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Your Money Or Your Life: A Study Of Medical Debt in The Southeastern United States

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YOUR MONEY OR YOUR LIFE: A STUDY OF MEDICAL DEBT IN THE SOUTHEASTERN U.S.

by

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ABSTRACT

GRACE BARRETT: Your Money Or Your Life: A Study of Medical Debt In the Southeastern U.S. (Under the direction of Melissa Bass)

A major issue has emerged from the U.S. healthcare system: medical debt. Medical debt is a serious problem in the U.S. that often cripples those who received healthcare services, but are unable to pay the bill. The most common scenario is when an unexpected major medical issue occurs, e.g. a heart attack, an automobile accident, cancer or anything requiring an emergency room visit. These hospital visits often result in very large, very unexpected expenses. These expenses are ultimately owed to the healthcare provider by the patient (or the patient's insurance policy) and increasingly, cause lifelong financial stress to those who cannot pay due to a lack of insurance or to those patients who are under-insured.

The primary objective of this study is to better understand medical debt in America, with a concentration on the Southern U.S states. This research intends to shed light on the intricacies of healthcare affordability and access. The study examines the detriments of the current medical debt issue and ways to solve this complex problem. Five individuals were interviewed who have a background with medical health policy and individuals who have actually incurred medical debt. From these interviews, four themes were identified from the responses: 1) lack of insurance as a contributing factor, 2) the complexity of the U.S. healthcare system, 3) the financial and emotional impact of medical debt, 4) and the need for multifaceted solutions. Policy proposals were developed based on these findings, including simplification of the healthcare system in the , and expanding medical debt relief programs at both the state and federal levels. By advocating for the simplification of the healthcare system and the expansion of medical debt relief programs at both the state and federal levels, this study aims to provide solutions that could potentially

alleviate the financial burdens that individuals and families face across the country, ultimately leading to a more equitable and accessible healthcare system.

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Chapter 1: Introduction

Medical debt is a legal obligation to pay a healthcare provider for healthcare services, procedures, drugs, or medical supplies rendered. Once the service is provided and the debt is incurred by a person unable to pay whether with or without proper insurance, it can plague the individual (and in many cases, their family) for years. In the U.S., medical debt is problematic for several and varied reasons. The expense of healthcare in the U.S. ranks among the highest in the world (Commonwealth Fund, 2022). Despite attempts to increase access to healthcare coverage through programs such as the Affordable Care Act (ACA), millions of Americans remain uninsured or, more commonly, underinsured. Individuals without adequate health insurance coverage face significant out-of-pocket medical expenses, such as deductibles, copayments, and coinsurance. These expenses can be even higher when patients receive care outside their health insurance network, knowingly or unwittingly, which can result in surprise medical bills.

Of course, illness, accidents, and medical crises happen unexpectedly, resulting in unforeseen medical expenses. Low-income households, in particular, may have to prioritize other necessities, such as shelter and food, above paying for medical care. All these factors can lead to unpaid medical debt which can threaten people's financial stability and general well-being (Blavin, Braga, Gangopadhyaya, 2022). Often, people with medical debt put off necessary medical care, struggle to pay for other necessities, and are at an elevated risk of bankruptcy (Blavin, Braga, Gangopadhyaya, 2022). Overall, medical debt causes significant financial hardship and stress for many. Addressing the underlying causes of high healthcare costs, increasing access to affordable health insurance coverage, and implementing policies to protect consumers from unexpected medical bills are all critical to mitigating the impact of medical debt

on individuals and society as a whole. This is important because, as of 2022, approximately 20% of Mississippi adults have medical debt in active collections", meaning their payment is long overdue and has been sold to a debt collection agency (Blavin, Braga, Gangopadhyaya, 2022). This can result in consumers facing aggressive collection tactics and harm their credit score.

I had the opportunity to learn about this issue when I served as an intern for the senior U.S. Senator from Louisiana, Dr. Bill Cassidy, in the summer of 2022. My internship was focused on healthcare policy. Not only is Senator Cassidy a medical doctor (gastroenterologist) who has practiced for over thirty years, I was fortunate to be paired with his health policy advisor in charge of legislative affairs. One topic we studied was how to best address the scourge of medical debt in relatively poor and rural southern states such as Louisiana and Mississippi.

This experience helped fuel a passion for learning more about the fundamentals of medical debt and understanding how, through policy initiatives, we may be able to help alleviate this financial burden. The question guiding this research is “What are the causes, consequences and solutions to medical debt, especially in the South?” To answer this question I did thorough background research and also interviewed several individuals with expertise on the topic.

My research consisted of background research and existing knowledge before I began my interviews. For Chapter Two: Background Research, I focused on an overview of medical debt, the medical debt collections process and balance billing. Regarding Chapter Three: Existing Knowledge, several studies on medical debt address were explored, focusing on medical debt in the U.S. and policy issues surrounding medical debt. Chapter three includes peer-reviewed publications, non-peer-reviewed journals, and other news articles.

To further explore the state of medical debt, especially in the southeastern U.S., I collected qualitative data through semi-structured interviews with five participants, who work in

various healthcare positions throughout the South. I asked questions about their knowledge of medical debt, what they believe is the biggest issue regarding medical debt, what they believe the most important solution to medical debt could be, and so on. From my interviews with the participants, I identified four main themes: lack of insurance, the structure of the U.S healthcare system, financial and emotional impact, and the importance of medical debt solutions. Respondents identified the uninsured as most likely to have medical debt, which causes a variety of problems. They also explained how the U.S. healthcare system itself contributes to medical debt. Furthermore, each participant identified one or more solutions to help combat the medical debt problem including: providing coverage for individuals facing catastrophic medical accidents, universal savings account, the way Medicare and Medicaid is funded, that healthcare should not be viewed as a business, and the promotion of medical debt relief companies

Based on my background research and interviews, I developed several policy recommendations to help solve the medical debt issue in the U.S. First, simplifying the healthcare system would increase access to care, lower administrative costs, and address the underlying causes of medical debt. My second policy recommendation involves promoting and expanding medical debt relief programs at both the state and federal levels, to reduce the burden of medical debt and foster financial stability for individuals and families.

Taking action to address the causes, consequences, and solutions to medical debt is vital for ensuring financial stability, improving healthcare access, and eliminating regional disparities. By implementing these policy recommendations, we can work towards a healthcare system that is more equitable, accessible, and supportive of individuals' financial well-being in the southeastern U.S. and beyond. Access to healthcare has been described as a fundamental human right, and no one should suffer from significant medical debt due to seeking necessary medical

treatment. It is critical to remember that healthcare is more than just a commodity; it is a fundamental requirement for preserving one's health and well-being. Regardless of socioeconomic class, race, ethnicity, or any other criteria, everyone should have access to high-quality healthcare without financial constraints.

