

The Consequences of Medical Debt

Evidence from Three Communities

Local Supplement

By

Champaign County Health Care Consumers

This Local Supplement to the report titled *The Consequences of Medical Debt: Evidence from Three Communities* is produced by the Champaign County Health Care Consumers for the Champaign County community. The purpose of this Supplement is to provide a local perspective on this national report, and to explain and discuss issues that are relevant at the community level, including policy changes that can be made to improve the lives of Champaign County residents who are struggling with medical debt.

<p>Purpose of “The Consequences of Medical Debt: Evidence from Three Communities” Report</p>

Health researchers and policy makers usually consider the problem of being without adequate health insurance as the most serious factor in health care access. However, consumer experiences at the community level indicate that whether consumers have insurance or not, a major factor affecting their access to health care is medical debt, and health care providers’ collections practices. Experiences at the community level also indicate that medical debt and health care providers’ collection practices affect consumers’ financial lives, as well as their health care access.

This research project was conducted in order to document the financial and health consequences of medical debt on individuals and families as a result of health care providers’ collection practices. Medical debt resulting from needed medical care can have severe and long-term consequences for individuals and families, especially those who are low-income, working poor, or financially vulnerable.

Interviews with individuals, social service providers, and health care providers in three communities found that the effects of medical debt include restricted access to health care, damaged credit status, and financial ruin.

<p>Why Champaign County Health Care Consumers</p>
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Was Selected to Participate in this Research Project

CCHCC's Medical Billing Task Force has been in the national forefront of health policy advocacy and community-based research in talking about how owing money for health care, and the ways that health care providers go about collecting that debt, can be devastating financially and health-wise for individuals and families in local communities.

Since 1997, the CCHCC Medical Billing Task Force has been documenting local consumers' problems with erroneous, unethical and illegal medical billing practices, medical debt, and health care providers' increasingly aggressive and coercive collection practices. In 1999, Ralph

Nader called CCHCC's Medical Billing Task Force a "national leader in the field – the first local group to take on this scandal in health care."

CCHCC's Medical Billing Task Force has been organizing for fair, humane, and legal medical billing and debt policies. CCHCC's staff and its accomplishments have received national recognition, including the Robert Wood Johnson Community Health Leadership Program award.

Framework for Understanding Medical Debt and Health Care Providers' Collection Practices: Challenging Assumptions About Medical Debt, Why It Is a Problem, and for Whom It Is a Problem

Health Care Is Not Like Any Other Business (p. 2-3)

Health care is a business unlike any others. The customers are, by definition, in a vulnerable position by virtue of the medical problem for which they seek services. The providers of these services differ from the sellers in most other markets because their product is essential and often life-saving or life-sustaining, and is governed by ethical responsibilities that exceed those that apply in typical commercial transactions. "Purchases" are often sudden and unplanned and, particularly for people without health insurance, may bring large financial burdens that are involuntary in the sense that they are not the result of a traditional consumer choice.

To be sure, health care services must be compensated. The uniqueness of the health care marketplace, though, as well as the health care and financial consequences that can result from large debts and aggressive pursuit of payment, argue for a posture of flexibility and accommodation of individual circumstances in negotiating and fulfilling payment arrangements.

Medical Debt Is Involuntary and Unplanned, and Can Happen to Anyone

- Medical expenses are often unexpected and unplanned. Anyone can incur medical debt (this is why medical debt is referred to as "involuntary debt.").

- Insured as well as uninsured patients can owe money for out-of-pocket health care costs.

Uninsured Patients Are Charged the Highest Prices for Health Care

- Hospitals and clinics expect uninsured patients to pay more than insured patients for services because the hospitals and clinics give discounts to insurance companies for health plan members.
- The average hospital discount for all third-party payers is estimated to be around 50%, with some health plans getting discounts as high as 70%. This means that uninsured Illinois residents are often expected to pay two to three times more than insured patients for the exact same treatment (this practice is referred to as “discriminatory pricing”).

Consumers Are Working Hard to Pay Their Medical Bills

- Consumers are working hard to pay their medical bills, but health care providers’ payment plans are frequently unreasonable and unaffordable for low-income consumers. Payment plans are not usually negotiated on a case-by-case basis, because if they were, health care providers would have to take into account the consumers’ capacity to pay based on their income, assets, and daily living expenses.
- More than half of the people interviewed tried to work out a payment plan to pay off their medical debt. (p. 16)
- Of those who tried to work out a payment plan but were not able to, the main reason was that the health care provider demanded too high a monthly payment. (p. 16)

Paying Medical Debt Is No Protection from Collections, Lawsuits, and Denial of Care

- Making payments towards medical debt does not appear to ease barriers to care. People who are making payments experienced no significant differences from those not making payments in terms of the likelihood of being refused care or being asked to pay cash upfront. (p. 16)
- Even when making payments at the level they can afford, consumers can get sued, have their credit ruined, or be taken to collections because of their medical debt.
- In the case of consumers with insurance, frequently the health care provider has already received some payment from the insurance company.

People’s Lives Are Being Ruined Over Relatively Small Amounts of Debt

- Some consumers are being sued in court for medical debt in amounts as low as \$100.

