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# How Can States Protect Residents Harmed by High Hospital Prices?

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# How Can States Protect Residents Harmed by High Hospital Prices and Medical Debt?

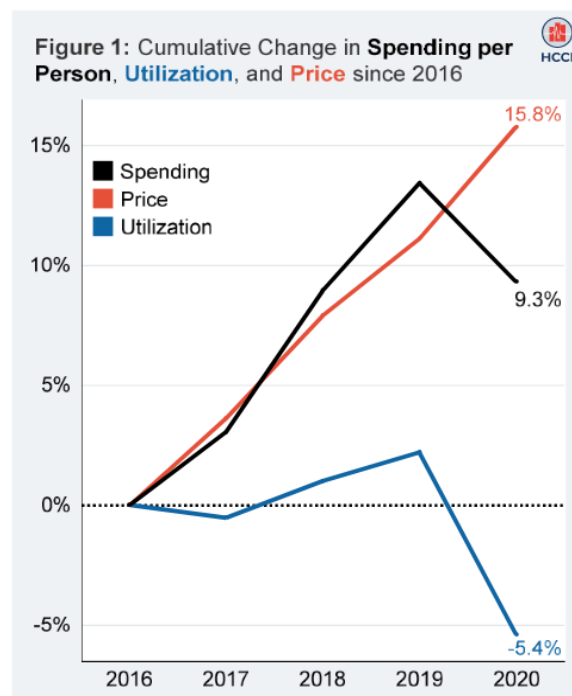
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## U.S. health care is the most expensive in the world, largely because of its prices

The U.S. spent nearly \$13,000 per person on health care in 2021.<sup>1</sup> That is over 40 percent more than the next highest country, Switzerland, and nearly double the level in many other wealthy countries.<sup>2</sup>

Prices and the pursuit of profit are the primary reasons for this country's high and rising health care spending. Health care prices increased 15.8 percent from 2016 to 2020, in contrast to the other major component of health care spending, utilization, which grew less than one percent per year from 2016 to 2019. Utilization then dropped drastically in 2020 as prices continued to rise.<sup>3</sup> (See Figure 1.) Private insurers' payments to hospitals – the largest component of health care spending – are twice what Medicare pays for the same services,<sup>4</sup> and people without insurance often are charged even higher prices. Prices vary widely across the country as well: overall health care prices in the most expensive metropolitan areas are double what they are in the least expensive.<sup>5</sup> For some hospital services, there can be up to a 39-fold difference in prices.<sup>6</sup>

Many hospitals today are thriving. From 2012 to 2019, nonprofit hospitals increased their mean operating profits, from \$43.01 million to \$58.61 million.<sup>7</sup> For-profit hospitals also increased their mean operating profits during that time, from \$31.85 million to \$43.38 million.<sup>8</sup> Hospitals' aggregate operating margin reached a record-breaking 8.7 percent of income in 2021 (though there was significant variation in performance across hospitals).<sup>9</sup> Despite these profit margins, both nonprofit and for-profit hospitals generally provide minimal charity care to patients – 2.3 percent of aggregate expenses among non-profit hospitals, and 3.8 percent of aggregate expenses among for-profit hospitals.<sup>10</sup>



Source: HCCI 2020 Health Care Cost and Utilization

## Rising Prices Shift Costs to Patients

Patients feel the burden of increasing prices in several ways. When the prices that providers charge insurers rise, the insurers pass along the increase to patients (and their employers<sup>11</sup>) as higher premiums or as increased cost-sharing – the deductibles, co-payments, and co-insurance that patients pay at the point of service. Insurers might also try to reduce costs by shrinking benefits or restricting access with narrower provider networks. In 2022, 88 percent of covered employees with single coverage from an employer had a deductible, up from 55 percent in 2006. Over that same period, the average deductible for single coverage tripled, from \$584 to \$1,763; 32 percent of covered workers had a deductible greater than \$2,000 in 2022, compared with just 7 percent in 2006.<sup>12</sup> Out-of-pocket health expenditures – cost-sharing and other fees paid by individuals in addition to their health insurance premiums – totaled \$433.2 billion in 2021, about \$1,300 for every person in the country.<sup>13</sup>

