

# The Casualties of Medical Debt: Sicker Consumers and Sicker Hospitals



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**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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*Funding for this paper was provided by Capio.*







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# Executive Summary

**Medical debt is a widespread problem affecting both insured and uninsured adults. In our September 2022 report we highlighted how providers, collection agencies and government can start helping to address the problem. This paper builds on that premise and takes a more holistic viewpoint to identify and devise pragmatic policy and industry solutions to the medical debt crisis.**

Specifically, we will spotlight how a particular consumer cohort, the ALICE citizen – Asset Limited, Income Constrained, and Employed – is disproportionately overburdened with medical debt and has few resources and financial support avenues available to help her manage the challenge. We also examine the stressors on the U.S. healthcare system to assess their challenges in sustaining positive operating margins to avoid cutbacks in service or closures, especially at rural healthcare facilities. And we evaluate the benefits of expanding Medicaid in non-adopting states which tend to have high concentrations of medical debt.

Finally, we advance recommendations on how the insurance industry can help defray the creation of medical debt and we offer a new model for the debt collections industry, one which is beneficial for patients, healthcare providers and forward-looking collections firms.



# State of Medical Debt in America

Medical debt in America has reached staggering proportions, with estimates that range between \$88 billion and \$195 billion depending on how it is defined and calculated.<sup>1,2</sup> According to KFF (formerly The Kaiser Family Foundation), four in ten adults currently have debt due to medical or dental bills.<sup>3</sup> Even more disconcerting is that 58% of all third-party debt collection tradelines were for medical debt, making medical debt the most common debt collection item on credit records.<sup>4</sup>

The amount of medical debt held per individual has been calculated and researched by many agencies, media outlets and institutions. **KFF estimates that 23 million people in the U.S. owe a significant amount of medical debt (at least \$250) with 6% owing over \$1,000 in medical debt.**<sup>5</sup> **The Urban Institute, a nonprofit research organization, estimates the median amount of medical debt in collections nationwide is \$703.**<sup>6</sup> (Data from these two entities have been used as the basis for thousands of media articles over the last 12 months, together helping to establish a common understanding of how much medical debt exists in America.)

When medical bills go unpaid, hospitals and provider groups often send those patients to collections where the past due bills officially become medical debt. In this section, we discuss the macro and micro causes of medical debt,

why medical debt is fundamentally different from other forms of household debt, the magnitude of the problem, the pandemic's impact, and the geographical disparities of medical debt.

## Causes of medical debt

The causes of medical debt can be viewed in two broad categories: macro and micro. Macro causes are the overarching reasons that individuals incur debt in the first place, while micro causes are the specific circumstances or events that lead to expenses for which payment must be deferred.

### Macro causes

The broadest, most literal cause of medical debt is a lack of financial resources. The KFF Health Care Debt Survey found that about half of all adults – including three in 10 of those without health care debt – would not be able to pay a \$500 unexpected medical bill without borrowing money. Of those with current medical debt, two thirds (67%) said they had not paid or only partially paid a medical bill for the simple reason that they did not have the financial means to do so. And this financial strain is compounded for people who need to pay for not only their own care, but also for the care of family members. Almost half of adults with medical debt (46%) say it was caused not by their expenses alone, but either for someone else's expenses or for theirs in combination with someone else's.

Inadequate health insurance is also a significant and systemic cause of medical debt. For example, a U.S. News survey found a large majority of Americans with unpaid medical debt (81%) actually had health insurance when they received services but went into debt anyway, in part because their plan only covered a portion of the costs. The American Hospital Association cites the rise in high deductible health plans (HDHPs) as a major cause of medical debt.<sup>9</sup> The percentage of Americans with HDHPs is at an all-time high, with more than half (55.7%) of private-sector workers enrolled in these plans in 2021, an increase of 83.7% since 2013.<sup>10</sup> Residents of states that have not expanded their Medicaid programs are much more likely to have medical debt than those who live in states that have expanded Medicaid (47% vs. 39%, respectively).<sup>11</sup> And for older Americans, gaps in Medicare coverage can lead to debt.

### Micro causes

The KFF survey<sup>12</sup> finds that most people (72%) incur medical debt after experiencing a one-time or short-term incident, such as a hospital stay or treatment for an accident, while 27% of respondents had medical debt that accrued over time to treat a chronic illness, such as diabetes or cancer. Unaffordable dental care is also a major driver of medical debt.

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## Top Sources Of Bills That Led To Health Care Debt

1. Lab fees or diagnostic tests such as X-rays or MRIs (59% of respondents)
  2. Doctor visits (56%)
  3. Emergency care (50%)
  4. Dental care (49%)
  5. Hospitalization (35%)
  6. Prescription drugs (30%)
  7. Outpatient surgery (27%)
  8. Ambulance services (20%)
  9. Mental health services (20%)
  10. Pregnancy and childbirth (12%)
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## Comparison to other forms of debt

The most common debts carried by Americans are credit cards (\$5,221), auto loans (\$20,987), student loans (\$39,487) and mortgages (\$220,380).<sup>13</sup> Medical debt does not register in the top four forms of financial obligations. While medical debt is not the most common type of debt, as recently as 2021 it was the most prevalent form of debt in collections, more than credit cards, utilities, auto loans, and other sources combined.<sup>14</sup>

Medical debt is uniquely problematic because it is involuntary and often unavoidable. A person can choose to take on a car or a house loan they cannot afford, and one can choose to put expensive purchases on a credit card, but people do not choose to experience illnesses or medical emergencies. The timing of the expense is also singular. Whereas a consumer may have time to shop around for a good deal on a car, a patient does not have time to compare prices during a medical emergency. Even a proactive

patient who looks for in-network hospitals and providers ahead of time may be hit with a bill they cannot afford given the limited ability to predict the extent of a medical expense. The inability to plan for a medical bill or to shop for a better price in the moment are two of the many reasons why so many medical bills end up in collections compared to other forms of debt. Making matters worse, medical debt is often tied to a medical condition or injury that makes it more difficult for a patient to return to work, further reducing their ability to earn income and pay their bills.

## Trendline

The financial strain of medical care has increased. A record high number of Americans (38%) put off their healthcare needs due to cost in 2022, up 12 percentage points from 2021.<sup>15</sup> Nearly one-third (27%) of respondents in Gallup's annual survey said the medical treatment they postponed was for a very or somewhat serious condition.<sup>16</sup> The Federal Reserve's annual *Survey of Economic Well-Being of US Households* saw a year over year increase in forgone medical needs and procedures as well, with significant disparities by income.<sup>17</sup>

## Impact of COVID on Medical Debt

During the pandemic, extraordinary partnerships with insurance payers and measures taken by the U.S. Government allowed patients to seek the care they needed and hospital systems to treat them. These measures temporarily mitigated the medical debt problem by extending insurance coverage to those who would not have been able to afford it at the time they needed it most. However, the end of the COVID-19 public health emergency (PHE) on May 11, 2023<sup>18</sup> and winding down of associated federal funding will

have major ramifications for hospitals and patients alike. It likely will lead to increased financial strain on hospitals and increased medical debt for patients who stand to lose Medicaid coverage.

The number of people who will lose Medicaid coverage due to redetermination and disenrollment is uncertain; however, estimates range from 8% to 28% of those currently enrolled. If the number falls at the midpoint of that range (18%), it would equal 17 million people, which is consistent with an HHS estimate of 15 million who would lose their insurance. An estimated 6.8 million will likely still be eligible but unfortunately, many are not aware that in order to keep Medicaid, they will need to re-enroll.<sup>19</sup> One survey found most Medicaid recipients had heard nothing at all about the resumption of Medicaid renewals.<sup>20</sup> The result could be an increase in the share of people who lack coverage from 8.6% in 2021 up to 10.1% by 2033, leading hospitals to provide even more uncompensated care.<sup>21,22</sup>

Additionally, having the virus itself left many Americans with medical indebtedness. In a University of Michigan study, 46% of hospitalized patients reported a lower credit score six months after COVID-19 infection and 27% had medical debt sent to a collections agency.<sup>23</sup> The study did not establish causation but mentioned that others have linked COVID-19 infection to the short- and long-term ability to work and therefore make debt payments more difficult.<sup>24</sup>

### Medical Debt By State

Location is a major factor in the likelihood of a person accruing medical debt with Southern states and counties being hit the hardest in terms of larger amounts of medical debt, higher percentages of residents with medical debt in collections, and lower credit scores.

While new estimates of the volume of medical debt have not been published since our Inaugural Annual Report was released in September 2022, bipartisan think tank Urban Institute took the size conversation a step further by estimating the proportion of each U.S. county that likely carries medical debt in collections using 10 million accounts from a national credit bureau.<sup>25</sup>

The Urban Institute found that 99 of the 100 counties with the largest shares of adults unable to pay their medical bills are in the South, and 79 of these 100 counties with highest levels of medical debt are in states that have not expanded Medicaid under the Affordable Care Act (ACA).

Their research also reinforces medical debt's proposed status as a social determinant of health, finding strong correlations between a county's population health and medical debt in collections. In its executive summary of the county characteristics that predict medical debt, predictive factors include high rates of uninsured people, lower average household incomes, higher concentrations of Black and Hispanic populations, and higher chronic condition prevalence compared to the national average.

Residents of states that have not implemented Medicaid expansion are significantly more likely to have medical debt in collections and to owe greater

amounts than their counterparts in Expansion states. These states are concentrated in the South.<sup>26, 27</sup> Studying an overlap of the Urban Institute data on "Medical Debt in Collections by State"<sup>28</sup> and a KFF report<sup>29</sup> on the status of state Medicaid expansion decisions, individuals in the non-expansion states have median balances that are 50% higher than those in expansion states. The same analysis shows the **average median medical debt in collections is \$923 in non-expansion states compared to \$617 in expansion states.**

Analysis of proprietary data supplied by Capio, a non-performing asset acquirer, were consistent with the KFF report and confirmed that the average 2021 medical debt balance in states where Medicaid had not expanded was 56% higher than states which had. Additionally, while balances did increase in Medicaid expansion states by 36% from 2019 to 2021, the increases were three times higher in states not expanding Medicaid (+103%).

A 2023 Washington Post analysis found credit scores were also significantly lower in the U.S. South.<sup>30</sup> The average FICO credit score for individuals with credit cards in the southeast region of the U.S. ranges between 687.2 and 726.0. In contrast, the FICO averages for the upper northwest, Midwest, and Northeast regions range between 740.3 and 774.3.

In testing disparities in race, education, poverty, and health conditions, columnist at the Department of Data for *The Washington Post*, Andrew Van Dam, found comparable areas with similar problems still carried very different credit scores. Medicaid Expansion states, however, could explain much more of the difference. Guided by the research of Ray Kluender of Stanford University as well as research conducted by the Urban Institute, Van Dam emphasized their finding that medical debt, "concentrated in lower-income communities in states that did not expand Medicaid." Access to Medicaid coverage for low-income individuals and families decreased their total medical debt in collections by about \$1,140 after the program was expanded.<sup>32</sup> Access to quality health insurance also lags in the South, with the share of the population with health insurance ranging between 67.5 to 87.1% in most southern states, compared to above 87.1% in northern and midwestern states.

When taken together, it is clear that those who do not have access to Medicaid also may not have access to an affordable alternative, adding to their medical debt risk. Less affordable and more unpaid bills contributed to a worse credit history and worse credit scores in states where access to Medicaid was more limited.

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***"The region's poor credit means Southerners are paying more to borrow money, assuming they can qualify for loans at all. That sets them back in everything from car and home purchases to credit card rewards. Yes, even credit card rewards,"*** writes data analyst Andrew Van Dam.<sup>31</sup>

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# Patients are Getting Sicker

## Medical debt takes a toll on financial and physical health

Numerous studies document the sometimes damaging impact of high healthcare costs and medical debt on people's lives. In addition to impeding financial wellness and security, carrying debt has also been found to correlate with declines in both physical and mental health. People with debt may find themselves trapped in a vicious circle that starts with having to choose between paying medical bills and affording necessities like housing and food, with medical expenses typically falling to the bottom of the pile of bills. The resulting emotional strain can lead to feelings of hopelessness and despair and cause or exacerbate stress-related illnesses. Compounding the problem, when patients choose to forgo or delay needed care in an effort to avoid increasing the debt burden on themselves or their families, this can result in their illnesses being caught at more advanced stages when they are more difficult and expensive to treat. There is an urgent need for policy solutions to break this cycle.

