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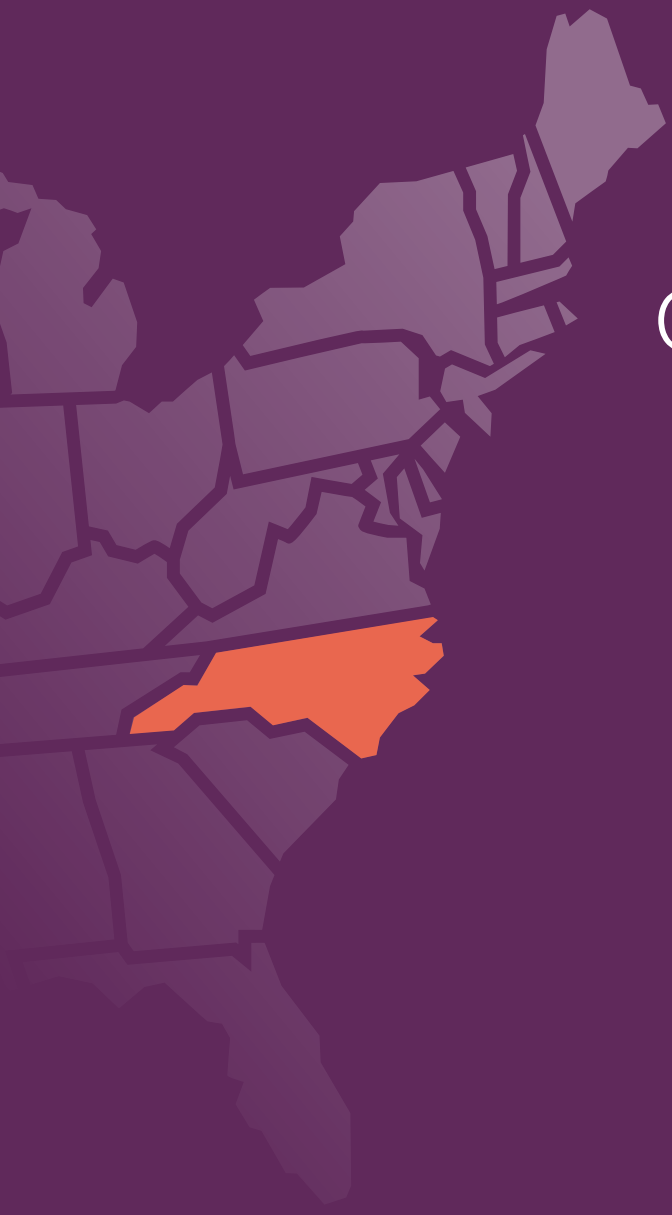

# State Spotlight:

## North Carolina's Comprehensive Medical Debt Relief and Reform Incentive Program

**Prepared by State Health and Value Strategies**

**November 2024**

## Overview

In an innovative, first-of-its kind approach, North Carolina is tackling the issue of medical debt through a comprehensive initiative that pairs immediate relief with long-term reform. By leveraging federal funding through the Medicaid program, hospitals are incentivized to cancel existing medical debt—up to $4 billion for approximately two million low-income North Carolinians—and enact a series of policies to prevent the future accumulation of medical debt, such as financial assistance requirements. Notably, all 99 eligible hospitals elected into the optional program. This state spotlight provides an overview of North Carolina's medical debt relief incentive program, underscores the unique efforts of the state to achieve buy-in from stakeholders, and highlights the opportunity as a model for other states.

## Background

### The Burden of Medical Debt

Nearly 100 million Americans, or 41% of adults have some form of medical debt, including past-due bills, bills owed to a collection agency or other lender such as a family member, or medical expenses paid for by credit cards. Approximately 44% of adults with existing medical debt report owing at least $2,500, while nearly 12% owe $10,000 or more.

A majority of medical debt comes from hospitals including bills for acute medical expenses, such as a short hospital stay or unexpected trip to the emergency room, as well as debt built up over time from the management of chronic health conditions and disabilities. Other interactions within the healthcare system, such as doctor's visits, diagnostic testing, and dental care visits are also common sources. Parents are generally more likely to report holding medical debt for themselves or a family member, and new mothers are twice as likely to have medical debt than individuals who have not recently given birth. Although health insurance is a protective factor, even those with coverage experience out-of-pocket costs that can lead to debt due to high deductibles and cost-sharing for healthcare services and prescription medications.

