Testimony by Luke Messac, MD, PhD
United States Senate Committee on Health, Education, Labor & Pensions
"What Can Congress Do to End the Medical Debt Crisis in America?"
July 11, 2024

Chairman Sanders, Ranking Member Cassidy, and distinguished members of the Committee, thank you for the opportunity to appear before you this morning. My name is Luke Messac, and I am an emergency physician and historian at Brigham and Women's Hospital and Harvard Medical School. My comments today reflect my own views and do not necessarily reflect the opinion of my affiliated institution.

The toll taken by medical debt, and by the fear of incurring it, are clear every day in the ER. My patients worry aloud that if they follow my advice to stay overnight to see if their chest pain is a heart attack, or to see if their dizziness is a stroke, they will face debts they cannot pay. Some fear debt so much that they show up too late. I will never forget the woman who came to the ER one evening with a large, fungating, cancerous mass. I had seen masses this large in southern Africa, but never in the United States. She told me she had noticed it six months before, but she did not go to her doctor. When I asked why, she said she feared the bills she would leave her family if she sought treatment. By the time she came to us, what had been a treatable cancer was now widely metastatic and inevitably fatal, and all she wanted was relief from her unremitting pain.

When my patients shared concerns about medical bills, I used to try to reassure them. But as I came to learn, too late, patients are right to fear their bills. Patients who cannot pay can find themselves in court, or even in jail. When I visited my county courthouse in Rhode Island during residency training, I found that my own hospital was suing hundreds of patients each year, including single working mothers and the disabled. Across the country, hospitals and third-party debt collectors report patients' debts to credit bureaus, garnish their wages, seize their bank accounts, foreclose on their homes, and even seek warrants for their arrest if they miss court hearings.

We know that patients in debt avoid or delay necessary medical care. Americans with medical debt are 3 times more likely to forego care than those who have none. Patients in financial distress after a cancer diagnosis are less likely to adhere to treatment recommendations, and more likely to die. While debts lead Americans to early graves, they do not die with them. Patients' spouses are hounded by debt collectors even after their loved ones are gone.

When I first learned what was being done to my patients in medical debt, I was overcome with surprise, then anger, and then, most of all, with shame. Patients come to us on the worst days of their lives. We use our years of training to diagnose and treat emergent and potentially fatal conditions. I chose emergency medicine as a specialty because it was, to me, the most direct way to treat patients in distress, to bring people on the verge of death back to health and to the people they love. It is difficult, and often distressing, but it involves, for me, a sacred promise to be there for anyone, to treat anything, at any time. I want to be worthy of my patients' trust, but I cannot do

that if I am part of a machine that uses lawyers and judges and collection agencies to squeeze the sick and the vulnerable for bills they cannot pay.

There are some simple and affordable solutions to this problem. In exchange for tax exemptions, nonprofit hospitals are required to publicize their policies on financial assistance, also known as charity care. This is meant to prevent debt from being incurred in the first place. But applying for this care is unnecessarily difficult, with onerous documentation requirements. Hospitals can use software to quickly determine whether a patient is likely eligible for free or discounted care. The IRS can use existing authority to allow hospitals to verify patient income in real time.

For patients already struggling with unpayable debt, we can cancel it in a way that helps struggling hospitals and delivers the maximal benefit for patients. Recent research suggests that the greatest benefits of debt cancellation come before hospitals and debt collectors pursue patients with threatening letters and lawsuits.

To finally end the deadly problem of medical debt, we will need universal, first-dollar coverage. This can take many forms, including Medicare for All, which has been endorsed by the American Public Health Association, the American College of Physicians, and National Nurses United.

Physicians, nurses and other health care workers have a calling, one that my mentor, the late Dr. Paul Farmer, called "expert mercy." It combines the best of scientific inquiry and our faith traditions. By ridding us of the scourge of medical debt, you can help us live up to this mission. Thank you.

Extended written testimony, adapted from Luke Messac, *Your Money or Your Life (Oxford University Press, 2023).*

The history of medical debt is the story of how debts once negotiated personally by doctors and patients have been transformed into numbers on a spreadsheet, pursued to the extent of the law (and sometimes beyond it) by collectors with no role in medical care. While for most of the twentieth century much of the work of collecting delinquent payments was done by hospitals' own in-house collection departments, by the early twenty-first century many hospitals had come to rely on outside collection agencies and debt buyers. How this works: Hospitals "assign" their debts to a collection agency; the agency works the debt and keeps a commission on the portion they successfully recoup. Sometimes hospitals sell their debt, in which case they receive an up-front payment and the buyer keeps all of the money collected thereafter. How common are these arrangements? As early as 2013, hospitals and healthcare providers were the largest group of customers for collection agencies and agencies' largest source of recoveries in dollar terms.[1] By 2018, a survey of 100 hospital executives found that 54 percent used a third-party vendor for at