## Financial health

From lower credit scores that make it difficult to obtain housing, auto loans, and sometimes even employment, to bankruptcies exacerbated by medical debt, the financial ramifications of medical debt are well documented by the Consumer Financial Protection

Bureau (CFPB) and others. In a survey conducted by U.S. News & World Report, 81% of respondents with medical debt shared that debt is holding them back from achieving other financial goals, such as repaying mortgages or credit card debt (32%), saving for a rainy day fund (28%), and buying or selling a home (15%).<sup>33</sup> As the next section will describe in more detail, the financial position of individuals with medical debt is also complicated and compounded by socioeconomic inequities.

Patients' precarious financial position makes them vulnerable to additional financial problems. Particularly problematic are medical credit cards for non-elective procedures and payment plans with deferred interest promotions that can push patients into even deeper debt. According to CFPB, the "typical medical credit card interest rate is 27%—substantially higher than the 16% average for general purpose credit cards."<sup>34</sup> With deferred interest, a patient pays zero interest if they pay their bill in full within a certain timeframe, often 12 months. The patients who need these financial products are often already financially vulnerable, which means oftentimes they cannot meet those terms. When patients cannot pay off the bill within the promotional period, all the accrued interest comes due at once. While different cards may have various terms, medical credit cards as a product category have a high probability of pushing a patient into deeper medical debt.<sup>35,36</sup>

In July 2023, the CFPB, U.S. Department of the Treasury, and U.S. Department of Health and Human Services (which oversees Medicare and Medicaid) launched a joint inquiry requesting information from the public about their experience with these deferred interest credit cards to better understand the hardships they cause. While ideally these financial instruments afford consumers an opportunity to pay their bills in smaller payments over time with zero interest, the reality is often quite different. For example, U.S. customers of CareCredit, a company owned by Synchrony Bank, spent \$3.7 billion on medical credit in the first three months of 2023 and had approximately \$12 billion in outstanding loans with the company. One quarter of CareCredit customers end up paying interest on their purchases.<sup>37</sup> In total, "Americans used specialty medical credit cards or loans with deferred interest periods to pay for almost \$23 billion in healthcare expenses for more than 17 million medical purchases from 2018 to 2020. They also paid \$1 billion in deferred interest."<sup>38</sup>

Medical credit cards are also concerning because patients can end up paying upfront for charges that are found later to be covered by insurance, inaccurate or eligible for charity care. Due to the complexities of hospital billing and insurance adjustments, often what is initially billed is not the same as what a patient ultimately is responsible

for. U.S. lawmakers have expressed concern about patients paying for services before the bill is settled and have asked the CFPB to find ways to ensure that medical credit is used only after insurance coverage has been determined and the patient has exhausted any available need-based financial aid.<sup>39</sup>

Even with their relatively lower interest rates, paying for medical services using conventional credit cards can be detrimental to consumers' financial health, especially in light of more consumer friendly practices adopted by the national consumer reporting agencies (NCRAs) and newly announced effort by the CFPB to remove all medical debt from credit reports.<sup>40, 41</sup> Patients lose those protections and others if they pay for medical expenses with a conventional credit card which, if delinquent, will appear on their credit report. In essence the medical debt is transformed into credit card debt, voiding any federal or state medical debt protections because credit card debt is governed by a different set of rules.

### Physical health

Medical care is essential for health and well-being, yet unpaid medical obligations prevent many people from seeking it. Sixty-nine percent of those with medical debt have avoided seeking medical care for financial reasons and four in 10 report they would not have gotten healthcare services if they had known upfront how much it would cost.<sup>42</sup> Among all Americans regardless of debt status, an annual Gallup survey found the percentage of Americans who put off medical treatment due to cost rose to a record high of 38% in 2022, with 27% saying the treatment was for a very or somewhat serious condition.<sup>43</sup>

In some cases, delaying care can be a matter of life and death. An American Cancer Society study found that cancer deaths were higher in U.S. counties where more residents had medical debt in collections as compared with people living in counties with less medical debt. A one percentage point increase in a county's population with medical debt was associated with a 1.12-point increase in death rates from cancer per 100,000 person-years, and each \$100 increase in average debt was associated with a 0.86 increase in death rates from cancer per 100,000 person-years. The association was seen for all cancers combined, as well as the five major cancer types of lung, colorectal, pancreas, prostate for men, and breast for women.<sup>44</sup>

While the numbers create a compelling picture, it is the personal experiences of individual patients that bring the challenges to life. The chief scientific officer for the American Cancer Society, Dr. William Dahut, says that once patients begin accumulating medical debt, they may decide to opt out of treatment for the sake of their families. "They have a cancer diagnosis, and they don't want to leave their family destitute because of their cancer diagnosis."<sup>45</sup>

Yet delaying care does not necessarily prevent additional costs, especially for those managing chronic conditions.<sup>46</sup> For example, diabetes patients already have higher medical expenses than the average person without the disease due to the frequency of appointments and medications needed to manage their condition. But patients who alter their medication regimen to save on costs may inadvertently worsen their conditions leading to emergency room visits that are much more expensive to treat than the amount saved by not

taking a medication dose.<sup>47</sup> As part of their investigation into medical debt, NPR merged data from the Urban Institute about medical debt in collections with the CDC's list of counties with high prevalence of diabetes (644 counties, mostly located in the South)... "And of those counties, NPR found that more than half have high levels of medical debt. That means at least 1 in 5 people have medical debt in collections."<sup>48</sup>

There is also evidence that medical debt in collections is connected to the prevalence of chronic health conditions, including obesity and diabetes. The Urban Institute highlights that the single most important predictor of a county's share of medical debt in collections is the percentage of the Medicare population with six or more chronic health conditions.<sup>49</sup> Patients with chronic health conditions require more medical resources and touchpoints than patients who are free of these burdens, leading to significantly different levels of medical expenses. This is one of many reasons why researchers in the *Journal of the American Medical Association* suggest that medical debt should be considered a social determinant of health.<sup>50</sup>



**Table 1: Comparing Top Medical Debt Counties with Obesity Rates**

County	Share with Medical Debt in Collections	Obesity Rate
Lenoir County, NC	43.8%	40.6%
Greene County, NC	43.8%	38.7%
Haskell County, TX	42.9%	37.1%
Anson County, NC	42.8%	40.0%
Harmon County, OK	42.1%	40.7%
Pecos County, TX	41.6%	39.5%
Tyrrell County, NC	39.8%	38.7%
Greer County, OK	39.7%	42.4%
Baker County, GE	39.2%	42.8%
Nolan County, TX	39.1%	39.9%
Average (US)	15.4%	32.0%
Average (Top 10 Counties % Med Debt in Collections)	41.5%	40.0%
Source	Urban Institute 2022	RWJF County Health Rankings 2021 <sup>51</sup>

**As illustrated in Table 1, the top ten counties with medical debt in collections exhibit average obesity rates well above the total U.S., +8.0 percentage points higher than the national average.**

The link between medical debt in collections and higher obesity rates also manifests by U.S. census region. Per the Urban Institute analysis, 99 out of the 100 counties with the largest shares of adults unable to pay their medical bills are located in the South—including 34 in Texas, 20 in Georgia, 12 in North Carolina, and 11 in South Carolina. This compares to 44 out of 50 states with the highest rates of obesity as being in the South.<sup>52</sup>

A study published in the American Journal of Preventive Medicine found significant relationships between obesity and multiple types of financial stressors, including property debt, unsecured debt, and bankruptcy. Property debt and unsecured debt increased the odds of obesity by 29% and 20%, respectively, and bankruptcy increased the odds of obesity by 43%.<sup>53</sup>

#### **Mental health**

A recent survey<sup>54</sup> found that nine out of 10 Americans with unpaid medical debt report being at least somewhat stressed about repaying it, with nearly a quarter (23%) being “extremely” stressed. Stress levels are even higher among the 44% of survey respondents

battling long-term or chronic illnesses, with more than half (54%) saying they are “very” or “extremely” stressed about repaying their medical debt.

In 2022, the CFPB noted that “People with debt have triple the incidence of mental health conditions such as anxiety, stress, or depression.”<sup>55</sup> The CFPB also cited a 2021 study in the Journal of Clinical Psychiatry which found that debt burden is strongly associated with increased likelihood of suicide attempt. A survey conducted by HPS/PayMedix found that medical debt related stress is most prominent among younger generations, people of color, and those with a credit score of 669 or lower.<sup>56</sup>

# Essential Workers Hit Hardest by Medical Debt

## *The ALICE Consumer's Plight*

Anyone can be hit with an expensive and unexpected medical bill at the wrong time, leading to medical debt. While poor health is related to systemic inequities and is thus more concentrated in some communities than others, diseases like cancer, tragic accidents, and other unanticipated events can happen to anyone. That said, the burden of the cost is unevenly distributed and weighs most heavily on those who can least afford to pay.

In our first report published September 2022, we introduced the ALICE consumer—household breadwinner(s) whose **A**ssets are **L**imited, **I**ncome is **C**onstrained, and is **E**mployed at one or more jobs.<sup>57</sup> This concept was developed by the United Way of Northern New Jersey and has been used across the country to shed light on a group of consumers who are struggling to make ends meet but are concurrently not eligible for typical financial assistance programs. In pandemic terms, this person was often considered an “essential worker” -- ALICE consumers commonly work in lower-earning service jobs such as waitressing, janitorial services, rideshare, factory line workers, truck driving, and certain healthcare positions.<sup>58</sup> As stated by United for ALICE, “these workers often struggle to keep their own households from

financial ruin, while keeping our local communities running.”

Medical debt is a particular challenge for the ALICE consumer because he/she does not have enough savings to pay for an unexpected and/or exorbitant medical bill, but is typically ineligible for charity care. Payment plans may be available for the full amount, but the monthly payments are difficult to manage for a household running paycheck to paycheck.

Last year we suggested that **addressing medical debt and making healthcare more affordable for ALICE families could be a key to fixing the entire system.** This year we have taken this proposition a step further by analyzing proprietary industry data to show the actual burden of medical debt for ALICE families and how that debt impacts the financial position of hospitals across the country.

Our hypothesis is that medical debt is making *both* patients and hospitals “sicker,” particularly financially. Our analysis of 80,000 patient collection accounts shows that, among all consumer cohorts, ALICE patients have the highest burden of medical debt in collections and their hardship is only getting worse.

### **Methodology**

Account data was provided by Capio to analyze the impact of medical debt on consumers across different levels of income. The data supplied was aggregated to maintain confidentiality and to preserve the proprietary nature of the information.

Critical to our analysis was to determine which income cohorts are most burdened by medical debt, with an emphasis on learning more specifics about the ALICE consumer. For our evaluation, we utilized a county-by-county analysis used by United for ALICE that compares the actual cost of living on an established ALICE Survival Budget per county vs. household income to determine a household's true ability to make ends meet.<sup>59</sup> (United for ALICE is a coalition of nonprofits, foundations, and corporate partners in 24 states led by United Way of Northern New Jersey, dedicated to advancing a more comprehensive measurement of financial hardship and solutions that promote financial stability at local, state, and national levels.<sup>60</sup>)

**Table 2: Demographic Breakdowns**

Status	Household Income Range	FPL (Family of 4)
Poverty	\$0 to \$30,000	Up to 100% FPL
ALICE 1	\$30,001 to \$41,400	100% to 138%
ALICE 2	\$41,401 to \$60,000	138% to 200%
ALICE 3	\$60,001 to \$75,000	200% to 250%
Middle Class	\$75,001 to \$120,00	250% to 400%
Wealthy	Greater than \$120,000	More than 400%

**Table 2 shows how we categorized our data into six income cohorts based on their relation to the federal poverty level (FPL) for a family of four.**

We selected these specific income breaks given their relationship to the Affordable Care Act (ACA), our data analysis findings, and a statistical cluster analysis.

- **Poverty** is aligned with the standard federal poverty guidelines, based on a family of four, because this is a benchmark for standard Medicaid eligibility as well as other public subsidies that augment household finances.
- **ALICE 1** begins at 100% FPL and ends at 138% because families earning up to 138% FPL are eligible for Medicaid in states that expanded the program under the ACA.<sup>61</sup>
- **ALICE 2** begins at 138% FPL and ends at 200%FPL. This upper threshold (200%FPL) was selected as a logical breaking point between those earning wages closer to poverty and those earning wages that are closer to middle class. Because the FPL does not adjust based on geographic location, this

break also helps us understand the behavior and debt profiles of different consumers within ALICE as they might relate to areas with a lower or higher cost of living. A statistical cluster analysis of the patient account data also leads us to believe the \$60,000 threshold is a meaningful one.