Chapter 2: Background

Medical debt is defined as unpaid financial responsibilities owed to healthcare providers, hospitals, or other medical facilities as a result of receiving medical services (KFF, 2022). This form of debt can result from a variety of medical expenses, such as hospital stays, surgeries, diagnostic tests, MRI, CT scans, prescriptions and other medical treatments. Healthcare costs in the U.S. have grown substantially and have caused many Americans to acquire staggering medical bills they cannot afford to pay. According to a KHN and NPR investigation, over 100 million Americans, including 41% of adults, are burdened by a healthcare system that frequently leads to debt (NPR, 2023). This means that a staggering portion of the population is burdened with the weight of medical expenses, highlighting the pervasive nature of financial strain within the healthcare system. According to a KFF poll, more than half of all adults in the U.S. have gone into debt in the last five years due to medical or dental expenses (KFF, 2022). A quarter of those with medical debt owe more than $5,000, and over one-fifth of those with any level of medical debt stated they do not anticipate ever paying it off (KFF, 2022).

A study from Lending Tree in 2021 researched what incidents lead to the most medical debts. They found that emergency room visits ranked the highest causing 39% of people to accrue medical debt. Regular visits with doctors and specialists came in second with 28% of individuals saying this led to medical debt. 22% of people said that childbirth and related care led to medical debt and 20% said dental care was the cause of their medical debt.

Process of Medical Debt Collection

Over the 20th century, the development and expansion of public and private health insurance, along with public hospitals and federally funded community clinics helped patients

pay for health care. In the 1930s, health care institutions began to create collections departments. These departments often left unpaid debts on their books for years and took a tax write off for unpaid debt. However, by the early 1990s, hospitals were working to settle debts faster and shifting the burden to the patients. For example, in the 1980s, the Halifax Hospital Medical Center in Daytona, Florida, paid bonuses to employees whose collections exceeded expectations (Messac, 2023).

Perhaps the most significant shift occurred when healthcare facilities began outsourcing their collections. A pattern emerged: the hospital or practice would send a bill to a collection agency six months after the patient failed to pay it. If the collection agency was successful in collecting by repeated letters, phone calls, and house visits, it would keep 20 to 35% of the monies recovered (Messac, 2023). Patients and legal groups claimed that hospitals did not screen patients well enough to ensure that poor patients' bills were not sent to collections. In fact, hospital executives admitted that sending bills to collectors without first determining patients' ability to pay was normal procedure (Messac, 2023). According to a 1999 Pittsburgh survey, patients were more likely to be referred to collections if they were African-American, uninsured, or had no regular provider of medical care (Messac, 2023). Medical debt collection became a major business: by 1993, hospitals accounted for more debt-collection business than any other industry. A decade later, hospitals in the U.S. generated $129 billion in unpaid debt per year, of which $42.6 billion was collected by debt collectors or sold to debt purchasers (Messac, 2023).

The selling of debt is the most recent debt collection strategy. Here's how it works: Instead of bill collectors receiving a percentage of the debt they receive, hospitals and medical providers sell the debt to bill collectors outright, for often just pennies on the dollar, sometimes as low as 3%. Then, those bill collectors go after the total gross amount patient bill. Further, they

use any means they can to collect – threatening phone calls, intimidating letters and in some cases, lawsuits. After all of these tactics, these bill collectors will negotiate a "discount"if the debtor pays now. To illustrate, let's say:

> *Mary Smith went to the hospital after being hit by a car. She was in intensive care for two weeks but fortunately lived. She had insurance, but it only covered a maximum of $50,000. Her total bill was $150,000, thus leaving her with $100,000 to pay. After 12 months of unsuccessfully trying to collect, the hospital sold her debt to the Scheister Debt Collection Agency for $5,000. Now Scheister has $5,000 invested, but has the legal right to collect all $100,000. Mary can negotiate with Scheister to pay it off, or, a third party could help Mary negotiate it from $100,000 to something lower. AllScheister cares about is getting more than the $5,000 it paid.*

There are, however, alternatives to these tactics. Recently, several non-profits organizations have formed to "purchase the medical debt" on behalf of debtors and then forgive it. One such organization is RIP Medical Debt, a 501c3 non-profit dedicated to ending medical debt.[1]

RIP's mission is to end medical debt and be a source of justice in an unjust healthcare finance system (Rip Medical Debt, 2023). In fact, RIP Medical Debt was founded by two former debt collectors. They used their expertise and compassion to create a unique way to relieve medical debt: they use donations to buy large bundles of medical debt in a region (e.g. Northern

[1] On April 15, 2024, RIP Medical Debt, rebranded as "Undue Medical Debt" For consistency purposes, the paper will refer to them by their original name.

Mississippi) and then forgive that debt with no tax consequences for donors or recipients. From this idea came RIP Medical Debt, a New York based 501(C)(3). The results have been spectacular— $6,748,483,828 in medical debts have been eradicated so far, providing financial relief to 3,619,950 individuals and their families (Rip Medical Debt, 2023).

A Special Case: What is Balance Billing

Balance bills are surprise medical bills that charge patients for the difference between what an out-of-network provider charges and what your insurer actually pays the provider (Mississippi Insurance Department, n.d). Usually this occurs when a consumer inadvertently sees an out-of-network provider in an emergency situation. Because insurers do not pay out-of-network providers the full amount of the service charges, some providers try to collect from the patients the remaining amount of their fees.

An example of balance billing is as follows: a patient visits his usual physician who participates in his insurance network. The physician orders blood work and sends the patient's sample to an out-of-network laboratory. The patient's insurance covers 50% of out-of-network care. The lab's total charges are $500, and the insurance network rate is $300. The patient's insurance pays $150, which is 50% of the network's rate, and expects the patient to pay the remaining $150 as outlined in the patient's policy. However, the lab adds on the $200 difference between its charge ($500) and the network rate ($300) to the bill sent to the patient, resulting in a bill for $350. This is a "balance bill,"where a healthcare provider bills a patient for the amount that insurance does not cover (Mississippi Insurance Department, 2023).

In Mississippi, the Insurance Department is authorized to enforce the law to protect consumers against surprise balance billing. State law prohibits balance billing. Under *MS Code*

83-9-5 (1)(i), if an out-of-network healthcare provider accepts a patient's insurance assignment, then the insurance company must pay the provider directly for the patient's treatment. That payment is considered payment in full to the healthcare provider, which means the provider cannot bill the patient later for any amount more than the payment received from the insurance company, other than normal deductibles, copays, or coinsurance.

Chapter 3: Existing Knowledge

Within the body of literature exploring medical debt, there are many studies that address aspects of the research presented in this thesis. Chapter Three consists of peer reviewed journals, non-peer reviewed journals, and various news articles. These include: overviews of medical debt, county's characteristics predicting medical debt, insured and uninsured individuals and medical debt, debt and foregone medical care, medical debt and gender differences, medical debt and bankruptcy, medical debt and cancer, solutions for medical debt, how many individuals in the U.S. struggle with medical debt but none that specifically address medical debt with a focus on the south.

Medical Debt in the U.S.

