

Medical Debt in the United States

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Professor David A. Hyman
Scott K. Ginsburg Professor of Health Law & Policy
Georgetown University Law Center

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I have organized my testimony around four key points:

1. Quantifying medical debt involves both methodological choices and definitional uncertainty.
2. Medical debt is a function of multiple interactive factors.
3. Modifications to credit reporting of medical debt may provide some relief but is also likely to have unintended consequences.
4. Medical debt is a symptom of a larger problem, which will not be solved by changes in credit reporting practices. If we want to fix the problem of medical debt, we should be focusing on making health care cheaper.

Quantifying Medical Debt: Methodological Choice and Definitional Uncertainty

Researchers have generally used credit reports to generate estimates of total medical debt, based on bills from medical providers that are unpaid and have been sent to a collection agency and reported to a credit reporting agency. There are good reasons to use this approach; credit reports are objective sources of quantifiable information, and if an account is labeled as coming from a medical provider, it is unlikely to be attributable to non-medical debt.

According to a recent report by the CFPB using this approach, about 20 percent of credit reports include such “medical collections,” totaling approximately \$88 billion.¹ Other estimates use the same approach.² These studies indicate that medical debt is not evenly distributed across the population, and a modest number of outliers are responsible for a heavily disproportionate share of total medical debt. The same studies find that higher medical debt is more likely among certain sub-groups of the population.

There are several distinct problems with using this credit report-based approach to determining the amount of medical debt -- let alone evaluating whether there are any time trends in the total amount of medical debt.

¹ CFPB, *Medical Debt Burden in the United States* (2022), at <https://www.consumerfinance.gov/data-research/research-reports/medical-debt-burden-in-the-united-states/>.

² See, e.g., Raymond Kluender et al. *Medical Debt in the US, 2009-2020*. 326 JAMA 250-256 (July 20, 2021), <https://jamanetwork.com/journals/jama/article-abstract/2782187> (estimate of \$140 billion); Michael Batty, Christa Gibbs and Benedic Ippolito. *Unlike Medical Spending, Medical Bills in Collections Decrease with Patients' Age*,” 37 Health Affairs 1257-1264 (July 25, 2018), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0349>. (estimate of \$81 billion).

All of these studies are based on data from a single credit reporting agency, and all three employ the same definition of medical debt (i.e., a medical bill that is sent to collections). The first problem is that not all medical debt that is sent to collections is reported to all three credit reporting agencies – so reliance on a single agency will predictably miss at least some amount of medical debt. The second problem is that not all medical debt is sent to collections -- so reliance on collections data will predictably miss some medical debt as well. The third problem is that not all debt attributable to medical evaluation and treatment is reported as medical debt. For example, patients can pay some of their medical bills (including deductibles and co-payments at the point of service) with a traditional credit card. Alternatively, they can use a credit card designed and marketed to cover health care expenses.³ Finally, they can tap other sources of funds, such as home equity loans, to pay medical bills. If any of these accounts ever go to collection, they will be treated by researchers as non-medical debt.⁴ For all these reasons, research that relies on collections data will predictably under-estimate total medical debt.

An alternative approach relies on survey data. For example, Rae et al (2022) use data from the U.S. Census Survey of Income and Program Participation (SIPP) to evaluate medical debt.⁵ They arrive at a much higher figure (\$195 billion) than the studies based on credit reports. Surveys have their own issues involving validity, including whether the sample size is sufficient, and whether respondents can accurately recall and report information. For these reasons, Rae et al (2022) note that “[t]he total amount of medical debt is difficult to estimate with any precision. While surveys capture a larger share of people and more types of medical debt than analysis of credit reports, there are challenges in capturing data from people who owe high levels of debt.”⁶ That said, like the studies based on credit reports, Rae et al (2022) also find that medical debt is highly concentrated, with large sums owed by a relatively modest number of individuals: “0.3% of adults account for well more than half of the total medical debt.”⁷

³ For several examples of such products, see Bankrate, *Best credit cards for medical expenses*, <https://www.bankrate.com/finance/credit-cards/should-you-have-a-medical-credit-card/>.

⁴ For a discussion of how such these strategies affect the amount of reported medical debt in the context of bankruptcy filings, see Melissa B. Jacoby & Mirya R. Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 Yale J. Health Pol’y L. Ethics 239 (2010).

⁵ Matthew Rae et al., *The Burden of Medical Debt in the United States*, KFF Issue Brief, Mar. 10, 2022 <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/> (\$195 billion). Other researchers have used similar strategies. See, e.g., U.S. Census Bureau, *Who Had Medical Debt in the U.S.?* (Apr. 7, 2021), <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>; Liz Hamel et al., *The burden of medical debt: results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, (Jan. 5, 2016), <https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/>; Robin A. Cohen & Jeannine S. Schiller, *Problems paying medical bills among persons under age 65: early release of estimates from the National Health Interview Survey, 2011–June 2015*, National Center for Health Statistics; (Dec. 2015), https://www.cdc.gov/nchs/data/nhis/earlyrelease/probs_paying_medical_bills_jan_2011_jun_2015.pdf; Sara R. Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families: Findings From the Commonwealth Fund Biennial Health Insurance Surveys, 2001-2007*, <https://www.commonwealthfund.org/publications/fund-reports/2008/aug/losing-ground-how-loss-adequate-health-insurance-burdening>.

⁶ Rae et al, *supra* note 5.

⁷ Id.

To sum up, researchers have used various strategies to quantify medical debt, and have arrived at figures ranging from \$81 billion to 195 billion. This range of figures is the result of different methodological choices, data (un)availability, and definitional uncertainty.

