Community Catalyst

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North Carolina: Following Medicaid Expansion, Advocates Try to "De-Weaponize" Medical Debt

Relative to most other states, North Carolina's public policies to moderate hospital prices and protect patients from medical debt are below average. Hospitals are not required to offer discounts to low-income patients. They must have financial assistance policies, but the specifics of those policies and how patients should be informed about their availability are left largely to each hospital. There are restrictions on billing and collection actions, but they seem to do little to stem the growth of medical debt. Lawsuits to collect outstanding bills are common, and many are brought against patients who are eligible for charity care.[i]

North Carolina recently took a large step toward improving affordability and reducing future medical debt for many state residents when it enacted the Medicaid expansion authorized by the Affordable Care Act. When the expansion took effect on December 1, 2023, about 372,000 people without insurance – 37% of North Carolina's uninsured population – became eligible for Medicaid.[ii] People who take advantage of the expansion and enroll in Medicaid will be much less likely to face high out-of-pocket expenses from hospital care and to incur medical debt.

Another initiative to address medical debt – the Medical Debt De-Weaponization Act (SB 321) – is currently pending in the North Carolina General Assembly. If passed into law, SB 321 would impose requirements on hospitals to provide patients with a financial assistance policy, prevent certain extraordinary collection actions, require price information to be posted on hospital websites, and report to the state government on these measures. It would also give patients the right to take legal action against hospitals and debt collectors that violate the law.

This spotlight reviews the details of the Medical Debt De-Weaponization Act, with a focus on its potential effectiveness in moderating hospital prices and reducing medical debt.

Overview of hospitals' prices and medical debt in North Carolina

Prices for health care in North Carolina are higher than average. A RAND study ranked North Carolina hospital prices in 2020 as the 20th highest in the U.S.[iii] By contrast, median household income in North Carolina that year was 40th highest among the states.[iv] In 2021, the average price for an inpatient service was about $21,400[v], more than one-third of the household median income of $61,972.[vi] People who lack health insurance are the most vulnerable to high hospital prices, and before North Carolina expanded Medicaid eligibility, the state had the 10th highest uninsured rate in the country.[vii] People with

insurance also feel the impact of high hospital prices through higher insurance premiums and out-of-pocket costs – the portion of the price that is directly charged to insured patients as copayments, coinsurance, and deductibles. North Carolina's insured hospital patients faced average out-of-pocket cost sharing of $1,149 in 2021, about 14% higher than the national average.[viii] Out-of-pocket obligations are a driver of medical debt for patients with insurance;[ix] the median medical debt in collections in North Carolina was $742 in 2022.[x]

The level of medical debt in North Carolina is high compared to the nation as a whole with evidence of inequity in how the debt is distributed. In 2022, 20% of North Carolina's population had medical debt in collections, the fourth highest percentage among states. That figure increases to 25% for communities of color.[xi] In certain counties, the proportion of residents with debt in collection exceeds 40%.

A series of recent reports shed some light on why North Carolina's levels of medical debt are so high. One found that most large non-profit hospital systems in the state were providing charity care valued at less than 60% of their tax exemptions.[xii] A second study found that many patients with unpaid bills were eligible for charity care: between 12% and 29% of such bad debt across all non-profit hospitals, and as much as 96% at one.[xiii] Some hospitals were very aggressive in trying to collect outstanding bills: a third study found 5,922 lawsuits brought by hospitals to collect outstanding debt between 2017 and 2022, nearly all of them by five hospital systems.[xiv] The most litigious of these systems, Atrium Health, "quietly" stopped taking patients to court recently, though they still collect from patients with existing judgments against them.[xv] Taken together, these data and reports paint a picture of a state where there is weak protection for people against high hospital prices and medical debt.

Details of the proposed bill

While Medicaid expansion will reduce future medical debt for those who become eligible for coverage, debt will remain a crisis for many families with members who are uninsured or cannot afford the high out-of-pocket costs of their insurance plans. Patient advocates, the state treasurer, legislators, and others are seeking to address the problems illuminated in the reports on hospital behavior and medical debt through legislation. The "Medical Debt De-Weaponization Act" was introduced in 2021 and again in the 2023-24 legislative session, but with a modified version.[xvi] The Senate passed the bill unanimously on May 1, 2023, and it moved to the House.

