been unable to pay the outstanding bill.

One problem related to the Uncompensated Care Pool was that the program still left many costs uncovered, such as those from ambulance companies or doctors who were not hospital employees. Consumers were often confused by the numerous bills they received after getting hospital care, for example from physicians, laboratories, and ambulance companies. People were often unclear about which services were and weren't covered by the Uncompensated Care Pool and, if they lacked the resources to pay all the bills, were forced to create separate payment plans with each provider.

DON is a self-employed automobile mechanic who severed his thumb repairing a car. He went to his local hospital but sat in the waiting room for a couple of hours until the doctors decided to transfer him by ambulance to another hospital, but by then it was too late to save his thumb. Don ended up with more than $3,000 in medical bills. The Uncompensated Care Pool paid his hospital bills, but he was left with more than $1,000 in bills to multiple doctors and the ambulance company. After negotiating with his providers for discounts, Don arranged payment plans to deal with the remainder. Unable to work after the accident, his income plummeted from $20,000 a year to zero. As a result, he began living off of his savings and had to sell his home.

Health Safety Net:

Under health reform, the Uncompensated Care Pool was replaced by the Health Safety Net. On October 1, 2007, the Division of Health Care Finance and Policy implemented new regulations surrounding use of the Health Safety Net. Certain people who were eligible for coverage under the Uncompensated Care Pool are not eligible for the new program, for example, people who have lost their coverage under state-subsidized plans because of their inability to maintain payment of premiums, or those who turned down employer-sponsored coverage that met state-mandated affordability criteria. It will be important going forward to track how the new regulations affect people who fall into these categories.

Certain problems have remained unchanged–for example, the Health Safety Net still does not cover all bills, such as those for ambulances or physicians not employed by the hospital, and consumers still receive multiple bills from multiple providers when they get care at a single point of service. Based on TAP's experiences with clients, hospitals seem to be doing a better job of screening people for coverage under the Health Safety Net than was the case under the Uncompensated Care Pool. However some clients were still unaware of their eligibility for the program when they sought help from the Medical Debt Resolution Program.

Some changes in the Health Safety Net rules have caused particular problems for many Medical Debt Resolution Program clients, especially the rules regarding the period of retroactive coverage. Under the new system, people who are only eligible for non-comprehensive MassHealth programs, such as MassHealth Limited or the Children's Medical Security Plan, or who have private insurance and need secondary coverage, still qualify for six months of retroactive payment under the Health Safety Net. However, people who are eligible for a subsidized health plan or for comprehensive MassHealth coverage only qualify for ten days of retroactive coverage. In addition, they only qualify for 90 days of prospective coverage under the Health Safety Net because there is an expectation that they will enroll in a health plan during this time. While the same rules apply as under the Uncompensated Care Pool regarding prohibition on collection of bills accrued prior to the establishment of safety-net eligibility, many clients still faced collection efforts.

Since the new Health Safety Net rules took effect, 19 clients of the Medical Debt Resolution Program have ended up with hospital debt because they were not able—or did not know—to apply for the Health Safety Net within 10 days of receiving care. Almost all of these people had hospital bills that would have been partially or completely covered by the Uncompensated Care Pool under the old regulations. Most of these cases remain unresolved, although a handful of people have received financial assistance from providers. TAP has worked with only two people who were able to establish Health Safety Net eligibility quickly enough for the ten-day retroactive period to cover their hospital bills.

JEAN was unemployed and uninsured after being laid off from her finance administration job. She delayed seeking care for an injured wrist until the pain became unbearable and she had to go to the Emergency Room of a local hospital. The staff at the front-desk handed her a blurry print-out of a form to apply for MassHealth and the Health Safety Net, but it was illegible. Jean went home and waited until she received a bill before contacting the hospital about financial assistance options. Since more than 10 days had passed since she had received treatment, Jean was no longer eligible for Health Safety Net retroactive coverage.

The new retroactive rules have also prompted confusion among both patients and providers, which was exacerbated by a problem in the state computer tracking system for applying to the program. The system did not show the original date of application, which was important because the retroactive period is based on this date. However, the state has now begun using a new computer system that allows providers and enrollment workers to track the date of application.

Medical Hardship Program:

The state also made major revisions to the regulations surrounding the medical hardship component of the Health Safety Net. The Medical Hardship program helps cover expenses when unpaid medical bills from any source comprise more than a certain percentage of a family's income.