The burden can be even greater for people without health insurance. A recent Wall Street Journal analysis found: “Hospitals routinely bill uninsured patients at their highest rates.”<sup>14</sup> Unprotected by the price discounts that insurers negotiate with hospitals and other providers, uninsured patients can be charged the full list price for services and procedures, as much as four times the price that insured patients are billed.<sup>15,16</sup> People without insurance tend to be lower-paid workers and are responsible for the full bill, not just the cost-sharing portion, so they are usually less able to pay than their insured counterparts.

## Higher Prices, Larger Bills Lead to Medical Debt

As prices rise and individuals take on more of the obligation to pay, they bear the burden of health care in many ways. They might, for example, delay or entirely forgo care that they need, resulting in worse health and, often, the need for even more costly care in the future.<sup>17</sup> One of the most significant effects of high prices is the accumulation of medical debt.

Medical debt – unpaid medical bills, or credit card debt and other loans used to pay medical bills – is common in the United States. A 2022 survey found that 41 percent of adults in the U.S. – over 100 million people – had debt due to medical or dental bills, and an analysis in 2020 estimated there was at least \$195 billion in outstanding medical debt.<sup>18</sup> Medical debt causes financial hardship, including damaged credit, which can be a barrier to employment and housing, reduced spending on other necessities, and bankruptcy. Efforts to collect outstanding bills by hospitals and their agents can exacerbate the problems of medical debt. Adding insult to injury, medical debt itself can bring on health problems because of the stress and anxiety it causes; it can also limit access to health care. Many people with medical debt forgo needed care because of the fear of accruing additional debt, or because a provider might deny them care until a bill is paid.<sup>19</sup>

## Medical debt fosters inequity

The impacts of high costs and medical debt are disproportionately felt by Black and Latinx families, women, people with no health insurance and people with low incomes.<sup>20</sup> Black and Latinx households are much less likely than white households to have private health insurance.<sup>21</sup> Even when insured, though, Black and Latinx families face greater affordability challenges, caused in part

by a history of discrimination that limits wealth accumulation and fosters distrust of the health care system, keeping people away until their health problems are too serious to ignore.<sup>22</sup> Racial and ethnic disparities in the incidence of chronic health conditions, such as diabetes and asthma, and in screening rates for certain cancers contribute to additional expenses.<sup>23</sup> The costs for these disparities and inequities fall, at least in part, on the people who are subject to them.

All patients, insured or not, are vulnerable to health systems' and providers' voracious need for revenue, which brings additional challenges. Physician practices that are part of a larger health system add facility fees to their charges for professional services, hospitals offer limited or inconsistently applied financial assistance policies, providers use aggressive bill collection tactics (such as wage garnishment and liens on homes), and corporate transactions result in the consolidation of provider markets, which limits choice and drives up prices.

## Prices and medical debt are driven by provider efforts to boost revenue and by market trends toward consolidation

Many factors drive health care prices and high prices, in turn, drive medical debt. States have an interest, on behalf of their residents, to try to slow price increases and reduce medical debt, and they have several policy levers at their disposal to accomplish this. This compendium is a catalog of how states are working some of these levers, using laws, regulations, and other means. Following is a summary of the drivers, the policy levers, and how the levers are being used, in two categories:

- *Profit-driven provider behaviors and practices.* Providers affect the accumulation of medical debt through their policies and interactions with patients. Profit-driven provider behaviors and practices that help determine how much medical debt patients acquire include: the expansiveness of financial assistance policies and how they make patients aware of them; the prices they charge patients who are not covered by insurance; and the addition of facility fees and other charges not directly connected to a medical service. States can limit the growth of medical debt by establishing requirements and setting parameters for these practices.
- *Consolidation and lack of competition.* Beyond individual patient transactions, providers influence prices and medical debt through activities at the market level. The consolidation of markets through horizontal and vertical mergers puts upward pressure on prices. In certain sectors, private equity investors, motivated by the goal of producing outsized returns, drive market activity that accelerates price increases. The harmful impact of this activity on prices and patients is abetted by a lack of transparency about prices and corporate relationships. States have policy levers, associated with their oversight of health care providers, public health, and market competition, available to manage these impacts.