Many owe debts of under \$5,000, but because of inflexible and unreasonable payment plans by health care providers, consumers are having their credit ruined, sent to collections, and taken to court.

- Bad credit resulting from medical debt can frequently results in individuals and families not being able to qualify for loans, homes, apartments, auto purchases, and even jobs (many employers are now running credit checks as part of the candidate screening process).
- Bad credit and harassment for payment of medical debt can result in low-income consumers having to file bankruptcy as a means of seeking financial relief.

Many of the People Being Sent to Collections and Being Sued Are Low-Income and Should Be Getting Assistance

- Low-income seniors with only Social Security as their income are being sued for collection of medical debt.
- Individuals and families using social services available only to low-income people or people in crisis are being sued.
- Many of the people being sued are so low-income that they are legally considered “judgment proof” – their income and assets are “exempt” from collections – but they do not know their rights or how to assert them, and they are not getting assistance for qualifying for other resources from the health care providers.
- According to ACA International, a trade association of collectors, the average recovery rate for hospital collections is 6.5% and for clinics it is 7.6% (p. 9). These data indicate a failure on the part of the health care providers to distinguish patients who are able to pay from patients who are not.

Medical Debt and Aggressive or Unreasonable Collections Practices by Health Care Providers Can Create a Downward Spiral Affecting Individuals, Families, and Communities

- Many people incur medical debt because of a serious illness or injury. That illness or injury can result in time lost from work, and in inability to resume work due to disability or the need for extended recovery and rehabilitation. Job loss or time away from work can result in lost wages and income for individuals and families at the same time that they are incurring new medical debt.
- If medical debt affects a consumer’s access to primary care services, they may be forced to use Emergency Room services, which are more costly for the consumer and for the community.

- If medical debt affects a consumer’s access to health care, they may have a health situation which becomes worse and interferes with their capacity to function and work, and which can ultimately lead to increased health care expenses.
- Medical debt affects individuals, families, and communities. Families help individuals pay the debt, or cover other living expenses. Social service providers with clients experiencing insurmountable medical debt are also affected and share in the burden by having to provide more support services for longer periods of time to clients experiencing these problems. Communities also pay the price when more people must resort to using the Emergency Rooms for health care if they are denied access to primary care because of medical debt.

Who Gains from Health Care Providers’ Aggressive Collection Practices?

- For both the insured and the uninsured, it appears that hospitals engage in aggressive collection practices that do not make distinctions based on individual patient circumstances. In one of our communities, for example, a hospital was seeking to garnish wages from a person living in a homeless shelter. It is hard to imagine who gains from this practice; the hospital is unlikely to yield significant return on these efforts, and the person in the shelter is faced with yet another obstacle to gaining self-sufficiency, particularly if the debt is eventually documented on a credit report. (p. 10)
- Despite the fact that many in our sample have very low incomes, many were never informed about the availability of public assistance, discount care programs, or other resources for which they might qualify which could have resulted in payment to the health care provider (ex. Medicaid, Medicare, SSI, etc.).
- Health care providers’ reputation in the community is damaged as they are perceived to be greedy at the expense of their patients’ lives.

<p>Key Findings from “The Consequences of Medical Debt: Evidence from Three Communities” Report</p>
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- Having health insurance does not always protect individuals from out-of-pocket medical bills they cannot afford to pay. In our survey of low-income individuals in three communities, respondents with and without insurance were struggling with comparable levels of medical debt.
- Confusing and multiple bills, and the challenge of understanding what is owed and to whom, add to the problem.
- Health Care Provider practices – requiring cash payment up front, flatly refusing care or

suggesting people use other sources of care – made it harder for many respondents with medical debt to access care when needed. Patients often responded to these practices by not seeking care or filling prescriptions, or otherwise not complying with treatment regimens.

- Health care providers are adopting more aggressive collection procedures, including turning over their accounts to collection agencies 30 to 60 days after a missed payment (instead of the more customary 150 to 210 days) and encouraging patients to pay off their medical bills with credit cards, a practice that burdens patients with not only larger debts, but with higher interest payments as well, effectively increasing their costs for health care.
- Many of the individuals we interviewed wanted to pay off their debt and had tried to negotiate payment plans, but found the terms of the plan very difficult to maintain given limited incomes and apparently inflexible hospital collection practices.
- Few respondents, in spite of very low incomes, were able to secure public assistance to defray the cost of their medical care. Many turned to family and friends for help, suggesting that communities may help relieve the burden of medical debt, but also share in it.
- Like other forms of debt, medical debt can have substantial financial consequences, including serious credit problems and, in extreme cases, personal bankruptcy. However, unlike other forms of debt, medical debt is often involuntary, the result of an event over which one has little or no control.
- Bankruptcy may offer a means to relief from medical debt and from the harassment of collection agencies and its attendant stress. This is particularly the case for the uninsured – people who are likely to have relatively fewer resources and be less able to make regular payments on their debt.
- Medical debt made it harder for respondents to achieve self-sufficiency. They were hindered in their ability to get a bank loan and other lines of credit, to save money, or to pay for basic goods and services.
- The effects of medical debt can be compounded if a health problem leaves a person unable to return to work. Because of the debt, people may be deterred from seeking the care needed to allow them to work. Job seeking may also be hindered by the fear of wage garnishments.
- Respondents told us that medical debt caused significant stress, anxiety and feelings of hopelessness. Medical debt can also be a source of embarrassment and shame, and many respondents were frustrated and angry that they were being financially punished for a medical event over which they had little control.

