PULSE

Biden Administration Takes Sweeping Actions to Lower Health Care Costs and Protect Consumers

The HHS announced measures to safeguard consumers from deceptive health plans, surprise medical bills and excessive medical debt, while projecting significant savings for seniors on prescription drugs.

In a major push to make health care more affordable and transparent for Americans, the Biden administration, through the U.S. Department of Health and Human Services (HHS), unveiled a series of protective actions. These measures aim to protect consumers from misleading health insurance plans, surprise medical bills and soaring medical debt, while simultaneously reducing prescription drug costs for seniors.

One of the significant highlights of these actions is the implementation of the $2,000 out-of-pocket prescription drug spending cap, a part of the Inflation Reduction Act. The report released by HHS projects that nearly 19 million seniors will benefit from this cap, saving an estimated $400 per year on their prescription drug costs. This landmark legislation, set to go into effect in 2025, is part of President Joe Biden's mission to improve prescription drug laws, offering financial relief to millions of American seniors and individuals with disabilities.

The Biden administration's plans also include empowering Medicare to negotiate prescription drug prices.

As a result, more than 18.7 million Medicare Part D enrollees could witness a significant reduction in their out-of-pocket expenses by nearly $400 each year. This measure is projected to save approximately 1.9 million enrollees at least $1,000 in 2025, resulting in a $7.4 billion decrease in annual out-of-pocket spending when all provisions are fully in effect.

Additionally, HHS, in collaboration with the Departments of Labor and the Treasury, has proposed rules aimed at distinguishing short-term, limited-duration insurance (STLDI) and fixed indemnity insurance from comprehensive coverage. These "junk" plans, which may come with benefit limitations and dubious marketing practices, lack essential consumer protections and can leave individuals without coverage for prescription drugs, pre-

Continued on pg 2

existing conditions, or impose financial limitations on services. The proposed rule seeks to ensure that these short-term plans genuinely fill temporary gaps in coverage, while providing clear information to consumers about their coverage options.

"No one should go bankrupt trying to get and keep themself or their family healthy," Centers for Medicare & Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure said. "CMS is committed to a more transparent, fair, and accountable health system for the people we serve. We will continue to clarify consumer rights under the No Surprises Act, work to better understand the impact of medical debt, and limit non-comprehensive junk insurance plans."

Evaluation of the No Surprises Act

The Biden administration also aims to increase transparency and protect consumers from unexpected out-of-pocket costs. Through the No Surprises Act and the Affordable Care Act (ACA), consumers will receive enhanced protections against surprise billing and access to price information.

The departments also released a frequently asked questions (FAQs) document further clarifying surprise billing and out-of-pocket cost protections for consumers under the No Surprises Act and the ACA, helping to ensure that consumers receive the appropriate protections under these laws. The FAQs also reiterate requirements for plans and issuers to make price information available to consumers, including information on facility fees.

Relatedly, a comprehensive framework for evaluating the impact of the No Surprises Act has been established through the first in a series of reports by the Office of the Assistant Secretary for Planning and Evaluation.

Request for Comment on Medical Payment Products

Additionally, HHS, along with the Consumer Financial Protection Bureau and the Department of the Treasury, issued a Request for Information (RFI) seeking public input on medical credit cards and other medical payment products.

The federal agencies' request for comment will help them understand the "harms and financial challenges raised by specialty medical payment products," the bureau reports. By addressing practices that lead to excessive costs and medical debt, this collaboration marks the first joint effort of its kind to support the needs of health care consumers.

Specifically, the agencies are requesting information about:

- Data and comments on the interest and fee costs for these products, as well as in understanding their marketing, application and approval processes. The CFPB is also interested in trends of medical payment product use, including the total outstanding consumer debt on medical credit cards, medical installment loans and other medical payment products. The data will help the agencies better understand how these products are being used, their scope of use and who controls that use.
- Product risks and whether consumers fully understand the risks.
- How medical credit cards and loans may exacerbate existing issues in health care billing and collections, such as charges to uninsured and out-of-network patients compared to those negotiated by in-network insurers for the same medical services.
- Incentives offered to health care providers to promote medical payment products, as well as how those incentives affect the promotion of these products by providers to patients.

To file comments, which are due Sept. 11, use the Federal eRulemaking Portal *or email* MedicalDebtRFI_2023@cfpb.gov. Include Docket No. CFPB–2023–0038 in the subject line of the message or when using the web portal.

Read the HHS's full release here.

Additionally, a new White House fact sheet on actions to lower health care costs and protect consumers is available here.

Hospital M&A Activity Surges in Q2 2023, Reaching Pre-Pandemic Levels

Three mega-mergers were announced, where the seller or smaller party has annual revenues exceeding $1 billion.

According to a recent report from Kaufman Hall, hospital merger and acquisition (M&A) activity in the second quarter of 2023 rebounded to pre-pandemic levels, signaling a robust recovery in the health care sector. The report revealed that 20 transactions were announced during Q2 2023, generating an impressive $13.3 billion.

The surge in hospital M&A activity in Q2 2023 surpassed the levels seen in both 2019 and 2020, marking a significant milestone for the industry. The 20 deals announced during this period were the highest number since Q1 2020 and were comparable to the transaction volumes in Q2 2019 and Q2 2018. These trends are a continuation of the M&A momentum that gained traction in 2022.