[1] Corey Stone, *Shining a Light on the Consumer Debt Industry,* Senate Subcommittee on Financial Institutions and Consumer Protection of the Committee on Banking, Housing and Urban Affairs, July 17, 2013, 4.

least a portion of their debt collection.[2] In 2020 alone, medical debt collection brought in $1.5 billion in revenue for America's 7000 debt collection agencies.[3]

Hospitals and debt collectors have tried a variety of tactics to get patients to pay up. To do this work, hospitals have turned to outside companies promising prompt debt collection and effective litigation. The simplest and oldest methods involved chastising letters, home visits and phone calls. If this was not enough, they reported the delinquent debt to credit bureaus. But when this proved ineffective, as it often did for debts that the patient simply could not pay, collectors turned to increasingly aggressive tactics. They filed lawsuits against patients and then sought to enforce payment. They did this by claiming a portion of patients' paychecks (wage garnishment), or by emptying their bank accounts (bank executions), or even by kicking them out of their homes (property foreclosure). If patients did not appear in court, collectors sometimes asked judges to arrest the patient and put them in jail (body attachment). These actions, in addition to selling debt and reporting debt to a credit bureau, are known as "extraordinary collections action," and have become all too ordinary. In Wisconsin, lawsuits against patients increased 37 percent between 2001 and 2018, and were disproportionately directed at Black patients as well as patients in poorer and more rural counties.[4] Between 2018 and 2020, 26 of the 100 largest hospitals in the United States filed lawsuits to collect bills owed by their patients.[5] Among a representative sample of hospitals surveyed in 2021 and 2022, more than two thirds had policies that included taking legal actions such as lawsuits, wage garnishment, and property liens against patients in debt.[6]

Bringing debt collectors into the billing relationship between doctors and patients is not a benign exercise. Divorced from any clinical or social bonds to patients, collectors of debt used draconian tactics. These became the norm, and hospitals, too, abandoned lenience. Hospitals and their collectors report patients to credit bureaus, harming their chances for home mortgages and jobs. They sue patients, adding legal woes to physical illness. After winning these cases, as they almost always do, hospitals and their agents garnish patients' wages, seize their bank accounts, and even foreclose on their homes. In extreme cases, police show up at the homes of patients who did not appear in court for these cases to bring them to jail. Hospitals used the might of the state to discipline the patient in debt. Those unfortunate enough to face destitution and illness at the same time are, in effect, treated like criminals.

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[2] "Bad Debt Exceeds $10M at a Third of Organizations, But Lack of Confidence Exists in How Much is Recoverable," *Sage Growth Partners*, June 19, 2018.

[3] Cheryl Cooper, "The Debt Collection Market and Policy Issues," *Congressional Research Service* Report R46477, June 22, 2021.

[4] Zack Cooper, James Han, and Neale Mahoney, "Hospital Lawsuits Over Unpaid Bills Increased by 37 Percent in Wisconsin from 2001 to 2018," *Health Affairs* 40, no.12 (2021): 1830-35.
Cooper et al, 2021, Richman et al, 2023, Bruhn et al 2019

[5] Farah Hashim et al., "Characteristics of US Hospitals Using Extraordinary Collections Actions Against Patients for Unpaid Medical Bills: A Cross-Sectional study," *BMJ Open* 12 (2020): e060501.

[6] Noam Levey, "Investigation: Many US Hospitals Sue Patients for Debts or Threaten Their Credit," *NPR,* December 21, 2022.

Here are a few examples of these actions. In 2014, *ProPublica* and *NPR* found that Heartland Regional Medical Center in Missouri had been seizing the wages of thousands of patients, including many who qualified for the hospital's financial aid program.[7] Five years later, *ProPublica* partnered with *MLK50* to report on Methodist Le Bonheur Healthcare, a Christian nonprofit hospital that sued its own low-paid, poorly-insured employees over unpaid medical bills. The hospital sued so many employees that it became normal to see court defendants in scrubs.[8]

The most aggressive tactic in debt collection, the body attachment, was the subject of an American Civil Liberties Union Report in 2018. The report documented cases of medical debtors being jailed even when they had not been properly summoned and were unaware that they were being sued. Many were already desperate, and for at least one, jail proved one burden too many. In January 2016, a deputy sheriff appeared at the door of a 45-year-old Utah man named Rex Iverson with a warrant for his arrest. His offense was civil, not criminal, stemming from the fact that he had not paid a $2,000 bill for an ambulance ride to the hospital two years earlier. A collector had sued him in small claims court and, after Iverson did not appear, the court had decided against him by default. The collector attempted to garnish his wages, but Iverson was recently unemployed, having lost his job as a heavy machine operator. The collector then arranged to have Iverson summoned to the court to investigate whether he had any other assets to seize. When Iverson did not appear, the judge issued a bench warrant. Iverson, who had recently lost both parents in a car crash, was living alone in their home when the sheriff arrived to take him to the county jail. Later that day, when the police went to check the holding cell, they found Iverson dead. After performing an autopsy, the coroner reported suicide by strychnine poisoning.[9] This was a particularly excruciating means of suicide, as strychnine, commonly used in rat poison, causes involuntary muscle contractions so forceful that they destroy muscle, shut down the kidneys, heat up the body and make it impossible to breathe. Worst of all, perhaps, strychnine does all of this without affecting consciousness, so Iverson was awake for the whole terrible episode.

