

# Executive Summary

Recent research has clearly documented that unaffordable medical bills and resulting medical debt are widespread in the United States. Although the uninsured are most at risk, people with insurance are vulnerable as well; one survey found that more than one quarter of people continuously insured over the previous year had medical bill problems or medical debt. However, while national surveys document the prevalence of medical bill problems among the insured, they are not able to demonstrate the specific ways in which health insurance products fail to protect people financially and fail to guarantee their access to needed care when ill or injured.

The purpose of this study is to investigate the gaps in coverage and the systemic problems that cause insured people to accrue medical debt, as well as the consequences of the debt for individuals and families. The findings are based on in-depth interviews with 45 people in seven states who had accrued medical debt while they were privately insured, either through an employer-sponsored or an individually purchased plan.

The findings are summarized below. However, because summary findings cannot easily convey the complexity of our interviewees' experiences, we recommend that all readers also review the stories and comments in the body of the report. To facilitate this process, we have highlighted some of the stories and comments within the text.

## Findings

Our interviews suggest that medical debt among the insured results from a variety of causes and the interaction of a number of factors, including the adequacy of people's insurance plans, the nature of their medical needs, the cost of their treatments, and their financial resources. In all cases, however, interviewees found that their insurance failed to fulfill its primary function—to protect them from financial losses and guarantee access to needed care when they became ill.

### ***Insurance Characteristics that Cause Medical Debt***

Some of the insurance characteristics that caused interviewees to accrue debt included the following:

- **Premiums, deductibles and other cost sharing.**

About two-thirds of our interviewees cited premiums, deductibles, co-payments, or co-insurance as one source of their medical debt; many cited a combination of these charges. People with lower incomes and/or chronic conditions were particularly vulnerable, even when their deductibles and other cost-sharing requirements seemed relatively modest. However, many with higher incomes also faced unaffordable out-of-pocket expenses because of high deductibles, co-insurance, and other forms of cost-sharing.

- **Caps on coverage.**

Some interviewees had insurance policies that set annual or lifetime caps on coverage. If they suffered catastrophic medical events, they then found themselves liable for enormous medical bills. Others had policies that capped coverage for particular services, such as rehabilitation or dental care, which caused them to accrue serious medical debt.

- **Uncovered services.**

Over a third of our interviewees accrued medical debt because of uncovered services. Some of the most common were prescription drug coverage, dental services, and durable medical equipment. People with children with special health care needs were particularly vulnerable because their children often required treatment not traditionally covered by insurance, such as occupational therapy or special nutritional supplements.

### ***Insurance Processes that Cause Medical Debt***

Many interviewees also described complex and confusing insurance processes that made it difficult for them to get claims issues resolved and left them with unaffordable medical bills and medical debt.

- **Confusing policy provisions.**

As health insurers have added complex combinations of cost-sharing components to their plans in order to shift risk to consumers, policies have become increasingly difficult to understand. Interviewees often found the provisions of their policies confusing, which made it difficult for them to understand which services should or should not be covered.

- **Out-of-network fees.**

A number of interviewees cited increased co-insurance or deductible payments that resulted from getting care from providers not in their plan's network. Many received care at hospitals that were in their network, but were not told that doctors who provided care in the hospital were not in their network. Others were charged out-of-network fees even when in-network providers were not available.

- **Procedural problems.**

Complex insurance plans often placed on patients the burden of complying with a complex web of requirements and procedures. Some interviewees were left with unpaid bills because they were not informed about procedures they needed to follow, or were asked to comply with procedures that seemed unnecessary.

- **Insurance disputes and errors.**

Many interviewees found they had to devote enormous amounts of time and energy to resolve insurance errors. When they tried to clarify issues with insurers, they often received confusing, inconsistent, or inaccurate information, and sometimes found it took

weeks or months to resolve problems. Some were unable to resolve problems and were left with unanticipated, unaffordable medical bills.

- **Complex provider billing and collections systems that compounded problems resulting from complex insurance processes.**

When people were left with unaffordable bills resulting from complicated insurance policies and difficult to navigate insurance systems, they often found their problems compounded by equally hard to navigate provider billing and collections systems. Often people found it hard to reconcile confusing hospital bills with confusing insurance statements. Providers also sometimes made mistakes when submitting claims to insurers, which created problems for interviewees.

