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Health and wealth: The connection

Health and wealth: Mired in medical debt

By Ruth Susswein

Four days after he was released from the hospital for back surgery, sheriff's deputies appeared at an Idaho man's doorstep threatening him with arrest. His "crime"? Failing to pay a previous medical bill.

According to the ACLU, 44 states permit debtors to be arrested if they do not appear in court after a creditor wins a judgment or if they don't provide financial information to a creditor after losing in court.

Debts from medical problems are not something people choose to acquire, nor is the cost of health care typically known in advance. While most states require hospitals to report pricing information, 44% of hospitals in 2016 would not provide price quotes for a hip replacement, according to the Aspen Institute. These debts represent a growing crisis. More than half (52%) of all collections placed on credit reports stem from medical bills, and 1 in 5 credit reports list outstanding medical debt, according to the Consumer Financial Protection Bureau (*https://www.consumerfinance.gov/about-us/newsroom/cfpb-spotlights-concerns-with-medical-debt-collection-and-reporting/*). In fact, medical debt (*https://www.nasdaq.com/articles/medical-bankruptcy-is-killing-the-american-middle-class-2019-02-14*) is the reason given by more than 6 in 10 people who file for bankruptcy.

Surprise billing

Getting hit with costly medical charges not covered by your health insurance can be traumatic and financially devastating, yet it's not unusual. According to a Kaiser Family Foundation survey (*https://www.kff.org/health-costs/press-release/new-kaisernew-york-times-survey-finds-one-in-five-working-age-americans-with-health-insurance-report-problems-paying-medical-bills/*), nearly 7 in 10 people with unaffordable, out-of-network medical bills had no idea at the time they received care that the medical provider they used was not covered by their insurance.

These surprise bills typically occur after a trip to a hospital emergency room where some—but not all—medical services are covered by your health insurance. This can happen when some doctors working at a hospital do not have a contractual relationship with your insurance provider, or are out-of-network. The most common kind of unexpected medical bill is for an ambulance ride to the hospital. One study, by the University of Missouri-Kansas City (*https://www.nytimes.com/2019/07/22/upshot/ambulance-surprise-medical-bills-law.html*), found that 51% of ambulance rides resulted in an out-of-network bill. Typically, out-of-network services are more common in emergency settings, where patients have no control over choosing a provider.

At least 25 states have passed laws to protect patients from surprise medical bills—also called "balance billing"—where a doctor or other medical service provider bills patients for the remaining balance (or the entire bill) after insurance pays its share or denies coverage. Another 20 states are considering legislation, as is the federal government. For more on surprise billing, see "Balance billing protections and loopholes," on page 3.

Aggressive medical debt collection

For those with health insurance, annual increases in deductibles and copays have made it harder for many to meet their medical bill obligations. These days, those mired in medical debt are finding themselves at greater risk of lawsuits, as hospitals have become more aggressive about collecting on overdue medical bills.

From 2014 to 2018, Methodist University Hospital in Memphis, Tennessee, filed more than 8,300 lawsuits for unpaid medical bills, according to an MLK50-ProPublica analysis (*https://www.propublica.org/article/methodist-le-bonheur-healthcare-sues-poor-medical-debt*). The non-profit hospital even sued dozens of its own employees for unpaid medical bills.

In Virginia, more than 20,000 patients were sued by the state's hospitals in 2017 alone, according to a study published by the American Medical Association (*https://jamanetwork.com/journals/jama/fullarticle/2737183*).

Health and wellbeing

For those drowning in medical debt—and who might now find themselves unexpectedly unemployed and uninsured—the burden can take its toll on physical, mental and financial health. In addition to jeopardizing consumers' access to future loans and credit, financial burdens dissuade people from getting needed medical attention, often not seeking care until their health deteriorates. Despair over debts has been cited as a cause of suicide.

New research from the Aspen Institute's Expanding Prosperity Impact Collaborative (EPIC) lists medical debt as one of the seven key areas that contribute to financial insecurity and damage consumers' wellbeing (*http://www.aspenepic.org/lifting-the-weight-consumer-debt-solutions-framework/*).

Some states, like Washington and Illinois, are aiding consumers by banning arrests for medical debt and capping interest rates on unpaid medical bills. Congress has included some financial protections for COVID-19-related medical expenses under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. However, some of these protections, such as safeguards to prevent surprise medical bills, are riddled with loopholes. For example, some states protect patients from surprise billing if they have coverage through an insurance company, but companies that self-insure their employee health plans and pay their employees' medical bills themselves are exempt from having to comply with balance billing protections. For more information, see "Balance billing protections and loopholes," on page 3.

Medical debt solutions

The Affordable Care Act requires non-profit hospitals to have financial assistance policies and to notify patients of potential eligibility for help with medical bills. The Aspen Institute think-tank has called on state and federal governments to enforce requirements that hospitals connect patients with repayment assistance options before turning their unpaid bills over to collections (*http://www.aspenepic.org/wp-content/uploads/2018/12/LiftingtheWeight_SolutionsFramework.pdf*).