What People Owe and To Whom (p. 13)

- Most respondents associated their medical debt with a hospital visit; almost two-thirds attribute the hospital expense to emergency room visits. Many also reported owing a primary care provider.
- Even relatively small amounts of medical debt can have devastating effects for low-income individuals and families because of health care providers' aggressive collections practices.
- Almost 20% of respondents owed less than \$1,000. Almost 40% of respondents owed less than \$5,000.

<p style="text-align: center;">Key Findings About the Medical Debt Problem in Champaign County</p>

Denial of Care and Demands for Payment Upfront for Consumers with Medical Debt (p. 16)

- Champaign County's health care providers are more likely to use denial of care and to demand payment upfront in order to try to collect outstanding medical debt from low-income consumers.
- Respondents in Champaign were more likely to report that they were asked to pay cash upfront for health care services (59%) than respondents in Alexandria, VA (8%) and Miami, FL (33%)
- Respondents in Champaign were significantly more likely to be refused or delayed care (50%) compared to respondents in Alexandria, VA (32%) and Miami, FL (21%).

Local Bankruptcy Data

- There were 279 bankruptcy cases during the month of December 2001, and approximately 3,200 for the entire year.
- Approximately 58% of the studied bankruptcy data involved medical debt. This number does not include medical debt that was paid for with credit cards or by borrowing from a loan company. A greater proportion of bankruptcy filings in December 2001 in Central Illinois (58%) involved medical debt than the national average (40%) from 1999.

Small Claims Cases

- Between May and December 2001, small claims cases brought directly by health care

providers in Champaign County numbered 229. This means that an average of 7 people per week were directly sued by health care providers in Champaign County small claims courts. This does not include medical debt lawsuits brought by collection agencies working on behalf of health care providers.

- About 20% of the small claims cases brought directly by health care providers were by non-profit health care providers.
- Health care providers were suing patients for balances as low as \$100 in some cases. The average amount of debt for which the consumer was being sued in these cases was \$997.38.

Policy Recommendations and Next Steps

What Health Care Providers Can Do Immediately to Address the Problem

- Cease the practice of denying access to care to people because of outstanding debt.

How health care providers gain from this change: People need access to health care so that they can function and work. They will be more likely to be able to keep up with, or begin payments for medical debt if they are able to be healthy.

- Work with consumers to make reasonable payment agreements that are affordable to the consumer and realistic.

How health care providers gain from this change: Avoid unnecessary costs and loss of revenue as a result of turning accounts over to collections or taking patients to court. Patients want to pay their debts; but they must be allowed to pay off debts in a way that is affordable to them and does not jeopardize their basic living needs.

- Do not report medical debt to credit bureaus.

How health care providers gain from this change: This action causes tremendous damage to patients' financial lives and their capacity for financial self-sufficiency. In addition, this action damages patients' relationships with health care providers, and health care providers' reputation in the community while there is no evidence that reporting medical debt to credit bureaus benefits health care providers in any way.

- Do not coerce or pressure patients to pay with credit cards or take out loans.

How health care providers gain from this change: Coercing patients to put medical debt on credit cards or to take out loans simply deepens the patients' debt and their cost for health care. Credit card debt is a major contributing factor to personal bankruptcies.

Pressure to put medical debt on credit cards rather than work out reasonable payment agreements with the patient is damaging to the relationship between patient and health care provider, and to the reputation of the health care provider.

- Make financial and collections policies public.

How health care providers gain from this change: Patients and the community can have a better understanding of the policies and can have more information with which to plan for how to deal with their medical debt. Protects health care providers from the public perception that they are capricious, punishing, or vindictive in their approach to collecting medical debt from their patients.

- Treat people with dignity and respect. Also, ensure that collection agencies that health care providers contract with also treat people with dignity and respect.

How health care providers gain from this change: Such treatment is consistent with the ethics of healing and helping patients. Patients will be much more likely to be able to develop a productive working relationship with the health care providers for dealing with repayment of medical debt. Patients do not differentiate between the health care provider and the collection agency contracted by the health care provider. How the collector treats the patient reflects on the health care provider.

The Medical Billing Task Force and the Community Health Partnership's Access to Care Work Group will conduct a survey of health care providers' financial policies.

- These two groups are joining together to ask local health care providers to answer a written survey about the health care providers' financial policies.
- By completing the survey, health care providers will have an opportunity to make public their financial policies, as recommended above.

The Medical Billing Task Force and the Community Health Partnership's Access to Care Work Group will solicit input from consumers and the community to develop additional policy recommendations regarding medical debt.

- Policy recommendations might take the form of addressing local health care providers' practices, creating local ordinances, or advocating for state or federal legislation.