In 2022, Cheryl Cooper wrote an overview of medical debt in the U.S. She cites a 2017 Census Bureau study that found that 9% of respondents said they had medical costs they couldn't pay in full for the entire year (Cooper, 2022). That study found that adults without health insurance were more likely than those with insurance to have medical debt, and according to some other studies, states that expanded Medicaid had fewer residents who owed money for medical expenses (Cooper, 2022). Still, adults with health insurance policies can owe money for medical expenses nevertheless. Overall, in June 2021, Americans carried $88 billion in medical debt on their credit reports, according to the Consumer Financial Protection Bureau (Cooper, 2022). This report correlates nicely to my research, by giving a broad overview of medical debt issues in the U.S. and my research builds on it by focusing particularly on medical debt in the South.

Another study from 2022, conducted by Kluender, Mahoney, and Wong, focuses on medical debt in the U.S. from 2009-2020. This team found that an estimated 17.8% of individuals in the U.S. had medical debt in collections as of June 2020, according to their retrospective review of credit reports from a nationally representative sample (for care given before the COVID-19 pandemic) (Kluender, Mahoney, and Wong, 2021). The researchers found that the percentage of people with medical debt was highest in the South and in zip codes with the lowest income deciles, and was not more prevalent in states where Medicaid was not expanded (Kluender, Mahoney, and Wong, 2021). My research will further explore medical debt issues in the South, building on this study.

Another study from 2022 by Blavin, Braga, and Gangopadhyaya studied the characteristics that predict a county's medical debt. The counties with the highest percentages of adults unable to pay their medical bills on time were located in Georgia, North Carolina, and Texas, according to exclusive Urban Institute credit bureau data from August 2021 for more than 10 million consumers (Blavin, Braga, Gangopadhyaya, 2022). In fact, Texas, Georgia, and North Carolina each have 20 of the top 100 U.S counties with the highest rates of medical debt in collections (Blavin, Braga, Gangopadhyaya, 2022). The researchers note that these three states are among the 12 that have not accepted the Affordable Care Act's (ACA) Medicaid expansion (Blavin, Braga, Gangopadhyaya, 2022). In fact, states that have not expanded Medicaid under the ACA account for 79 of the 100 counties with the highest levels of medical debt (Blavin, Braga, Gangopadhyaya, 2022). This research focuses on the South but specifically on counties in Georgia, Texas and North Carolina, while my research will focus on the South more broadly.

An additional cross-sectional and cohort study from 2022 was conducted by Himmelstein, Dickman, and McCormick. Using survey data from 2017 to 2019, they found that

10.8% of individuals reported having medical debt, 10.5% of whom were privately insured (Himmelstein, Dickman, McCormick, 2022). Additionally, 9.6% of Medicaid-expansion state residents reported having medical debt (Himmelstein, Dickman, McCormick, 2022). This study indicates that medical debt is widespread, even among those who are insured, and that it may be linked to a subsequent deterioration in patients' social determinants of health (Himmelstein, Dickman, McCormick, 2022). These social determinants of health include: socioeconomic status, physical environment, health behaviors, access to healthcare, economic stability, and education. My research will include not only the connection of a deterioration of health regarding medical debt but also other aspects and causes of medical debt.

According to a KFF 2022 study, individuals who are uninsured are more likely to suffer from medical debt, however most people who experience difficulty paying medical bills have health insurance (KFF, 2022). KFF conducted an analysis of government data estimates that nearly 1 in 10 adults (9%) – or roughly 23 million people – owe medical debt (KFF, 2022). The individuals in the study ranged in age from 20-60, lived in many different states, and their annual incomes ranged from less than $10,000 to more than $100,000. Most were insured continuously in job-based group plans and few were covered in non-group policies. Two were insured at the onset of illness, and then lost coverage. Three were uninsured the entire time. For the majority in the study, falling into medical debt was the first time they had experienced serious financial or credit issues. The onset of an illness, accident, or pregnancy generated expenses that they did not anticipate and which they were unprepared to pay. Some faced tens of thousands of dollars in medical debt. For others, just a few thousand dollars of bills proved unaffordable, particularly when a chronic illness meant bills would continue year after year. In some cases, patients were left to pay bills for care their policy simply didn't cover. Some also fell into debt trying to pay

health insurance premiums they couldn't afford. People with unaffordable medical bills report higher rates of other problems that include difficulty affording the bare necessities. My research will build on this KFF study as I will investigate in depth why individuals without insurance suffer from medical debt.

Kalousova and Burgard's 2013 research studied the correlation between debt and foregone medical care. In the wake of the late 2000s recession, a population-based sample of 914 people in southeastern Michigan were surveyed to determine correlations between debt and skipped medical treatment (Kalousova and Burgard, 2013). Even after adjusting for the poorer socioeconomic and health characteristics of those forgoing care as well as for respondents' household incomes and net worth, overall debt and ratios of debt to income and debt to assets were positively associated with skipping medical or dental care in the previous 12 months (Kalousova and Burgard, 2013). The primary drivers of these relationships were credit card and medical debt (Kalousova and Burgard, 2013). This study is ten years old but still has relevant information regarding my research, as I will look into why individuals suffer from medical debt and its consequences.

Wiltshire, Dark, Brown, and Pearson conducted a study regarding the financial hardships of medical debt and gender differences in 2011. In this study researchers found that because of medical debt, women were more likely than males to avoid, postpone, and ration medical care (Wiltshire et al., 2011). This study analyzed gender differences in five financial problems related to medical debt using data from the 2003–2004 Community Tracking Study Household Survey (Wiltshire et al., 2011). Making health care accessible and fair is crucial for both men and women. This report provides a helpful reminder about the gender disparities in regard to medical debt which is helpful for my research.

In 2016 Banegas studied how medical debt and bankruptcy create financial hardships for working-age cancer survivors. Cancer patients and their families in the U.S. experience severe financial difficulty due to the escalating cost of medical care linked with the disease (Banegas, 2016). This study calculated the proportions of survivors who reported entering into debt or declaring bankruptcy as a result of cancer, as well as the amount of debt incurred, using information from the LIVESTRONG 2012 survey of 4,719 adult cancer survivors (Banegas, 2016). About one-third of the survivors had accrued debt, and 3% had declared bankruptcy. Of those who had borrowed money, 55% had debts of $10,000 or more (Banegas, 2016). My research will focus on not only individuals who suffer from cancer but also other illnesses that result in high medical debt.

Lichtenstein and Weber conducted a study in 2016 of a Deep South county with high rates of poverty, health inequities, and a racial homeownership difference. This study looked at the impact of medical debt in relation to home foreclosure (Lichtenstein and Weber, 2016). African Americans, in foreclosure, who resided in racially segregated neighborhoods had disproportionately high rates of medical debt, according to statistical analysis and geographic information systems mapping of municipal court records for 890 foreclosures (Lichtenstein and Weber, 2016). African Americans had a higher rate of both non-medical and medical debt judgements than whites, and foreclosures in both groups had a larger medical debt load than non-foreclosures (Lichtenstein and Weber, 2016). This study is similar to my research because it discusses medical debt issues in the south. However, they differ in that this study focuses specifically on foreclosures, while mine looks at a broader array of effects.