To help reduce the heavy burden of medical debt on consumers, the National Consumer Law Center (NCLC) has written a model law (*https://www.nclc.org/images/pdf/medical-debt/model-medical-debt-protection-act-082017.pdf*) to provide medical debt protection for people of modest means. It would set specific guidelines for hospital charity care. Discounted repayment plans for eligible consumers would limit monthly payments to 5% of a patient's household income. It would broaden eligibility for financial assistance by requiring for-profit hospitals, surgical centers and outpatient clinics to provide financial help and would protect consumers from aggressive debt collection. For more innovative solutions, see "Programs that make care more financially accessible," on page 4.

In addition to devising better ways to deal with medical debt, healthcare professionals and consumers are turning to more efficient ways of providing and receiving medical care. Since the country began coping with the coronavirus pandemic, healthcare providers have relied on telemedicine to offer safe and efficient care. Virtual visits can offer easy access to care when testing, treatment or in-person examinations are not needed. Telehealth appointments can be quite effective, as long as the patient has access to the internet, a reliable broadband connection, and a smartphone or computer. (Learn more in "Telemedicine: Tomorrow's health care today," on page 7.) As we come to rely on virtual visits for all types of health care, it's essential to know whether insurance will cover the bills for these visits even when the pandemic is behind us. For more about telehealth coverage, see "Does my insurance cover virtual visits?" on page 6.

During these unprecedented times, consumers appear willing to temporarily share their health data. In this newsletter, we also examine how our personal medical information is being used and what safeguards need to be in place to ensure that our health-related information is secure and protected. For more about data privacy during the COVID-19 era, see "Medical data protection," on page 8.

Balance billing protections and loopholes

By Lauren Hall

As surprise medical bills wreak havoc on household finances, states have stepped in, writing laws to protect patients who have been hit with unexpected out-of-network charges.

"Surprise" medical bills occur when patients receive bills for balances owed when their health insurance doesn't cover the entire cost of hospital or office visits. As an example, if a patient unwittingly sees an out-of-network provider for a $150 visit and their insurance company agrees to cover only $50, the remaining $100 would be billed to the patient. Surprise (or balance) billing occurs because patients either do not or cannot know in advance if a healthcare provider who ends up treating them is in-network or out-of-network. Often this problem arises when patients receive emergency services—even at an in-network hospital, because they are unaware that they are being treated by an out-of-network physician.

State protections

While there is no national law to prevent this medical debt trap, 15 states offer their citizens fairly comprehensive protections against surprise billing, while 14 more states have partial protections. The other 21 states, plus the District of Columbia, provide no surprise billing protections, according to research by the Commonwealth Fund (*https://www.commonwealthfund.org/publications/maps-and-interactives/2020/apr/state-balance-billing-protections*). State balance billing laws do not apply to people who knowingly choose out-of-network providers.

The Commonwealth Fund (*https://www.commonwealthfund.org/sites/default/files/2019-01/Criteria_for_Meeting_Standards_v2.pdf*) defines "comprehensive" state patient protections as those that:

- Require insurance companies to hold patients "harmless" for expenses that patients involuntarily incur beyond in-network costs (i.e., deductibles, copayments, etc.);
- Forbid out-of-network healthcare providers from billing patients more than in-network rates;
- Apply to a variety of healthcare plans (HMO and PPO plans, emergency and non-emergency services, etc.);
- Require the use of a "payment standard" to determine whether the amounts billed are appropriate (i.e., fair and not exorbitant); and
- Require an established dispute resolution process.

According to the Commonwealth grading system, states with "comprehensive" protections include California, Colorado, Connecticut, Florida, Illinois, Maine, Maryland, New Hampshire, New Jersey, New Mexico, New York, Oregon, Texas, Virginia and Washington. To see where your state stands on balance billing protections, visit *https://www.commonwealthfund.org/publications/maps-and-interactives/2020/apr/state-balance-billing-protections*.

Loopholes in state protections

Despite their protections for patients, state balance billing laws contain many sizable loopholes. For instance, private employers who fund their own insurance ("self-funded" plans) are exempt from state insurance regulations, including any that prevent balance billing. These are usually larger employers who choose to pay medical claims themselves rather than pay premiums to insurers for employee coverage. According to the Pew Charitable Trusts, over half of privately insured employees (61%) are covered under this type of self-insured plan, leaving them unprotected from unexpected, perhaps devasting, medical bills.

Even when individuals are supposedly covered by state protections, they may end up on the hook for hundreds of thousands of dollars in medical expenses due to loopholes in the type of insurance they have or their state's rules for provider coverage.

