Office of Attorney General Andrea Joy Campbell

2024 EXAMINATION OF HEALTH CARE COST TRENDS


OFFICE OF THE ATTORNEY GENERAL
COMMONWEALTH OF MASSACHUSETTS

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EXECUTIVE SUMMARY

This is the Office of the Attorney General's ("AGO") report of its 2024 examination of health care cost trends conducted pursuant to Section 11N of Chapter 12 of the Massachusetts General Laws. Despite almost universal health insurance coverage in Massachusetts, too many Massachusetts households are having trouble paying for their health care. In this report, we look at these affordability gaps through the lenses of income, consumer medical debt, and hospital "bad debt," with a focus on Massachusetts households with commercial health insurance.

In Section II, we examine how much, on average, Massachusetts households are spending on their health care through cost share expenditures, like deductibles, as well as household premium contributions. First, we find that Massachusetts households in the lowest-income zip codes, on average, spent approximately 4.5 times more of their income in 2022 on cost sharing relative to households in the highest-income zip codes. We then assess potential differences in affordability across market segments, finding, for instance, that in 2022, Massachusetts households with employer-sponsored insurance living in the lowest-income zip codes spent, on average, nearly $550 more on cost sharing expenditures than households in the same zip codes enrolled through the individual market. This result likely reflects the effect cost sharing reduction subsidies are having in enhancing health care affordability for lower-income Massachusetts households getting health insurance through the Massachusetts Health Connector; it also highlights the need to address health care affordability for lower-income residents with employer-sponsored plans who are not similarly eligible for subsidized insurance.

We also consider the additional impact that premium contributions have on household budgets. Statewide, our analysis shows that, on average, households in the lowest-income zip codes enrolled in fully-insured plans spent the highest percentage of household income on health care (13%) relative to other income quintiles in 2022, and nearly five times more than households in the highest-income quintile (2.7%). We also find that, while there is wide variation in average household spending on cost sharing and premium contributions across different regions of the state, our analysis of a sample set of zip codes within a single geographic region makes clear that analyzing health care spending at a statewide or even regional level understates affordability burdens and can obscure important nuance and variation—and potential policy solutions—at the community level. Finally, we observe that for households living in lowest- and highest-income zip codes, average annual spending on health care is disproportional to total premium paid for coverage, raising questions as to whether and to what extent some lower-income households are cross-subsidizing wealthier households' spending on higher-priced providers in their communities.

In Section III, we examine which Massachusetts communities are most likely to be burdened with hospital medical debt and explore financial assistance provided by hospitals to patients who are struggling to pay their portion of hospital bills. Using a sample of data provided by eleven Massachusetts hospitals on their patients with unpaid 2022 bills, we find that patients who (1) live in lower-income zip codes, (2) are female, and (3) are Black were more likely to have debt from hospital bills. We also find that outpatient services resulted in more patient hospital debt, while inpatient services led to patients having higher amounts of debt on average. We next compare twelve hospitals' Financial Assistance Policies ("FAPs") and find that there is significant variation in the criteria for hospital financial assistance, including the income limits and in-state residency requirements that apply to patients seeking aid with hospital bills. Finally, we find that FAP discounts are usually inapplicable to amounts owed by patients as part of a deductible or co-insurance responsibility.

In Section IV, we consider the impact of unpaid bills on hospitals. Patient bills that are left unpaid may eventually become "bad debt" for hospitals: debt that is not collected and is ultimately written off as a loss. If a hospital incurs a high amount of bad debt compared to revenue, this impacts its ability to pay staff and vendors and make needed investments in services and infrastructure. In this section, we examine the characteristics of hospitals in Massachusetts with the highest levels of bad debt. We find that sampled hospitals with lower commercial relative prices and higher public payer mixes had a higher proportion of commercial revenue written off as bad debt. We explore the uneven impact of bad debt by comparing two nearby community hospitals with different payer mixes and profitability, and we find that the hospitals serving a higher share of Medicaid and other subsidized patients had a much higher share of commercial revenue written off as bad debt and weaker long-term financial performance.

Based on our findings, the report concludes with recommendations in Section V.

I. INTRODUCTION

On April 11, 2006, the day before the Massachusetts health care reform law[1] became effective, then-Governor Mitt Romney published an editorial in the Wall Street Journal proclaiming that, not only would "all Massachusetts citizens [ ] have health insurance," but "private insurance finally [would be] affordable."[2] In fact, the forthcoming affordability of health insurance in Massachusetts was, optimistically, mentioned at least three times in the editorial, as was the observation that "the costs of health care will be reduced."[3]

Nearly twenty years later, Massachusetts residents *do* have near universal health insurance coverage; data reported over the last several years indicate that less than 2.5% of Massachusetts residents have gone without some type of health insurance coverage.[4] This comprehensive coverage across the state population, in turn, contributes to Massachusetts consistently being ranked as one of the top performing states for health care, including access to health care.[5]

Moreover, significant efforts have been made at both the state and federal level to make health care expenditures—both the cost of insurance itself as well as out-of-pocket exposure—more affordable, particularly for lower-income Massachusetts residents who buy plans in the individual (non-employer) market. For example, qualifying individuals enrolled in private plans offered through the Massachusetts Health Connector marketplace (the "Connector") receive federal tax credits that can offset premium costs.

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[1] *See* Chapter 58 of the Acts of 2006.

[2] Mitt Romney, *Health Care for Everyone? We Found a Way.,* Wall Street Journal, April 11, 2006, https://www.wsj.com/articles/SB114472206077422547.

[3] Romney, *supra* n. 2.

[4] According to the American Community Survey (ACS) 1-year estimates released on September 14, 2023, by the U.S. Census Bureau, Massachusetts had a 2.4% uninsured rate in 2022—the lowest in the country. *See Health Insurance Coverage Increased in Over Half of U.S. States in 2022,* U.S. Census Bureau, September 14, 2023, https://www.census.gov/newsroom/press-releases/2023/acs-health-insurance-coverage.html; Douglas Conway and Breauna Branch, *Health Insurance Coverage Status and Type by Geography:2021 and 2022,* U.S. Census Bureau, p. 2, 10, September 2023, *https://www.census.gov/content/dam/Census/library/publications/2023/acs/acsbr-015.pdf.* At the time of CHIA's 2023 MHIS, 98.3% of respondents reported having health insurance. *See Findings from the 2023 Massachusetts Health Insurance Survey* ("2023 MHIS"), CHIA, p. 5, June 2024, https://www.chiamass.gov/assets/docs/r/survey/mhis-2023/2023-MHIS-Report.pdf.

[5] *See, e.g.,* David C. Radley, et al., *2023 Scorecard on State Health System Performance,* Commonwealth Fund, June 22, 2023 (finding Massachusetts achieved the best overall score on the seven dimensions of health system performance evaluated, including a number one rank for the lowest number of uninsured adults and children), https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance; Sara R. Collins, et al., *2024 State Scorecard on Women's Health and Reproductive Care,* Commonwealth Fund, July 18, 2024 (based on the metrics examined, Massachusetts "is the best-performing health system for women overall," including number one ranking with respect to the percentage of women ages 19-64 who had health insurance coverage), https://www.commonwealthfund.org/publications/scorecard/2024/jul/2024-state-scorecard-womens-health-and-reproductive-care; M. Reinert, et al., *The State of Mental Health in America 2024,* Mental Health America, July 2024 (Massachusetts ranked number one overall on measures related to mental health care, including a high ranking for "access" measures that indicates Massachusetts provides relatively more access to insurance and mental health care than nearly every other state), https://mhanational.org/sites/default/files/2024-State-of-Mental-Health-in-America-Report.pdf.

Depending on income level[6] and the health plan chosen, tax credits can result in a zero-premium plan.[7] Additionally, Massachusetts residents at certain income levels may qualify to enroll in "ConnectorCare" plans.[8] Qualifying individuals pay relatively low premiums and are eligible for cost sharing reduction ("CSR") subsidies on an income-based scale that lower out-of-pocket cost sharing; members pay no deductible.[9]

And yet, despite almost universal health insurance coverage in Massachusetts and evolving efforts to reduce out-of-pocket ("OOP") health care costs, a substantial number of Massachusetts residents, across demographic and socioeconomic groups,[10] are still struggling to pay for their health care. In Massachusetts Health Insurance Surveys ("MHIS") conducted in 2021 and, most recently, in 2023, for example, over 40% of Massachusetts residents reported that they or their families experienced affordability challenges with respect to obtaining health care.[11]

While it has been observed that "[a]ffordability may be the most ubiquitous buzzword in health reform,"[12] there is not a singular, uniform definition. However, any policy discussion on affordability should start with consideration of what it *means* for health care to be "affordable." Generally speaking, health care affordability is assessed in context, necessarily taking into account not just absolute health care prices and costs but also the ability of an individual or family household, given their income and available resources (including insurance coverage), to pay their health care bill without sacrificing other essential needs, experiencing financial hardship, or incurring debt.[13]

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[6] In recent years, Congress, through the 2021 American Rescue Plan Act and then the Inflation Reduction Act, extended the reach of Premium Tax Credits in various ways, including by extending eligibility to certain individuals with incomes above 400% of the federal poverty level (FPL). These enhancements are set to expire in 2025. Gideon Lukens, *Health Insurance Costs Will Rise Steeply if Premium Tax Credit Improvements Expire*, Center on Budget and Policy Priorities, June 4, 2024, https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire; *see* Ariel Cohen, *House, Senate Democrats Renew Health Care Subsidies Push*, Roll Call, September 18, 2024, https://rollcall.com/2024/09/18/house-senate-democrats-renew-health-care-subsidies-push/.

[7] *See Explaining Health Care Reform: Questions About Health Insurance Subsidies,* Kaiser Family Foundation, October 6, 2023, https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

[8] Currently, people with household incomes that are at 500% of the Federal Poverty Level ("FPL") or lower may qualify for ConnectorCare. *See* Appendix for FPL income equivalents for 2022-2024.

[9] Beginning January 1, 2024, as part of the Connector's "largest expansion in health care affordability," income eligibility for ConnectorCare plans was expanded from 300% of the FPL up to 500% of the FPL through 2025 as part of a two-year pilot program. *See Massachusetts Expands Access to Affordable Health Care,* Massachusetts Health Connector, August 15, 2023, https://www.mahealthconnector.org/connectorcare2024; *see also ConnectorCare Health Plans: Affordable, high-quality coverage from the Health Connector,* Massachusetts Health Connector, https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare-Overview-2024.pdf. The analyses in this report focus on 2022, before the pilot program expansion.

[10] *See 2023 MHIS, supra* n. 4, p. 55, 56; *Findings from the 2021 Massachusetts Health Insurance Survey* ("2021 MHIS"), CHIA, p. 60, July 2022, https://www.chiamass.gov/assets/docs/r/survey/mhis-2021/2021-MHIS-Report.pdf.

[11] *See 2023 MHIS*, *supra* n. 4, p. 6 ("Two in five (41.3%) Massachusetts residents reported that their family faced health care affordability issues over the past 12 months."); *2021 MHIS*, *supra* n. 10, p. 57 ("41% of residents reported that they or their families had health care affordability issues in the past 12 months.").

[12] Aaron Glickman, *Can Affordability of Health Care Be Measured?*, University of Pennsylvania Leonard Davis Institute, November 21, 2017, https://ldi.upenn.edu/our-work/research-updates/can-affordability-of-health-care-be-measured/.

[13] *See*, *e.g.*, David Axene and Joshua Axene, *Healthcare Affordability Index: 2024*, Axene Health Partners, https://axenehp.com/healthcare-affordability-index-2024; Glickman, *supra* n. 12.

To assess the state of health care affordability, then, certain contextual indicators are examined, often by using population surveys like those referenced above. These indicators typically include one or more of the following:

1. out-of-pocket expense relative to income;
2. existence and amount of medical debt incurred by health care consumers, including whether medical bills have been sent to collections;
3. financial burdens incurred due to payment for health care, including not being able to pay for other essential needs; and/or
4. health care and/or medication not obtained due to perceived inability to pay.[14]

In this report, we focus on the first two health care affordability indicators for Massachusetts residents with commercial health insurance, looking for population segments that are caught in affordability gaps despite having this coverage. In Section II, we look at how much, on average, Massachusetts households are spending on their health care—both through actual cost share expenditures (e.g., financial responsibility in the form of deductibles, co-insurance, or co-pays) and household premium contribution—relative to household income.[15] In Section II.A, we examine different market segments, looking at how actual cost sharing expenditures vary as a percentage of family income for Massachusetts households with employer-sponsored insurance and those households with plans purchased in the individual (non-employer) market. In Section II.B, we look at how affordability burdens for households with commercial insurance may differ across different regions of the state, as well as the variation in spending as a percentage of income by households living within a sample set of zip codes in the same geographic region.

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[14] *See*, *e.g.*, Michael Karpman, et al., *Health Care Affordability Improved between 2019 and 2022 under Pandemic Health Coverage Policies*, Robert Wood Johnson Foundation, p. 1, June 2023 (examining data collected from the Urban Institute's annual Well-Being and Basic Needs Survey (WBNS) concerning the share of adults who were unable to pay/had difficulty paying medical bills, and the share of adults who did not get needed medical care due to inability to pay, to assess trends in health care affordability), https://www.urban.org/sites/default/files/2023-06/Health%20Care%20Affordability%20Improved%20between%202019%20and%202022%20under%20Pandemic%20Health%20Coverage%20Policies.pdf; Dan Witters, *In U.S., Affording Healthcare More of a Struggle Since 2022*, Gallup, July 17, 2024 (using survey responses to evaluate three "key factors" in determining the ability of Americans to afford health care: avoiding treatment due to cost; forgoing prescribed medication or drugs due to cost/being unable to pay; being able to afford immediate access to health care if needed), https://news.gallup.com/poll/646994/affording-healthcare-struggle-2022.aspx; *2023 MHIS*, *supra* n. 4, p. 53 (assessing "health care affordability by asking residents about difficulties paying family medical bills in the past 12 months, medical debt held by the resident or family members in their household, the amount and share of family income spent on out-of-pocket health care costs in the past 12 months, and whether the resident or their family chose to forgo health care that the resident felt was needed in the past 12 months due to the cost of that care"); Sara R. Collins, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer*, Commonwealth Fund, October 26, 2023 (for U.S. adults with health insurance, and those without, examining their ability to afford their health care through survey asking whether costs prevented them from getting care, whether provider bills left them with medical debt, and how these problems affected their lives, including ability to pay other bills), https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey; Larry Levitt, *Medical Debt—The Canary in the Coal Mine for Health Care Affordability*, JAMA Forum, September 5, 2024, ("[T]he high level of medical debt is a tangible reflection of [health care affordability challenges]"), https://jama-network.com/journals/jama-health-forum/fullarticle/2823514.

[15] These analyses are based on data and records provided by eleven Massachusetts health plans pursuant to our Civil Investigative Demand authority under M.G.L. c. 12C, § 17.

In Section II.B, we also examine the extent to which spending on premiums for commercial health insurance coverage is proportional to total spend on health care services. Finally, Section II concludes with a brief discussion on expenditures that health care consumers face when their commercial health plans do not cover care, such as out-of-network behavioral health visits, and that may significantly impact household budgets—or inhibit consumers from seeking needed health care in the first place.

In Section III, we examine medical debt, described by one commentator as "the canary in the coal mine for health care affordability."[16] We look at medical debt stemming from hospital services in Massachusetts and analyze how this debt is distributed across patients based on the average income of their zip code, whether the service provided was inpatient or outpatient, their gender, and their race. We also look at hospital Financial Assistance Policies to determine what hospitals are doing to assist patients who are unable to pay their portion of their bill upfront in full. In Section IV, we examine bad debt—patient bills that will never be paid that eventually become debt for the hospitals that provided the service—to determine whether hospitals serving *lower-income communities* are disproportionately impacted by bad debt.

This report concludes with policy recommendations in Section V.

[16] Levitt, *supra* n. 14.

II. HEALTH CARE SPENDING FOR COMMERCIAL HEALTH PLAN MEMBERS

In reporting results of the Commonwealth Fund's 2023 Health Care Affordability Survey, the report authors observe what many Massachusetts health care consumers are now experiencing: "insurance frequently fails to provide affordable access to care for large segments of the U.S. population."[17] This section examines the struggles Massachusetts households with commercial health insurance, in particular, may face in affording heath care costs, including cost sharing for services covered by insurance, household premium contributions, and payment for health care services outside insurance coverage.

We note at the outset that our findings in this section, for the most part, are based on averages— namely, we report the average spend by Massachusetts households in relation to average incomes across zip codes and income quintiles and in different regions of the state. We find, for instance, that *on average* Massachusetts households in the lowest-income zip codes spent nearly 2.9% of their income on cost sharing responsibilities for health care services— co-pays, co-insurance, and deductible— in 2022. While useful as a tool to begin to understand affordability gaps across the state and across different groups, as discussed in Section II.B, averages can obscure important nuance and variation that can only be seen at a more granular level.

Moreover, it must be acknowledged that even a relatively small percentage of income spent on health care expenses belies real-life affordability struggles many Massachusetts residents encounter when faced with medical bills. For those households with ample income, spending a couple thousand dollars annually on health care may be an afterthought at most as they pull together receipts for their Flexible Spending Accounts. For households with limited assets and unbendable budgets, the same amount and less[18] may well be debt-inducing, particularly if the bill(s) are unexpected and/or come over a short period of time, as often happens with health care expenses. To that point, we also observe that this report, based in part on cost share data provided by eleven Massachusetts health plans, refers to average household "spending" on OOP cost sharing expenditures. In reality, these numbers represent average amounts Massachusetts households were responsible for paying under their benefit plan in 2022; however, it is certain that some (unknown) number of Massachusetts residents did not actually "spend" this amount because they simply could not afford to pay some or all of their medical bills and have, instead, incurred debt.[19]

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[17] Collins, *supra* n. 14, p. 15.

[18] *See, e.g.*, Gregory Young, et. al, *How Many People Have Enough Money to Afford Private Insurance Cost Sharing,* Peterson-KFF Health System Tracker, p. 9, March 10, 2022, (stating, for example, that "about a third (32%) of single-person households with private insurance in 2019 could not pay a $2,000 bill . . ."), https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/.

[19] Additionally, the data examined for this report does not reflect any Health Reimbursement Arrangement (HRA) contributions employers may be making that allow employees to pay for qualified health care costs.

