Preventing Medical Debt From Disrupting Health and Financial Health

Recommendations for Insurers

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Introduction

Medical debt is the nation's most common form of debt, impacting more than 1 in 6 adults.[1] Medical bills are the leading cause of bankruptcy in the United States.[2] Unlike other forms of consumer debt, medical debt is often unexpected.[3] The financial disruption and ruin caused by medical debt can harm physical and mental health, as well as social well-being by impairing people's ability to pay for basic necessities like food or housing, avoid credit card debt, save, and pursue education or career plans.[4] People of color and those with disabilities are among those most likely to experience medical debt and its adverse complications.[5]

The COVID-19 pandemic has magnified the interdependencies of health, financial health, and equity. Medical debt, as well as financial health, are therefore key social determinants of health. Disrupting the cycle of downward financial, physical, mental, and social well-being requires collaboration from players across the healthcare ecosystem to take action *before* consumers incur medical debt.

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Key Recommendations

Target impact areas and interventions showcased within this report focus on opportunities for insurers to improve outcomes for their members.

Aid members in plan selection, and ensure members understand key health insurance terms

Proactively inform members of out-of-pocket expectations and help them navigate lower-cost options through price transparency resources

Incentivize primary and preventive care services by reducing or eliminating associated out-of-pocket expenses

Improve claims adjustment and prior authorization processes

[1] *Raymond Kluender, Neale Mahoney, Francis Wong, & Wesley Yin, "Medical Debt in the US, 2009-2020," JAMA, July 2021.*

[2] *David U. Himmelstein, Deborah Thorne, Elizabeth Warren, & Steffie Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," American Journal of Medicine, 2009.*

[3] *Sarika Abbi & Raquan Wedderburn, "Medical Debt and its Impacts on Health and Wealth: What Philanthropy Can Do to Help," Aspen Institute Financial Security Program, Asset Funders Network, March 2021.*

[4] *Jennifer J. Griggs & Carlos F. Mendes de Leon, "Medical Debt as a Social Determinant of Health," JAMA, July 2021.*

[5] *Neil Bennett, Jonathan Eggleston, Laryssa Mykyta, & Briana Sullivan, "19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away," U.S. Census Bureau, April 2021.*

Defining Financial Health

Financial health considers the totality of an individual's financial life. Unlike narrow metrics like income and credit scores, financial health considers whether individuals are spending, saving, borrowing, and planning in a way that will either contribute to, or detract from, their resilience in the face of unexpected events and ability to thrive in the long term. Currently, 34% of people in the U.S. are Financially Healthy, 52% are Financially Coping, and 14% are Financially Vulnerable.[6]

The Case for Change: Why Medical Debt Should Concern Insurers

Health insurance does not always provide adequate financial protection against medical debt. **Nearly 3 in 4 Americans report that they are somewhat or very worried about insurance covering the cost of care when they fall ill.**[7] Among U.S. adults younger than 65 who report problems paying a medical bill, 62% say that the person who incurred the bill was insured at the time.[8]

More than a quarter of adults in employer-sponsored plans (26%) are now considered underinsured, given high deductibles and other out-of-pocket healthcare costs relative to income, up from 17% in 2010.[9] Almost half of underinsured adults report issues paying medical bills or report that they are paying off medical debt over time.[10]

[6] *Necati Celik, Andrew Dunn, Thea Garon, & Jess McKay, "Financial Health Pulse™ 2021 U.S. Trends Report," Financial Health Network, October 2021.*

[7] *"West Health-Gallup 2021 Healthcare in America Report," West Health & Gallup, 2021.*

[8] *Mollyann Brodie, Gary Claxton, Liz Hamel, Larry Levitt, Mira Norton, & Karen Pollitz, "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey," Kaiser Family Foundation, January 2016.*

[9] *Gabriella N. Aboulafia, Sara R. Collins, & Munira Z. Gunja, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability," Commonwealth Fund, August 2020.*

[10] *Ibid.*

Medical debt, as well as general out-of-pocket costs, disincentivize receipt of needed care.[11] Avoiding necessary healthcare can lead to poorer health and well-being, which can then lead to higher costs for insurers. **About 1 in 4 underinsured adults (24%) say they don't visit a doctor when they have a medical issue, 26% skip recommended testing or treatment, and 25% do not fill necessary prescriptions.**[12] Many insured people must choose to pay for food, housing, transportation, utilities, and other necessities over healthcare expenses, which can exacerbate the risk of medical debt.

