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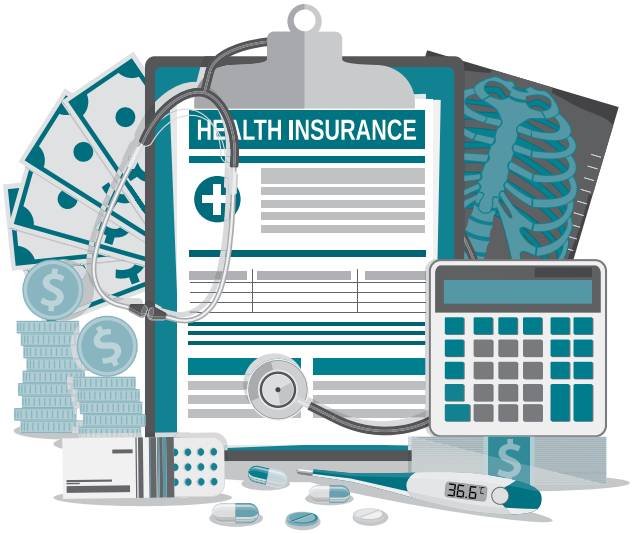
Medical Debt Reporting Requirements Take Effect in September: What You Need to Know

By Andrew Pavlik

The National Consumer Assistance Plan (NCAP) has brought many changes to data furnishers, and there are more on the way, including in the healthcare collections field.

For a refresher, NCAP is the result of an agreement between the big three consumer reporting agencies (Experian, Equifax and TransUnion) and multiple state attorneys general. The final result is a set of reforms that are reshaping, in many ways, how data is furnished to CRAs. While many of the NCAP reforms have already been implemented, a new round of reforms is set to take effect.

Medical debt continues to be a huge market in the credit and collection industry. In 2013, healthcare-related debt represented nearly 38 percent of debt collected through the third-party collection industry, according to the ACA International white paper, "The Role of Third Party Debt Collection in the U.S. Economy."



Required by Sept. 15, 2017 for Debt Collectors and Debt Buyers

- Do not report medical debt collection accounts (as defined by Creditor Classification Code 02) until they are at least 180 days past the date of first delinquency with the original creditor that led to the account being sold or placed in collection.
- Delete accounts that are being paid by insurance or were paid in full through insurance. This does not include accounts paid in full by the consumer.

The date of first delinquency with the original creditor needs to be determined by the provider and furnisher based on the underlying financial agreements and the creditor's policies for when an account becomes "delinquent."

Date of delinquency, as defined in the Fair Credit Reporting Act, is "the month and year of the commencement of the delinquency on the account that immediately preceded collection activity, charge to provide or loss, or similar action."

Practical Considerations

Now is the time to tackle these changes in order to make the transition smooth. Begin working with your operations personnel to update your policies and procedures and train your staff. Consult with other agencies that you may be in contact with to see how they are dealing with the new requirements. Educate clients on NCAP and work with them as you move forward. Most importantly, carefully review any information provided by the CRAs and contact the CRAs as soon as you have questions. The CRAs are the entities steering the implementation of the NCAP, so they are in the best position to provide clarification to furnishers.

Andrew Pavlik formerly served as ACA International's senior compliance analyst.

STUDY:

'Balance Billing' From Providers Shows Need for State, Federal Protections

Consumers in some states are receiving "balance bills" for healthcare if they are treated by an out-of-network provider not covered by their health insurance plan, according to an issue brief from The Commonwealth Fund.

"Privately insured consumers expect that if they pay premiums and use in-network providers, their insurer will cover the cost of medically necessary care beyond their cost-sharing," The Commonwealth Fund reports in the brief, *Balance Billing by Health Care Providers: Assessing Consumer Protections Across States*. "However, when obtaining care at emergency departments and in-network hospitals, patients treated by an out-of-network provider may receive an unexpected 'balance bill' for an amount beyond what the insurer paid. With no explicit federal protections against balance billing, some states have stepped in to protect consumers from this costly and confusing practice."

The Commonwealth Fund researched the issue to better understand the state laws to protect consumers from balance billing by an out-of-network provider and found that most states do not have laws in place.