A. Cost Sharing

The Massachusetts Health Policy Commission ("HPC"), in its 2023 Health Care Cost Trends Report, observed that, "[f]rom 2019 to 2021, commercial spending in Massachusetts grew at an average annual rate of 5.8 percent, faster than spending in the rest of the U.S. . . . and faster than in any single year in Massachusetts since 2010."[20] By 2022, the annual health care spending per person in Massachusetts exceeded the national average by more than $2,000.[21] As further observed by the HPC, spending growth in the commercial market has been primarily driven by increases in the *prices paid* for the same care, rather than the amount of care provided.[22] These high prices, in conjunction with health plan benefit designs that make members' total cost sharing responsibility dependent on health care prices (i.e., deductibles and co-insurance), have driven a marked increase in commercial health plan members' OOP spending for health care. An analysis from the Center for Health Information and Analysis ("CHIA"), for instance, found that, between 2021 and 2022, cost sharing for Massachusetts commercial members increased 6%.[23]

The ability of Massachusetts residents to absorb this increase, of course, varies greatly depending on a multitude of factors, including income level and the amount of household budget allocated for other necessities. In this subsection, we examine the OOP exposure of Massachusetts commercial health plan members—both actual and potential (e.g., deductible levels)— relative to income to identify potential affordability gaps.

i. Deductible Levels

- **From 2019 to 2023, commercial membership enrollment has moved away from plans with no deductibles (six percentage point drop) and towards higher-level deductibles, including a five percentage point increase in enrollment in plans with deductible levels ranging from $2,500-4,999.**

- **There is relatively even distribution of Massachusetts residents' enrollment in health plans by deductible level across income quintiles.**

[20] *2023 Annual Health Care Cost Trends Report and Policy Recommendations*, Massachusetts Health Policy Commission, p. 8, September 2023, https://masshpc.gov/sites/default/files/2023%20Cost%20Trends%20Report.pdf.

[21] *Massachusetts Cost Trends: Impact on Affordability*, Massachusetts Health Policy Commission, presentation p. 21, https://www.mass.gov/doc/benchmark-data-presentation-2024-benchmark-hearing/download.

[22] *2023 Cost Trends Report*, *supra* n. 20, p. 8; *see also Massachusetts Cost Trends*, *supra* n. 21, p. 25. The HPC also determined that the prices driving increased spending in 2021 included $3 billion of "excessively high prices" across seven high-priced service categories. *See 2023 Cost Trends Report*, *supra* n. 20, p. 18, 28.

[23] *See 2024 Annual Report, Performance of the Massachusetts Health Care System*, CHIA, p. 54, March 2024, https://www.chiamass.gov/assets/2024-annual-report/2024-Annual-Report.pdf.

From a consumer affordability perspective, deductibles are often particularly problematic. As one think tank has observed, "[c]ombining a deductible (which requires individuals to pay the full negotiated cost of the service) with exorbitantly high underlying service prices . . . is a recipe for financial disaster."[24,25] Health plans with high deductible levels can be an especially pernicious barrier to affordability for individuals with medical needs that require relatively high utilization of health care services[26] and for lower-income individuals, even when accessing lower-priced health care services in their local communities.

To understand how health plan benefit design, in a time of ever-increasing health care prices, may be affecting the affordability of health care, we analyzed data provided by Massachusetts health plans concerning the deductible levels applicable for enrolled Massachusetts residents for calendar years 2019, 2022, and 2023. In line with CHIA's (and others') past reporting, we found that Massachusetts commercial health plan members are increasingly enrolling in higher deductible health plans.

Specifically, data we examined shows that from 2019 to 2023, there was a six percentage point drop in overall enrollment in commercial health plans with no deductibles. There was also a five percentage point increase in enrollment in plans with deductible levels that range from $2,500-$4,999, driven by a ten percentage point jump to this deductible level for fully-insured commercial members from 2019 to 2023.

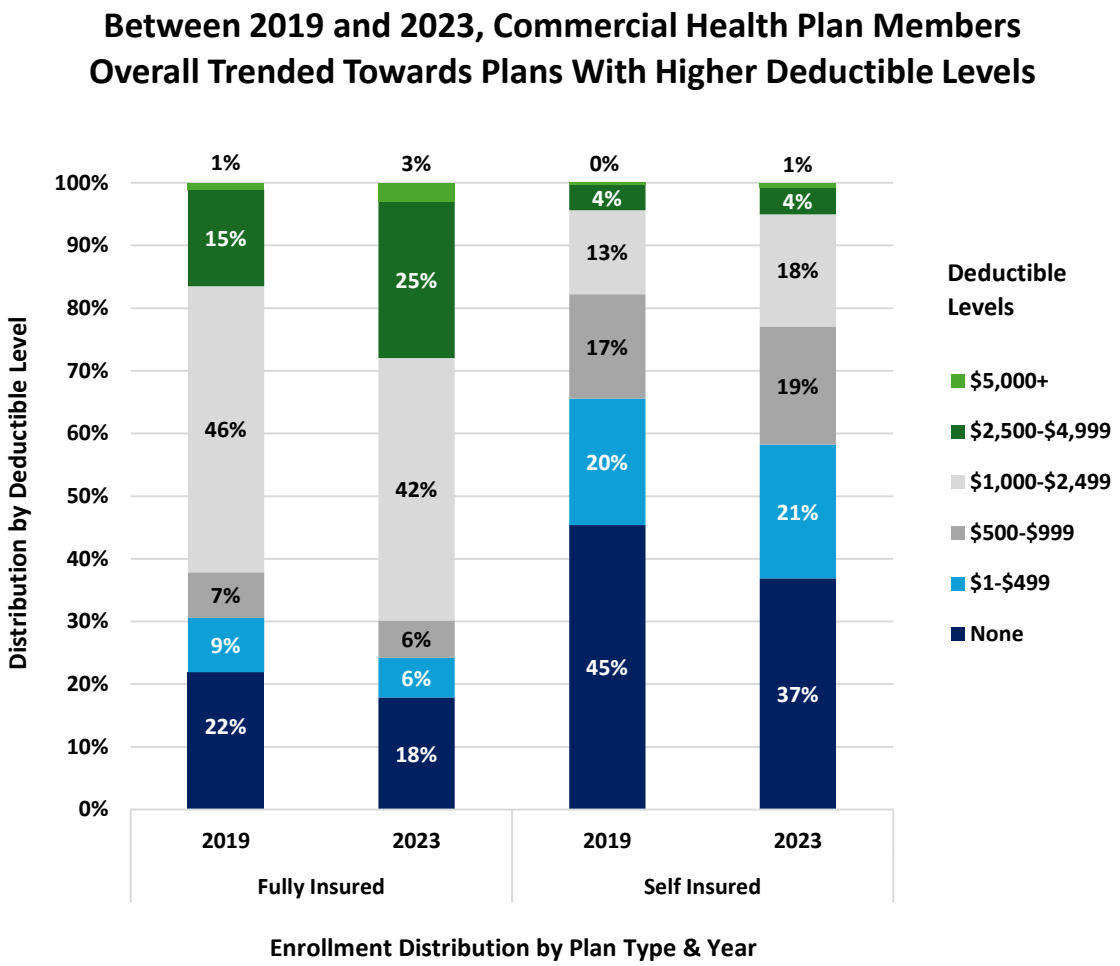
[24] *Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges,* Center on Budget and Policy Priorities, p. 15, April 10, 2024, https://www.cbpp.org/sites/default/files/4-10-24health.pdf. Notably, researchers analyzing survey data from the Census Bureau's 2018, 2019, and 2020 Surveys of Income and Program Participation to assess risk factors for medical debt concluded that participation in a high-deductible plan was among the factors that "appeared to leave enrollees particularly exposed." David U. Himmelstein, et al., *Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US*, JAMA, September 16, 2022, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796358.

[25] A recent *New York Times* article made clear that the financial burden of deductibles is a touchstone of the American health care system. It includes references to both "deductible parties"—individuals actively celebrating when they met their deductible and therefore significantly reduced on-going health care expenses for the remainder of the benefit year—and a "deductible-driven stampede," where individuals rush to get needed health care services at the end of a benefit period once their deductible has been met and before a new benefit period begins. *See* Connie Chang, *They Hit Their Health Care Deductible. It Was Time to Party.*, The New York Times, July 10, 2024, https://www.nytimes.com/2024/07/10/business/health-care-deductible-party.html.

[26] CHIA, for example, observed in its 2024 annual report that over half of respondents with chronic conditions and who had high-deductible plans reported affordability issues, including forgoing health care, in response to survey questions fielded in 2021. *See 2024 CHIA Annual Report*, *supra* n. 23, p. 58; *see also Building on the Affordable Care Act*, *supra* n. 24, p. 5.

Figure 1 below breaks down enrollment shifts from 2019 to 2023 for both self-insured and fully-insured membership.

Figure 1



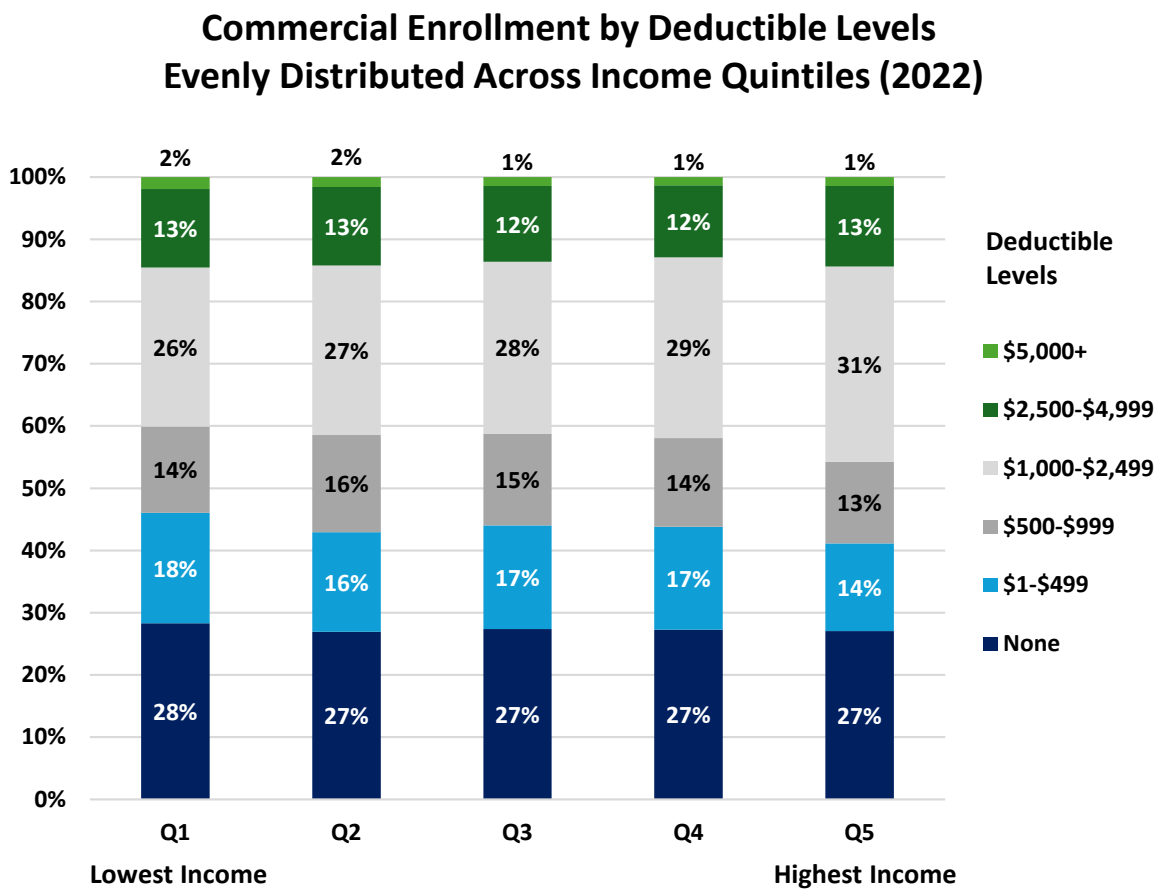
Notes: Health plans were asked to provide the following data: for Massachusetts residents only, member month data by zip code and deductible level, including both fully-insured and self-insured commercial business but excluding data relating to any plans for members receiving CSR subsidies. Deductible levels were to be reported based on applicable individual (single) policy amounts for all members, even those enrolled in family policies. For tiered network products, plans were asked to report the deductible level for the most utilized tier. Data includes reporting from eight Massachusetts health plans. Percentage totals for bars do not always equal 100% due to rounding.

In addition to understanding overall enrollment trends, we also sought to assess deductible exposure relative to income. In particular, we questioned whether deductible risk might be disproportionally burdening lower-income neighborhoods, where individuals may be especially at risk of being unable to pay for health care services subject to a deductible, depending on the size of a bill, or may choose to hold off on necessary health care altogether when concerned about paying the bill.[27]

As reflected in Figure 2, for calendar year 2022, we found that residents in lower-income zip codes are *not* disproportionately enrolled in higher deductible plans; rather, there has been relatively even distribution of commercial enrollment in various deductible levels across income quintiles. Moreover, excluding plans with no deductible, across all income quintiles, the highest enrollment in 2022 is seen in the $1,000-2,499 deductible level.

[27] In 2022, for instance, 43% of adults in the United States responding to polling questions reported that they or a family member in their household postponed needed medical care due to cost. *See* Shameek Rakshit, et al., *How Does Cost Affect Access to Healthcare?*, Peterson-KFF Health System Tracker, p. 1, January 12, 2024, https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/. *See also 2023 MHIS, supra* n. 4, p. 55, 68.

Figure 2



Notes: Health plans were asked to provide the following data: for Massachusetts residents only, member month data by zip code and deductible level, including both fully-insured and self-insured commercial business but excluding data relating to any plans for members receiving CSR subsidies. Deductible levels were to be reported based on applicable individual (single) policy amounts for all members, even those enrolled in family policies. For tiered network products, plans were asked to report the deductible level for the most utilized tier. Income ranges for quintiles are as follows: Q1: $0 - $70,354, Q2: $70,354 - $86,737, Q3: $86,737 - $111,544, Q4: $111,544 - $164,299, Q5: $164,299 - $1,960,079. The analysis is based on data from nine Massachusetts health plans. Percentage totals for bars do not always equal 100% due to rounding.

From a consumer affordability perspective, the findings are, on the one hand, encouraging in that households in lower-income zip codes are not overrepresented in higher deductible plans that can present significant financial risk. However, given economic realities, many lower-income Massachusetts residents enrolled in plans with deductibles will likely face financial hardship paying bills subject to the deductible, especially for larger bills that may be incurred in relation to a single, unexpected medical event.[28] For enhanced health care affordability in Massachusetts—and to protect lower-cost hospitals that provide care to lower-income communities from unsustainable levels of bad debt incurred when health care consumers cannot pay bills subject to the deductible—the distribution of enrollment across deductible levels will need to change; a larger percentage of lower-income households will need to be enrolled in plans with lower deductibles in order to limit their financial exposure in accordance with their income levels.

[28] As noted in the Federal Reserve's most recent report on the Economic Well-Being of U.S. Households, "[r]elatively small, unexpected expenses, such as a car repair or a modest medical bill, can be a hardship for many families, especially those without a financial cushion." Further, when faced with a hypothetical unexpected expense of $400, 37% of all adults in 2023 said they could *not* have covered it exclusively using cash, savings, or a credit card paid off at the next statement. Rather, they would have had to pay by borrowing or selling something or said they would not have been able to cover the expense. *See Economic Well-Being of U.S. Households in 2023*, Board of Governors of the Federal Reserve, p. 31-32, May 2024, https://www.federalreserve.gov/publications/files/2023-report-economic-well-being-us-households-202405.pdf.

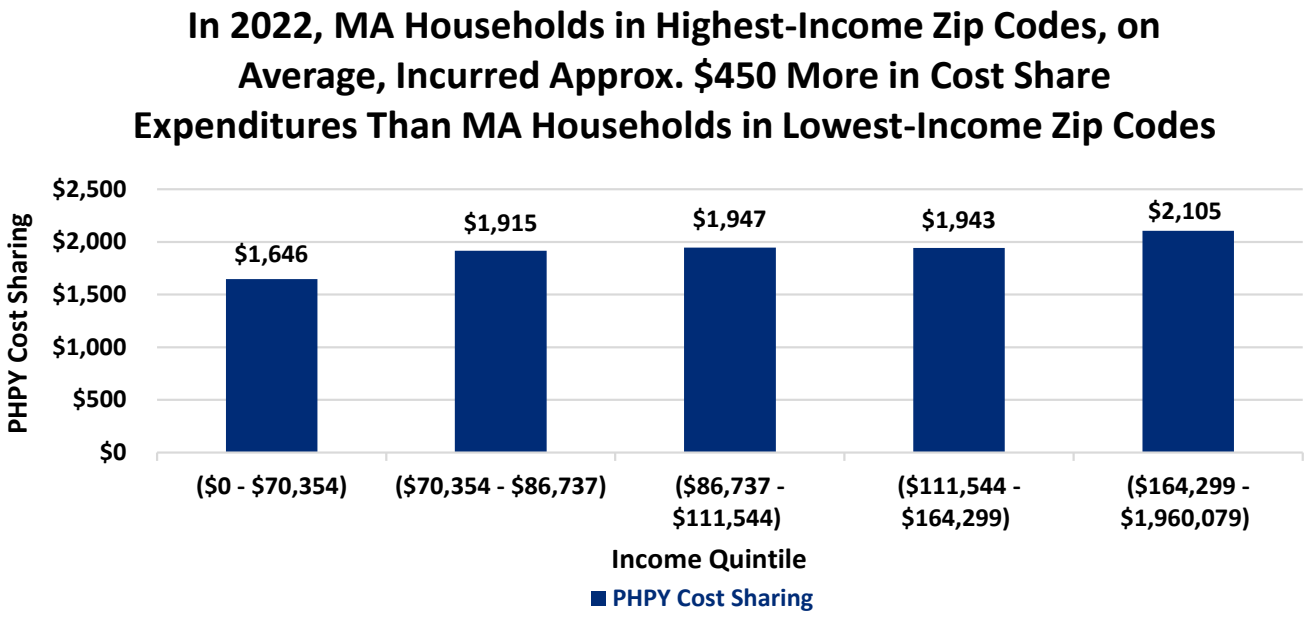
ii. Cost Share Expenditure Relative to Income in 2022

- **While Massachusetts households in the highest-income zip codes had the highest average spending on cost sharing in 2022, households in the lowest-income zip codes, on average, spent approximately 4.5 times more of their household income on cost sharing relative to households in the highest-income zip codes.**

With an understanding of the distribution of potential risk through benefit design across income quintiles, we next assessed actual cost share expenditure (deductible, co-pay, and co-insurance) for Massachusetts commercial health plan members in 2022, ultimately seeking to understand cost sharing burden relative to income.

As shown in Figure 3, in 2022, Massachusetts households living in the highest-income zip codes had the highest average Per Household Per Year ("PHPY") spending on cost share expenditures ($2,105); conversely, average PHPY spending on cost sharing was lowest for Massachusetts households living in the lowest-income zip codes ($1,646).