Even when hospitals have charity care programs in place, many qualifying patients are pursued for these debts, often because they have not been informed or did not have the wherewithal to complete all the paperwork.[10] In one particularly egregious case, the nonprofit hospital system Providence paid the consulting firm McKinsey $45 million in 2019 to help prevent low-income patients from learning about charity care that the hospital was legally required to provide according to Washington state law.[11] This unmerciful attitude to debtor-patients conflicted with the reigning vision of nonprofit hospitals as pillars of community service and charity, and with their obligation to provide community benefits in exchange for tax exemption. In a rational response to the cascade of misery that could follow unpaid bills, low-income patients delayed necessary care.

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[7] Chris Arnold, "Senator 'Astounded' that Nonprofit Hospitals Sue Poorest Patients," *NPR,* July 22, 2015.
[8] Wendi Thomas, "A Tennessee Hospital Sues its own Employees when they Can't Pay their Medical Bills," *NPR,* June 28, 2019.
[9] American Civil Liberties Union. A Pound of Flesh: The Criminalization of Private Debt, 2018, pg. 4.
[10] Jordan Rau, "Patients Eligible for Charity Care Instead Get Big Bills," KFF Health Newsˆ, October 14, 2019.
[11] Jessica Silver-Greenberg and Katie Thomas, "They Were Entitled to Free Care. Hospitals Hounded them to Pay." *The New York Times*, December, 15, 2022.

Their wounds festered; their cancers metastasized. The modern hospital emerged from the medieval almshouse, but today it can resemble another relic—the debtor prison.

Press coverage of debt collection tactics proved a public relations debacle for hospitals. In the mid-2000s and again in the late 2010s, the burden of debt on patients has become the focus of investigative journalists at local and national publications. In these moments, legislators and regulators at the state and federal level launched investigations and proposed new laws. Various state and federal regulations and laws have tinkered at the edges of this problem: forbidding collectors from verbally abusing patients over the phone, requiring hospitals to have written charity-care policies, and, more recently, limiting reporting of medical debt to credit bureaus. But consumer protections in the legal code aim mostly to encourage collectors to maintain a certain decorum over the phone. The heart of the problem, burgeoning debt and aggressive tactics to recoup it, have continued. Here is a morsel: the Fair Debt Collection Practices Act of 1977, the major legislative protection for consumers, allows debt collectors to threaten to take a patient to court, but only if the threat is real.

I am an emergency doctor and a historian. I have seen the impact of debt collection on my patients; in fact, I feared losing my job when I spoke up about lawsuits against patients filed by my own hospital's collection agency. I have seen firsthand that in the United States debt and debt collection are changing the most important relationships in medicine, driving a wedge between doctors and patients, and destroying patients' trust that medical professionals are looking out for their best interests. Worse, debt collection ruins patients' financial lives, and the fear of this ruination keeps many others from seeking care when they need it.

The history of medical debt collection encompasses law, finance, and medicine. It is a tale of swashbuckling entrepreneurship, of ruthless empire-building, of infuriating bureaucracy, and of dogged protest. But most surprising of all, it is a story about blindness. Even as the amount of medical debt came to reach hundreds of billions of dollars, and as local hospitals sued patients by the thousands, most doctors and even administrators knew little about what their patients were facing.

In the meantime, medical debt has become a behemoth. Tallies vary, depending on whether you count medical debt placed on credit cards, or borrowed from friends, or placed on payment plans, or all bills past due, or just those delinquent debts that are reported to credit bureaus, but a 2022 survey estimated that 100 million Americans carry medical debt in some form.[12] A 2021 study with a more restricted definition, including only medical debt in collections that appeared on Americans' credit reports, totaled $140 billion. This study found that 17.8 percent of Americans had medical debt in collections. The average person had $429 of medical debt in collections, more than every other source combined ($390).[13] Other experts on medical debt have encouraged an even more

[12] Noam Levey, "Sick and Struggling to Pay, 100 Million People in the U.S. Live with Medical Debt," *NPR*, June 16, 2022.
[13] Raymond Kluender et al., "Medical Debt in the US, 2009-2020," *Journal of the American Medical Association* 326, no. 3 (2021): 250-56.