The bill that passed the Senate includes strong medical debt protections and restrictions on the use of facility fees, which are fees not related to patient care that hospitals add to bills, effectively increasing their prices. The bill would prohibit these fees for procedures not performed at a hospital's main campus or a facility that includes an emergency department. They would also be prohibited for any services the state determines can be safely and reliably done in a non-hospital setting. The Department of Health and Human Services would have enforcement authority, including the ability to audit facilities and assess fines for violations.[xvii]

Regarding medical debt protection, the bill would require hospitals and other large health care facilities to develop a Medical Debt Mitigation Policy (MDMP), which must include a written financial assistance policy, eligibility criteria for financial assistance, information about the application process, and the facility's billing and collections policy. Hospitals would be required to submit copies of their MDMP annually to the state Department of Health and Human Services. They would be required to determine whether a patient had health insurance and, if not, to offer to screen the patient for eligibility for public or private insurance and other public programs, before they could pursue payment for care. The bill would require hospitals to widely publicize their MDMP, and to print it in the 10 languages most frequently spoken by people in the community with limited English proficiency. Hospitals would be required to post price information on their websites, including gross charges and the amount Medicare pays for services.

Medical debt collectors would be prohibited from using certain extraordinary collection actions: causing an individual's arrest or for an individual to be held in civil contempt, foreclosing on real property, and garnishing wages and state income tax refunds. Other collection actions, such as selling debt, reporting to a credit bureau, and placing liens on property, would not be allowed for at least 180 days after the first bill was sent and 30 days after sending notice of the MDMP. If a patient is later found to be eligible for financial assistance, the collector must reverse any extraordinary action that has been taken. Interest on medical debt would be limited to 5% but could be no lower than 2% (the current allowable interest rate is eight percent.)[xviii] A patient's spouse could not be made liable for their medical debt.[xix]

To enforce these provisions, the bill gives patients a private right to bring a lawsuit against a creditor or debt collector they believe has violated the law. In addition, the Attorney General has the authority to enforce the provisions of the law and to establish a complaint process.

Potential effectiveness of the law

As passed by the Senate, the Medical Debt De-Weaponization Act would limit some of the most egregious debt collection tactics that have been used by hospitals and collection agents. It would do less about moderating hospital prices, particularly when compared with an earlier version of the bill.

Curbing hospital prices

When it was filed in March 2023, the De-Weaponization Act, in addition to requiring hospitals to produce and publicize an MDMP, included provisions that required hospitals to provide specific discounts to patients who were below certain income eligibility standards. For example, it required free care for patients with a household income at or below 200% of the federal poverty level (FPL).[xx] For patients above that level but at or below 400% FPL, the bill described a discount formula based on the Medicare rate, which would limit a hospital bill to a maximum of $1,150. Further, patients with income below 400% FPL would not be liable for more than $2,300 per year in cumulative hospital bills. In 2022, more than 60% of North Carolina's residents had incomes at or below 400% FPL.[xxi] Finally, patients with income up to 600% FPL would be eligible for the same discount if their medical bills over the previous 12 months exceeded 10% of household income. The discounts would apply to any charges not covered by insurance, which presumably would include copayments and deductibles for insured patients as well as all charges to uninsured patients.[xxii]

Unfortunately, the version of the bill that passed the Senate excludes the discount formula from the filed version of the bill. While it requires hospitals to develop a written MDMP that includes eligibility criteria for financial assistance, it does not require any specific eligibility standards or discounts. Because of this, the version that is now before the House is less likely to have a significant systemic impact on hospital prices.

Improving affordability

The bill's requirement for MDMPs, including the requirement that all collection attempts include information about financial assistance, would improve the affordability of hospital services for patients who in the past have been pursued for outstanding bills despite being eligible for financial assistance. Limiting interest on medical debt to a maximum of 5%, rather than the current 8%, will reduce the financial burden on people who are paying off their bills over time. Additionally, restrictions on extraordinary collection actions

reduce (but do not eliminate) the threat of larger financial repercussions from damaged credit and property lines, for example.