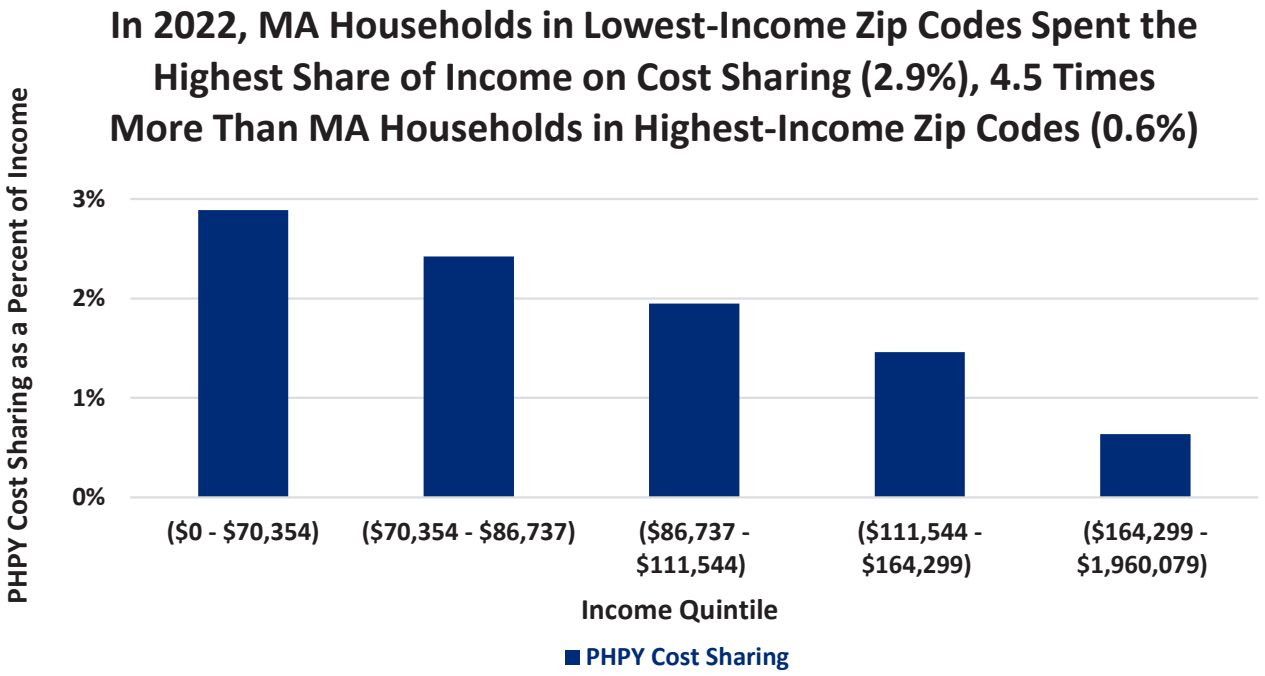
Figure 3



Notes: Income quintiles are derived from the most recently available (2021) IRS Tax Return Data. A weighted average by income per return was calculated for each Massachusetts zip code to approximate average household income. Cost sharing metrics are derived from responses from eleven Massachusetts commercial health plans, which were asked to provide member cost share responsibility and member months by zip code for Massachusetts residents. This data was used to calculate spending on a Per Member Per Year ("PMPY") basis. To estimate Per Household Per Year ("PHPY") metrics, PMPY cost share was multiplied by 2.46, the average number of members in a Massachusetts household as calculated by the United States Census Bureau. *See QuickFacts, Massachusetts,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/MA/HSD310222.

However, as shown in Figure 4, while Massachusetts households in the lowest-income quintile had, on average, the lowest PHPY spend on cost sharing, their relative financial burden, as measured by the approximate percentage of household income spent on household cost share responsibility in 2022, was approximately 4.5 times higher compared to households in the highest-income quintile. Specifically, on average, we estimate that households in the lowest-income quintile spent approximately 2.9% of their household income on cost sharing, while households in the highest-income quintile spent just over 0.6%.

Figure 4



Notes: Income quintiles are derived from the most recently available (2021) IRS Tax Return Data. A weighted average by income per return was calculated for each Massachusetts zip code to approximate average household income. Cost sharing metrics are derived from responses from eleven Massachusetts commercial health plans, which were asked to provide member cost share responsibility and member months by zip code for Massachusetts residents. This data was used to calculate spending on a Per Member Per Year ("PMPY") basis. To estimate Per Household Per Year ("PHPY") metrics, PMPY cost share was multiplied by 2.46, the average number of members in a Massachusetts household as calculated by the United States Census Bureau. *See* https://www.census.gov/quickfacts/fact/table/MA/HSD310222.

It should be noted that the data shown above represent calculations based on average amounts of cost share responsibility incurred on a *yearly* basis. This obscures a significant component of real-life health care affordability—that often households incur much of this expense over a short period of time, sometimes unexpectedly, rather than in evenly divided, regular bills over the course of a year, as happens with rent or a loan payment. Households in the lowest-income quintile, in general, may have difficulty allocating nearly 3% of an already limited budget to cost sharing expenses over the course of a year; this may be impossible to do when most of that responsibility hits over the course of several months, due to expensive prescription drugs, for example, or even all at once, due to expensive imaging or a hospital stay, before a deductible is met.[29] In fact, as discussed in Section III, our examination of debt associated with hospital services shows that households in the lowest two income quintiles are associated with over 50% of patient medical debt.

iii. Percentage of Household Income Spent on Cost Sharing By Market Segment

- **In 2022, Massachusetts households with employer-sponsored insurance living in the lowest-income zip codes spent, on average, nearly $550 more on cost sharing expenditures than households in the lowest-income zip codes enrolled through the individual (non-employer) market.**

- **In 2022, Massachusetts households with employer-sponsored insurance in the lowest-income zip codes spent, on average, one percentage point more of their household income on cost sharing (3.1%) compared to households in the lowest-income zip codes (2.1%) enrolled through the individual (non-employer) market.**

- **In 2022, Massachusetts households living in the lowest-income zip codes and enrolled through the individual (non-employer) market but not receiving CSR subsidies spent the highest percentage of income on cost sharing expenditures (5.0%).**

[29] For this reason, one think tank recommends *monthly* caps on cost sharing, which "would more closely reflect the way individuals are paid at their jobs and manage their household budgets, while also reducing cost sharing peaks that occur when individuals need an expensive emergency or hospital intervention, especially when they are still in the deductible phase of coverage." *See Building on the Affordable Care Act*, *supra* n. 24, p. 22-23.

In Massachusetts, nearly all residents enrolled in private commercial insurance do so through their employer.[30] While some number of employers nationwide offer reduced premium contributions or cost sharing based on employee pay level, more typically, employees' premium contributions and cost share levels within a place of employment do not vary by pay level or job type.[31] Accordingly, lower-paid workers typically will owe a greater share of their pay towards health care coverage than higher-paid colleagues,[32] and, as commentators have observed, may be more likely than higher-paid workers to have difficulty paying bills[33] or to delay needed health care.[34]

Moreover, in contrast to residents in lower-income households who enroll through the Connector, workers with employer-sponsored insurance are not eligible for CSR subsidies (or premium assistance) that could significantly reduce their OOP health care spending. As reflected in Figure 5, our analyses show that households in lower-income zip codes in Massachusetts with employer-sponsored insurance may face significant affordability burdens relative to similarly-situated households who are enrolled through the individual (non-employer) market. Specifically, as shown below, in 2022, on average, we estimate that households in the lowest-income zip codes with employer-sponsored insurance spent nearly $550 more annually on cost sharing expenditures than did households in the lowest-income zip codes enrolled through the individual (non-employer) market.[35]

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[30] In its July 2024 enrollment trends update, CHIA reports that "[a]s of September 2023, 92.3% of Massachusetts residents enrolled in private commercial insurance received plans through their employer . . ." *Enrollment Trends through September 2023; Private Commercial Enrollment*, CHIA, https://public.tableau.com/app/profile/chiamass/viz/EnrollmentTrendsthroughSeptember2023/EnrollmentTrends (last accessed on October 27, 2024).

[31] *See* Sam Hughes, et. al, *Health Insurance Costs Are Squeezing Workers and Employers*, Center for American Progress, p. 12, 14, November 29, 2022, https://www.americanprogress.org/article/health-insurance-costs-are-squeezing-workers-and-employers/; *2024 Employer Health Benefits Chart Pack/Employer Health Benefit Survey*, Kaiser Family Foundation, ppt. Figure 9, October 9, 2024 (reflecting the percentage of firms which have programs to help lower wage workers pay for health expenses, including reduced cost sharing for lower wage workers), https://www.kff.org/slideshow/2024-employer-health-benefits-chart-pack/#; *see also U.S. Employers Double Down on Controlling Healthcare Costs, Enhancing Affordability*, WTW, September 15, 2022, https://www.wtwco.com/en-us/news/2022/09/us-employers-double-down-on-controlling-healthcare-costs-enhancing-affordability; Joanne Sammer, *Is it Time to Tie Employee Health Care Costs to Pay?,* SHRM, April 17, 2021, https://www.shrm.org/topics-tools/news/all-things-work/time-to-tie-employee-health-care-costs-to-pay.

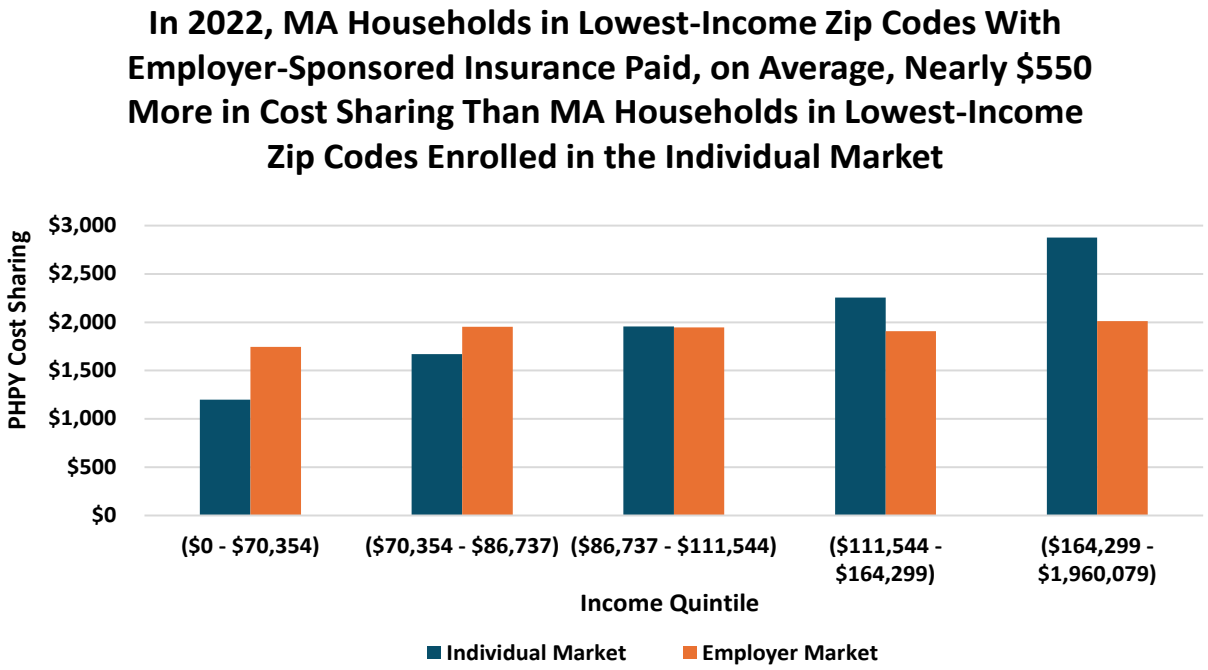
[32] Hughes, *supra* n. 31, p. 12.

[33] *See, e.g.,* Rayna Wallace, et. al, *Lower Income Adults with Employer Sponsored Insurance Face Unique Challenges with Coverage Compared to Higher Income Adults*, Kaiser Family Foundation, p. 2, December 19, 2023, https://www.kff.org/private-insurance/issue-brief/lower-income-adults-with-employer-sponsored-insurance-face-unique-challenges-with-coverage-compared-to-higher-income-adults/.

[34] *See, e.g.,* Liz Hamel, et. al, *Kaiser Family Foundation/LA Times Survey of Adults With Employer-Sponsored Insurance; Section 2: Affordability of Health Care and Insurance*, Kaiser Family Foundation, p. 14, May 2, 2019 ("Both difficulty affording health care expenses and forgoing or delaying care due to cost are more commonly reported among certain groups [with employer-sponsored insurance], including those with lower incomes . . ."), https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance/.

[35] The Center for American Progress has observed that one reason for this disparity may be that "[f]or lower-income individuals, the deductibles in [employer] plans are higher than those they would face in ACA marketplace plans if subsidy eligible." *See* Hughes, *supra* n. 31, p. 13.

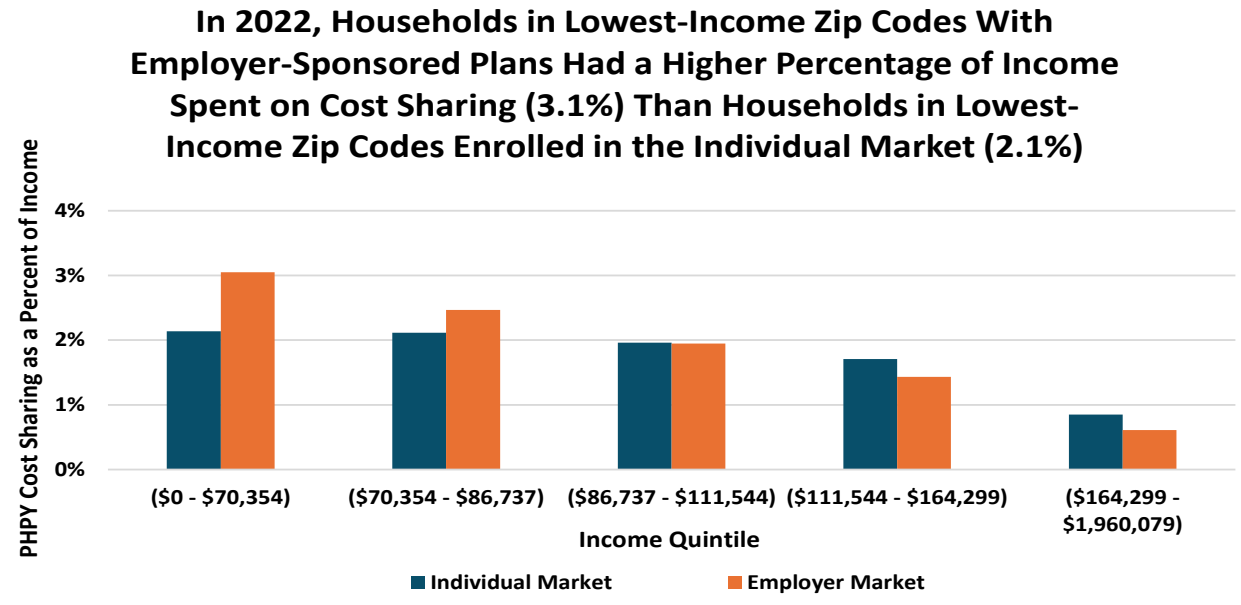
Figure 5



Notes: Data for the individual market includes enrollees with and without CSR subsidies. For a description of income quintiles and the calculation of PHPY metrics, see notes for Figure 3 above.

Relatedly, Figure 6 below shows the average percentage of household income spent on cost sharing in 2022 for households enrolled in the individual (non-employer) market and households with employer-sponsored health plans across income quintiles. As reflected in the chart, households in the lowest-income zip codes with employer-sponsored insurance spent, on average, one percentage point more of their household income on cost sharing (3.1%) compared to households in the same zip codes that were enrolled through the individual market (2.1%).

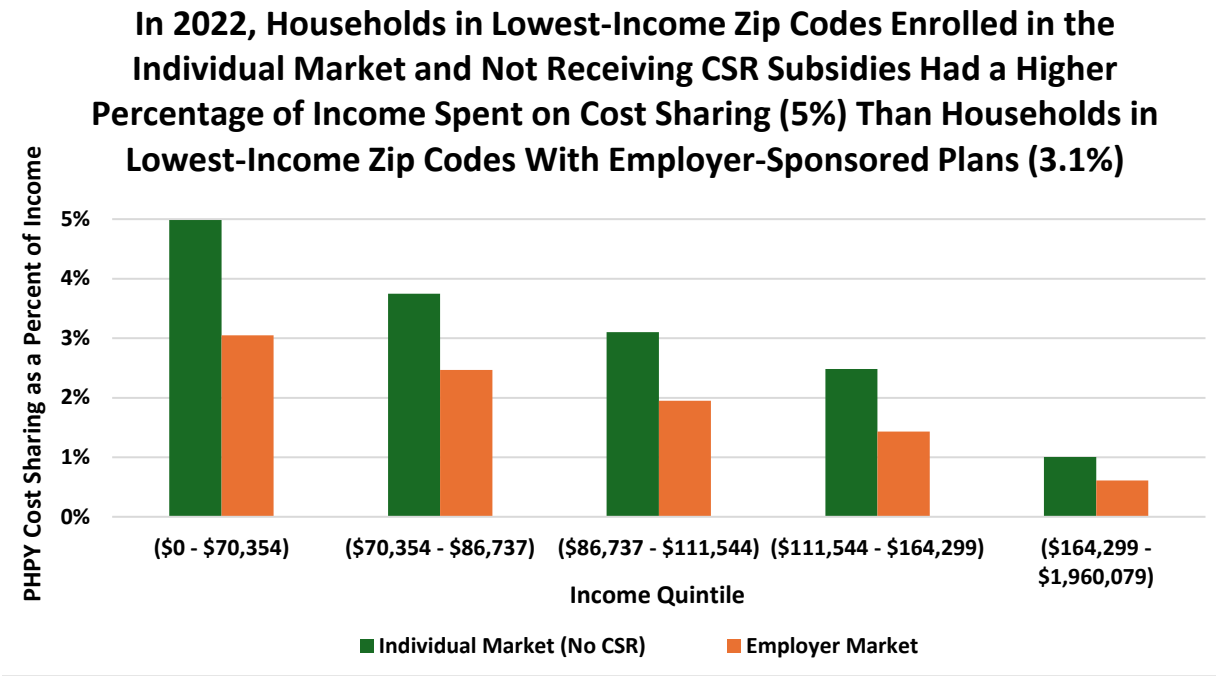
Figure 6



Notes: Data for the individual market includes enrollees with and without CSR subsidies. For a description of income quintiles and the calculation of PHPY metrics, see notes for Figure 3 above.

However, when enrollees receiving CSR subsidies are excluded from the data, as shown in Figure 7 below, we estimate that Massachusetts households in the lowest-income zip codes enrolled through the individual market spent, on average, 5% of their household income on cost sharing in 2022—over 1.5 times more than households in the lowest-income zip codes with employer-sponsored insurance.

Figure 7



Notes: Data for the individual market plans excludes those with CSR subsidies. For a description of income quintiles and calculation of PHPY metrics, see notes for Figure 3 above.

The findings above likely reflect the impact of the CSR subsidies available for income-eligible households buying ConnectorCare plans; for those households, the CSR subsidies are enhancing health care affordability, as intended. Still, some households in the lowest-income zip codes purchasing plans through the individual market may exceed the income eligibility to receive CSR subsidies; these households, in 2022 paying 1.5 times more of their income on cost sharing, on average, than similarly-situated households with employer-sponsored insurance, may well be falling within health care affordability cracks.

