

Eliminating Healthcare Debt A Liberatory Approach

by Chuck Bell

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 A liberatory or emancipatory approach to eliminating medical debt begins with truly hearing the voices of one hundred million Americans who are struggling with bills they can't afford to pay. . . . The United States needs to fully recognize the scope and extent of medical debt as a systemic problem, and take responsibility for its harsh ongoing impacts—including the income and racial disparities it exacerbates.

Approximately one hundred million people in the United States, or 41 percent of all US adults, currently have health-care/medical debt, according to a national survey report by the Kaiser Family Foundation.¹ Released in June 2022, the survey captured more debt than previous surveys, because in addition to counting unpaid bills from medical and dental providers, researchers collected survey data regarding credit card balances, debts in collection, and other types of loans for the purpose of paying off medical debt, including personal loans from friends and family.

The amount of medical debt held by individuals and families is substantial: \$195 billion in 2019, according to the KFF report. Of the respondents, 34 percent said they owed less than \$1,000 in unpaid medical and dental bills; 22 percent said they owed \$1,000 to \$2,500; 32 percent said they owed between \$2,500 and \$10,000; and 12 percent said they owed \$10,000 or more.² Fifty-nine percent of those polled said they expected they could pay off their medical debt in two years or less; 16 percent said it would take them three to five years; and 6 percent said it would take them six or more years. Eighteen percent said that they didn't think they would ever be able to pay off their medical debt.³



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The impact of healthcare debt on individuals and families is staggering in its scope and severity:

- Sixty-three percent of respondents with current or recent medical debt said it caused them to cut spending on food, clothing, utilities, and other basics.
- Forty-eight percent of people with medical debt said that they had used up all or most of their savings to pay it off.
- Two-thirds of adults with medical debt said that they or a member of their household have put off getting needed medical care because of costs.
- One out of seven respondents said that they have been denied care by a medical provider because of unpaid bills.
- Eleven percent or so of adults with medical debt said that they had been forced to declare bankruptcy at some time in their life.
- Six percent of Americans with medical debt said that they have lost their home due to eviction or foreclosure at least in part because of that debt.⁴

WHAT CAUSES HEALTHCARE DEBT? THE FIVE KEY DRIVERS

According to the national advocacy organization Community Catalyst, there are five key drivers of medical debt:⁵

1. Poor Health Status and Low Income. Not surprisingly, people who are sick or have chronic illnesses and disabilities are more likely than others to have higher medical expenses and go into debt. Families with a disabled household member, for example, are “two times more likely to have medical debt than those families where [there is] no disabled member.”⁶ In addition, people living in poverty and from paycheck to paycheck are at much greater risk of

accumulating debt than higher-income households. According to the Kaiser Family Foundation, half of US adults do not have the cash on hand to cover an unexpected \$500 medical bill.⁷ The problem is especially acute for people of color and people with incomes under \$40,000. Seventy-five percent of Black respondents and 66 percent of Latinx respondents said they would not be able to pay a medical bill or would go into debt to pay it.⁸

2. Lack of Health Insurance Coverage. While the Affordable Care Act expanded coverage to some thirty-five million Americans, “approximately 30 million people in the United States lack health insurance coverage.”⁹ A primary reason continues to be the high cost of insurance and lack of either a job that provides it (or adequate financial assistance to purchase it) or eligibility to enroll in coverage through Medicaid (or not living in a state that even expanded Medicaid in the first place).¹⁰ Because of historic practices of exclusion, “many of the uninsured people are immigrants and low-income people of color.”¹¹ The lack of insurance coverage is especially evident in “the twelve states that continue to refuse to expand Medicaid, eight [of which] are in the South.”¹² According to a study by the Stanford Institute for Economic Policy Research, “annual rates of new medical debt fell roughly 50 percent . . . in states that expanded Medicaid, but they dropped only about 10 percent in states that didn’t.”¹³ Undocumented immigrants are ineligible for Medicaid or ACA Marketplace coverage, and Congress has not acted on proposals to expand either program. A handful of states have taken action to expand coverage for populations in critical need of coverage who would otherwise fall through the cracks, such as immigrant children and pregnant women.¹⁴