More than 1 in 4 (27%) Americans report forgoing medical care because they are unsure what is covered by their health plan.[13] Only 9% of Americans demonstrate an understanding of all four of these basic health insurance terms: premium, deductible, out-of-pocket maximum, and coinsurance.[14] Low levels of health insurance literacy are associated with delaying, avoiding, or forgoing care, which can trigger higher-than-expected medical bills and, ultimately, medical debt.[15] In fact, those with higher health insurance literacy have lower medical debt than those with lower health insurance literacy.[16]

Insurers' efforts to support members in navigating their benefits and understanding out-of-pocket costs can **reduce medical debt, improve member experiences, drive utilization of higher-value and lower-cost care, and help insurers build a competitive advantage.** Insurance plans that proactively help members minimize out-of-pocket expenses have significantly higher overall consumer satisfaction scores compared with plans that do not.[17]

Additional efforts to support members with speedy prior authorizations and clarity on covered services prior to receipt of care may further improve member satisfaction and lower risk of medical debt while improving insurer reputation. Together, these concerted efforts may deliver a competitive advantage to insurers in tight markets, while also increasing value to members and employers purchasing coverage for their employees. This is particularly timely for those shifting from government-sponsored health insurance to private health insurance, as could happen at the end of the ongoing public health emergency, and for those who experience post-COVID symptoms.[18]

[11] Mandy Pellegrin, "How Medical Debt Affects Health," Sycamore Institute, May 2021.

[12] Gabriella N. Aboulafia, Sara R. Collins, & Munira Z. Gunja, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability," Commonwealth Fund, August 2020.

[13] Myles Ma, "Health Insurance Literacy Survey 2019: Americans are increasingly confused about health care," Policygenius, October 2019.

[14] Les Masterson, "UnitedHealth survey: Most Americans don't understand basic health plan terms," Healthcare Dive, October 2017.

[15] Susan D. Goold, Edith C. Kieffer, Jeffrey T. Kullgren, Mary C. Politi, Aaron M. Scherer, & Renuka Tipirneni, "Association Between Health Insurance Literacy and Avoidance of Health Care Services Owing to Cost," JAMA Network Open, November 2018.

[16] Edlin Garcia Colato, Caress A. Dean, Keith Elder, Echu Liu, & Jacqueline Wiltshire, "Health Insurance Literacy and Medical Debt in Middle-Age Americans," Health Literacy Research and Practice, October 2021.

[17] "Health Plans Have a Customer Engagement Problem, J.D. Power Finds," J.D. Power, May 2020.

[18] Matthew Buettgens & Andrew Green, "What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency?," Urban Institute, September 2021.

Recommendations for Insurers

While there are a number of upstream policy changes around insurance coverage and benefit design that can reduce member exposure to medical debt, the focus of this report is on immediate actions insurers can take to prevent medical debt and related financial harm. Health insurers can be more proactive in supporting member decision-making by offering price transparency tools and navigation resources, and improving insurance literacy. Insurers can also incentivize preventive care to reduce the need for more expensive, avoidable care, and improve administrative processes to reduce excessive medical bills. Insurers can frame these strategies as part of ongoing efforts to create more responsive, member-driven care experiences.

The Financial Health Network developed these recommendations with input from members of its Stakeholder Advisory Council for this report series. While each one alone can contribute to medical debt prevention, implementing them all can achieve the greatest possible impact.

Aid members in plan selection, and ensure members understand key health insurance terms.