Medical Debt is a Function of Multiple Interactive Factors

The amount of medical debt that is incurred is a function of the billed cost of care, less any discounts and payments (including insurance, charity care write-offs, and direct payment by the patient). This formula means the amount of medical debt incurred by any given patient is affected by multiple factors, including how much care they receive; the list price of the care that is rendered; whether the patient has insurance; whether the care is provided in-network or not; the “generosity” of applicable insurance coverage (i.e., how large the deductibles and co-payments are); the “generosity” of provider charity care policies and whether they pursue patients for balance bills; and the amount of any payments made by the patient at the time of service.

This list makes clear how many moving parts there are associated with any given episode of medical debt, as well as the potential interactions of each of those parts. For example, people who don’t consume health care won’t have medical debt, even if they don’t have insurance – or have insurance with large co-payments and deductibles. People who do consume health care but have “rich” insurance coverage (i.e., insurance with no co-payments or deductibles) are unlikely to end up with material medical debt. Patients who receive care from a retail clinic are less likely to have material medical debt than those who always go to a hospital emergency department. Patients who receive care from in-network providers are less likely to end up with material medical debt than those who receive care from out-of-network providers. Patients who receive care from a hospital with a robust charity care policy are less likely to have material medical debt than those who receive care from a hospital that has a more restrictive charity care policy. Patients who receive care from a provider that does not balance bill are less likely to have material medical debt than those who receive care from a provider that aggressively seeks to collect balance bills. And so on.

Credit Reporting and Medical Debt

Until recently, credit reporting agencies reported medical debt like any other form of debt. In the last week, Equifax, Experian, and Transunion have all announced changes in how they will handle medical debt. In general, these changes involve (i) deferring the reporting of medical debt that is in collections until a year has passed (for debt that exceeds \$500); (ii) not reporting medical debt that is in collections if the amount owed is less than \$500; and (iii) removing information on collection of medical debt from credit reports if the debt has been paid off.⁸

It remains to be seen how credit rating scores will be affected by these changes, or by other possible changes to credit reporting practices regarding medical debt. There are reasons to expect that individuals with modest medical debt may experience an increase in their credit rating, affecting their ability to obtain credit on favorable terms. Depending on the details of credit scoring and adjustments made in response to the elimination of most medical debt from credit reports, the increase in credit rating may be temporary. Alternatively, even if the credit rating bump is persistent, the meaning of any given credit score to issuers may change as well.

⁸ Jessica Merrit, Most Medical Debt May Soon Vanish From Credit Reports, US News Money, Mar. 25, 2022, <https://money.usnews.com/credit-cards/articles/most-medical-debt-may-soon-vanish-from-credit-reports>.

There are likely to be other follow-on consequences as well. At the margin, changes in credit reporting may make some patients less willing to pay their medical bills. Non-hospital providers are likely to adapt by restricting available appointments to those who can pay in full at the time of service, or otherwise limiting access to care to patients unable to pay in full at the time of service -- the very group of patients whom this change in credit reporting aims to help.⁹ I would also expect more consolidation on the delivery side of the market, as small groups and individual providers come under increasing financial pressure. There will doubtless be other unintended consequences.

Solving the Problem of Medical Debt

Medical debt is a symptom of a larger problem – the American health care system is too expensive. Attempting to solve the problem of medical debt with tweaks to the credit reporting system is the equivalent of treating a symptom instead of the underlying disease.

Congress has already taken a big step to address the problem of medical debt with the No Surprises Act, although disagreement about implementation has already resulted in litigation.¹⁰ There is no shortage of additional ideas on how to make health care less expensive, although there is considerable disagreement on which ideas are worth pursuing. One strategy that should not be controversial is ensuring non-profit hospitals are providing sufficient charity care to justify the sizeable tax exemption they receive.¹¹ Another strategy that should not be controversial is to encourage the use of lower-cost providers (including retail clinics and para-professionals) when the requisite services are within their scope of expertise. There is also considerable price variation among providers for a variety of shoppable medical services – creating obvious opportunities for lowering health care spending, as long as there is sufficient pricing transparency.¹² I have spelled out other ideas for making American health care cheaper in my academic work and am happy to discuss those issues further if there is interest and time.¹³

⁹ Hospitals that receive Medicare are subject to EMTALA, and may not deny evaluation and treatment based on insurance status or ability to pay.

¹⁰ See Katie Keith, *Court Sets Aside Key Parts of No Surprises Act Rule*, Health Aff. Feb. 24, 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220224.298748/>.

¹¹ Ge Bai & David A. Hyman, *Nonprofit hospitals' community benefits should square with their tax exemptions. They often don't*, StatNews (Feb. 17, 2022), <https://www.statnews.com/2022/02/17/nonprofit-hospitals-not-earning-tax-exemptions/>; Ge Bai & David A. Hyman, *Tax exemptions for nonprofit hospitals: It's time taxpayers get their money's worth*, StatNews (Apr. 5, 2021), <https://www.statnews.com/2021/04/05/tax-exemptions-nonprofit-hospitals-bad-deal-taxpayers/>

¹² John Jiang, Martin A. Makary & Ge Bai, *Commercial Negotiated Prices for CMS-specified Shoppable Radiology Services in U.S. Hospitals*, 302 Radiology (Nov. 30, 2021), <https://doi.org/10.1148/radiol.2021211948>. See also Melanie Evans, *Some Hospitals Charge Up to 10 Times More For Medical Scans Than Others, Study Finds*, Wall St. J. Nov. 30, 2021, <https://www.wsj.com/articles/some-hospitals-charge-up-to-10-times-more-for-medical-scans-than-others-study-finds-11638284400>.

¹³ CHARLES SILVER & DAVID A. HYMAN, *OVERCHARGED: WHY AMERICANS PAY TOO MUCH FOR HEALTH CARE* (Cato, 2018).