RIP Medical Debt, The American Cancer Society Cancer Action Network (ACS CAN) and The Leukemia & Lymphoma Society recently completed a study entitled “Trapped:

America's Crippling Medical Debt Crisis," (2023). The study found that having medical debt has become a common experience among patients across the country: nearly seven out of ten adults in the U.S. report receiving medical expenses they could not afford (Undem, 2023). Many people are obliged to put off paying their bills, put them on credit, or contest them. More than four in ten (42%) people postponed medical care because they didn't want to go further into debt. One in every five people (21%) avoided returning to the same provider to whom they owed money because they were afraid they would be mistreated. One-third (32%) report feeling more depressed and nervous as a result of their medical debt, and nearly half say they feel trapped by it. 45% believed they would never pay their debts off (Undem, 2023).

There are several ways to challenge a medical charge, but most consumers are unaware of them. Seven in ten adults in the U.S. had never contested or appealed a medical bill, and nearly half were unaware that providers offer financial assistance. The study showed that people of color were more likely not to contest a bill, nor are they likely to take advantage of financial assistance,while younger patients are less likely to be aware of provider financial aid. Only one out of every four patients reported receiving financial aid from their provider to help them pay their medical bills (Undem, 2023).

There are numerous reasons why a state may have more medical debt than others, including (but not limited to): population size, whether the state has extended Medicaid, and whether the state has established any medical debt protections, or legal regulations for selling medical debt.

It is also worth noting that the nature of medical debt makes it incredibly difficult to determine how widespread the problem is. The "Trapped: America's Crippling Medical Debt Crisis," study discovered that 18% of respondents had to pay their bills with a credit card

because they couldn't afford them (Undem, 2023). Even though this is medical debt, it might be classified as credit card debt. 8% of respondents borrowed money from friends and relatives, which is probably not a debt that any official agency or entity tracks (Undem, 2023).

According to Debt in America: An Interactive Map, credit can be a lifeline in an emergency and a pathway to education and property (Ratcliffe and McKernan, 2023). However, debt, which can be incurred through credit or unpaid payments, frequently stresses the financial well-being of families and communities alike. This map depicts the location of debt in America, as well as the debt disparities that can exacerbate the wealth disparity between white and minority populations (Ratcliffe and McKernan, 2023). The chart depicts the medical debt of communities of color, white communities and the overall average. White communities and communities of color are defined by zip codes in which the majority of residents are white (at least 60%) or people of color (at least 60%). In Mississippi, the average for individuals to have medical debt is $719, but in white communities it is $683 and in communities of color it is $812 (Ratcliffe and McKernan, 2023). Nationally, the average is $703 for all individuals, $678 in white communities and $738 in communities of color (Ratcliffe and McKernan, 2023). In Mississippi, 12% of people do not have health insurance, 10% in white communities, and 15% in communities of color (Ratcliffe and McKernan, 2023). Additionally, in Mississippi the average household income is $68,048, $80,924 in white communities and $50,044 in communities of color (Ratcliffe and McKernan, 2023).

In an article from RIP Medical Debt where they outline their priorities for helping solve medical debt, they found that people all around the country need lower cost health care, which includes not only lower premiums but also lower deductibles, coinsurance, and copayments (RIP

Medical Debt, 2023). People need access to affordable and comprehensive health coverage, regardless of zip code or state of residence.

People require fewer out-of-pocket expenses to ensure that health insurance is actually affordable. This includes lowering deductibles, strengthening cost-sharing mechanisms, and ensuring that high-deductible health plans and related plan designs do not cause consumers to incur medical debt (RIP Medical Debt, 2023). The recent spike in ACA plan enrollment emphasizes the significance of affordable rates and lower deductibles; the authors argue that the interim changes introduced by the Inflation Reduction Act (IRA) should be permanent (RIP Medical Debt, 2023). They further argue that all states should narrow the Medicaid coverage gap and offer a road to coverage for all low-income people, as this has been shown to minimize medical debt and enhance racial justice. Strategic reforms to government regulations would help ensure that more individuals have access to cheap and comprehensive coverage (RIP Medical Debt, 2023). This includes making it easier to pick and enroll in health plans, as well as expanding innovative models that reduce individuals' out-of-pocket expenditures (RIP Medical Debt, 2023).

RIP Medical Debt advocated for providing clear information and quick enrollment alternatives for hospital financial assistance policies (FAP). People require continuing support to navigate the cost of health care, regardless of insurance status (RIP Medical Debt, 2023). They argue that to reduce staff strain and improve patient experience, health systems and provider groups should use tools that make enrolling in financial assistance easy. This involves implementing 'presumptive eligibility' policies and procedures that qualify patients for a hospital's financial aid policy without requiring an application process (RIP Medical Debt, 2023). Presumptive eligibility uses current data to identify potential FAP users, speeding up the

process and eliminating administrative barriers for providers and consumers (RIP Medical Debt, 2023). Importantly, telling patients when they are fully qualified for financial aid is critical for decreasing patient stress. Health systems and provider organizations can enhance community connections and increase patient trust by providing clear information about their financial assistance policy (FAP) and facilitating easy enrollment (RIP Medical Debt, 2023). This involves prominently displaying the policy on the health system's webpage, ensuring language and literacy accessibility, and highlighting eligibility criteria for easy reference. Furthermore, they argue that health systems should make their FAP publicly known to the community and its stakeholders, particularly nonprofit organizations that address the social determinants of health (RIP Medical Debt, 2023). The federal government can give more incentives for hospitals to provide charity treatment, such as financial assistance in establishing presumed eligibility processes.

According to research from a PubMed article by Thomas Richardson, Peter Elliot, and Ronald Roberts, worry about medical expenses is associated with poor health outcomes and an increased risk of mental health concerns. This report provides a thorough review of the literature on the association between personal unsecured debt and health. The authors' study included 65 papers, which were composed of panel surveys, nationally representative epidemiological surveys, and psychological autopsy studies, along with studies of specific populations such as university students, debt management clients, and elderly people. Most studies focused on mental health, particularly depression (Richardson, Elliot, and Roberts, 2013). Physical health research has also demonstrated a link between self-rated health and consequences such as obesity. There is also a substantial correlation with drug and alcohol abuse and suicide

(Richardson, Elliot, and Roberts, 2013). The majority of research revealed that more severe debt is associated with poorer health; nevertheless, causality is difficult to prove.

A substantial body of research has shown that specific populations have a higher prevalence of health problems, particularly mental health issues. Specifically, people with a low'socio-economic status have been found to have an elevated risk of poor mental health, depression, poor physical health, and death (Richardson, Elliot, and Roberts, 2013). One potentially crucial socioeconomic element that is frequently disregarded is debt. Debt levels are higher in poorer households, and income and education levels are linked to debt levels, implying that debt may explain some of the link between socioeconomic status and health (Richardson, Elliot, and Roberts, 2013).