3. High Out-of-Pocket Cost Sharing. One of the shocking aspects of the healthcare debt crisis is that most people who are struggling with medical debt have insurance coverage. Insurance does not necessarily pay for all the expenses a person incurs when they receive medical treatment. Many consumers are enrolled in high-deductible plans that require patients to come up with substantial additional funds for deductibles and copayments. According to a 2019 survey by the Kaiser Family Foundation and the *Los Angeles Times*, 40 percent of people with employer-based coverage said they had problems affording their healthcare cost sharing, premiums, and medical expenses for themselves or a family member.¹⁵ Many households do not

have enough liquid savings to pay for the typical deductible costs of \$2,000 for single-person households and \$4,000 for multi-person households.¹⁶

4. Complicated Insurance Adjudication Process. The medical billing process in the United States is extremely complicated and confusing, and many mistakes and errors are made that are difficult and time-consuming for patients and others to correct. Often, patients receive multiple bills and insurance forms for the same visit, which are hard to decipher and interpret, especially for non-native speakers. Providers and insurers go back and forth over whether a particular treatment or service is covered by the patient's insurance, and the patient is caught in the middle. Frequently, providers go ahead and send bills to collection even while they are still arguing with the insurance company as to whether the service is covered or not.

5. Unfair Billing and Aggressive Collection Practices. Patients are frequently hit with excessive charges by providers that amount to unfair price gouging. In addition, many nonprofit hospitals have charity care and financial assistance programs but do not inform eligible patients that they could qualify for free or discounted care. "Patients are often unable to negotiate to lower their bills or establish a reasonable repayment plan," leading to higher debts that are then sent to collectors and reported to credit reporting agencies.¹⁷ Aggressive collection practices can therefore ratchet up the price of care far beyond the actual cost of delivering the procedure or service, and consumers are subject to additional interest charges on the debt that may exceed the value of the debt itself.

MEDICAL DEBT MAKES PEOPLE SICK

Medical debt undermines the ability of individuals and households to have stable incomes, avoid financial stress and poverty, and achieve economic stability. In addition, medical debt *in itself* can cause sickness. "Medical debt and associated financial hardship are likely to be associated with substantial adverse health effects," wrote Dr. Carlos Mendes de Leon and Dr. Jennifer J. Griggs in a July 2021 recent editorial published in the *Journal of the American Medical Association*.¹⁸ They continued:

Medical debt may compromise seeking or receiving appropriate medical care that may lead to delayed diagnosis of health conditions or exacerbations in

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preexisting conditions and may potentially contribute to increased risk of premature mortality. There is also clear evidence for a link of personal debt and financial hardship with poor mental health, which in the case of medical debt could worsen the adverse effects of medical conditions on mental health or vice versa.¹⁹

Healthcare debt can be thought of as a *negative externality* (to use an economic term), like air pollution. It makes people sick and stressed out. Further, it shifts financial costs from the healthcare system to patients and families and to the support systems in communities that exist to help support people when they are in crisis. Indeed, healthcare debt has negative impacts on other nonprofits in the community. For nonprofit housing, social services, and mental health providers, medical debt can create a significant added workload, because it undermines the stability and economic health of individuals and families and increases demand for a variety of services.

WHO IS CARRYING MOST OF THE HEALTHCARE DEBT AND WHY?

According to the KFF report, Black adults are 50 percent more likely, and Latinx adults are 35 percent more likely, than white adults to be carrying medical debt.²⁰ Over a quarter (27.9 percent) "of Black households carry medical debt compared with 17.2 percent of white non-Hispanic households."²¹ These racial disparities reflect long-standing gaps in healthcare access (17 percent of Black adults lack health insurance compared with 12 percent of white adults) but also gaps in wealth and income related to discrimination in jobs, education, and housing.²² In some areas of the country, medical debt is particularly heavily concentrated in communities of color. For example, as the Urban Institute has reported, "Medical debt in Washington, D.C.'s predominantly