Debbie Moehnke, a Washington consumer, was unknowingly transferred to an out-of-network Oregon hospital for urgent cardiac care, spending two weeks in this out-of-network facility while recovering from a resulting infection. She amassed more than $450,000 in medical bills, only half of which her insurance paid. The other half—surprise!—was considered her responsibility. Moehnke's story was featured in a 2019 Kaiser Health News article (*https://khn.org/news/even-with-insurance-she-faced-227k-in-medical-bills-what-it-took-to-get-answers/*). The article points out that the "patchwork protection" in Oregon meant that the state's prohibitions on surprise billing would not apply to Moehnke, because the law applies only to out-of-network charges billed to a patient who received care by an in-network hospital. Patients in an emergency situation are likely in no condition to ask about the network status of a hospital or its doctors.

A similar problem arises when patients need to be evacuated via helicopter for emergency care and transport costs are not limited or regulated (*https://www.bendbulletin.com/localstate/air-ambulance-flights-can-leave-patients-*

with-major-bills-that-insurance-won-t-pay/article_5da337b1-09b5-5d0b-bec3-a8312073b94d.html).

What's more, Oregon law only applies to insurers regulated in the state, and Moehnke's insurer was not. Oregon's law also requires that patients be informed of pending out-of-network charges in advance. In Moehnke's case, the hospital and insurance company argued over which party was responsible for informing her—meanwhile, neither let her know.

Doctors' bills can also slip through the cracks of many balance billing laws when a radiologist or anesthesiologist working in a hospital is out-of-network even though the hospital participates in the patient's insurance plan. Sometimes a surgeon is in-network but the anesthesiologist is not, or the surgical center where the surgery is performed is not. Sometimes doctor-ordered lab results do not come from an in-network lab. Hospitals are free to hire providers regardless of the insurance they accept (or don't accept). These out-of-network doctors and services are not bound by in-network caps on costs set by patients' insurance companies. With large loopholes in state laws, insurers may refuse to pay anything at all.

CARES Act protections

The federal government, through the U.S. Department of Health & Human Services (HHS), has allocated a whopping $175 billion under the Coronavirus Aid, Relief, and Economic Security (CARES) Act to reimburse healthcare providers across the country who are testing and treating patients for COVID-19.

Healthcare providers who want to be reimbursed for COVID-related charges must explicitly agree not to balance-bill patients, according to HHS. For instance, emergency room doctors are not allowed to bill COVID-19 patients more than what insured patients are required to pay in-network providers. This applies to those covered by Medicare and Medicaid as well. Even if a patient goes out-of-network or is uninsured, balance billing is prohibited for COVID-19 testing, medical visits and treatment, according to HHS (*https://www.hrsa.gov/coviduninsuredclaim*).

If you suspect that a healthcare provider is committing fraud by billing you, regardless of the rules, you can report (*https://oig.hhs.gov/fraud/report-fraud/index.asp*) the doctor or hospital to 800-HHS-TIPS.

National help for surprise billing

There's hope that national legislation will help protect all Americans from this often unavoidable financial problem. Members of Congress have been crafting legislation to ban surprise billing, but even a bipartisan plan was stymied last year by medical industry opposition. The balance billing battle pits insurers against medical providers. Insurers want to pay a set amount for medical care while providers believe they are being asked to be compensated for their services at an unreasonably low rate.

Two new bills have been introduced in 2020: the Consumer Protections Against Surprise Medical Bills Act (HR 5826), and the Ban Surprise Billing Act (HR 5800). HR 5826 would forbid healthcare providers from billing patients for care that the patients could have "reasonably expected" to be in-network, or from charging them more than the in-network amount their insurer typically would pay. It does not rely on set payment amounts for out-of-network bills (called benchmarking). Instead it allows healthcare providers and insurance companies to negotiate out-of-network charges.

HR 5800 also allows providers and insurance companies to negotiate out-of-network fees, but only for medical bills of $750 or more. Bills under $750 would be paid at the median amount a patient's insurance would typically pay its in-network providers.

Both legislative proposals would require that the insurers and healthcare providers attempt to resolve billing disputes by negotiation; then, if necessary, by arbitration. The two bills would apply even to the many people covered under self-funded insurance plans, who are currently excluded from state balance billing regulations. For more information on the legislation, visit *https://www.commonwealthfund.org/blog/2020/update-surprise-billing-legislation-new-bills-contain-key-differences*.

Programs that make care more financially accessible

By Monica Steinisch

Affording health insurance and medical care is challenging under the best of circumstances, and even more so in an uncertain economy with record unemployment. The plans, programs and services below can help you now, during the COVID-19 pandemic, and after the crisis

ACA coverage

The vast majority of people who lost their employer-sponsored insurance when they became unemployed

(or underemployed) because of the pandemic will now be eligible for healthcare coverage through Medicaid or subsidized insurance through the Affordable Care Act's (ACA) Health Insurance Marketplace (*https://www.healthcare.gov/*), according to the Kaiser Family Foundation's (KFF) recent report (*https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/*).

