Community Catalyst

The Compendium and Beyond

November 2023

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Summary of state policies

The Compendium presents information about state policies in five categories that are intended to have some impact on health care prices and medical debt. Using the criteria described in the Methodology, state policies in each of the categories were classified on their likely effectiveness as low, medium or high. Table 1 shows the number of states[1] with rankings of each level for each category:

Table 1. Count of State Policies, by Category and Rating Level

Category	**Low**	**Medium**	**High**
Prescribed discounts/caps on charges	37	8	6
Free care and financial assistance	30	10	11
Limits on billing and collections	35	11	5
Price transparency	35	11	5
Facility fees	38	9	4

Table 2 lists the states with high ratings in each category and in the overall, composite rating:

Table 2. States with Ratings of "High," By Category

Category	**States Rated "High"**
Prescribed discounts/caps on charges	CA, CO, NJ, OR, VT, WA
Free care and financial assistance	CA, CO, DC, IL, ME, MD, MA, NJ, OR, VT, WA
Limits on billing and collections	CA, CO, DE, IL, NM
Price transparency	CO, FL, MN, RI, SD
Facility fees	CO, CT, MD, NY
Overall	CA, CO, IL, ME, NY, OR, WA

Discussion

In total, 27 states have a rating of "Low," indicating significant shortcomings in several of the policy categories. Sixteen of these states are rated "Low" in all five categories, and none of the 27 has a "High" rating in even one of the categories. Seventeen states have composite ratings of "Medium" and the remaining seven, listed in Table 2, are rated "High." Only Colorado is rated "High" in all five categories, and California is the only other state with as many as three "High" category ratings. The other five states' "High" ratings are concentrated in the categories that are given the most weight in our methodology as the policies with the greatest influence on hospital prices and medical debt.

The ratings suggest that there are many opportunities to improve efforts to rein in prices and reduce medical debt in all policy categories and all states, including those states that appear the most

progressive. Indeed, five of the seven states rated “High” overall had “Low” ratings in at least one category. Advocates may use the information in the Compendium to pursue activity in states where policies in one or more categories are completely lacking or very weak. They may also look at policies that appear robust but include little or no enforcement.

The importance of enforcement

Even the most comprehensive policies to contain health care prices and limit medical debt are likely to be ineffective unless accompanied by strong enforcement provisions. The presence of a strong enforcement mechanism was a key criterion in the Compendium rating methodology and helped to distinguish “Medium” policies and “High” ones. Enforcement may be the responsibility of a state agency – such as the department or commission responsible for the policy. For example, the Department of Health Care Policy or Finance in a respective state or the Attorney General’s office, acting as the state’s consumer protection authority may lead efforts to limit the impacts of medical debt on people within their state.

It is important to note, however, that Attorneys General are charged with enforcing all state laws and, unfortunately, the AG is sometimes on the other side of the equation, pursuing patients for unpaid bills from state-run facilities.[2] Regarding these conflicting roles, state policy should favor efforts to reduce medical debt, not to amplify its damage.

Penalties for failing to comply with the rules may include monetary fines, which can be significant or merely symbolic. States may also allow for the suspension or revocation of a provider’s operating license. A provider may also be excluded from state programs, such as access to reimbursement from the Indigent Care Pool (as in New York), if it does not follow financial assistance rules.

Another strong enforcement approach is to grant a private right of action, either by making a formal complaint to a state agency on which it must act, or by bringing suit against a provider for disregarding state laws or regulations. Idaho and Oregon, for example, allow patients to sue a hospital for the use of unlawful collection practices, and to recover damages and attorneys’ fees if successful.

Hospitals may also be required to take actions that are in their community’s collective interest. One example is a practice that several states have adopted: setting health care cost benchmarks. A state agency or commission sets a target level of annual health care cost growth and publishes reports about whether the benchmark has been met. If the target is exceeded in a particular health care sector, representatives of that sector may be publicly called to account; some states require entities to submit a performance improvement plan to rein in costs. Today, nine states have health cost benchmarking laws in some form.[3] This is a policy tool that acknowledges there are many contributors to high health care spending and medical debt, while identifying the actors that contribute the most to harmful practices.

Looking beyond individual hospital practices

The compendium highlights state policies that address the practices of health care providers – mainly hospitals – that contribute to high prices and medical debt. But health care is a system, albeit a dysfunctional one, with clinical and economic policy areas affecting each other and the health care system as a whole. This means that the policy categories in the compendium are a starting point in identifying levers that can make a difference in prices and medical debt. To get a full picture, we should

go beyond individual hospital actions and look at trends in hospital markets and the influence of other key health care sectors on prices and medical debt. Those include, but are not limited to: drug manufacturers[4], prescription benefit managers, insurance companies[5], private equity firms[6], and companies that contract with health care facilities to provide staffing. For more information, see our brief titled: "How Can States Protect Residents Harmed by High Hospital Prices and Medical Debt?"

