

## Keeping Patients Insured: Utilizing Continuation of Care to Create Healthier Bottom Line

### Combatting Increased Financial Risk Among ACA Subsidy Expiration

For both patients and health systems, the cost of care is poised to intensify over the next several years, and now a new set of challenges is emerging, a rapidly expanding population of uninsured patients.

Rising costs are no surprise to the executives who are being tasked with mitigating financial risk; however, expiring ACA subsidies will create a new set of challenges. Addressing the uncertainty of ACA premium tax subsidies is essential to maintaining an organization's financial stability.

A recent Becker's article stated, "Millions of people are [projected](#) to lose insurance coverage in the coming years following the expiration of enhanced ACA tax credits and upcoming cuts to Medicaid [under](#) the One Big Beautiful Bill Act. Nearly 15 million people could become uninsured over the next decade: 5 million without an extension of the subsidies, and another 10 million under OBBBA's Medicare and Medicaid provisions, according to [estimates](#) from the Urban Institute and Congressional Budget Office."<sup>1</sup>

[Many patients will trade down their ACA health plan choice to gain more affordable monthly premiums.](#) The bad news is that this creates a new population on catastrophic HDHP with large out-of-pocket responsibilities. Essentially uninsured and can't afford to engage in preventative care, or even for some, to engage in chronic disease management.

For Medicaid patients, be aware of the new work requirements and other new rules will result in many Medicaid patients losing their coverage. Fortunately, loss of coverage does qualify as a QLE (Qualifying Life Event) to help these patients enroll in an ACA plan and regain coverage.<sup>2</sup>

For any patients who continue without coverage, they will experience limited access to primary and specialty care. These individuals tend to rely on the emergency department for all of their healthcare needs, often resulting in little to no preventative care, lack of follow-through, and a high occurrence for readmission. For these patient accounts, traditional financial assistance strategies like charity care, self-pay discounts, and patient financing are vital but often produce limited results. These strategies address the cost of care *after coverage is lost*, rather than preventing coverage loss altogether.

The result is a rapidly growing patient demographic: those who are clinically complex, financially challenged, and eligible for commercial insurance, but are financially unable to maintain coverage premiums. For financially fragile patients, some of whom are already undergoing intense treatment, even modest premium increases can have a devastating result. Things like coverage loss, delinquency, or failure to enroll in a plan altogether, which will mean more patients who are unable to afford the care they are receiving.

<sup>[1]</sup> [How Systems Are Preparing to Care for a Spike in Uninsured Patients](#)

<sup>[2]</sup> [Qualifying life event \(QLE\) - Glossary | HealthCare.gov](#)

## Financial Risk is Shifting

Over 24 million people rely on the ACA Marketplace for their coverage, and according to a recent KFF study, marketplace premiums are rising by an average of 26%. That, coupled with expiring ACA tax credits, is projected to result in a premium increase of nearly 114%. At that rate, premiums can quickly become more expensive than a monthly rent or mortgage payment.<sup>3</sup>

The risk is amplified for providers. If your organization is in a non-expansion state, the ACA patient population is larger and more vulnerable to the premium subsidy cuts, and in an expansion state, the issue is similar, just less acute.

## What Happens When Coverage Becomes Unaffordable?

We are already seeing effects from rising premiums at every level of care. The increase in premiums will often force patients into 1 of 4 scenarios:

- Drop insurance altogether or halt the pursuit of coverage
- Discontinue or delay ongoing treatment
- Face premium delinquency
- Use high interest credit cards or loans to pay increased premiums - further adding to an already elevated cost of care and creating additional financial strain

From a provider perspective, this creates additional roadblocks to payment or reimbursement:

- Increased transition of insured patients into self-pay or grace-period delinquency
- Higher volumes of charity care and bad debt concentrated in high-cost service lines
- Higher than average patient balances with lower propensity to collect
- Reduced reimbursement for care that will still be delivered
- Dollars earmarked for charity care quickly depleted

The result is an increased amount of care that will be delivered *regardless* of payment outcome. This is particularly projected for 2026–2028, as coverage instability intersects with rising acuity and cost of care.

## A Small Population With Outsized Financial Impact

The most financially damaging uncompensated care is typically driven by high-acuity patients concentrated in select service lines:

- Oncology and infusion
- Organ and bone marrow transplant
- Thoracic surgery
- Advanced cardiac care
- Trauma
- Burn

<sup>[3]</sup> [ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increases in What They Pay](#)



Let's put a finer point on it by looking at two service lines.

### Infusion therapy

For rheumatoid arthritis, hospital-based infusion therapy costs \$57k-\$131k per year. So, for every 100 patients, that's gross charges in play of **\$6M to \$13M**.<sup>4</sup>

### Organ Transplant

Transplant care highlights the problem with larger impact. From diagnosis to organ availability, timelines often extend 12 months or longer. During this period, patients can lose employment, benefits, or insurance coverage.

Estimated uninsured billed costs for a single patient:

- Liver transplant: ~ \$823k
- Heart transplant: ~ \$1.6M

Again, looking at a health system managing 100 of these patients, total uncompensated exposure can range from **\$44M to \$160**. These charges will now be classified as charity care or bad debt, resulting in a small patient population consuming a majority of scarce charity care funds.<sup>5</sup>

### Traditional Financial Strategies Fall Short

In-house payment programs have all the right intentions. However, they deal with a very small amount of total patient responsibility, typically less than \$1k. With budget cuts and financial strain, many health systems are already overwhelmed, and few are equipped with the staff and tools to meet federal regulations required for in-house patient lending. External patient financing programs tend to be for episodes with a lower total cost, typically less than \$20k. Charity care is part of the Community Benefit calculation and is best preserved for a large population where there is no other means to remedy their situation.

*Providers need a solution to help those who are eligible gain and maintain insurance coverage.*

### Curae's Sponsorship Offers a New Approach for a Defined Patient Population Who Need It Most

To help assist patients who are eligible for commercial insurance, Curae has developed a groundbreaking new solution: **Sponsorship**. Sponsorship focuses on enabling patients with qualifying financial need to *enroll in* and *remain* covered by ACA Marketplace or COBRA plans. Sponsorship allows providers to convert care that would otherwise become charity or bad debt into reimbursable revenue.

<sup>[4]</sup> [Analysis of Drug and Administrative Costs Allowed by U.S. Private and Public Third-Party Payers for 3 Intravenous Biologic Agents for Rheumatoid Arthritis](#)

<sup>[5]</sup> [How Much Do Organs Cost? A Look at Legal and Black Market Prices](#)



## **Reduce the Strain of Uncompensated Care**

Uncompensated care for clinically complex, financially challenged patients does not have to be a cost of doing business. For a small but significant population, it is a solvable financial problem. Curae Sponsorship allows providers to deliver necessary care to their community's most vulnerable while improving reimbursement and increasing financial stability.

Interested in learning more? Visit [www.curaercm.com](http://www.curaercm.com) or reach out to schedule a time to talk.

### **Gary Johnson**

Chief Growth Officer  
gary.johnson@curae.com  
678.643.9801