ABIM FOUNDATION

ADDRESSING MEDICAL DEBT:
REBUILDING TRUST IN HEALTH CARE

June 2024

Why Medical Debt?

Medical debt in the United States has become a pressing issue – it affects more than 100 million Americans, who owe nearly $220 billion, and severely diminishes both patients' trust in the health care system and their ability to access care. Many patients face financial burdens due to the increasing costs of care, inadequate insurance coverage, and unexpected medical emergencies. The 2022 KFF Health Care Debt Survey found that one in five adults in the United States reported having problems paying medical bills, and among those, 63 percent reported using all or most of their savings to pay these bills.

Additionally, the Consumer Financial Protection Bureau reported that medical bills are the most common reason for individuals to be contacted by collection agencies.

A wide variety of attributes of our health care system contribute to the problem of debt, from the prices of health care products and services to changes in insurance policies to the billing practices of health systems and hospitals. Although there are many causes, their clear effect is to reduce trust in the health care system: only 15 percent of Americans with health care debt report that they trust that their providers have patients' best interests in mind.

Medical Debt Convening

On June 10, 2024, the ABIM Foundation convened more than 60 health care leaders and advocates to discuss best practices and promising approaches to address medical debt in the United States. More than 50 of the participants were still present for the final session of the 4-hour convening.

Discussion topics included:

- encouraging policy changes that states and localities have adopted;
- best practices for addressing medical debt, including strengths, weaknesses, and further research needs;
- the current media landscape and coverage of the issue;
- barriers and incentives for hospitals and health systems;
- how addressing debt could enhance system-physician and system-community relationships; and
- opportunities for collaboration between participants.

Richard Baron, MD, MACP, president and CEO of the American Board of Internal Medicine (ABIM) and the ABIM Foundation, welcomed participants and introduced the topic of the meeting. He highlighted why addressing medical debt is necessary to rebuild trust, touched on the ABIM Foundation's interest in medical debt, and recognized the contribution of leading organizations in attendance. Dr. Baron also acknowledged the many upstream drivers of medical debt while focusing the day's discussion on downstream intervention opportunities, particularly those available to hospitals and health systems.

Factors Eroding Trust in Health Care:

- Medical debt and costs of care
- Medical errors and patient safety issues
- COVID-19 pandemic
- Conflicts of interest and the financialization of health care
- Misinformation, disinformation, and the polarization of science
- Racism and inequities
- Burnout and moral injury
- Erosion of relationships and the transactional nature of care delivery
- Dwindling primary care access

Factors Driving Medical Debt:

- Income and other inequities
- Rising costs of care
- Limited access to affordable, comprehensive insurance
- Cost-sharing and out-of-pocket costs

Graphic by Rio Holaday

State Policy Activity on Medical Debt

Eva Marie Stahl, PhD, vice president of public policy and program management at Undue Medical Debt, discussed the severity of the medical debt problem, highlighting research showing that medical debt creates stress, anxiety, and shame and noting the painful tradeoffs people with outstanding medical bills face. Dr. Stahl noted that 86 percent of Americans blame the health care system rather than the individual incurring the debt— a stark contrast with other forms of debt (e.g., credit card debt), for which the public does blame the consumer.

Dr. Stahl also highlighted recent state and local policy efforts to address medical debt, including:

- Improving bankruptcy protections
- Limiting extraordinary collection actions (e.g., banning the reporting of medical debt to credit agencies, suing patients for unpaid bills, wage garnishment, or selling debt to a third party)
- Restrictions on how medical services can be billed and financed
- Increasing health system obligations to provide financial assistance/charity care (e.g., defining an income-based eligibility "floor" or a uniform application)

She pointed to Oregon, Colorado, New York, and Cook County (IL) as innovators in addressing medical debt. For example, in Oregon, patients with medical bills greater than $500 can apply for financial assistance before receiving a bill. New York prohibits hospitals from pursuing legal action for debts owed by patients whose income falls below 400 percent of the Federal Poverty Line.

SMALL GROUP DISCUSSION

Best Practices & Promising Approaches to Combat Medical Debt in Hospitals and Health Systems

Attendees divided into small groups to discuss the best practices that hospitals and health systems should adopt to avoid debt creation and areas where more research is needed:

Establish/expand financial aid programs:

- Adopt a presumptive eligibility policy to qualify patients for immediate financial assistance automatically based on their income, their use of other means-tested programs (such as food stamps) or other characteristics.
- Expand financial assistance (charity care) to more patients (i.e. lower income threshold or %FPL) and make financial assistance applications simpler and less invasive. For example, don't require details on patients' assets, pay stubs, tax returns, or other personal information that people are reluctant to share.
- Increase the number of financial counselors and patient advocates, support their retention, involve them in QI projects, and communicate with patients about their availability.
- Collaborate with providers to encourage enrollment in financial assistance and encourage ordering financial counseling for inpatients before discharge.

Improve billing:

- Prohibit inequitable, extraordinary collection actions such as reporting patients to credit reporting companies and taking legal action against patients (including liens and wage garnishment).
- Improve clarity, simplicity, and accuracy of patient billing and set limits for what patients can be billed.
- Adopt a policy not to deny care based on previous unpaid bills and prohibit sending bills to those being assessed for Medicaid.
- Support the extended care team to get involved, offer billing training for all employees and ensure processes to correct billing mistakes.

Work on systems changes:

- Ensure that HDHPs offered to own employees include essential covered items; limit out of pocket premiums.
- Commit to price transparency with reliable price estimates for scheduled services.
- Create a system to report and investigate any time that medical debt occurs to learn the cause and use continuous process improvement to avoid it in the future.
- Make it clear to patients the organization is committed to billing ethically so they are not deterred from seeking needed care.