expansive definition, arguing that lost income due to illness and caregiving responsibilities place even greater burdens on American families than direct charges from health care.[14]

While personal irresponsibility is nowhere near a sufficient explanation for the rising burden of consumer debt, it explains next to nothing when it comes to medical debt. These debts are almost entirely outside of an individual's control and fall most heavily on the most vulnerable. Medical debt and aggressive collection are widespread, but they are not a universal experience. Like other hardships in American life, their frequency rises as one moves further down the steep gradient of historically determined inequality. In March 2022, the Consumer Financial Protection Bureau (CFPB) reported that 43 million Americans had medical debt on their credit reports. These debts were particularly prevalent among Black (28 percent) and Hispanic (22 percent) individuals, while white (17 percent) Americans experienced debt less frequently.[15] Other studies have found additional factors that render people more likely to be in medical debt, including living with a disability,[16] living in a low-income zip code,[17] living in a state that did not expand Medicaid after the passage of the Affordable Care Act,[18] and being a woman.[19] These disparities are longstanding; studies in the 1980s and 1990s found that pregnancy and childbirth were the most common diagnoses for patients who ended up with unpaid bills.[20] Regional variations in medical debt are massive, with much higher burdens in the South. Among the 20 most populous counties in the United States, the percentage of people reporting medical debt ranged from a low of 3 percent of respondents in New York to a high of 27.3 percent in Tarrant County, Texas, home of Fort Worth.[21]

There are hospital administrators who do seem strangely enthusiastic about using exploitative tactics on vulnerable patients, but most sincerely believe they are trying to be fiscally responsible when they hound patients to pay unaffordable debts. But they are misguided. First of all, not all hospitals are in financial trouble. In 2019, America's hospitals recorded their highest average profit margin ever, at 6.7 percent. And while many hospitals struggled during the early days of the COVID-

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[14] See Elizabeth Warren and Amelia Warren Tyagi, *The Two-Income Trap: Why Middle-Class Parents are Going Broke* (New York: Basic Books, 2004), and Teresa Sullivan, Jay Lawrence Westbrook, and Elizabeth Warren, *As We Forgive Our Debtors: Bankruptcy and Consumer Credit in America* (Fairless Hills, PA: Beard Books, 1999).

[15] Consumer Financial Protection Bureau, *Medical Debt Burden in the United States,* March 2022.

[16] "1 in 10 Adults Owe Medical Debt, with Millions Owing More Than $10,000," *Kaiser Family Foundation*, March 10, 2022. https://www.kff.org/health-costs/press-release/1-in-10-adults-owe-medical-debt-with-millions-owing-more-than-10000/#:~:text=A%20new%20KFF%20analysis%20of,who%20owe%20more%20than%20%2410%2C000.

[17] Kluender et al., 254.

[18] Kluender et al., 254.

[19] Levey, "Sick and Struggling to Pay."

[20] Robert Saywell et al., "Hospital and Patient Characteristics of Uncompensated Hospital Care: Policy Implications," *Journal of Health Politics, Policy and Law* 14, no.2 (1989): 287-307; Joel Weissman et al., "Bad Debt and Free Care in Massachusetts Hospitals," *Health Affairs* 11, no. 2 (1992): 148-61.

[21] "Levey, "Sick and Struggling to Pay, 100 Million People in the U.S. Live with Medical Debt," *NPR*, June 16, 2022.

19 pandemic, massive federal support led them to finish 2020 with similar profit margins as they had in 2019.[22]

Of course, there are many hospitals that do not operate with such comfortable margins. Many struggle to stay afloat, and every year some close, depriving local residents of a life-saving resource and important source of employment. But hounding patients who cannot afford to pay does precious little to help. TransUnion Healthcare reports that in 2016, 68 percent of hospital bills under $500 were not paid in full. Heftier bills were even less likely to be paid, with 99 percent of hospital bills over $3,000 not paid in full.[23] Other estimates are even more dismal: Crystal Ewing, manager of data integrity at a billing software firm called Zirmed, estimates that uninsured patients pay only 6 percent of what they are billed.[24] This meager repayment is the reason hospitals will accept mere cents on the dollar when they sell their debt to outside buyers. It makes sense that uninsured and underinsured patients are not able to afford out-of-pocket bills; roughly half of Americans say they have difficulty finding the money to pay for a $400 emergency expense. Most patients in arrears just do not have the money to pay without risking their financial health, a problem that has given rise to a saying long in use among hospital administrators: "Self-pay equals no pay."[25]