B. Affordability: Household Premiums and Cost Share

- **When 2022 premium contributions are coupled with cost share expenditures, on average, households in the lowest-income quintile enrolled in fully-insured plans spent the highest percentage of household income on health care (13%) relative to other income quintiles and nearly five times more than households in the highest-income quintile (2.7%).**

- **Regionally across Massachusetts, in 2022, there was significant variation in average spending on cost sharing and premium contribution for fully-insured households.**

- **Analyses involving *average* spending on premium contributions and cost share relative to *average* income across the state, or even regions of the state, understate affordability burdens.**

- **For Massachusetts households in the lowest- and highest-income quintiles, there is significant disproportionality between spending on total premiums for health care coverage and spending on health care services for these households.**

i. Household Premium Contributions and Cost Share By Income Quintile

Any discussion of health care affordability must include a recognition of the financial strain faced by many Massachusetts commercial health plan members due to premium contributions. In findings from its 2022 Biennial Health Insurance Survey conducted nationwide, the Commonwealth Fund, for example, observed that premium costs are the primary reason—by a significant margin—that survey respondents nationwide cited as to why they did not buy a marketplace plan or dropped their health insurance coverage.[36]

While health plans in Massachusetts report total premiums (employer and member contributions) for fully-insured members to CHIA,[37] historically there has been less clarity on what portion of the total premium *members* with employer-sponsored insurance are required to contribute.[38] However, pursuant to provisions in the Consolidated Appropriations Act, 2021,[39] insurance companies and employer-sponsored health plans must now submit to the Centers for Medicare and Medicaid Services ("CMS") certain information about health care spending, including spending on premium paid by *both* members and employers. Using data reported to CMS from eight Massachusetts health plans, we derived estimated household premium contributions for Massachusetts commercial members (excluding self-insured plans).[40] Based on our modeling, we estimate that, on average, *household* premium contributions in 2022 by income quintile ranged from just over $5,640 in the lowest-income quintile to about $6,770 in the highest-income quintile, with most Massachusetts households with fully-insured health plans contributing over $6,000, on average, towards their health insurance premium.

While households in the lowest-income zip codes, on average, spent less on premium contributions in 2022 than households in other income quintiles, they spent the highest percentage of household income. Moreover, as reflected in Figure 8 below, when household premium contributions in 2022 are combined with cost share responsibility, our analysis shows that households in the lowest-income quintile, especially, are spending a significant percentage of their household income—13%, on average—on health care. And households in the lowest-income zip codes are spending nearly five times more of their household income on health care relative to Massachusetts households in the highest-income zip codes (2.7%).

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[36] Sara R. Collins, et. al, *State of U.S. Health Insurance in 2022, Findings From the Commonwealth Fund Biennial Health Insurance Survey*, Commonwealth Fund, p. 6, September 29, 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.

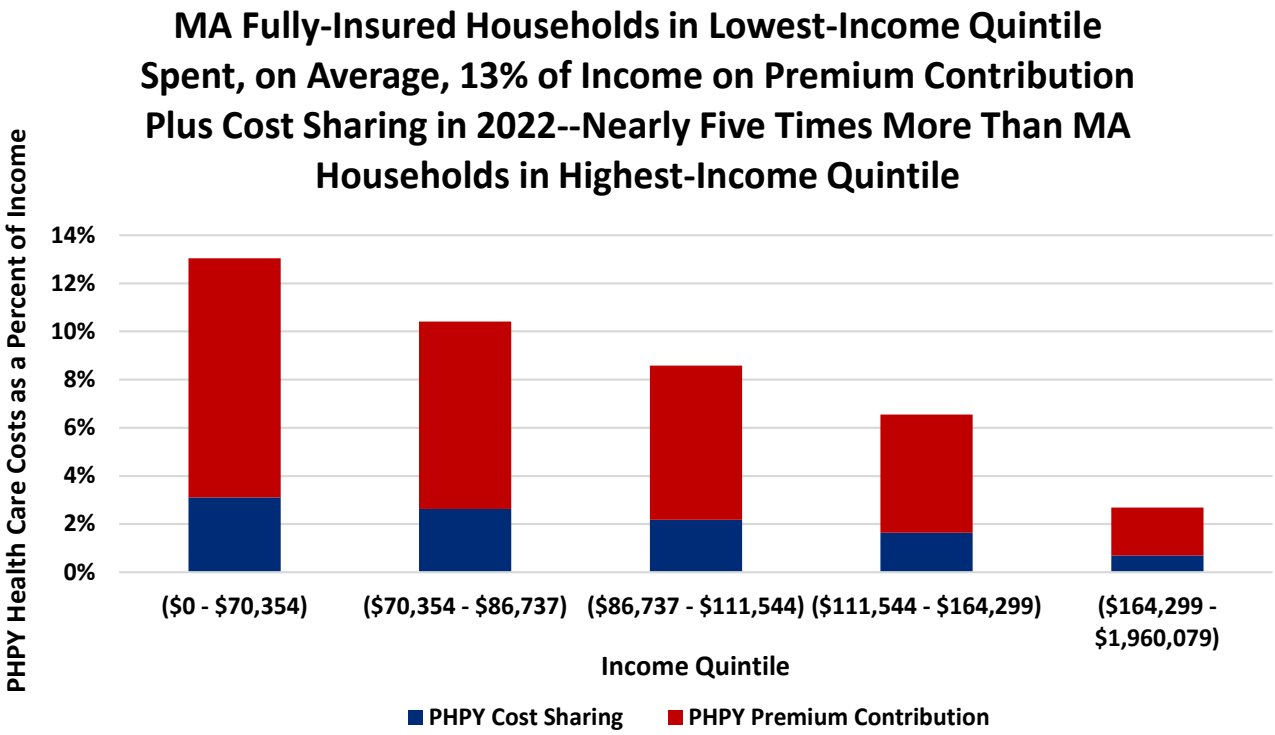
[37] Similar to CHIA, for this examination, we requested that plans report to us premium gross of Medical Loss Ratio ("MLR") rebates and the Advance Premium Tax Credit ("APTC") and to provide APTC amounts. However, while CHIA reports premium data gross of APTC and net of MLR rebates, the premium data reported in this report are net of the APTC and gross of MLR rebates.

[38] Certain information concerning employee premium contributions is collected by CHIA through its Massachusetts Employer Survey. *See*, *e.g.*, *2021 Massachusetts Employer Survey: Summary of Results*, CHIA, June 2022, https://www.chiamass.gov/assets/docs/r/survey/Massachusetts-Employer-Survey-CHIA-2021.pdf.

[39] *See Consolidated Appropriations Act, 2021*, Title II, Division BB, Section 204, https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf; *see also* CMS.gov, *Prescription Drug Data Collection (RxDC)*, Center for Medicare & Medicaid Services, https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc.

[40] As noted above, data used for our premium contribution analyses is derived from relatively new reporting requirements. Health plans that provided us copies of their reports to CMS indicated that they relied on surveys sent to their customers to populate the reporting, and, therefore, the quality of the data reported is dependent on the quality of surveys received back from their customers. Moreover, not all clients responded to such surveys.

Figure 8



Notes: For a description of income quintiles and calculation of PHPY metrics, see notes for Figure 3 above. Premium contributions are derived from responses from "D1" reports[41] provided by eight Massachusetts health plans in conjunction with premium data reported by those plans for their fully-insured members pursuant to our CID. Cost share data is based on reporting from ten Massachusetts health plans. Data includes commercial members receiving CSR subsidies.

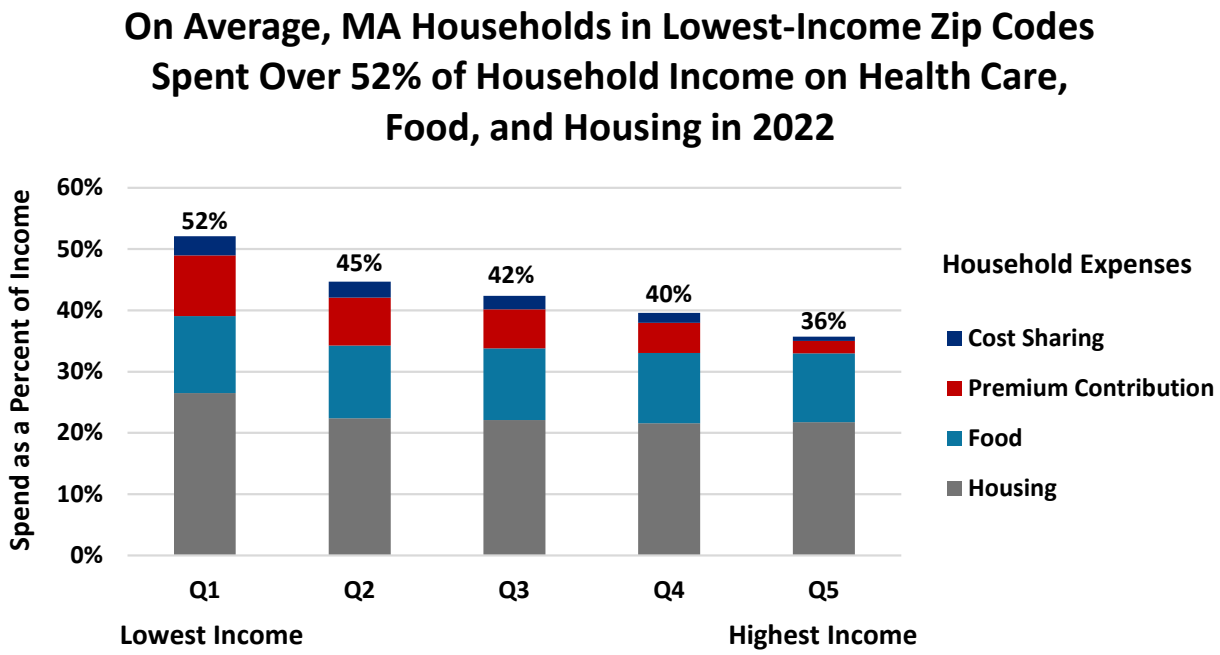
As a final observation, we note that the data reported above focuses on average *household* premium contribution only; it does not incorporate amounts contributed by employers. An employer's premium contribution is one component of an employee's total compensation, in addition to the employee's actual wages; employers commonly contribute between 70-75% of premium cost. As health care economists have observed, higher health care costs and premiums effectively depress wages; stated differently, if the cost of health insurance premiums were to decrease, a greater percentage of total compensation could be converted to take-home pay.[42]

[41] The "D1" report includes premium data at the insurer, market segment, and fully-insured/self-insured level.

[42] *See* Kurt Hager, et. al, *Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families*, JAMA, p. 2, January 16, 2024 ("… it is generally accepted that increasing health care premiums result in lower wages for employees"), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927; Ezekiel J. Emanuel, et. al, *Measuring the Burden of Health Care Costs on US Families: The Affordability Index*, JAMA, November 21, 2017, https://jamanetwork.com/journals/jama/fullarticle/2661699.

For lower-income households, in particular, premiums not only take up a significant portion of their household income, but also depress their income in the first place,[43] leaving families challenged to pay for the actual health care for which they have coverage as well as other household essentials, including food and housing. As shown in Figure 9, our modeling estimates that, in 2022, Massachusetts households in the lowest-income zip codes spent, on average, 52.1% of household income on health care, food, and housing alone.

Figure 9



Notes: For calculations of PHPY health care metrics, including premium, see Figures 3 and 8 above. Health care expenses (cost sharing and premium contribution) are based on data for fully-insured households. Household spending on housing as a percentage of income was calculated by taking a weighted average of median gross rent and median monthly owner costs based on 2022 American Community Survey data, weighted by the proportion of households within applicable zip codes who rent and the proportion that own their housing unit. Gross rent includes the contract rent plus utilities. Owner costs include mortgage principal payments, interest payments, real estate taxes, property insurance, homeowner fees, condo or coop fees and utilities. Household spending on food as a percentage of income is based on estimates put out by PolicyMap and Quantitative Innovations (QI) for small areas for 2022 using the Bureau of Labor Statistics Consumer Expenditure Survey (2021-2022) and the U.S. Census American Community Survey (2018-2022). Estimated costs include food purchased at grocery stores and meals purchased away from home, including at restaurants, cafeterias, and vending machines. Income data is derived from the most recently available (2021) IRS Tax Return Data. Income ranges for quintiles are as follows: Q1: $0 - $70,354, Q2: $70,354 - $86,737, Q3: $86,737 - $111,544, Q4: $111,544 - $164,299, Q5: $164,299 - $1,960,079.

As reflected in Figure 9, health care is just one "essential needs" expense for which households must account. And, when households with depressed wages and limited budget flexibility are required to make substantial monthly payments for premium contributions, they may need to make tradeoffs where possible, including reducing spending in other areas, such as food, or choosing not to get health care to avoid incurring further expenses.[44]

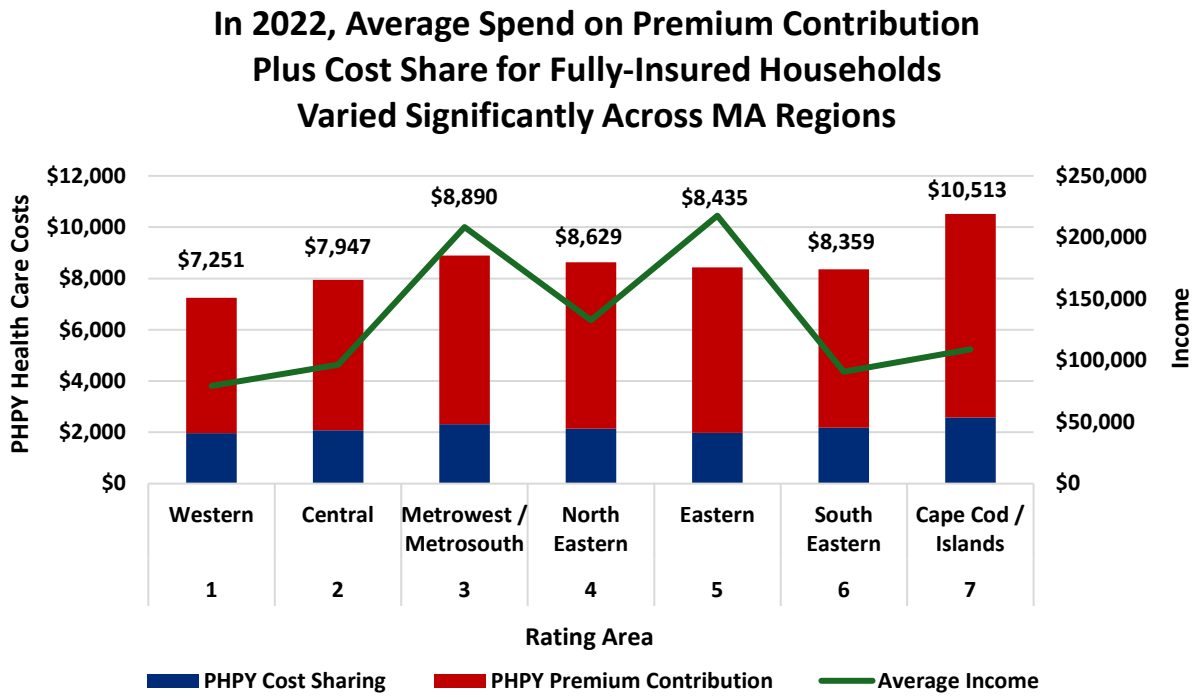
[43] Notably, a 2024 Tufts University study found "that the percentage of [employee] compensation going toward premiums was substantially higher for Black and Hispanic workers and lower-income workers, and likely contributed to income inequality." Jen A. Miller, *Cost of Employer-Sponsored Health Insurance is Flattening Worker Wages, Contributing to Income Inequality*, TuftsNow, January 16, 2024, https://now.tufts.edu/2024/01/16/cost-employer-sponsored-health-insurance-flattening-worker-wages-contributing-income; *see also* Hager, *supra* n. 42, p. 7.

[44] *See, e.g.,* Hamel, *supra* n. 34, p.11-13.

ii. Household Premium Contribution and Cost Share By Region

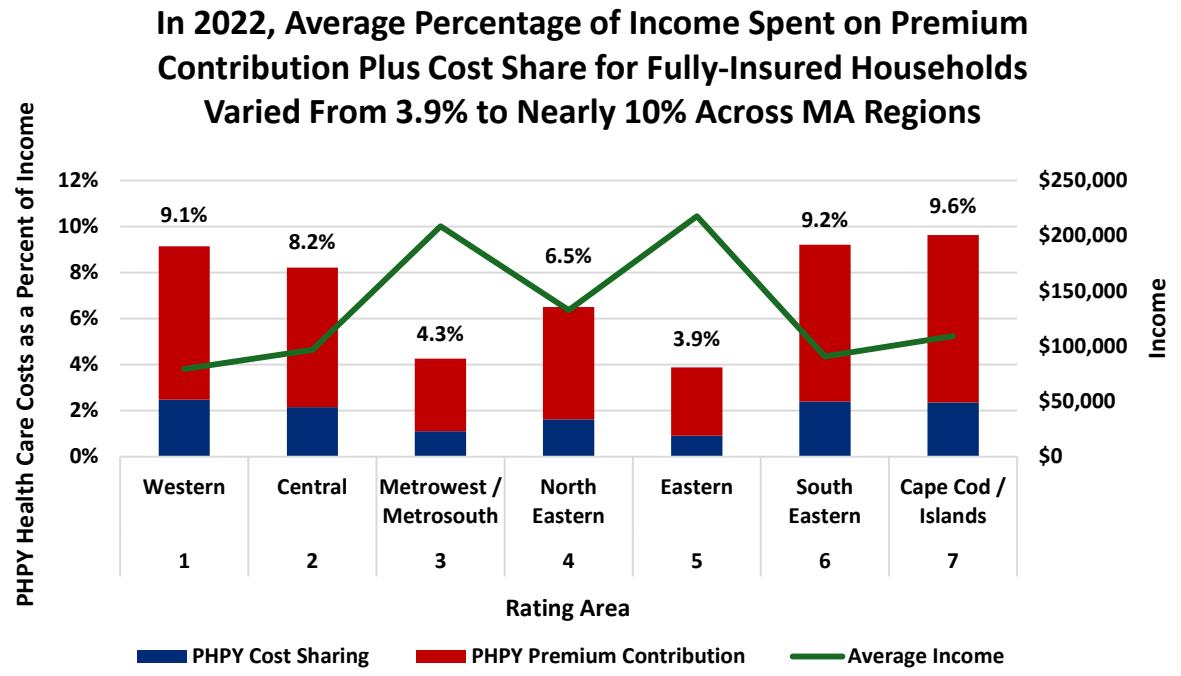
Next, we examined the extent to which health plan members in different parts of the state may be experiencing differences in health care affordability by looking at the average spend on premium contributions and cost share in 2022 for households with fully-insured members across different geographic regions in Massachusetts. As shown in Figure 10, the average household spend varied significantly, from the lowest ($7,251) in the Western region to the highest ($10,513) in Cape Cod/Islands. This spending is not adjusted for health status, so this variation reflects regional differences in morbidity and age. Due to both regional variation in average household spend—largely driven by differences in average premium contribution—and variation in average household income, there is also significant regional variation in the average percentage of household income spent on health care in 2022. As Figure 11 reflects, averages ranged from 3.9% of household income in the Eastern region (which had the fourth lowest spend, on average, of all regions as well as the highest average income), to nearly 10% in Cape Cod/Islands (which had the highest spend of all regions, on average, but only the fourth highest average income).