This won't be a solution for everyone; some adults will fall into the coverage gap in states that haven't expanded Medicaid, and undocumented immigrants are not eligible for Medicaid or ACA coverage and subsidies. But for those who qualify, it can be worthwhile to find out what type and amount of assistance you could receive. If you apply for insurance through the HealthCare.gov website, it will automatically send your information to your state agency if it looks like anyone in your household is eligible for Medicaid.

Buyer beware! Short-term health insurance plans may appear to be more affordable than ACA-compliant policies, but they often come with exclusions for pre-existing conditions, offer very limited coverage, and result in huge out-of-pocket expenses or denials of coverage when medical care is needed, making them almost worthless. Read about the risks of these plans at FamiliesUSA.org (*https://familiesusa.org/resources/seven-reasons-the-trump-administrations-short-term-health-plans-are-harmful-to-families/*).

Free and low-cost clinics

Federally Qualified Health Centers (FQHCs), located in both urban and rural areas, charge based on income for services including general primary care, women's care, prenatal care, oral health care, substance abuse services and referrals to specialized care. This can be a solution for those with low income who aren't covered through work, can't afford to buy coverage (even with subsidies) and don't qualify for a government health insurance program (Medicare or Medicaid). Since health center employees do not ask for proof of immigration status, they can be an option for undocumented immigrants. Find a low-cost community health center near you (*https://www.findahealthcenter.hrsa.gov/*).

In addition to the network of FQHCs, there are approximately 1,400 free or charitable clinics and pharmacies nationwide that receive little to no state or federal funding. These safety-net healthcare non-profits provide a range of medical, dental, pharmacy, vision or behavioral health services either free or for a nominal, sliding-scale fee. To be eligible for services, you must be uninsured, underinsured and/or have limited or no access to primary, specialty or prescription health care. Find a free or charitable clinic near you (*https://www.nafcclinics.org/find-clinic*).

Hospital financial assistance

The prospect of racking up insurmountable medical debt keeps some people from getting the care they need. For those who've had urgent medical care whether they could afford it or not, the National Consumer Law Center's (NCLC) Guide to Reducing Hospital Bills for Lower-Income Patients (*https://library.nclc.org/guide-reducing-hospital-bills-lower-income-patients*) advises patients to inquire about the availability of hospital financial assistance.

The Affordable Care Act requires all non-profit hospitals to have a financial assistance policy, and some states require all hospitals to have one; some for-profit hospitals have one even if not required by law. Federal law doesn't mandate a specific level of financial assistance or set eligibility criteria for non-profit hospitals. However, NCLC says that state laws often set standards for the amount of financial assistance that must be provided to patients at various income levels. These state laws can vary considerably from state to state and typically apply to both for-profit and non-profit hospitals. Learn more in NCLC's An Ounce of Prevention report (*https://www.nclc.org/images/pdf/medical-debt/report-ounce-of-prevention-jan2020.pdf*).

Ask the hospital billing office if it has a financial assistance policy, and read NCLC's guide (*https://library.nclc.org/guide-reducing-hospital-bills-lower-income-patients*) for additional tips for avoiding or dealing with medical bills.

Prescription assistance programs

The pharmaceutical industry sponsors patient assistance programs (PAPs) that distribute free or discounted drugs to financially needy patients. The Pharmaceutical Research and Manufacturers of America's (PhRMA) Medicine Assistance Tool (MAT)(*https://medicineassistancetool.org/*) can match you with the programs that could lower your out-of-pocket prescription costs, whether you have insurance or not.

RxHope (*https://www.rxhope.com*), RxAssist (*https://www.rxassist.org/*) and NeedyMeds (*https://www.needymeds.org/*) are three more tools that help users find and navigate PAPs. These services and others, like WellRx (*https://www.wellrx.com/*), offer a mix of other types of prescription savings help, such as cost comparisons, coupons and prescription discount cards, which they claim can save users up to 80% on their medications.

Does my insurance cover virtual visits?

By Monica Steinisch

Workplace retirement plans are one of the best ways for employees to continuously contribute to their long-term investments without having to think about where their money goes every month. With an automatic enrollment plan, even those who know nothing about retirement savings can benefit.

Medicare, Medicaid and VA coverage

Medicare, the federal health insurance program for seniors and some younger disabled people, provides coverage for telemedicine services that take the place of a face-to-face visit. Until recently (*https://www.medicare.gov/coverage/telehealth*), patients had to live in a rural area where there is a shortage of hospitals and healthcare providers, and had to participate in the virtual visit from an approved facility, such as a rural health clinic, skilled nursing facility or community mental health center—but not from their homes.

However, as of March 6, and lasting "for the duration of the COVID-19 Public Health Emergency," Medicare is covering telemedicine services in all parts of the country, and from any site, including patients' homes. For more, see the Medicare Telemedicine Health Care Provider Fact Sheet (*https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet*).

Whether this new policy, intended to address the specific challenges posed by the pandemic, will continue after the crisis ends is unknown. If Medicare reverts to its more restrictive pre-COVID rules, Medicare Advantage Plans (Part C) may become more attractive because they have greater flexibility in the types of services covered and where the services can take place (any part of the country and from any site, including the patient's home).

