SOLVING THE MEDICAL DEBT CRISIS

Brianna Wells | March 2021

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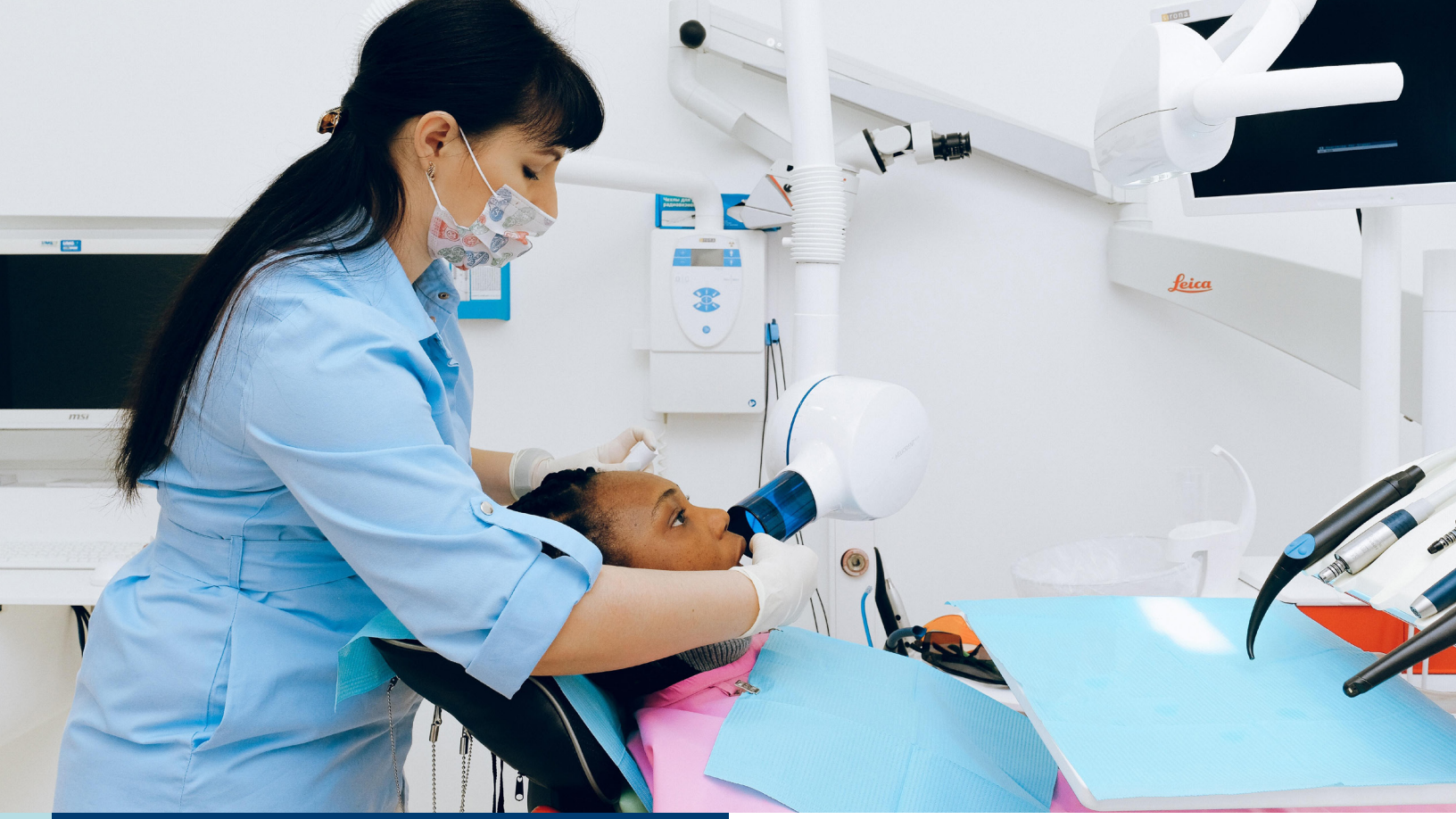