## Profit-driven provider practices increase prices and medical debt

To a large degree, high prices and medical debt result from actions – or inactions – taken by health care providers. Financial motives that prioritize profits leave patients of limited means without necessary assistance and vulnerable to debt and its consequences.

## Non-profit hospitals provide underwhelming community benefits

Non-profit hospitals are exempt from many federal and state taxes and may receive tax-exempt donations because it is expected that they will provide services that benefit the public. In the case of hospitals, these “community benefits” include policies for providing free or reduced-price care to patients with low incomes. A recent study estimated the value of the tax exemption for non-profit hospitals – that is, the amount of federal, state, and local taxes non-profit hospitals do not pay – at \$28 billion in 2020. About half of this is the value of the state and local sales, property and income taxes from which non-profits are exempt. The same study found that non-profit hospitals provided only \$16 billion worth of charity care in 2020.<sup>24</sup> Another study found that for-profit hospitals provide more charity care, on average, than non-profit hospitals.<sup>25</sup> This evidence suggests that hospitals are pocketing millions of dollars in tax breaks every year, rather than putting them into the community, for example as increased financial assistance to patients that would reduce medical debt.

## Hospital pricing practices are inflationary

Hospital prices increased 25 percent from 2016 to 2020, and researchers found a markup in price for some procedures of up to 20 times the actual cost.<sup>26,27</sup> Insurers negotiate with hospitals about what they will pay, but the payments are often based on the hospital’s charges, which, unlike most prices, often bear little relationship to a hospital’s cost of providing a service. Negotiations are also influenced by the relative market power of hospitals and insurers. By 2017, 90 percent of hospital markets were considered “highly concentrated” under Federal Trade Commission standards, meaning the hospitals in those markets have great latitude in setting prices.<sup>28</sup>

Markups are passed on to insured patients in their deductibles, co-payments, and co-insurance. Patients who are uninsured and do not qualify for or are not informed of a hospital’s financial assistance policy are even more exposed; they may be billed the full price. Hospitals might inflate bills by “unbundling” charges – disaggregating what could be a single charge for an entire visit – and billing for itemized services such as the delivery of a medication<sup>29</sup> or answering an email. Hospitals and other providers owned by large systems, including physician practices and outpatient services, may add a “facility fee” to a bill – even if the patient did not visit the facility.<sup>30</sup> Errors on medical bills also inflate payments and debt. As many as 80 percent of medical bills have at least one error.<sup>31</sup>

## Aggressive billing and collection practices exacerbate hardships caused by medical debt

Hospital bills and the methods used to collect them are a major driver of health care spending and medical debt. The passage of the No Surprises Act prevented millions of unjust surprise medical bills, though there are still gaps in this law that block its full potential.<sup>32</sup> But millions of hospital bills that are not a surprise – bills for the patient’s share of in-network, covered services – remain a source of hardship because of their magnitude and the harsh tools used to collect them. Many hospitals, non-profit and for-profit alike, outsource collection actions to outside vendors. Tactics

such as credit reporting, deferred interest medical credit cards, wage garnishments, property liens, lawsuits, and even arrest warrants are not uncommon.<sup>33</sup>