Figure 10



Notes: The regions referenced above are based on the seven rating regions used by Massachusetts health plans for merged market rating, as referenced here: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/ma-gra. These rating regions are defined by three-digit zip codes and are generally known as Rating Area 1, Rating Area 2, etc. We added geographic-based names for each rating region to provide geographic context. Average income is derived from the most recently available (2021) IRS Tax Return Data. For calculations of PHPY metrics, including premium contribution, see Figures 3 and 8 above.

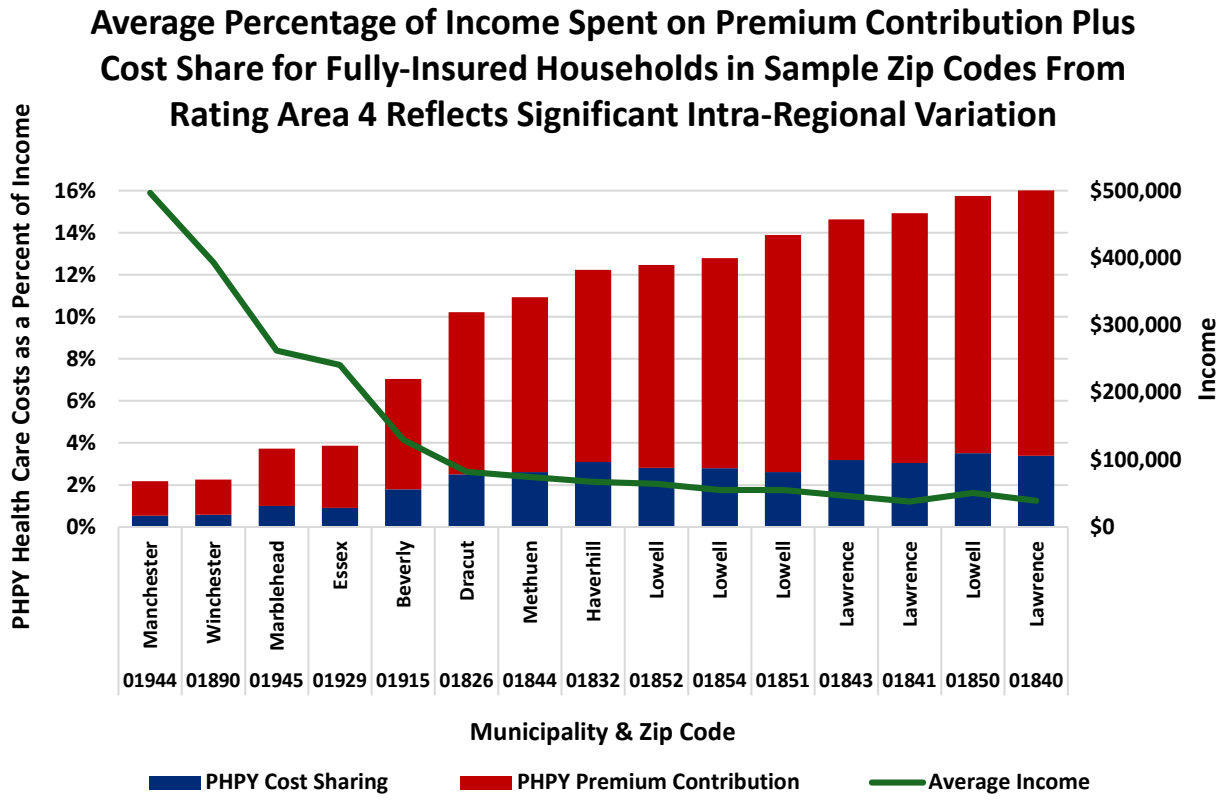
Figure 11



Notes: For the calculation of PHPY metrics, including premium contributions, and a description of the regions referenced above, see notes for Figures 3, 8, and 10.

While the data in Figure 11 points to significant regional variation in relative affordability at a high level, regions may include within them zip codes with substantial income variation. In some instances, there may be more affordability variation *within* the regions than across them. To get behind regional averages, then, we pulled out a subset of zip codes within the North Eastern region, including zip codes with relatively high average incomes and relatively low average incomes. While households with fully-insured commercial health plans across the North Eastern region in the aggregate spent, on average, 6.5% of household income on cost share expenditures and household premium contributions in 2022, Figure 12 shows, for the sample zip codes within the North Eastern region we examined, average household spend relative to income ranged from 2.2% in Manchester to approximately 16% in both one Lowell zip code and one Lawrence zip code.

Figure 12

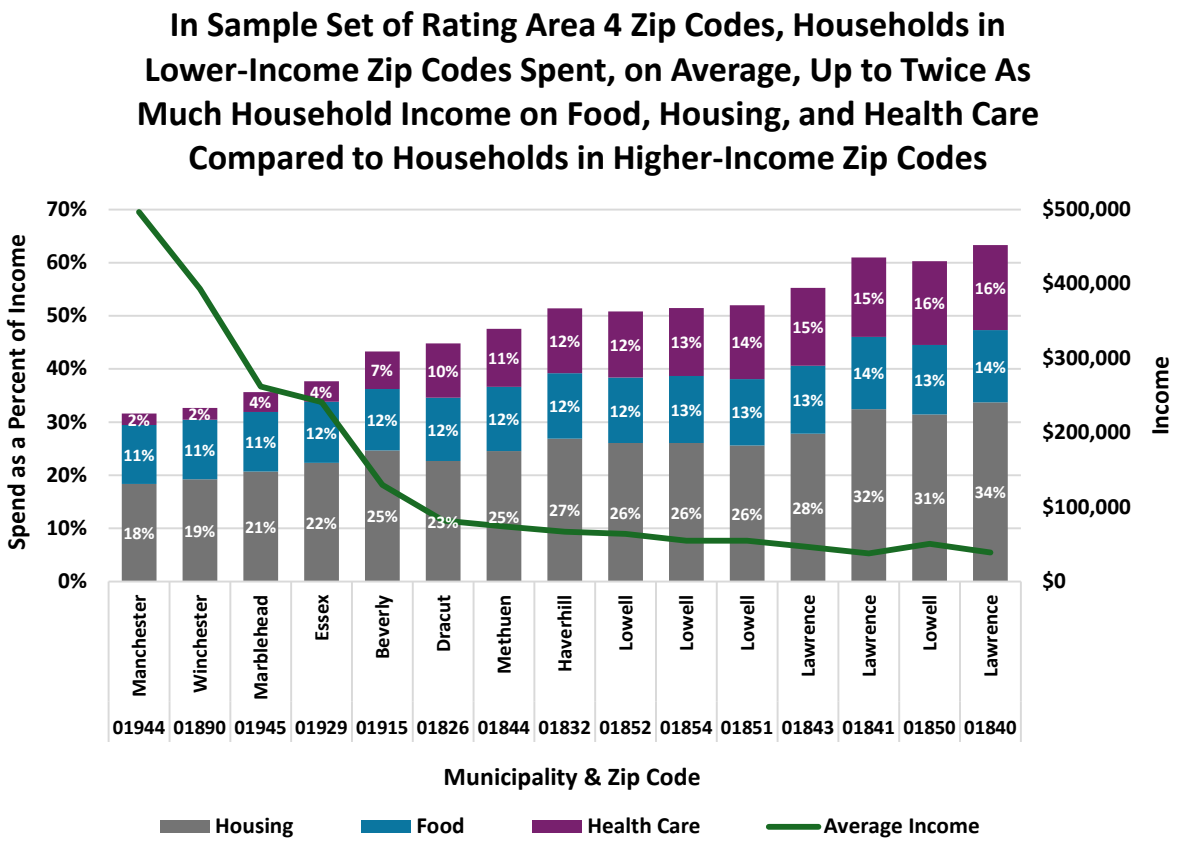


Notes: Average income is derived from the most recently available (2021) IRS Tax Return Data. For calculations of PHPY metrics, including premium contributions, see Figures 3 and 8 above.

While we cannot ascertain all the reasons (outside of income level) that contribute to the significant variation in relative affordability burden across the zip codes in Figure 12, data on premium contribution and cost share spend disaggregated to the zip code level can provide focus areas for further study and help identify potential localized factors contributing to health care affordability burdens and more targeted responses.

Finally, we examined the implications of disparate health care affordability burdens in relation to income by combining average costs of two other household necessities—food and housing—to average household spending on health care across the same set of zip codes as examined above.

Figure 13



Notes: Average income is derived from the most recently available (2021) IRS Tax Return Data. "Health Care" costs include household cost sharing and premium contribution only (i.e., employer contribution is not shown). For calculations of PHPY metrics, including premium contributions, see Figures 3 and 8 above. Household spending on housing as a percentage of income was calculated by taking a weighted average of median gross rent and median monthly owner costs based on 2022 American Community Survey data, weighting by the proportion of households within applicable zip codes who rent and the proportion that own their housing unit. Gross rent includes the contract rent plus utilities. Owner costs include mortgage principal payments, interest payments, real estate taxes, property insurance, homeowner fees, condo or coop fees and utilities. Household spending on food as a percentage of income is based on estimates put out by PolicyMap and Quantitative Innovations (QI) for small areas for 2022 using the Bureau of Labor Statistics Consumer Expenditure Survey (2021-2022) and the U.S. Census American Community Survey (2018-2022). Estimated costs include food purchased at grocery stores and meals purchased away from home, including at restaurants, cafeterias, and vending machines.

As shown in Figure 13 we estimate that households in lower-income zip codes (e.g., Lowell and Lawrence) that are, on average, spending a much higher percentage of annual income on health care expenses relative to households in higher-income zip codes must *also* allocate a substantially higher percentage of household income to housing costs. Of particular note: on average, households in parts of Lowell and Lawrence spent 31%-34% of their income on housing costs;[45] these same households, on average, needed to allocate nearly one sixth of their annual income to health care costs. It is highly likely, then, that many of these households struggle with health care affordability, as defined in the beginning of the report: being able to pay a health care bill without sacrificing other essential needs, experiencing financial hardship or incurring debt.

[45] A household is generally considered "housing cost burdened" if more than 30% of its income is spent on rent, mortgage, or other housing costs. *See Nearly Half of Renter Households Are Cost-Burdened, Proportions Differ by Race*, U.S. Census Bureau, September 12, 2024, https://www.census.gov/newsroom/press-releases/2024/renter-households-cost-burdened-race.html.

iii. Total Premium Alignment With TME Spending

To further understand differentials in Massachusetts households' spending on health care across income quintiles—and what may be driving it—we looked at how total spending on household cost sharing and total premium (both employer and employee contribution) in each income quintile compared to statewide averages in 2022, with a focus on households enrolled in fully-insured employer-sponsored health plans. As shown in Figure 14, we first found that, statewide, Total Medical Expenses ("TME") spending—the total amount paid by health plans and consumers for health care—varies significantly across income quintiles. For example, spending for households in the lowest-income quintile was 7.4% *below* the statewide average, while spending for households in the highest-income quintile was 0.8% *above* the statewide average (Figure 14, Column B).

Figure 14

For Households Living in Lowest- and Highest-Income Zip Codes, Annual Total Medical Expenses Spending is Disproportional to Spending on Total Premium

Income Quintile	A Total Medical Expenses ("TME") PHPY	B TME % Above / Below Statewide Average	C Cost Sharing % Above / Below Statewide Average	D Total Premium % Above / Below Statewide Average
1 ($0 - $70,354)	$15,820	-7.4%	-8.6%	2.3%
2 ($70,354 - $86,737)	$17,660	3.3%	0.8%	2.3%
3 ($86,737 - $111,544)	$17,716	3.7%	2.6%	0.9%
4 ($111,544 - $164,299)	$17,030	-0.3%	-0.5%	-0.2%
5 ($164,299 - $1,960,079)	$17,225	0.8%	4.1%	-3.6%
Statewide Average	$17,089	0.0%	0.0%	0.0%
Lowest 2 Quintiles	$16,699	-2.3%	-4.1%	2.3%
Highest 2 Quintiles	$17,136	0.3%	2.0%	-2.1%

Notes: Total Medical Expenses ("TME") is derived from the total allowed claims and non-claims amounts, consistent with CHIA's definition of TME, reported by ten Massachusetts health plans for their fully-insured employer-sponsored membership in 2022; cost sharing data is from the same ten plans. "Total Premium" spending includes both employer and employee contributions towards premium reported by eight health plans for their fully-insured employer-sponsored membership in 2022. For a description of income quintiles and the calculation of PHPY metrics, see notes for Figure 3 above.

We also found that, across income quintiles, household spending on cost share expenditures (Figure 14, Column C), such as deductible responsibility, is largely proportional with TME spending: households in the lowest-income quintiles combined spent less on cost sharing relative to the statewide average, and households in the highest-income quintiles combined spent more. Specifically, in 2022, TME spending (Figure 14, Column B) for households in the two lowest-income quintiles was 2.3% *below* the statewide average; correspondingly, these households' total spend on cost sharing was 4.1% *below* the statewide average. Spending for households in the two highest-income quintiles reflected similar proportionality: while TME spending was 0.3% *above* the statewide average, these households' total spending on cost sharing, similarly, was 2.0% *above* the statewide average.

The spending differential between lowest- and highest-income quintiles on cost sharing is consistent with this Office's past reporting. In our 2022 cost trends examination, for instance, we observed that "[l]ow-income communities disproportionately face barriers in accessing care, such as lack of transportation, inability to take time off from work, unaffordable cost sharing, language barriers, lack of childcare, lack of broadband access, and housing instability."[46] These barriers, in turn, contribute to fewer health care visits and lower spending relative to wealthier populations. As recognized in the 2022 report, lower-income patients need improved health care access.[47]

The lower spending on cost sharing on the part of households in the lowest-income zip codes may also be driven by the reality that lower-income communities are more likely to receive health care from lower-priced hospitals and providers that serve their communities, while higher-income communities are more likely to receive health care from higher-priced hospitals and providers. Because OOP spending on cost sharing usually reflects the specific negotiated prices of the services provided to health care consumers, the differentials in cost share spend between the lowest- and highest-income quintiles reported above are generally as expected.

In contrast to cost share spending, our analysis shows that, for households in the lowest- and highest-income quintiles, spending on total premium (employer and member contributions) in 2022 was *not* proportional to TME spending. For example, TME spending for households in the two lowest-income quintiles combined was 2.3% *below* the statewide average in 2022; by contrast, spending for these households on total premium (Figure 14, Column D) was 2.3% *above* the statewide average—a significant disconnect between what these households are paying to have commercial health insurance coverage and what they are actually spending—or, the value they are getting—under this coverage. Likewise, disproportionality is seen across the higher-income quintiles. While TME spending for households in the two highest income quintiles combined was 0.3% *above* the statewide average, spending on total premium was 2.1% *below* the statewide average.

Together, these analyses raise questions as to whether and to what extent the premium amounts paid for households in lower-income zip codes for health insurance coverage are cross subsidizing higher-priced hospitals and providers located in and used by wealthier communities. As significant hospital and provider price variation has taken root in Massachusetts over the past twenty years,[48] current approaches to building premiums may not adequately account for regional provider pricing differences or utilization data concerning which communities tend to use higher- versus lower-priced providers. These dynamics may now be contributing to the socialization of price differences paid by households in lower-income communities and households in higher-income communities for the same health care services.

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[46] *Examination of Health Care Cost Trends and Cost Drivers Report: 2022*, Office of the Massachusetts Attorney General, p. 7, 2022, https://www.mass.gov/doc/examination-of-health-care-cost-trends-and-cost-drivers-report-2022/download.

[47] *See generally 2022 Cost Trends Report*, *supra* n. 46.

[48] *See generally Investigation of Health Care Cost Trends and Cost Drivers: Preliminary Report*, Office of the Massachusetts Attorney General, January 29, 2010, https://www.mass.gov/doc/2010-investigation-of-health-care-cost-trends-and-cost-drivers-preliminary-report/download.

C. Expenditures For Health Care Not Covered By Insurance

- **Additional OOP exposure for Massachusetts residents for health care not covered by health insurance adds to affordability barriers and inhibits some Massachusetts residents from seeking care.**

In addition to hefty premium contributions and cost share responsibility, Massachusetts residents, including those with health insurance coverage, may face significant health care costs for services and items that are not covered by their health insurance, including for services from health care providers not within the network of the consumer's health plan. While the federal No Surprises Act ("NSA") provides some consumer protection against OOP costs in relation to out-of-network ("OON") services, there are notable gaps. For example, as examined in this Office's 2023 Cost Trends Report, Massachusetts residents incur significant OOP costs—and medical debt—for OON ground ambulance transports, which are not included within NSA protections.[49]

Moreover, it is well established that a substantial number of Massachusetts consumers needing behavioral health treatment go OON for care,[50] requiring them to foot the entirety of the provider's bill when they do not have coverage for OON providers or, at a minimum, pay the resulting "balance bill" (the difference between the provider's charge and what the health plan has allowed for payment) where there is coverage under a health plan. The magnitude of these OON bills tax the budgets of many Massachusetts residents.[51] And for a significant number of individuals and families, they are financially untenable. In the 2021 Massachusetts Health Insurance Survey, for example, 8.6% of Massachusetts residents reported that they or someone in their family had forgone behavioral health care that they felt was needed due to cost in the past 12 months prior to the survey response.[52] Finally, there is a cohort of consumers who choose to get needed behavioral health care but cannot afford the OOP expense and so incur debt to do so.

In the next Sections we consider this last scenario—what happens when health care consumers with commercial health insurance cannot pay their bills and accrue debt, and how this may affect hospitals, particularly the hospitals providing health care to the state's lowest-income communities.

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[49] *Examination of Health Care Cost Trends*, Office of the Massachusetts Attorney General, November 2023, https://www.mass.gov/doc/examination-of-health-care-cost-trends-report-2023/download.

[50] An analysis of private claims data by the Research Triangle Institute, a non-profit research entity, found that, in 2021, 14.4% of behavioral health office visits in Massachusetts were out of network (compared to 1% of medical/surgical office visits). Tami L. Mark and William Parish, *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue*, Research Triangle Institute, p. 8, C-81, April 17, 2024, https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf.

[51] Consider the following scenario—generally representative of consumer experiences shared with this Office—where a Massachusetts consumer receives OON therapy once a week, and the consumer's therapist bills $180 per session. The consumer does have OON coverage under their plan; but, instead of a $10 co-pay applicable for in-network therapy visits, the consumer's OON therapy visits are subject to an individual deductible of $500; when that is met, they must pay a 20% co-insurance for each visit. The health plan's applicable allowed amount—what it determines the therapist will be paid for each session—is $96. The $84 balance bill left over after the allowed amount ($96) is applied to the provider's $180 bill must be paid entirely by the consumer for each weekly bill. After six months (26 weeks) of weekly therapy, the consumer will need to pay a total of $3,083.20 ($500.00 in deductible; $399.20 in coinsurance; $2,184.00 in balance bills)—*thousands* of dollars OOP even though they have commercial health plan coverage.

