

PRESCRIPTION FOR MEDICAL DEBT

How Care Providers, Collection Agencies
and Government Can Help



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LEADERSHIP SOLUTIONS PROGRAM FOR HEALTH + PROSPERITY

The Business for Impact at Georgetown University [Leadership Solutions for Health + Prosperity](#) program brings together executives, nonprofit leaders, government regulators and the public health community to put teeth into advancing actionable, real world solutions to food and health problems confronting Americans. Forums and convenings organized by the program are designed to drive thought leadership positions to arrive at practical, holistic and sometimes contrarian solutions to health, nutrition and other pressing societal problems.

The Program is led by nationally recognized industry thought leader, Hank Cardello.

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Hank's perspectives have been shared in numerous publications, including the Wall Street Journal, The New York Times and the Washington Post as well as the major television networks and CNN, NPR and the BBC. He is the author of the book [Stuffed: An Insider's Look at Who's \(Really\) Making America Fat](#) and several landmark reports including the Robert Wood Johnson Foundation supported Better-for-you Foods: It's Just Good Business. He has moderated expert panels at the White House, the U.S. Chamber of Commerce, and the Partnership for a Healthier America among others.

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EXECUTIVE SUMMARY

Medical debt is a widespread problem putting millions of Americans and their families at risk for serious economic and health distress—especially working-class families. Helping families escape from medical debt today and avoiding additional medical debt in the future would not only improve their immediate outcomes, but it is also in the best interest of health systems, insurers, and collection agencies to be part of the solution.

This paper aims to understand and identify:

- 1 What is medical debt and why is it different
- 2 Who carries medical debt and how it impacts them
- 3 How our healthcare system exacerbates the problem
- 4 The major players of the U.S. healthcare system and their role in generating medical debt
- 5 The medical debt collection process and its issues
- 6 The current regulatory and legislative environment
- 7 What industry needs to do to resolve the ills of medical debt in our society
- 8 Implications for policy





WHAT IS MEDICAL DEBT AND WHY IS IT DIFFERENT

Medical debt arises after a patient receives healthcare services (whether in a doctor's office, urgent care, hospital, paramedic/ambulance, dentist's office, etc.) and is unable to pay for those visits or procedures. Even with insurance, patient burdens can be unmanageable. When costs are not covered by insurance, or the patient does not seek or is not eligible for charity care, or the patient does not have the credit or personal savings to pay for these expenses, they must seek additional sources of funds. Often this comes in the form of credit card loans, borrowing from friends and family, and other borrowings.

Several key characteristics of medical debt differentiate this liability from other types of consumer debt, such as tuition debt, home mortgages or auto loans.

Patients unable to pay their bills compromise their healthcare.

While unsecured debt has been shown to result in adverse health effects, such as stress, anxiety, depression, and high blood pressure, medical debtors often do not seek the healthcare services they cannot afford for immediate or chronic problems.¹ Research studies at Vanderbilt University Medical Center, the American Cancer Society, and others have begun to link serious health consequences to the presence of medical debt. When patients cannot afford their bills, they tend to skimp on their health needs to save costs or prevent new debt. Without the appropriate subsidies, Vanderbilt researchers found that 30% of Medicare Part D patients did not fill prescribed cancer treatments, 22% did not fill curative treatments for hepatitis C, and 50% of patients skipped prescriptions for immune disorders.²

Incurring medical debt is usually involuntary.

While a home or car loan may be functionally necessary, individual buying power dictates what level of debt the individual will incur. However, for medical debt that is not the case. Unexpected illnesses, accidents and arcane healthcare systems put patients in circumstances where they are unable to properly prepare or budget for medical expenses.

Price transparency is elusive.

It is difficult to comparison shop for lower-cost healthcare services because of the limited price transparency and constraints on available "network" providers. The cost of care is determined by a

combination of factors such as insurance coverage, the intensity of the care, state legislation and regulation, and even location. Though recent legislative efforts such as the No Surprises Act are making inroads on price transparency to empower patients, a person diagnosed with diabetes or cancer cannot simply opt-out of care because it is too expensive—at least not without serious consequences.

This lack of transparency is worsened by the inflationary pressures on the cost of healthcare. Patients who are unprepared for such accelerating expenses can easily and quickly incur enormous amounts of medical debt.

Individuals are not screened for creditworthiness prior to receiving care.

When their medical expenses exceed their ability to pay, patients are automatically extended credit. An individual may be denied a mortgage or auto loan based on their creditworthiness, typically experiencing a credit pre-check before they are approved to borrow. This step helps to protect the borrower from taking on too much debt and protects the lender from the risk of default. When it comes to healthcare, while some primary care providers may refuse service to a patient based on an unpaid bill, it is illegal for a hospital to deny care due to creditworthiness. This practice is a vital extension of the provider's oath to "do no harm," but it creates unintended financial consequences for patients and providers. For example, provider losses on uncompensated care are often rolled into future price increases, exacerbating the medical debt problem by inflating the cost of future services.

MEDICAL DEBT AFFECTS MILLIONS OF CONSUMERS



Consumer debt, including medical debt, represents a significant strain on our economy. Debt payments prevent individuals from investing in themselves, their families, their homes, or communities. Therefore, it is important to understand how much medical debt exists before anyone can begin to discuss how to resolve the problem. According to Dr. David A. Hyman, the Scott K. Ginsburg Professor of Health Law & Policy at Georgetown University Law Center, “researchers have used various strategies to quantify medical debt and have arrived at figures ranging from \$81 billion to \$195 billion.”³

While having medical debt does not mean it is overdue or in collections, the Consumer Financial Protection Bureau reports that medical collections line items appear on 43 million credit reports. The same report cited that 58% of bills that are in collections and on people’s credit records are medical bills.⁴

From 2009 to 2020, medical debt became the largest source of debt in collections, according to a study published in the *Journal of the American Medical Association* which examined TransUnion credit scores.

Researchers learned that individuals had an average of \$429 in medical debt in collections versus \$390 in collections for all other sources of debt combined.⁵ According to the 2022 Personal Capital Wealth and Wellness Index, “almost half (47%) of Americans cannot manage an unforeseen \$500 expense without worry.”⁶ For lower income families, these amounts can be devastating as they have no reserve funds available to cover such expenses.

In testimony to the U.S. Senate Committee on Banking, Housing, and Urban Affairs, Dr. Benedic N. Ippolito of the American Enterprise Institute testified that these relatively low amounts of medical debt suggest medical debt stems from “relatively typical interactions with the health care system rather than rarer catastrophic events.”⁷ Of great concern is that these typical interactions represent measures for preventative care, screenings, and medications that help people manage their health and prevent extreme illness for themselves and their family members. These are the same activities that families tend to reduce or eliminate to avoid bills they cannot afford.^{8,9}

Thus, while the overall value of individual medical debt in collections is not extraordinary, we argue in this paper that the alarming concentration of debt in the hands of those who cannot afford to pay it is extremely detrimental to them as well as our economy. Further, relatively small individual balances may point to flaws within the larger U.S. healthcare payment system overall, rather than problems with how individual patients navigate the system. In the absence of greater healthcare reform, this paper proposes near-term industry solutions to help patients better navigate the existing system and avoid accruing debt balances that will destabilize their lives and ultimately the healthcare providers that serve them.



WHO CARRIES MEDICAL DEBT?

Though it is possible for anyone to incur medical debt in the U.S., those least likely to have access to high-quality medical care and make adequate income are the most likely to experience medical indebtedness. From multiple studies, this includes those who are uninsured and under-insured, communities of color (specifically Black and Latinx households), households with at least one member in poor health or who is disabled, people holding less than a bachelor's degree, those currently raising children, people between the ages of 18 and 29, and people between the ages of 50 and 64 (who often have significant health needs but are not yet eligible for Medicare).^{10,11,12,13} As reported in the *Journal of the American Medical Association*, residents who live in states that did NOT expand Medicaid eligibility as part of the Affordable Care Act were likely to carry MORE medical debt than those who live in a Medicaid expansion state.¹⁴

These characteristics begin to shape our understanding of where the effects of medical debt hit the hardest. In other words, medical debt is most difficult for the ALICE Family.

WHO ARE THE ALICE FAMILIES?

In a 2022 interview with Arkansas Public Radio, Abby Hughes Holsclaw, founder of Arkansas Asset Funders Network, defined the ALICE Family as “Asset Limited, Income Constrained, and Employed.”¹⁵ These are key factors in our discussion of medical debt and medical debt in collections. ALICE Families typically have enough assets and income to be disqualified from public assistance programs, but not enough to “afford essentials in the communities where they live.”¹⁶ And the involuntary nature of medical debt only exacerbates this financial vulnerability.

The term “ALICE” is useful in thinking about the significance of medical debt to everyday people. While a medical bill of \$500 may be manageable for many Americans, it can be especially devastating for the ALICE Family whose breadwinner may be working two or even three jobs to make ends meet.¹⁷ The ALICE in Arkansas website further illustrates the hardship these families experience:

“The cashiers, waitresses, delivery drivers, janitors, and home healthcare workers who serve us every day, go home to struggle to pay the next electric bill because their child needs medicine, or can’t make it to work because they had to sell their car to keep from losing their home.”

While even those making decent wages and working typical white-collar jobs are also known to struggle with medical debt, the ALICE Family is on the brink of losing everything and the smallest disruption can threaten their quality of life. Compounding those problems, medical debt can lower a person’s credit score by an average of 25 points even if they have no other debts.¹⁸ This reduces their future access to credit and makes it more difficult to secure housing, transportation, and employment.