The De-Weaponization Act as filed had stronger affordability provisions than the version that passed the Senate. In addition to the prescribed discounts, the original bill prohibited *any* interest or late fees for patients who qualified for financial assistance. Qualifying patients would also have to be offered a payment plan of at least 24 months with monthly payments not exceeding 5% of gross monthly income.[xxiii]

Enforcement

The De-Weaponization Act includes two enforcement provisions, including the right for a patient to challenge a hospital's compliance with the law. Patients who establish a hospital's non-compliance would be entitled to triple the amount of damages determined by a legal action. The bill does not provide for assistance in bringing such an action, however.[xxiv]

The North Carolina Attorney General also is authorized to enforce the law, by establishing a complaint process and adopting rules to enforce the law. The language in the bill does not set out requirements for investigating claims, nor does it establish penalties for failure to comply with the law.[xxv]

The North Carolina Department of State Treasurer played a significant role in bringing policy attention to hospital practices and medical debt leading up to the introduction of the De-Weaponization Act – which can be a possible model for other states. As a steward of state finances, the Treasurer's office, partnering with researchers and the State Health Plan, brought to light behavior such as hospitals not providing sufficient charity care and suing patients for debt that many of them should not have had. Because so much of the health care system relies on public funds – as payment for services and through tax exemptions for non-profit institutions – state financial officials can play an important role in holding hospitals accountable.

Community Catalyst's compendium ranked North Carolina's current policies addressing hospital prices and medical debt 35th among the states.[xxvi] If the De-Weaponization Act were to become law, the state would move up substantially in the rankings, to 16th. Further, if the financial assistance eligibility standards and discount requirements from the as-filed version of the bill were included, North Carolina would have the second-strongest set of policies in the nation, according to Community Catalyst's methodology. A table contrasting current law with the two versions of the De-Weaponization Act is presented in the Appendix.

What more could/should be done to address high hospital prices and medical debt?

The differences between the as-filed and Senate-passed versions of the Medical Debt De-Weaponization Act suggest that compromises were necessary to move the bill's debt collection protection provisions along in the legislative process. Lost to that process, though, were strong free care and discount requirements that would have directly addressed high hospital prices for more than half of North Carolina's population. In the future, advocates and policymakers may want to revisit this and other policy approaches that directly address high prices.

Another way to address high and increasing prices is to take action against hospital consolidation, which often reduces competition and allows providers remaining in an area to increase their prices. The Federal Trade Commission has become more active in exercising its enforcement authority in this area. For example, in January, the FTC announced a lawsuit seeking to block the acquisition of two North Carolina hospitals by Novant Health, on the grounds that the transaction threatened to raise prices and reduce incentives to invest in quality and innovative care.[xxvii]

Conclusion

The Medical Debt De-Weaponization Act is an attempt to rein in aggressive and unfair collection practices that left many in North Carolina with medical debt they should not have. Earlier versions of the bill would also have made major strides in making hospital care more affordable for many people in the state, but that is no longer part of the legislation. With Medicaid expansion as the first step, and the version of the De-Weaponization Act now before the House as the second, perhaps advocates and allied lawmakers and policymakers will return soon for a third act and take on hospital prices.

Appendix: Comparison of Current Law and Provisions of SB 321

Category	Current Law	CC rating*	SB 321, as passed by Senate	CC rating	SB 321, as filed	CC rating
Financial Assistance	Hospital designs policy, no specific rules for free care	Low	Requires hospitals to have a medical debt mitigation policy but no standards for eligibility for free or discounted care	Low	Requires hospitals to have a medical debt mitigation policy and specifies that patients with income at or below 200% FPL receive free care	High
Required Discounts	No provision	Low	No provision	Low	Discounts required up to 400% FPL and 600% FPL for patients with high medical expenses; maximum OOP spending $2,300 per year. Applies to uninsured and insured patients	High
Billing & Collections limits	Prohibits wage garnishment and some limits on liens; few time requirements on when collection may begin or resume; spouse may be liable for debt; up to 8% interest allowed	Low	Expands extraordinary collection action (ECA) prohibitions and restricts use of permissible ECAs; strong notice requirements; redress for erroneous collections; interest limited to 5%; spouses not liable for medical debt; private right of action for violations	Medium	Same as as-passed, **plus** must screen for financial assistance eligibility before seeking payment; if eligible for financial assistance, • No interest on debt • Payment plan of at least 24 months, with payments not exceeding 5% of monthly income	High
Price Transparency	Exceeds federal transparency standards by requiring prices to be posted for a larger number of services	Medium	Hospitals must post on their websites: • Gross charges for all services • Medicare rates for all services	Medium	Same as passed	Medium

			• Plain language descriptions			
Facility Fees	No provision	Low	Facility fees prohibited except for services provided on a hospital's main campus or at a facility that includes an emergency department. No facility fees for services, regardless of where performed, that can be reliably and safely provided in non-hospital setting	High	Not addressed in bill	Low
Overall Rating		Low		Medium		High
Ranking Among States		35		16		2