The new rules expanded coverage in various ways. They eliminated an asset test, so eligibility is now based solely on the percentage of income taken up by unpaid medical bills. They also allow both paid and unpaid bills to count as expenses in determining people's eligibility for the program. (Previously, only unpaid bills were counted.) In addition, while the Uncompensated Care Pool required families at any income level to have unpaid bills equal to at least 30 percent of the families' income, the new rules prorate the percentage depending on income. Finally, the new rules allow people to apply for medical hardship twice within a 12-month period, rather than only once. There is no income limit for the program.

The Medical Hardship Program is a valuable part of the Massachusetts safety net as it can cover medical debt not otherwise covered by the Health Safety Net, because of income ineligibility or the time limit on covering past bills. However, initially the only medical bills that qualified for payment were unpaid bills incurred during the year before the person's date of application. Thus, older bills or those that people had already paid with their savings or put on a credit card could not be reimbursed. (As explained previously, this rule has now been changed.)

In addition, the Medical Hardship Program only reimburses for care provided at acute care hospitals or community health centers. Ambulance and doctors' bills remain uncovered, although they do count towards meeting an applicant's hardship contribution. Some Medical Debt Resolution clients accrued debt because of these types of bills. Others, especially clients with low-incomes, were unable to afford the percentage of income that constituted their hardship contribution.

This is not surprising given the findings from an Urban Institute report from 2003 that nearly three-quarters of people earning 200 percent of the FPL or less experienced food, housing, or health care hardship during the past year.[7] While the Commonwealth Care program does not require any premium contribution for individuals earning 150 percent of the FPL or less, the Medical Hardship program requires individuals earning less than 200 percent of the FPL to pay 10 percent of their income as a hardship contribution.

Implementation of the program was slow: it took five months for the Division of Health Care Finance and Policy to render a decision on a Medical Hardship application submitted by a TAP client around the time the program was initiated. Having to wait so long for a decision can be a serious financial hardship, as unpaid medical bills are likely to be sent to collections.

THE JONESES

applied for the Medical Hardship Program to cover thousands of dollars in medical debt. While the couple waited for a decision, they received a letter from an ambulance company threatening to send their bill to collections. The family didn't want the bill to damage their credit, but they also couldn't pay the bill because it would no longer qualify under the Hardship Program. Upon advice from TAP staff, the family called the ambulance company to request that the bill be put on hold. The company complied with their request and even offered a settlement discount after the family finally received coverage through the Medical Hardship Program, five months after their date of application.

Finally, application for the program must be initiated by a hospital or health center. TAP advised two families to apply for the Medical Hardship program and, in both cases, the client had to inform the hospital or health center administrators about their eligibility for the program. In one case, a hospital administrator was not aware that higher income people could be eligible for the program, so she did not inform the client about this option.

The revamped Medical Hardship Program has assumed great importance as a safety net for people who incur substantial medical bills. Even universal insurance coverage would not protect all people from the health access and financial consequences of catastrophic illness or injury. As long as co-insurance, deductibles, payment caps, and other forms of cost-sharing remain an integral part of insurance policies, people will remain vulnerable to unaffordable medical expenses if they need expensive medical procedures or frequent testing and treatment. Also, the limited period of retroactive coverage under the Health Safety Net has already forced some clients to rely on the Medical Hardship Program as their last resort. Continued monitoring of the program will be important, especially to ensure that both healthcare administrators and patients are aware of its existence and eligibility requirements.

Charity Care:

Although the Health Safety Net sets certain standards for the provision of free or discounted hospital care, hospitals and other providers can create charity care or financial assistance policies that exceed these standards. While all hospitals should provide charity care to patients in need, this is especially true for non-profit hospitals, which have an obligation to provide community benefits that are commensurate with the tax exemptions that they receive. This includes providing free care to those who cannot afford it or discounting the cost of care for those with limited resources.

Some hospitals do have clear charity care policies filed with the Division of Health Care Finance and Policy that specify the financial assistance they offer beyond what is required under the Health Safety Net (or, previously, the Uncompensated Care Pool). For example, one hospital's 2006 policy states that the hospital:

> offers financial assistance to qualifying patients to assist with certain self-pay obligations for services not covered by third party payors and for co-payments, deductibles, or co-insurance on covered services. Financial assistance is offered to: (1) patients who do not qualify for free care or medical hardship under the Free Care Pool, and (2) patients who qualify for free care or medical hardship under the Free Care Pool but have received services not eligible for Free Care.