- **ALICE 3** begins at 200%FPL and ends at 250%FPL because the data analysis shows stark differences in behavior and attitudes at \$75,000 of household income.<sup>62</sup>
- **Middle Class** begins at 250%FPL and ends at 400% because our analysis of 2022 survey data regarding individuals with medical debt<sup>63</sup> showed that individuals with incomes above \$75,000 were more secure in their finances and more trusting of financial institutions. At 400% FPL, families are no longer eligible for tax credits to help them afford health insurance purchased from the Health Insurance Marketplace.<sup>64</sup>
- **Wealthy** households made up a small percentage of the study, and account for all households earning more than 400%FPL.

A key element of the ALICE definition is that ALICE is employed so we narrowed the sample to only those who are employed to ensure a fair comparison to the United for ALICE methodology. Out of 80,000 patient accounts, 52,497 (66%) had an employer listed (and were not deemed retired, disabled or otherwise unemployed).

Further, each patient's zip code was used to estimate their approximate disposable income for analysis.

### Key Findings

Analysis of actual medical debt current balances across the country revealed the following key points:

**1)** The vast majority of patient accounts evaluated (nearly 70%) proved to be ALICE consumers.

**2)** ALICE patients are saddled with the worst medical debt problem, especially ALICE households at the lower end of the cohort income definition.

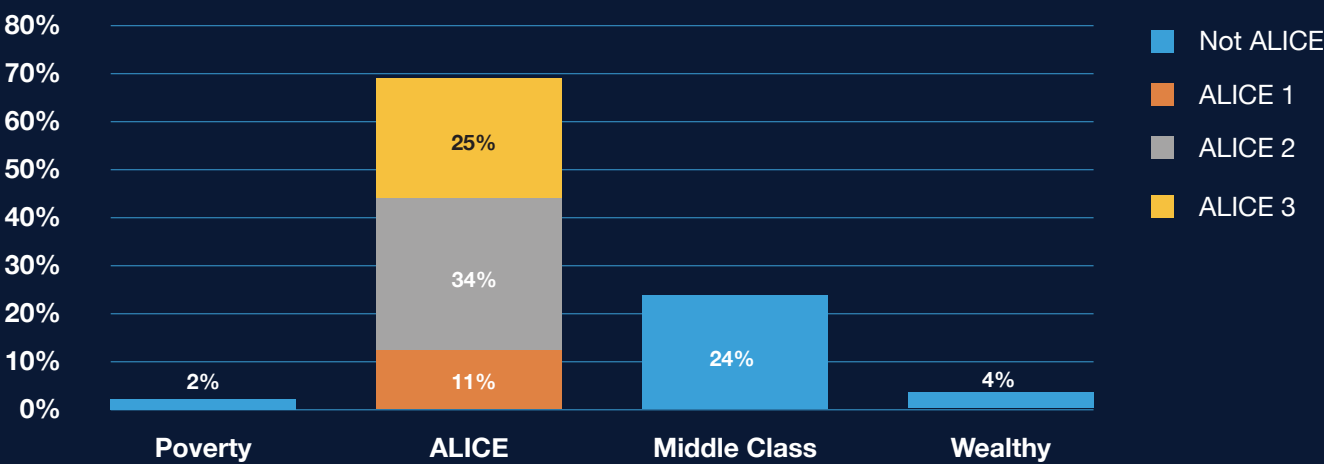
**3)** Underinsurance is a major driver of medical debt. Counterintuitively, eighty-five percent of patient records analyzed listed an insurance provider signifying some level of healthcare coverage. While purchasing healthcare insurance is perceived to drastically reduce the risk of medical debt, a significant portion of those with medical debt end up being underinsured. This explains why patients are often surprised to find that not only is their bill unaffordable, but accurate.

**4)** Medical debt owed by those who can least afford it is unlikely to ever be paid back, generating enormous financial gaps for hospitals that seem inconsistent with their continued operations. (See section titled Hospitals Are Getting Sicker)

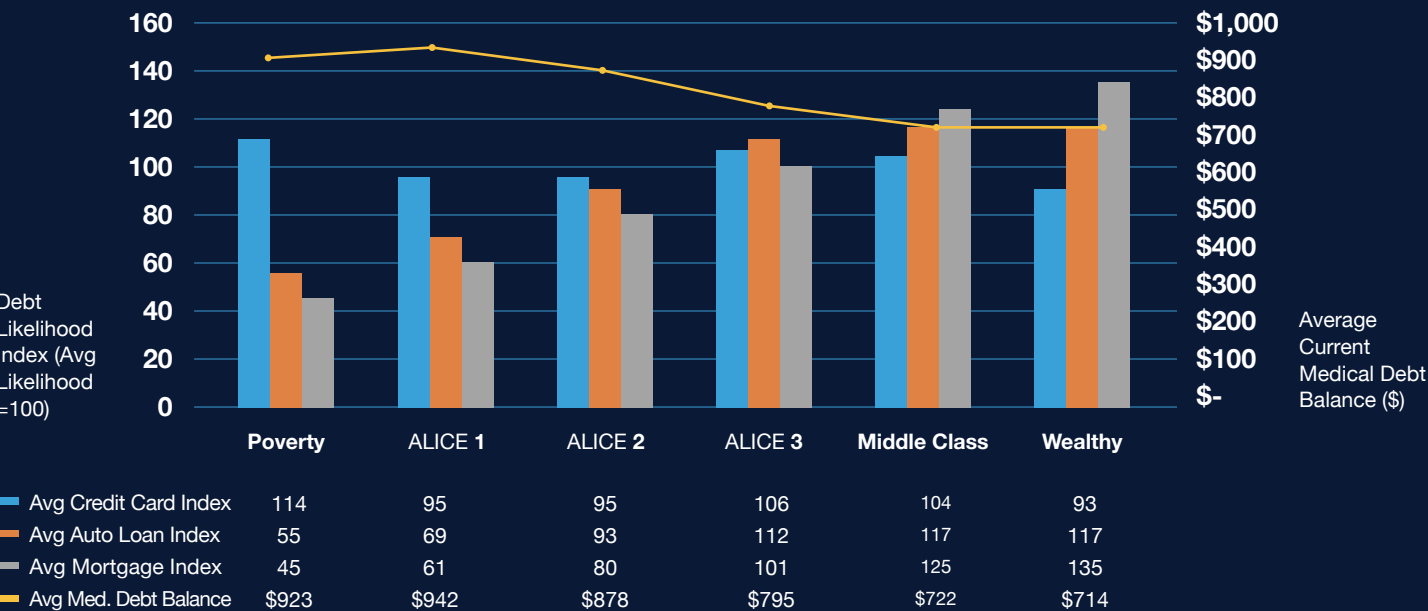
A detailed discussion of key findings follows.



# Exhibit A: Patient Accounts by Income Segment



# Exhibit B: Projected Debt Profiles of Patients with Medical Debt in Collections



Index Definition: Likelihood compared to the U.S. average that the guarantor has at least one mortgage, auto loan or credit card. (A score of "100" represents the average U.S. consumer).

### 1) Most accounts in collections are ALICE consumers

Of the confirmed employed patients, **70% earn a household income that places them in an ALICE income bracket** (Exhibit A). In a world where the poor often qualify to receive charity care and middle class and wealthy households are expected to have available savings for unexpected events, ALICE households get little relief and are carrying a disproportionate share of the medical debt burden.

The data confirmed that ALICE is asset-limited and, thus, have few tangible assets to be able to build wealth and climb out of their current financial situation.<sup>65</sup> Our research finds that this assumption holds for patients whose medical debt is in collections as well. Exhibit B measures the likelihood of an individual to have a credit card, mortgage or auto loan compared to the average U.S. consumer.

The data demonstrates ALICE's limited access to credit due to her household's

limited assets. As income falls, patients are less likely to carry a mortgage or auto loan and are significantly more likely to carry at least one credit card.

**ALICE Level 1 is 38% more likely to have a credit card than an auto loan and 56% more likely to have a credit card than a mortgage.**

This trend indicates that ALICE households may be approved for revolving debt but do not have the creditworthiness to secure access to assets that will help them generate wealth. Homes accrue value over time and vehicles help families maintain stable employment and income. In contrast, credit cards are increasingly used to pay for daily living expenses and carry considerably higher interest rates, eating away at household income. The Federal Reserve's monthly report on consumer credit shows the average APR for all credit card accounts is 20.68%<sup>66</sup> while the average interest rate on a 30-year fixed mortgage as of September 30, 2023 is 7.31% per The Federal Reserve Bank of St. Louis.<sup>67</sup>

In the media, politicians and reporters often repeat the statement that medical debt is a “leading cause” of bankruptcy in the U.S. A New England Journal of Medicine study suggests these claims may be overstated.<sup>68</sup> According to Carlos Dobkin and his colleagues, while “medical expenses do cause bankruptcies in the United States, they may cause far fewer than have been claimed.”

Reinforcing Dobkin's conclusions, while the indices to the left suggest patients with medical debt in collections are juggling multiple types of debt, less than half a percent (0.2%, N=164) of the patients in our analyzed database are listed as having experienced bankruptcy for any reason. Rather than medical debt being a “leading cause” of bankruptcy, our data suggests unaffordable medical expenses pile on to existing financial challenges—such as those caused by mounting credit card debt, or a loss of income caused by a medical emergency or injury.



## 2) Medical Debt affects ALICE consumers the most...and is getting worse

ALICE consumers have higher debt than those in the middle or wealthy classes, almost certainly due to their constrained incomes and limited assets. **When all ALICE patients are averaged together, they hold an average of \$871 in medical debt.** This means the average ALICE consumer owes 26% more than those in the middle class and 28% more than a wealthy consumer.

ALICE Level 1 has the highest medical debt of any group, indicating that earning an income just above the poverty line is the worst financial position to be in—being nearly as poor as those in poverty with none of the public supports (Exhibit C).

There is strong evidence that medical debt is getting worse for ALICE consumers. Medical debt balances **increased** across all income cohorts from 2019 to 2020. However, coming out of the first year of the Covid pandemic, from 2020 to 2021, medical debt decreased for those in poverty, the middle class, and the wealthy, but increased for all three ALICE cohorts (by about 20%), indicating an unfavorable shift in the health care payment ecosystem for ALICE patients.

## 3) Underinsurance is exacerbating the medical debt problem

The quality of a household's health insurance coverage drives the amount a patient is charged for a service as well as their final bill amount. These factors, combined with the patient's financial position, determine the current medical debt balance.

From 2018 to 2021, **85.3%** of all patients with medical debt in collections analyzed had at least one form of health insurance. Insured patients in our study clearly had enough health coverage to get their total charges reduced, but not enough to prevent them from being sent to collections, indicating that most individuals with medical debt in collections are **under-insured**.

Another **14.2% of all patients** in the database **were totally uninsured**. According to the CDC, that is **double the uninsurance rate for all U.S. adults (7.7%).<sup>69</sup> Therefore, households without health insurance are at twice the risk of incurring medical debt.** This helps explain why medical debt is so much higher in states that did not expand Medicaid. Without a federal mandate and without the funds to pay their premiums, some households simply go without coverage.

Again, the ALICE framework plays a helpful role. In 2021, the lowest income cohorts (poverty, ALICE 1, and ALICE 2 households) were much less likely to have access to health insurance than their counterparts (see Table 4). They also lost ground from 2018 to 2021 despite seven additional states adopting Medicaid Expansion in the same time period, a policy change targeted at ALICE 1 (Idaho, Maine, Missouri, Nebraska, Oklahoma, Utah, Virginia).<sup>70</sup>

Thus, it is not surprising that the total sum of current medical debt for accounts in our study increased 7.9%, from \$10.3 million in 2018 to \$11.2 million in 2021.

## The least likely to pay end up paying more

Uninsured patients are not only more likely to incur medical debt, but the balance is typically higher because there is no insurance company to relieve the burden. The average total charge for uninsured patients in our study after all adjustments made by the hospital was \$4,490. With an average current medical debt balance of \$1,600, uninsured patients are expected to pay 36% of their total charge compared to just 11% for insured patients (Table 5).

Making matters worse, the uninsured patient's cost burden worsened in each year of the study. As shown in Exhibit D, from 2018 to 2021, the ratio of "debt balance to total charges" jumped 19 percentage points for those without insurance, while staying consistent year-over-year for the insured.