A 2022 investigation by Kaiser Health News and KFF revealed that the U.S.' health-care system generates tremendous debt, forcing families to make heartbreaking compromises. In a radio interview on the study, conducted by A. Martínez of NPR with Kaiser Health News, Noam Levey, the two delve into the investigation on medical debt.

Levey explained, “(s)o one of the things we did was conduct a nationwide poll with the polling team at KFF, the Kaiser Family Foundation. And we didn't want to just find out how many people had medical bills and collections. That's the usual way of measuring medical debt. We wanted to know about people using credit cards, payment plans and other loans. And what we found is pretty sobering, I think. About 50 million adults - 1 in 5 - are on a payment plan with a hospital or medical provider. These are the kind of installment plans that can weigh people down for years. One in 10 owe a family member or friend who covered their medical or dental bills. And 1 in 6 - that's about 42 million people - put a medical bill on a credit card they haven't

been able to pay off, which, as you know, often means fees and interest get piled on top of what folks owe for health care (Martínez, 2022).

Levey further explained, “So some owe just a few hundred dollars. But we found about 1 in 4 owe at least $5,000, and 1 in 8 owe more than $10,000. And many of these folks - 18% of all people with medical debt - don't expect to ever pay it off. There's no question that medical debt hits vulnerable Americans hardest. Lower-income households are more likely to have debt; so are the uninsured. But one of the remarkable aspects of health care debt in this country is how widespread it is. Even wealthier Americans can't escape it. We found that nearly half of adults in households making more than $90,000 a year have incurred health care debt in the last five years. And having insurance is no magic bullet either. Close to two-thirds of working-age adults with coverage have gone into debt” (Martínez, 2022).

The same radio program interviewed Allyson Ward, who was part of the study. A nurse practitioner in Chicago, Ward, and her spouse are middle-class and had health insurance when their twin boys were born ten years ago. However, the boys arrived early and had to spend months in the neonatal intensive care unit (NICU). Ward shared “we started seeing bills that were, like, a few hundred dollars. And then we would get bills - I think we got a bill at one time that was around $12,000” (Martínez, 2022). Levey explained: “In the end, they got hit with about $80,000 in medical debt. They loaded up credit cards. They borrowed from relatives. Ally took on extra nursing shifts. We talked to lots of people like Ally all over America who found themselves in the same boat after an unexpected or serious illness” (Martínez, 2022). Levey concluded: “You get sick in this country, and you're basically headed for debt. We worked with the Urban Institute in Washington to analyze which counties have the highest medical debt in the

U.S. and why. And what we found is that the most powerful predictor of debt in a community is how sick the residents are. So places with the highest levels of chronic illness - diabetes, heart disease, cancer - they have the most debt. So on top of struggling with a life-threatening illness or an unexpected emergency, like premature twins, millions of Americans have to navigate the stress of going into debt. “Here Ward gave her perspective; “I mean, I think cruel is the word to describe it because no one should have to think, OK, well, what if I get sick with something that's completely out of my control, and I don't have a way to deal with my sickness without, in some ways, going completely bankrupt or affecting my financial health of our family for the rest of our lives?” (Martínez, 2022).

Policy Issues Regarding Medical Debt

Due to the pressing nature of medical debt there has been significant research in the policy field regarding medical debt. Cheryl Cooper conducted a study in 2021 researching the debt collection market and selected policy issues. The collection of medical debts brings up special policy concerns around irregular reporting and billing procedures (Cooper, 2021). Consumers are unlikely to know in advance how much different medical procedures will cost, especially those connected to accidents and emergencies, according to a 2014 Consumer Financial Protection Bureau study. Co-pays and health insurance deductibles are frequently difficult for people to estimate, and depending on the medical provider, medical debts are frequently turned over to debt collectors after varying amounts of time (Cooper, 2021). As a result, medical debts may show up inconsistently on a person's credit report (Cooper, 2021). My research will further study policy issues regarding medical debt, especially in the South, and also cover the current status of policy issues.

Another research team, Ahmadi, Kendall, Kessler, and Murdock, conducted a study on ending medical debt. This research team from the policy organization Third Way, studied the medical debt crisis, and developed a plan to address it in the present and avoid it in the future (Ahmadi et al., 2023). They recommend Congress to refinance unpaid debt through a provider tax, make adequate coverage affordable, and forgive debt for patients with adequate coverage (Ahmadi et al., 2023). This report focuses on how to combat medical debt, which provides a starting point for my study's policy recommendations.

According to a new Survivor Views survey from the American Cancer Society Cancer Action Network (ACS CAN), a majority of cancer patients and survivors say they were unprepared for the costs of their care both in terms of their ability to pay for it (54%) and in what they thought it would cost (64%). More than 70% of respondents said they made significant lifestyle changes in order to afford care, including delaying major purchases (36%), depleting most or all of their savings (28%), going into more credit card debt (28%) and borrowing money from relatives and friends (20%) (Cancer Action Network, 2022). 11% percent reported taking out a loan, borrowing from a payday lender, or refinancing their homes to afford care. Roughly half (51%) of those surveyed say they have incurred cancer-related medical debt, the majority of whom (53%) report having their debt go into collections, and 46% of whom say the debt has negatively impacted their credit (Cancer Action Network, 2022). Among those with medical debt, about half (51%) said they had balances of more than $5,000 and nearly a quarter (22%) had debt of more than $10,000 (Cancer Action Network, 2022). My research will investigate the causes and consequences of how individuals obtain medical debt. This research correlates nicely with my research because some of these medical debt causes include cancer.

Chapter 4: Research Design

The purpose of this study is to understand medical debt in the U.S., with a special focus on the South. I look at the detriments and any benefits of the medical debt system, and how it causes financial problems for lower economic classes. This study is based on interviews. I will use these findings to develop recommendations for medical debt relief. The questions guiding my research are: What are the causes, consequences and solutions to medical debt, especially in the South? What are the negative societal impacts that medical debt has on those indebted individuals and families? How can the public and private sectors best help those in need be freed from medical debt?

For my interviews, I used purposive sampling, choosing my interviewees for their specific expertise regarding medical debt. I chose people who have a background with medical health policy and individuals who have actually incurred medical debt. When deciding on individuals to ask to be interviewed, I wanted a variety of viewpoints: a Medical Doctor that billed patients, an expert in medical debt remediation, an upper income professional who owes medical debt, and a professional at an academic research healthcare center that provides cancer care.

Research Protocol

I employed qualitative methods, specifically semi-structured interviews, to help identify the causes, consequences, and solutions to medical debt, especially in the South. The semi-structured interview format allowed me to follow-up questions, change the order of questions, and skip questions based on the participants' responses.

I intended to interview at least eight individuals with a medical or healthcare policy background. I contacted individuals whom I thought would help give substantial feedback

regarding this topic. To find participants to ask for interviews, I drew on family friends, professional acquaintances, University of Mississippi faculty listings, and the RIP Medical Debt staff directory.