Medicaid, the public health insurance program for those with low income, also provides reimbursement for some telemedicine services. However, each state has the flexibility to determine exactly what it will cover and for whom. Consequently, Medicaid reimbursement (the amount paid by the program to the health service provider) varies widely among states and can influence the availability of virtual visits to Medicaid beneficiaries. To find out which telemedicine services are Medicaid-eligible in your state, use the National Telehealth Policy Resource Center's (NTPRC) Current State Laws & Reimbursement Policies online tool (*https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies*).

For a chart showing all Medicare and Medicaid COVID-19-related telemedicine coverage policy changes, visit the Center for Connected Health Policy's website (*https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies*). The Department of Veterans Affairs (VA) offers telemedicine options, including video appointments, for veterans receiving VA medical benefits. Learn more at the VA Telehealth Services website (*https://telehealth.va.gov/*).

Private insurance coverage

Under normal (non-crisis) circumstances, whether your private insurance covers virtual visits and other telemedicine services depends in part on state law. Generally, in any of the dozens of states with "parity" laws (*https://www.americantelemed.org/in-the-news/telehealth-policy-and-reimbursement-vary-widely-from-state-to-state-ata-report-finds/*), any healthcare provider eligible for payment by your insurance for an in-person visit would also receive payment for a virtual visit (service parity). Some states also require insurers to reimburse all providers at the same rate (payment parity), while others allow them to reimburse telehealth services at a lower rate than for the same service delivered in person. Coverage typically applies regardless of patient location, meaning that patients engaging in a virtual visit can be at home or at work rather than at a designated facility (as often required by Medicare). However, there can be other requirements and exclusions—for example, some states require an initial in-person visit to establish a patient relationship before a physician can bill for a virtual visit, and other states allow small group plans to opt out of telemedicine coverage—so you should verify coverage directly with your insurance company before seeking service (*https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/*). For detailed information about each state's laws, use the NTPRC's online tool (*https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies*).

Even in states without parity laws, many—if not most—health insurance companies voluntarily cover telemedicine. Among those that do, coverage often is the same regardless of how the covered services are delivered. For example, if mental health services are covered under your insurance plan, you would most likely be covered for them both in person and virtually.

Still, the company could have any number of limitations—provider, condition, urgency, etc.—on virtual visit coverage. For example, you might be covered for video visits to address any one of a long list of acute

illnesses or issues (sinus problems, a rash, coughing, etc.) but not for certain chronic conditions. Likewise, if you choose to use a virtual healthcare company—Teladoc, American Well and Doctor on Demand are some examples—your insurer may not reimburse every telemedicine platform at the same level (in-network versus out-of-network), leaving you responsible for the unpaid portion of the bill.

Unless mandated by law, policies and practices are established by the insurer and shouldn't be assumed. To avoid an unpleasant surprise in the form of an unpaid claim or a bill for the balance not covered by insurance, you should understand—before seeking service—what your insurer's requirements and exclusions are related to virtual healthcare coverage.

The widespread use of virtual visits now, to reduce spread of the coronavirus, could result in insurance coverage of telemedicine becoming standard practice. If you haven't already participated in a video appointment, U.S. News & World Report's A Beginner's Guide to a Virtual Doctor's Visit (*https://health.usnews.com/conditions/articles/a-beginners-guide-to-a-virtual-doctors-visit*) can help you prepare for your first one.

Telemedicine: Tomorrow's health care today

By Ruth Susswein

Doctor's visits, among many other things, have been upended by the coronavirus pandemic, forcing most appointments to go virtual. Practically overnight, consumers found themselves talking to their doctors online. Virtual visits on computers and smartphones replaced most in-office care to help suppress the rapid spread of COVID-19.

Virtual visits are likely to remain a staple in healthcare providers' repertoires long after the pandemic subsides. For starters, telehealth (also called telemedicine) can offer far more efficient health care and, in some cases, even better access to care. Originally intended to treat patients in remote or rural areas with few providers, telehealth visits eliminate extensive travel time to and from appointments, as well as time spent in the waiting room.

Convenience

You can't beat virtual visits for convenience. Older patients with mobility issues, and those with disabilities, may find it far easier to receive care, and may be more likely to keep an appointment that doesn't require travel. Doctors report that virtual visits reduce patients' tendency to ignore follow-up care, which can improve patient outcomes. Virtual visits also allow for caregivers and long-distance family members to participate if the patient agrees.

Outside of a pandemic, virtual visits are used for appointments that don't require physical examination or testing. They are frequently relied on for medication management that only requires a check-in with a prescribing physician; to review test results; for pre-operative consultations; to diagnose common conditions like pinkeye, colds and flu; for dermatological issues; and even for mental health care.

Access

With appointments typically being briefer, telemedicine allows doctors to see more patients in a day, offering greater access to care. It also can reduce the wait time for patients to get an appointment for non-urgent concerns. Doctors also may have better ability to consult with specialists on a patient's behalf.