When interviewees did end up owing money to hospitals and other providers, they often found themselves subject to aggressive billing and collections processes. Some were never informed about hospital financial assistance options. Many said they were willing to pay reasonable charges for services but felt that providers charged grossly inflated prices.

### ***Lack of Meaningful Choice of Plans***

Interviewees did not willingly choose to have insurance that left them vulnerable to serious financial exposure if they became ill. Usually they had inadequate insurance because it was the only option offered to them or because it was the only option they could afford. As a result of problems with their coverage, many interviewees began to question whether their policies were worth the premiums they paid for them, or whether they would be better off without coverage.

About 70 percent of our interviewees had group insurance, that is insurance provided through their employer. The following problems were experienced by people with group insurance:

- **No real choice of plans.**

Only about half of interviewees who received coverage through their employment were offered a choice of plans. Those with the highest deductibles—\$2,000 or more—did not have a choice of plans. Even when people had a choice, they often chose the policy with the lowest premium because they felt it was all they could afford, even though it left them subject to other unaffordable out-of-pocket expenses.

- **Increasing costs and worsening coverage.**

The majority of interviewees with group coverage said their premiums and cost-sharing had gone up significantly in the last few years, while their coverage had gotten worse. Some noted that their wage increases had not kept pace with their increased insurance-related expenses.

Almost one-third of our interviewees had coverage they purchased individually or

through associations they joined simply to be eligible to purchase coverage. While people purchasing coverage in the non-group market theoretically have a choice of plans, in practice their choices were often highly constrained by cost factors. In addition, people purchasing insurance in the non-group market were particularly vulnerable to certain types of problems.

- **Higher premiums and levels of cost sharing.**

Interviewees with non-group coverage tended to have higher levels of cost-sharing than those with employer-sponsored coverage. Almost all interviewees with non-group coverage who reported on the size of their deductibles had deductibles equal to or greater than \$2,000 a year, compared to only one of the interviewees with group coverage who reported on the size of their deductibles. People with non-group coverage also tended to have higher monthly premiums.

- **Pre-existing condition exclusions.**

People with non-group coverage also confronted problems related to the exclusion of pre-existing conditions. Some were only able to purchase coverage that excluded their medical condition, some were faced with prohibitively high prices if they had existing conditions, and some were refused coverage altogether. One interviewee had his coverage rescinded when he became ill and started to file claims.

- **Deceptive marketing practices.**

People with non-group coverage were particularly vulnerable to deceptive and possibly fraudulent marketing that misrepresented the coverage being offered. Some interviewees purchased high-deductible policies that they thought would provide catastrophic coverage. However, when they needed care, they discovered that fine print exclusions in the policies meant that almost none of their care was covered.

### ***Consequences of Medical Debt***

Medical debt had serious consequences for our interviewees related to access to care, financial security, employment, access to credit, and psychological quality of life.

- **Access to care.**

Nearly nine out of ten interviewees said their medical debt affected their ability to access care, and nearly half said reduced access to care had negatively affected their health. In most cases, people postponed or did not get needed care because they couldn't afford the cost sharing and feared incurring more debt. In some cases, providers refused to see them because of their unpaid bills. Sometimes people did not get preventive or diagnostic care.

Sometimes the failure to get care in a timely way resulted in more serious and expensive health problems later on. Most interviewees feared getting sick because, even though they had insurance, they felt they could not afford the cost of the care.

- **Financial consequences.**

Almost all of our interviewees experienced negative financial consequences as a result of their medical debt. For some people who experienced catastrophic medical events, enormous medical expenses required them to take out very large loans. For people with lower or moderate incomes, medical debt contributed to the existing difficulties of living on a limited budget. Over a third of our interviewees used up their savings or were unable to save for retirement because of their medical bills. Many interviewees were forced to refinance their mortgages or take out loans against their homes to pay medical bills. In the most extreme cases, some interviewees were forced into bankruptcy.

- **Employment consequences.**

Almost three-quarters of our interviewees said medical bill problems affected their employment. Some people were forced to reduce their work hours or stop working because of their or a family member's illness. Other people found they had to work longer hours to help pay their families' medical bills. A number of interviewees felt they needed to find new employment because their health benefits were so poor. The costs of health insurance also made it difficult for people to start or maintain their own businesses.

- **Access to credit.**

Medical debt had negative affects on many interviewees' ability to access credit. Nearly half had been contacted by collection agencies because of their medical bills, and several were encouraged to pay their bills with credit cards, which can saddle people with interest payments and sometimes excessive late fees. Some were denied loans, for example to pay for a child's education, and others had to get loans with higher interest rates.