This research project was deemed exempt and approved by the University of Mississippi Institutional Review Board (IRB) before I reached out to potential participants. Following exemption by the IRB, I began by contacting eight individuals who I believed would help give informative insight to this research. I contacted these individuals via email.

I planned to conduct my interviews over Zoom, a teleconferencing platform with audio and video options, to accommodate any travel concerns. Each zoom recorded interview would then be transcribed using Otter.ai software. In the recruitment email, I informed each participant that the interview questions would pertain to the nature of their work, and asked for their consent to use their name and title in the study and to attribute direct quotations to them by name. In addition, I needed to obtain each participant's agreement before recording audio and video of the interview.

I prepared the following interview questions; which I modified based on each interviewee's specific position.

Background Questions

1. *What is your name and current occupation?*
2. *How long have you worked in your current occupation?*
3. *What got you interested in the field of medical debt?*

Substantive Questions

1. *Can you tell me the history of RIP medical debt. Why is this needed?*
2. *What seems to be the biggest issues revolving around medical debt today?*
3. *Why do you think the south has such an issue with medical debt?*
4. *What age and demographic is plagued most by medical debt?*
5. *How do your clients get their medical debt extinguished? Can you give me an example of a case study?*
6. *How do individuals engage with RIP medical debt?*
7. *What states have the lowest medical debt and why is this?*
8. *What states have the highest medical debt and why is this?*
9. *Can you discuss any examples or instances in which an individual acquired medical debt and had no plans to pay this off? Is this a common instance?*
10. *What do you believe could be the sole resolver to addressing medical debt?*

Chapter 5: Results

In Chapter Five, I share the interviewees' responses to the questions. Within this chapter, the responses provided by the interviewees are examined and analyzed, shedding light on their perspectives, experiences, and opinions. During my recruitment procedure, I contacted eight individuals with information about my study and invited them for an interview. Five responded to the recruitment email, expressing an interest in participating, and four completed the Zoom interview, with one sending their answers to the questions over email. Those who participated in the interview are: Dr. Christian Briery, Shara Avis Pecoraro, Jennifer Pou, Dr. Sumner Abraham, and Sofia Del Valle. Sofia Del Valle sent her interview answers to me via email.

TABLE 1

Dr. Christian Briery	Shara Avis Pecoraro	Jennifer Pou	Dr. Sumner Abraham	Sofia Del Valle
-Medical Doctor -High risk pregnancy specialist at Regional Perinatal Group for WillisK Health. -Extensive healthcare and medical background. -Shreveport, LA	-Associate Director of the Strategic Industry Ventures office at MD Anderson Cancer Center. -Extensive knowledge of the healthcare industry -Houston, TX	-Business analyst for a venture capital firm. Works closely with Ochsner Health, New Orleans. -Medical debt holder -Shreveport, LA	-Medical Doctor, Professor -Internal medicine physician and serves as the Chief medical officer for Relias Healthcare. -Oxford, MS	-Development coordinator at RIP Medical Debt -Extensive knowledge about medical debt -Long Island City, NY

Dr. Christian is a family friend, a high risk pregnancy specialist, and has an extensive healthcare and medical background. I chose to interview Dr. Christian due to his multifaceted expertise and extensive background in healthcare and medicine, particularly in the field of high-risk pregnancy. As a specialist in high-risk pregnancies, Dr. Christian possesses a wealth of knowledge and experience that is highly relevant to my research on medical debt and healthcare access.

Shara Avis Pecoraro is the associate director of the strategic industry ventures office at MD Anderson Cancer Center. I chose to interview Shara because her position puts her at the intersection of healthcare innovation, industry partnerships, and strategic initiatives, providing her with a unique perspective on the healthcare landscape.

Jennifer Pou is a business analyst for a venture capital firm. I chose to interview Jennifer because she is a young adult, highly educated, a high earner and she currently holds medical debts and knows of individuals that hold medical debts as well.

Dr. Sumner Abraham is an internal medicine physician and serves as the Chief medical officer for Relias Healthcare. I chose to interview Dr. Sumner Abraham because of his extensive experience and expertise in the field of internal medicine. As the Chief Medical Officer for Relias Healthcare, Dr. Abraham brings a wealth of knowledge and insight into healthcare delivery systems, medical practices, and patient care.

Sofia Del Valle is the development coordinator at RIP Medical Debt. I chose to interview Sofia because I believed that she would provide insightful information regarding RIP Medical Debt, other non profits, and information regarding medical debt in the U.S. today.

During my interviews I asked each participant about their personal connection to medical debt and their knowledge of the topic, particularly regarding the southeastern U.S. Four themes

emerged from their responses: 1) Lack of insurance as a contributing factor, 2) the complexity of the US healthcare system, 3) the financial and emotional impact of medical debt, 4) and the need for multifaceted solutions. I have also included unique insights that were raised by one or two of the participants but were not recurring themes amongst all respondents. All responses included in this chapter are attributed to the participants using their names, with their consent.

Lack of insurance as a contributing factor

The participants most commonly cited lack of insurance as a reason why Americans and especially those in the south struggle so much with medical debt. Shara Avis Pecoraro, who serves as the Associate Director of the Strategic Industry Ventures office at MD Anderson Cancer Center, in Houston, Texas, described her thoughts:

> I think a little bit has to do with immigration. We do have a substantial portion of uninsured immigrants that come through, for example the ones who live in Houston, in the major areas, and then also in our rural areas. You know, my grandparents were farmers, I don't think they had insurance. They had to wait till they had Medicare or Medicaid, you know, something like that. There's a lot of layers to this issue but I would say underinsured people are one of the problems. And then general immigrants without insurance do put a strain on the healthcare system.

Three of the five participants shared that cost shifting is a significant issue contributing to medical debt. Shara Avis shared:

> I was going through IVF. My insurance paid for my first round. When I got the itemized bill of how much my insurance paid I saw they paid $8,000. For my second round I had to pay out of pocket and I was shocked to see it cost $18,000. I asked my insurance provider why they paid $8,000 and why I had to pay $18,000. They said that they can't afford to function if they only ran on patients who just had insurance. They shared that they would never be able to afford to stay in business so they had to charge out of pocket patients more than they charge insurance and therein lies the cost shifting.

Dr. Abraham shared that he believes one of the reasons medical debt is such an issue in the South is due to lack of Medicaid expansion. He stated:

> I think in the southeastern U.S., people that don't have insurance because they may not be able to have a job, etc. and Medicaid is not expanded, or there's work requirements surrounding Medicaid. That becomes problematic, and those are the patients that wind up with the most debt. And that is why we're in the conundrum that we're in from our perspective.

Complexity of the U.S. healthcare system as a contributing factor

Medical debt and the healthcare system go hand in hand. The participants shared how they believe the U.S. healthcare system is contributing to the growing medical debt. Dr. Christian Briery believes that healthcare is very expensive but he does not think it has to be. He shared:

> If you were to interview a hospital group, they're going to tell you that doctors are the problem. If you interview a political group, they're going to tell you that it probably should be free health care, or doctors make too much money. And hospitals make too much money. And the drug companies charge too much for their products. So you're never going to find the root cause, you know, by polling different groups, in my opinion.