[52] *2021 MHIS*, *supra* n. 10, p. 77; *2024 CHIA Annual Report*, *supra* n. 23, p. 133.

III. PATIENT MEDICAL DEBT RESULTING FROM HOSPITAL SERVICES

Medical debt can have negative consequences for individuals and communities. Patients have reported being denied care by providers due to unpaid medical bills, forgoing needed medical services, and cutting spending on necessities like groceries to pay medical bills due to the burden of medical debt.[53] Most recent credit data shows that in Massachusetts, the median amount of medical debt in collections is $1,438.[54] This number represents only a portion of outstanding payments, since residents may have additional medical debt outside of collections and may continue to accrue bills for additional health care services. Individuals with complex medical conditions that require ongoing care are more likely to accumulate debt due to their frequent hospital encounters.[55] In this section, we examine which Massachusetts communities are most likely to be burdened with hospital medical debt and explore financial assistance provided by hospitals to patients who are struggling to pay their portion of hospital bills.

This analysis is based on data collected from a sample of eleven hospitals spread across Massachusetts. These hospitals have varying sizes, service areas, prices, and public payer mixes. Each hospital provided data on patients with commercial coverage who received services rendered in 2022[56] and who, as of April 2024, had a balance overdue past 120 days. We focused on patients with commercial insurance coverage in order to explore the impact that high deductibles and other cost sharing responsibility, especially as a percentage of income in lower-income communities, has on patient ability to pay medical bills.[57] This examination is limited to debt arising from hospital services, and more study is needed to understand the burden of debt stemming from physician practices, dental practices, and other non-hospital sites of care.[58]

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[53] Lunna Lopes, et. al, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, Kaiser Family Foundation, June 16, 2022, https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/.

[54] *Debt in America: An Interactive Map*, Urban Institute, September 2024, https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=medcoll&state=25.

[55] Shameek Rakshit, et. al, *The Burden of Medical Debt in the United States*, Peterson-KFF Health System Tracker, February 12, 2024, https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.

[56] Ten of the hospitals provided information for services rendered in 2022. One hospital provided information for services rendered April 2022 through March 2023 in order to have a full year of data.

[57] Himmelstein, *supra* n. 24, p. 10.

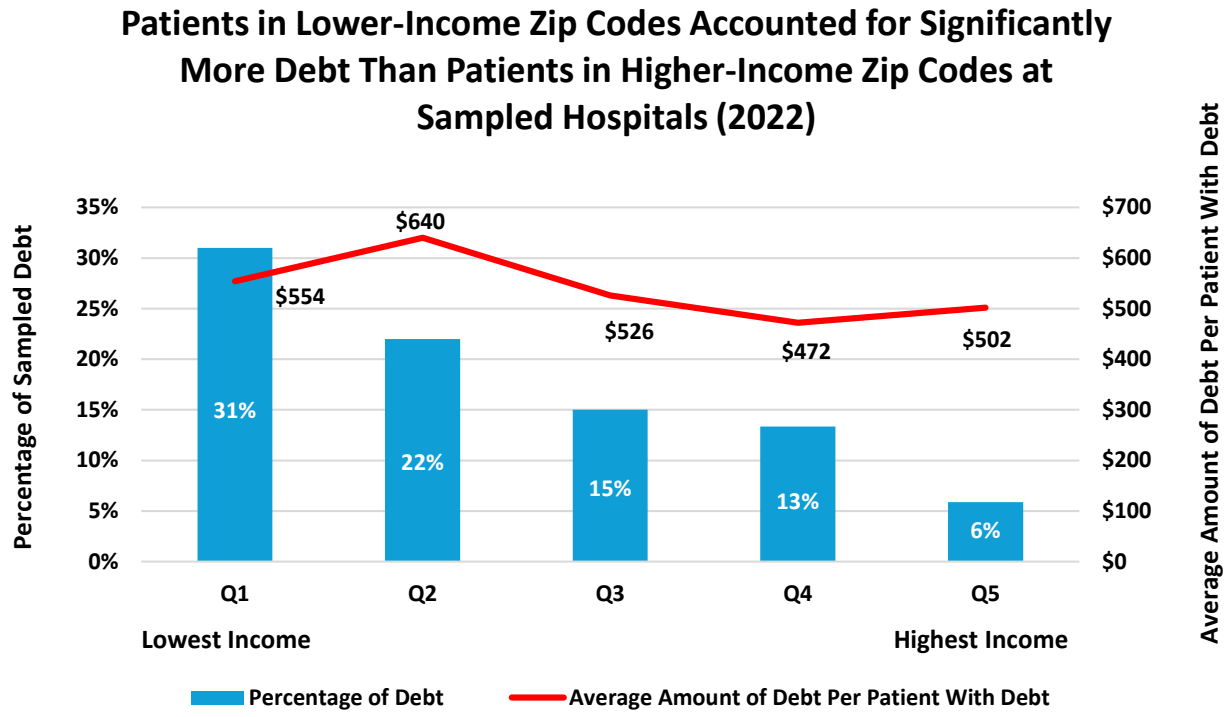
[60] *See generally* Lopes, *supra* n. 53.

A. Demographics Of Patients With Hospital Debt

i. Hospital Medical Debt by Patient Income

- **Patients who live in lower-income zip codes were more likely to have debt than patients who live in higher-income zip codes.**

Figure 15



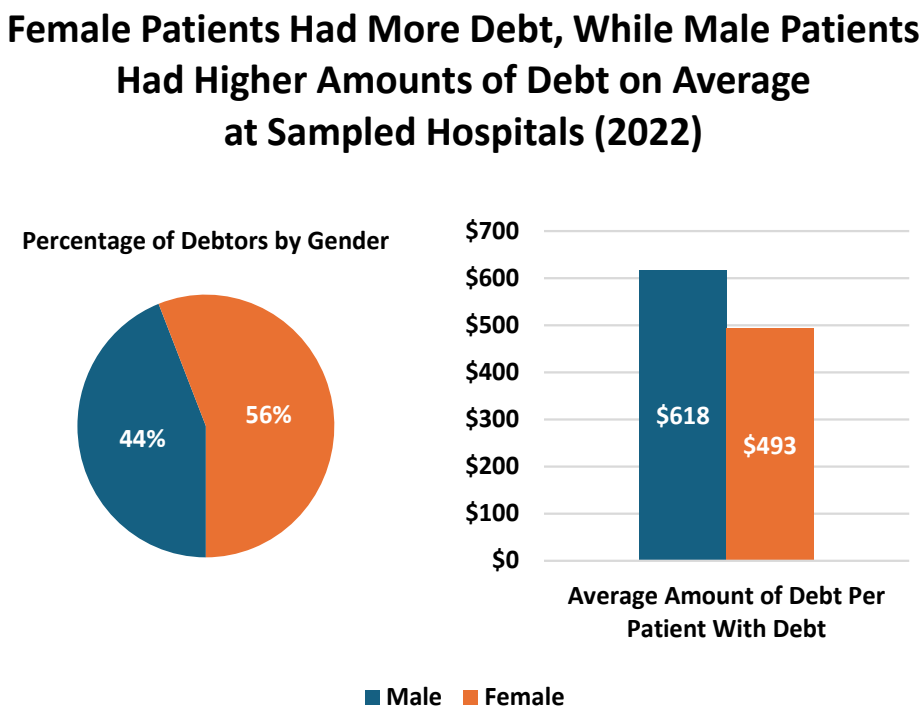
Notes: Data is based on zip code information provided by eleven Massachusetts hospitals for commercial patients who, as of April 2024, had a balance overdue past 120 days from a service rendered in 2022. Income quintiles were calculated using average income by tax return per zip code from the 2021 IRS data. Q1 represents incomes ranging from $0 - $70,354, Q2 represents incomes ranging from $70,354 - $86,737, Q3 represents incomes ranging from $86,737 - $111,544, Q4 represents incomes ranging from $111,544 - $164,299, and Q5 represents incomes ranging from $164,299 - $1,960,079. This analysis does not account for patients with multiple zip codes during the same year or patients who received services from multiple hospitals during the same year. Percentage total for bars does not equal 100% due to rounding and due to 11% of debt being held by patients for whom an income quintile could not be determined.

In our analysis, we found a correlation between the average income of a patient's zip code and the likelihood of that patient incurring hospital medical debt from the service they received. Figure 15 shows that patients with medical debt living in zip codes that fell within the lowest-income quintiles shouldered a disproportionate amount of medical debt – on average amounting to $554 for the lowest-income quintile and $640 for the second lowest-income quintile for services rendered in 2022. In comparison, individuals with hospital medical debt residing in the highest-income quintile had on average $502 in debt. Only 6% of patients with medical debt in our sample lived in the highest-income quintile, while 53% lived in the two lowest-income quintiles.

ii. Hospital Medical Debt by Gender

- **Female patients were more likely to have debt than male patients, although male patients had higher amounts of debt than female patients on average.**

Figure 16



Notes: Data on gender was provided by eleven Massachusetts hospitals and includes commercial patients who had a balance overdue past 120 days from a service rendered in 2022, as of April 2024. Data was separated into three categories: male, female, and other/unknown. The other/unknown category made up less than 1% of patients with debt and was omitted due to small sample size. Data for male and female patients was separated into percentage of debtors by gender and average amount of debt per patient with debt.

It is well known that factors like sex and gender have impacts on an individual's health outcomes. Recent data has found that women tend to live longer than men but experience higher levels of non-fatal illness throughout their lives (such as anxiety and depressive disorders, musculoskeletal disorders, Alzheimer's Disease and other dementias)[59] – illnesses that require consistent medical care and interventions. Our analysis on gender and medical debt found that female patients accounted for the majority (56%) of individuals with debt stemming from services received at the sampled hospitals in 2022. The fact that more women are carrying medical debt may be driven by higher utilization of medical services.

[59] Taylor L., *Women Live Longer Than Men But Have More Illness Throughout Life, Global Study Finds*, The BMJ, May 2, 2024, https://www.bmj.com/content/385/bmj.q999.long.

iii. Hospital Medical Debt by Race

- **Black patients made up a larger proportion of patients with debt than their share of the statewide population.**

Building on this Office's report on racial health disparities in Massachusetts,[60] we examined the proportion of patients with hospital medical debt by race. In our analysis, we found that the proportion of patients who were reported by the sampled hospitals as Black and who had debt stemming from a service rendered in 2022 was higher than the proportion of Massachusetts residents who identified as Black in response to the 2020 Census. Specifically, 12% of Black patients had medical debt despite only making up 7% of the Massachusetts population.

In contrast, white and Asian patients made up a smaller proportion of patients with debt compared to their share of the statewide population.[61] The sampled hospitals reported that approximately 3% of patients with hospital medical debt were Asian while approximately 7% percent of the statewide population identifies as Asian, and the hospitals reported that approximately 63% of patients with hospital medical debt were white while approximately 68% of Massachusetts residents identify as white.[62]

Within this sample of hospitals, we saw a disproportionate burden of hospital debt on Black patients, a population facing well-documented health disparities.

[60] *See generally Building Toward Racial Justice and Equity in Health: A Call to Action*, Office of the Massachusetts Attorney General, https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download.

[61] Due to limitations from the data reported, we were unable to make findings as to other racial or ethnic groups.

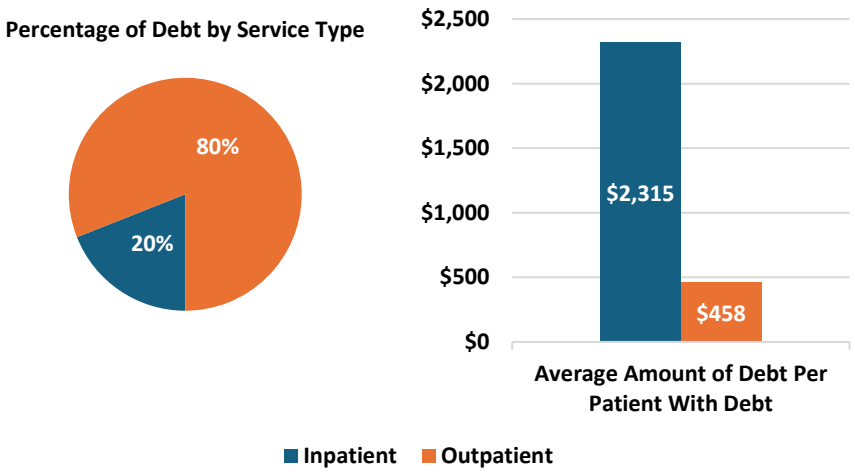
[62] *Massachusetts Population by Race/Ethnicity*, Commonwealth of Massachusetts, 2020, https://www.mass.gov/info-details/massachusetts-population-by-raceethnicity.

B. Services That Led To Hospital Debt

- **Outpatient services resulted in more patients going into debt, while inpatient services led to patients having higher amounts of debt on average.**

Figure 17

Outpatient Services Generated More Debt, While Inpatient Services Generated Higher Amounts of Debt on Average at Sampled Hospitals (2022)



Notes: Data on service type was provided by eleven Massachusetts hospitals and includes commercial patients who had a balance overdue past 120 days from a service rendered in 2022, as of April 2024. Totals do not account for patients who received inpatient and outpatient services simultaneously. Emergency room services were included in outpatient numbers for the purposes of this analysis. Data was separated into percentage of debt by service type and average amount of debt per patient with debt.

As shown in the figure above, outpatient services (medical visits or surgical procedures that allows a patient to go home the same day) accounted for 80% of hospital medical debt compared to inpatient services (services that require an overnight stay at the hospital), which accounted for 20% of hospital medical debt. This finding is likely driven by higher utilization of outpatient services as compared to inpatient services. The twelve sampled hospitals reported approximately six million outpatient encounters compared to less than a quarter million inpatient discharges in 2022.

Finally, we find that inpatient services generate higher amounts of debt than outpatient services. The average amount of debt per patient stemming from inpatient services was $2,315 compared to $458 for outpatient services. This is likely because inpatient bills tend to be much higher than outpatient bills and therefore generate higher patient deductible obligation, co-payment, and cost sharing.

C. Hospital Financial Assistance Policies

The Patient Protection Affordable Care Act ("ACA"), enacted in 2010, not only expanded health care coverage to millions of individuals, but also added new regulations for non-profit hospitals seeking to maintain their tax-exempt status.[63] The ACA requires that a non-profit hospital must limit the amount charged for any emergency or other medically necessary care it provides to an individual eligible for financial assistance, conduct a Community Health Needs Assessment on a triennial basis, make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in any extraordinary collection actions, and maintain financial assistance policies for emergency care and medically necessary services.[64]

The Health Safety Net ("HSN") pays acute care hospitals and community health centers for medically necessary health care services provided to eligible lower-income, uninsured and underinsured Massachusetts residents up to a predetermined amount of available funding.[65] To qualify for HSN coverage, individuals must be Massachusetts residents with an income between 0-150% of the FPL, and for individuals with an income above 150% and less than or equal to 300% of the FPL, HSN may be available with a deductible.[66] Per state regulations, if a patient qualifies for public assistance from the HSN, a Massachusetts hospital must offer a payment plan.[67] If a patient is not eligible for HSN coverage, hospitals can generally offer payment plans at their discretion.

[63] Patient Protection Affordable Care Act of 2010, Pub. L No. 111-148 (124 Stat. 119 (2010)); *Requirements for 501(c)(3) hospitals under the Affordable Care Act – Section 501(r)*, Internal Revenue Service, https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[64] Affordable Care Act, *supra* n. 63.

[65] *See generally* 100 CMR 613.00.

[66] 100 CMR 613.04(8)(c)(1).

[67] 101 CMR 613.08(1)(g)(4).

To understand the financial assistance landscape in Massachusetts, we compared twelve hospitals' Financial Assistance Policies ("FAPs").

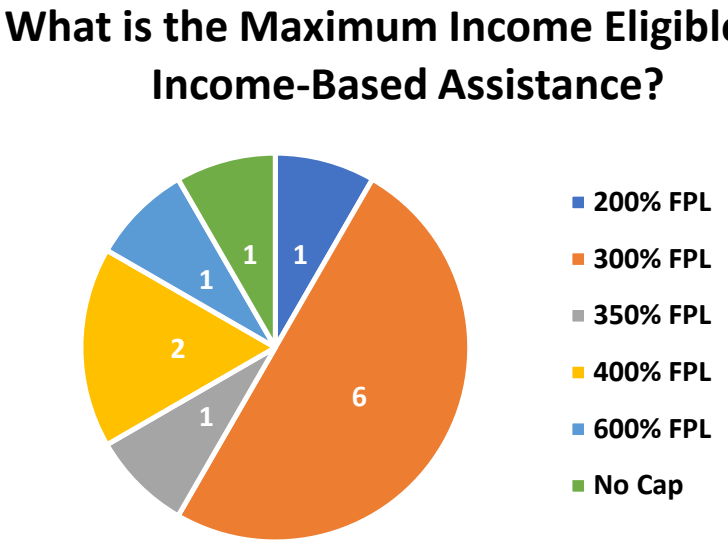
i. Variations in Criteria for Hospital Financial Assistance

- **The twelve sampled hospitals had varying income limits for a patient to be eligible for financial assistance.**
- **A majority of the sampled hospitals do not provide financial assistance to patients if the patient has already received financial support from the Health Safety Net for the same bill.**
- **A majority of the sampled hospitals do not provide financial assistance to out-of-state patients.**

Hospitals may provide discounts to qualifying patients based on income in relation to the FPL. To qualify, patients must go through a screening process established by the hospital. Whether a patient will actually receive a discount for a particular bill depends on many factors, including income, insurance status, and in-state residency status. Our examination found that many of these factors varied significantly from hospital to hospital, resulting in a patchwork of standards for financial assistance that may pose challenges for patients seeking to apply for assistance or understand in advance of a service whether assistance is likely to be available from hospitals.

Our analysis found that income limits for financial assistance eligibility varied across the twelve sampled hospitals. Approximately half of the hospitals use 300% of FPL as the cutoff for offering financial assistance to lower-income patients. Across the twelve hospitals, there were five different income caps for receiving discounts, as shown below in Figure 18.

Figure 18



Notes: Data on income eligibility for hospital financial assistance discounts was provided by twelve Massachusetts hospitals. Income eligibility is defined by patient income in relation to the Federal Poverty Level.

The maximum discounts available to patients vary by hospital within the same geographic region, making it difficult for patients to know what level of financial assistance they can expect to receive based on their income and the hospital they choose. We surveyed four hospitals in the Metro Boston area to better understand the variation in FAPs across a set of nearby hospitals that patients may be comparing when considering hospital services. Our analysis found that all four hospitals had different income eligibility requirements for financial assistance. Specifically, as summarized below, the hospitals used different definitions of what income qualifies a patient as lower-income for purposes of financial assistance eligibility and offer different maximum discounts to qualifying bills based on income level and service type.