Insurers need to support members in selecting plans based on their particular health and financial circumstances. This requires insurers to have a more comprehensive picture of members' needs, including their financial lives, constraints, and the day-to-day trade-offs they must choose between, like paying for essential healthcare or housing expenses.

Plan selection support has little value if patients do not fundamentally comprehend basic health insurance terminology. Health plans should decode insurance jargon terms like copay, coinsurance, out-of-pocket maximum, deductible, in-network, and prior authorization. Moreover, improving rates of health literacy among members also promotes greater informed decision-making through a greater understanding and ability to use healthcare information.

Tools and one-on-one support can help members understand the cost and benefit differences before selecting a plan. Insurers should simplify plan information as much as possible to support patient choice. Studies show that people make better choices when:

- Price and quality differences are ranked using symbols instead of numbers.
- Information is presented graphically.
- Users can compare key information side by side.[19]

Insurers should also account for members' preferred languages and preferred formats, offering options to access important information online, by mail, or other convenient methods.

Online Tools Supporting Plan Selection

- UnitedHealthcare provides online, step-by-step tips to guide its members through key decisions around employer plan selection, like assessing household healthcare needs, checking for in-network providers, and providing explanations of lower premium vs. lower copay plans.[20] The plan also posts a simplified list of health insurance terms.[21]
- Excellus BlueCross BlueShield HDHP Calculator is an online tool to help its members determine the plan best suited for their healthcare needs by estimating and comparing anticipated out-of-pocket expenses between a High-Deductible Health Plan (HDHP) and other plan types, like a health maintenance organization (HMO) or preferred provider organization (PPO).[22]

Proactively inform members of out-of-pocket expectations and help them navigate lower-cost options through price transparency resources.

Insurers have a responsibility to help members make informed decisions. By providing user-friendly, accessible, transparent, and plain-language explanations of out-of-pocket expenses, members can better understand, plan for, and navigate these costs. Prior to receipt of care, clear explanations need to outline how much of the total cost of care the insurer will pay and how much the member will be required to pay.

[19] *Katherine Grace Carman, Christine Eibner, Andrea Lopez, Ashley N. Muchow, Parisa Roshan, & Erin Audrey Taylor, "Consumer Decisionmaking in the Health Care Marketplace," RAND Corporation, 2016.*

[20] *"3 tips for choosing your health insurance plan through work," UnitedHealthcare.*

[21] *"Simplifying health plan terms," UnitedHealthcare.*

[22] *"HDHP Calculator," Excellus BlueCross BlueShield.*

Insurers should also provide members with clear information about how in-network and out-of-network classification of providers will impact out-of-pocket obligations. A number of insurers provide online cost calculators that can help members compare anticipated out-of-pocket expenses across plans and providers, but it's unclear whether members use them, or find them easy to navigate. Importantly, tools and resources intended to support decision-making must bring clarity to and align with members' healthcare needs. This is particularly important for members experiencing chronic health challenges.

Plan members want these tools to be easy to navigate and easy to understand – clear, simple language with quality-of-care information included.[23] Most members report that knowing costs of care in advance allows them to budget for payments, or at least make partial payments (70% and 65%, respectively).[24] Additionally, insurers can provide members access to advisors who can explain these tools and help members navigate out-of-pocket expenses.

When implementing this recommendation, all insurers should comply with the new federal health plan price transparency rule, which requires insurance carriers for fully insured group and individual health plans to disclose price information to consumers so that they can determine out-of-pocket expenses and compare services from different healthcare providers.[25] This price transparency information will enable consumers to understand the costs they will be responsible for prior to billing and shop for lower-cost options before receiving care. The rule goes into effect in stages, starting July 2022.

Online Tools and Resources Helping Members Navigate Out-of-Pocket Costs

- UnitedHealthcare's Cost Estimator is an online tool that lets members see how much they can expect to pay for medical services based on their specific plan type and explore quality ratings for providers and facilities.[26]
- Health Care Service Corporation (HCSC), which operates Blue Cross Blue Shield plans in Illinois, Montana, New Mexico, Oklahoma, and Texas, created a suite of price transparency tools to help HCSC members assess their out-of-pocket costs for network providers.[27] The price comparison tool outlines the cost information for available providers and hospitals. In addition, Benefits Value Advisors are accessible by phone to assist members in comparing costs for common procedures.[28]

Incentivize primary and preventive care services by reducing or eliminating associated out-of-pocket expenses.