**Even when ALICE patients are insured, their medical debt balance is the highest compared to all other income cohorts (see Exhibit E).**



# Exhibit C: Average Current Medical Debt Balance

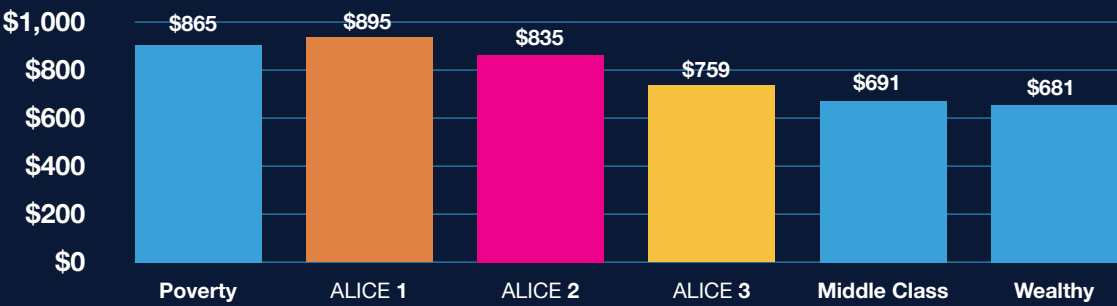


Table 3: Change in Average Current Medical Debt Balance Year over Year

Income Cohort	2019 to 2020	2020 to 2021
Poverty	+135.3%	-22.7%
ALICE	+32.0%	+20.8%
Middle Class	+37.5%	-1.5%
Wealthy	+71.0%	-22.6%
N=52,497		

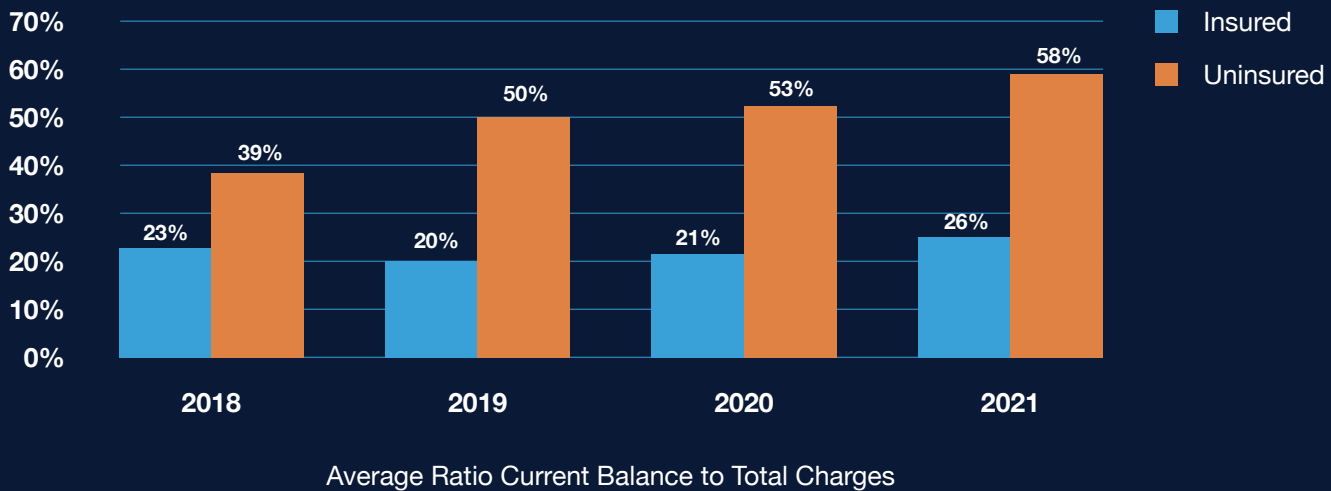
Table 4: Insurance Coverage

Income Cohort	Total Uninsured Accounts	% Change in Insurance Coverage 2018-2021
Poverty	15.8%	-5.9%
ALICE 1	14.1%	-1.9%
ALICE 2	11.1%	-0.8%
ALICE 3	8.8%	+2.2%
Middle Class	8.3%	+2.5%
Wealthy	7.9%	+5.5%

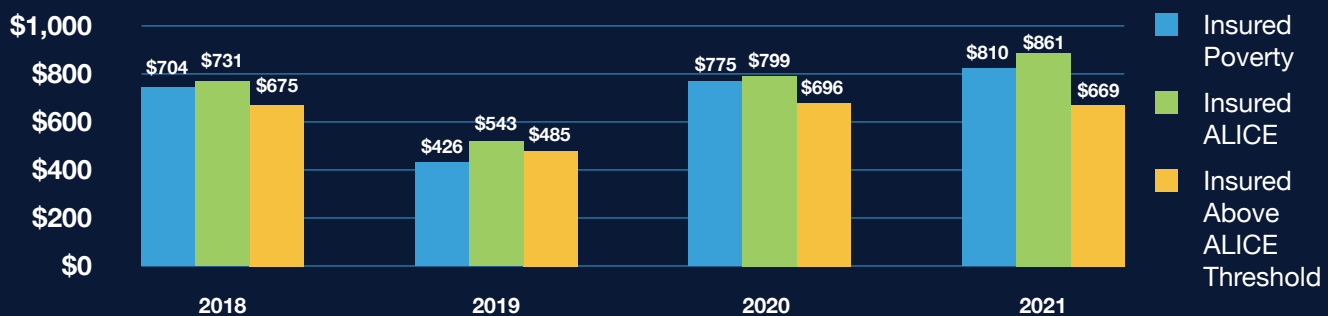
Table 5: Ratio of Medical Debt Balance to Total Charge by Insurance Status

	Avg Current Med. Debt Balance	Avg Total Charges	Ratio: Debt Balance to Total Charge
Insured	\$681	\$6,225	11%
Uninsured	\$1,600	\$4,490	36%

## Exhibit D: Average Current Medical Debt Balance to Total Charges



## Exhibit E: Insured ALICE Medical Debt Balances Higher than other Cohorts



# Hospitals Are Getting Sicker

## Increasing Bad Debt

Major hospital systems regularly cite as a business risk factor that any increase in the volume of uninsured patients or deterioration in the collectability of uninsured accounts receivable could adversely affect their cash flows and results of operations. According to a Crowe Revenue Cycle Analytics report published last year, total patient statements with balances of more than \$7,500 have more than tripled from 5.2% in 2018 to 17.7% in 2021.<sup>71</sup> The report highlighted that collectability on self-pay patient accounts dropped significantly when the out-of-pocket expenses exceed \$7,500. As a result, hospitals reported higher bad debt write-offs associated with patient balances that are deemed uncollectible after significant collection efforts by the provider. In fact, 2021 was the first time self-pay-after-insurance accounts were the leading source of bad debt, accounting for 57.6% of patient bad debt compared to 11.1% in 2018. The research also revealed that the percentage of patients with health insurance who paid their out-of-pocket bill dropped sharply from 76.0% in 2020 to 54.8% in 2021.

## Pressures on Operating Margins

A report by the American Hospital Association finds that increasing costs for labor, supplies and drugs, continued workforce shortages, and

sicker patients and longer hospital stays, are threatening patients' access to care.<sup>72</sup> The April 2023 report<sup>73</sup> says that between 2019 and 2022, hospitals experienced:

- *"A 17.5% increase in overall hospital expenses, outpacing Medicare reimbursement, which increased only 7.5% during the same period.*
- *A 20.8% increase in labor costs, which on average account for about half of hospitals' total budget.*
- *A 19.7% increase in drug expenses per patient.*
- *An 18.5% increase in hospital supply expenses per patient, outpacing increases in inflation by nearly 30%.*
- *An 18% increase in purchased service expenses such as IT, environmental services and facilities, and food and nutrition services."*

Unnecessary prior authorization requirements and improper claim denials on the part of commercial insurers also have added significant costs, as they require the purchasing of new IT tools and the hiring of additional staff to manage the paperwork. Administrative costs make up nearly a third (31%) of total health care spending, 82% of which can be attributed to billing and insurance.<sup>74</sup>

Another pressure on hospitals is the

influx of patients with worse or more advanced health conditions, some of which is due to delayed care. Between 2019 and 2021, patient acuity as measured by the average length of stay was up nearly 10%.<sup>75</sup> Caring for sicker patients often requires more staff time, the use of more intensive treatments and higher cost drugs, as well as the need for more supplies and equipment.<sup>76</sup>

The nursing shortage has a uniquely negative impact on both patient care and hospital finances. According to a study by the National Council of State Boards of Nursing, approximately 100,000 Registered Nurses (RNs) left the workforce during the past two years due to stress, burnout and retirements, and another 610,388 reported they intend to leave by 2027.<sup>77</sup> A separate survey of 18,000 nurses found just 15% plan to stay in their current job, many of them pursuing travel nursing positions.<sup>78</sup> To fill the gaps created by the nursing shortage, many hospitals are forced to turn to higher cost contract staffing firms. The added overtime, training, recruitment, and administrative costs of maintaining nurses led to a 17% increase in nursing costs alone during the pandemic.<sup>79</sup>

## Financial Outlook

For hospitals already operating on razor-thin margins – a median of 0.0% year-to-date as of April 2023—the



loss of the additional federal funding that had been provided under the Public Health Emergency (PHE) could contribute to even worse financial performance.<sup>80</sup> Most notably, hospitals will lose the 6.2% increase in the Federal Medical Assistance Percentage (FMAP). The FMAP increase was put in place to incentivize states to keep individuals enrolled in Medicaid by temporarily removing the requirement to redetermine enrollees' eligibility and disenroll those who no longer qualified.<sup>81, 82</sup>

Financial experts expect the strain to continue for some time. Healthcare management consulting firm Kaufman Hall's Operating Margin Index shows that more than half of hospitals ended 2022 operating at a financial loss.<sup>83</sup> Beckers Hospital Review reported that Q1 2023 witnessed the most 1st quarter hospital bond defaults since 2011. Just a month before the PHE officially ended, "bonds of eight hospitals lapsed in impairment" compared to just one in Q1 2022.<sup>84</sup> Credit rating agencies have taken note of the financial strain that hospitals are under as well, with Moody's, Fitch, and S&P Global all predicting constrained margins and high expenses leading to continued operating losses for years to come.<sup>85, 86, 87</sup>

### **Hospital Closures, Conversions, and Acquisitions**

While large health systems may be able to withstand such financial strains, small community hospitals and rural hospitals whose patients are primarily low income likely cannot. Rural closures are particularly troubling because they increase the time it takes a patient to access their care. In 2020, the Government Accountability Office found "one-way travel time to health care services increased approximately 20

miles from 2012 to 2018 in communities with rural hospital closures."<sup>88</sup>

Since 2005, researchers at UNC Chapel Hill have documented 197 rural hospital closures and conversions, 52% which resulted in the end of health care services.<sup>89</sup> A 2022 study by the Bipartisan Policy Center of 2,176 rural hospitals found that 28% were experiencing 3 or more financial risk factors including negative total operating margins, negative operating margin on patient services alone, negative current net assets, and negative total net assets.<sup>90</sup>

A map of these 197 closures and conversions shows these closures and conversions are concentrated in the South where medical debt is significantly higher. It is possible that struggling hospitals are charging patients more to compensate for the uncompensated care they cannot afford to provide. Patients in turn cannot afford the higher rates, transforming their medical bills into debt.

Not all hospital closures result in the complete end of health care services. Some are converted to emergency hospitals without in-patient services and others may not offer in-patient services but continue to provide some primary care, skilled nursing care, and long-term care. Many small hospitals are often acquired by larger hospital systems (for example, UPMC in western Pennsylvania) or sold to private equity groups.