Figure 19

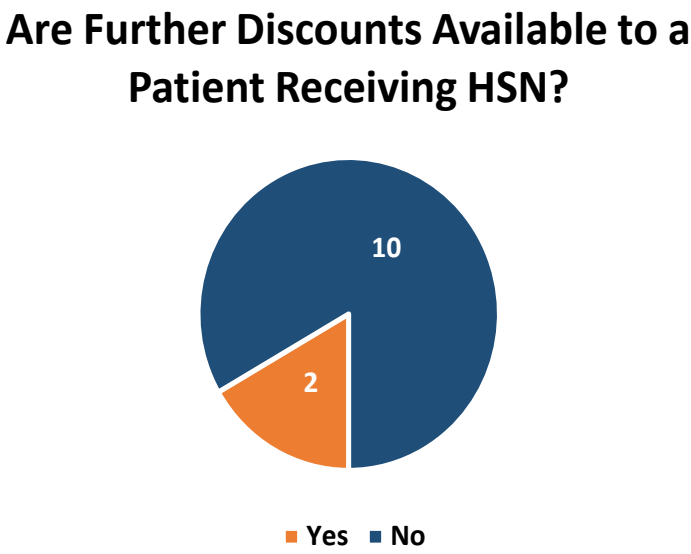
Sampled Metro Boston Hospitals Have Different Maximum Financial Assistance Available Based On Patient Income

Hospital	Maximum Discount Available by Patient Income
Hospital A	100% Discount: 0-150% FPL 85% Discount: 150- 250% FPL 70% Discount: 251- 300% FPL
Hospital B	25% Discount: No income threshold specified
Hospital C	100% Discount: 0- 400% FPL
Hospital D	100% Discount: 0- 150% FPL 49.5% Discount (Inpatient) & 69.5% Discount (Outpatient): 150%- 300% FPL 20% Discount: >301% FPL

Notes: Data on maximum percent discounts offered by hospitals to patients based on patient income was provided by twelve Massachusetts hospitals. "Maximum Discount Available by Patient Income" is defined as the percent discount a patient may receive at a given hospital based on the patient's income in relation to the Federal Poverty Level. This chart only considers income and does not describe other criteria or screening requirements for public assistance or other coverage hospitals may use to determine discount eligibility.

Most – but not all – sampled hospitals limit discounts on bills if a patient has already received assistance from the HSN for those bills. As shown below in Figure 20, very few hospitals provide discounts to patients who also receive assistance from the HSN. Of the surveyed hospitals, two of the twelve allow patients with HSN funding to also receive a discount. Notably, many hospitals require patients to apply to receive HSN funding before they can be considered for a discount from the hospital.

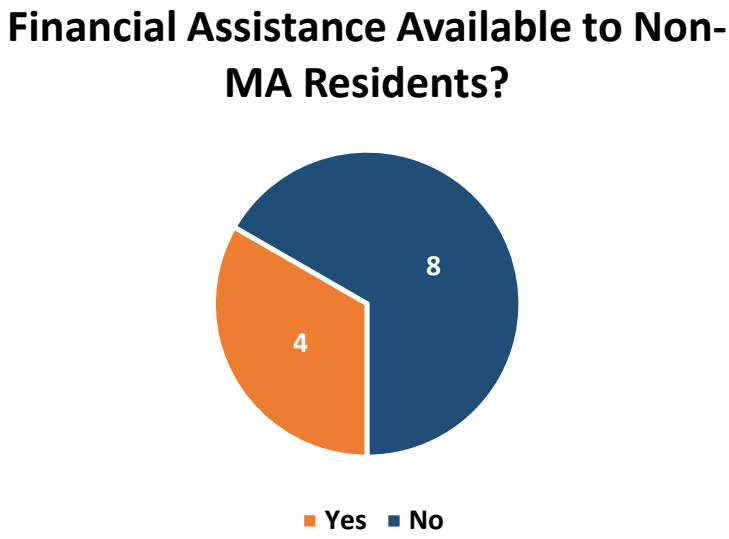
Figure 20



Notes: Data on hospital FAPs allowing patients who receive HSN funding to also receive a discount from the hospital was provided by twelve Massachusetts hospitals.

Figure 21, below, shows that four of the twelve hospitals offer discounts to patients who come from out of state, while the other eight do not. These policies may have affordability implications for patients who travel to Massachusetts to receive hospital services.

Figure 21



Notes: Data on hospital FAP discount availability to out-of-state patients was provided by twelve Massachusetts hospitals.

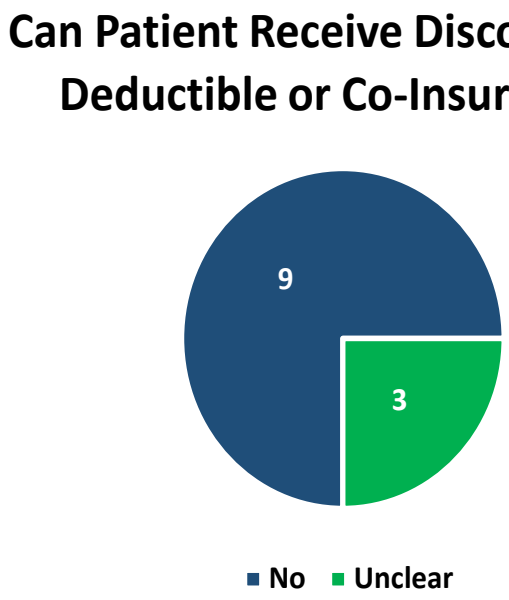
In this examination of FAPs, we found that discounts offered by the sampled hospitals may depend on the patient's income, whether the service was inpatient or outpatient, whether the patient has already received support from the HSN, and whether the patient is from Massachusetts. These policies may be cumbersome and difficult to navigate, especially for those who may qualify for assistance under some but not all of these FAPs.

ii. Exclusion of Deductibles and Co-insurance from Hospital Financial Assistance

- **Lower-income patients hoping to receive discounts from the sampled hospitals toward their deductibles and/or co-insurance responsibility will find that policies are inconsistent and usually inapplicable to commercial patients.**

Even if a patient meets the other criteria for financial assistance, they will likely not qualify for a discount if they have commercial insurance coverage. If an individual receives a bill from the hospital after insurance has paid its portion, it is likely that patient will not qualify for a financial assistance discount.

Figure 22



Notes: Data on hospital FAP discount applicability to deductibles or co-insurance was provided by twelve Massachusetts hospitals.

Of the twelve hospitals sampled, nine clearly stated that discounts did not apply to amounts owed toward deductibles or co-insurance. Some of these nine hospitals stated that patients with commercial insurance were excluded from receiving discounts entirely. The three remaining hospitals seemed to offer limited discounts in deductibles or co-insurance in some situations, but this was not evident from the FAP published online. Two hospitals had written internal policies stating discounts could be offered for deductibles or co-insurance above $5,000. Another hospital had a policy stating that co-insurance and deductibles would be capped at 30% of the gross service cost for patients with qualifying incomes. However, the likelihood of these limited discounts being offered to patients is uncertain given that these details are not included in the published and publicly accessible versions of the FAPs.

These restrictions on the applicability of hospital financial assistance to most cost sharing expenses incurred by commercially insured patients likely contribute to affordability challenges for patients who might otherwise qualify for discounts based on income if the policy were to be more expansive or more easily understood.[68] Commercial patients who are unable to afford their hospital bills and who cannot receive a discount often do not pay a portion or all of their bill, resulting in bad debt for the hospital that provided the services.

IV. HOSPITAL BAD DEBT

The previous sections of this report have focused on the impact of out-of-pocket spending and medical debt on patients. In this section, we consider the impact of unpaid bills on hospitals. Patient bills that are left unpaid may eventually become "bad debt" for hospitals—debt that is not collected and is ultimately written off as a loss. If a hospital is incurring a high amount of bad debt compared to revenue, this may impact its ability to pay staff and vendors, invest in low-margin but needed services like maternity care [69] and pediatric services, carry out capital expenditures like new technological equipment and renovations, and continue operations in a competitive marketplace. Below, we examine the characteristics of hospitals in Massachusetts that have higher percentages of bad debt.

A. Disproportionate Burden of Bad Debt on Lower-Cost Hospitals and Hospitals Serving Public Payer Populations

i. Hospital Commercial Bad Debt Compared to Medicaid/ Subsidized Population Payer Mix and Commercial Statewide Relative Price

- **Sampled hospitals with lower Commercial Relative Prices and higher Medicaid/Subsidized Population Payer Mixes had a higher proportion of commercial bad debt as a percentage of commercial revenue.**

In the charts below, we examine, first, the relationship between each hospital's 2022 Medicaid/ Subsidized Population Payer Mix and the percentage of the hospital's 2022 Commercial Gross Patient Service Revenue ("GPSR") that is commercial bad debt, and second, the relationship between each hospital's 2022 Commercial Statewide Relative Price and the percentage of the hospital's 2022 Commercial GPSR that is commercial bad debt.

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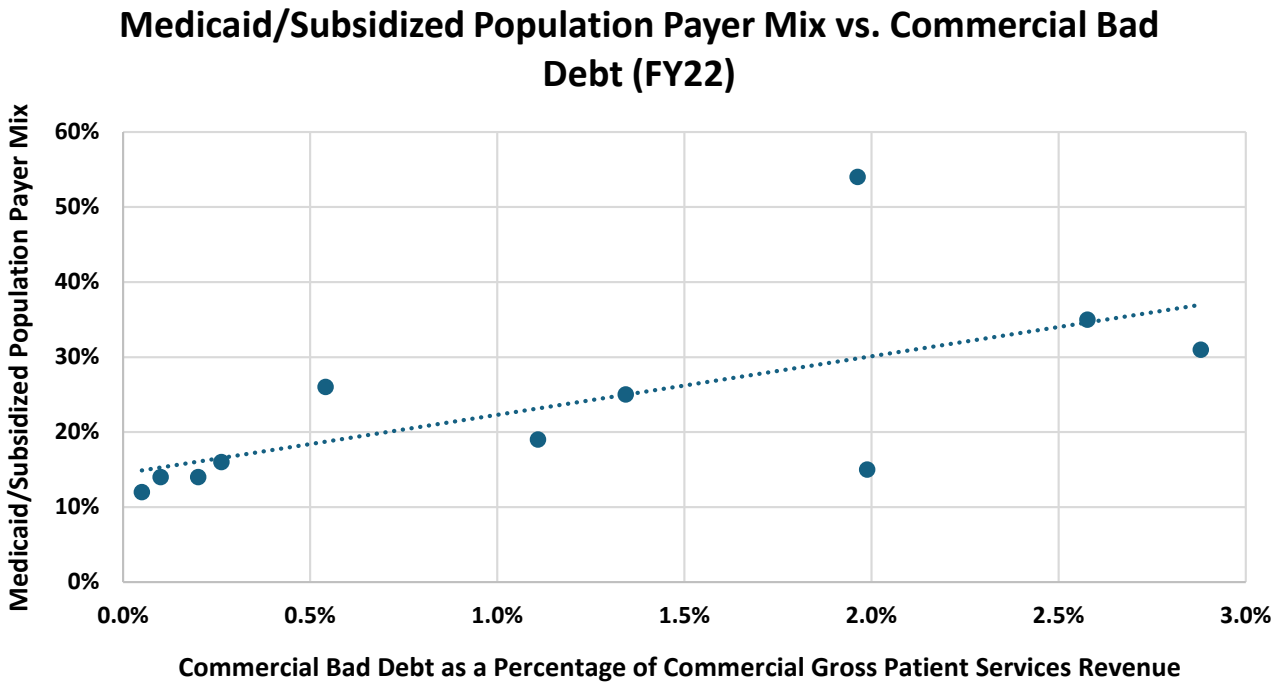
[68] The 2023 Massachusetts Health Insurance Survey found that among residents who reported that their family was continuously insured in the past twelve months, 39.1% faced affordability issues. The restrictions might also put patients at increased risk of incurring medical debt. The survey found that 86.4% of residents who reported medical debt in 2023 incurred that debt when the resident and all of their family members had insurance coverage. Additionally, the survey found that cost sharing expenses, in particular deductibles, were the highest driver of medical debt among Massachusetts residents who incurred family medical debt while all family members were insured. "Over three-quarters (78.2%) reported that they held medical debt from care that had to be paid as part of their health plan deductible, and about three-fifths (62.7%) reported that they held medical debt from copayments or coinsurance." *2023 MHIS*, *supra* n. 4, p. 54, 56, 64.

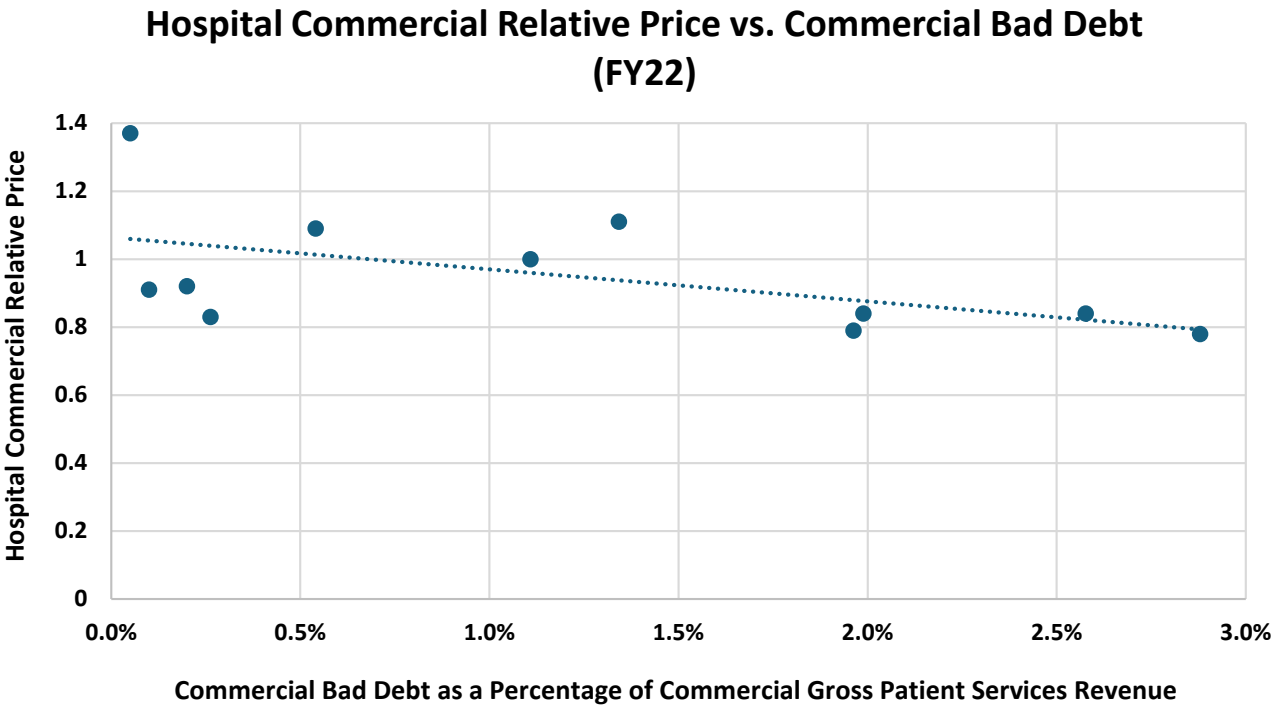
[69] *See* Jessica Bartlett and Zeina Mohammed, *Maternity Units in Mass. Keep Closing. But Is That Harming Care?*, Boston Globe, August 7, 2023, https://www.bostonglobe.com/2023/08/07/metro/maternity-units-massachusetts-keep-closing-is-that-harming-care/; s*ee e.g.*, Amy Roeder, *Maternity Ward Closures Exacerbating Health Disparities*, Harvard School of Public Health, December 13, 2023, https://www.hsph.harvard.edu/news/features/maternity-obstetric-closure-health-disparities/.

Figure 23



Notes: Data was provided by eleven Massachusetts hospitals for commercial patient bills stemming from services rendered in 2022 that were unpaid as of April 2024. This data is used as a proxy for commercial bad debt for 2022 given that the debt is past 120 days overdue and is unlikely to be paid. Commercial GPSR data is from CHIA's 2022 Hospital Profiles Databook. Each hospital's 2022 commercial bad debt as a percentage of Commercial GPSR was compared to the hospital's 2022 Medicaid/ Subsidized Population Payer Mix. The 2022 Medicaid/Subsidized Population Payer Mixes were calculated using the proportion of each hospital's total GPSR in 2022 that came from Medicaid Managed, Medicaid Non-Managed, ConnectorCare, and HSN. Hospital revenue data is from CHIA's 2022 Hospital Profiles Databook.

Figure 24



Notes: For notes on the Commercial Bad Debt as a Percentage of Commercial Gross Patient Service Revenue, please see Figure 23 above. Hospital Commercial Relative Price is the Statewide Relative Price reported in CHIA's 2022 Relative Price Databook.

As shown in Figure 23 and Figure 24, we found that hospitals with a higher Medicaid/Subsidized Population Payer Mix and lower relative price had a higher percentage of commercial bad debt than hospitals with lower public payer mixes or higher relative prices. This means that hospitals serving a higher number of non-commercially insured and/or lower-income patients are more likely to not be paid for their services. Bad debt deprives these lower-priced hospitals of the resources needed to address the greater health burden lower-income communities experience compared to higher income communities.[70]

ii. Uneven Burden of Bad Debt Across a Sample of Hospitals

- **When comparing two nearby hospitals with different public payor mixes, the hospital serving a higher share of Medicaid/Subsidized Population patients had a much higher share of commercial revenue written off as bad debt and weaker long-term financial performance.**

Commercial bad debt as a percentage of Commercial GPSR varies significantly across hospitals depending on the average household income of the communities they serve. To illustrate this, we compared two community hospitals that are only 1.7 miles apart but serve very different communities, have significantly different payer mixes, and very different overall financial performance.