EXECUTIVE SUMMARY

Medical debt is the number one cause of bankruptcy in the United States, with 62% of bankruptcies caused by medical bills.[1] In 2016, one in six Americans had past due medical bills, resulting in $81 billion in debt.[2]

In a 2015 survey by the Kaiser Family Foundation, 26% of Americans aged 18 to 64—52 million—said that they struggled to pay medical bills.[3] Medical expenses were the largest factor increasing the number of people in poverty last year.[4]

Medical debt is not distributed equally across communities:

- Nationally, about a third of Black adults have past-due medical debt, compared to just under a quarter of White adults.[5]
- In California, 31% of people of color have some type of past-due debt in collections, compared to only 19% of White residents.
- Twelve percent of people from communities of color in California owe medical debt.[6]

The COVID-19 pandemic threatens to worsen health disparities and the burden of medical debt on communities of color. Health care costs due to COVID-19 have already left people in severe debt, and layoffs due to COVID leave historical numbers of people unemployed and uninsured.[7] Communities of color have been especially devastated by the pandemic, leaving them especially vulnerable.

Recommendations

- Expand comprehensive financial assistance policies for all large, for-profit health care facilities, including ambulatory surgical centers and outpatient clinics.
- End the practice of turning over medical debt to third-party collection agencies and prohibit such agencies from reporting medical debt to credit reporting bureaus.
- Mandate public reporting of debt collection practices by healthcare providers.
- Center medical debt elimination as a part of the state's COVID-19 recovery package via measures such as the proposed COVID-19 Medical Debt Collection Relief Act, which would suspend the collection of medical debt retroactively from February 1, 2020 until the "end of the public health emergency" and ban wage garnishment and bank account seizure.
- Cancel medical debt outright. The government can purchase medical debt from debt collectors and health care providers at discounted rates, aiding consumers while avoiding a financial windfall for debt collectors.
- Incorporate debt cancellation into California's larger strategy toward reparations for racial injustice. Closing the racial wealth gap by addressing debt (including medical debt) in California requires a reparations package for the Black community.

INTRODUCTION

This issue brief reviews the policy landscape on medical debt in the United States, with recommendations for California. It focuses on the burden of medical debt among communities of color and the determinants of medical debt. Medical debt affects all other social determinants of health, including access to health care and wealth-building resources, perpetuating conditions that lead to poor health outcomes for people of color. Furthermore, the disparate racial impacts of the COVID-19 crisis make medical debt alleviation an urgent mechanism for equitable economic recovery. Policy approaches for alleviating medical debt in California through a racial equity lens should prioritize consumer protections and transparency within health systems and financial institutions; economic relief for communities of color amidst COVID-19; and debt elimination as a part of a broader strategy to address racial injustices.

MEDICAL DEBT AND RACIAL HEALTH & ECONOMIC DISPARITIES

The extent to which medical debt creates financial hardship for American families needs much more attention. Medical debt is the number one cause of bankruptcy in the United States, with 62% of bankruptcies caused by medical bills.[8] In 2016, one in six Americans had past due medical bills, resulting in $81 billion in debt.[9] And in a 2015 survey by the Kaiser Family Foundation, 26% of Americans aged 18 to 64—52 million—said that they struggled to pay medical bills.[10] Medical expenses were the largest factor increasing the number of people in poverty last year.[11]

- Medical debt is not distributed equally across communities:
  - Nationally, about a third of Black adults have past-due medical debt, compared to just under a quarter of White adults.[12]
  - In California, 31% of people of color have some type of past-due debt in collections, compared to only 19% of White residents.
  - Twelve percent of people from communities of color in California owe medical debt.[13]

Forty-four percent of adults who reported struggling to pay medical bills said that the impact of those bills on their families was major.[14] Seventy-percent of individuals with medical debt reported spending less on essential expenses such as food, clothing and basic household items. Additionally, over half of these individuals reported exhausting all or most of their savings on medical bills.[15] Medical debt can deepen racial household income disparities in California, as Black families are already twice as likely as White families to be at the bottom of the income distribution.[16]