*ALICE Families live in a
healthcare demilitarized zone.*

The United for ALICE coalition estimates that 35 million U.S. households (about 29%) would be considered ALICE families, based on data from the 2018 U.S. Census American Community Survey. Combined with those who earn below the Federal Poverty Level (FPL), a total of 42% of U.S. households struggle with the “cost of household basics.” Given rising inflation and the disparities between health insurance costs and the average American household’s liquid assets, it is likely that the ALICE nomenclature will apply to an increasingly greater proportion of American households.¹⁹

Addressing medical debt and making healthcare more affordable for ALICE Families could be a key to fixing the entire system. CFPB and Kluender both found that after the passage of the Affordable Care Act, total medical debt decreased, yet residents of states that did not expand Medicaid still had significantly higher medical debt than residents in Medicaid Expansion states. ALICE Families live in a healthcare demilitarized zone where they earn too much money to qualify for Medicaid, but not enough income to help them escape the current cycle of living paycheck-to-paycheck.

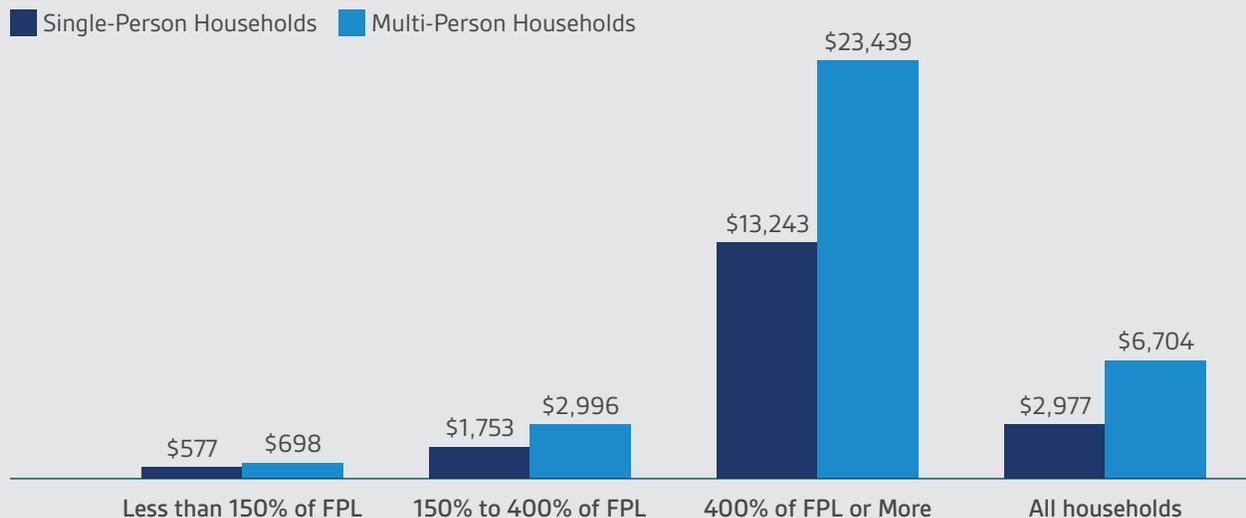
Systemic changes that increase access to healthcare for all demographics, especially those vulnerable to medical debt, have significant opportunity to control rising healthcare costs by shifting away from expensive emergency care and toward preventative and maintenance care which is cheaper for healthcare systems and patients. Additionally, keeping these families healthy and allowing stability for their families not only supports a good quality of life for ALICE Families, but it helps maintain our economy as a whole. ALICE workers are the essential workers who support our economy. As we have witnessed during the pandemic, huge supply chain issues occur when factory line workers, truck drivers, healthcare workers, and other service-based jobs go unfilled for long periods of time. Therefore, any recommendations or policy implications for addressing medical debt must take this group of families into account.

THE TROUBLE WITH OUT-OF-POCKET EXPENSES

It is worth repeating that ALICE Family breadwinners are employed sometimes as essential workers who may work for an employer that does not offer high-quality health insurance. However, even with some level of health insurance coverage (whether through the Affordable Care Act or an employer), it is very easy for an ALICE Family to fall into medical debt.

According to a 2019 KFF analysis of the Survey of Consumer Finance, single-person and multi-family households below 400% of the FPL had extremely limited liquid assets to cover an emergency expense of any kind.²⁰ Households below 400% of the FPL in the KFF analysis on average had between \$577 and \$2,996 on hand, amounts easily wiped out by a single emergency medical bill.

Median liquid assets of households by household's federal poverty level, 2019



Liquid Assets includes the sum of checking and saving accounts, money market accounts, certificates of deposit, savings bonds, non-retirement mutual funds, stocks and bonds. Among non-elderly households, those in which the head of house and his/her spouse are less than 65.

Source: KFF analysis of the Survey of Consumer Finance, 2019

Peterson-KFF
Health System Tracker

Note: In 2019, the household income for a family of four at 100% of FPL was \$25,750.²¹ The federal minimum wage in 2019 was \$7.25 per hour.²² One person working one or more minimum wage jobs in 2019 could earn a maximum of \$47,500 if they never

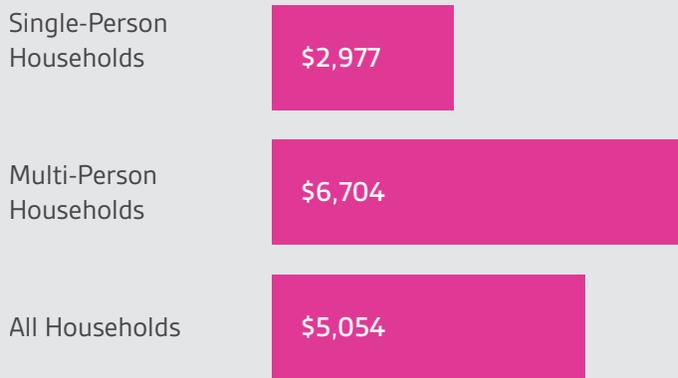
did anything but work or sleep. That salary would equate to about 185% of the FPL, which still exceeds the threshold for many assistance programs. Benefit eligibility in Medicaid Expansion states is household income at 133% of the FPL.²³

Even with some level of health insurance, rising healthcare premiums and deductible limits continue to put the ALICE Family at risk. According to the Peterson-KFF Health System Tracker chart below, the maximum out-of-pocket limit for a private plan for in-network services far outweighs available liquid assets for the

average single-person or family household.²⁴ Over time, employers have also shifted more of the financial burden onto employees in the form of higher premiums and/or high deductible plans.²⁵ This is especially true for those workers adding dependents to their plan, as the \$15,800 out-of-pocket maximum shows for family coverage.

Median liquid assets of households and maximum out-of-pocket limit allowed in private plans for in-network services, by household size, 2019

Median liquid assets, 2019



Maximum out-of-pocket limit in private plans (for in-network services), 2019



Liquid assets include the sum of checking and saving accounts, money market accounts, certificates of deposit, savings bonds, non-retirement mutual funds, stocks and bonds. Among non-elderly households, those in which the head of house and his/her spouse are less than 65.

Source: KFF analysis of the Survey of Consumer Finance, 2019

Peterson-KFF
Health System Tracker

BYPRODUCTS OF MEDICAL DEBT

Carrying medical debt brings additional challenges, including financial complications, tolls on a patient's health and legal pressures.

Financial Consequences

Despite its involuntary nature, medical debt brings both short- and long-term financial consequences for patients. Several studies have reported patients depleting all or most their savings to keep up with their medical bills—including 28% of cancer patients.²⁶ In many cases, patients utilize credit cards, pay-day loans, and other risky financial products to repay their debt, only to face even higher interest rates and financial stress. Adding to the frustration and shame of not being able to afford their bills, patients may have to borrow from friends and family, straining their support systems.²⁷ A 2019 survey published in the American Journal of Public Health found that medical expenses contributed to bankruptcy for 59% of respondents.²⁸

Medical debt can also have a serious effect on a person's long-term financial wellness and complicate existing financial problems. As stated above, the CFPB found that medical debt lowers an individual's credit score by an average of 25 points, even if they have no other debt.²⁹ A low credit score can prevent an individual from securing an affordable mortgage, auto loan, insurance rate or credit card. Credit reports are also used to evaluate applications for employment and rental properties and can become a barrier to securing a job or home altogether.

The Center for the New Middle Class writes that “one of the most important measures of individuals' financial resilience is whether or not they have access to credit instruments that allow them to manage the normal ups and downs of financial life.”³⁰ In other words, an individual's credit score can either significantly advance or handicap an individual's economic mobility. A lack of access to credit due to a lower credit score makes it even more difficult for the ALICE Family to survive—let alone gain financial stability—because they do not have savings or available credit to absorb any new or unexpected expenses such as rising food and gas expenses. **Making matters worse, despite their inability to afford basic needs, ALICE Families earn too much income to be eligible for safety net programs such as SNAP or Medicaid.**

The Impact on Health Outcomes

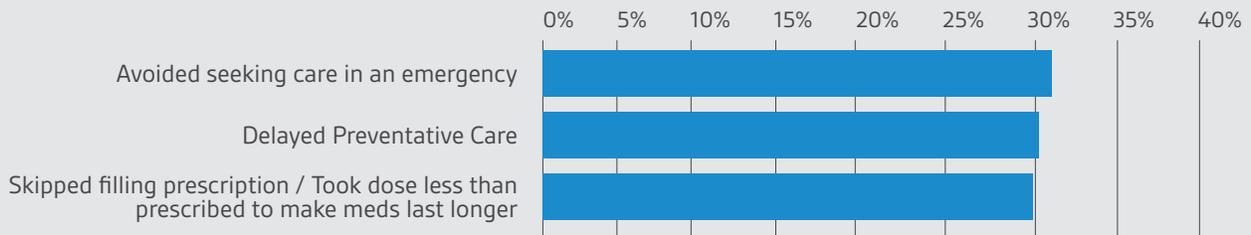
One of the most insidious results of medical debt is the avoidance of routine or essential healthcare in order to avert additional medical expenses. In a nationwide survey of 517 U.S. residents commissioned by BuoyFi in April 2022, researchers found that 60% of respondents had taken at least one of three actions due to their overdue medical bills: 1) avoided seeking care in an emergency; 2) delayed preventative care; and/or 3) altered their prescription regimen (either by taking less than the prescribed dosage or skipping filling a prescription).³¹

Have Likely Experienced Health Implications

60% of all respondents have taken at least one of these actions as a result of their overdue medical debt

“Which of the following have you personally experienced as a result of your overdue medical debt?”