Actions requiring coordinating efforts:

- Advocate for Medicaid expansion and elimination or stricter regulation of high-deductible health plans.
- Create a national pledge or campaign for hospitals who bill ethically.
- Measure and report medical debt data to a health system's C-Suite and Board of Directors, including debt's impact on the system's workforce.

Potential areas of research needed:

- Understanding if training all hospital staff members about their institution's financial assistance policies reduces debt burden.
- Measuring the administrative burden and cost to hospitals of collecting medical debt and the return they receive on that investment (i.e., Does collecting debt actually improve hospitals' profitability? Would advertising a hospital as "billing ethically" change patient behavior and impact the hospital's bottom line?).
- Understanding the impact on debt burden of simplifying health systems' financial assistance policies, such as through the adoption of presumptive eligibility.
- Quantifying the effect that medical debt—and the fear of incurring it—has on health outcomes (e.g., through the avoidance of care).
- Creating a model legal or regulatory framework for ending debt that hospitals can adopt/adapt.

Current Media Landscape

Noam Levey, KFF senior correspondent, shared his experience covering medical debt and discussed the broader trend of reporting on the issue. He noted that the media is increasingly paying attention to how organizations are approaching medical debt with a sense of responsibility and that *everyone* has a role to play.

Mr. Levey touched on his reporting about patients who are suffering because of debt they owe to hospitals and health systems, and the providers who care for them. He suggested that hospitals and health systems would benefit from examining what they might have done differently in the stories he has covered, and said that journalists would be interested in covering positive stories about health systems alleviating patients' debt or adopting policies that avoid the creation of debt in the first place. He did note that it is a challenge for journalists to know whether health systems follow their stated policies.

SMALL GROUP DISCUSSION

Barriers, Incentives, and Collaborative Solutions

Attendees again divided into small groups to discuss three interrelated aspects of medical debt.

Group I: *What are barriers and incentives for hospitals and health systems to address medical debt?*

Participants discussed the motivations hospitals and health systems could have to address medical debt, and what might hold them back.

Incentives:

- Potential for positive media coverage from acting to mitigate medical debt
- Concrete way of demonstrating trust in patients and community
- Opportunity to improve overall health of the community by increasing the community's willingness to seek care without fear of incurring debt

Barriers:

- System leaders do not always have a clear understanding about their own policies, or the impact of those policies on patients
- Leaders are focused on financial performance
- Insufficient policy protections exist at the state and federal level
- Leaders and clinicians are disconnected from one another
- Clinicians are unaware of patients' financial status and the costs of tests and treatments they order - Patients with medical debt are fearful of speaking up

Group II: *Who can help hospitals and health systems address this problem?*

Attendees brainstormed and discussed potential roles for:

- Hospital financial leaders and organizations that represent them
- Groups involved in community needs assessments
- Health foundations
- Hospital associations
- Medical schools
- Medical societies
- National organizations to recognize those implementing best practices
- Patient advocacy organizations and networks
- Patient and family advisory boards
- Payers
- Policymakers (e.g., state health commissioners and attorneys general, legislators, mayors)
- Researchers

Group III: *How does addressing medical debt help hospitals/health systems build stronger relationships with physicians and communities?*

Approaching medical debt from a trust lens, a third group discussed benefits that communities, physicians, and hospitals and health systems could obtain by addressing debt.

Communities:

- Better health and satisfaction
- Acknowledgement of past harms
- Reduced fears of seeking needed care
- Increased economic prospects
- Reduced economic toll on communities
- Enhanced trust in hospitals and health systems

Physicians:

- Reduced moral injury and burnout
- Potential for reduced workload (e.g., improved medication adherence, less financial counseling)
- Potential for improved care (e.g., improved continuity of care, adherence, outcomes)
- Affirmation that their organization's values are aligned with physician values

Hospitals & Health Systems:

- Opportunity to put an investment behind DEI commitments
- Stronger relationships with physicians, particularly younger doctors

Opportunities for Collaboration

Dr. Baron led a final discussion with all the attendees. Many participants shared their interest in partnering with hospitals and health systems, and vice versa, to tackle medical debt in different ways, such as collaborating on a new financial screening tool or sponsoring research with patients, clinicians, or community members about medical debt.

The convening ended with recognizing the momentum for addressing medical debt together, including the deep engagement of participants on the call.

APPENDIX

Participants shared the following resources with peers:

- A New Category of "Never Events"—Ending Harmful Hospital Policies *JAMA Health Forum*
- Allina Health Ends Medical Billing Practice Based on Past-Due Debt *RevCycleIntelligence*
- Billing Ethics
  The Leapfrog Group
- Debt Collection in American Medicine — A History *The New England Journal of Medicine*
- FACT SHEET: The Biden Administration Announces New Actions to Lessen the Burden of Medical Debt and Increase Consumer Protection
  The White House
- Medical Billing Quality Lacking According to Leapfrog Measures *RevCycleIntelligence*
- Navigating the Maze of Health Care Finances: A Revenue Cycle Perspective *Undue Medical Debt and Neighborhood Trust Financial Partners*
- The Affordability Accelerator: A Road Map to Improve Patient Out-of-Pocket Costs and Trustworthiness in Health Care
  NEJM Catalyst
- Their First Baby Came with Medical Debt. These Illinois Parents Won't Have Another. *NPR*
- VCU Health Announces Changes to Billing and Collection Practices
  VCU Health
- What You Need to Know About Presumptive Eligibility for Hospital Financial Assistance
  Undue Medical Debt