However, other hospitals do not include information on financial assistance or charity care programs in the Credit and Collections Policies they are required to file with the state. Of the 14 Massachusetts hospitals whose polices TAP reviewed in the course of providing guidance to clients, only the one quoted above included eligibility criteria for financial assistance above and beyond what was then required under state regulations, although some hospitals did outline their prompt pay discount and payment plan policies. The policies in one hospital system did mention the availability of "financial assistance" beyond what was covered under state regulations, but did not provide concrete guidelines for the program and said that patients requesting financial assistance would be dealt with on a case-by-case basis. The Medical Debt Resolution Program had numerous clients who received care at hospitals in this system, and the clients' experiences reflected this unsystematic, case-by-case method of eligibility determination; some received financial assistance and some did not, and the outcomes did not seem to be based on any specific criteria regarding family finances. Obtaining assistance seemed to depend more on individuals' persistence than on clear financial guidelines.

In fact, many providers—including ambulance companies and private physicians as well as hospitals—were willing to provide discounts, affordable payment plans, or reduced cost care to people who were in need. About half of the clients of the Medical Debt Resolution Program who were able to resolve their medical debt received provider discounts, and more than half received affordable payment arrangements. Some of these payment plans and discounts were even more generous than the terms specified in the hospitals' credit and collections policies. However, it often took some effort to negotiate these arrangements because providers gave inconsistent information about their availability. Front-line billing people often said that their institutions didn't offer charity care, negotiated discounts, or payment plans, while billing department managers were more forthcoming.

MAUREEN, an uninsured resident of New Hampshire, needed emergency surgery and hospitalization while she was in Massachusetts visiting her family. She incurred over $40,000 in medical bills from the hospital and an additional $7,000 for physician services, lab work, and an ambulance ride. Because she was not a Massachusetts resident, she was ineligible for Uncompensated Care Pool coverage. Maureen called the hospital several times to ask about charity care and financial assistance but received different information from different staff members. One told her that the only financial assistance that the hospital offered was through the Uncompensated Care Pool. Another said that the hospital did not have a charity care policy but offered her a 50 percent discount, which Maureen still could not afford. At TAP's suggestion, Maureen wrote to the hospital about her financial situation and included a copy of her 2006 tax return. A few weeks later she received a letter saying that the hospital had written off the entirety of her $40,000 hospital bill.

REPORTING MEDICAL BILLS TO CREDIT BUREAUS

Many medical providers send bills with unpaid balances to collection agencies after a certain amount of time (which varies with the provider). Some collection agencies then report these bills to credit bureaus. When medical bills appear on credit reports, TAP has documented serious consequences – a poor credit rating makes it difficult or impossible for a family to access affordable credit, for example to qualify for affordable mortgages or car loans.

Although it is not always clear in their written credit and collections policies, some hospitals have indicated in discussions with TAP that they do not contract with collection agencies that report bills to credit bureaus. However, a number of Medical Debt Resolution Program clients have had medical bills from Massachusetts providers appear on their credit reports, including bills from acute care hospitals, physicians, dentists, and ambulance companies. In a few of these cases, people should have been eligible for the Uncompensated Care Pool or Health Safety Net at the time they received medical services. In addition, in a few cases a single medical bill incorrectly appeared multiple times on people's credit reports.

CAREY, an uninsured nursery school teacher in her early 20s, required emergency hospitalization that resulted in bills totaling $250,000. No one informed her about the financial assistance options, so she did not apply to the Uncompensated Care Pool or MassHealth until TAP suggested it. The Uncompensated Care Pool covered nearly $240,000 of her hospital bills, but she was left with over $9,000 in doctors' bills. While some providers discounted or wrote off her bills, many more sent them to collections. The unpaid bills damaged her credit rating, leaving her unable to secure a much-needed car loan. The only negative items on her credit report are medical bills.