While being insured may reduce medical bills, medical debt still burdens individuals and families regardless of their insurance status. Among those with medical bill problems, equal shares of the insured and uninsured reported that medical bills have a major impact on their families. Even those with insurance pay high out-of-pocket healthcare costs: 75% of adults surveyed said that they were insured but could not pay their medical bills.[17]

Racial gaps in income, wealth and health status create a vicious cycle of inequality leading to a disproportionate burden of medical debt on communities of color. [18]

Medical debt is both a symptom and a cause of the racial wealth gap. Government policies throughout our history have systematically restricted communities of color from accessing financial services, employment and housing, generating disparities in income and wealth that make paying for medical expenses more difficult for people of color. Discriminatory policies like redlining intentionally limited resource-building in communities of color and enforced the racial segregation that led to the wealth inequities that persist today.[19] Medical debt exacerbates these racial wealth disparities by limiting individuals' ability to participate in the economy and access wealth-building channels such as homeownership: "Nearly 40% of adults with medical debt have been denied the opportunity to secure a mortgage loan."[20]

Additionally, medical debt creates conditions of economic insecurity that lead to poor health outcomes and premature death for people of color, particularly Black and Indigenous people. In this way, medical debt acts as a social determinant of health. Research from the Federal Reserve of Atlanta found an association between debt delinquency and higher mortality.[21] The stress of being saddled with debt wreaks havoc on the physical and mental health of individuals, leading to increased risk of chronic health problems. There is compelling evidence that debt-related stress leads to higher incidence of depressive symptoms, more commonly among Black individuals than White individuals.[22] Black Americans already die on average four years earlier than Whites,[23] illustrating why medical debt alleviation must be a public health policy priority.

Carrying medical debt is also a strong predictor of going without medical care.[24] People with medical debt report delaying or avoiding seeking health care, meaning that their conditions may become more severe, and therefore costly to treat, when finally addressed.[25] Twenty-five percent of American households said that they delayed medical care due to high costs last year.[26] The number was even greater for low-income individuals, with 36% of low-income people reporting that they avoided treatment for serious health issues.[27] In 2008, Latino families were far more likely than Black or White families to forego medical treatment in order to reduce their out-of-pocket medical debt.[28] Added to many other reasons why people of color avoid care, such as an earned distrust of the health care system, medical debt creates a barrier to care that can worsen already negative health outcomes for people of color.

Delaying preventative health care can lead to more frequent hospital stays as patients end up in the hospital for conditions that have not been managed successfully by primary or preventative care. In California, the rates of preventable hospitalizations among Black people are significantly higher than any other race/ethnicity. This stark disparity raises questions about the burden of hospital bills on Black communities in California, given that Black people also experience the highest rates of chronic illness in the state. [29]

Twenty-five percent of American households said that they delayed medical care due to high costs last year.[26]

FINDINGS: CAUSES OF MEDICAL DEBT

Surprise Medical Billing

Surprise billing occurs when an individual goes to a health care facility that is within their insurance plan's network, but ends up receiving care from a doctor who is not in that network, leading to higher charges than would apply to an in-network doctor.[30] Surprise billing may also occur when someone is taken to a non-contracted facility in an emergency and the facility bills them for the balance for services that were not covered by their health plan.

California law already prohibits surprise billing for emergency and non-emergency care at in-network facilities. Under AB 72, which took effect July 2017, consumers are only billed at the rate for in-network services when they seek care at an in-network facility.[31] Still unprotected, however, are patients who end up at out-of-network facilities, usually in cases of emergencies. The surprise billing protections under the federal No Surprises Act, taking effect in 2022, would prohibit out-of-network providers and facilities from charging an amount greater than a patient's in-network cost sharing.[32] The impact of these protections on medical debt remains to be seen.