Compared to the previous year, the

Continued on pg 3

NEWS & NOTES

Workforce Shortages Drive Providers to Outsource Revenue Cycle Services

Ambulatory provider organizations are increasingly turning to outsourced revenue cycle management services as they face challenges due to changing payer requirements and workforce shortages.

A KLAS report based on responses from 61 primary and specialty care clinics revealed that recent payer process changes have led to confusion, increased A/R days, denials, and more time spent processing appeals.

Additionally, staffing shortages at payer and provider organizations are exacerbating revenue cycle challenges. Two-thirds of respondents said workforce issues influenced their decision to outsource. Providers seek transparent, accessible and accurate vendors for outsourcing services, and they prefer domestic support over offshoring.

Outsourcing revenue cycle tasks has become more common, with 61% of surveyed providers planning to outsource in the next 24 months, according to a separate study from CWH Advisors.

Read the report here.

FTC and DOJ Propose Changes to Merger Reviews, Impacting Health Care Deals

The Federal Trade Commission and U.S. Department of Justice are proposing changes to the premerger review process that could have significant implications for health care deals and other mergers.

The proposed modifications aim to enhance competition screenings in the health care sector and would require entities involved in mergers and acquisitions to provide additional information to facilitate more effective and efficient reviews. This move comes as the current premerger notification form, implemented under the Hart-Scott-Rodino (HSR) Act, has become insufficient to address the complexities of modern transactions and their potential competitive impact. The agencies seek detailed information on transaction rationale, investment vehicles, revenue projections, market conditions and the structure of involved entities.

Additionally, information on products and services, previous acquisitions and subsidies from foreign entities would be required. While these changes aim to promote competition, health care organizations considering mergers may face increased hurdles. Public comments on the proposal are open until Aug. 28, 2023.

Read more here.

Learn More

For more health care collections news, visit ACA's Health Care Collections page at www.acainternational.org/pulse-newsletters-archive.

Hospital M&A Activity Surges cont. from page 3

number of transactions announced in Q2 2023 increased, with 13 deals in Q2 2022 and 14 deals in Q2 2021. Even the first quarter of 2023, which saw 15 deals announced, couldn't match the activity seen in Q2 2023.

Despite the slightly reduced average size of the seller or smaller party in Q2 2023 transactions ($664 million) compared to the year-end average of 2022 ($852 million), the total transacted revenue was still impressive. Similarly, the $13.3 billion generated from the transactions was down from $19.2 billion in Q2 2022 but surpassed the quarter two pre-pandemic figures of $3.0 billion (2018), $11.3 billion (2019), and $12.0 billion (2020). The total transacted revenue in Q2 2023 was higher than that generated in Q1 2023 ($12.4 billion).

Q2 2023's acquisitions were carried out by various organizations, including eight not-for-profit health systems, four investor-owned health systems, four academic/university-affiliated organizations, two religiously affiliated organizations, one governmental organization, and one academic organization partnering with multiple not-for-profit organizations.

Notably, Q2 2023 saw the announcement of three mega-mergers, where the seller or smaller party had annual revenues exceeding $1 billion. Froedtert Health and ThedaCare revealed merger plans, Kaiser Permanente aimed to acquire Geisinger Health, and BJC HealthCare and St. Luke's Health System signed a letter of intent to form an integrated health system. These mega-mergers underscore the industry's efforts to optimize organizational capabilities through strategic consolidation.

Another key trend observed in hospital M&A activity is the focus on organizing regional markets amidst rising labor expenses and low operating margins. The BJC HealthCare and St. Luke's merger, for example, aims to create a more robust financial foundation that will enable the combined health system to enhance care delivery.

Additionally, some health systems have undertaken divestitures to reposition their portfolios. Community Health System sold the Medical Center of South Arkansas to South Arkansas Regional Hospital, and Ascension sold Ascension Providence Hospital to the University of South Alabama.

Read the Kaufman Hall report here.

DATAWATCH

Medical Debt Disproportionately Affects People of Color and Low-Income Residents in New York

A recent Urban Institute report based on February 2022 data from credit records of over 600,000 New York state adults reveals the uneven impact of medical debt on communities. While the overall average of consumers in medical debt was relatively low at 6%, those with a median household income below $54,200 were three times more likely to have medical debt compared to those with incomes above $88,500.

Geographical variations were evident, with medical debt more prevalent in communities of color and low-income regions. The Central New York, Mohawk Valley, North Country, and Southern Tier regions had the highest rates of medical debt, ranging from 10% to 14%. In contrast, Long Island and New York City had lower rates, at 3% and 4%, respectively.

Furthermore, medical debt rates were consistently higher among communities of color in all regions, exemplified by Central New York, where 28% of consumers in such communities had medical debt compared to 12% in predominantly White communities.

The report also highlighted the influence of health insurance coverage on medical debt prevalence, as individuals without insurance were more likely to face debt. Additionally, communities experiencing higher medical debt rates also encountered additional barriers to health care access due to rural settings, lower education levels, reduced income and limited employment opportunities.

Source: Urban Institute, Medical Debt in New York State and Its Unequal Burden Across Communities. https://tinyurl.com/54je6a26

PULSE

is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

Communications Department
ACA International
3200 Courthouse Lane
Eagan, MN 55121
comm@acainternational.org

ACA® INTERNATIONAL
The Association of Credit and Collection Professionals