* Community Catalyst rating of policy, using criteria described in the Methodology of The Compendium of State Policies to Curb Hospital Prices and Reduce Medical Debt

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[i] Barak Richman, Sara Sternberg Greene, Sean Chen, and Julie Havlak. Hospitals Suing Patients: How Hospitals Use N.C. Courts to Collect Medical Debt. Duke University School of Law, 2023.
[ii] Kaiser Family Foundation, Who Could Medicaid Reach with Expansion in North Carolina? https://files.kff.org/attachment/fact-sheet-medicaid-expansion-NC, accessed February 7, 2024.
[iii] The study computed the ratio of prices paid by private insurers with those paid by Medicare. North Carolina's relative price was 266 percent of Medicare; the national average ratio was 224 percent. Christopher M. Whaley et al., Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative. RAND Corporation, 2022.
[iv] Kaiser State Health Facts, analysis of data from the 2021 American Community Survey. https://www.kff.org/other/state-indicator/median-annual-income/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Median%20Annual%20Household%20Income%22,%22sort%22:%22desc%22%7D, accessed February 7, 2024.
[v] Health Care Cost Institute, 2021 Health Care Cost and Utilization Report, April 2023. Data files: https: healthcostinstitute.org/images/pdfs/HCCUR2021_Downloadable_Data_Files.zip
[vi] U.S. Census Bureau, American Community Survey 1-Year Estimates, 2021.
[vii] Kaiser State Health Facts, estimates using data from the 2022 American Community Survey. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7
D, accessed February 7, 2024.
[viii] Health Care Cost Institute.

[ix] Debt reported to a major credit bureau. Includes past-due credit lines that have been closed and charged-off on
the creditor's books as well as unpaid bills reported to the credit bureaus that the creditor is attempting to collect.
[x] Debt in America: An Interactive Map. The Urban Institute. https://apps.urban.org/features/debt-interactive-map/, accessed February 7, 2024.
[xi] Debt in America: An Interactive Map. The Urban Institute. https://apps.urban.org/features/debt-interactive-map/, accessed December 12, 2023.
[xii] North Carolina Hospitals: Charity Care Case Report. North Carolina State Health Plan and Johns Hopkins Bloomberg School of Public Health. October, 2021.
[xiii] N.C. Nonprofit Hospitals Bill the Pool. North Carolina State Health Plan, Rice University's Baker Institute for Public Policy, and the Office of the N.C. State Treasurer. January, 2022.
[xiv] Barak Richman et al., Hospitals Suing Patients.
[xv] Michelle Crouch, Atrium Health halts lawsuits against patients for unpaid medical bills. NC Health News, https://www.northcarolinahealthnews.org/2023/10/16/atrium-health-halts-lawsuits-against-patients-medical-debt/, access February 9, 2024.
[xvi] Senate Bill 321, https://www.ncleg.gov/BillLookUp/2023/S321
[xvii] Senate Bill 321, https://www.ncleg.gov/BillLookUp/2023/S321
[xviii] Barak Richman et al., Hospitals Suing Patients.
[xix] In general, spouses are not liable for the other spouse's debt in North Carolina, but there is an exception for medical costs under the "doctrine of necessaries," a common law concept. https://www.bills.com/learn/debt/doctrine-of-necessaries, accessed February 22, 2024.
[xx] In 2024, 200 percent of the federal poverty level for a family of four is $62,400.
[xxi] U.S. Census Bureau, Table B17002, 2022 American Community Survey 1-year estimates.
[xxii] Medical Debt De-Weaponization Act, version as file March 16, 2023. https://www.ncleg.gov/Sessions/2023/Bills/Senate/PDF/S321v0.pdf, proposed §131E-214.24(b). Accessed February 12, 2024.
[xxiii] Medical Debt De-Weaponization Act, version as file March 16, 2023. https://www.ncleg.gov/Sessions/2023/Bills/Senate/PDF/S321v0.pdf, proposed §131E-214.24(f) and (g). Accessed February 12, 2024.
[xxiv] Senate Bill 321, proposed §131E-214.37.
[xxv] Senate Bill 321, proposed §131E-214.39.
[xxvi] https://communitycatalyst.org/resource/50-states/
[xxvii] FTC Sues to Block Novant Health's Acquisition of Two Hospitals from Community Health Systems. https://www.ftc.gov/news-events/news/press-releases/2024/01/ftc-sues-block-novant-healths-acquisition-two-hospitals-community-health-systems, accessed March 19, 2024.