A study in Wisconsin found, for example, that medical debt-related lawsuits increased by 37 percent from 2001 to 2018, that Black patients were sued more often, and that nonprofit hospitals were more likely to sue their patients than were for-profit hospitals.<sup>34</sup> Similarly, a study of Virginia hospital lawsuits found that nonprofit hospitals were more likely to garnish wages than for-profit hospitals.<sup>35</sup> While garnishment is financially ruinous for patients, it is trivial to hospitals' bottom line – the average garnishing hospital obtained only one-tenth of one percent of its gross revenue through garnishment.<sup>36</sup> Forty-four states have laws permitting the arrest and incarceration of debtors who do not comply with debt-related judgments; the ACLU documented arrests and jailing of people with medical debt, often for small amounts, in many of these states, including “hundreds of cases” in Maryland.<sup>37</sup>

## State policymaking can address profit-driven provider behaviors and practices that increase prices and debt

State governments have well-established and accepted authority – in public health, financial stewardship, consumer protection, and regulation of charities – which offer points of leverage for policymakers to address high health care prices and medical debt.

Hospitals and other entities are health care providers, and they also are businesses, government vendors, and, sometimes, charitable institutions. States have influence over providers in all these capacities in ways that can affect prices.

### Ensure a fair share of community benefits

A state may set standards for what community benefits fulfill a hospital's public obligations, including parameters for charity care and financial assistance. Oregon, for example, enacted a law in 2019 that directs the state to set a minimum community benefit spending level for each non-profit hospital, considering factors such as past expenditures on community benefits, identified community needs, the overall finances of the hospital, population demographics, and spending on social determinants of health.<sup>38</sup> It should be noted, however, that a recent study found lower investment in community benefits in states that have established a minimum community benefit.<sup>39</sup>

Hospitals may also have policies that offer financial assistance to patients with limited means. If the specifics of the policies are left to the discretion of individual hospitals, however, they may be inadequate, inconsistently applied, and not well-publicized.

States can require that all hospitals – not just non-profit hospitals, as federal tax law requires – have financial assistance policies with explicit eligibility standards to provide free or heavily discounted care to patients with low incomes or extraordinarily high medical expenses. States may require that hospitals screen all patients for eligibility for financial assistance, and, for patients who do not qualify, prohibit hospitals from imposing an upfront deposit or asset test before the patient can receive care. About 19 states have laws or regulations setting minimum standards for hospital financial assistance policies that exceed federal standards by including a broader group of hospitals under the rules, setting specific income thresholds for eligibility, making financial assistance available to all eligible patients regardless of insurance status, or establishing strong enforcement

rules. California, for example, requires all acute care hospitals (with minor exceptions) to provide financial assistance to patients with income less than four times the federal poverty level (about \$58,000 per year for an individual) who are uninsured or who have high medical costs, as defined in the law.<sup>40</sup>

## Regulate hospital pricing practices

Despite major gains in coverage following enactment of the Affordable Care Act (ACA), high premiums and out-of-pocket costs (co-insurance, co-payments, and deductibles) continue to cause affordability burdens for millions of Americans. There still are over 27 million uninsured people in the U.S.<sup>41</sup> Many others, while insured, do not have resources to pay out-of-pocket expenses. As explained earlier, patients who are not protected by insurance and the discounts that health plans negotiate might be billed the full price of a service or procedure - a charge that can be many times the cost of providing it or what any insurer, public or private, pays for it. To reduce the burden of cost for patients in these circumstances and limit, or eliminate, their medical debt, states can place limits on the prices uninsured patients may be charged. For example, states can be required to be on par with Medicare or Medicaid rates or by establishing a discount formula, as 19 states have done in some fashion. The practice of providers that are part of a larger health system adding a “facility fee” to bills – charges unrelated to the professional services a patient received – has also become more common. Several states have enacted transparency requirements or restrictions on such fees, and momentum may be building for action in other states.<sup>42</sup>