(N=517)



Buoyfi, Medical Debt Survey, April 2022

These findings echo studies conducted by the American Cancer Society and KFF in 2022. Nearly half of the respondents (45%) in the American Cancer Society study had delayed care for a serious issue due to their medical debt and about two-thirds (64%) of the respondents in the KFF study had purposely avoided care or delayed care for themselves or a family member due to cost.^{32,33}

A recent study of diabetes patients by CharityRx found of the 60% of respondents who rationed their insulin due to medical debt, "54% reported that they couldn't do everyday activities, 44% said they couldn't work, and 37% said they couldn't go to school. One-third reported becoming sick as the result of rationing their insulin and 38% wound up in the hospital for one or more days."³⁴

In an article about the impact of medical debt on Black Americans, the Urban Institute illustrated this concept with the story of Mike Jackson, who struggled to pay his medical bills after a job loss and divorce:

*"To save money, he cut back on the insulin he needs for his diabetes, planning to manage his condition with diet and a smaller dosage. His efforts left him with numbness in his feet and toes and nerve damage to his eye, complications he is now struggling to treat—and pay for. 'If anything goes wrong,' Jackson told NPR, 'I'm one step away from disaster.'"*³⁵

According to the CFPB, medical debt may also block patients from non-emergency care, citing cases where patients were turned away by their medical provider due to unpaid bills. Additionally, KFF found about 1 in 7 respondents with medical or dental debt "had been denied access to a hospital, doctor, or other provider because of unpaid bills."³⁶

The presence of debt can also have long term effects on patient health, including higher levels of perceived stress and depression.³⁷ After analyzing 20 years of national data, the Urban Institute discovered a correlation between medical debt and the ability to care for oneself as a senior citizen.³⁸

Bottom line: While at first these tactics might postpone an expensive medical bill, eventually the delayed care for chronic and acute health needs becomes even more difficult to treat and ends up costing even more than the original service the patient avoided.



Legal Pressures

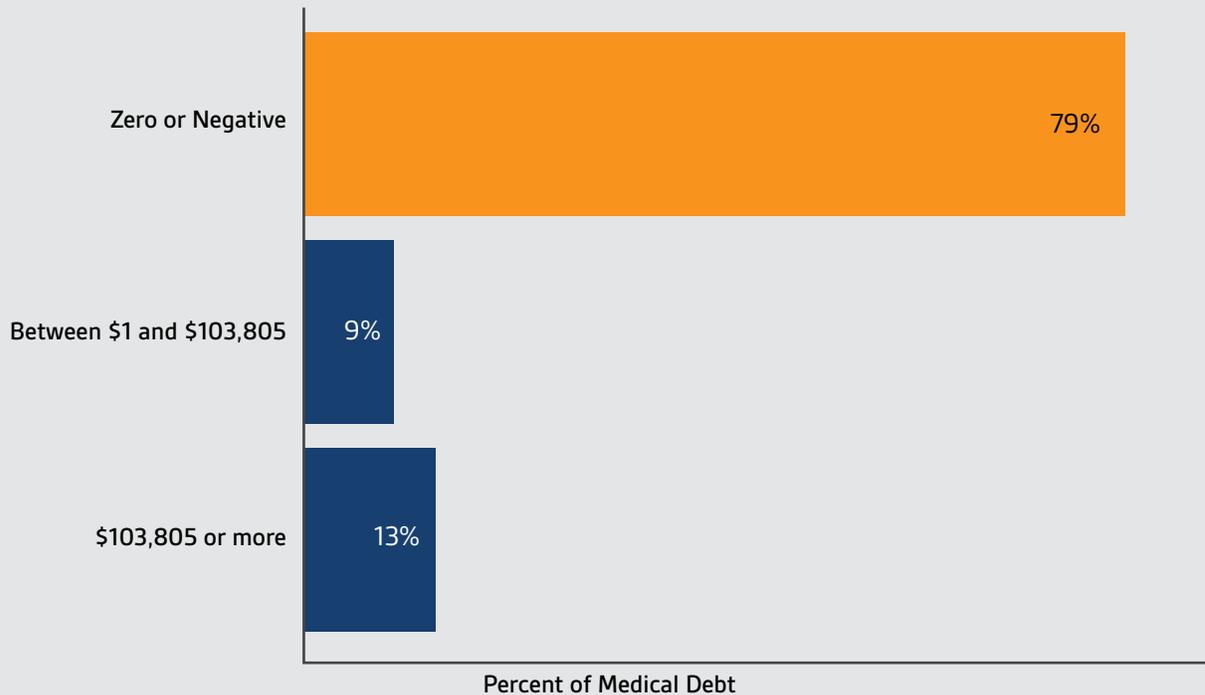
Patients may also face legal consequences when they cannot afford to pay their medical debt. Depending on the state, providers and collections companies may file lawsuits against patients to secure wage garnishments or to place a lien on their home to recover the amount owed.³⁹ Those who ignore these lawsuits can also be arrested for failing to appear in court, which can lead to unemployment and further inability to pay off debt.⁴⁰ In the case of Ms. Robin King of Ohio, who testified to the U.S. Senate Committee on Banking, Housing, and Urban Affairs, she was sued by her late mother's nursing home for a \$70,000 bill that had been submitted to but denied by Medicaid. Though she avoided having to lose her own home, the company is still suing Ms. King's mother's estate, depleting her family's only source of generational wealth.⁴¹

Like Ms. King, ALICE Families are asset-limited and likely do not have generational wealth or wealthy networks to rely on to generate additional resources to pay off debt.

Even a study of GoFundMe pages for medical expenses found that these campaigns tend to benefit people who are already connected to wealth, rather than the people who are in most need of financial assistance.⁴² While some ALICE Families may own their own home or vehicle, as in the case of Ms. King, a recent study by The Brookings Institution found that **79% of households with medical debt had zero or negative net worth.**⁴³

Vast majority of medical debt held by those with zero or negative net worth

Percent of total medical debt by household net worth



Source: Brookings analysis of 2018 SIPP data

THE DRIVERS OF MEDICAL DEBT

High deductible plans and expensive out-of-pocket costs

Though over 90% of the U.S. population is covered by some level of health insurance, simply having insurance does not guarantee that all medical costs will be reimbursed.⁴⁴ Insurance does not inoculate against being saddled with medical debt. Most consumers assume that their healthcare is adequate, especially given its high cost. However, they often get surprised that they derive little benefit from their policies.

The wide variety in coverage as well as the complexity of plans make it difficult to understand what services are covered and by whom. Even medical office clinical staffs have a difficult time and cannot advise patients on whether the service they are about to receive will be covered by their insurance.

The allure of high deductible plans to keep monthly expenses low has only exposed families to higher out-of-pocket costs,

reflecting Dr. Ippolito's point that medical debt most likely stems from the co-pays and balance bills charged for everyday visits and procedures.^{45,46} For the ALICE Family barely making enough to cover anticipated expenses, likely without good credit or emergency savings to cover budget overages, these surprise bills are extremely difficult to manage. In 2021, the Federal Reserve found that about 40% of U.S. adults would struggle to pay an unexpected \$400 bill.⁴⁷ (This corroborates United for ALICE's estimate that 42% of Americans struggle with daily expenses.) Even without surprise bills, nearly 20% planned not to pay a bill or only pay part of a bill in the same month, both surefire ways to accrue unaffordable interest and debt. Kluender et. al. writes that when these high out-of-pocket costs go unpaid, they are often classified as medical debt and sent to collections.⁴⁸

Price Variation and Lack of Transparency

Another issue leading to medical debt is the difficulty in estimating how much a checkup or procedure is going to cost. There is extreme price variation based on negotiated rates between providers and insurance companies, and the differences may not even be tied to

the cost of care.⁴⁹ The same service can be billed at a different rate based on what a particular insurance plan covers, and which provider is seen, sometimes varying by thousands of dollars. According to a 2021 New York Times analysis, "a single insurer can have a half-dozen different prices within the same facility, based on which plan was chosen at open enrollment, and whether it was bought as an individual or through work."⁵⁰

In non-emergency settings, patients may be able to shop around for a service or medication and seek care where it is the most affordable, but historically, prices for care have been difficult to find. Providers and provider associations often argue that supplying prices upfront may deter patients from seeking the care they need or may hamstring providers by only allowing them to offer specific services that will be reimbursed. At the same time, providers are hesitant to be transparent about their prices as they would be revealing whether they really deliver the best rates possible. Deanna Cuadra from Employee Benefits Network writes, 'If you're a big health system negotiating with a smaller insurer, you will get more beneficial rates. But big plan providers like Aetna or Cigna can demand the prices they want.'⁵¹

In emergency situations, individuals may not be able to choose where they find help at all since timing and immediate interventions do not allow for the question to be asked. Additionally, while the hospital or primary provider may be in-network, other people who support the medical intervention—such as the anesthesiologist or the lab that processes bloodwork – may be out-of-network, leading to surprise bills. The No Surprises Act is meant to help alleviate this problem, but as a later section explains, there are serious gaps in its application.

These dynamics make it nearly impossible for medical office staff to help patients estimate their costs ahead of time, requiring the patient to do the legwork to do the math themselves and advocate over the phone with countless faceless billing representatives if they hope to correct their bills.⁵² Given the types of jobs and the types of hours ALICE breadwinners work, these are simply hours that they do not have to spend "waiting for the next available representative."