Nevertheless, consolidation and private equity purchases are controversial and their impact on healthcare delivery is mixed. Some research shows that these changes lead to reduced and more expensive care.<sup>91, 92, 93</sup> A systematic review in The BMJ Today illustrated that

private equity ownership was correlated with higher costs to patients or payers in nine of 12 studies and "none showed lower costs...Private equity ownership was also associated with mixed to harmful impacts on quality."<sup>94</sup>

The short-term incentives of private equity may have long-term impacts on the ability of acquired hospitals to meet patient needs. Research published in HealthAffairs in 2021 found that acquired hospitals tended to be concentrated in areas with high uninsurance rates and tended to increase their charge-to-cost ratios (mostly by reducing non-nursing staff).<sup>95</sup>

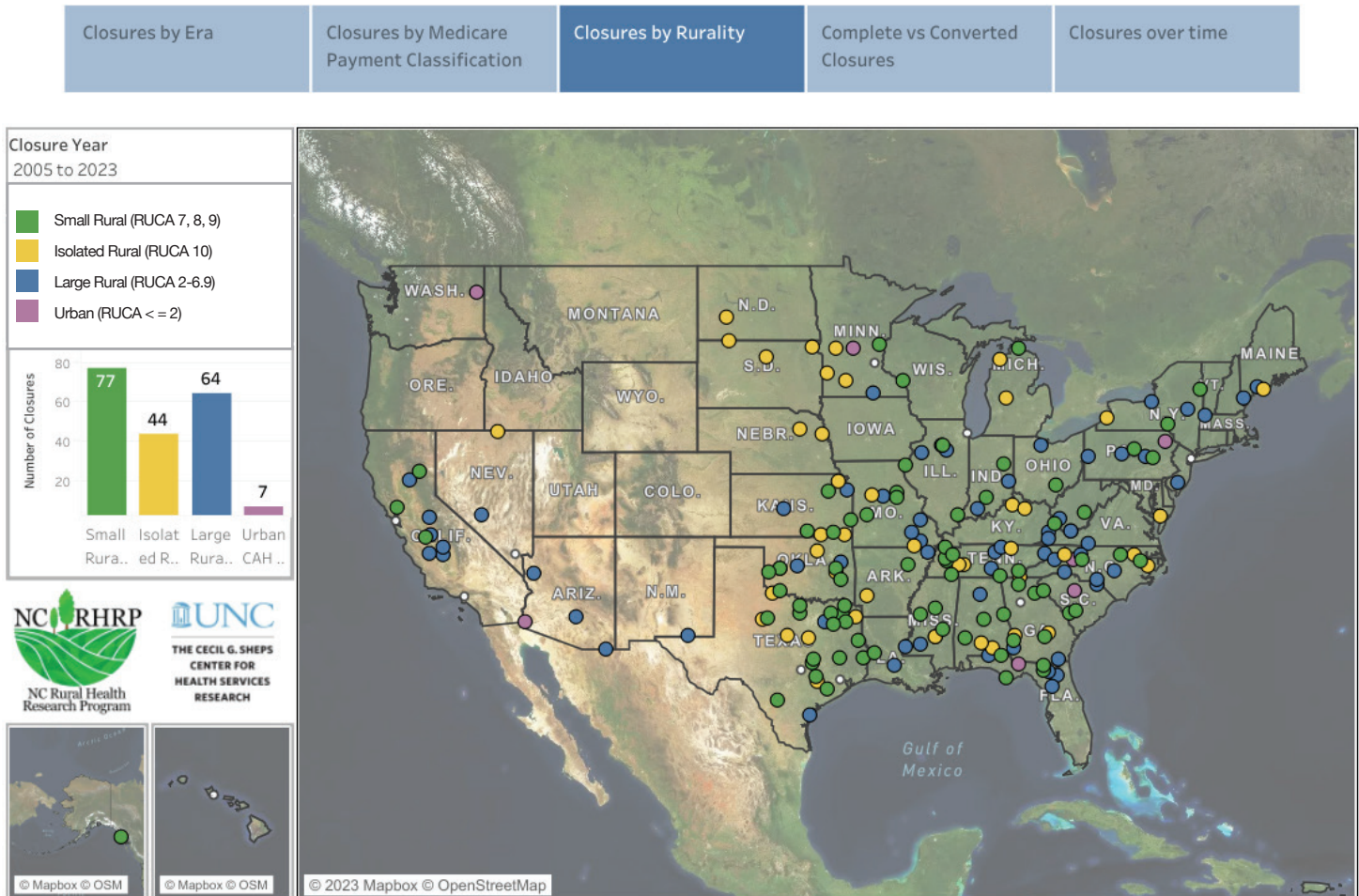
### **Critics Question Hospital Finances**

As hospitals work to navigate their tenuous financial positions, they also face intense skepticism and scrutiny from multiple third parties: 1) hospitals have been cited for prioritizing operational efficiencies at the expense of patient care, focusing on dollars and volume (fee for service) over quality of service (value-based care); 2) nonprofit hospitals have been called out for reaping more benefits from their tax-exempt status than they provide in community benefits;<sup>96</sup> and 3) in some instances, healthcare systems' financial hardships may be less of an operational issue and, instead, tied to investment losses.<sup>97</sup>

### **Pursuit of Operational Efficiency at Odds with Patient Care**

The new emphasis on speed and efficiency is captured in the concept of relative value units (R.V.U.), "a metric used to measure physician reimbursement that some feel rewards doctors for doing tests and procedures and discourages them from spending too much time on less remunerative functions, like listening and talking to patients."<sup>98</sup> The Texas Medical

## Rural Hospital Closures Maps, 2005 – Present



**Image Source:** Rural Hospital Closures Maps, 2005 – Present. NC Rural Health Research Program, UNC Sheps Center for Health Services Research. Chapel Hill, NC. <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

Association recommends using R.V.U.s to “measure physician productivity” as “one element in tracking a practice’s financial health.” Additionally, practices can utilize this standard unit as a justification for physician compensation or bonuses.<sup>99</sup>

Some extreme cases of profits over people have been singled out in the

last year by major media outlets. For example, Providence Health lost a major class action lawsuit alleging the health care system trained its representatives to pressure patients to pay their medical debt who should have qualified for charity care. A New York Times investigation led Allina Health to end a policy denying non-emergency care to patients with at least \$4,500

in medical debt. NBC News ran a high-profile story about Hospital Corporation of America (HCA), a for-profit hospital system accused of pushing patients toward hospice care to better manage their mortality rate and number of available beds.<sup>100</sup>

Ironically, these efforts to improve efficiency are not reducing costs. An analysis published in the

*Journal of the American Medical Association* supports this assertion, finding that even though the U.S. spends more on healthcare than any other country, approximately 25% of total healthcare spending is wasted, costing between \$760 billion and \$935 billion annually.<sup>101</sup> U.S. healthcare spending accounted for 18% of GDP in 2021, up from 5% in 1960, and during this same time period, patients' out-of-pocket spending rose at twice the rate of US GDP growth, totaling \$443 billion.<sup>102</sup>

### **Falling Short on Charity Care and Community Benefit**

Analyses from various entities claim that nonprofit hospitals derive more benefits from their tax-exempt status than they provide in community benefits, including charity care. For instance, the Lown Institute evaluated 1,773 nonprofit hospitals and found that 77% spent less on charity care and community investment than the estimated value of their tax breaks.<sup>103</sup> Hospital groups dismiss this argument, claiming to “deliver nine times the community benefit for every dollar of federal tax avoided.”<sup>104</sup>

The issue is in the definition of “community benefit.” IRS rules allow hospitals to include in their community benefit total Medicaid shortfall compensation, research spending, and training for medical professionals in addition to charity care. Consumer groups argue these indirect community benefits are not enough, essentially diverting hospital resources from what communities actually need--charity care, nutrition programs, mental and behavioral health services, and other direct service areas.<sup>105</sup>

### **Investment Losses**

In a piece entitled “What’s Behind Losses At Large Nonprofit Health Systems?”, policy experts affiliated with RAND Corporation and Johns Hopkins University reviewed quarterly financial statements from 10 large nonprofit hospital systems and found that average overall profit margin fell from 9% in 2021 to -6% in 2022.<sup>106</sup> It further found that patient care revenue increased by slightly less than 1% in relative terms from 2021 to 2022, while investment income declined by 185% during that same period. In their conclusion, researchers questioned why patients, employers and insurers should bear the brunt of increased healthcare costs when hospital losses are driven by “risky financial investments.” The American Hospital Association vehemently disagreed with the analysis,<sup>107</sup> pointing to many of the cost drivers explained above as the reason for hospital financial pain as well as bureaucratic glitches in the Medicare reimbursement process that prevent hospitals from being compensated for various elements of patient care.<sup>108</sup>

### **Is Medical Debt Causing Hospitals to “Get Sicker”?**

Unprecedented costs, poor reimbursement rates, and contradictory financial incentives have left hospitals and providers with operating margins more typical of grocery stores. Ashwini Kotwal, CEO of Arietis Health, a company that specializes in patient-centric, data-driven revenue cycle solutions, noted at our Annual Medical Debt Forum in 2022 that 15 years ago, outstanding balances represented 5% of revenues for most healthcare

providers and hospitals, whereas today that figure has jumped to 10 - 15%.<sup>109</sup> Some hospitals are barely scraping by despite their best efforts to promote efficiency, and still the quality of care is not demonstrably better. Meanwhile, major players draw negative attention to the industry as a whole for policies and investment strategies that may leave patients worse off both financially and physically. Therefore, the need to collect medical debt to recoup lost costs is a symptom of the problem rather than a driver; however, containing rising costs and filling gaps in reimbursements would address many of the levers that cause hospitals to pursue patient debt in the first place.



# Uncompensated Care Hits Bottom Lines Hard

On the hospital side, our data analysis demonstrates that hospitals and providers indeed incur enormous write-offs due to uncompensated care. What is less clear is how these institutions withstand the loss when payments from insurance and patients are inadequate and the sale of medical debt returns just pennies on the dollar compared to the total charges.

Twenty-eight healthcare systems were analyzed in our study. In addition to current debt balance, each account came with information about the patient's total charges, their insurance status, insurance and patient payment status, and adjustments made to the bill. We examined these values in aggregate to better understand the impact of uncompensated care on the operating budgets of the hospital and provider partners evaluated.

- **Total Charges (i.e., Revenue)** – The amount the hospital or provider deems should be charged for the service provided. For accounting purposes, this is the amount the hospital would like to capture.
- **Total Adjustments (i.e., Deductions)** – Contractual agreements with payers determine the amount that is allowed to be charged for the service provided. For accounting purposes these are considered deductions.
- **Total Charges Net of Adjustments**

– Total charges are reduced by the total adjustments to arrive at total charges net of adjustments. This value represents the “price” for the service provided that is expected from all payers.

- **Cash Inflows** – Payments from insurance companies, government payers like Medicare and Medicaid, and patient contributions are considered cash that can be used to support hospital/provider operations.
- **Hospital/Provider Uncompensated Revenue**
  - The value remaining on the balance sheet of the hospital systems after taking into account various contractual “adjustments,” payments made by insurance companies, and payments made by patients (either before or after the medical debt was sent to collections). This amount is designated as “revenue” for accounting purposes because the amounts have been charged, but they were not paid. Most of the uncompensated revenue amount will be written off as bad debt and removed from the hospital or provider’s balance sheet.

In this analysis it is also important to note that, with a few exceptions, the accounts in our sample do not include cases that should already have qualified

for charity care. The sample also excludes patients who are paying their medical bills on time. This means our analysis focuses primarily on patients who are uninsured or underinsured, or who have no access to traditional financial assistance.

Reviewing Table 6, for \$17 million in medical services provided (Total Charges), the average healthcare system is only allowed to charge patients and their insurance \$5 million, net of adjustments. For that \$5 million in potential revenue, the average hospital receives about \$1.6 million in cash payments to support their operations (9.3% of the initial estimated total charges and 31.6% of the allowable charges).

The remaining \$3.4 million is considered uncompensated revenue. This value can be sent to a third-party collections contingency agency to recoup some of the dollars or sold to a non-performing asset acquirer (medical debt buyer) and taken off the books completely. In the case of a nonprofit hospital system, this write-off can be recognized as “community benefit.” In the case of for-profit hospitals and providers, the write-off is considered a loss, which has its own tax implications.

## Table 6: Deriving Uncompensated Revenue

Average per System*	
Health Care Systems (28)	
Total Charges ( <i>i.e., Revenue</i> )	\$17,041,384
Total “Adjustments” ( <i>i.e., Deductions</i> )	\$12,009,797
Total Charges Net of “Adjustments” ( <i>i.e., Net Revenue</i> )	\$5,031,587
Cash Flow	
Insurance Payments	\$1,563,261
Patient Payments**	\$26,861
Total Cash Inflow	\$1,590,123
Hospital/Provider Uncompensated Revenue	\$3,441,464

\*Entity=Either Hospital or Provider

\*\*Most often occur before entity chooses to sell bad debt

### How can hospitals and providers afford to stay open?

Based on the above figures, **it would be difficult for any business to survive and grow when 68% of net revenues are uncompensated for.**

With such slim operating margins and such poor reimbursement rates from private and government payers, it is surprising how hospitals and medical providers stay in business at all.<sup>110</sup> And, because hospitals must serve all patients who come through their doors regardless of their ability to pay, the current model will face continued downward pressure.

**This suggests an inconvenient truth: that unless hospitals and healthcare providers can recoup a larger portion of uncompensated revenues, their ability to invest in equipment, provide necessary services and maintain rural facilities may be severely impaired.**

Major health care systems may be able to withstand these financial pressures better than the small, rural, and community hospitals. Large systems may be able to find other income sources to supplement their operating needs, such as creating their own financial and insurance products or investing in the capacity to perform nonemergency surgeries and procedures.<sup>111</sup>

But struggling healthcare systems, especially in small and rural communities, do not have the capital to take on the risk of a new venture and or investments in new medical equipment.<sup>112</sup> Media

coverage suggests that these systems are moving in the opposite direction to providing adequate patient care — cutting essential services to the bare bones, including the elimination of critical community resources, radiology/imaging services, inpatient care, and behavioral, psych, and drug addiction services.<sup>113, 114, 115</sup>

One way where progress might be made is presenting the discounted bill upfront along with a proposed payment plan. This would lessen the shock of receiving a demand for \$10,000 in the future. While hospital CFOs might object to the idea of adjusting a patient bill upfront for what they can afford to recoup some fixed costs, we question the logic of sending patients to collections for amounts they will never be able to pay back and that require additional hospital time and resources to collect.