Telehealth can be very effective for chronic conditions that need frequent follow-up care. Remote monitoring of heart conditions and blood sugar levels via internet-enabled apps can ensure that patients are being properly observed and evaluated without having to leave their homes.

Compensation

In dozens of states, doctors must be financially compensated by private insurers at the same rate as an in-person visit. What varies greatly are restrictions on the types of services doctors can be reimbursed for and under what conditions. Telehealth Resource Centers (*https://www.telehealthresourcecenter.org/*) offer information on virtual visit coverage and restrictions. Since the COVID-19 crisis began, some regulations have been relaxed to broaden the circumstances under which healthcare providers will be paid for virtual care by Medicare or Medicaid. Some health privacy protections have been temporarily loosened to increase access to virtual care.

Two models of care

There are two telehealth models: one where you meet virtually with your own doctor, and another where you

meet with a doctor that is part of a telehealth platform, such as Teladoc Health, MDLIVE or Doctor on Demand. Should you have a medical problem on an evening or weekend, a telemedicine platform can offer prompt access to a medical pro who can diagnose whether you need a prescription or in-person care. Some telehealth platforms contract with your health insurer to provide access to quality care—in some cases 24/7.

Patient satisfaction

By necessity during the pandemic, patients' prior reluctance to try telemedicine has reversed course. Some studies show very high overall satisfaction with telehealth care. According to the health maintenance organization Kaiser Permanente, 93% of patients surveyed were satisfied with their virtual medical visit. Another study reported that most patients found "no difference in the overall quality" of care between an in-person and a virtual visit (*https://www.ajmc.com/journals/issue/2019/2019-vol25-n1/patient-and-clinician-experiences-with-telehealth-for-patient-followup-care?p=2*).

Consumers report that they highly value the ease and convenience offered by virtual visits. Most patients who turn to telemedicine like it—particularly when they meet with their own doctor.

Cost savings

When consumers can visit with their doctors online, costly emergency room visits may sometimes be avoided. At some hospitals, telehealth for chronic care patients has drastically reduced hospital readmissions, cut emergency room visits in half and slashed treatment costs by 50%. Philadelphia-based Jefferson Health's telemedicine program saved from $300 to more than $1,500 per patient each time an ER visit was avoided.

Telehealth visits can reduce absenteeism, saving employers money because employees don't have to take as much time away from work for medical appointments. According to Kaiser Permanente (*https://business.kaiserpermanente.org/kp-difference/high-quality-care/telehealth-value-in-connected-system*), telehealth has the potential to save companies more than $6 billion a year.

Of course, not all medical appointments can be virtual. If a patient requires bloodwork, a strep test or wound care, for example, an in-person visit is required.

Telehealth drawbacks

Access to teleheath may not be as available as you might think, particularly for older or low-income patients, who may have technical barriers to online meetings with their doctors. Some patients have poor (or no) broadband access. Smartphones and computers are costly devices.

Doctors must be licensed in the states where they practice medicine, which could limit a patient's virtual access to certain specialists, even one state away.

Some patients are not comfortable with a telehealth platform model that allows a random doctor to treat you rather than one you know and trust.

Additionally, during the pandemic, some insurance companies have been more accommodating in offering COVID-19 treatment via virtual care; it is unclear if that flexibility will remain once the crisis is just a memory.

Some are concerned that patients and doctors may become overly reliant on virtual visits, ordering unnecessary tests or appointments, which would cut into the cost savings that telemedicine delivers. Some healthcare providers worry that doctors employed by telehealth platforms won't have access to patients' medical records, won't monitor patients' conditions, and may, in fact, not reduce the need for in-person visits for many conditions.

Some who study the future of medical care say telehealth visits that are part of an interconnected system that links you with your doctors and medical records, virtually and in person, and that are covered by your insurer, are what's needed for the future of chronic care, preventive care, and sometimes even urgent care. Dr. Daniel Kraft, who speaks internationally on the convergence of technology and healthcare, predicts that telehealth can transform our medical system from a "disease care system to a health care system."

Medical data protection

By Alegra Howard

The pandemic and its social distancing guidelines have increased the time people are spending online. Those wanting connections and access to information have rapidly adopted new technologies for meetings, social interactions and medical consultations. Big tech firms have developed contact tracing apps to let people know if they've come close to someone who tests positive for COVID-19.

Although seeing a doctor from the comfort of your couch is convenient, there are serious privacy concerns about how personal and health-related data is being collected and disseminated through virtual health services

and contact tracing programs. Here's what you should know to make sure you're protecting your private health information during the pandemic.

Tracking and contact tracing

Private companies (including Google and Apple) and government entities worldwide are using technology to help limit the spread of the coronavirus (*https://www.cnbc.com/2020/04/15/apple-google-coronavirus-tracing-plan-what-it-needs-to-work.html*). But efforts to stop COVID-19 from spreading might put data security and privacy protections at risk.