The burden of medical debt in the U.S. is not equitably distributed and the disparities are considerable. For example, low- and moderate-income adults, individuals with poor health status, such as individuals with cancer, and those living with a disability are more likely to report having medical debt. Furthermore, Black and Latino/a communities are far more likely than their White counterparts to hold medical debt. Not surprisingly, medical debt is also higher in states that have not expanded Medicaid under the Affordable Care Act (ACA). This may account in part for the fact that across North Carolina, which only recently expanded Medicaid, the prevalence of overall medical debt (8%) is significantly higher than the national average (5%). In addition, the share in collections for White residents is 8% versus 10% for communities of color; and in Anson county, which has the highest rate of medical debt in the state at 32% overall, the share in collections for White communities is 21% compared to 34% for communities of color.

Medical debt has both profound economic and health consequences, not only making Americans poorer, but also sicker. Individuals often make decisions between obtaining healthcare and paying off their debts, or affording other basic necessities like rent and groceries. Additionally, high healthcare costs often lead to delays or avoidance in seeking care, or rationing and forgoing prescription medications, which exacerbates health disparities. This reality is salient as those who are most likely to hold and accrue medical debt in the U.S. have historically experienced other forms of structural barriers to health and economic wellbeing. For Black populations in particular, oppressive and mutually reinforcing systems—such as housing access, lending and employment opportunities, and access to health coverage—further maintain the racial wealth gap and make it even more difficult to manage medical debt.

### State Efforts to Address Medical Debt

Policymakers are increasingly turning their focus and deploying a number of strategies to address the issue of medical debt. For example, a number of states and localities are leveraging federal COVID-19 funding from the American Rescue Plan Act of 2021 to buy down medical debt for many low- and moderate-income residents, or those with debt equal to 5% or more of their income. The debt is sold at a fraction of the cost, for pennies on the dollar. Cancellation is an immediate step to lift individuals out of debt, and testimonials illuminate the value of this approach.

States have also moved to address the consequences of medical debt that impede economic mobility. Several states have enacted legislation that prohibit the reporting of medical debt to credit agencies and have banned the inclusion of medical debt in credit reports. Although according to the Consumer Financial Protection Bureau (CFPB), a medical bill on an individual's credit report is not a good predictor of creditworthiness, debt on an individual's credit report can harm their chances to obtain a loan, including for the purposes of buying a home, or their chances at employment. CFPB also notes that medical debts reported to credit bureaus are often inaccurate or inflated due to the complexities of medical billing, insurance, and collections. Other state efforts to reduce the burden of medical debt include capping interest rates, or prohibiting the sale of medical debt to debt collectors, who often engage in aggressive collection tactics. Although these policy interventions provide critical relief and address the symptoms of medical debt, solutions that prevent the accumulation of medical debt in the first place are crucial. States that are implementing financial assistance standards or presumptive eligibility for charity care are getting to the problem sooner, protecting consumers who would otherwise struggle to afford, or ultimately forgo needed care.

## Overview of North Carolina's Medical Debt Incentive Program

Medical debt is a predatory and self-perpetuating system. The healthcare system in the U.S. is unaffordable for so many; people struggle to pay for health services, falling into a hole where they delay future care, get sicker, and ultimately need more expensive care—leading to greater debt. North Carolina hospitals are estimated to hold more than $4 billion of debt, which experience shows they are unlikely to collect on. When hospitals are able to collect on debt, it is typically for only a fraction of the cost. To disrupt this vicious cycle, North Carolina's innovative medical debt incentive program combines immediate relief with long-term reform.

In July 2024, the North Carolina Department of Health and Human Services (NCDHHS) received approval from the Centers for Medicare and Medicaid Services (CMS) to provide enhanced Medicaid payments to hospitals that meet conditional criteria of the state's medical debt mitigation program. The requirements include eliminating existing medical debt for low- and moderate-income North Carolinians—up to $4 billion for approximately two million individuals—as well as a suite of policies that will improve affordability and shield individuals from accumulating medical debt when seeking care at participating hospitals. Importantly, the state crafted the program with hospital input, and in August 2024, all 99 eligible acute care hospitals in the state agreed to participate in the program. Hospitals recognized the financial opportunity that signing onto the program provides to support their infrastructure and remove patients' barriers to affordable care.

### Immediate Relief: Medical Debt Cancellation Efforts

Patient medical debt owed to participating hospitals, dating back to January 2014, will be eliminated for all North Carolinians enrolled in the state's Medicaid program. Additionally, hospitals will eliminate debt that is more than two years old, dating back to January 2014, for individuals up to 350% of the federal poverty level (FPL) or with debt that exceeds 5% of their annual income. Hospitals have already begun this work and are entering into agreements with non-profit organizations, such as Undue Medical Debt, by March 2025, which will assist with debt abolishment. Debts will be removed for Medicaid enrollees effective July 1, 2025, and full implementation will occur over the next two years. The responsibility rests with the hospitals; patients will not need to take any action, will be notified of their debt forgiveness through a letter in the mail within 30 days, and will not experience any tax implications.