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minority neighborhoods is nearly four times as common as in white neighborhoods.”²³ In other words, the financial and psychological burden of medical debt falls most—and very—heavily on historically disenfranchised populations whose living situations place them squarely at risk vis-à-vis the social determinants of health (SDOH). According to the Department of Health and Human Services,

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains: Economic Stability, Education Access and Quality, Health Care Access and Quality, Neighborhood and Built Environment, and Social and Community Context.²⁴

Medical debt falls clearly into at least three of these domains. First, it discourages and prevents people from seeking regular, ongoing, comprehensive healthcare, thus directly undermining *Health Care Access and Quality*. Second, it obstructs the ability of individuals and households to maintain stable incomes, avoid financial stress, and achieve *Economic Stability*. Third, it causes psychological distress and trauma, and impacts people’s relationships with friends, family, and community: the *Social and Community Context*.

At a time when hospitals, medical providers, insurers, foundations, and public health experts are urging increased attention to addressing and improving the social determinants of health, *eradicating the sources and impacts of medical debt* ought to be placed at the top of their list. This is an extremely effective concrete step we could take to improve the health and well-being of historically disenfranchised and economically stressed communities.

THE PUNISHING CULTURE OF DEBT COLLECTION

Large portions of medical debt are being carried on credit cards (17 percent) or are being paid off directly to a doctor,

medical provider, or hospital over time through a payment plan (21 percent).²⁵ When people fail to make payments, the medical debts can be turned over to debt collection agencies, worsening what is already an intolerable situation. In 2022, the Consumer Financial Protection Bureau reported that 58 percent of all bills in debt collections and on people’s credit records were medical ones.²⁶ Medical debt is now the number one source of debt collections, surpassing debt in collections from credit cards, utilities, auto loans, and other sources combined.²⁷

According to the National Consumer Law Center, hospitals and medical providers often place unpaid accounts with third-party debt collectors, who use frequent calls and other communications to pressure consumers to pay. “Many facilities and providers also authorize debt collectors to report alleged medical debts to credit bureaus” (and/or providers file collection lawsuits on the debts).²⁸ If they win and obtain a court judgment, they can then use a variety of onerous collection tools—depending on state law—such as “seeking liens on homes, wage garnishment, tax refund garnishment, attachment and seizure of bank accounts, and even . . . civil arrest warrants when debtors fail to show up for court proceedings.”²⁹ Typically, when the medical provider or hospital obtains a court judgment, the debtor is neither present nor represented by counsel to give their side of the story.

“About 1 in 7 adults who have had health care debt say they’ve been threatened with a lawsuit or arrest, according a nationwide KFF poll.”³⁰ Further, one out of twenty (5 percent) said that they had been sued by a medical provider, collection agency, or debt buyer for a past-due medical or dental bill.³¹

This punishing culture of debt collection further disenfranchises individuals and families already burdened by multiple inequities, and further erodes their ability to function in the societal system as it is set up.

POLICY SOLUTIONS TO THE HEALTHCARE DEBT CRISIS

There are three basic tiers of potential policy solutions to the serious national problem of expanding medical debt. The first is to level the economic field so that all have access to comprehensive, high-quality medical care. The second is to achieve reforms in medical billing to reduce and eliminate the amount of debt incurred in the first place. The third is to prohibit unfair and needlessly harsh debt collection practices, such as wage garnishment and placing liens on primary

residences, and to give patients better tools for protecting and defending themselves against court actions.

The first tier, of course, is the bigger issue, and it won't be achieved in the short term; but there is substantial opportunity to make more immediate change at the second and third tiers. For example, reforms to limit the growth of medical debt and protect patients from its harsh effects can be achieved at the state level. The National Consumer Law Center has developed an excellent model state law to increase consumer protections for low-income patients against health-care debt and reduce the number of patients facing lawsuits or other harsh tactics.