Insurers should ensure their members are not delaying or forgoing needed or preventive care because of cost concerns. Lowering or eliminating out-of-pocket costs for these kinds of services – as well as incentivizing their use – could prevent the need for unnecessary or costly care, including emergency room and inpatient visits. Delaying care can lead to higher total care costs that put patients at risk for medical debt. This is particularly important for those with chronic conditions, who tend to require more frequent and sometimes more customized care to manage their conditions.

[23] "Consumer-Facing Healthcare Cost and Quality Tools," Consumer Reports, November 2016.
[24] "TransUnion Healthcare: 2021 Sees 55% Rise in Financial Assistance Transactions," TransUnion, November 2021.
[25] "Health Plan Price Transparency," Centers for Medicare & Medicaid Services, January 2022.
[26] "Get cost estimates before choosing care," UnitedHealthcare.
[27] "Find a Doctor or Hospital," Blue Cross and Blue Shield of Illinois.
[28] "Benefits Value Advisors: Helping you maximize your benefit plan," Blue Cross and Blue Shield of Texas.

In designing strategies that incentivize necessary primary and preventive care, insurers need to better understand why members choose to delay or forgo. Leveraging social needs screening and, more importantly, maintaining a close connection to members and communities can help insurers better understand members' circumstances, needs, and preferences, and gauge where disparities and inequities exist to guide resources, strategies, and investments. Taking these actions can also reduce inequities for members who disproportionately experience health disparities and adverse health outcomes.

Improve claims adjustment and prior authorization processes.

Insurers should coordinate with providers to ensure disputed claims are settled quickly, and that members are not caught in the middle or left with excessive medical bills. Insurers should also streamline prior authorization, given the wide variations in submission processes, required documentation, and inconsistent requirements, which can often be burdensome for members and providers and create delays in care. Perhaps more importantly, insurers should reconsider retrospective denials of services already received, for which prior authorization was granted. News reports document insurers' increasing use of retrospective denials, which leave members vulnerable to unexpected medical bills and ultimately medical debt.[29]

Incentivizing Primary and Preventive Care With Centivo

Centivo is a third-party insurance administrator for self-funded employers that incentivizes collaboration between physicians and patients to lower the cost of care. The plan provides members with a primary care team that helps them navigate the healthcare system and coordinate care through a user-friendly and personalized Health Action Plan that outlines their preventive care needs, health goals, and care management strategies. Centivo reports that primary care visits increased by 24%, use of preventive care grew by 50%, and emergency room visits decreased by 24%.[30]

Improving Prior Authorization Processes With America's Health Insurance Plans

In January 2020, America's Health Insurance Plans (AHIP) launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative, which brought together health insurers and technology providers to understand the impacts of electronic prior authorization on the prior authorization process.[31] The initiative resulted in faster prior authorization decisions, faster time to patient care, lower provider burdens, and improved understanding of prior authorization information for providers and patients.

