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Hospitals and Medical Debt: A Report on Policies and Practices

Executive Summary

Up to 41% of Americans are estimated to have medical debt, broadly defined to include past due medical or dental bills as well as payments made over time to providers, financed through credit cards or other lending avenues.[1] The burden of medical debt has wide-ranging consequences for patients and their families, including delaying health care, depleting savings, diminishing physical and mental health, increasing mortality, and eroding trust in health care.[1-3] Federal and state policies have provided some protections, although progress has been uneven.

Hospitals have addressed medical debt through their financial assistance programs and by curtailing the use of aggressive collection actions. To better understand hospital efforts, AcademyHealth, with funding from the ABIM Foundation, conducted a two-part environmental scan consisting of 1) a literature review; and 2) key informant interviews. The environmental scan addressed two research questions: 1) what is the nature and prevalence of health system policies and practices related to medical debt mitigation and collection; and 2) what is the impact of these policies and practices on patients and clinicians?

By identifying priorities for further research and highlighting effective and promising approaches for addressing medical debt, this report is intended to aid health system leaders, researchers, clinicians, and patient and community groups working to address medical debt.

Background on Federal Regulations

Under federal law and the Affordable Care Act (ACA), nonprofit hospitals must adopt and publicize a financial assistance policy, sometimes known as a charity care policy, that defines eligibility criteria for free or discounted care.[4] However, there are no federal standards about how generous those policies must be, with no required minimum eligibility thresholds or benefit amounts.[5] Federal protections related to medical debt collection are also limited. Nonprofit hospitals can take extraordinary collections actions (ECAs) against patients once they have made a "reasonable effort" to assess a patient's eligibility for financial assistance. ECAs include credit reporting, selling debt to third parties, denying non-emergent care, and taking legal action through such means as lawsuits, wage garnishment, and property liens.[5]

What We Know: Addressing Medical Debt

Key strategies for mitigating medical debt include:

- hospital financial assistance,
- Hospital Presumptive Eligibility (HPE) for temporary Medicaid coverage,
- financial navigation services, and
- medication-focused assistance.

Research has found these strategies to be effective, with increased patient access to care, cost savings, and improved health outcomes.[6-13] Strategies for addressing medical debt collection focus on ethical billing practices, including itemized billing and avoiding legal action.[14] Recent research has shown a decline in ECAs, such as credit reporting, lawsuits, wage garnishments, and liens.[15-17] However, in the absence of standardized federal requirements, considerable variation remains, and research has highlighted misalignment between factors such as hospital financial performance and levels of financial assistance provided, or the value of tax benefits and levels of financial assistance provided.[18-22]

Understanding hospital behavior requires looking beyond policies and practices to broader structural factors, as hospitals face a number of pressures that may complicate their ability and willingness to prioritize addressing medical debt. These include pressures related to financial sustainability, the role of payers and insurance, influence of private equity, and heath policy. Among the multitude of factors at play, the high cost of health care was highlighted as a key underlying factor in the creation of medical debt.

What We Do: Current Hospital Policies and Practices

While the evidence identifies strategies that can help mitigate medical debt, hospital actions vary widely, with discrepancies between hospital policies and actual practices, and between evidence-based strategies and current practice. More than 80% of hospital policies indicate they provide free and discounted care, but eligibility criteria vary substantially.[23] In terms of actual financial assistance provided, 45% of hospitals spend less than 1% of their operating expenses on financial assistance.[24] When it comes to medical debt, over half of hospitals (59%) permit at least one kind of ECA, while only a small minority (4%) do not permit any.[23] Evidence on actual debt collection practices is limited and fragmented. However, research has indicated that one-third of hospitals report taking legal action against patients.[25]

States play a critical role in addressing medical debt through policy protections, but fewer than half of states set a minimum amount of financial assistance that hospitals should provide. For states that regulate debt collection, protections also vary, with some states imposing specific limits on ECAs and others prohibiting them outright.[5]

What We Need to Know: Key Evidence Gaps

Understanding the full scope of medical debt requires more comprehensive and standardized data across several sources, including hospitals, credit reporting agencies, courts, and state-level data collection. Significant gaps remain in estimates of the prevalence of medical debt, hospital reporting practices, financial transparency, and evaluations of existing interventions as outlined in the table on evidence gaps.