North Carolina is the first and only state to implement expansive medical debt relief without the use of state or federal dollars to pay for it. Instead, hospitals were incentivized to opt into the program and donate debts as one criterion in order to receive future enhanced Medicaid reimbursement through the Healthcare Access and Stabilization Program (HASP). The HASP is a State Directed Payment (SDP) program authorized by CMS, which gives states the option to direct managed care organizations to pay hospital providers according to a specific methodology capped at the average commercial rate. The SDP program allows states to design reimbursement formulas and condition provider eligibility for their programs; many states have leveraged the SDP program to advance specific state policy goals, such as addressing workforce shortages or improving access to care, quality, or delivery system reform. The HASP began at the same time North Carolina officially implemented Medicaid expansion in December 2023, and the funding provides support to enable hospitals to cover the non-federal share of the enrollment increase due to expansion. While hospitals were always set to receive base payments under the HASP, North Carolina is the first state to condition enhanced payment for the purposes of addressing medical debt. By participating, hospitals will receive enhanced HASP payments that will bring an estimated $4 billion into the state for fiscal year 2024 and a projected $6.3 billion for the next year.

### Long-Term Reform: Medical Debt Mitigation Efforts

All eligible hospitals in North Carolina—from the largest system in the state to the smallest rural hospital—will also implement comprehensive reforms. This will help prevent the future accumulation of medical debt by guaranteeing low- and moderate-income North Carolinians are able to obtain financial assistance to receive the essential healthcare services they need. Hospitals will meet a series of deadlines to come into compliance, with reporting requirements to NCDHHS to affirm they are meeting the milestones.

### Charity Care and Presumptive Eligibility

Beginning January 1, 2025, participating hospitals will comply with charity care requirements established by NCDHHS. The policies will be communicated and made available to all patients in a variety of formats and languages, including the hospitals' websites, in plain language to ensure this information is accessible and transparent.

The below financial assistance requirements apply to inpatient and outpatient services, on a sliding scale based on patient income.

- A 100% discount for individuals with incomes below 200% FPL.
- A discount of at least 75% for individuals with incomes between 200% to 250% FPL.
- A discount of at least 50% for individuals with incomes between 250% to 300% FPL.

To guarantee an accessible pathway to financial assistance for the communities who are most likely to benefit, hospitals will automatically qualify certain individuals for charity care beginning January 1, 2025. Individuals who are enrolled in, or have a child enrolled in Medicaid or the Children's Health Insurance Program, or those who are enrolled in other means-tested public assistance programs like the Women, Infants and Children (WIC) program or the Supplemental Nutrition Assistance Program (SNAP) will qualify for charity care automatically, without having to apply. Patients who are experiencing homelessness or are found to be mentally incapacitated with no one to act on their behalf will also be automatically eligible.

Financial assistance plays an important role in ensuring access to affordable healthcare for those who have traditionally experienced barriers to maintaining or improving their health. The NCDHHS Office of Health Equity's 2024 Health Disparities Analysis Report reveals inequities in healthcare access across the state, including the increased likelihood for the Hispanic and Black populations to forgo care due to cost. North Carolina also has a significant population of farmworkers, many of whom have no health insurance and live below the federal poverty level. Additionally, low-income immigrants, particularly those without legal documentation, are generally excluded from federally subsidized health insurance coverage under Medicaid or the ACA Marketplace, illuminating the vital importance of comprehensive charity care policies.

By January 2026, hospitals will implement screening policies to determine presumptive eligibility for individuals with incomes up to 300% FPL, if they do not already meet the non-income-based criteria described above. This effort is a comprehensive step to make certain all eligible patients are guaranteed financial support, prior to receiving a bill. Hospitals may leverage third-party software services to verify patients for presumptive eligibility, and prior to implementation of this requirement, NCDHHS will work with hospitals to identify best practices related to presumptive eligibility to assist hospitals with selecting a third-party vendor.

Given that serious and unexpected trips to the emergency department (ED) often leave individuals with significant medical bills, hospitals will also comply with a new policy limiting copayments for ED visits. Those copayments will be the greater amount of 1) the amount the patient would owe under the above percentage discounts, or 2) $35, not to exceed cost-sharing under an insured patient's health plan.

**Payment Plans and Interest Rates**

According to a survey of those with medical debt, nearly one in five adults (18%) think they will never be able to pay it off—a measure which is higher for Black adults (24%), adults with incomes under $40,000 (26%), and the uninsured (25%). In an effort to reduce the length of time low-income debt holders are burdened by their debt, NCDHHS established a new policy for hospital payment plans. For those with incomes between 200% to 300% FPL, the length of the plan may not exceed three years, and payments may not be greater than 5% of the individual's monthly household income. Alternatively, the payment plan may exceed three years, with the condition that the total principal and interest payment collected does not exceed what would have been collected under the three year/5% income plan. Additionally, the interest rate for all medical debt held by participating hospitals, beginning July 2025, will be capped at 3%, and medical debt sold to third-party debt collectors will have interest rates capped at the Secured Overnight Financing Rate plus one percentage point. For individuals previously subject to greater payment amounts and high interest rates, these requirements will free up a greater portion of their income to afford other basic necessities like housing, food, or childcare.