# Role of Insurers

Central to the ongoing national debate over medical debt and how to resolve it is the complex U.S. health insurance ecosystem. On one side are payers, such as private health insurance plans and government programs, and on the other are healthcare providers such as hospitals and health systems. The two sides are often at odds over precisely what will be covered and the amount that will be reimbursed. Medicare and Medicaid reimbursement rates are set nationwide, giving hospitals no room to negotiate on care for those patients. Private health insurance plans and hospitals and providers go through cycles of negotiation, where a contracted amount is set until the next round of negotiations.<sup>116</sup> In both instances, hospitals can end up undercompensated for the services they provide as they assume the risk of fluctuations in labor and supply costs. As a result, patients can be left owing larger out-of-pocket costs than they expected or can afford when those price increases are passed on to them.

## Sources of Insurance

Broadly speaking, there are two types of health insurance: taxpayer-funded programs and privately-funded ones. Taxpayer-funded, or government programs, include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and VA healthcare for veterans. Privately-funded, or commercial programs, are typically sponsored by employers, but plans can also be purchased individually. Examples of private health insurance companies include Blue Cross Blue Shield, which

insures one in three Americans, non-Blues such as United Healthcare and others, Health Maintenance Organization plans (HMOs) and Preferred Provider Organization (PPO) programs.<sup>117</sup>

Approximately 160 million people are insured through employer-sponsored health plans but those who are not can get insurance through the Health Insurance Marketplace, also called the exchange, that was established as part of the Affordable Care Act.<sup>118</sup> The marketplace is an online platform that enables people to shop for and enroll in medical insurance programs. Many lower income individuals with ACA plans qualify for government subsidies and the platform is government-run, but the insurance itself is private.<sup>119</sup>

## High-Deductible Health Plans and Medical Debt

The IRS defines a high-deductible health plan (HDHP) as one with a deductible of at least \$1,400 for an individual or \$2,800 for a family, and yearly out-of-pocket expenses capped at \$7,050 for an individual or \$14,100 for a family.<sup>120</sup> Enrollment in HDHPs grew 43% from 2014 to 2019.<sup>121</sup>

While appealing to consumers because they offer lower monthly premiums, HDHPs become problematic when out-of-pocket costs rise beyond a patient's ability to pay. In a survey of 2,206 individuals, including 179 with employer sponsored HDHPs, half of those with HDHPs said they had received a surprise medical bill; more than a third (34%) said they had

been approached by a medical debt collection representative; and 44% said they had experienced financial hardship from bills. According to revenue cycle firm AKASA which commissioned the survey: "With high health insurance premiums, deductibles, and cost of care, patients are shouldering more of the financial burden of healthcare. This has led to increasing rates of bad debt for hospitals and health systems."<sup>122</sup>

Related to HDHPs, the American Hospital Association also points to the rise of short-term, limited-duration insurance (STLDI) (also known as "skinny" health plans) as a contributing factor to the rise of medical debt.<sup>123</sup> These plans are intended to be used between jobs or between retirement and Medicare age and are not subject to the patient protections within the ACA.<sup>124</sup> While their contribution to medical debt overall has not been quantified, The Biden Administration says many Americans chose to rely on them more heavily when access to these (usually cheaper plans) were expanded in 2018.<sup>125</sup>

## Uncompensated Care

The American Hospital Association analyzed hospital financial data to calculate the aggregate total of government insurance underpayment, which results when the cost of providing care, such as for personnel, technology and other goods and services, exceeds the amount paid to them by Medicare or Medicaid.

It found that in 2020, **hospitals received only 84 cents for every dollar spent caring for Medicare patients and 88 cents for every dollar spent caring for Medicaid patients.**<sup>126</sup>

Differences between private insurers and hospitals about which entity should bear the brunt of these costs are also creating chaos in some markets. While negotiating new reimbursement contracts, patients are often prevented from receiving in-network prices that they would normally be able to access with their insurance. UnitedHealthcare in particular has been in disputes with hospital systems in Arizona and Florida in 2023.<sup>127, 128</sup> At the time this paper is being written a similar skirmish is playing out in Virginia and Ohio between Bon Secours Mercy Health and Anthem Blue Cross Blue Shield in which case care for tens of thousands of patients could be disrupted.<sup>129</sup> These disruptions cause hardship for patients who need to either transfer their care to in-network providers, or pay higher costs for out-of-network care, thereby increasing their potential to incur medical debt.

### **Chargemaster Pricing Hurts the Uninsured**

Hospital chargemasters list the “sticker price” for a given item or service and are “essentially the health care market equivalent of [the] Manufacturer’s Suggested Retail Price (MSRP) in the car buying market.”<sup>130</sup>

Most healthcare consumers don’t pay these prices because they are represented by a payer, such as a commercial insurer that negotiates prices down on their behalf, or Medicare and Medicaid, which set their own rates regardless of what the hospital chargemaster says. While debate over chargemaster pricing continues, higher chargemaster markups are associated with higher hospital profitability.<sup>131</sup>

These rates are implicated in medical debt, however, because “the cruel irony of the chargemaster is that the uninsured are the most likely to be billed chargemaster rates because they are not represented by a payer.”<sup>132</sup> Recall, in our earlier data analysis, we found evidence that households with less income were 4-8% more likely to be uninsured than wealthier counterparts and thus more vulnerable to chargemaster pricing they cannot afford.

### **Insurer Profitability**

As the costs of quality insurance rise, health insurers have come under increasing criticism over the amount they charge consumers compared to their high levels of profitability. According to the 2022 Kaiser Family Foundation Employer Health Benefits Survey, individual coverage premiums rose 58 percent, from an annual average of \$5,049 in 2010 to \$7,911 in 2022. Over the same period, family coverage premiums rose more than 63 percent, from \$13,770 to \$22,463.<sup>133</sup>

At the same time, according to an analysis by Fierce Healthcare, the six largest healthcare insurance companies collectively generated a profit of \$40.9 billion in 2022, signaling that they have the wherewithal to make adjustments to their policy structures.<sup>134</sup>

### **Do Insurance Companies Have a Responsibility to Correct the Medical Debt Issue?**

Like hospitals, conflicting interests and financial incentives put insurance companies at the center of the medical debt debate. With the rise of high deductible health plans, the burden of all healthcare costs has shifted away from insurers and toward consumers via out-of-pocket costs, facility fees, and copays that their plans simply do not cover. As noted earlier, hospitals spend 82% of their administrative costs on hospital billing and following up with insurance companies for payments.<sup>135</sup> Insurers have captured more and more of the value within the U.S. healthcare payment system at the expense of patients and their finances yet are expected to contribute very little in the way of charity care. Given insurance companies’ huge profits in comparison to hospitals and their vast resources compared to patients, insurance companies need to be part of the solution for identifying patients who need financial assistance long before those expensive bills turn into debt.



# Legislative and Regulatory Environment Is Heating Up

## Federal Legislation

Medical debt affects families in every U.S. state and is governed by a tangled web of federal and state regulations. Given that private and government payers, as well as several large health care systems, are involved across state lines, there is a case to be made that federal intervention is required to slow the growth of medical debt.

On July 25, 2023, Senator Chris Murphy (D-CT) and Senator Mike Braun (R-IN) introduced *The Strengthening Consumer Protections and Medical Debt Transparency Act* to “put in place standard practices to make sure that health care entities communicate with consumers about any debt that is owed and require public reporting about medical debt collection practices.” The bill addresses a key problem: many, if not most, complaints about medical debt in collections submitted to the CFPB regard mistakes in billing and confusion about what insurance is supposed to cover on patients’ behalf.<sup>136</sup> This legislation would require the health care entity to wait until all insurance coverage appeals are resolved AND screen patients for financial assistance eligibility before sending their debt to collections. It also requires these entities to provide itemized bills and payment statements to the patient to clarify where the debt originated and how much is left to pay. The bill even provides some teeth to these measures,

making entities liable for patient actual damages, patient payments up to \$1,000, and patient attorney fees in the case of a successful class action suit, if they do not comply.<sup>137</sup>

## Changes by National Credit Reporting Agencies (NCRAs)

Beginning in 2022 and culminating on April 11, 2023, the three national credit reporting agencies (NCRAs) began rolling out a series of voluntary changes to how they handle medical debt reported to them by debt collection agencies. The first changes took effect on July 1, 2022 when Equifax, Experian and TransUnion removed from credit reports all medical collection debt balances that had been paid in full by the consumer.<sup>138</sup> Previously that debt may have stayed on the consumer’s credit report for seven years, even when it was paid.<sup>139</sup> NCRAs also delayed the reporting of the debt from six months after the first delinquency to one year after the first delinquency.<sup>140</sup> This means that medical debt that was less than a year old would not appear on a patient’s credit report, acknowledging that consumers needed more time to pay, dispute or negotiate their unpaid bill before it should be considered relevant to their creditworthiness.<sup>141</sup> Finally, in April 2023, the NCRAs removed all medical collections tradeline balances under \$500 from consumer credit reports.<sup>142</sup>

It is important to note that National Credit Reporting Agencies are private

companies providing a service to financial institutions across the country. They aggregate data from various sources to build credit reports and credit scores which are used to help those financial institutions determine the creditworthiness of consumers seeking loans and other financial products. While they are regulated by the CFPB, they do not serve consumers directly and the changes they have committed to are voluntary, rather than official laws or regulations. In the unlikely scenario NCRAs decide they no longer wish to support these policies; it is possible for these modifications to be reversed. This is why individual states have moved to institutionalize these changes within their own state laws to enshrine protections for consumers.

## Impact of NCRA changes

According to a joint press release published by the NCRAs, the recent changes have resulted in nearly 70 percent of the total medical collection debt tradelines being removed from consumer credit files.<sup>143</sup> Among an estimated 43 million Americans with “allegedly unpaid medical debts on their credit reports,” an analysis of CFBP data estimates that the NCRA changes will result in 22.8 million consumers having at least one medical collection tradeline removed from their credit reports and a 21 to 32 point increase in their credit scores in the first quarter after their last medical collection tradeline is removed.<sup>144, 145</sup>

One major criticism of these changes is that average medical debt balances are reported above \$500, which means that while many people will be helped, those who are left behind have the highest and most difficult to manage debt. An Urban Institute analysis finds that the median balance of medical debt in collections is above \$508 in 39 of 50 states and some of the most financially devastating medical debt burdens total thousands of dollars or more.<sup>146</sup>

Shortly before this paper was completed, Vice President Kamala Harris and Rohit Chopra, Director of the CFPB, announced a new rulemaking effort to remove all medical debt tradelines from consumer credit reports to prohibit such tradelines from impacting consumers' eligibility for credit.<sup>147</sup> Consumer advocates applaud the effort, but financial experts and hospital leaders are concerned about the unintended consequences. For one, the total removal of medical debt from credit reports might alleviate challenges associated with poor credit scores, but it does not eliminate the reality that patients are in need of care they cannot afford. Meanwhile, their credit scores will not accurately reflect their debt ratios, allowing those consumers to pursue additional debts they may not be able to afford. If instituted, these rules could also explode hospital deficits by drastically reducing the incentive to pay medical expenses at all or even carry health insurance, per The Editorial Board of The Wall Street Journal.<sup>148</sup>

### **Limited Impact of Price Transparency**

Federal hospital price transparency regulations and the No Surprises Act have been rolling out in phases since January 1, 2022.<sup>149</sup> Collectively, the rules intend to empower patients to shop around for the best prices for

non-emergency care and benefit from qualified payment amounts when receiving out of network care during an emergency.