Miscommunication and Inefficiencies at the Health System / Provider Level

The current U.S. healthcare payment system makes thousands of assumptions about patients and their capacity to advocate for themselves in the case of a mistake in billing or miscommunication from a provider. A recent survey conducted by BuoyFi found that respondents who were aware of the possibility they could be eligible for financial assistance programs or charity care were four times more likely to explore these options than those who were unaware. **Those who were aware and ultimately eligible for assistance were also eight times more likely to secure some level of financial assistance than those who were eligible for assistance but did not know about the possibility ahead of time.**⁵³ Patients' comprehension of their health plan (network care, co-pays, H.S.A. options, etc.) and understanding of their medical bills are also keys to their ability to evade medical debt. Those without any insurance are at an even greater disadvantage. **This suggests a fundamental flaw with the way charity care and payment plans are communicated.**

Recent studies from Axios, The Lown Institute, and the North Carolina State Treasurer's office have begun to question the deficit in charity care provided to local communities compared to the generous tax breaks and incentives many hospital systems receive. Deficits range from millions to billions of dollars, depending on which hospital systems are studied. At the time this paper is being written, North Carolina is considering a uniquely bipartisan bill that would codify new rules around the provision of charity care and limit medical facilities' power to set unreasonable interest rates.⁵⁴

With ALICE workers mostly on their own to estimate their health care expenses, given vague data about how much services could cost, and with little time or resources to manage the difference between their estimate and their bills, it is inevitable that many of them will accrue expensive medical bills once they seek care for themselves or a family member, quickly becoming medical debt. NPR terms these individuals and families "functionally uninsured."⁵⁵



*ALICE workers are
"functionally uninsured"*

THE ROLES OF MAJOR PLAYERS IN THE U.S. HEALTHCARE SYSTEM

Before we can identify ways to provide ALICE Families with relief, it is important to understand key players within the medical debt collections ecosystem and the roles they play.

Patients

The patient is the central point of contact for the health provider system, insurer, employer, and collections company. Each player has their own incentive for understanding the patient well, but what is most important to understand about patients is that they do not make decisions in a vacuum.

Given the status of the ALICE family, the common experience of being “functionally uninsured,” and how closely tied financial and physical wellness have become, it is easy to see why debt itself was identified as a potential socioeconomic determinant of health by Social Science & Medicine in 2013.⁵⁶ Any solution designed to help the ALICE family resolve their medical debt and regain their financial footing must take into consideration the ecosystem in which they make choices and navigate health payment systems.

An important feature of that ecosystem is how little time the ALICE breadwinner has to manage personal matters. With minimal days off (either as weekend days or PTO), we should assume the ALICE breadwinner is exhausted and does not have 20 to 45 minutes or more to wait on hold for a customer service representative to resolve an issue with their medical bill—and especially not during the workday. Yet, regardless of which major player they are interacting with, it almost always comes down to the patient advocating on their own to get a response to their question or need.

The BuoyFi medical debt survey also found that patients with current overdue medical debt typically have two or three other types of debt owed. Examples included credit card debt, student loans, auto loans, and mortgages, among others.⁵⁷

Additionally, when asked about barriers to paying their debt, 47% in the BuoyFi survey reported they simply could not afford the bill, while 41% stated that they

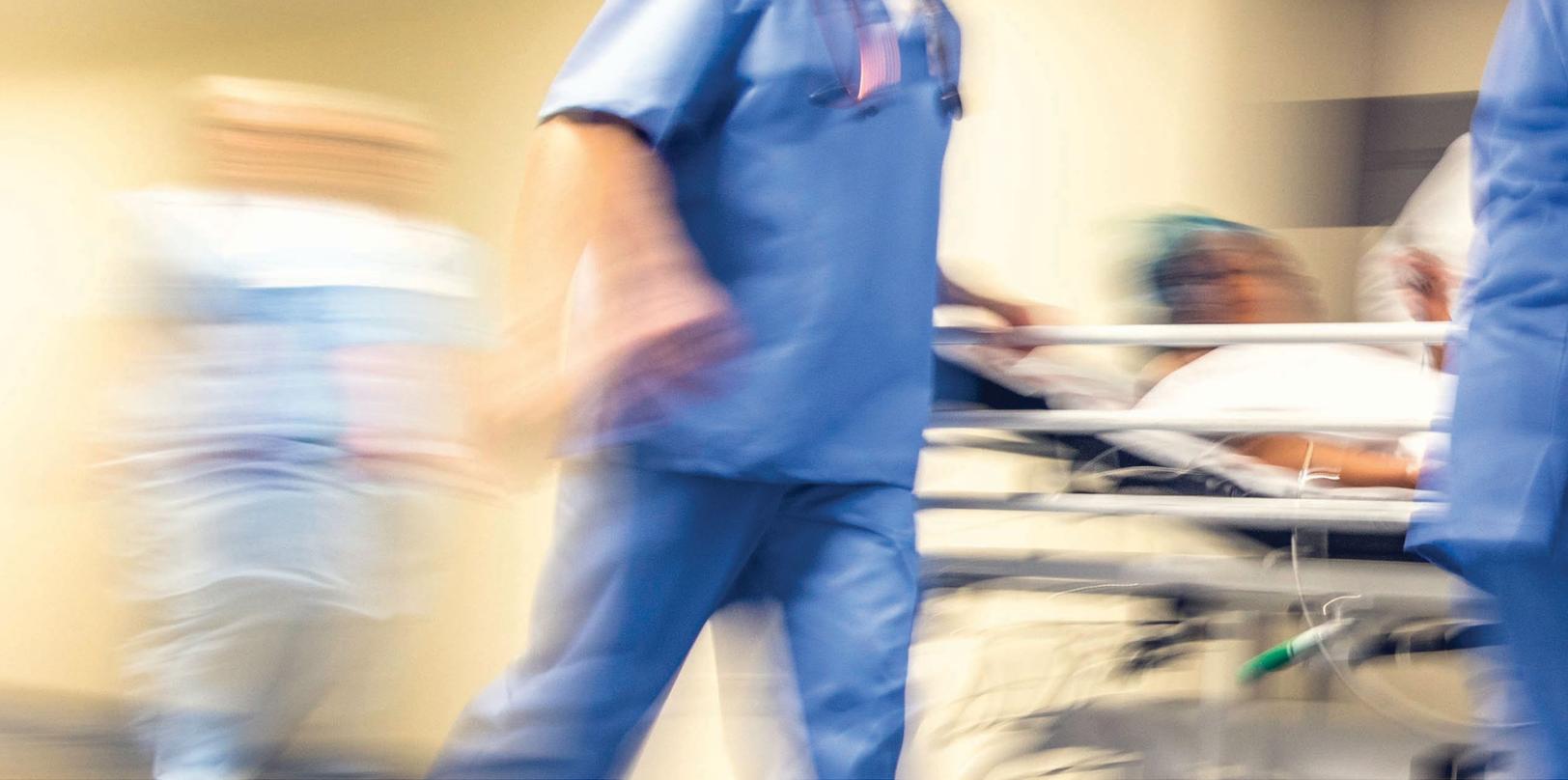
had other bills that took priority. This means that when non-payment can lead to the loss of a life necessity (e.g., debt tied to a home or car), patients use their limited resources to pay these bills rather than medical debt—which cannot be repossessed and thus drops to the bottom of the bill pile.

Healthcare Providers and Supporting Staff

As the individuals responsible for administering care, providers play a pivotal role in the patient’s physical and financial health. Working either in private practice or as part of a larger system, clinicians and their staffs have the first opportunity to discuss a care plan with the patient as well as the potential costs. However, their ability to talk about the costs of care is dependent on the setting, whether the visit is a regular/preventative visit or an emergency/urgent care visit. Neither setting is ideal to discuss cost.

Compounding this, tort risk also inclines physicians to encourage proactive medical services and to avoid discussing the risks of non-care.⁵⁸ Inexperienced patients may be unaware that they can challenge whether a particular service is the best option for their health or their financial well-being.

In a primary care or preventative setting, providers are under pressure to see as many patients as they can during the day. This limits their ability to talk with patients about all the factors affecting their physical and mental health, let alone their ability to afford care. Similarly, staffing shortages limit support staff’s time with patients to have the same conversation. Researchers at the University of Michigan found that conversations about the cost of care do not typically occur unless the care is specifically known to be expensive (such as cancer treatments or diabetes).⁵⁹ This makes it difficult to help patients select treatment plans that are effective and affordable.



The provider's support staff also plays a key role. They are responsible for collecting a patient's insurance information, confirming the proper coding for services provided, and submitting the proper paperwork to insurers.

In an emergency room, the federal Emergency Medical Treatment and Labor Act (EMTALA) "requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay."⁶⁰ This prevents any discussion of finances until after the patient has been served, which is appropriate and logical given the patient's needs and their likely frame of mind when facing serious health issues. Because EMTALA is an unfunded mandate, hospitals must either treat this service as charity care or seek payment from patients and their insurance, if applicable. Unfortunately, about 50% of a hospital's inpatient admissions (inpatient care) begins in the ER and inpatient care is extremely expensive.⁶¹

Healthcare and Hospital Systems

Health and hospital systems establish the price of each service based on their actual costs to operate the system as well as their expected reimbursement rates from private insurance, Medicare, and Medicaid. The terms hospital system and health system are used interchangeably in this paper but refer to an interconnected system of medical facilities which employ

hundreds and thousands of providers and staff. This is in contrast to a single provider or small group of providers operating a private practice, which would not have the resources of a large system which handles billing and collections on behalf of providers.

Once a medical service has been coded, the billing department prepares the patient's bill, which is usually submitted to the insurer for payment. After any third-party coverage (insurer) has determined and reported the patient's liability, the patient receives a bill for their co-pay and out-of-pocket costs. This is a patient's first opportunity to question or dispute a charge, but many patients do not know they can or should. One reason the Consumer Financial Protection Bureau has pushed for delayed reporting of medical debt to credit reporting agencies is that it often takes longer than the prescribed 180 days to correct billing errors and file and navigate disputes between the insurance company and provider.⁶²

In recent months, hospitals have been heavily criticized for not making charity care more accessible to patients despite receiving millions of dollars in tax-exemptions and federal funds (e.g., Atrium Health in North Carolina and Providence Health in Washington State). Patients who are eligible for a payment or charity care may not know this is an option unless they are screened ahead of time or are especially educated about the process. Therefore, many



About 50% of a hospital's inpatient admissions (inpatient care) begins in the ER and inpatient care is extremely expensive.

who are eligible for assistance receive bills anyway. Even if patients are made aware of the process, the paperwork can be overwhelming and cumbersome, requiring levels of documentation that are difficult to provide and discourage the patient from applying.