Dr. Briery believes that there is not one single root case of medical debt but there are many reasons why the South struggles significantly with medical debt. Dr. Christian shared that the root cause is multifactorial. He shared:

> I mean, you know, we're (the South) overweight. We have a poor diet, poor nutrition. There's a lot of social factors. Health is not emphasized, like if you compare us to a Washington State where there's a huge outdoor movement to get outside and move. I mean, we eat highly processed foods. It's subsidized. In fact, good quality nutrition is not taught in school, it's high calorie, highly processed, processed foods. And so what does that lead to? It leads to unhealthy populace. So we have the highest rates of chronic hypertension, diabetes, morbid obesity, I mean, the list just goes on and on. And so when you have a sicker population, they're going to need to consume more healthcare services. That's us. That's what we do. So of course, we have that. And that behavior, never, it's reinforced. It's never, it's never de-emphasized, you know, there's no, there's no incentive to get healthy. There's no incentive to go to the doctor and get your blood pressure checked. And so that has a cascading effect in that particular patient plus that patient, they end up teaching the next generation, hey, this is how we eat. This is how we exercise or not exercise at all. And that's why we're sick.

Dr. Sumner Abraham shared another example of how the healthcare system in the U.S. can be complicated. He states:

> Before the No Surprises Act (NSA) versus post NSA, right. Pre NSA, the tactic was that big healthcare companies would intentionally not be in network with insurance companies, or what I like to help younger people understand is those are the negotiators. So you don't get in at work with the negotiators. So the patient does not have a negotiator to negotiate the rate. And the provider builds an out of network cost. And that out of network cost is going to be highly marked out from the end network costs.

He then provided an example of a potential situation.

> Patients that they're in a motor vehicle accident, and they are traveling to some sort of family event across state lines, and they have to go to the emergency department. And so they are out of network with probably one of those providers. And they have to go and get a CT scan, an MRI and all this lab work, some of which may not be necessary. But the providers do it from fear of medical malpractice litigation. And so the patient winds up with this huge bill, they pay their copay. And then 45 days later, they get this huge bill. And it could be a bill from the hospital and then a separate bill from the company that employs the providers for the professional fees. So there's facility fees that the patient is responsible for. And then there's professional fees for the medical professionals that are rendering the care. And so people will get double billed for stuff and they become outraged at the fact that they're receiving two different bills for the same care provided. And that's really confusing to the average American who doesn't understand how U.S. healthcare economics are upside down, backwards, inside out whatever metaphor you want to use.

Financial and emotional impact

The participants had a common response regarding the impact of medical debt on individuals. They all believed that medical debt is a big problem that causes serious financial and emotional strain. Shara Avis Pecoraro described how patients feel when told they are going to have to pay a significant medical bill:

> Our patients at MD Anderson Cancer Center, they face it (medical debt) every day, But I would say when someone has a cancer diagnosis, the first question is, how am I going to pay for this? There are their feelings and their thoughts and their emotions. And a lot of them are, like, say, are lucky enough to have insurance. But that does vary on how much is covered. So medical debt for our patients is a high concern. And yeah, I saw

> the medical debt limits with my aunt and uncle during my early 20s, and I was starting off and didn't have insurance myself. I always racked up a good bit of medical debt myself just being alive, but I've been able to pay for that.

When the participants were asked " If they knew someone with medical debt who has no plans to pay it off, every single one knew of someone in this situation. Dr. Christian Briery, the high risk pregnancy specialist, had some key insight into this issue and sees it all the time in his practice. He shared the following:

> We'll have a patient with a large deductible before her plan kicks in. And whatever this number of the deductible is, she'll come to us and say, "Hey listen, I can't come up with this whole amount that is due to you today. Can we work out a payment plan? And we usually relent and say, yes, pay how much you're able to pay today, they'll give us a value, and they may or may not come back for additional appointments, where they pay on that plan, but then they just disappear. And so we usually will send out collection letters. Say hey, your bills are delinquent, we'll do that three or four times and get no response. And then at a certain point, we have to turn it over to a collection agency. So we sell our debt to them, and it's pennies on the dollar. Then they try to collect the balance of that. This happens all the time.

Jennifer Pou, a financial analyst who works at a venture capital firm shared her own and other's experiences from individuals:

> I know a handful of people with young kids who have insurance. And when they get the bill from having the kid, they can pay the copay part of the bill but not the bill in its entirety."
>
> "And then these friends also have had to have emergency room visits with their kids. The debt is not staggering, but it's a couple thousand dollars that, you know, a handful of people have, but they're all intending to pay it back. It's all kind of that, you know, keep making progress on the bill, but it does need to be a priority type culture is what I have found." She continued to say, "I thought with my first baby, I just wrote a check for the, you know, a couple thousand dollars that hospital stay ended up being. And like I remember thinking at times, gosh, I don't know how most people do this. They can't just write a check for $3,500. And then by the time I had my third kid, I started getting a little bit smarter about it, and just kind of slowly made payments on that over time.

Dr. Sumner Abraham shared that “None of these insurance companies have debt. But patients do. And so that doesn't really make sense. But that's because healthcare is a business. And should it be or should it not be?”

The participants also noted that there is a stigma associated with medical debt. Sofia Del Valle shared, “An inability to keep up with medical bills leads to shame, stress, and anxiety. People with problematic medical debt often delay or forgo seeking needed healthcare services due to fears about incurring more medical bills.” Many individuals get into situations where they cannot pay their medical debts or they have to put the debt off to pay something else and no one knows because people are embarrassed to discuss the issue. Feelings of guilt, embarrassment, and self-blame may discourage people from seeking assistance or reporting their financial difficulties to loved ones, aggravating feelings of isolation and pain. Furthermore, the fear of being judged or discriminated against because of their financial condition may dissuade people from seeking healthcare services or pursuing medical treatment, resulting in further health issues and financial hardships.

Need for multifaceted solutions

When asked the question, “What do you believe could be the sole resolver to addressing medical debt?” Many participants believed simplification and straightforward pricing would be the best way to combat medical debt. Dr. Christan Briery shared:

> I mean, there are a lot of things. I think, getting the bureaucracy that's between a patient and their physician, and the different middlemen that are between patient and physician, getting them out of the way. I think that would do a lot of good. So if you knew the price list, and when you went to the doctor, you would know the straightforward pricing. I think that works a lot better, because if you know what the visit is going to cost you can plan for it.
>
> I also think that the way that we do health care in this country, it's broken. I think there needs to be some type of universal health savings account that's multigenerational,

so that if you die with money in your HSA, you can gift it to your children or your grandchildren and that can be spread out.