The No Surprises Act requires hospitals to provide clear and accessible pricing information online for at least 300 shoppable services as well as costs for related items like outpatient visits, x-rays and lab tests.<sup>150</sup> In addition, the law requires providers, upon request, to provide individuals who are uninsured or who plan to self-pay for a planned service regardless of their insurance status with a Good Faith Estimate (GFE) of their reasonably expected cost.<sup>151</sup> Starting in 2024, health plan price comparison tools must include costs for all covered items and services, including prescription drugs.<sup>152</sup>

While these rules are intended to help patients, the data being shared is more likely to overwhelm and confuse them. Information is defined inconsistently, complicated to understand and interpret, and in some cases is not truly accessible without machine-learning technology or consumer-facing apps that distill the available figures.<sup>153</sup> Thus far, implementation is proving to be a challenge and results-to-date are mixed. Additionally, just because prices are transparent, it does not mean the resulting bills will be affordable or adjusted for what patients can pay.<sup>154</sup>

### **State Medical Debt Legislation**

While compliance with the federal price transparency rule is mandatory and the National Credit Reporting Agencies (NCRAs) have voluntarily modified their practices, lawmakers in more than a dozen states are taking additional actions to address medical debt and mitigate its impact on their residents.<sup>155</sup>

Much of the legislation of interest to the medical debt collections industry that has been passed or is under consideration falls into two general categories. One essentially codifies the changes in medical debt reporting voluntarily adopted by the NCRAs. The other category penalizes hospitals that fail to comply with federal price transparency rules, including by barring them from collecting on or selling medical debt. The resulting web of regulations makes it complicated and expensive for companies that operate across state lines to comply with the entire body of regulations they face, suggesting a national set of standards might offer a better alternative than a state-by-state approach for patients, hospitals, providers, and industry players alike.

Below we have included several examples of each type of law to demonstrate what has taken place since our 2022 report was published:

### **Provisions that would affect the credit reporting of medical debt:**

- Prohibiting credit reporting when medical debt is more than 7 years old (Colorado HB1126)
- Requiring an itemized bill be sent to the consumer before the medical debt may be reported (Colorado SB93)
- Prohibiting medical debt credit reporting unless the principle amount is \$50,000 or more (Massachusetts HB284/SB189)
- Removing medical debt from credit reports after 7 years have passed (Massachusetts HB3564)
- Outright bans on medical debt credit reporting (New York AB6275)
- Prohibiting nonprofit hospitals from engaging in "aggressive collections actions", which could include selling medical debt to a third party collection agency (Pennsylvania SM40369)



### Provisions that would tie debt collection or sales to compliance with federal price transparency laws:

- Medical debt cannot be sold unless the accounts have first been screened for charity (Florida HB1413)
- Out of network parity – if the creditor is not in compliance with NSA, this bill would prohibit the reporting of out of network charges to any credit agency if they are above what the in-network price would have been (Georgia SB20, signed by Governor 5/2/23)
- Hospitals must screen for public insurance and charity eligibility or enter the account into a payment plan prior to referring the account to a collections agency (Illinois HB2719, sent to Governor 6/16/23)
- Prohibits the selling or referring of debt to a collector if a hospital is out of compliance with price transparency regulations (New York SB7005)
- Hospitals may not take collection actions against patients during a period of noncompliance with price transparency (Ohio HB49)

The third nature of state legislation that has been very popular this year has been county and state level bills that authorize the government body to collaborate with a nonprofit partner to facilitate debt forgiveness. Relying on remaining American Rescue Plan Act funds, the legislation awards a grant to the nonprofit organization to purchase and forgive available medical debt from local providers on behalf of the local government entity. The legislation is typically written with a particular partner in mind—RIP Medical Debt—as there are few other organizations capable of fulfilling the role. The first government entities to pass such legislation included: Cook County, IL, the City of Toledo and

Lucas County, Ohio, the City of New Orleans, and the City of Pittsburgh (among many more at the time this paper is being written). Between just those five municipalities, the legislation is poised to forgive more than \$325 million collectively in medical debt for locally qualified residents for just under \$16 million in cost. We will take a closer look at this effort later in this paper.

Citizen-led ballot initiatives have also been successful in changing the rules around medical debt in collections and could serve as a model in more progressive states. In Arizona, for example, where 12% of the population has a median \$719 in medical debt in collections<sup>156</sup>, Proposition 209 *The Predatory Debt Collection Act* sought to cap the maximum interest rate on medical debt to 3%, limited the percentage of wages subject to garnishment, and similarly protected a larger portion of home equity and savings accounts from seizure. The issue passed with 72% in favor, and was held up in court despite challenges from local Chambers of Commerce that argued the new rules would further limit credit to poor families.<sup>157</sup>

Other states taking actions of note include North Carolina, where the *Medical Debt De-Weaponization Act* is hotly contested by state leaders, hospitals and hospital trade associations.<sup>158, 159</sup> Among other items, the expansive North Carolina bill would require hospitals to offer to screen patients for charity care, mandate free coverage for patients up to 200% of the federal poverty level, and prevent hospitals from foreclosing on patients' homes or garnishing their wages.<sup>160</sup>

One example of a balanced legislative approach to address medical debt is

Delaware Senate Bill 8. The law would protect patients from unfair medical debt collection practices through a variety of mechanisms while also not completely eliminating hospitals' ability to recoup certain debts, including<sup>161, 162</sup>

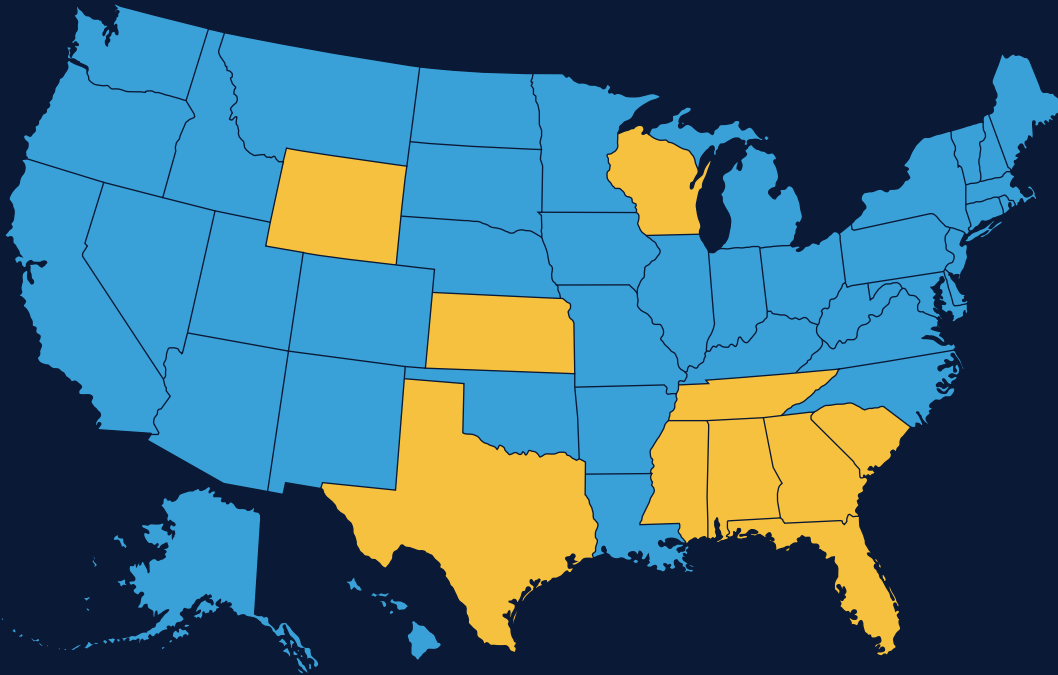
- "Prohibiting large health care facilities from charging interest and late fees,"
- "Requiring facilities to offer reasonable payment plans,"
- "Limiting the sale of debt to debt collectors unless an agreement is made to keep protections in place,"
- "Providing minimum time before certain collections actions may be taken,"
- "Limiting liability for the medical debt of others," and
- "Preventing the reporting of medical debt to consumer credit reporting agencies for at least one year after the debt was incurred."

More bills of this nature could keep all players at the table, while also implementing better patient protections to ensure those who cannot afford to pay are not punished for their lack of resources.

### Medicaid Expansion

As discussed earlier in this paper, possibly the most consequential piece of legislation with respect to medical debt and the financial health of those who carry it is the Affordable Care Act and the resulting Medicaid Expansion provisions. When the ACA was passed in 2014, states were offered additional federal matching dollars if they expanded Medicaid eligibility in their state to 138% of the federal poverty line. Medicaid Expansion has been a political football from the start, but recent studies show that the presence of Medicaid Expansion in a state is a significant, if not driving, factor in the amount of medical debt individuals carry as well as their

# States Yet to Accept Medicaid Expansion



credit scores. Less access to affordable healthcare (specifically Medicaid for those earning up to 138% of FPL), means a higher propensity to accrue medical expenses the household cannot afford. Those bills become medical debt, which until very recently demonstrated poor credit history and dragged down credit scores.<sup>163</sup>

North Carolina became the 40th state to approve Medicaid Expansion on March 27, 2023, with an effective date of January 1, 2024.<sup>164</sup> The governor's office says the expansion will provide health coverage to more than 600,000 people

and that without Medicaid expansion, North Carolina had been missing out on an estimated \$521 million each month that could have gone to improving mental health and helping rural hospitals remain open. Because North Carolina is a traditionally conservative southern state and most of the 10 other states that have not expanded Medicaid are in the South, the passage of the law has been characterized as “the beginning of the end” of state opposition to Medicaid expansion.<sup>165</sup>

Ten states have still not expanded Medicaid: Alabama, Florida, Georgia,

Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming. The residents of these states bear the burden of a lack of expansion and will continue to do so until their leaders begin to see the connection between overall financial security and access to healthcare. A solution for resolving medical debt overall is a long way off, but the option of expanding Medicaid is low hanging fruit that has already been proven to help many families—especially ALICE—escape medical debt.

# Industry at a Crossroads

With increasing awareness of the medical debt epidemic and debt collection practices under scrutiny, the industry's traditional business model is under attack. At this juncture, there appears to be three approaches that are being taken by firms to collect on overdue medical bills:

1. Continue using the current collections model and risk government intervention;
2. Evolve the model to focus more on how the patient can affordably pay medical bills, with an eye toward assisting with building financial health; and/or
3. Leveraging financial technology instruments to collect debt and help consumers get their financial footing

## An Update on Debt Collection Tactics

As the cost burden for health care services has shifted increasingly toward patients, the role of medical debt collection agencies and supportive technology vendors to help hospitals manage accounts receivable is evolving. For instance, credit reporting of medical debt has proven to be a very effective way to convince patients to pick up the phone and try to resolve their debt. While this tactic has always been legal, CFPB and academic research have shown credit reporting to be harmful to patients and some companies are choosing to move away from these tools toward a kinder, gentler model for debt collections.

## Teaching Old Dogs New Tricks

Since our last annual report was published, the CFPB has increased its scrutiny of medical debt collection practices and the companies that employ them. In addition to publishing research about the impact of medical debt and working closely with state attorneys general and state insurance departments to enforce national consumer finance protection laws, CFPB has also targeted some companies with enforcement actions.

In a news release on June 8, 2023, CFPB announced they would take action against a major debt collection player headquartered in Indiana for attempting to collect on debts that were disputed by consumers and reporting those consumers to the credit bureaus for debt they potentially did not owe. In addition to ceasing the illegal behavior, punishments included assessing a \$1.675 million penalty, requiring redress to consumers who paid on an unverified debt after receiving an unlawful letter, and “subjecting the company to CFPB’s supervisory authority for the duration of the order.”<sup>166</sup>

In some cases, CFPB enforcement action does not stop the illegal behavior. In March, the CFPB fined a repeat offender after learning they had continued to engage in deceptive debt collection tactics despite a 2015 order and fine. CFPB assessed a \$24 million fine for “collecting on unsubstantiated

debt, collecting on debt without providing required documentation and disclosures to consumers, suing or threatening legal action against consumers without offering or possessing required documentation, and suing to collect on debt outside the statute of limitations. The company also failed to properly investigate and resolve consumer disputes about the company’s credit reporting.”<sup>167</sup>

## Changes in the Debt Collection Model

RIP Medical Debt (RIP), a non-profit organization engaged in direct debt relief efforts, has purchased and forgiven more than \$10 billion of medical debt in its history (as of September 19, 2023).<sup>168</sup> It uses donations and now government partnerships to purchase bad debt from hospitals and rather than pursue patients for the balance, the nonprofit sends the patients a letter stating their medical debt has been forgiven. The key to the RIP model is not to say debt forgiveness is the final solution to medical debt—quite the contrary. The campaigns and resulting patient stories generate an enormous volume of earned media for RIP—with the RIP message reaching hundreds of millions of online readers every month. RIP President Allison Sesso leverages the attention to advocate for a systemic change that would prevent the generation of medical debt altogether, in their words “abolishing” all medical debt. One particular concern regarding this

approach is whether the debt forgiven could be considered taxable income, adding to the expenses patients cannot afford.<sup>169</sup> According to debt relief firm Tayne Law Group, forgiven debts over \$600 could be counted as income and thus taxable, which would be a surprise for those completing their tax returns.<sup>170</sup>

Capio is experimenting with a new model for medical debt collection in several ways. The company is committed to a Patient Bill of Rights, which guides its policies and procedures in engaging patients to resolve their debt. For example, the company has a policy of not charging fees or interest on debt, and does not pursue legal action. In 2022, Capio spun off a separate company called BuoyFi, LLC which offers consumers an app that uses verified income information to estimate the amount of debt they can afford to pay.