## Prohibit abusive billing and collections practices

States can limit the hardships caused by medical debt by restricting or banning the most egregious medical debt collection practices — wage garnishment, property liens, and lawsuits that can sometimes lead to imprisonment. States can also use their authority to require protections for patients with income below a certain level, for example, requiring that hospitals offer a reasonable, no-interest payment plan, setting a maximum percentage of a patient’s income that can be collected on a monthly payment plan, and requiring that people are screened for financial assistance before a bill can be sent to collection. Many states have such policies in place, in various combinations. Eight states, for example, require hospitals to offer patients a payment plan based on their income or ability to pay; more than half of these states restrict the use or reach of extraordinary collection actions such as wage garnishment, liens on or forced sales of property, and imprisonment for nonpayment. Some of the most effective policies can be models for other states. Colorado, for example, has tied its rules concerning medical debt collection to federal requirements for hospital price transparency: a hospital not in compliance with the federal law is prohibited from pursuing a debt collection action against a patient.<sup>43</sup>

Notably, some of the hospital collections actions that are most harmful to patients have little impact on hospital finances. For instance, wage garnishment can impose significant financial difficulties on patients, particularly those with low incomes. A recent study in Virginia found, however, that on average wage garnishment generates only 0.1 percent of hospital revenues.<sup>44</sup> States therefore can protect vulnerable patients without compromising hospital financial stability.



## Consolidation and lack of competition in health care markets push prices upward

In the United States, we largely rely on the forces of market competition to set prices in the private sphere of our health care system. Without meaningful competition, providers have the market power to dictate prices without fear of losing patients. Providers may also take advantage of other market imperfections, such as the lack of price transparency and the fact that most bills are paid by third party payers, which can dampen patients' price sensitivity. These circumstances drive prices higher, amplifying the impact on people who are responsible for paying for all or part of their care and, inevitably, increasing their medical debt.

Transactions that consolidate the health care market – mergers among institutions, acquisitions of provider practices by hospital systems, leveraged buyouts by private investors – can restrict competition and enable providers to raise prices. Policy makers have authority to strengthen states' oversight of markets to limit further integration or mitigate the harms caused in markets that have already consolidated. This oversight affects prices and medical debt less directly than regulating prices, but market characteristics are important in determining prices, and price levels drive medical debt, so tending to market impacts should be part of suite of policies addressing the specific circumstances in a state.

### Consolidation restricts provider supply and increase prices

Market conditions have moved hospitals and physician practices to consolidate by merging with one another and through vertical integration, for example when hospital systems acquire physician groups. Mergers might concentrate an area's provider market and restrict choice, thereby increasing market power for the providers that remain. Evidence is strong that hospital prices and spending increase as a result.<sup>45</sup> Mergers might also result in greater use of facility fees by hospital-acquired physician groups. Hospital consolidation tends to concentrate services in middle income and affluent, predominantly white communities where prices can be raised, and to reduce capacity and critical access among populations that are less able to support higher prices, which disproportionately include Black, Latinx, Indigenous, Asian, other people of color, and people living in rural areas.<sup>46</sup>

### Private equity investment prioritizes large profits

Many mergers are executed by private equity firms, which have become more active in acquiring hospitals, nursing facilities, and physician practices. A typical private equity strategy is to acquire a "platform" company – a hospital or specialty medical practice, for example – and then add on with smaller, related acquisitions, concentrating the market and reducing competition when possible. The goal of much private equity investment is to maximize revenue and reduce costs to realize large profits within a few years' time, then exit the investment. Numerous studies have found that private equity ownership leads to price and spending increases.<sup>47</sup>

In their pursuit of generating large profits quickly, private equity firms also have become significant players in the revenue cycle management (RCM) business. RCM companies work on behalf of hospitals in pursuing payment for outstanding bills. Eighteen percent of hospitals outsourced their bill collection activities in 2018, and many RCM companies are being acquired by private equity firms.<sup>48</sup> Private-equity-owned RCM companies often use the aggressive tactics described earlier,

violating fair debt collection laws and the Healthcare Financial Management Association's "Patient Friendly Billing" principles in the process.<sup>49</sup>