Suing patients does not meaningfully contribute to a hospital's financial well-being. A 2017 study of Virginia hospitals that garnished the wages of patients found that they collected, on average, 0.1 percent of hospital revenue through this practice.[26] Even the hospital that sued the most patients in the state, Mary Washington Hospital in Fredericksburg, gained only 0.2 percent of its revenue from wage garnishments, even though it sued so many patients that a Virginia court convened special sessions to hear the cases.[27] Marty Makary, the senior author on the study, pointed out that on average, hospitals that sued patients collected less than health system CEOs typically make in a year. "The argument that we have to do something this ugly in order to stay afloat is not supported by the data," he said.[28] For the struggling hospital, suing low-income patients is akin to using a bucket to bail water out of a sinking cruise ship, and then throwing the water into a crowded lifeboat. And most often it is not the financially insecure safety-net or rural access hospital filling

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[22] Yang Wang et al., "COVID-19 and Hospital Financial Viability in the US," *JAMA Health Forum* 3, no. 5 (2022): e221018. See also Levey, "100 Million Americans in Debt."
[23] Rozanne Anderson, "Powering up the Rev Cycle—Hot Topics for Healthcare Providers," *InsideARM*, November 22, 2017.
[24] Crystal Ewing, "Hospitals Seek Out New Ways to Reduce Bad Debt, Focus on Self-Pay Patients," *Becker's Hospital Review*, November 14, 2017.
[25] M. P. Pell, "Patients in Arrears Face Collectors: Agencies Buy up Delinquent Accounts," *The Atlanta Journal-Constitution*, June 5, 2011.
[26] Will Bruhn et al., "Prevalence and Characteristics of Virginia Hospitals Suing Patients and Garnishing Wages for Unpaid Medical Bills," *Journal of the American Medical Association*, 322, no. 7 (2019): 691-92.
[27] Selena Simmons-Duffin, "When Hospitals Sue for Unpaid Bills, It Can be 'Ruinous' for Patients," *NPR,* June 25, 2019.
[28] Tara Bannow, "Few Hospitals Aggressively Sue Patients to Pay Bills," *Modern Healthcare,* October 5, 2019.

the court dockets. Institutions that pursue patients as aggressively as possible frequently have comfortable operating margins and very well-paid executives.[29]

Beyond the fact that they do not solve a hospital's financial problems, there are three additional major problems with aggressive medical debt collection.

The first is that medical debt does tremendous harm to patients' financial well-being. Perhaps the easiest way to see how much damage has been done to those who owe medical debt is to see what it has cost them. A 2019 survey found that 16 percent of Americans had put off major household purchases to pay medical bills, while 12 percent had used up most of their savings, and 9 percent had increased their credit card debt.[30] Americans with new medical debt are at increased risk of food insecurity, eviction, and foreclosure.[31] A 2018 survey found that most people feared the costs associated with a serious illness more than a serious illness itself.[32] These burdens of medical debt fall hardest on people who are already in arrears; according to an analysis of 2018 Census Bureau survey data, 79 percent of medical debt is held by households with zero or negative net worth.[33]

The second problem is that medical debt prevents patients from accessing necessary medical care. Hospitals can and do refuse to care for patients with outstanding debts, as long as the patient does not have an emergency. But even when patients are not refused care outright, debtors will avoid an encounter that only further increases their shame and debt.[34] We have known this for some time, and we keep relearning it. The RAND Health Insurance Experiment, conducted in the 1970s, found that low-income Americans with high blood pressure experienced a 10 percent increase in the likelihood of death if they were enrolled in health insurance plans with high out-of-pocket payments.[35] In 2005, a survey found that non-elderly Americans who reported problems with medical bills were more than six times as likely to have skipped a medical test, treatment, or

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[29] Marty Makary, *The Price We Pay: What Broke American Healthcare and How to Fix It* (New York: Blooms Bury Publishing, 2019), 57.

[30] Ashley Kirzinger et al., "Data Note: Americans' Challenges with Health Care Costs." *Kaiser Family Foundation*. June 11, 2019. https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/view/footnotes/

[31] David Himmelstein et al., "Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US," *JAMA Network Open* 5, no. 9 (2022): e2231898.

[32] *Americans' Views of Healthcare Costs, Coverage and Policy*. Westhealth Institute, 2018. https://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf

[33] Andre Perry, Carl Romer, and Nana Adjeiwaa-Manu, "The Racial Implications of Medical Debt: How Moving Toward Universal Health Care and Other Reforms Can Address Them," *Brookings Institute*, October 5, 2021.

[34] Chi Chi Wu, "Medical Debt," *Clearinghouse Review Journal of Poverty Law and Policy* 39, nos. 7-8 (2005), 467.