Numerous technologies, like location tracking, proximity tracking, fever detection, facial recognition and mask-wearing compliance, have been introduced in response to the pandemic (though not all these are widely used in the United States). These responses can capture and store personal details like your name, age, gender, facial images, temperature and heart rate (called biometrics), your up-to-the-minute location, the people who you come into contact with, and any credit card purchases you make. Are the threats to privacy worth it in order to save lives? Some cybersecurity experts argue that contact tracing poses monumental privacy concessions even though its effectiveness is not clear. Privacy experts also warn that once you give private companies and the government access to your personal details, it's hard to know exactly how they're being used and who may be privy to the information.

Telehealth privacy risks

As a result of limited access to in-person health care during the pandemic, many patients have turned to telemedicine via apps and the internet. But how private are these video visits? The data collected through video streaming includes live, private conversations about your mental and/or physical health, any medications you're taking, and potentially revealing details about the inside of your home and your personal belongings.

Smartphone apps and video sharing platforms have been found to contain security flaws that make them susceptible to hackers and malware. This means that third parties, including telehealth platform companies, could access telehealth video sessions (live or recorded) and the details shared because current rules and regulations fail to provide sufficient oversight of telehealth companies. The Health Insurance Portability and Accountability Act (HIPAA) is the primary law that guides the privacy and security of patient health information, but it applies only to healthcare providers and insurers. Its application to virtual visits through telehealth platforms is murky, at best. During the pandemic, regulators have given providers latitude to use non-HIPAA-compliant access methods. Telehealth platforms that do comply with HIPAA standards generally tout that they are "HIPAA-compliant." The Food and Drug Administration regulates medical devices, but not smartphone apps or websites. So, while using telehealth is convenient, it may be up to you to learn how private that access will be.

HIPAA waivers

In March, as shelter-in-place orders began around the country, the U.S. Department of Health and Human Services relaxed HIPAA restrictions (*https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html*) on video conferencing platforms to allow healthcare providers to easily connect with patients during the pandemic. Before the pandemic, video platforms used by healthcare professionals had to be encrypted and secure to comply with HIPAA security requirements. Since the pandemic started, platforms like Zoom, Skype and FaceTime are all allowed to operate without the same requirements for patient privacy, as long as others cannot view the meeting.

A second, unprecedented and very broad HIPAA waiver allows third parties to use or release protected patient health information without the permission of a hospital, clinic or healthcare provider. This normally protected information may be released for any reason, as long as the patient is notified within 10 days of its release. While the waiver calls for the use of a "good faith" standard, it's not clear that all potentially involved third parties have adequate judgment to make such a decision.

The security waivers, intended to ease restrictions so that patients can access health care more easily while sheltering in place, are in effect until the pandemic ends. While the waivers are active, healthcare providers are urged to take cautionary steps to keep visits as secure as possible on telehealth platforms they choose, including using complex meeting IDs, passcodes known only to the patient and provider, and video encryption. Providers also must communicate any privacy risks to the patient. Healthcare providers and video conferencing companies still must protect patient data, including notes and lab reports, as they flow between doctors and patients across online platforms.

While there have been no reports so far of abuse of protected health information, patients should not assume that the security risks are negligible. We've all come to rely on Zoom for virtual meetings in recent months, yet Zoom's past security issues, and those of its competitors, remind us that the risk of privacy violations is significant. Consumer Reports (*https://www.consumerreports.org/video-conferencing-services/videoconferencing-privacy-issues-google-microsoft-webex/*) found that the best-known video platforms available to the public collect data from video conferencing and use it to build

consumer profiles. Notably, the report found that companies can collect audio and video from videoconferences, and combine face recognition and other information with personal details data brokers already have about individuals.

In today's unique environment, many patients believe that the benefits of using virtual healthcare options outweigh the risks of sharing personal information. An Oliver Wyman Forum survey (*https://www.oliverwymanforum.com/future-of-data/2020/apr/data-sharing-in-the-time-of-coronavirus.html*) found that most people supported sharing their personal health data (from a recent doctor's visit) with medical experts if it helped protect their health and the public's health. However, they were not willing to share their biometrics, location or financial transaction data with non-medical experts (including app developers).

Protecting your health data

So, what can you do to protect your personal health information during the pandemic? Be prepared to ask questions, conduct some research and gauge your comfort level with the answers. Ask your doctors' offices which telehealth platforms they use, and research the platforms online to check for recent security breaches. Ask if the video exchange is encrypted and how the provider protects the information you share during telehealth visits. If the security standards seem sketchy, ask if you can connect with the doctor through a HIPAA-compliant telehealth platform. These include GoToMeeting (*https://www.gotomeeting.com/meeting/resources/hipaa-compliant-video-conferencing*), VSee (*https://vsee.com/hipaa/*), Doxy.me (*https://doxy.me/patients*) and thera-LINK (*https://www.thera-link.com/*), among others.