Health Insurance Companies

Insurance companies play two vital roles in the medical debt ecosystem—paying for health care services for their customers and using their influence to negotiate with hospital systems and providers for the best rates. Hospital systems and providers have an incentive to work with the insurance companies because once their services are deemed “in-network,” they have access to a new pool of paying patients. The incentive for insurance companies to work with hospital systems lies in the ability to provide customers with an attractive selection of health care services and providers for an affordable rate.

Though the specifics of a given plan vary in their complexity and readability, health insurance plans typically fall into two categories. Patients either pay a higher monthly premium in exchange for a low deductible plan or pay a lower monthly premium in exchange for a high deductible plan. Both may come with co-pays for certain services and out-of-pocket costs that count against the deductible. Insurance companies help

the patient secure a lower rate for a particular service and pay a portion of the bill until the patient has met their deductible. After this point, the insurance company is supposed to pay most or all of the bill. Patients are encouraged to see providers within the insurer's network to get the best rates on care. While these statements apply to many plans, the prices that are negotiated can vary widely even within the same market and the in-network pool of providers can change frequently without a patient knowing.⁶³ Even medical office staff have a difficult time understanding what a patient's insurance will cover despite having some discretion over the medical billing codes that will ultimately determine the patient's bill.⁶⁴

As discussed earlier in the section outlining the drivers of medical debt, patients are often stuck in the middle when insurance companies and providers duel over allowable costs. In addition to being a major inconvenience, these disagreements can also dangerously disrupt care as patients of the University of Vermont Medical Center found when the hospital and UnitedHealthcare disputed recent cost increases and UnitedHealthcare threatened to stop paying for medical care sought at UVMC.⁶⁵ **With limited time and bandwidth to find new providers or deal with insurance companies, it is just as easy for an ALICE Family to avoid care altogether, which has its own consequences.**

THE FABERGÉ EGG THAT IS THE U.S. HEALTHCARE PAYMENT SYSTEM

While many would argue that all medical debt should just be forgiven, this stance does not account for the financial stability of hospitals and healthcare systems themselves. Hospital balance sheets are under pressure from rising healthcare costs.⁶⁶ From 2019 to 2020, “health spending in the U.S. increased by 9.7% to \$4.1 trillion or \$12,530 per capita.”⁶⁷ Of that total, \$389 billion was paid out-of-pocket by patients.

Staffing shortages, increases in drug prices, and inflation's effect on medical supplies and PPE during the pandemic only aggravated these challenges for hospitals.⁶⁸ The American Hospital Association notes these factors contributed to “billions of dollars in losses over the last two years for hospitals,” and reports “over 33% of hospitals are operating on negative margins.” These disparities are especially dangerous in small communities where the hospital may be the biggest employer and the only healthcare provider. An unsustainable financial condition could result in the curtailment of essential services or closure of facilities. Uncollected medical debt only exacerbates this situation.

While the American Hospital Association is correct that hospitals are experiencing rising costs, hospital leaders

are not absorbing all the difference. A study conducted by Axios in partnership with Johns Hopkins University noted that “most hospitals charge more for a procedure than what it costs them.”⁶⁹ This tactic helps to cover expenses and future needs and is often used as a point of leverage with insurers, according to industry leaders. That said, when a patient carries insurance, the full amount is rarely ever paid by the insurance company, and these rates can be charged in full to uninsured patients. The Axios/Johns Hopkins University study found that the median markup tends to be five times the cost of a procedure for nonprofit and governmental hospitals, and twelve times the cost for for-profit hospitals. Additionally, researchers argue hospitals are incentivized to charge higher markups as “each additional dollar of list price results in an extra 15 to 20 cents in revenue for the hospital.” The health system's ability to negotiate prices is also determined by their size and stature in the region. Large systems (or systems that have a monopoly in a particular region) have better leverage to negotiate with these payment institutions than small systems.⁷⁰

Ultimately, cost increases are passed on to patients via higher health insurance premiums, deductibles, and out-of-pocket costs for non-network providers.

THE DEBT COLLECTIONS PROCESS

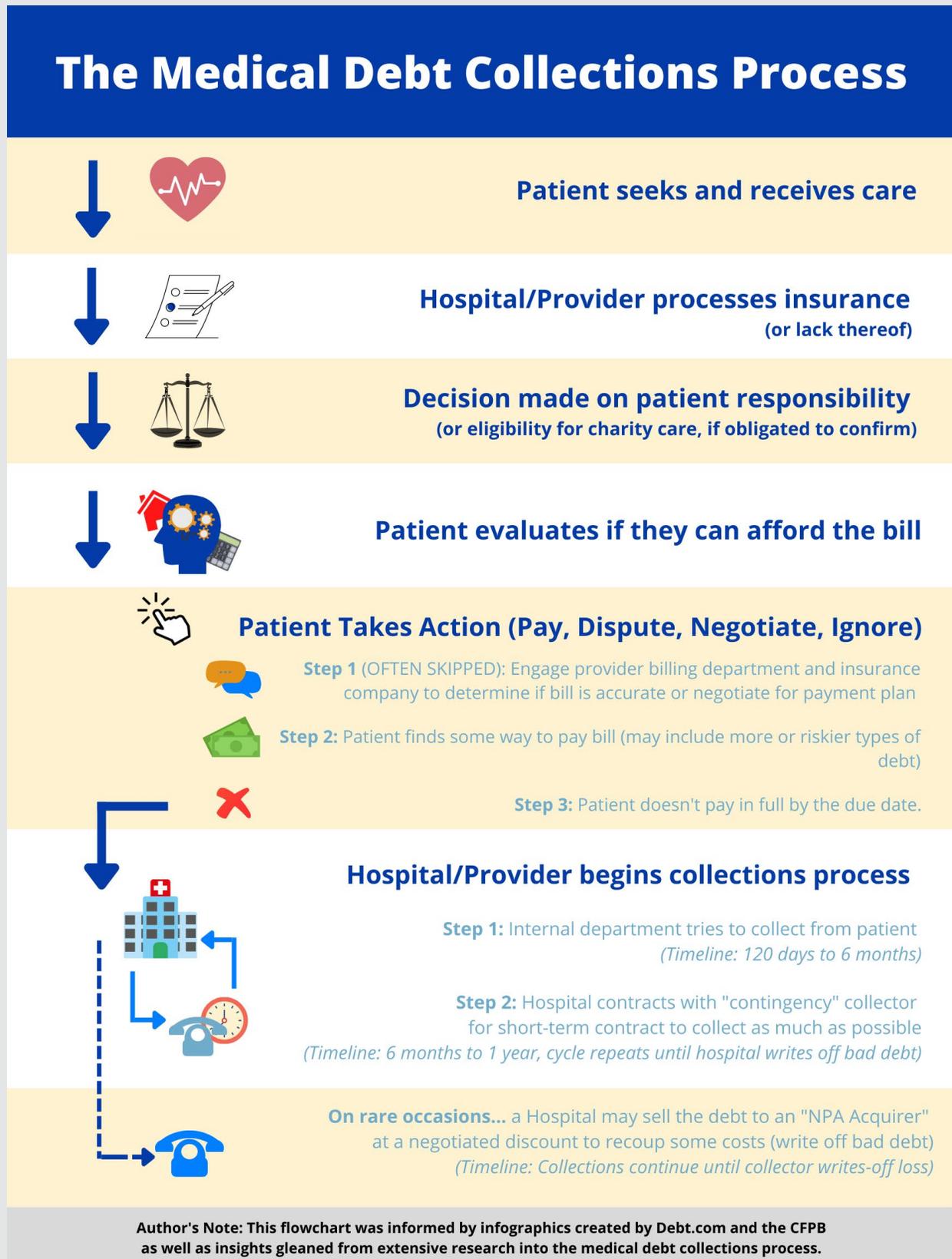
Once a provider has exhausted their internal efforts to collect the patient liabilities from the patient, the bill becomes overdue. Outstanding medical balances are either turned over to an internal collections individual/department, or a contracted agency to engage the first round of bad debt collections. At this stage, the bill still usually lists the services and providers, which helps the patient understand why they should pay this bill.⁷¹

When bills continue to go unpaid, the health system has several options to address the bad debt and may pursue one or a combination of the following pathways based on their tax-exemption status:

- Write-off the obligation as uncollectible bad debt and/or charitable care
- Attempt to collect the debt using an external collection agency, which is responsible for collecting as much of the debt as quickly as possible for a stated commission
- Sell the debt to an acquirer of Non-Performing Assets (NPAs) at a negotiated rate for a fraction of the cost to remove the debt from their books
- Take legal action against patients to recoup their losses (i.e., wage garnishment, property liens, and lawsuits)

Reporting medical debt to the national credit reporting agencies is also a path to pursue and depends on the tax-exempt status of the provider/hospital, state regulations, and hospital policies.

An overview of the debt collections process is illustrated below.^{72,73}



THE STORY OF ALICE

An illustration of this process for ALICE patients might be helpful.

ALICE has sharp stomach pains and—under intense pressure from loved ones—goes to the local emergency room. ALICE has a physical exam, an x-ray, and some lab tests, and is diagnosed with acute appendicitis which requires emergency surgery. ALICE undergoes the procedure and is discharged as an inpatient from the hospital after an overnight stay. At this point, ALICE will be receiving at least six different bills for this visit – Hospital, ER physician, Radiologist, Surgeon, Anesthesiologist and Pathologist. Each of these billings will have a separate and distinct life of its own, but our story will focus on the Hospital bill.