[35] Beatrix Hoffman, "Restraining the Health Care Consumer: Deductibles and Copayments in U.S. Health Insurance," *Social Science History,* 30, no. 4 (2006), 520.

follow-up.[36] Another study published in 2013 found that people with medical debt had odds of foregoing care 3.3 times greater than respondents with no medical debt.[37] A rigorous econometric analysis of financial assistance program in Northern California published in 2021 found that low-income people who qualified for debt relief and elimination of cost-sharing were far more likely to seek medical care than patients with slightly higher incomes, who did not qualify for the financial assistance. This difference led to profound consequences: The low-income patients who qualified for financial assistance were, the researchers found, benefiting from diagnosis and management of treatable conditions.[38]

The third problem with medical debt is that it destroys the trust that makes medical care both morally meaningful and physiologically effective. How likely are you to listen to a doctor when you suspect their recommendation, if followed, will land you in a courtroom, or cause you to lose your home? Will you really believe your best interest is their main concern? Even if you trust them, will you believe the hospital is looking out for patients, rather than its own bottom line? "There has to be a balance between getting their bills paid but also being a reasonable community member," argues Erin Fuse Brown, a law professor at Georgia State University.[39]

Already, the public has lost trust in hospital leadership. While 70 percent of respondents in a nationwide survey conducted in 2021 said they trusted physicians "to do what is right for you and your family" at least "most of the time," only 22 percent professed such trust in hospital executives.[40] Administrators do not generally inspire the same confidence as caring professionals, but this is a striking disparity, and one that may eventually drag down trust in doctors and nurses, particularly as more and more clinicians come under the aegis of corporate entities like mammoth hospital systems and private equity companies.

Nonprofit hospitals are not the only aggressive collectors of medical debt, but they are particularly important. Nonprofit hospitals form the backbone of acute care in the United States. In 2022, while 18.5 percent of community hospitals (a term that excludes federal government hospitals and psychiatric hospitals) were owned by state or local governments and 23.9 percent were for-profit institutions, 57.6 percent were private nonprofit hospitals.[41] Historically known as "voluntary" or

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[36] Michelle Doty et al., "Seeing Red: Americans Driven Into Debt by Medical Bills," *The Commonwealth Fund*, August 2005.

[37] This study found that credit card debt was the only other kind of consumer debt with a strong association with foregone care: Lucie Kalousova and Sarah Burgard, "Debt and Foregone Medical Care," *Journal of Health and Social Behavior* 54, no. 2 (2013): 204-20.

[38] Alyce Adams et al., "The Impact of Financial Assistance Programs on Health Care Utilization," National Bureau of Economic Research, Working Paper 29227, August 31, 2021.

[39] Selena Simmons-Duffin, "When Hospitals Sue for Unpaid Bills, It Can be 'Ruinous' for Patients," *NPR,* June 25, 2019.

[40] Kelly Gooch, "70% of Americans Trust Their Physicians, 22% Trust Hospital Execs, Survey Finds," *Becker's Hospital Review*, August 10, 2021.

[41] American Hospital Association, "Fast Facts on US Hospitals, 2022," 2022 Edition. https://www.aha.org/system/files/media/file/2022/01/fast-facts-on-US-hospitals-2022.pdf

charity hospitals, the private nonprofits are the places that Americans most often turn to in times of unexpected severe illness, when they are at their most vulnerable. Unlike pharmaceutical companies or even private doctors' offices, they have forsworn profits. They have no shareholders demanding payouts. Instead, they find their historical origins in almshouses, community associations, and religious institutions. They are exempt from taxation specifically because of the community benefits they promise to provide. In a capitalist society driven by the profit motive, nonprofit hospitals profess to stand apart, to be driven not by private avarice but by communal care. They are also the institutions that train the majority of America's physicians, and for specialties like mine (emergency medicine), they are where most of us are employed. In addition, hospitalization accounts for a disproportionate share of catastrophic medical expenditures, the types that are hardest to repay and most likely to result in aggressive collections.[42]

Doctors, nurses, and other professionals involved in direct care of patients generally have little to do with billing and collections. We almost never know how much patients will be charged for the care they receive, nor do we know about the work of our billing and collections departments.[43] Most of us know about the Emergency Medical Treatment and Active Labor Act (EMTALA), the federal law stating that hospitals with emergency departments must provide a medical screening exam to any patient, and if an emergency condition exists, must stabilize the patient or transfer them to another facility, regardless of ability to pay. Most of us are vaguely aware that charity care exists for the poorest patients, though for the most part we are not able to tell our patients precisely who qualifies or precisely how to obtain it.

Yet we cannot claim perpetual ignorance; that time has come and gone. Aggressive medical debt collection does not keep hospital doors open, and it certainly does not pad our salaries, but it does do violence to our patients and undoes the work of healing that healthcare workers struggle so hard at each day. By burdening patients with psychological stress and financial harm, by frightening them away from care they need, by destroying their trust in medical institutions, and by seizing their wages, their savings, their shelter, and even their freedom, medical debt collection works against our patients' well-being. It attacks what is best in the profession of medicine: the idea that our patient's interests ultimately supersede all else.