Addressing systemic inequities

Laws, policies, and practices in the health care system and across society routinely discriminate against people because of their race, ethnicity, income, immigration status, gender identity, age, or disability. Systemic discrimination contributes to the problem of medical debt.[7] Racial and ethnic disparities in the diagnosis and treatment of disease, driven in part by implicit bias and explicit discrimination, have been exhaustively documented over many years.[8] There are corresponding inequities in the outcomes of chronic diseases (such as asthma, diabetes, and hypertension), cancer, mental health conditions, and heart disease. These inequities account for $320 billion per year in health care spending, according to a recent estimate.[9] These costs add to the burden of medical debt, particularly for people of color and historically disadvantaged groups who – in addition to being most impacted by these inequities – are more likely to have low incomes and lack health insurance. Clearly, efforts to eliminate this source of medical debt must extend beyond the policies of individual providers and to federal and state policymaking and enforcement. Additionally, these to efforts should aim to shift provider perceptions, practices, and community attitudes.

The importance of community engagement

Policymaking to eliminate inequities should be informed by the local communities affected by them. Meaningfully engaging communities in policymaking ensures that a diverse range of voices, expertise, and perspectives are centered in solutions to create a health system rooted in race equity and health justice. In contrast, excluding communities from the policymaking process reinforces barriers, undermines trust, and can exacerbate existing inequities. A hospital's triennial Community Health Needs Assessment (CHNA) is an opportunity for effective community engagement. A process that seriously solicits and considers community input can forge strong partnerships with hospitals and ensure that hospitals' community benefit resources are appropriately targeted to achieve equity and rectify longstanding injustices. Non-profit hospitals are required by federal regulations to conduct a CHNA every three years. States may also require CHNAs under their public health responsibility; failure to produce a CHNA in these cases may have impacts on hospital licensure.

Federal policies bolster states

The best state policies to control health care prices and reduce medical debt use federal policy as a floor and build on it by filling gaps and adding policies. Examples are strong rules prohibiting extraordinary bill collection actions; expansive, specific rules for capping charges; and application of financial assistance requirements beyond non-profit providers. Still, further federal action – both administrative and legislative – is needed when states' authority does not have sufficient reach, or when states choose not to use it. Examples include:

- Federal action, through Medicare Conditions of Participation or by statute, to ensure that people who receive services from for-profit providers are as able to access assistance as those

who use non-profit hospitals subject to the provisions of Section 501(r) of the Internal Revenue Code.
- Further action to close gaps in the No Surprises Act (NSA), such as one that exempts ground ambulance services from surprise billing prohibitions.
- Additions to the Conditions for Participation for the Medicare and Medicaid programs[10] that limit medical debt, using the law's authority to "impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals."[11]

Conclusion

Public policy is needed to help rein in soaring health care prices and reduce medical debt. The Compendium displays a range of state aggressiveness in policies that address hospital practices across several areas that affect prices and debt. Some states have exemplary policies, which seek to protect individuals' rights, access, and pocketbooks, and which can serve as models for other states' policymakers and advocates. For the states that lag behind, the Compendium can be used as a benchmarking tool and a reference guide to what is possible.

We have the most expensive health care in the world; as prices and debt continue to rise, further measures to protect individuals and communities are needed. Looking beyond individual hospital behavior – including drug manufacturers, insurance companies, and staffing agencies – and to systemic cost drivers like market consolidation and structural inequities – can point to additional policy levers. As we look to the work ahead, federal efforts can fill gaps that are beyond state authority and states can build on federal foundations.

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[1] Counts include Washington, D.C.
[2] Fred Clasen-Kelly, "A Mom Owed Nearly $102,000 for Hospital Care. Her State Attorney General Said to Pay Up." Kaiser Health News, July 20, 2023. https://kffhealthnews.org/news/article/north-carolina-attorney-general-medical-debt-collection/, accessed August 21, 2023.
[3] Adney Rakotoniaiana, How States Use Cost-Growth Benchmark Programs to Contain Health Care Costs. National Academy for State Health Policy, January 2023. https://nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/, accessed August 29, 2023.
[4] Quynh Chi Nguyen and Michael Miller, "Addressing Out Of Control Prescription Drug Prices: Federal and State Strategies." May 2018. https://communitycatalyst.box.com/s/bhzmp13zrgdeylm0nwbvq1ar1jlvthnh
[5] Community Catalyst, "Essential Health Benefits: Gaps and Inconsistencies." April 12, 2023 https://communitycatalyst.org/resource/essential-health-benefits-gaps-and-inconsistencies/
[6] Robert Seifert, "Doctored by Wall Street: Private Equity Bodes Ill for Health Care." June 2023. https://ourfinancialsecurity.org/wp-content/uploads/2023/07/AFREF-Doctored-by-Wall-Street-COMPANION-final.pdf. Robert Seifert, "Policy Solutions for Private Equity in Healthcare." June 2023. https://ourfinancialsecurity.org/wp-content/uploads/2023/07/AFREF-Doctored-by-Wall-Street-PRIMARY-final.pdf
[7] Berneta L. Haynes, "The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families." National Consumer Law Center, March 2022 https://www.nclc.org/resources/the-racial-health-and-wealth-gap/
[8] See for example H. Jack Geiger, "Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes" in Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; Smedley BD, Stith AY, Nelson AR, editors.
Washington (DC): National Academies Press (US); 2003.
[9] "US Health Care Can't Afford Health Inequities," Deloitte Insights, accessed January 10, 2023, https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html.
[10] 42 CFR 482
[11] 42 CFR 482.1(a)(1)(ii)