Figure 25

	2022 Commercial Statewide Relative Price	Medicaid / Subsidized Population Payer Mix	2022 Commercial Bad Debt (in Millions)	2022 Commercial Bad Debt as % of Commercial GPSR	2012-2022 Average Surplus/Deficit (in Millions)	2012-2022 Average Margin
Hospital A	Low	45%	3.93M	2.00%	-5.03M	-1.11%
Hospital B	High	11%	0.51M	0.20%	17.24M	5.43%

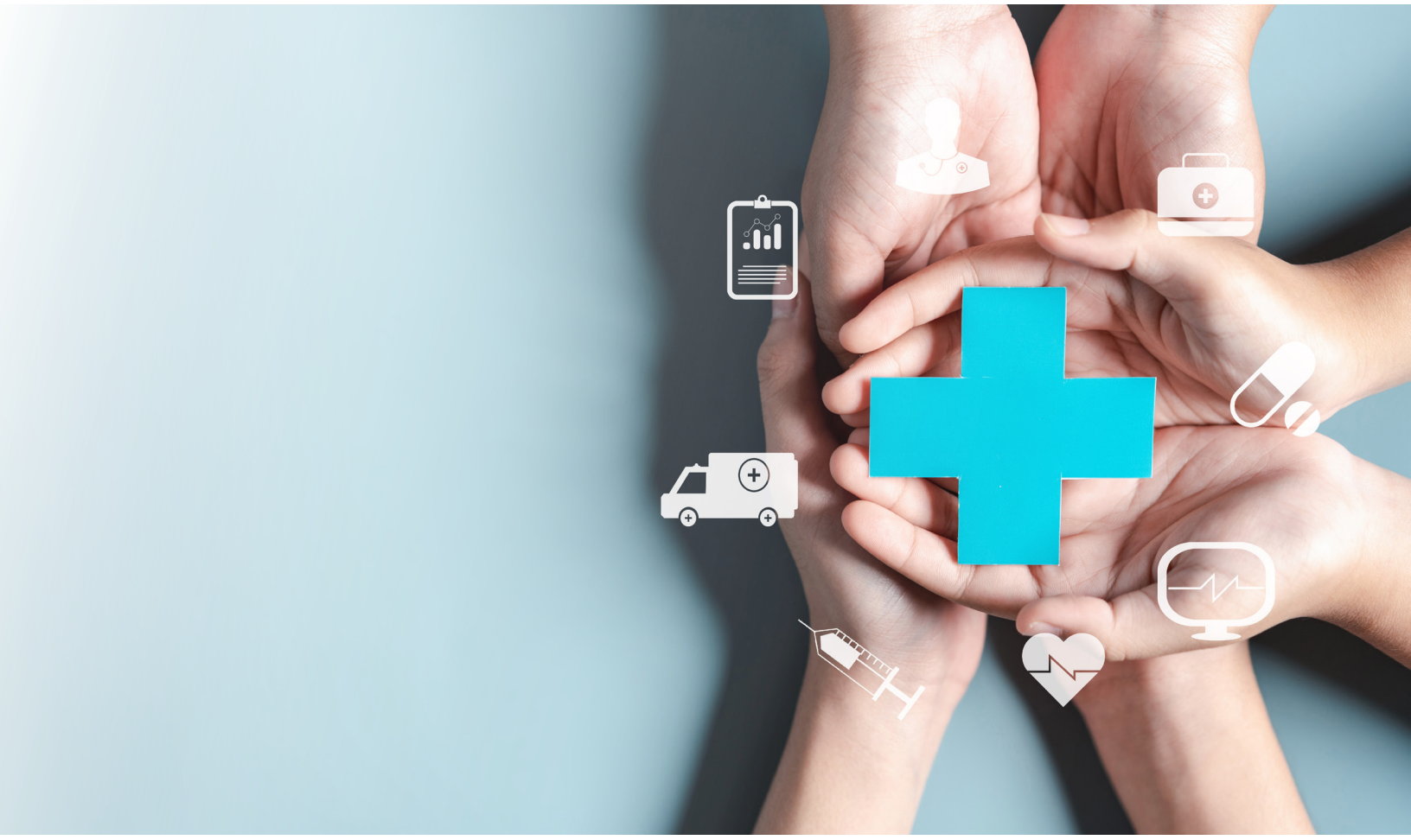
Notes: Data was provided by two Massachusetts hospitals for commercial patient bills stemming from services rendered in 2022 that were unpaid as of April 2024. Medicaid/Subsidized Population Payer Mix is taken from CHIA's 2022 Hospital Profiles Databook. Each hospital's 2012-2022 average surplus/deficit in millions and average margin from 2012 to 2022 are from CHIA's 2012-2022 Hospital Profiles. 2020 and 2021 were excluded from these averages due to the unusual circumstances caused by COVID-19.

[70] Recent data has found a 23-year age gap between Roxbury and Back Bay residents—an individual residing in Back Bay is more likely to live to 91.6 years old compared to an individual from Roxbury whose life expectancy is 68.8 years. *See BPHC Releases First Round of Issue-Based Health of Boston Reports*, Boston Public Health Commission, May 12, 2023, https://www.boston.gov/news/bphc-releases-first-round-issue-based-health-boston-reports.

Hospital A had $3.93M in commercial bad debt stemming from services rendered in 2022, which amounted to approximately 2% of its Commercial GPSR, whereas Hospital B had just $514K in 2022 commercial bad debt amounting to only 0.2% of its Commercial GPSR. The bad debt at Hospital A amounts to a loss of 2% of commercial revenue. Notably, Hospital A's commercial prices are, on average, already 15% lower than Hospital B's prices. Hospital A had negative average deficits and margins, compared to Hospital B which consistently earned a profit.

With a lower Commercial Statewide Relative Price and four times the Medicaid/Subsidized Population Payer Mix of Hospital B, Hospital A already struggles to generate a sustainable margin. The additional $3.93 million in commercial revenue lost to bad debt could be invested in programs that better serve the community, such as primary care services.[71]

Furthermore, bad debt at hospitals that are already paid lower commercial rates puts a strain on public resources as struggling community hospitals will increasingly need to rely on public funds to make up for bad debt losses. Policies related to consumer medical debt mitigation should consider that many of the hospitals that could be impacted by expanding debt forgiveness or discounts are already disproportionately impacted by bad debt.



[71] For instance, the September 2023 HPC Health Care Cost Trends report showed that lower income communities are less likely to get primary care services than higher income ones. The analysis showed that the lowest deciles compared to the highest had more than double the percent of children with zero primary care spending (4.4% v. 10.8%) and more adults with no primary care spending (23.1% v. 17.3%). *2023 Annual Health Care Cost Trends Report and Policy Recommendations: Chartpack*, Massachusetts Health Policy Commission, p. 12, September 2023, https://masshpc.gov/sites/default/files/2023%20CTR%20Chartpack.pdf. $3.93 million annually could be invested in primary care access to reduce this gap.

V. RECOMMENDATIONS

This report looks at the affordability of health care for Massachusetts residents with commercial health insurance through the lenses of income and medical debt accumulation. As reflected in the report, many lower-income households in the Commonwealth, despite having commercial health insurance coverage, are spending relatively high percentages of their income on health care—or are going into debt when they cannot afford a medical bill. Health care cost burdens have a real impact on these households' ability to meet their daily needs as well as save for education and retirement. Moreover, lower-income households' struggle to afford health care is having an outsized impact on the hospitals that we count on to provide care to lower-income communities. The recommendations outlined below focus on efforts to address specific findings made in the report.

But, it is also true, as one commentator has observed, that "[u]ntil health care costs (and particularly the prices patients pay) are addressed, patients will not be well protected from going into debt."[72] There is a direct correlation between increases in health care prices and costs and increases in the cost of health insurance premiums and how much Massachusetts households are paying OOP for cost share expenditures. Any holistic effort to address health care affordability in Massachusetts must include containment of health care costs and, importantly, preservation of lower-price, high quality health care options.

There are additional steps that can be taken to ensure that Massachusetts residents with commercial insurance do not fall within health care affordability cracks. As a starting point, the Commonwealth should have a means to measure, assess, and monitor affordability trends across the state at the community level to inform and target future policy efforts. We also observe that Massachusetts, while a leader in many health care metrics, lags behind others states with respect to consumer protection efforts around the collection and reporting of medical debt; we recommend the legislature consider some recent legislation in other states as a template for the Commonwealth to adopt and expand upon. Given that health care affordability will always be inextricably linked to income, we also recommend that stakeholders continue to think about ways to enhance equity in the health care system, so that lower-income Massachusetts households are not in a position where a higher percentage of their incomes (and already stretched budgets) is spent on needed health care relative to Massachusetts' highest-income households.

[72] Levitt, *supra* n. 14.

To achieve the above, we offer the following:

Affordability Measures

1. **We recommend that the legislature consider creating an affordability index that measures how much Massachusetts consumers are paying for health care relative to their income,** including through deductibles, co-payments, and premiums (both employer and employee share), **as well as a target affordability benchmark.**[73] Importantly, this affordability index should allow policymakers to understand affordability burdens and monitor affordability trends at least at the municipal or zip-code level[74] for a more nuanced understanding of affordability burdens (and potential identification of geographic pain points) than can be gleaned through state-wide analyses relying on data averages. Disaggregation of health care spending data, including TME spend relative to premium, to the community level could highlight the potential need for adjustments in underwriting and premium development, for example. We recommend the legislature also consider enhancements to data collection and reporting, including premium contributions, to allow for the building of the index.

Consumer Protection

2. **We recommend that the legislature consider enhanced consumer protections around providers' Financial Assistance Policies ("FAPs") and practices, including uniform income thresholds for discount eligibility;[75] discounts that apply to cost sharing and deductibles for eligible patients;[76] eligibility screening requirements; and applicability of FAP requirements to a wider scope of other health care providers beyond hospitals.** Standardizing eligibility for discounts would reduce confusion for patients seeking to navigate FAPs. Applying these discounts to patient cost sharing, including deductibles, for patients who meet an income threshold would decrease medical debt for patients who have commercial coverage but who cannot afford their patient portion, a population often left out of policies designed to address medical debt despite being increasingly burdened by it. Contracts between hospitals and payers should not prevent hospitals from providing more expansive financial assistance to patients. Legislators should also consider applying financial assistance requirements to other types of Massachusetts health care providers to support patients with medical debt arising from services at other sites of care. Any policy changes should be assessed for impact on cost containment and exacerbation of provider price variation before implemented.

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[73] This index could be used in conjunction with measures of other cost burdens Massachusetts residents face. Massachusetts agencies, for example, use federally defined thresholds for housing affordability (e.g., a household is considered "housing cost burdened" if more than 30% of its income is spent on rent, mortgage, and other housing costs, and "severely housing cost burdened" if that proportion exceeds 50%) to guide policymaking. *See, e.g., Nearly Half of Renter Households Are Cost-Burdened*, *supra* n. 45; Adam Jones, *32% of Children Live in Cost-Burdened Households: MassBudget Urges Lawmakers to Focus on Affordability*, Massachusetts Budget and Policy Center, June 10, 2024, https://massbudget.org/2024/06/10/kids-count-data-book-release-2024/.

[74] The affordability index could build on existing work through CHIA's community-level dashboard. *See Total Medical Expense (TME) Trends Across Massachusetts Communities Dashboard*, CHIA, https://www.chiamass.gov/total-medical-expense-tme-trends-across-massachusetts-communities/#dashboard.

[75] *See e.g.*, 18 V.S.A. c. 221, subchapter 10 § 9482(b)(2)(A)-(E) (outlining various levels of discounts based on patient income and the amount of free or discounted care that should be available to patients who are insured or uninsured).

[76] *See e.g.*, WA RCW 70.170.020(1) (defining charity care requirements to include deductibles and co-insurance) ("'Charity care'" means medically necessary hospital health care rendered to indigent persons when third-party coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductibles or coinsurance amounts required by a third-party payer, as determined by the department"); 18 V.S.A. c. 221, subchapter 10 § 9482, *supra* n. 75 (mandating discounts on out-of-pocket costs for insured patients who meet certain income thresholds).

3. **We recommend that the legislature consider enacting enhanced consumer protections around collection of medical debt, such as requiring providers to proactively offer affordable payment plans[77] and prohibiting providers from sending bills to collections or taking any "extraordinary collection actions" while bills are subject to good faith disputes.[78]** Patients will continue to be burdened by unaffordable bills unless they are routinely offered affordable payment plans. The length and amount per payment should be based on the patient's income and ability to pay over time. This approach would provide individualized support for patients and lessen the weight of medical debt. Routinely offering affordable payment plans would also increase the likelihood of hospitals receiving payment for their services from patients who otherwise would be unable to pay upfront in full or in large amounts across a short period of time. Prohibiting providers from sending bills to collection or engaging in extraordinary debt collection during good faith bill disputes would also streamline payment schedules and decrease the likelihood of patients having to pay amounts that would later be determined to not be their responsibility–a not uncommon occurrence given the proliferation of medical billing errors.[79]

4. **We recommend that the legislature consider a prohibition on reporting medical debt to credit reporting bureaus.** The federal government is currently considering policy changes to prohibit the reporting of medical debt to credit bureaus;[80] a handful of other states have recently passed legislation with such prohibitions.[81] Doing so would prevent debt stemming from health care services from acting as a credit barrier for individuals accessing housing and other necessities.

5. **We urge hospitals to adhere to the AGO's recommended medical debt collection practices.**[82] The AGO publishes Recommended Hospital Debt Collection Practices as Appendix 1 of its Community Benefits Guidelines for Non-Profit Hospitals. These recommendations direct hospitals to follow fair debt collection practices that take into account the unique nature of medical debt by providing reasonable protections for patients while allowing providers to seek appropriate reimbursement.

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[77] *See e.g.*, NJ Louisa Carman Medical Debt Relief Act, NJ P.L. 2024, c.048, C.56:11-59(4)(a), C.56:11-59(4)(e).

[78] *See e.g.*, MN SF 4097, Sec. 28, Subdivision(1)(a) (prohibiting providers from billing for **any** treatment subject to billing error review during a review); RI S 2709 Substitute A, 6-60-4 (prohibiting creditors and debt collectors from reporting unpaid charges to a credit reporting agency, attempting to collect the unpaid charges from the consumer, or initiating a lawsuit during any review or appeal of health insurance decision).

[79] Berkeley Lovelace Jr., *Yes, You Should Challenge That Medical Bill*, NBC News, August 30, 2024, https://www.nbcnews.com/health/health-news/medical-bills-cost-negotiate-errors-study-rcna168808.

[80] *CFPB Proposes to Ban Medical Bills from Credit Reports*, Consumer Financial Protection Bureau, June 11, 2024, https://www.consumerfinance.gov/about-us/newsroom/cfpb-proposes-to-ban-medical-bills-from-credit-reports.

[81] *See e.g.*, NJ Louisa Carman Medical Debt Relief Act *supra* n. 77; RI S 2709 *supra* n. 78; CT Public Acts No.24-6, Sec. 1 (b)-(c); NY S4907A, § 4926; Code of Virginia, Title 59, Ch. 35.1, § 59.1-444.4.

[82] S*ee The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals*, Office of the Massachusetts Attorney General, Appendix I, February 2018 (outlining the AGO's recommendations for hospitals regarding debt collection), https://www.mass.gov/doc/updated-nonprofit-hospital-community-benefits-guidelines/download.

Lower-Cost Coverage for Lower-Income Households

6. **We recommend that policymakers consider maintaining enhanced subsidies for Connector members.** As discussed in Section II of this report, in 2022, Massachusetts residents in the lowest-income zip codes and who were enrolled in the individual market but did not receive any cost sharing reduction subsidies spent, on average, 5% of household income on cost sharing alone. In addition to cost sharing subsidies, expanded access to affordable plans, like the recent ConnectorCare expansion pilot,[83] plays an important role in helping lower-income households to better afford health care. Policymakers should consider maintaining this expansion and consider further enhancements at the state level if federal Advance Premium Tax Credit enhancements put in place in 2021 are not made permanent.

7. **We recommend that employers consider use of pay-based "tiered" premium contributions and/or programs to lower cost sharing to assist lower-paid employees with affordability.**[84] As one policy research organization has observed, "[b]ecause most employers do not adjust premiums or cost sharing based on employee wages or income, those who can least afford it often end up paying a higher portion of their wages towards coverage."[85] And because lower-income households with employer-sponsored insurance are not eligible for subsidies that may make plans more affordable, they generally pay more for health care than do households purchasing plans on the Connector and receiving cost sharing reduction subsidies. According to our analysis, for example, households with employer-sponsored insurance in the lowest-income zip codes paid, on average, nearly $550 more in cost sharing compared to those in the lowest-income zip codes enrolled through the individual market in 2022. Tailoring lower-paid employees' premium contributions to their pay level and/or lowering their cost sharing responsibility could enhance affordability for these lower-income households and allow for more equitable cost distribution.

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[83] Pursuant to a 2024 ConnectorCare pilot program, eligibility for enrollment in ConnectorCare plans was expanded from 300% of the federal poverty level up to 500% through 2025. According to the Massachusetts Health Connector, as of August 2024, the expansion has enabled access to lower-cost health insurance to over 51,000 Massachusetts residents, including, for some new ConnectorCare members, savings of $150 or more per month on their premiums. *See ConnectorCare Expansion Pilot: Delivering Affordable, Accessible Health Care To More Massachusetts Residents*, Massachusetts Health Connector, p. 2, August 2024, https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare-Pilot-Expansion-Report-082624.pdf; *see also* related press release, *ConnectorCare Pilot Expansion Creates Lower Costs, Better Access to Health Care for 51,000 Residents*, Massachusetts Health Connector, August 28, 2024, https://betterhealthconnector.com/connectorcare-pilot-expansion-press-release.

[84] *See, e.g., 2024 Benefits Decision Guide*, Blue Cross Blue Shield of Massachusetts, p. 7, 24, https://www.bluecrossma.org/sites/g/files/csphws1866/files/acquiadam-assets/002346712%20HR%20Internal%20OE%202024%20Digital%20Decision%20Guide_101823_MD_FINAL%20(1).pdf.

[85] *See* Hughes, *supra* n. 31, p. 12.

Support for Hospitals Serving Lower-Income Communities

8. **We recommend that Massachusetts policymakers consider increased support for hospitals that serve lower-income communities and that are disproportionally shouldering bad debt.** Safety net hospitals and hospitals with lower commercial relative prices serve the Commonwealth's most vulnerable communities who are already at higher risk of accumulating medical debt. Protecting lower-income households necessarily involves sustaining and supporting the hospitals that serve them. Policymakers should consider supports for lower-cost hospitals that have a disproportional amount of bad debt, including strategies to reduce unwarranted provider price variation.

Acknowledgments

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Appendix

Income as % FPL	Family Size			
Year	1	2	3	4
2022				
100% FPL	$13,590	$18,310	$23,030	$27,750
200% FPL	$27,180	$36,620	$46,060	$55,500
300% FPL	$40,770	$54,930	$69,090	$83,250
400% FPL	$54,360	$73,240	$92,120	$111,000
2023				
100% FPL	$14,580	$19,720	$24,860	$30,000
200% FPL	$29,160	$39,440	$49,720	$60,000
300% FPL	$43,740	$59,160	$74,580	$90,000
400% FPL	$58,320	$78,880	$99,440	$120,000
2024				
100% FPL	$15,060	$20,440	$25,820	$31,200
200% FPL	$30,120	$40,880	$51,640	$62,400
300% FPL	$45,180	$61,320	$77,460	$93,600
400% FPL	$60,240	$81,760	$103,280	$124,800

Notes: Numbers derived from the Department of Health and Human Services, which is responsible for publishing federal poverty guidelines. The numbers are for the 48 contiguous states and the District of Columbia, which include Massachusetts, but do not include Alaska and Hawaii. 2024 numbers were in effect as of January 17, 2024. For 2023 and 2024 numbers, *see* https://www.healthcare.gov/glossary/federal-poverty-level-fpl/. For 2022 numbers, *see* https://aspe.hhs.gov/sites/default/files/documents/4b515876c4674466423975826ac57583/Guidelines-2022.pdf.