Solutions

One of the proposed solutions here is medical debt cancellation. This is an entirely necessary step, one that would relieve patients of the fear of debt collectors and the legal trouble that comes with it. The research suggests there are better and worse ways to go about this. A randomized controlled trial found that cancelling medical debts *more than one year after the date of medical service* did not have a meaningful impact on patient credit access, financial distress, or mental

[42] Sixty-three percent of people in the top five percent of annual medical spending experienced a hospitalization in that year. See Carlos Dobkin et al., "Myth and Measurement: The Case of Medical Bankruptcies," *New England Journal of Medicine* 378, no. 12 (2018): 1076-78.
[43] Raj Tek Sehgal and Paul Gorman, "Internal Medicine Physicians' Knowledge of Health Care Charges," *Journal of Graduate Medical Education* 3, no. 2 (2011): 182-87.

health.[44] In another study, many of the same authors found that financial assistance, offered to patients *much sooner* after the date of service, had a profound effect on health, increasing detection and treatment of treatment-sensitive conditions like diabetes and high blood pressure.[45] Taken together, these studies suggest that the benefits of debt relief are greatest when the relief comes *before* hospitals and debt collectors pursue patients with threatening letters and court actions. The Medical Debt Cancellation Act does this, by requiring hospitals to do more to make sure eligible patients receive financial assistance, by halting the harmful effects of medical debt collection, and by focusing on cancelling debt that is less than 15 months old. Stanford economist Neale Mahoney, one of the authors of the medical debt cancellation trial, has written in support of this bill.[46]

We should also, as Mahoney has argued, "cut off medical debt at the source" by ensuring that eligible patients receive hospital financial assistance. Hospital billing departments can use presumptive eligibility software to determine, within minutes and without any paperwork from patients, whether they are likely to qualify for free or discounted care under the hospital's own financial assistance policy. These programs use information such as the patient's zip code, enrollment in public assistance programs such as food stamps, a soft pull on a credit report, and proprietary machine learning algorithms licensed by private companies to determine whether the patient's income is likely to be low enough to qualify for free or reduced-cost care according to a hospital's own financial assistance program. Software programs for these presumptive eligibility determinations are sold by private companies and can be tailored to the specifications of individual health systems.[47] Despite the widespread availability of such software, hospitals are not required by federal law to attempt to determine presumptive eligibility at the point of care.[48]

There is another step that the federal government could take that would allow hospitals to make eligibility determinations even more easily. The Internal Revenue Service can create a program that allows hospitals to verify the patient's income, with patient authorization.[49] The legal authority for this step already exists, in 26 USC 60.103, allowing the IRS to give tax data to third parties and is analogous to the existing IVES (Income Verification Express Service) program used by mortgage

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[44] Raymond Kluender, Neale Mahoney, Francis Wong & Wesley Yin. "The Effects of Medical Debt Relief: Evidence from Two Randomized Experiments." National Bureau of Economic Research Working Paper 32315, April 2024.

[45] Alyce S. Adams, Raymond Kluender, Neale Mahoney, et al. "The Impact of Financial Assistance Programs on Healthcare Utilization." National Bureau of Economic Research, Working Paper 29227, September 2021.

[46] Sanders, Merkley, Khanna, Tlaib Introduce Legislation to Eliminate Medical Debt for Millions of Working Class Americans. Press Release, US Senator Bernie Sanders, May 8, 2024.

[47] Eva Stahl. What you need to know about presumptive eligibility for hospital financial assistance. *Medium*, June 20, 2023.

[48] Luke Messac, Imani Fonfield, Nirvana Maleki, and Karina Delaney. "The Policy Alliance Between Hospitals and Debt Collection Agencies: Content Analysis of Public Comments on Regulations on Billing and Collections." *Inquiry: The Journal of Health Care Organization, Provision, and Financing* 61 (2024).

[49] Elise Goldstein, Eli Rushbanks, Jared Walker, Christy Snodgrass, and Rachel Gregory. The Path to Charity Care: Exploring the Journey & Roadblocks to Financial Assistance for Medical Bills. Dollar For, 2024.

lending companies, banks, and credit unions.[50] This would eliminate the administrative hurdles of the current application processes, as well as the costs and potential inaccuracies of private presumptive eligibility software.

Ending the problem of medical debt once and for all will demand bolder action. Many countries point the way. Healthcare systems have been devised around the world that do not cause patients to fall into debilitating debt. Universal health insurance programs exist in every member country—except the United States—of the Organization for Economic Co-operation and Development (OECD), a group of developed nations. All these countries have universal health insurance, either through public or heavily regulated private plans.[51] Many, though not all, have instituted single-payer health care, which eliminates the expensive and superfluous middleman of private health insurance companies.