For your part, conduct your appointment in a private location, ensure your Wi-Fi connection is secure (*https://www.wired.com/story/secure-your-wi-fi-router/*), and avoid using public-facing video sharing platforms like Facebook Live for medical visits, since anyone can view the video feed. Above all, consider that these platforms may be recorded.

Pandemic privacy legislation

Legislators looking to protect Americans' privacy during the pandemic are introducing bills aimed at entities, such as contact tracing apps and some video sharing platforms, that have not been HIPAA-compliant.

The COVID-19 Consumer Data Protection Act of 2020 (S 3663), introduced by Senator Roger Wicker (R-MS), and the Public Health Emergency Privacy Act (S 3749), introduced by Sens. Richard Blumenthal (D-CT) and Mark Warner (D-VA), require consent for personal data collection and consumer notification about how health data is being used and who it's shared with. Both bills prohibit companies from reusing any of the data for other purposes, including for advertising. Both bills require companies to delete any information that could identify consumers once the pandemic is over. While these bills offer meaningful privacy protections, the Wicker bill only applies to private companies; the Public Health Emergency Privacy Act applies to private companies and government. Consumer Action has endorsed the Public Health Emergency Privacy Act. Learn more about the bill at *https://www.govtrack.us/congress/bills/116/s3749*.

Tips to deal with medical debt

By Alegra Howard

Medical debt can be scary, especially when it's unexpected. When doctors' bills pile up, you may be tempted to ignore them. Don't! Avoiding medical debt can destroy your future credit options, or even lead to bankruptcy. Here are some tips for tackling medical debt head-on.

Checking medical bills

• Verify the debt is yours. Ask for an itemized copy of the medical bill. Make sure the dates you received care (including the exact dates of your hospital stay) are accurate.

• Billing mistakes happen. On the bills, circle any procedure or treatment you don't remember getting and check for duplicate charges. Ask the billing department about any discrepancies. (Get help reading a medical bill at *https://www.policygenius.com/blog/how-to-read-a-hospital-bill/*.)

Dealing with insurance

• **Take notes.** When dealing with insurance companies and billing departments, document all calls. Note the dates, times and phone numbers you called, whom you spoke with and any key details they shared.

• **'Insurance pending.'** Your first notice might have "insurance pending" printed on the bill. If it does, don't pay it yet. Your insurance company may yet cover a portion of the bill.

• **Double-check charges with your insurer.** Call your health insurer and, with the representative, review the bill item by item. Ask the rep to check for mistakes or

duplicate charges (including items the insurance company already paid but are still outstanding on hospital bills). You may have to wait on hold while they check things, but since insurance reps know the billing codes intricately, they may be able to find discrepancies you wouldn't easily catch.

• **File an insurance appeal.** If your insurance denies a claim, you can appeal for up to 180 days after you are notified of the decision. Your doctor may help sway the insurer by providing further documentation to show that the procedure was necessary. (Get tips on filing an appeal at *https://www.patientadvocate.org/explore-our-resources/insurance-denials-appeals/*.)

More tips and protections

• **Balance billing protections.** Learn if your state protects you against surprise medical bills due to out-of-network charges. (Find out at *https://www.commonwealthfund.org/publications/maps-and-interactives/2020/apr/state-balance-billing-protections*.) Also, know the name of your closest in-network emergency room before you need it. Once there, request to see only in-network doctors to avoid surprise bills. (This might not be possible, but it can't hurt to ask.)

• **Call and negotiate.** Ask to speak to the hospital's billing department, a patient ombudsman or a social worker who can help with your situation. Inquire if you can reduce what is owed before the bill goes to collections. If you can't pay the balance all at once, ask for an interest-free payment plan (but avoid medical credit cards with deferred interest rates [*https://www.cnbc.com/select/medical-credit-cards/*]). Hospitals often have financial assistance funds that you may be eligible for. See NCLC's guide to reducing hospital bills for lower-income patients (*https://library.nclc.org/guide-reducing-hospital-bills-lower-income-patients*).

• **Compare out-of-network test costs.** If you're asked to take an out-of-network medical test, call around and ask the testing companies how much they charge out-of-pocket patients for the service. This figure can vary greatly.

• **Check your credit report.** There is a 180-day grace period before unpaid medical debts are listed on your credit report (Experian, Equifax and TransUnion). This gives consumers time to verify the debt and gives insurers time to pay their portion of the bill before a collections account is added to your credit report.

• **Don't go without health insurance.** If your employer doesn't offer health coverage, check your state health insurance exchange (*https://www.healthcare.gov/*) for coverage options. If you have a low income (usually less than about $40,000 per year), you may be eligible for a premium subsidy from the government that will drastically reduce your (and your family's) premiums.

Consumer Action

www.consumer-action.org

Consumer Action has been a champion of underrepresented consumers nationwide since 1971. A non-profit 501(c)(3) organization, Consumer Action focuses on financial education that empowers low- and moderate-income and limited-English-speaking consumers to financially prosper.

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