Medical Credit Cards

Medical credit cards are offered by medical providers like dentists, eye doctors, cosmetic surgeons and veterinarians.[33] In California, many patients face severe debt from using medical credit cards to pay for treatment.[34] These cards have high deferred-interest rates (interest

payments deferred for a set period of time but collected later) that can range from 13 to 29% [35] and which deepen existing racial and socio-economic inequities in credit and debt."[36]

Latinos in California may be at a particular risk for falling into debt traps with these cards due to challenges with Medi-Cal and dental care. Latinos account for 50% of all Medi-Cal eligible enrollees.[37] Many dental offices refuse to check for Medi-Cal authorization or are unable to get it for medically necessary care. As a result, Medi-Cal recipients may be targeted for medical cards early in the process, a situation that raises both practical and ethical questions.[38]

Medical credit cards may also prevent patients with outstanding hospital bills from being offered help from hospitals' charity care or financial assistance programs.[39]

Medical credit cards are sometimes marketed to low-income Californians in a predatory manner. Patients can sign up for medical credit cards right in a provider's office and get approved in seconds. Consumer complaints about the cards revealed that many people felt pressured to sign up for a medical credit card or were given misleading information about repayment.[40]

SB 639, a state law that went into effect in July 2020, prohibits health care providers from enrolling patients for deferred interest credit cards in their offices.[41] This sort of consumer protection against these predatory practices can go a long way in preventing medical debt, though it remains to be seen how this new law will work out in practice.

Third-Party Debt Collection

Medical debt is the number one reason why people are contacted by debt collectors.[42] These problems occur when hospitals refer unpaid medical balances to external debt collection agencies. Kaiser Permanente, for example, transfers unpaid balances to a collections agency 30 days after a patient has been notified of delinquency.[43] Third-party collections agencies often employ abusive debt collection tactics, sometimes even attempting to collect debt that is not owed.[44] The Consumer Financial Protection Bureau reports that "medical debts accounted for 52% of all collections items on consumers' collections reports," damaging the credit of one in five adults.[45]

Health systems like Kaiser Permanente choose to outsource debt to outside collections agencies, despite having the resources to provide free or low-cost services through their charity care programs to patients who do not qualify for government assistance.[46]

Uninsurance and Underinsurance

While health insurance does not fully protect against medical debt, people with health insurance *are* less likely to report past-due medical debt. Lack of health insurance means higher out-of-pocket costs for care, making the uninsured more susceptible to acquiring medical debt. Black and Latino workers in California had lower rates of employer-based health insurance coverage than their White counterparts (67%, 57% and 72%, respectively), due to being overrepresented in sectors that are less likely to have job-based coverage.[47] Nationwide, Black, Hispanic and Native American people are more likely to experience higher uninsurance rates: About 11%, 20%, 21% and 8%, respectively, compared to 8% for White people, and in some states uninsurance rates for Asian and Pacific Islander people also greatly exceed those for Whites.[48] In California,

Latino people are twice as likely to be uninsured than White people.[49]

The Affordable Care Act increased coverage rates for people of all races and somewhat reduced racial disparities in uninsurance rates.[50] COVID-19-related job and health insurance loss will likely increase the number of people with medical debt in the near future.[51] Protecting and expanding the ACA will be key to maintaining the gains in coverage made for people of color and reducing racial disparities in insurance coverage.

Credit Inequities

Current figures for medical debt prevalence may be an underestimation, given the amount of medical expenses carried on credit cards. Medical debt often becomes other types of debt when patients put their balances on credit cards, take out loans, or refinance their homes to pay it off.

According to a 2008 Demos survey, more than half of all Black and Latino Americans carried medical debt on their credit cards.[52] Medical debt accounts for over half of all collections tradelines that appear on consumer credit reports.[53] Partly as a result, Black and Latino people are more likely to have poor credit than White people. Poor credit can prevent an individual from getting a job, renting an apartment or securing a loan, or require the individual to pay higher interest rates, ultimately worsening existing racial inequities in wealth and assets.

However, medical debt only damages credit scores if reported to a credit bureau, which usually stems from outstanding balances being sent to debt collection agencies. Stopping this cycle will alleviate some of the negative consequences of medical debt.

"Medical debt often becomes other types of debt when patients put their balances on credit cards, take out loans, or refinance their homes to pay it off."