UNIVERSITY STUDENTS AND THE HEALTH INSURANCE MANDATE

University students in the state, who have been mandated to purchase health insurance coverage since 1989, are categorically ineligible for state-subsidized plans. Instead, if they are not covered under their parents' policies or through an employer, students who are enrolled three-quarters-time or more at institutions of higher learning must purchase health insurance through their schools. These plans, which are called Qualifying Student Health Insurance Plans (QSHIP), are specifically excluded from the minimum creditable coverage requirements that the state has established to determine which insurance policies satisfy the individual insurance mandate. Last year TAP released a report, Not Making the Grade, which documented the major inadequacies of many of these student insurance policies.

In fact, one-fifth of the calls to the Medical Debt Resolution Program from clients with private insurance calls were from students covered under these plans. In cases where the Health Safety Net did not cover bills and providers did not offer charity care, students were left with significant medical debt.

ANDRES was a student when doctors diagnosed him with cancer. He had university-sponsored insurance that left him with tens of thousands of dollars in hospital and doctors' bills. As an insured person, he was eligible for six months of retroactive coverage under the Health Safety Net, which paid $28,000 of his medical bills. Hospital-based physicians wrote off an additional $8,000 in bills. Andres also appealed his insurer's coverage denials, and his insurance ended up covering $9,800 in claims that it had previously denied. Unwilling to seek additional medical care under his QSHIP plan, Andres tried to purchase insurance, but found that as a student he was not eligible for a state subsidized health plan. However, as a student with no income, he could not afford to buy a non-subsidized plan and had to borrow money to pay for a Commonwealth Choice plan.

While QSHIP plans limit annual deductibles to $250 a year, they contain other provisions that leave students at serious risk for medical debt. For example, they allow low annual coverage caps (as low as $50,000 per illness or injury). They also don't prohibit low service caps; some plans have caps as low as $1,500 per year for all out-patient care. A serious medical event can easily result in costs that exceed these caps, leaving students with major medical debt. However, even more routine health care needs have caused debt and access problems for students who have QSHIP plans.

JOHN, an undergraduate university student, tore a ligament playing soccer. His student insurance plan required that he pay 20 percent of cost to surgically repair the ligament, around $2,000. As a student on financial aid at his university, he knew that he could not afford this amount. He thus opted not to get the surgery and instead lives with the injury, which causes him chronic pain.

RECOMMENDATIONS

The goal of the Chapter 58 health reform law was to ensure that all Massachusetts residents have insurance. In spite of the success in covering many Massachusetts residents, significant numbers remain uninsured, including those who have been granted exemptions from the individual mandate because private insurance premiums were deemed unaffordable for them. While Massachusetts strives to achieve universal coverage, a robust safety net must remain in place to assist people who face unaffordable medical expenses, whether they are uninsured or have inadequate insurance coverage.

Based on its experiences helping clients in the Medical Debt Resolution Program, TAP recommends the following:

1. Initiate a public awareness campaign to inform Massachusetts residents and health care providers about the safety net resources available to people struggling with high healthcare costs and medical debt.

As the Massachusetts health insurance environment transitions under Chapter 58, the rules are changing for patients and providers alike. Far too many residents are not well informed of changes to vital safety net programs such as the Health Safety Net. Likewise, in some cases the staff at hospitals and other providers are not adequately informed about the new programs and regulations.

Increasing consumer and provider awareness of public programs is essential to helping people avoid medical debt. We recommend that a public education campaign be initiated to inform uninsured and insured Massachusetts residents that the Health Safety Net may be available to help them pay for outstanding medical bills. Such an effort would complement the current advertising campaign that informs Massachusetts residents about the individual insurance mandate.

We also encourage the state to better integrate the Medical Hardship Program into the overall Health Safety Net. Currently, the application and approval process for the Medical Hardship Program is separate from the general Health Safety Net application process. It appears that many front-line staff at healthcare facilities are uninformed about this program. Given that applications for Medical Hardship must be initiated by providers, we urge the Division of Health Care Finance and Policy to provide more training and support to hospital and health center personnel about screening and application for this program.

Some providers also seem to be unaware of Health Safety Net regulations that limit their ability to pursue payment from patients under certain circumstances. While a patient is covered by the Health Safety Net, providers cannot pursue payment for services covered by this program (excepting co-payments and deductibles) even if the bills were accrued prior to enrollment and the retroactive coverage period. TAP suggests that the Division of Health Care Finance and Policy work to increase providers' awareness of these regulations.