The model law's provisions include:

- Requiring more healthcare providers—not just nonprofit hospitals—to have a financial assistance policy
- Setting a floor for those financial assistance policies to ensure more low-income people qualify for free or discounted medical care
- Capping the total amount of medical debt a low-income person can accrue at a hospital, capping monthly payments at 5 percent of a patient's income, and capping the interest rate that debt collectors can put on medical debt
- Incentivizing patients to sue healthcare providers who violate this law³²

In 2021, state-based advocates were active in at least twelve states fighting for new protections against unfair medical billing and debt collection practices, according to Community Catalyst.³³ Eight states succeeded in passing bills to protect patients, in some cases incorporating sections of the NCLC's model law. New protections were enacted that require healthcare providers to:

- "Screen and provide free or discounted care to low-income patients regardless of their immigration status.
- "Clearly notify all patients about hospital policies regarding financial assistance programs, billing, and collections.
- "Limit hospital charges and extraordinary collection practices.

- "Comply with reporting requirements that aim to explore disparities.

- "Solicit feedback from patients and patient advocates on notification of patients' rights."³⁴

A series of excellent case studies prepared by Community Catalyst highlights how patient advocates developed state-wide coalitions to curb unfair medical billing and debt collection in their states:

- In Maryland, advocates succeeded in "a ban on all lawsuits for medical bills under \$1,000, . . . prohibiting arrests for medical debt and liens on homes for all patients, prohibiting wage garnishments for low-income patients, and requiring hospitals to offer income-based repayment plans. . . . [The 2021 law also] require[s] hospitals to submit an annual report on debt collection activity" that includes the impact by race and ethnicity, to bring more public attention to racial disparities in collection practices. The bill was supported by End Medical Debt Maryland, a broad-based coalition of "unions, churches, and state and local community advocacy organizations representing approximately 400,000 Marylanders."³⁵

- In Colorado, patient advocates helped pass a new law that requires hospitals to screen patients for participation in public insurance programs and hospital financial assistance programs. The bill also requires steep discounts on hospital bills for low-income patients who do not qualify for discounted care under the state indigent care program.³⁶

- In New York, the statewide End Medical Debt Campaign initiated by Health Care for All New York succeeded in enacting reforms to cut the amount of time a hospital can sue patients from six years to three years; reduce the interest rate charged for medical debts from 9 percent to 2 percent; and close a loophole in the state surprise billing law that exempted hospital emergency rooms.³⁷ In 2022, the End Medical Debt coalition continued its advocacy and passed a bill to ban liens on primary homes and wage garnishments for nonprofit hospital debts that is now under consideration by the governor.³⁸ The coalition's

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hard-hitting reports about medical debt lawsuits in different parts of the state resulted in several large hospital systems voluntarily announcing that they will no longer sue patients for medical debt.

The Medical Debt Policy Scorecard, developed by Innovation for Justice, provides a detailed score for each state based on its medical debt protection policies. “Only 7 states had a composite score of 50 points or higher”—indicating that while some states have taken significant actions to protect patients, many have barely begun to grapple with reforming the policies that leave patients vulnerable to unfair billing and collection practices.³⁹

The Medical Debt Policy Scorecard lists nine different steps that states could take to limit the amount of debt incurred by patients in the first place, including: (1) expanding Medicaid, (2) mandating screening of patients for Medicaid and charity and/or discounted care, (3) requiring “hospitals or other providers to offer a reasonable payment plan before sending bill to collections,” and (4) “limit[ing] pricing for medically necessary care.”⁴⁰ Community-based advocates can press to adopt these important building blocks of a comprehensive strategy to limit unfair billing practices.⁴¹

WHAT ABOUT NONPROFIT HOSPITALS AND CHARITY CARE PROGRAMS?