– Jen Flory, Western Center on Law & Poverty

HEALTH CARE COSTS DUE TO COVID-19 AND MEDICAL DEBT

The effect of the COVID-19 pandemic on medical debt owed by low-income households of color in California should be a serious area of concern for policymakers. From March 2020 to January 2021, almost 14 million Californians filed initial unemployment claims (including the Pandemic Unemployment Assistance, Pandemic Emergency Unemployment Compensation and Federal-State Extended Duration programs).[54] At the height of the crisis, about 22% of Black people and 26% of Latino people were unemployed in California, compared to 17% of White workers.[55] For 5.4 million people across the country, layoffs meant losing employer-provided health insurance.[56]

Medical expenses due to the coronavirus have already left many in massive debt. Loopholes in The Coronavirus Aid, Relief and Economic Security Act (CARES) left many unprotected from high out-of-pocket costs for COVID-19 tests and treatments done at an emergency room or a private health facility.[57]

While we lack data for COVID-19 hospitalizations by race in California, the cost of COVID-19 treatment raises concerns given the disproportionate impact of COVID-19 on California's Latino communities. As of February 2021, Latinos accounted for a staggering 55% of coronavirus cases, while making up only 39% of the state's population.[58] The financial repercussions of this disparity should worry policymakers.

POLICY RECOMMENDATIONS

While much of the available evidence on medical debt is national rather than state level, the racial wealth gap and disparate health outcomes in California suggest a need for these proposed approaches to alleviating medical debt within the state.

1 Institutionalize Equity into Health Systems

Expand comprehensive financial assistance policies for all large, for-profit health care facilities.[59] FAPs provide free or low-cost medical services for eligible patients who are unable to pay for their medical treatments. As recommended by the National Consumer Law Center, health systems should implement the following measures to improve FAPs:

- Require free-standing ambulatory surgical centers (which often provide the same services as hospitals) to adopt FAPs.
- Ensure that outpatient clinics or other facilities affiliated with any nonprofit or for-profit hospital are covered by the hospital's FAP.
- Mandate that all healthcare professionals who provide care in any of these settings be covered by the FAP.
- Require "large health care practice groups with revenues over $20 million annually" to create FAPs.[60]

However, adoption of more comprehensive FAPs is not sufficient without accountability mechanisms in place to ensure that these policies are enforced and widely advertised to patients.

Cease the practice of transferring debt to third-party debt collection agencies. Health systems should prohibit collecting medical debt from low-income patients eligible for financial assistance programs. Hospitals have the resources to provide care regardless of ability to pay, as evidenced by charity care programs.[61] If they fail to do this voluntarily, the state should consider making it mandatory.

Implement stronger consumer protection and transparency standards regarding billing.[62] This could include:

- Requiring large health care facilities to screen patients for insurance eligibility and eligibility for other assistance programs like California Health Families, etc.).
- Requiring that large health care facilities give patients a copy of the FAP, publicize the FAP on a website, and provide the application form upon request.
- Ensuring that health care facilities offer language assistance as needed to help patients navigate the FAP application process.[63]

2 Institutionalize Equity into Financial Institutions

Prohibit debt collection agencies from reporting medical debt to credit reporting agencies.[64] Interrupting this cycle will reduce the negative consequences of medical debt on people's credit scores.

Require that medical debt be disregarded in mortgage loan applications. Medical collections reduce individuals' credit scores and hurt their chances of qualifying for a mortgage. Notably, studies have shown medical debt to be a poorer predictor of credit risk than other types of debt because medical debt often arises in circumstances beyond an individual's control.[65] The three main credit bureaus—Equifax, Experian and TransUnion—already treat medical debt differently than other types of debts, allowing 180-day grace periods and medical debt removal once the debt is paid.[66]

3 State Government Policies

Mandate public reporting of debt collection practices by health care providers.[67] The dearth of information regarding hospitals' debt collections practices makes it difficult to capture the full magnitude of medical debt in communities of color. Public reporting of data should include:

- Race/ethnicity of individuals contacted by collectors about medical debt.
- ZIP codes of medical debt accounts referred to a collector.
- Types of extraordinary collection methods used, including wage garnishment, bank account seizure, liens, arrest warrants, reporting to a consumer reporting agency.
- Number of medical bills paid using credit cards.[68]

Establish the Office of Health Care Affordability. The OCHA would improve the affordability of care for Californians through:[69]

- Increasing transparency on cost and quality, and enforcing compliance with these standards.
- Monitoring market transactions that may raise the overall cost of care.
- Supporting health care workforce training needs and "report quality performance and equity metrics on the entire health care system."
- Promoting payment models that incentivize high-quality, cost-efficient care.
- Advancing investments in primary care and behavioral health.

These measures would facilitate health care cost containment and help prevent medical debt in the first place.

Center medical debt elimination as a part of the state's COVID-19 recovery package. The proposed federal COVID-19 Medical Debt Collection Relief Act offers helpful language for potential state legislation.[70] The Act would suspend the collection of medical debt retroactively from February 1, 2020 until the "end of the public health emergency." Wage garnishment and bank account seizure would be banned. Additionally, the state should require suspension of repayment plans throughout the duration of the public health emergency, and enact consumer protections against medical debt acquired as a result of COVID-19 testing and treatment.

- Other types of debt, such as student loans and housing debt, should also be addressed under the umbrella of COVID-19 relief. Debt cancellation will help "avoid mass defaults that threaten collective economic health and free up disposable income to stimulate the microeconomy."[71]
- A medical debt-conscious COVID-19 response should also address the inevitable increase in uninsured Californians due to loss of jobs and the accompanying health coverage.

Incorporate debt cancellation into California's larger strategy toward reparations for racial injustice. Closing the racial wealth gap by addressing debt (including medical debt) in California will require a reparations package for the Black community.[72] The conditions that lead to negative economic and health outcomes for Black Americans are a direct consequence of slavery and racist policies like redlining. California's recently established task force on the study of reparations must examine health inequities as a product of slavery and other historical injustices.

Cancel medical debt outright. The government can cancel individuals' medical debt by purchasing it from debt collectors and health care providers. Debts should not be purchased at face value, as "this would create a windfall for debt collectors who purchase medical debts for a fraction of the amount owed. The [California state] government could pursue a number of options to avoid this, including negotiating directly with debt collectors, limiting payments to the amount the debt collector paid for the debts, and implementing a moratorium on debt collection payments while offering to purchase the underlying debts."[73] The government has the responsibility to provide for economic security, and cancelling medical debt would provide relief to countless Californians amidst the COVID-19 crisis, as well as stimulate the state's microeconomy by freeing up disposable income.

CONCLUSION

Medical debt represents an opportunity to address the systemic barriers to health and wealth faced by communities of color, as well as the economic and public health crises created by the COVID-19 pandemic. Medical debt threatens the physical, mental and economic well-being of vulnerable communities, and the material consequences of this harm cannot be ignored. Medical debt relief in California will require institutionalizing racial equity in health systems, financial institutions and state government policies.

"In the absence of universal healthcare it's imperative that we remove cost barriers to treatment for low income families. Eliminating medical debt is critical to closing the racial wealth gap, incentivizing treatment, and preventing health disparities."

– Kelsey Lyles, The Greenlining Institute

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The Greenlining Institute

The Greenlining Institute works toward a future when communities of color can build wealth, live in healthy places filled with economic opportunity, and are ready to meet the challenges posed by climate change. To achieve this vision, Greenlining is committed to building a just economy that is inclusive, cooperative, sustainable, participatory, fair, and healthy. Our multifaceted advocacy efforts address the root causes of racial, economic, and environmental inequities in order to meaningfully transform the material conditions of communities of color in California and across the nation. We act as an incubator of new policy ideas, a bridge builder between people, communities and government, and an advocate to build momentum for transformative change.

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Brianna's work at Greenlining focuses on the health implications of economic and social inequity. She leads the health team's research on medical debt, and is passionate about advancing health justice for communities of color through research and advocacy.

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