**Credit Reporting**

Medical debt that shows up on an individual's credit report can drag down their credit score and be an impediment to financial mobility. This can make it challenging for an individual to rent or purchase a home, qualify for a credit card, become employed, and ultimately build wealth. In North Carolina, participating hospitals will no longer report medical debt to credit reporting agencies, and previous reports will be removed if the individual's debt has been relieved. This effort builds on a recently proposed rule by CFPB to remove medical bills from credit reports and prevent lenders from making decisions based on medical information. The prohibition of medical debt on consumer reports is a move towards addressing the legacy of structural racism, which has led to credit disparities for Black and Hispanic communities compared to White communities, driving the racial wealth gap.

**Debt Collection Practices**

North Carolina's hospital incentive program also includes a series of policies that address harmful medical debt collection practices and their economic consequences, all of which are effective July 1, 2025. Participating hospitals will no longer sell debts owed by individuals with incomes up to 300% FPL to a third-party debt collector (unless that debt is sold with the purpose of eliminating the debt). For patients with incomes above 300% FPL, hospitals must wait at least 120 days after sending an initial bill to a patient, prior to selling the debt to a third-party—granting individuals more time to pay their bills.

Collections tactics are often aggressive, frightening, and a deterrence for many individuals from seeking future care. To mitigate these actions, debt collectors that have entered into arrangements with participating hospitals in North Carolina will be prohibited from several actions, which build on the federal Fair Debt Collection Practices Act to protect consumers. Prohibited actions include garnishing wages or state income tax refunds, foreclosing on an individual's

property, causing an individual to be held in civil contempt or imprisoned, or causing an individual's arrest. Additionally, hospitals must reverse any extraordinary debt collection actions if a patient is later found to be eligible for financial assistance. Finally, no individual, with the exception of spouses, will be held liable for medical debt for any other person age 18 or older—and spouses will be eligible for the same mitigation policies offered to the patient.

In 2023, the North Carolina Office of State Treasurer issued a report which found that hospitals in the state sued over 7,517 patients and their family members to collect on medical debt from January 2017 through June 2022. Patients reported that even when they did try to fight the lawsuits, they lacked needed information to understand their hospital bills. To better protect patients against legal action, debt collectors that hospitals enter into arrangements with will not be able to initiate action against patients for any medical claims where an insurance appeal/review is pending within the previous 60 days.

## Achieving Stakeholder Buy-In in North Carolina

North Carolina was uniquely positioned to secure stakeholder buy-in for the program, thereby facilitating the implementation of comprehensive policies to hold hospitals accountable and improve affordability. After years of debate, in December 2023, North Carolina became the 41st state to expand Medicaid under the ACA, increasing coverage to approximately 600,000 residents. The cancellation effort recognizes that uninsured residents accumulated medical debt through no fault of their own for almost ten years before expansion, and thus covers debt back to 2014, when the state first had the opportunity to expand Medicaid.

NCDHHS was also able to uniquely leverage the Healthcare Access and Stabilization Program (HASP), which began at the same time as Medicaid expansion. Although hospitals were slated to receive base payments from the HASP, the enhanced payments, along with the growth in Medicaid enrollment, created momentum and support for these reforms.

## Considerations for Other States

North Carolina's medical debt relief and reform incentive program is an innovative and first-of-its-kind approach, offering a template for other states interested in addressing the burden of medical debt and healthcare affordability through the Medicaid program.

Importantly, because this policy works by capitalizing on the State Directed Payment program to incentivize these reforms, states interested in modeling their efforts after North Carolina's must have Medicaid managed care programs. According to KFF, 41 states (including the District of Columbia) contract with managed care organizations to care for at least some of their Medicaid population. While North Carolina offered hospitals the opportunity to opt into the program to receive enhanced Medicaid payments, other states may choose to be more restrictive or even go beyond the requirements that North Carolina put in place.

Essential to any state policymaking is the recognition of who stands to be most impacted, with the inclusion of input from people with lived experiences. States should consider what populations have been historically disenfranchised by medical debt, and policies should be designed intentionally to drive structural change that advances health equity.

Support for this State Spotlight was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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This State Spotlight was prepared by Laura Buddenbaum and Heather Howard. State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at *www.shvs.org*.

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ACKNOWLEDGEMENTS

The authors thank North Carolina Department of Health and Human Services staff for reviewing and offering insightful feedback on this publication.