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PULSE

Quarter of Insured Americans Face Health Care Affordability Crisis

Roughly 23% of insured Americans struggle to afford necessary medical care despite having medical coverage.

A new Commonwealth Fund survey reveals a troubling trend in American health care: 23% of those with year-round insurance in 2023 were effectively "underinsured," struggling to afford necessary medical care despite having coverage.

The survey, which polled working-age adults between 18 and 64, found that the majority of underinsured Americans (66%) received coverage through their employers. The remaining underinsured population was split between Medicaid/Medicare recipients (16%) and those with marketplace or individual plans (14%).

The consequences of being underinsured are significant, with 57% of these individuals reporting they avoided necessary health care due to costs. Additionally, 44% were actively paying off medical or dental debt. Among those who delayed care due to financial concerns, 41% reported their health conditions worsened as a result.

Understanding "Underinsured" Status

The Commonwealth Fund defines "underinsured" through several criteria:

- Out-of-pocket costs (excluding premiums) reaching 10% or more of household income over 12 months.
- Individual or family deductibles constituting 5% or more of household income.
- For those below 200% of the federal poverty level, out-of-pocket costs exceeding 5% of household income.

Impact on Health Care Access

The survey highlighted significant barriers to accessing timely health care among both underinsured and uninsured populations. While 57% of underinsured individuals reported skipping needed care due to cost, this number rose to 70% among those lacking continuous coverage. These delays included:

- Not visiting doctors when sick
- Skipping recommended follow-up visits or tests
- Avoiding specialist consultations
- Not filling prescriptions

Additionally, one in five respondents reporting delayed mental health care due to cost concerns. The survey also found

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that 42% of adults who skipped care were dealing with ongoing health conditions, while 29% needed care for new health problems.

The financial burden of medical debt is also notable, including:

- Three in 10 respondents reported ongoing medical debt payments.
- Forty percent of those with medical debt had depleted all or part of their savings.
- Twenty-eight percent experienced lower credit ratings due to medical debt.
- Those with employer coverage and lower incomes reported higher rates of medical debt than those with higher incomes.
- Medicaid recipients reported significantly lower rates of medical debt compared to those with employer or marketplace plans.

What's Next?

The Commonwealth Fund suggests several policy changes to address these issues:

- Making enhanced marketplace premium tax credits permanent beyond 2025.
- Extending continuous Medicaid eligibility periods.
- Creating automatic enrollment systems for comprehensive health coverage.
- Reducing deductibles and out-of-pocket costs in marketplace plans.
- Implementing income-based adjustments for premiums and cost sharing.
- Working to control overall health care cost growth.

"The United States has made considerable gains in health insurance coverage since the Affordable Care Act's passage, but more work is needed to cover the remaining uninsured, eliminate gaps in coverage, and ensure that all health insurance does what it's supposed to: enable people to get health care when it's needed, without fear of incurring debt," the survey states.

DOJ Recovered $1.7 Billion in Health Care Fraud Cases in 2024

The department charged 193 individuals across 32 federal districts relating to health care fraud last year.

The Department of Justice (DOJ) concluded fiscal year 2024 with remarkable achievements in fraud enforcement, recovering $2.9 billion from False Claims Act settlements and judgments, with health care fraud representing $1.7 billion of the total. This year's success was amplified by unprecedented enforcement actions and a historic surge in whistleblower participation.

The year witnessed an unprecedented 979 whistleblower cases, contributing $2.4 billion to the total recovery and generating over $400 million in whistleblower rewards. This record-setting participation demonstrates growing public involvement in combating health care fraud.

In a separate intensive two-week operation, the DOJ's Health Care Fraud Strike Force charged 193 individuals across 32 federal districts in schemes totaling $2.75 billion in intended losses and $1.6 billion in actual losses. Notably, 76 of those charged were licensed health care providers, highlighting the concerning involvement of medical professionals in fraudulent activities.

Several landmark cases defined the year's enforcement efforts, including:

- Community Health Network paid $345 million to resolve Stark Law violation allegations.
- Endo Health Solutions agreed to a $475.6 million bankruptcy claim over aggressive opioid marketing.
- Walgreens settled for $106.8 million regarding billing for unclaimed prescriptions.
- Oak Street Health paid $60 million over alleged kickback schemes.

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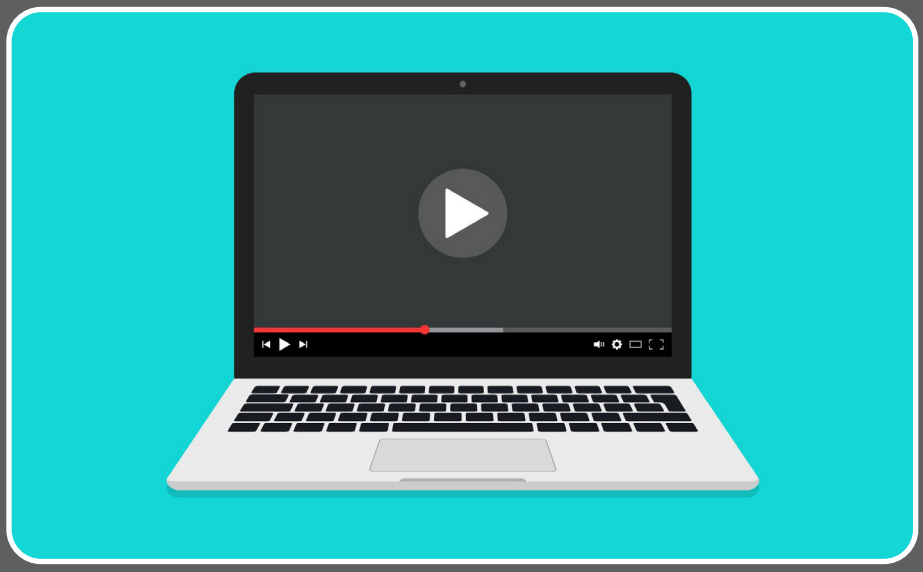
NEWS & NOTES