- **Psychological consequences.**

Most interviewees reported that their unpaid medical bills contributed to increased stress and tension in their families. A number of interviewees felt that the increased stress had affected their health and ability to heal.

## Discussion & Recommendations

In recent years, much attention has been paid to hospitals' lack of transparent pricing and their aggressive billing and collections practices. However, similar attention has not been paid to the policies and practices of insurance companies. Our interviews suggest that states are not seriously monitoring benefit packages and premium rates to ensure that consumers are being offered real value in exchange for their premiums. They indicate that insurance companies are not being held accountable for inadequate customer service systems and error-prone claims handling processes that often leave consumers liable for expenses that they should not have to bear. And they reveal that some insurance products are being marketed deceptively and possibly even fraudulently.

These issues assume particular importance as policymakers increasingly turn to the private insurance market as the vehicle for expanding coverage. Some propose shifting more costs to consumers in order to make them more prudent purchasers of health care. Others support allowing the sale of policies with limited benefits, maintaining that such plans will make coverage more affordable or allow people to choose the level of coverage that best meets their needs. Our interviews indicate that the assumptions behind these proposals are deeply flawed. Most of our interviewees had few meaningful options when they purchased coverage and, rather than frivolously seeking inappropriate care, have gone deeply in debt to obtain needed care or delayed necessary care because of the cost.

In addition, some policymakers are proposing that uninsured individuals be required to purchase private insurance; Massachusetts has already passed a law including such an "individual mandate." However, before relying on the private insurance market as the means of expanding coverage for the insured, it is important to understand how well the market is working, identify existing problems, and, where they exist, rectify them. Otherwise, we will simply replace the problems related to lack of health insurance with problems related to inadequate insurance. For insurance to fulfill its primary goals of mitigating the financial risk associated with illness and guaranteeing people access to necessary care, it must meet three criteria:

- 1. It must be comprehensive.** This includes covering medically necessary and effective treatments, such as prescription medications, as well as preventive care and disease management.
- 2. It must be affordable.** Affordability must take into account not only the cost of premiums, but also all of the other out-of-pocket expenses for which people will be liable, such as deductibles, co-payments, and out-of-network fees.
- 3. It must be accessible, including to people who have pre-existing medical conditions or health risk factors.**

To achieve these goals, we recommend the following:

**Set standards for what constitutes comprehensive, affordable insurance.**

Standards must include both the range of benefits covered and the out-of-pocket amounts for which consumers may be liable.

**Ensure that people are provided with information that allows them to be informed consumers when they try to purchase health insurance.**

For example, insurance companies could be required to provide consumers with standard disclosure forms that clearly detail the services products cover and the out-of-pocket expenses for which consumers are liable.

**Enact guaranteed access, guaranteed renewability, and community rating laws in states where they are not already in place.**

These types of laws prohibit insurers from refusing to sell insurance to individuals because of health status and prevent them from charging premiums based on health status that would effectively shut people with medical conditions out of the insurance market.

**Conduct oversight to ensure that health insurance premiums are reasonable.**

States should require insurers to file requests for premium increases and hold public hearings on the requests. Requests should be evaluated with respect to insurers' efficiency (the amount of each dollar they spend directly on covering health insurance claims) and resources (profits, surpluses, and reserves).

**Develop public/private partnerships to help share the cost of comprehensive, affordable coverage for people with limited resources.**

Some states have already implemented programs that combine state and private funding to provide comprehensive coverage for groups that could not otherwise afford it.

**Create mechanisms to help consumers resolve insurance-related problems.**

States should create and staff strong customer service departments to record and investigate customer complaints about health insurance contracts and practices. Some states have appointed independent ombudsmen to assist consumers who have insurance-related problems and to intercede with insurance companies to help resolve them.

**Set rules that prohibit unfair insurance practices.**

These might include prohibiting post-claims revocations of policies or charging out-of-network fees when patients receive care in in-network hospitals. States also need to regularly

monitor insurance industry compliance with existing laws and require corrective actions when necessary.

**To protect people who are left with unaffordable medical expenses that their insurance will not cover, require hospitals and other providers to offer appropriate discounts and financial assistance.**

Financial assistance programs should be available to both the uninsured and to people with inadequate insurance.



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