What We Can Do Now: Effective and Promising Approaches

Even as research continues, our environmental scan revealed valuable insights into effective and promising approaches for reducing medical debt, including:

Approaches That Hospitals Can Lead

1. **Patient-Centered Financial Assistance and Other Programs**
   - Optimize financial assistance to improve both eligibility and access issues
   - Hospital participation in Hospital Presumptive Eligibility (HPE) programs for temporary Medicaid coverage, although recent and pending health policy changes may present a more complex environment for providing such coverage
   - Staff support to help patients manage costs of care, apply for health insurance and medication assistance, and coordinate with care teams and clinicians
   - Offer sliding-scale, zero-interest payment plans and avoid predatory medical credit cards[28]
2. **Ethical Billing and Responsible Debt Collection**
   - Adopt ethical billing practices and avoid aggressive collections
   - Engage with all hospital contracted entities to ensure that consistent billing ethics and socially responsible financial practices are in place
3. **Organizational Leadership, Culture, and Decision-Making**
   - Engage hospital leaders who consider the hospital's broader role and impacts in the community
   - Focus on a hospital's mission of improving people's health, while also considering the value of ensuring financial resources remain in communities for the well-being of both patients and the institution
   - Engage clinicians, the community health or community benefit department, hospital social workers, hospital boards, and patient and community representatives in determining hospital financial policies (e.g., financial assistance and debt collection)
   - Consider trust as a unifying force as both hospital leaders and clinicians may experience a loss of trust with the increasing corporatization of health care
4. **Partnerships with Community-Oriented Organizations**
   - Partner with community organizations to streamline processes and offer support in such areas as financial assistance navigation, cultural sensitivity, and debt relief
   - Explore the potential for investing in financial products developed under a patient-centered model focused on public benefit, such as billing services that provide support for achieving administrative efficiencies without engaging in predatory practices

Key Evidence Gaps	
Topic	**What is Missing**
Population-Level Data	
Prevalence of Medical Debt	Full extent of medical debt remains unclear, as medical debt takes many forms and is inconsistently measured, with most surveys capturing only partial indicators
Credit Reporting	Credit data are largely proprietary and held by private credit bureaus, creating high administrative barriers and costs to researchers
Court Records on Medical Debt	Litigation data are difficult to compile given inconsistent digitization and unclear identification of originating providers
Credit Card Data	Extent of medical debt that exists on credit cards to pay medical bills, which is technically considered financial debt
Hospital-Level Data	
Financial Assistance Applications	Hospitals do not routinely report on the number of financial assistance applications attempted, completed, and approved, including patient demographics, although some states have started to require reporting on these data
Debt Collection Practices	Hospitals do not routinely report on the number of patients with unpaid bills, the debt size, insurance status, and the number of ECAs, including patient demographics
Hospital Financial Transparency	Despite Internal Revenue Service (IRS) and other reporting requirements, there is limited hospital financial transparency, such as information on assets, reserves, and profits, and there is lack of consensus about which data would be most meaningful to track
Hospital Operational Expenses and Revenue	Given the complexity of hospital financial administrative processes, there is limited insight into distributions of revenue (e.g., what percentage goes to the hospital vs physicians vs third parties)
Return on Investment of ECAs	While available data suggest a limited benefit to pursuing ECAs, rigorous research is needed to assess return on investment of various debt collection practices and whether this varies across hospital types[26,27]
Landscape of Financial Tools	Lack of transparency of vendors and products (e.g., presumptive eligibility tools, revenue cycle management companies, medical credit cards) that hospitals are using, and market share
Research/Evaluation Studies	
State Policies	Variations in enforcement, implementation, and consumer awareness make it difficult to evaluate state policy protections, including making the business case
Programmatic Interventions	Rigorous evaluations are needed to assess different programs for addressing medical debt (e.g., financial navigation programs)
Business Case for Underfunded Services	Rigorous evidence quantifying the economic and broader societal value of underfunded health care services, such as preventive care and palliative care

Approaches That Require Broader, External Leadership

5. Engaging Policy, Industry, and Public Support

- Establish state requirements for financial assistance reporting and/or minimum financial assistance spending, along with medical debt protections and reporting[29,30]
- Maintain mandatory state or voluntary industry billing standards
- Highlight model financial assistance policies for hospitals to adopt or adapt
- Develop a list of vendors vetted at the state or federal level, for example for financial navigation services or revenue cycle management companies
- Hold insurers accountable for plan design and affordable insurance[3]
- Draw wider media and public attention to medical debt and the impacts of aggressive debt collection practices

Medical debt and prohibitively costly care undermine trust and must be confronted. While policy debates about health

care financing are ongoing, health services researchers, health system leaders, and other partners can take meaningful steps now to rebuild trust and focus on an issue that impacts so many. By adopting patient-centered financial assistance and ethical billing practices, hospitals can play a critical role in leading this effort. However, lasting change requires collective action—especially in the current health policy and financial environment—bringing all who are affected to the table to develop an attainable, just, and equitable approach to addressing medical debt.

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