## States have policy levers to address the harmful effects of consolidation and lack of competition

### Monitor and control systemic price increases and promote transparency

One of the market imperfections that thwarts effective price control is that prices are not easy to know or to compare. While hospitals are now required to make available their charges and payer-specific negotiated rates for common services and procedures, there is inconsistency in definitions, quality, and completeness of the information.<sup>50</sup> States may use their regulatory authority to clarify and enforce transparency requirements. More than twenty states go beyond the federal transparency standards by including other providers (such as ambulatory surgery centers) in the requirements, requiring hospitals to provide good faith price estimates to patients prior to procedures, and enacting strong enforcement of transparency rules, often in the form of financial penalties for non-compliance. Alaska, for example, requires insurers, non-emergency facilities, and providers to provide estimates for services – including disclosure of in- or out-of-network status, procedure codes for each service, facility fees, and the identity of anyone else who may charge for a service – at the request of any patient, regardless of the patient's insurance status. Facilities and providers that do not comply with the requirement may be fined up to \$10,000 per violation.<sup>51</sup>

A state also can take measures to regulate prices more generally. Some states have instituted cost transparency boards and commissions and set cost growth benchmarks to limit the annual growth in health care spending. These mechanisms limit and monitor the price increases allowed from year to year, with varying degrees of enforcement power. Increased transparency allows for fairer price comparisons and competition that can lower prices and medical debt.

Some states maintain an All Payers Claims Database and require insurers to report their claims directly to the state, allowing for a wider view of the cost and care landscape. States have used these data to create consumer-friendly websites so residents have full knowledge of their options.

### Mitigate price increases resulting from mergers<sup>52</sup>

A state may use its antitrust authority to review mergers and set conditions for their approval – agreements to limit price increases and strengthen financial assistance, for example. A state also has leverage to review the equity impact of mergers, such as whether price increases might disproportionately affect underserved communities. A state can extract further commitments regarding pricing behavior by reviewing merger transactions from a public health perspective through its licensing and certificate of need authorities, as Medicaid administrator through its discretion in designating a hospital as a Medicaid Disproportionate Share provider (which triggers additional Medicaid payments), and, in the case of non-profit consolidations, through its power to grant tax exemptions.<sup>53</sup>

### Scrutinize private equity acquisitions

Many states have laws that require medical practices to be owned by licensed physicians and can use these Corporate Practice of Medicine (CPOM) provisions to place restrictions on the reach of corporations in health care.<sup>54</sup> States may require transparency around ownership of health care entities, which promotes accountability and can reveal overlapping relationships that might conceal anti-competitive or fraudulent practices. They may also review acquisitions for anti-competitive impacts under their antitrust enforcement authority and raise questions and challenges that federal authorities might not.

New York and Oregon have recently enacted laws giving state health agencies authority to review proposed hospital acquisitions (by private equity investors and others) for their impacts on the communities they serve. New York's Certificate of Need process requires an independent assessment of how a proposed transaction might affect medically underserved groups in terms of access, financial assistance, and community services. This equity assessment is now a factor in whether the state will grant a Certificate of Need to a newly acquired hospital, allowing it to operate.<sup>55</sup> In Oregon, the Oregon Health Authority now has the power to approve, disapprove, or conditionally approve transactions based on its assessment of how an acquisition will affect cost, access, equity and quality.<sup>56</sup> These health equity assessment laws are examples of how states can protect their populations from the harmful price, debt, and other effects of hospital consolidations.

## Conclusion

Medical debt is a byproduct of high prices and the forces that push health care prices upward are strong and varied. However, states have a number of levers at their disposal to affect these forces. Depending on the particular circumstances – the health care market, the economy, the political environment, to name only a few – a state might use some or all of them to achieve policy objectives. Those objectives might include the macro – slowing growth of health care prices – and the corresponding micro – reducing the burden of medical debt for individuals and families.

State policies interact with federal policies. In some cases, federal policies provide a foundation and allow states to go beyond. This is the case with the No Surprises Act and rules about price transparency, for example. In other cases, however, federal policy is controlling and preempts further state action. Medicare rules are set entirely at the federal level, as are rules governing employee health benefits that are self-funded by employers. States cannot solve the problems of high prices and medical debt by themselves, but their complementary efforts can have a great impact.

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