ALICE has insurance and goes home to convalesce from her surgery so she can get back to her normal life as quickly as she is able. Meanwhile, the hospital compiles and codes all her services into a single bill, which takes about three to five days and then submits the bill to ALICE's insurer. The insurer then processes her hospital bill, applying her covered benefits, network discount, and ALICE's liabilities (deductible and co-pay). ALICE has chosen a high deductible health plan (it is the cheapest monthly premium, and she has always been healthy) so the insurer applies \$5,000 as ALICE's amount to pay. This process takes about 60 days. The insurer then sends a remittance advice letter to the hospital detailing their processing of the hospital's bill and sends an Explanation of Benefits (EOB) to ALICE with a similar detailing of their processing of her claim.

ALICE is now 8-9 weeks recovered from her surgery; things are getting back to normal. This is when she receives her EOB from her insurer that she owes \$5,000. She thinks, "This cannot be. I have been devotedly paying my premiums. This must be some processing error." ALICE is picking up an additional shift to help get back on a solid financial footing and will call the insurer later.

About two weeks later, ALICE receives her first bill from the hospital showing she owes \$5,000. The shock of

the prior letter is relived. ALICE tries to call her insurer/hospital and just cannot hold the line. Her child is home sick from school. With no partner to help and the exorbitant cost of childcare, ALICE stayed home to care for him. She will call later. A month goes by, and the Hospital's second billing notice shows up in her mailbox. ALICE repeats the cycle and continues to "try again later." A third Hospital billing statement shows up in ALICE's mailbox a month after the last. She makes a note to herself to call during her break at work.

ALICE is not aware that charity care could possibly apply to a person like her—a person with a steady job and a household income above the poverty line, but without the means to meet basic needs. While the Hospital website offers instructions on how to apply for charity care and mentions opportunities for payment plans in every statement, ALICE is not looking for that information because she 1) believes the amount may be a mistake, and 2) does not want to waste time looking into a process she does not believe will apply to her anyway.

It has now been about six months since ALICE's brush with death when she gets a collection notice from a third-party collection agency. As ALICE has made no payments and the hospital has no record of ALICE attempting to apply for charity care, the Hospital has declared ALICE's balance bad debt and sent it to an external collection agency. ALICE calls the agency and explains her \$5,000 balance is a mistake and is not owed. The collector attempts to help ALICE but cannot as all the account information shows is that ALICE owes a \$5,000 deductible for her Hospital bill. ALICE says she will call the insurer or hospital and get this error corrected.

After an additional 6 months of receiving no responses to their letters and calls, ALICE's medical debt is reported to the credit bureau by the collection agency at the direction of the provider (in this case the Hospital).

Three Types of Medical Debt Collection Agencies

Because medical debt originates with their services, hospitals and providers have great influence over how medical debt is collected and if/when it is reported to credit reporting agencies. Collection agencies must follow the rules established by the contract with the provider as well as an intricate web of state and federal regulations established by the U.S. Centers for Medicare & Medicaid Services, the Consumer Financial Protection Bureau (CFPB), and the Department of Health & Human Services (HHS).

“Early Out” or Internal Provider Agencies are involved as either a department within a health/hospital system or as a direct contractor working on their behalf to collect patient debt. After a series of bill notices have gone unpaid, agency representatives contact patients to let

them know the bill is overdue. This is where most medical balances are resolved – especially when the patient has the funds to pay or just needs time to correct a bill with the provider/insurance company. One advantage Provider Agencies have in working with patients is their access to patient data. Information about the provider and service administered helps patients understand where the debt comes from and can offer an incentive to pay the debt.⁷⁴

If the bill continues to go unpaid and no other arrangement has been made with the patient, the hospital system can either write off the debt, or engage a Contingency Collection agency or NPA Acquirer to continue attempting to collect on the debt. In a Contingency Collections contract, the medical debt is still owned by the hospital. In a contract with an NPA Acquirer, the collections company owns the debt.

There are three types of agencies to collect unpaid medical balances:

1 “Early Out” or Internal Provider Agencies (Pre-Bad Debt): Internal employee staff or those employed by the hospital/provider or who are contracted by those organizations to collect on debt for the first time. These individuals operate in the provider’s/hospital’s name and could be an internal department within the hospital or a contingency outsourcer.

2 Third Party Contingency Collection Agencies: Those working in their own name on a contingency basis to collect on bad debt, but do not own it.

3 Non-Performing Asset (NPA) Acquirers: Those that purchase the medical paper and own the bad debt.

Third-Party Medical Debt Collections: Comparing Contingency Agencies and Non-Performing Asset Acquirers

SIMILARITIES

There are many similarities between Contingency Agencies and NPA Acquirers. Both are contracted by a hospital or provider to continue to try to collect debt from patients. Representatives for these agencies may send letters, call, or email patients about the debt, although they do not always have access to the provider’s name or service attached to the debt.

While many representatives are respectful of patients and try to empathize, others have been known to try to scare and coerce patients with a myriad of tactics. The Consumer Financial Protection Bureau logs consumer complaints regarding collections practices. The majority of complaints regard consumers who do not believe they owe or concerns about written notifications of debt containing too much or too little information about their medical record. That said, consumers also complain

about representatives who threaten to take illegal actions against them.⁷⁵ While industry representatives may not like talking about these behaviors, they can and do happen, especially when hiring collections subcontractors who work on a monthly quota basis and are not well managed.⁷⁶

During these later stages of the process, as medical debt is transferred between many different agencies, the connection to the healthcare service itself and identifying information about the debt can be lost. Patients may receive a bill from a collection agency with no reference to the provider’s name, location, or date of service. The bill may not even show the interest or fees separately from the original bill. According to the CFPB’s most recent report about consumer complaints, 32% of closed debt collection complaints related to medical debt concerned the topic of “written notification.” In these cases, either consumers could not recognize their debt at all, or there was personally identifiable information in the communication that compromised their privacy according to HIPPA.⁷⁷



DIFFERENCES

The biggest difference between Contingency Collection Agencies and NPA Acquirers is their relationship to the debt itself, which fosters different incentives and tactics for collecting on the debt.

Contingency Collection Agencies do not own the medical debt. They are contracted by the hospital/provider for a specific amount of time to collect as much of the balance amount as possible. This allows the hospital to bring in as many additional dollars as possible, but the amount is dependent on the effectiveness of the Contingency Collection Agency and there is no guarantee the hospital will recoup any of the debt. The contingency agency is paid a commission on the debt they collect. This incentivizes the agency to pressure patients to pay as much as possible upfront by paying the entire balance or an agreed upon settlement. They are also constrained by the timeline defined in the contract, which typically lasts 6 to 12 months. The agency may choose to charge fees and interest on the debt while they are under contract with the hospital, adding to the financial burden for patients. When the contract is over, the debt accounts are returned to the hospital which may continue to try to collect on them with another agency or simply write off and forgive the balances. These high-pressure and quick turnaround arrangements can be very hostile to patients as there is little incentive to negotiate or forgive a balance, regardless of the patient's ability to pay. Many CFPB complaints stem from this subgroup in the industry.⁷⁸

NPA Acquirers purchase the debt from the hospital/provider at a discounted rate. This allows the hospital/provider to recoup a guaranteed reimbursement for the medical debt even though it is a lesser amount than if the patient had paid in full. The NPA Acquirer now owns the debt balance, meaning their revenue is comprised of payments secured from patients. Reselling the debt would run contrary to this role of NPA acquirers. This arrangement means the agency is not constrained to a particular timetable and has more flexibility to negotiate with patients based on what they can afford over time.

NPA Acquirer agencies are in a unique position to become part of the solution to medical debt in collections. The absence of a time-bound contract allows debt repayments to be spread out over time, which is more palatable for the patient and may even be more profitable for the agency as they can collect more revenue versus a smaller lump sum payment. This arrangement also gives the agency an opportunity to build a long-term relationship with the consumer and to create solutions that can put the patient on track for financial wellness.

Hospitals also have something to gain by working with a collection agency that can treat patients to a better experience overall. By working through an agency that treats its patients respectfully and works with consumers over time to address their medical debt, hospitals are in a better position to sustain their reputations and to gain "repeat" business from their patients.

Recurring Problems with the Debt Collection Process

In May of 2022, The New Yorker published a story called, "If You Give a Mouse a Routine Checkup," based on the children's book If you Give a Mouse a Cookie. Using humor and illustration, the piece pinpointed the problems with the medical billing system that translate to even bigger problems with the medical debt collections process.⁷⁹ In a nutshell, patients do not know what they do not know. Yet the healthcare payment system assumes that consumers have the knowledge, experience, and time to ensure 1) they can afford the care they seek, and 2) they are billed the correct amount after receiving care.

The reality is that these assumptions are plain wrong for most patients, otherwise how could so many Americans carry medical debt? Patients do not always know enough to dispute how medical codes were applied or question whether their insurance was appropriately billed. They do not recognize their potential eligibility for charity care, or they may not have the wherewithal to ask or fill out paperwork correctly. Once a bill is in collections patients often are intimidated and may not realize they could negotiate a settlement or payment plan they can afford. Patients with means simply pay up, but when 35% of Americans cannot afford a \$400 emergency expense, these problems translate to debt that can bury them.⁸⁰ They simply stop answering the phone, dealing with whatever consequences that result.

Other problems persist with the rules collections representatives have to follow that exacerbate the problem,⁸¹ including:

1

Improper billing. Collection agencies are technically responsible for making sure that debt is properly billed to the patient, but it is extremely difficult to do so. Lax enforcement of this rule allows bad actors to continue pursuing accounts that should be forgiven or corrected.

2

Lack of patient education. Many people signed up for very high deductible plans under the Affordable Care Act and accrued very expensive medical bills with large out-of-pocket expenses. Most consumers in this situation were not fully aware of their health insurance plan's benefits to the extent that they could have avoided incurring medical debt.

3

Coverage gaps by Medicare and Medicaid. These plans do not pay hospitals for the full cost of various services, creating unintended incentives to shift the balance of operating costs to private payer insurance and patients without insurance.