"Of the 21 states offering protections, only six have a comprehensive approach to safeguarding consumers in both settings, and gaps remain even in these states," The Commonwealth Fund reports. "Because a federal policy solution might prove difficult, states may be better positioned in the short term to protect consumers."

Private health insurance purchased by consumers is a mechanism to offset the high cost of healthcare.

"They expect that if they pay their premiums and use in-network providers, their insurer will cover the cost of medically necessary care beyond their specified copayments, coinsurance, and deductibles," according to The Commonwealth Fund.

However, if consumers are treated by an out-of-network provider, such as during an emergency room visit, they may face extra costs. Out-of-network providers do not have contracts with health plans and therefore no negotiated payment rates, according to The Commonwealth Fund.

In some cases, consumers will receive "balance bills" totaling thousands of dollars when an out-of-network provider issues a charge that is the difference between health insurance coverage and doctor's fees.

And, oftentimes when a consumer is cared for out-of-network, they did not have a choice about the provider.

Research published in *Health Affairs Web First*, "One in Five Inpatient Emergency Department Cases May Lead to Surprise Bills," cited by The Commonwealth Fund shows 14 percent of emergency department visits and 9 percent of hospital stays were likely to result in an unexpected bill. Twenty percent of patients admitted to the hospital from the emergency department were likely to receive an unexpected bill, according to the research.

Additional findings in the issue brief include:

- Twenty-one states have "direct protections" in their statutes or regulations for consumers who would be subject to balance bills as a result of out-of-network care, however they do not prevent balance billing for consumers in all situations;
- Six states—California, Connecticut, Florida, Illinois, Maryland and New York—have a comprehensive approach to protecting consumers, including "holding them harmless from extra provider charges and prohibiting providers from balance billing;"
- In 12 states, "balance-billing protections only require insurers to hold consumers harmless from the billed charges of providers but do not prohibit providers from sending bills. Because these states do not prohibit providers from balance billing, consumers may still receive a bill from a physician, hospital, or other provider." In those states, Colorado for example, regulators have reported consumers receive balance bills and may not understand their rights not to pay.
- Additionally, in 29 states and the District of Columbia, there are no laws or regulations "that explicitly protect consumers from unexpected balance billing by out-of-network providers in [emergency departments] or in-network hospitals.

The Commonwealth Fund concludes in the issue brief that balance billing can create financial troubles as much as impact consumers' views on the healthcare system.

"Consumers expect that their health insurance will cover the cost of most medically necessary care beyond their cost-sharing amounts. But when emergencies or other unexpected circumstances expose them to out-of-network providers, balance billing can create financial burdens and undermine their confidence that health insurance will protect them from financial hardship," it reports.

"Concerns about balance billing are not new but may be growing as the use of narrow provider networks becomes increasingly common. The fact that consumers are more likely to experience balance billing in situations where they have no control over which providers treat them suggests that additional state and federal policy solutions are needed to protect consumers fully and limit financial risk."

Read more in the issue brief here: http://ow.ly/esqL30cQIqA

MEDICARE:

CMS Proposes Updates to Reduce Burdens Under Quality Payment Program in 2018

The Centers for Medicare and Medicaid Services has proposed changes to the Quality Payment Program instituted by the Medicare Access and CHIP Reauthorization Act of 2015 that aim to simplify the program.

The proposed changes would occur in the second year of the Quality Payment Program and would especially help streamline the requirements for small, independent and rural healthcare practices, "while ensuring fiscal sustainability and high-quality care within Medicare," CMS reports (*http://ow.ly/U9rN30cQpuA*.)

Under the program, healthcare providers that bill more than $30,000 to Medicare Part B and care for more than 100 patients a year should start recording their quality data and documenting how they are using technology to support their practice, ACA International's *Collector* magazine editor Anne Rosso May previously reported.

The first performance period of the program is currently underway and during this time providers can pick their pace to report data to Medicare. They can choose to test the Quality Payment Program on a limited basis, participate for only part of the calendar year or participate for the full calendar year. This reduced set of requirements for 2017 gives providers time to fine-tune their basic infrastructure and get familiar with what's expected of them.