Why Gathering Accurate Patient Information is Important

ACA's Healthcare Committee recently put together a series of training videos for health care providers. One of their videos, "Why Gathering Accurate Patient Information is Important," provides a valuable training resource for frontline staff in health care provider offices. This informative video emphasizes the critical role of accurate patient information collection in maintaining a successful medical practice. It explains how proper information gathering directly impacts a facility's financial health, insurance processing, and overall operational efficiency. Through practical insights, it demonstrates that accurate patient data collection is not just an administrative task but a fundamental business necessity that affects everything from quality of care to staff satisfaction. The video highlights how thorough information gathering at the point of service helps maintain steady cash flow, ensures proper insurance filing, and creates a more streamlined workflow that benefits both the facility and its staff. This is valuable for health care administrators, front desk staff, and medical professionals who want to understand the broader impact of proper patient information management.



Access the video here.

DOJ Recovered cont. from page 2

- Rite Aid faced multiple settlements, including $7.5 million plus a $401.8 million bankruptcy claim.
- DaVita agreed to pay $34.5 million related to kickback allegations.

The DOJ's enforcement actions also addressed a wide spectrum of fraudulent activities:

- Opioid-related misconduct and improper dispensing.
- Medicare Advantage program abuse.
- Telemedicine and laboratory fraud schemes.
- Medically unnecessary services.
- Kickback arrangements.
- Controlled substance violations.
- Adulterated medication distribution.

The department continues to pursue significant cases, including active litigation against major health care entities such as UnitedHealth Group, Elevance Health, and Kaiser Permanente.

"The False Claims Act and its whistleblower provisions remain a critical tool in protecting the public fisc and ensuring that taxpayer funds serve their intended purposes," said Principal Deputy Associate Attorney General Benjamin Mizer.

Since the Civil False Claims Act's enhancement nearly 40 years ago, the DOJ has recovered more than $78 billion through settlements and judgments.

While the 2024 health care recovery of $1.7 billion slightly decreased from 2023's $1.8 billion, the overall fraud recovery increased from $2.7 billion to $2.9 billion.

The year's data also included significant asset seizures, with law enforcement officials recovering over $231 million in cash, luxury vehicles, gold, and other assets connected to health care fraud schemes.

"The results announced today highlight once again that such conduct will not be tolerated, and those who knowingly misuse taxpayer funds will be held accountable," said Brian Boynton, principal deputy assistant attorney general.

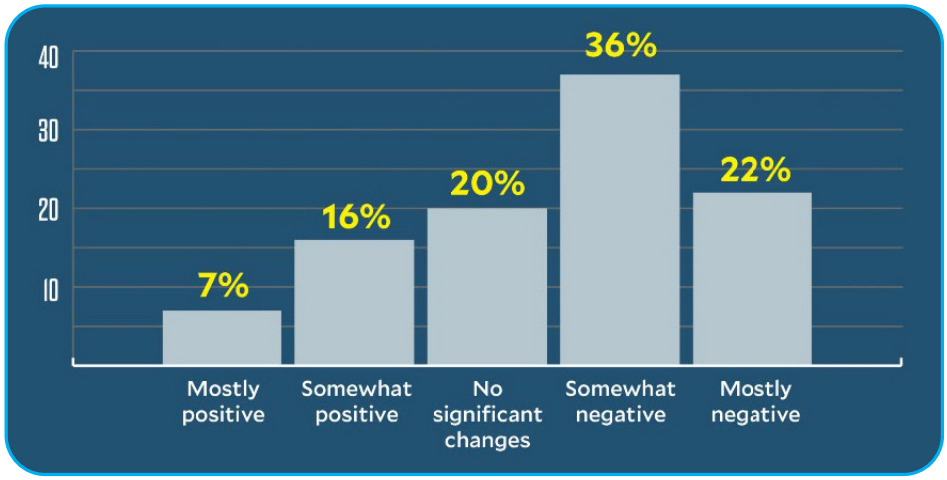
Read more here.

DATAWATCH

Health Care Providers Report Deteriorating Relationships with Insurance Payers

A recent Healthcare Financial Management Association (HFMA) report reveals a significant decline in payer-provider relationships, with 60% of health system CFOs reporting worsened interactions over the past three years. The study highlights several critical issues, including increased denial rates (which 80% of CFOs believe is intentional), stagnant fee schedules despite rising costs, and growing administrative burdens that have forced 75% of providers to expand their financial services staff. The situation has become so severe that 87% of CFOs say these dynamics impede optimal patient care delivery, while prior authorization delays contribute to both provider burnout and patient dissatisfaction.

Survey Question: How would you characterize the changes in your organization's relationships with payers over the past three years?



***Source**: HFMA Survey, Bridging the Payer-Provider Divide, August 2024* https://tinyurl.com/4am9xr65

PULSE

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