2. **Clarify and publicize information about provider-based charity care and financial assistance programs that are available to help patients with unaffordable medical expenses.**

Health Safety Net regulations establish a minimum standard for financial assistance, but some hospitals have expanded their charity care programs to provide assistance beyond this minimum. We encourage all hospitals and other providers to clarify their financial assistance policies beyond what is required under the Health Safety Net, and to include the eligibility criteria for these programs in the credit and collections policies they are required to file with the Division of Health Care Finance and Policy. We also urge hospitals and other providers to conduct public outreach and education to inform patients and other community members about their financial assistance programs.

3. **Extend the retroactive coverage period under the Health Safety Net for uninsured people who are eligible for state-subsidized insurance plans to at least six months.**

Under the new Health Safety Net regulations, uninsured people who qualify for a state subsidized insurance plan are granted 10 days of retroactive coverage for medical expenses incurred at community health centers or acute care hospitals. This brief retroactive coverage window has left many newly insured residents with medical debt that previously would have been covered under the Uncompensated Care Pool. This problem is a cause of particular concern because many previously uninsured enrollees in the subsidized plans will now be responsible for monthly premiums, co-payments, and other cost-sharing in addition to coping with past medical debt.

4. **Protect the financial security of low-income Massachusetts residents who are eligible for Comonwealth Care or the Medical Hardship Program.**

Under current regulations, Commonwealth Care enrollees who experience severe financial hardship can request a premium hardship waiver. Although un-reimbursed medical expenses incurred while enrolled in Commonwealth Care can be grounds for waiving premiums, medical debt incurred prior to enrolling in the program is excluded from consideration. The Connector Board should allow medical debt incurred before enrolling into the program to count towards meeting the criteria for a premium hardship waiver.

The Medical Hardship Program is a crucial safety net for individuals who incur steep medical costs that are left unpaid by insurance or the Health Safety Net. However, current regulations unfairly burden Massachusetts residents earning less than 200 percent of the FPL by requiring that they pay 10 percent of their income in medical expenses. TAP urges the Division of Health Care Finance and Policy to re-examine the hardship contribution for eligible residents who earn 200 percent of the FPL or less.

5. **Monitor the quality of private insurance coverage.**

Given the central role that private insurance plays under Chapter 58, the Commonwealth has a responsibility to ensure that insurance products are affordable and adequate to meet the needs of Massachusetts residents. The minimum creditable coverage standards for private insurance set by the Connector Authority will take effect on January 1, 2009. Until

then, Massachusetts residents who want to comply with the individual mandate may be forced to purchase employer-sponsored coverage that leaves them at risk for medical debt. Many of the insured people who sought assistance from TAP had coverage that will not be allowed under the new standards.

When the minimum creditable coverage standards become applicable to most insurance products in the state, it will be important to monitor whether these standards are in fact adequate to protect policy holders financially if they get sick. TAP strongly encourages the Connector Authority Board and other public agencies to do on-going monitoring of the private insurance market and to hold public hearings on this issue.

6. Increase public awareness about the Office of Patient Protection, which can help adjudicate claims that have been denied by insurance companies.

There is a lack of consumer awareness about the Office of Patient Protection and the services that it provides to residents with health insurance. We urge the Commonwealth to make information about this program more widely available and to clarify the roles and purview of this agency. The Office of Patient Protection could play an important role in monitoring the practices of insurance companies and working to develop policies to mitigate any identified problems.

7. Allow income-eligible college students to qualify for Commonwealth Care insurance products.

A disproportionate number of students covered by QSHIP plans sought help from the Medical Debt Resolution Program. This suggests that many of these plans are extremely inadequate. We urge the state to require that QSHIP plans adhere to minimum creditable coverage standards. Also, students who are Massachusetts residents and eligible for MassHealth are allowed to enroll in that program. Students who are otherwise eligible for state-subsidized insurance plans should be allowed to obtain coverage under these plans as well.