The proposed rule for 2018, "would amend some existing requirements and also contains new policies for doctors and clinicians participating in the Quality Payment Program that would encourage participation in either Advanced Alternative Payment Models or the Merit-based Incentive Payment System," CMS reports.

CMS has also used feedback from healthcare providers to craft the second year of the program.

"We've heard the concerns that too many quality programs, technology requirements, and measures get between the doctor and the patient," said CMS Administrator Seema Verma in the news release. "That's why we're taking a hard look at reducing burdens. By proposing this rule, we aim to improve Medicare by helping doctors and clinicians concentrate on caring for their patients rather than filling out paperwork."

Healthcare providers who participate in Medicare serve more than 57 million seniors and the Quality Payment Program is designed to promote greater value within the industry.

If finalized, the proposed rule would further advance the agency's goals of regulatory relief, program simplification, and state and local flexibility in the creation of innovative approaches to healthcare delivery, CMS reports.

More information on the Quality Payment Program is available here: qpp.cms.gov and in a fact sheet from CMS: *http://ow.ly/CXKn30dRMTH*

NEWS & NOTES

Minnesota Nurses Association Buys Past-Due Debts

In June, the Minnesota Nurses Association purchased the past-due accounts of 1,800 families with medical debt as a way to give back for the support they received during strikes against Allina Health. The debt totaled $2.6 million secured for $28,000 between the MNA and New York-based nonprofit RIP Medical Debt. The credit reporting bureaus received notification that the consumers' debts were paid. *http://ow.ly/YvcE30cOGRj*

CMS Issues Long-Term Data on Health Spending by State

The recession had a "sustained impact" on health spending and insurance coverage, according to a Centers for Medicare and Medicaid Services report on spending. "Every state experienced slower growth in per capita personal healthcare spending from 2010-2013 than experienced during the period 2004-2009," according to the report. *http://ow.ly/cIHL30cOKxZ*

Pace of Healthcare Sector Expansion Slows

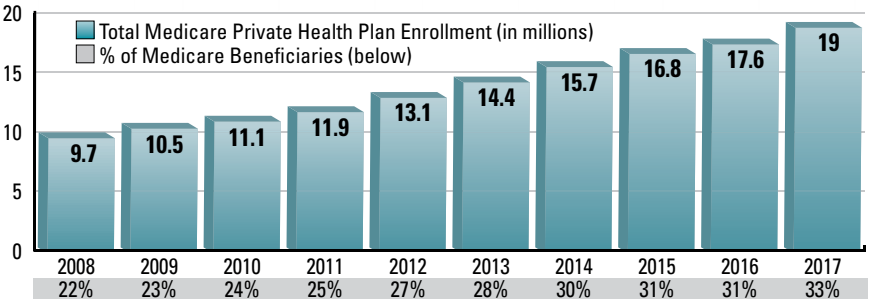
The healthcare industry added 24,300 new jobs in May and overall monthly job growth this year is lagging behind 2015 and 2016. Job growth through the first five months of this year averages less than 22,000 jobs each month, compared to 32,000 monthly in 2015 and 2016, according to the Altarum Center for Sustainable Health Spending. *http://ow.ly/HUR930cQhRP*

For more healthcare collections news, visit ACA's Healthcare Collections page at *www.acainternational.org/pulse*.

datawatch

Private Medicare Plan Enrollment Grows

The share of Medicare beneficiaries enrolled in private plans, known as Medicare Advantage, has increased steadily over the past 10 years, according to an analysis by the Henry J. Kaiser Family Foundation. For example, since the Affordable Care Act was passed, enrollment has increased 71 percent. As of this year, one in three people with Medicare was enrolled in an Advantage plan.



Source: Henry J. Kaiser Family Foundation Analysis of Centers for Medicare and Medicaid Services Medicare Advantage enrollment files 2008-2017. http://ow.ly/fFDm30cQiWZ Altered by ACA International, based on Henry J. Kaiser Family Foundation Analysis of Centers for Medicare and Medicaid Services Medicare Advantage enrollment files 2008-2017.

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