### FinTech Innovations in Accounts Receivable

Given the enormous administrative cost of billing, insurance, and now compliance with new price transparency rules, some companies have chosen to support the healthcare industry by developing software and apps to improve efficiency within the accounts receivable management industry, rather than address medical debt head-on. Some examples include:

- **TrueAccord** offers software products for both early and late-stage collections that use machine learning to understand patients and engage them digitally to resolve their debts.<sup>171</sup> Currently the technology is being used in a wide variety of industries—except for healthcare—but there are many areas where the innovation could be game-changing.
- **Turquoise Health** is leveraging price transparency data provided by hospital systems to help patients

seek affordable care in their area. It now offers a product for providers to improve their ability to negotiate insurance contracts using benchmark rates.<sup>172</sup>

- **Atkos** is an early-stage startup building products that improve the workflow for debt collection representatives.<sup>173</sup>
- **Omega Healthcare** is a “healthcare management solutions partner” using AI and data-analytics to “streamline medical billing, coding, and collections.”<sup>174</sup>

While innovation in fintech offers the promise of generating and using better data to make decisions and streamline processes, these tools only scratch the surface of the problem for hospitals and healthcare systems. They offer very little in the way of resolving medical debt patients already have or preventing it in the first place for patients—especially for ALICE consumers.





# Key Takeaways & Recommended Actions

Tackling the medical debt problem is a complex challenge. Not only is the patient a central player, but unprecedented costs, poor reimbursement rates, and contradictory financial incentives have left hospitals and providers with operating margins more typical of grocery stores. And government bodies and legislators are moving quickly to revamp the way medical debt is handled.

We believe that a 4-pronged approach should be applied to directly address and ameliorate the medical debt crisis in the United States:

01

## Provide more assistance to those least able to repay medical debt.

We have identified the ALICE consumer – Asset Limited, Income Constrained, Employed – as the cohort confronting the largest average medical debt balances while being the least able to repay them. ALICE consumers are barely making ends meet and are receiving little or no charity assistance such as many under the Federal Poverty Level do. With many being either underinsured or uninsured, their dilemma is magnified once a medical bill shows up.

### Three ways to help ALICE patients include:

- **Cap their out-of-pocket costs.** Given their difficulty in absorbing the high costs of medical care and paying their bills, a ceiling (or % of bill) could be set for uninsured and underinsured ALICE patients' out-of-pocket expenses. This way they would be more likely to affordably pay off their obligations.
- **Adjust their bill upfront.** Rather than playing a guessing game regarding all the charges that might accrue for medical treatment, hospitals can apply all deductions from the top. Without any adjustments the ALICE consumer is less likely to be able to pay the hospital at all.
- **Set affordable/flexible repayment plans at the outset.** With caps and deductibles in place, both patients and healthcare providers will benefit by putting an affordable and flexible repayment plan in place as there will be more certainty in the consumer's ability to pay. Providing payment apps / tools to the patient would also help them keep on course.

## 02

### **Expand Medicaid to more states.**

In its first two years, Medicaid expansion reduced medical debt sent to collections by \$3.4 billion and reduced bankruptcies nationwide by 50,000. A study found that after enrolling in Medicaid expansion coverage, low-income adults possessed about \$1,140 less in overall unpaid debt sent to third-party collections. By preventing medical debt and bankruptcies, Medicaid expansion also provides indirect financial benefits to low-income adults by way of improved credit scores and, in turn, better terms for credit cards, mortgages, and loans.

With 79 of 100 counties recording the highest levels of medical debt located in states that have not expanded Medicaid, adding the remaining states would help significantly in alleviating the burden. A Center on Budget and Policy Priorities study has shown that the rate of uninsurance in states that adopted Medicaid declined sharply from 35% to 17% between 2013 and 2019.<sup>175</sup> However, in non-Medicaid states, rates were higher and declined at a much smaller rate (43% to 34%).

The CBPP analysis also demonstrated that Medicaid expansion reduces the uncompensated care burdens of hospitals and improves their operating margins, particularly for rural and safety-net hospitals. A location in a Medicaid expansion state decreases the likelihood that a rural hospital will close by 62 percent.

States would benefit also. Under the Affordable Care Act (ACA), the federal match to cover the Medicaid expansion population is 90% for every state. On top of that, the American Rescue Plan Act of 2021 (ARP) provides states that implement a Medicaid expansion after March 11, 2021 (the date of the law's enactment) with a two-year, five percentage point increase in the federal medical assistance percentage (FMAP) that applies to most non-expansion Medicaid populations and activities. A KFF analysis estimates that the increase in the traditional match rate would more than offset the increased state costs of the expansion in every state.<sup>176</sup>

## 03

### **Give relief to hospitals.**

As government payments to hospitals lag inflation and increasing costs, and as more programs are introduced to alleviate the medical debt burden on consumers, hospitals are at risk of further eroding low operating margins. As noted earlier, additional cutbacks on available services and rural facilities can be expected if there is no relief.

According to the U.S. Government Accountability Office, "More than 100 (or 4% of) rural hospitals closed from 2013 through 2020. As a result, residents had to travel about 20 miles farther for common services like inpatient care, and 40 miles farther for less common services, such as alcohol or drug misuse treatment. Often rural residents lack insurance coverage, which is associated with less access to care and increased risk of poor health outcomes."<sup>177</sup>

For example, obesity rates are significantly higher among adults residing in rural counties compared to those living in urban counties.<sup>178</sup> According to the National Alliance on Mental Health, rural Americans also experience higher rates of depression and suicide than people who live in urban areas, but they are less likely to access mental health care services.<sup>179</sup> And in older adults living in rural areas, there is an increased risk of functional decline, threatening their ability to live independently.

Government needs to better match accelerating hospital costs or risk loss of services and/or closure of rural facilities. Hospitals will receive a 3.1% payment bump for 2024 under a rule recently finalized by the Centers for Medicare and Medicaid Services that sets Medicare reimbursement rates for inpatient, or hospital, care.<sup>180</sup> However, this comes nowhere close to addressing inflationary pressures hurting hospital bottom lines and more needs to be done.

Increasing their “match” will also serve government by ameliorating the physical (e.g., obesity) and mental (e.g., stress, anxiety, and depression) health conditions which are exacerbated when under financial duress. In other words, helping hospitals to help unburden patients with medical debt would assist in enhancing their physical and mental well-being.

By helping to improve these health conditions, the cost to the U.S. public health system would also be reduced. These costs are significant. An American Psychological Association report cites that stress related outcomes cost the United States \$300 billion every year.<sup>181</sup> Estimates of the medical cost of adult obesity in the United States are also significant, ranging from \$147 billion to nearly \$210 billion per year.<sup>182</sup>

### Insurers need to get in the game.

Given insurance companies’ huge profits in comparison to hospitals and their vast resources compared to patients, insurers need to be part of the solution. Insurance companies have shifted more risk to consumers via high-deductible plans. For higher income insureds, this is not a problem. For ALICE, this can be financially harmful in a medical emergency as we have learned that underinsured ALICE consumers carry higher levels of medical debt.

There are three approaches which should be considered to help alleviate the insurance burden for ALICE:

- **Identify patients who need financial assistance long before expensive medical bills become debt.** This would assist hospitals and healthcare providers in determining price deductions and to establish affordable repayment plans early in the process.
- **Reduce the maximum out-of-pocket requirements.** This would help alleviate the absolute financial burden that lower income households would be encumbered with.
- **Stop the sale of high-deductible plans to those who cannot afford it.** Only those who can demonstrate an ability to pay should be permitted to take on high-deductible coverage.

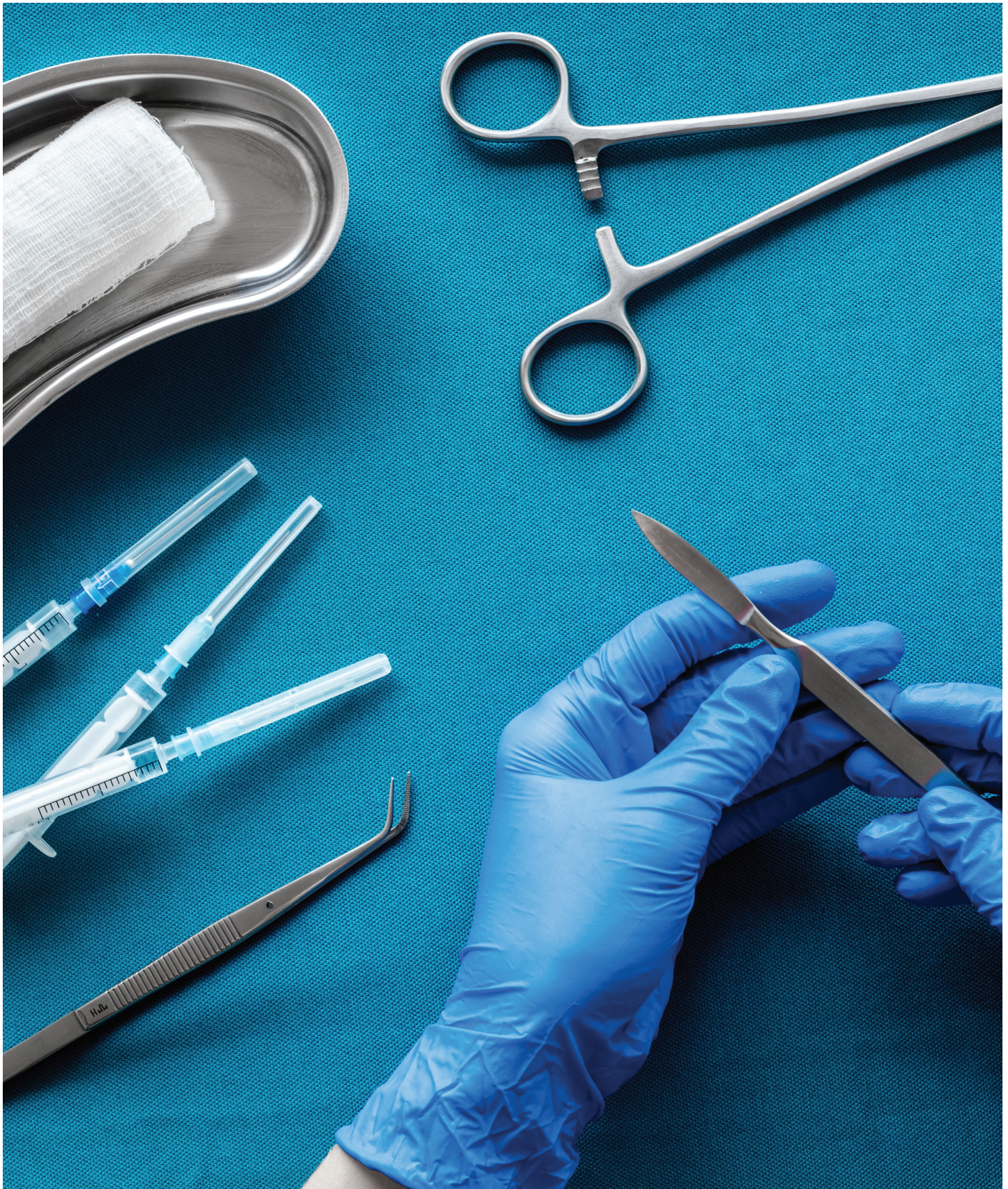
# A New Model for the Debt Collections Industry

**The collections industry needs an overhaul.** Traditional methods of recovering outstanding medical debt are under attack by the media, CFPB and legislators. Practices such as attempting to collect on debts that were disputed by consumers and reporting those consumers to the credit bureaus for debt they potentially did not owe, threatening legal action if payments are not made, tacking on interest and fees on top of the original debt owed, and suing to collect on debt outside the statute of limitations must be eliminated. In its place, the

following protocols should be adopted by those engaged in helping hospitals and healthcare providers recover unpaid medical debt amounts:

- Offer affordable payment plans based on the patient's ability to pay.
  - Charge no interest or fees on outstanding amounts.
  - Eliminate any legal threats or actions on patients.
  - Healthcare debt buyers/acquirers should not re-sell accounts. Consumers must know where their outstanding medical bills come from.
- Ensure that all debt is validated and stop collections on any debt that is inaccurate.
  - Determine up front if the debt qualifies for charity.
  - Shift collections model from “one-and-done” to helping patients get on sounder financial footing. The use of apps can go a long way in helping consumers achieve this state if consumers consent to sharing income information with the hospital to determine their eligibility for financial help.







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