8. Prohibit Massachusetts healthcare providers and collections agencies from reporting medical debt to credit bureaus.

Medical debt is different than other forms of consumer debt because it is involuntary and unanticipated. One of the major credit scoring companies, Fair Isaac and Company (FICO), describes medical debt as “atypical and non-predictive” of overall credit worthiness. [8]

Very few medical providers report unpaid medical bills directly to the credit bureaus. However, many healthcare providers outsource or sell their accounts receivable to attorneys or collection agencies that routinely report these accounts to the credit bureaus. Medical bills are thus appearing on Massachusetts residents’ credit reports and contributing to family economic insecurity.

We urge Massachusetts healthcare providers to prohibit any collection agency working on their behalf from reporting medical bills to credit bureaus.

9. Conduct ongoing monitoring of the financial burden of health care costs and medical debt on Massachusetts residents.

As the state moves forward in its implementation of health reform, it is balancing its available resources against the costs it is asking residents to bear. It is important to conduct ongoing monitoring to track the impact of the cost of insurance premiums and other out-of-pocket healthcare costs on policy holders, including those in both the subsidized and unsubsidized plans. Statewide polling can provide some information relevant to this topic, such as the percent of the state population with medical debt or who have foregone care because of cost. The number of residents applying for waivers from the individual mandate and the number who drop coverage because of inability to afford premiums or uncompleted paperwork can serve as other indicators of financial distress. Outreach and enrollment workers, as well as programs such as the Medical Debt Resolution Program, can also provide invaluable information that will help the Connector Authority and the state refine the public and private coverage options available under Chapter 58.

10. Build and support outreach capacity among providers and advocacy groups to help Massachusetts residents enroll in public programs and better navigate the health system.

The drive towards universal insurance coverage depends on broad-based public awareness about and support for the health reform effort. Great strides were made in the first year and a half of implementation of Chapter 58, yet gaps in public understanding still remain. The 2008 Urban Institute report found that nearly one-third (32%) of uninsured people were "unaware of the individual mandate" in the fall of 2007.[9] Beyond simple awareness about health reform, navigating the array of interlocking new and old rules and programs is a daunting task for most. Eligibility re-determination and re-enrollment into public programs will be on-going processes even if universal coverage is achieved.

However, outreach work that begins and ends with enrollment is not sufficient. TAP's Medical Debt Resolution program clearly showed that with guidance and support, people were much more successful in getting insured, maintaining coverage, resolving past debt, and accessing needed care. As clients became better informed, they were able to ask more targeted questions that facilitated more effective communication with the staff of medical providers and state agencies. More informed and pro-active consumers were better equipped to handle the problems that they encountered. Without such guidance, loss-to-care is common. Monetary support for organizations doing outreach, enrollment, and systems navigation are essential to ensure the success of Chapter 58.

CONCLUSION

By many standards Chapter 58 has been a great success: 355,000 individuals are newly insured through state-subsidized health plans, MassHealth, or private insurance coverage. The 2006 health reform law has been very successful in enrolling people into insurance, yet there is still more work to do to ensure that everyone in Massachusetts has adequate and affordable coverage. Medical debt and access problems have not been eliminated in Massachusetts. Implementation of new programs with complicated rules and regulations that overlap with existing programs has created confusion and coverage gaps. Private insurance has also been inadequate to protect some people from access and medical bill problems.

Medical Debt Resolution Program clients are already shouldering a significant burden of medical debt in addition to insurance premiums and on-going out-of-pocket costs. While the findings in this report are based on their particular experiences, we believe they suggest patterns and provide information that can help policy makers refine and improve implementation of the legislation.

Ongoing monitoring of Chapter 58 reform efforts will be crucial to identifying remaining coverage gaps and crafting policy and regulatory solutions that benefit everyone in the Commonwealth. Greater coordination by stakeholders, including information sharing between providers, insurers, and state agencies, will be crucial to monitoring the progress of reform and maintaining a sense of shared responsibility across stakeholders. Policy makers must also consider some targeted regulatory and legislative action to minimize the gaps that create medical debt and guarantee access to care.

NOTES

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[7] Long, Sharon K., "Hardship among the uninsured: choosing between food, housing, and health insurance," *The Urban Institute*, Series B, No. B-54, May 2003.

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[9] Long, *op.cit*.

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The Access Project (TAP) has served as a resource center for local communities working to improve health and healthcare access since 1998. The mission of TAP is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. TAP conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. TAP's fiscal sponsor is Third Sector New England, a nonprofit with more than 40 years of experience in public and community health projects.

This report is also available on The Access Project website.

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