Over the last several years, media coverage has highlighted the glaring contradiction between the role of nonprofit hospitals as institutions with a charitable mission and their role in aggressive medical billing and debt collection. One study in New York found that fifty-five hospitals had sued over four thousand patients since the COVID-19 pandemic began, in March 2020.⁴² A *ProPublica* report in 2019 found that Methodist Le Bonheur Healthcare, which includes Methodist University Hospital, “filed more than 8,300

lawsuits” over five years for unpaid hospital bills. Many of the defendants were low-income.⁴³ In addition, more than 20,000 debt lawsuits were filed by Virginia hospitals in 2017. More than 9,200 garnishment cases occurred that year, *and nonprofit hospitals were more likely to garnish wages than for-profit hospitals.*⁴⁴

According to Community Catalyst:

Non-profit hospitals in the U.S. have a longstanding obligation to provide community benefit in exchange for savings that result from their tax-exempt status. Under the ACA, the IRS was directed to establish Section 501(r), requiring new community benefit, including establishing and publicizing financial assistance programs for low-income patients. In addition, hospitals are prohibited from charging patients who are eligible for financial assistance more than the amounts generally billed to insured patients. Finally, before engaging in extraordinary collection actions, hospitals must make reasonable efforts to determine whether a patient is eligible for financial assistance.⁴⁵

Despite these requirements, the National Consumer Law Center reports that “hospital spending on charity care . . . varies from hospital to hospital. In 2017, hospitals spent \$14.2 billion on financial assistance (\$9.7 billion to uninsured patients and \$4.5 billion to insured patients), while generating \$47.9 billion in net income.”⁴⁶

While charity care or hospital financial assistance policies help some uninsured patients from falling into debt, many hospitals “do the bare minimum to satisfy the ACA’s requirements and maintain their tax-exempt status.”⁴⁷ Further, some hospitals limit assistance to “patients with no insurance and extremely low incomes, excluding patients with any form of health insurance from receiving assistance,” even though such patients can be harshly impacted by high out-of-pocket costs for deductibles, coinsurance, and copayments.⁴⁸

According to the NCLC report, “charity care policies fall short for several reasons:

1. Failure of hospitals to inform patients of their eligibility for charity care before commencing debt collection;

2. “Lack of specific guidelines and minimum eligibility criteria in the ACA’s financial assistance policy requirements; and
3. “Overall lack of effective implementation, enforcement and oversight of charity care programs.”⁴⁹

If hospital financial-assistance programs were widely publicized, many patients could avoid going into debt in the first place. Advocates are responding to the issue by promoting state legislation to standardize and increase the availability of hospital financial assistance, and by encouraging federal regulators and the IRS to tighten the standards for provision of charity care. Advocates would also do well to hold nonprofit hospitals accountable for their billing and debt collection practices and invite them to be allies in the fight for greater health equity.

Under the Affordable Care Act, nonprofit hospitals are required to prepare and update Community Health Needs Assessments (CHNAs) every three years, by engaging in dialogue with stakeholders and the public to identify and analyze community health needs. The process provides a way for communities to prioritize health needs and to plan and act upon unmet community health needs. Many methods exist for conducting an assessment, but assessment generally includes stakeholder meetings, community focus groups, surveys, interviews with community leaders, and analysis of population health and other health-related data.⁵⁰

Given the harsh consequences that medical debt imposes on individuals and the community as a whole—increased stress and anxiety, less access to medical care, risk of eviction, foreclosure and bankruptcy, and more—all CHNAs should include plans for preventing and reducing the risk that patients will incur debts for unpaid medical bills. At a minimum, nonprofit hospitals and other medical providers should avoid taking actions that undermine the financial well-being of residents in their community. In fact, they should help lead the fight to reduce the scourge of medical debt, in order to improve health status and outcomes.

TAKING ON THE ELEPHANT IN THE ROOM

I have my medical debt, and I try to pay it off, but then I can't pay my rent and my car loan, and all these other things. It feels like I can't get out of this hole. It stresses me out and worries me day in and day out.

—Robert Parish, electrician from Tennessee⁵¹

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A liberatory or emancipatory approach to eliminating medical debt begins with truly hearing the voices of one hundred million Americans who are struggling with bills they can't afford to pay. As a nation, the United States needs to fully recognize the scope and extent of medical debt as a systemic problem, and take responsibility for its harsh ongoing impacts—including the income and racial disparities it exacerbates and reinforces. Only then can we begin to realize the depth of policy reforms that will be needed to extend full protections against unfair billing and collection practices.