Today, Canadian citizens pay no money at all for hospitalizations.[52] In Germany, a patient is charged nothing to visit a physician.[53] A survey of OECD countries found that the United States had by far the greatest burden of healthcare bills on individuals, with 7.4 percent of its residents facing catastrophic healthcare bills each year. In a distant second place, Australia had a rate of 3.2 percent. Most other countries were far lower: Japan was 2.6 percent, France 1.9 percent, Germany 1.4 percent, the Netherlands 1.1 percent.[54] As one UK resident explained of the National Health Service (NHS), "There are no bills, no paperwork, no deductibles, no insurance companies to deal with, no 'patient statements,' no risk of going bankrupt if you get the 'wrong' disease."[55] A 2022 survey found that while only 35 percent of Americans had a positive view of their own health system, 78 percent of Britons approved of the NHS.[56]

In the United States, the struggle to forge such a system has been going on for over a century, and continues still. "Medicare for All" is a new slogan, but it is not a new idea. Publicly financed national health insurance is an idea with a history in the United States, a history in which such a system has at many points come tantalizingly close to realization.[57] Though it remains elusive, it has long been

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[50] "Income Verification Express Service," Internal Revenue Service, https://www.irs.gov/individuals/income-verification-express-service.

[51] Kelly Gooch, "Americans Struggle More with Medical Debt than People in Other Countries, LA Times Reports," *Becker's Hospital Review,* September 13, 2019.

[52] Sara Allin et al., "International Health Care System Profiles: Canada," *The Commonwealth Fund*, June 5, 2020.

[53] Ross Tikkanen et al., "International Health Care System Profiles: Germany," *The Commonwealth Fund*, June 5, 2020.

[54] Noam Levey, "Americans' Struggles with Medical Bills are a Foreign Concept in Other Countries," *Los Angeles Times*, September 12, 2019.

[55] "Medicare-for-All Prevents Medical Bankruptcies," *Public Citizen*. https://www.citizen.org/article/medicare-for-all-prevents-medical-bankruptcies/ (accessed January 15, 2023)

[56] Linley Sanders, "Comparing American and British Attitudes on Health Care in 2022." *YouGov*, October 24, 2022.

[57] Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry. Basic Boooks, 2017.

popular.[58] In recent years, Medicare for All has been endorsed by some of the largest associations of medical and public health professionals in the country, including the American Public Health Association, the American College of Physicians, and National Nurses United.

Still, this kind of transformation is seen as a pipe dream. Proponents of more incremental reform have argued it is counterproductive to focus on this goal given the powerful special interests—namely, health insurance companies, pharmaceutical companies, and risk-averse voters who have relatively good insurance coverage—that oppose it.[59] It is absolutely true that single-payer healthcare legislation would not be easy to pass. The history of similar legislation, in the United States and abroad, demonstrates as much. In the United Kingdom, the Labour Party inaugurated the NHS in 1948 even as the president of the British Hospital Association accused the government of "mass murder."[60]

But change has never been easy in the United States, either. Medicare, a form of universal national health insurance for America's elderly, was a contentious idea up to and after its passage. In a recording commissioned by the American Medical Association around 1961, then-actor and conservative activist Ronald Reagan declared that a bill introduced by Rhode Island Congressman Aime Ferand, which was a precursor to Medicare, would mark the end of American liberty. Reagan warned that if Americans did not contact their members of Congress *en masse* to stop the passage of the bill, "one of these days you and I are going to spend our sunset years telling our children, and our children's children, what it once was like in America when men were free."[61] Today, 94 percent of Americans with Medicare coverage report being satisfied with the quality of their medical care, and a far smaller portion of America's elderly face financial distress as a result of medical bills than do non-elderly adults.[62]

Prognosticators and pundits often deem political transformations (for better and worse) impossible until the moment they become reality. The study of history does not vindicate cynicism. Our impoverished political imaginaries serve only to further entrench the status quo, when so much more is possible.

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[58] Douglas Sherlock, "Indigent Care in Rational Markets," *Inquiry* 23 (Fall 1986): 261-67.
[59] See, for instance, Paul Krugman, "Don't Make Health Care a Purity Test," *The New York Times,* March 21, 2019.
[60] Ronan Burtenshaw, "How the NHS was Won," *Tribune Magazine,* May 7, 2019.
[61] Ronald Reagan, Radio Address on Socialized Medicine, circa 1961. https://www.americanrhetoric.com/speeches/ronaldreagansocializedmedicine.htm
[62] Nancy Ochieng et al, "Medicare-Covered Older Adults are Satisfied with Their Coverage," *Kaiser Family Foundation*, May 17, 2021; K, Robin Yabroff et al., "Prevalence and Correlates of Medical Financial Hardship in the USA," *Journal of General Internal Medicine* 34, no.8 (2019): 1494-1502.