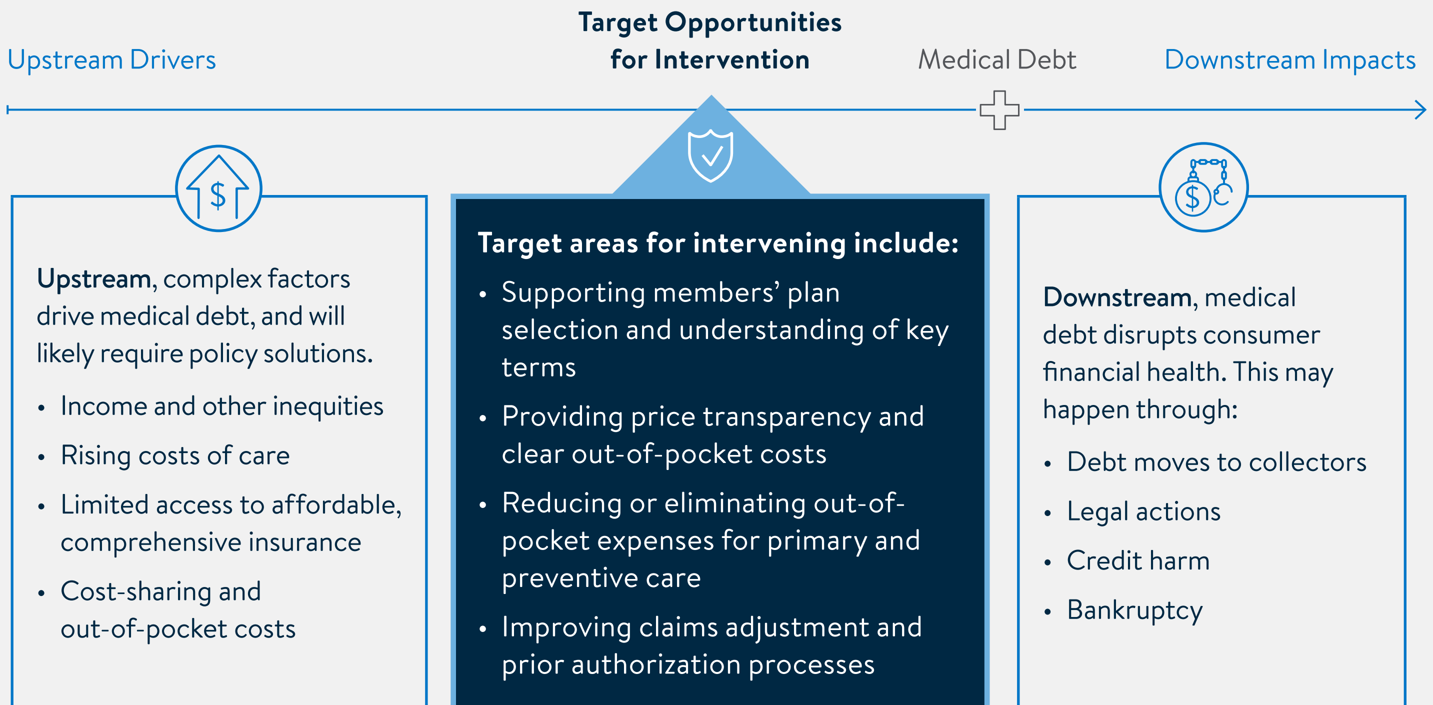
[29] Lauren Weber, "Patients Stuck With Bills After Insurers Don't Pay As Promised," Kaiser Health News, February 2020.
[30] "Centivo raises $51 million as more employers seek affordable, quality healthcare for their employees," Centivo, September 2021.
[31] "Prior Authorization," America's Health Insurance Plans.

Conclusion

Medical debt is a widespread, systemic, and pervasive problem impacting millions, including those with commercial insurance. Medical debt can financially ruin members while also deteriorating physical, emotional, and social well-being. By taking these key actions, insurers can lower members' risk of medical debt while also improving care experiences and health equity.

Figure 1. Opportunities to take action ***for insurers.***

While many upstream factors lead to medical debt, this report focuses on interventions that insurers can implement to prevent medical debt and its devastating impacts on financial health and health.



Acknowledgments

About the Report Series

The Financial Health Network is a trusted resource for business leaders, policymakers, and innovators united in a shared mission to improve financial health for all. We believe financial health is a social determinant of health.

Developed with the support of the Robert Wood Johnson Foundation and informed by a council of stakeholder experts, this report series was created by the Financial Health Network to identify actionable interventions and strategies that health system stakeholders should take to prevent medical debt – particularly among commercially insured patients who too often remain unprotected from healthcare costs.

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Recommendations for Hospitals and Healthcare Systems

Recommendations for Employers

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