National Credit Reporting Agencies (and what they are doing to affect change)

Credit reporting agencies are for-profit companies that collect consumer data to compile reports that indicate creditworthiness.⁸² Equifax, Experian, and TransUnion are the largest and most well-known nationwide credit

reporting agencies (NCRAs).⁸³ Hospitals and medical debt collection agencies can furnish data to these bureaus as a method of pressuring consumers to pay their debt. This has serious consequences for those with medical debt in collections as it makes it harder to qualify for credit or loans which might help them get back on their feet financially.

The three largest NCRAs announced in March 2022 significant changes to the way medical debt will appear on consumer credit reports:

1

Medical debt that has been paid in full will be removed from credit reports (effective July 1, 2022)

2

New unpaid medical debts will not be added to credit reports until a full year after being sent to collections (effective July 1, 2022)

3

Unpaid medical debt balances of \$500 or less will be removed from credit reports (effective January 1, 2023)

Although the actions do not absolve patients of their responsibility to repay their medical debt, regulators and patient advocates applauded the measures as a means to relieve a major burden on millions of Americans due to the way poor credit reports can damage a person's financial stability overall. The move will also give consumers more time to resolve billing errors and coverage disputes with their insurance companies and providers. This is critical for ALICE breadwinners as it may take months to resolve just one concern based on their availability to engage with customer service, etc. Critics argue that while these moves will help many people prevent unnecessary dings on their credit reports, it will not help those saddled with thousands of dollars in medical debt they cannot afford to pay.⁸⁴

On the industry side, there is also disagreement about how these changes will play out. Unintended consequences could include patients becoming less willing to pay their medical debt and putting health care providers and systems at higher financial risk (as well as the agencies that attempt to collect on the debt). The 2022 BuoyFi Medical Debt Survey highlighted that patients were more willing to pay their medical debt when there was the possibility of a lower credit score, legal action, or financial penalties. Nearly half (47%) reported they were more likely to pay due to a

lower credit score, and a majority (58%) reported being more likely to pay due to possible legal or financial penalties.⁸⁵ Removing those pressures could possibly have the opposite effect on a patient's willingness to repay debt given their limited financial resources, especially the ALICE patients. After the national credit reporting agencies announced they would be changing reporting for medical debt in the spring of 2022, the collections industry projected that there would be a 30-40% reduction in healthcare collections.⁸⁶ Should these projections hold, that would further squeeze the financial health of healthcare providers.

On July 27, 2022, the CFPB weighed in with a report citing that "more work must be done to address medical debt credit reporting problems." The analysis noted that "the changes likely will result in the majority of individual medical collections tradelines being removed from credit reports. However, in terms of dollar amount, a large majority of reported medical collections likely will still remain." The assessment concluded that while two-thirds of medical collections on credit reports will no longer be reported, residents of lower income, majority Black or Hispanic census tracts are slightly less likely to benefit from the announced changes. This suggests that the ALICE consumer may not benefit as much as hoped for.⁸⁷



LEGISLATIVE AND REGULATORY ENVIRONMENT

As attention and focus have intensified around the medical debt crisis, legislators and regulators have begun to act at both the federal and state levels.

Federal Legislation

A complex web of federal legislation has both improved access to healthcare and made it more difficult. The three most important laws to understand in the context of medical debt are the Affordable Care Act, No Surprises Act, and the Fair Debt Collection Practices Act.

The Affordable Care Act (also known as Obamacare):

One of the key features of the Affordable Care Act (ACA) is the partnership agreement it makes with states to expand Medicaid coverage to those adults earning below 133% of the Federal Poverty Level who are under 65 years old.⁸⁸ Today, 38 states and Washington, D.C. have fully expanded Medicaid as it was outlined in the ACA. In states where Medicaid has not been expanded, such as Arkansas, ALICE Families continue to struggle to access affordable healthcare insurance as their income disqualifies them from the federal program.⁸⁹

The American Rescue Plan under President Biden in 2021 expanded Medicaid coverage and benefits in the remaining 12 states during the public health emergency for COVID-19 by temporarily removing the income cap of 400% of the FPL for federal subsidies.⁹⁰ Millions of people have enrolled in plans under these terms, but those benefits will need to be extended or codified into law to continue.

No Surprises Act / Price Transparency Rules: In 2020, President Trump signed the bipartisan No Surprises Act, which aimed to eliminate the problem of patients receiving exorbitant bills after seeking care at an in-network facility because a member of their care team was considered out-of-network.

The law aims to correct this problem by requiring such facilities to charge a rate for those out-of-network services that is equivalent to the median in-network rate in the region. The bill also contains new requirements for price transparency to allow patients to “shop around”

for care based on the expected cost and establishes rules that require charity care and financial assistance policies to be publicly accessible and well communicated to patients. This is especially important for nonprofit and government healthcare facilities which are required to provide and record their community benefit in exchange for preferential tax treatment.

Unfortunately, there have been several snags with the implementation of the No Surprises Act which have delayed relief for Americans across the country. Many providers have been slow to comply with the law, not all services that cause surprise bills are covered, and lawsuits have stalled or struck down parts of the legislation, such as the process to determine what the negotiated price should be for out-of-network care.⁹¹

An example of a lawsuit is one filed by acute-care surgeon Daniel Haller that this legislation is unconstitutional since it prevents him from billing patients directly for any “balance of fair value” of his services. Ryan Marino, MD, Assistant Professor at Case Western Reserve University School of Medicine and an emergency care physician, also weighed in citing that the bill would negatively impact payments and hospital reimbursements.⁹²

Though one of the goals of the price transparency act was to encourage consumers to shop around for their healthcare services, many patients are not well equipped to utilize this information in a way that helps them save money. It is nearly impossible to shop for care in an emergency, and even in the case of a birth or planned surgery, a patient’s doctor may or may not have admitting privileges at the facility offering the lowest cost for the service.⁹³

Rather, the audiences most interested in published hospital prices and negotiated rates are insurance companies who now know what the hospital has negotiated with their competitor. An unintended result

is tremendous downward pressure on hospital pricing by insurance companies fighting for increasingly better deals for in-network care. Though at first this dynamic could help save consumers a lot of money on their medical bills, it is difficult to gauge what the long-term effect on patient liabilities will be.⁹³

Fair Debt Collection Practices Act (FDCPA): One of the most important laws for medical debt collections specifically is the Federal Fair Debt Collection Practices Act, which protects consumers from “false, deceptive or misleading representations.”⁹⁴ Under pressure to collect large sums from consumers who simply cannot afford to pay, debt collectors may harass patients with hundreds of phone calls, mislead the consumer about the balance owed, or intimidate patients by suggesting legal actions will be taken if they do not pay their debt, among other

deceitful tactics.⁹⁵ FDCPA (and its counterparts in 19 states and Washington D.C.) applies to contingency and debt-ownership collection agencies, but not internal hospital collections departments or the agencies they contract during the initial rounds of collections.⁹⁶ Consumers may submit collections complaints to the CFPB, the Federal Trade Commission, or their state attorney general, but unless a patient has the finances to pay a lawyer to sue the collector, there is not much else an individual can do to prevent this behavior.⁹⁷

Future legislative action at the federal level is largely on hold due to gridlock in Congress. With Midterm Elections on the horizon, and the debate about student debt forgiveness still boiling, medical debt forgiveness could become a topic of interest among politicians who wish to gain favor ahead of some very tough races.⁹⁸

Executive Branch Actions and Priorities:

In March and April of 2022, President Biden used a series of Executive Orders to direct federal agencies to make a series of changes that are intended to ease the burden of medical debt.

To help ease the burden of medical debt, in April 2022 the White House announced it would work with the IRS to fix a problem with the ACA commonly known as “The Family Glitch.” Due to the rise in high deductible plans—especially for family coverage—an estimated 5 million Americans were in a situation where their insurance was unaffordable, but they were also disqualified from tax credits that were intended to help because the single-person insurance offered through their employer was technically affordable. Proposed rule changes aim to address this glitch by offering premium tax credits for ACA coverage when family coverage offered by an employer is unaffordable as well. This change could offer a lifeline to families in this situation, especially those like ALICE Families who already live paycheck to paycheck and may now be able to afford health insurance.⁹⁹

The White House also announced a review of how medical debt is used to determine creditworthiness for programs across the federal government.¹⁰⁰ Key areas of consideration include:

- USDA will remove medical debt from consideration in mortgage and financing decisions for their rural home loan programs.
- OMB will review processes across the federal government to ensure medical debt is not considered in decisions about creditworthiness.
- CFPB will launch a public education campaign to educate consumers about their rights regarding debt collection and how to advocate for themselves, especially when disputing inaccurate information or reporting a bad actor.
- VA forgiving \$1.5 billion in medical debt for veterans accrued through the VA healthcare system and streamlining the process to apply for financial assistance and charity care. The VA separately announced it will stop reporting medical debt to the credit reporting agencies to limit its effect on veterans' credit scores.¹⁰¹

State Legislation

There are two types of state legislation initiatives attempting to address the medical debt dilemma.

The first concerns reforming medical debt collections practices and reinforcing ethical conduct within the industry.

These types of proposed rule changes are not intended to disrupt the overall payment system, but would make the process better for consumers. Some examples of State activities follow:

In **Washington**, Substitute HB 1531 & Substitute HB 1602, were passed and took effect in July 2019. These bills set a 9 percent prejudgment interest rate cap for medical debt and prevents collection agencies from viewing arrest warrants for actions related to medical debt. The bills also prohibit the sale of medical debt until at least 120 days after an initial billing statement.¹⁰²

In June 2022, **Colorado** passed HB22-1285, which prohibits a hospital from collecting medical debt if it is not in compliance with federal price transparency laws.¹⁰⁴

In **Nevada**, S.B. 248 was passed and was supposed to take effect in July 2021, but it has been held up in court over alleged conflicts with the Federal Fair Debt Collection Practices Act. The bill puts new requirements in place for communicating with patients and impedes collection agencies from taking any action to collect a medical debt during the mandated 60-day notification period.¹⁰³

North Carolina is working on HB 1039, the Medical Debt De-weaponization Act which is a bipartisan bill that would set new rules around charity care provisions and limit large medical facilities' power to charge unreasonable interest rates on medical debt. The state legislature is also considering HB 149 Expanding Access to Healthcare in North Carolina, which would expand Medicaid coverage to 500,000 to 600,000 additional people. The House has set a timeline of mid-December to vote on the Medicaid expansion proposal.¹⁰⁵

The second type of legislation is to ban the sale of all medical debt or alter the way medical debt may be collected.