To fully protect people across the nation from bills they can't afford to pay, policy-makers and advocates will also have to take on the elephant in the room: The United States has the most expensive healthcare system in the world, yet for all we pay, it is failing to deliver safe, affordable, and efficient care—across multiple dimensions. Many of the worrisome practices are highlighted in Dr. Elisabeth Rosenthal's excellent book *An American Sickness*, based on her “Paying Till It Hurts” series in the *New York Times*.⁵² One of the key problems is that Americans pay higher “unit prices” for almost all of the healthcare we buy relative to costs in other countries.⁵³ “While the United States medical system is famous for drugs costing hundreds of thousands of dollars and heroic care at the end of life, it turns out that a more significant factor in the nation's \$2.7 trillion annual health care bill may not be the use of extraordinary services, but the high price tag of ordinary ones,” writes Dr. Rosenthal.⁵⁴

And there's also plenty of routine outrageous price gouging and profiteering. Hospitals and providers charge markups that greatly exceed the actual costs of providing care. For

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example, a 2021 study found that fifty-seven of the largest one hundred US hospitals were charging patients more than five times the amount their care cost the hospital.⁵⁵ Nine hospitals marked up their prices more than ten times the cost of actual care.⁵⁶ Similarly, "it is estimated that hospitals mark up the prices of drugs for patients with private insurance by an average of 140% to 280%," according to one recent study.⁵⁷

And the medical billing and collections system is itself fraught with financial and administrative waste. "For every office-based physician in the United States, there are 2.2 administrative workers. That exceeds the number of nurses, clinical assistants, and technical staff put together. One large physician group in the United States estimates that it spends 12 percent of revenue collected just collecting revenue. . . . Canada, by contrast, has only half as many administrative workers per office-based physician."⁵⁸

While low-income patients are in the greatest, most urgent need of protection from medical debt, we should create firm rules to prevent patients from ever receiving medical bills they can't pay *across the entire healthcare system*. Otherwise, the system will continue to shift costs to other individuals, families, and employers, and postpone the day of reckoning for stamping out overcharges and creating a fairer, more rational system of pricing.

A key process reform would be to cap and strictly limit the amount of financial cost sharing for healthcare experienced by patients *across the entire marketplace*, so that almost all expenses are covered by insurance as a matter of course for all patients. The proliferation of high-deductible health plans has created a system whereby many patients are afraid to seek care because they are routinely charged more money

at the point of service for copays and deductibles. We can and should get rid of high-deductible health plans; but in doing so, it is imperative to implement sweeping reforms in the pricing and efficiency of care delivery, so as to limit the markups charged by providers and prevent price gouging for services that can and should be more reasonably priced.

Savings from innovations and improvements in care delivery and reduction in the complexity of billing and administration could then be clawed back to reduce the cost of care for patients. There is no doubt that savings of the annual national cost of \$195 billion for medical debt could be rapidly found in a \$3 trillion healthcare system *if* social movements demand these savings and *if* the United States finds the political will to look for them. The Institute of Medicine estimated in 2012 that \$750 billion is wasted every year in our healthcare system—literally 30 percent of every dollar we were spending at the time.⁵⁹

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Finally, a liberatory and emancipatory approach to medical debt would also include forgiveness and elimination of medical debts above a certain threshold. As advocates point out, no one takes on medical debt voluntarily. Refusing medical care because of financial factors is fraught with risk and danger to patients and their families. The nonprofit organization RIP Medical Debt has already purchased \$6.7 billion in medical debts from creditors for pennies on the dollar and released 3.7 million patients from the burden of paying it back.⁶⁰ The cost of buying debt from creditors is often less than the actual debt, because creditors don't expect to collect the full amount. "Every \$100 donation relieves \$10,000 in medical debt," the organization's website says.⁶¹

"The millions under the weight of medical debt deserve help, both because medical debt is a uniquely unfair form of predatory lending and because of its devastating effects on American families," Dr. Rosenthal wrote in a recent op-ed.⁶² "Government could take action in the short term to relieve this uniquely American form of suffering by buying the debts for a modest price. And then, it needs to tackle the underlying cause: a healthcare system that denies millions of people adequate care while still being the most expensive in the world."⁶³

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