Passed without a federal structure that allows hospitals to recoup costs in other ways, this type of legislation is very disruptive to the current healthcare payment system. Examples include

The **New Mexico** Patients Debt Collection Practices Act "prohibits collection actions against indigent patients (those making less than 200% of the FPL)." The bill also requires health care facilities "to offer to provide certain health insurance verification services to patients before seeking payment for medical care."¹⁰⁶

In **New Jersey**, the state legislature introduced A3802 which would prevent the reporting of medical debt to the national credit reporting agencies.¹⁰⁹

In May 2022, the **Vermont** Governor signed H287, which prohibits the sale of medical debt.^{107,108}

In **Virginia**, the governor recently **vetoed** HB 573 "Statute of limitations; Collection of medical debt," a bipartisan bill that would have shortened the statute of limitations on the collection of medical debt from five to three years.¹¹⁰

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21
3

Banning the sale of medical debt does not address the source of medical debt—underinsurance

FAIR DEBT COLLECTION PRACTICES ACT

While the sentiment behind the outright bans on the sale of medical debt is based in fairness and an understanding that the vast majority of medical debt is accrued involuntarily, the action is often met with vehement pushback from industry players for a variety of reasons. One of the most compelling is that the inability to sell medical debt could hurt hospital systems that operate on razor thin margins, if not at a loss.¹¹¹ Especially in small rural communities where there are few providers or where the hospital is the largest employer in town, the ability to sell medical debt at a reduced rate allows the hospital to recoup some of its costs.¹¹² Most importantly, banning the sale of medical debt does not address the source of medical debt—underinsurance. So even if the hospital cannot sell the debt to a third-party collection agency, medical debt can still accrue and cause problems for patients. Additionally, when hospitals are not reimbursed for hospital services and cannot recoup the costs via collections, the resulting losses may be rolled into the next year's price increases, contributing to rising healthcare costs for all patients. The net impact is that prohibiting non-performing asset sales will not help consumers, as collection activities will likely continue in spite of the "no sale" provision. Providers are the projected losers as they need to secure accelerated funds.

There is also a political breakdown as far as which states are more likely to pursue each pathway above.

Legislatures from conservative leaning states tend to pursue consumer protections but do not go as far as banning the sale of medical debt, whereas legislatures in more progressive states are more likely to pursue total bans. Today, two-thirds (**67%**) of states have codified the Federal Fair Debt Collection Practices Act, **29%** have passed additional consumer protection laws, **10%** have attempted outright bans on collecting medical debt, and **31%** have passed laws specifying charity care policies for hospitals in their state.¹¹³

Because the states regulate their own insurance markets, but operate within a federal system, the patchwork of laws and regulations is difficult to understand, and even more challenging to overhaul.

Medical debt is a massive and complex problem that affects millions of struggling Americans. Those encumbered by medical debt in collections are confronted with a host of challenges in dealing with insurers, healthcare providers and, ultimately, debt collection agencies. At the same time, this report has also examined the financial needs of providers along with the structure of the debt collections system to gain a more holistic understanding of the issue and how solutions can emerge. Key conclusions and implications along with specific recommendations follow.

CONCLUSIONS

Medical debt is hitting "ALICE" Families (Asset Limited; Income Constrained; Employed) particularly hard.

This cohort is often functionally uninsured and lives in a healthcare demilitarized zone above the poverty level yet unable to make ends meet. They are not equipped with enough income or assets to crawl out of debt easily. On top of the financial burden, those with medical debt exhibit worse physical and mental health and often neglect to purchase necessary medicine or postpone health visits in order to save money.

1

The medical debt system is a labyrinth that contributes to the problem.

Financially stressed ALICE Families often have multiple jobs and no time to combat the onslaught of insurance hurdles, lack of billing transparency, and confrontations with collections personnel. Until these issues are addressed, the medical debt problem will persist.

2

Underinsurance is the biggest problem facing medical debt holders.

Most amounts in collections are under \$500 which suggest out-of-pocket expenses are driving this problem. Even with some level of health insurance, rising healthcare premiums and deductible limits continue to put the ALICE Family at risk.

3

Current collections practices do not help consumers regain their financial footing.

"One-and-done" collection tactics and sometime legal threats only serve the needs of collection agencies. Few traditional players offer services that address BOTH medical debt and helping consumers regain financial health.

4

The financial health of healthcare providers is integral to solving medical debt.

Hospitals and providers must generate revenues in order to offer necessary services. They operate on very low profit margins which gives them little room to maneuver. If they lose too much revenue due to non-payment, these organizations run the risk of curtailing important services or closing their facilities, especially in rural locales.

5

Government is fully engaged in tackling the issue of medical debt.

The executive branch along with federal and state legislators have advanced laws and proposed legislation to reign in industry practices surrounding medical debt. Actions taken involve either reforming medical debt collections practices and reinforcing ethical conduct within the industry, or banning the sale of all medical debt and altering the way medical debt may be collected.

6

IMPLICATIONS

Instituting more affordable repayment plans over time would yield better results for both patients and healthcare providers.

Most consumers with medical debt in collections, especially ALICE Families, have difficulty making ends meet. Reduced payment terms over time would help them meet their obligations. Concurrently, healthcare providers would benefit from recovering more revenues to buttress their thin profit margins.

1

Collection agencies need to help patients get back on firm financial footing.

The traditional "one-and-done" model of collections under a commission arrangement can be abusive to consumers and yield less revenues to hospital systems and other providers. Working with patients to secure affordable repayments over time and helping them understand how to avoid future debt can nurse them back to financial health.

2

Collections companies must do more.

The collections industry needs leaders and best-in-class companies to continue cleaning up harmful practices in order to be viewed as part of the solution. Consideration should be given to eliminating pressure tactics, such as threats of legal action; implementing more affordable repayment plans; and helping patients regain access to credit.

3

Healthcare providers need to be more transparent.

Consumers need to be fully educated so that they can be informed about their financial exposure for treatments. Greater price transparency as well as a clearer picture of the patient's insurance status will help providers and their staff direct patients toward the right care plans as well as needed financial assistance, such as payment options or charity care.

4

Healthcare services will suffer if providers cannot recoup adequate medical debt.

Ensuring that healthcare providers can generate predictable revenues is a key piece to solving the medical debt puzzle. With their low margins, healthcare providers and hospitals run the risk of reducing services or closing if they are unable to recover delinquent revenues.

5

Most amounts in collections are under \$500 which suggest out-of-pocket expenses are driving this problem.



RECOMMENDATIONS

Solving America's medical debt crisis will require a holistic approach involving key interdependent players – healthcare providers and hospitals, patients, collection agencies, and policymakers.

1. Hospitals and Healthcare Providers

A. Guarantee transparency by continuing to improve pre-treatment education and disclosures detailing a menu of pricing and services. Information should be supplied in a simple-to-understand format.

B. Set tough standards for medical debt collection agencies to treat patients humanely and resolve payments affordably. This feature would be enhanced if endorsed and promoted by a credible industry association such as the American Hospital Association.

C. Work with private industry and the credit reporting agencies to bring technology to bear to:

- Foster patients' long-term financial wellness, including how to avoid future medical debt and become a better self-advocate
- Provide patients with more information so they can understand their obligation and how to determine the accuracy of amounts due
- Improve consumer access and comprehension of charity care

2. Collections Industry

A. The Collections industry must look to assist patients by helping consumers avoid future debts, providing solutions that help with building credit, and/or creating reasonable monthly payment options. Tactics, such as threatening legal action, placing liens on homes and garnishing wages that impinge on consumer rights and call regulatory and media attention to the industry, are archaic and will not solve the issues facing patients. Without aggressive self-regulation, the industry can expect harsher regulatory action that will recalibrate the way the industry operates.

B. The current collections system should morph into one that educates and assists debtors (i) to affordably reduce and eliminate the debt, and (ii) gain financial stability.

C. The collections industry needs to recognize the situation of ALICE patients and apply fairer terms to their medical debt. (The same goes for patients who should have qualified for charity care in the first place.)

- No lawsuits or wage garnishments
- Screen for additional charity coverage
- Eliminate charges over-and-above the original bill, including interest or fees of any kind
- Offer payment options based on the patient's ability to pay (For instance, payments based on a patient's income level)
- Eliminate the ability of NPA Acquisition companies to resell patient accounts.

D. Industry should provide easy-to-use tools and technology to achieve these goals; for example, electronic tools ("Apps") that:

- Serve as reminders to pay (versus collections calls)
- Provide flexible payment plans/options to accommodate different income levels, such as automatic withdrawal of fixed amounts or a percentage of monthly after-tax income
- Reinforce the benefits of paying
- Offer improved self-service options that empower and educate consumers.

3. Policymakers

A. Establish affordable payment solutions

- Since 40% of those with debt in collections are managing 2-5 collections accounts, any calculation must account for the total percentage of disposable income that can feasibly be paid back without jeopardizing the family's basic needs.

B. Regulators must not further diminish healthcare providers' ability to collect on medical debt. Hospitals and providers are at risk of losing significant amounts of reimbursement which would cause reductions in service and potential closures of necessary care and treatment facilities, especially in rural areas.

C. Examine ways to incentivize employers of ALICE workers to provide better and more comprehensive health insurance plans.

D. Government should consider ways to help ALICE Families contend with the repayment of their medical debt. These households reside just above the poverty line and receive little help to make ends meet. Any proposed actions could help alleviate financial strains from medical bills, such as unemployment or bankruptcy, but would also help ameliorate accompanying health conditions and their associated costs, such as stress linked to hypertension, which costs the nation \$131 billion to \$198 billion annually.

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