Moreover, I think right now the way that we fund low income families for health care through Medicaid and even Medicare, I think that needs to be done differently. Right now in Louisiana, Medicaid patients have to pick a provider. Well, most of those providers are Blue Cross Blue Shield, United, Aetna, so they're your major insurance carriers. But they take that money that state taxpayers pay, and then they allow these patients to use it any way they want. Personally, I think that should be put in a separate account for each individual patient. And so they have X amount of dollars spent on their health care, and then they approach their providers, and they look at that fee list and they say, okay, it's $100, to see the doctor today as a new patient. And if I have pharyngitis, or have bronchitis or whatever, it's going to cost me an extra $10. On top of that, well, they look at that account, and they say, okay, well, I'm good for this. But that's not how it works. I mean, there's just unlimited, you know, dollars that aren't necessarily, enough or used responsibly. And so there's a lot of waste, a lot of that money gets eaten up by the corporate executives.

So in summary, I'd like to see that gap between the provider and the patient close on that in the deal. It's a one on one relationship that you have with the patient. And so does the payment, it should be easier. It shouldn't be hard. We shouldn't have these lengthy explanations of benefits statements that we get. Anytime we see a doctor, it should just be “Hey, you came in for an upper respiratory infection. This is what I charged. This is what she paid. And we're just done.” It does not have to be that complicated. I think simplification would be better.

He continued to explain that when you walk into any doctor's office there is no price list. If there was some document stating prices for healthcare visits this would be a great help to both the insured and uninsured patients.

Two of the five participants believed that coverage for individuals who suffered from a catastrophic event would significantly help the medical debt problem. They also believe that bipartisan agreements could help create the changes we want to see regarding medical debt.

Shara Avis shared her thoughts on this topic:

I was actually just having a conversation with the surgeon about this about a month ago at a conference. And he's really into government issues. And he's not a fan of some of the recent health care passages, and we've not been able to pass a good health care bill in the U.S. But when we were talking, we thought that the one thing that would help Americans and help everyone, and I think everybody could agree to it as a bipartisan issue is if we took care of the patients that had a tragic, a serious event that was going to be very costly. If someone breaks an arm, and they need to go to the doctor, get a cast,

> that's not going to put them in medical debt for the rest of their lives. It's a cancer diagnosis. It's the major life events, the catastrophic events that happen if someone needs a liver transplant, you can go on and on about the major event, those are the ones that actually bankrupt patients.

One participant suggested that medical debt forgiveness companies are one solution to the medical debt crisis in the U.S.

Sofia Del Valle shared that "companies like RIP Medical Debt are one solution to the detrimental medical debt issues in the U.S." RIP Medical Debt purchases medical debt portfolios at a fraction of their face value using donations, freeing those who are plagued by healthcare bills. This direct support not only relieves the immediate financial strain, but it also helps to save people from going deeper into debt or declaring bankruptcy owing to medical bills. Furthermore, the RIP Medical Debt technique targets the root causes of the healthcare affordability crisis by addressing the systemic issue of medical debt. By acquiring and forgiving medical debt, RIP Medical Debt highlights the shortcomings of the present healthcare system, in which people are frequently stuck with excessive medical costs despite having health insurance.

Del Valle further shared that "We need Medicaid Expansion (an established policy fix that can be quickly enacted) in holdout states. We need public oversight from local and federal governments of providers and payers. We also need to streamline how people interact with the healthcare system."

When asked the question: "What do you believe could be the sole resolver to help address medical debt in the U.S.?" Dr. Abraham shared:

> I think it's like a fundamental borderline existential question of is healthcare a business or is it a humanitarian right? And if healthcare is a business and insurance companies are privately held, and they make money off of providing insurance for patients, then that's a huge problem.
>
> So I think as long as insurance companies are able to profit off of patients, that's going to continue to be a problem. Like you look at United Health Care's vertical

> integration, and they now own physicians. And they own a clearinghouse for payments of medical claims. And they own a pharmacy benefit manager about how drugs are distributed. And they're publicly traded. So their goal has value to the shareholder. But they are the negotiator for patients to receive health care services. That doesn't make any sense, right?

Dr. Abraham continued to say, “And so I think until there's transparency with how these privately held companies make money off of patients, I don't think it's going to get any better. So the easy answer for that is universal health care.”

He continued to share:

> And then there's medical debt. And there's also legal debt. Yeah, it's these patients that are getting their cars repossessed and their homes repossessed and their wages garnished, they don't have money to go hire a high powered attorney, you know. But then there's also really, really great people out there that are defending these patients, because they understand that it's not the patient's fault. So I think that the problem is the insurance companies have got to be more transparent about their practices, and should they make money? Absolutely. Should they make as much money as they're making? Absolutely not.

Limitations

A possible limitation for this study is that I only interviewed five individuals, so the given responses may not compose a comprehensive list of opinions regarding the medical debt issue in the southeastern U.S. Each of the participants reside in a different state in the southeastern U.S. and there were consistent themes between the five individuals.

In addition, the southeastern U.S. is disproportionately rural and low income. Poor healthcare access and poverty are widespread and have negative implications for healthcare outcomes. As such, these findings on medical debt may be unique to the southeastern U.S. and may not be applicable for other regions.

Chapter 6: Discussion and Policy Recommendations

This study's results provide a clearer picture of the current state of the medical debt issues, especially in the southeastern U.S. While RIP medical debt and other medical debt forgiveness companies help pay off individuals' medical debt, this study has shown that there is much more to be done to provide a long term solution for the serious medical debt issue in the U.S. Each participant interviewed believed that there are other solutions to help fix the detrimental issues medical debt causes.

Overall, the participants' responses reflected existing literature regarding lack of insurance as a contributing factor, the complexity of the U.S. healthcare system as a contributing factor, the financial and emotional impact and the need for multifaceted solutions**.** I had hypothesized after reviewing the literature that medical debt and healthcare, medical debt and the uninsured and medical debt solutions would be three primary factors surrounding medical debt in the southeastern U.S. Each of these was raised by the participants in my interviews. Therefore, what these results reveal about the state of medical debt in the southeastern U.S. aligns with the literature. Without meaningful intervention, the repercussions of unpaid medical debt in the southeastern U.S. will echo for centuries, impeding progress toward a more just, equitable, and prosperous society. Policymakers, healthcare providers, community organizations, and advocates must work together to develop comprehensive solutions that prioritize affordability, accessibility, and dignity in healthcare delivery and financial assistance programs, ensuring that all residents can live healthy, fulfilling lives without the burden of medical debt.

The respondents most frequently stated that individuals who suffer from medical debt are less likely to be insured and this leads to a number of problems. Uninsured people frequently face challenges to receiving timely and comprehensive healthcare services. Without insurance,

individuals may postpone seeking medical treatment, skip preventive care, or rely on emergency room visits for urgent health needs. This can lead to unrecognized or untreated illnesses, resulting in lower health outcomes and higher long-term healthcare expenses. Uninsured people carry the entire financial burden of their healthcare bills, including out-of-pocket fees for medical consultations, diagnostic testing, prescriptions, and hospitalizations. As a result, individuals are more likely to accumulate medical debt, which can cause financial stress, bankruptcy, and asset depletion. Failure to pay medical expenses may result in aggressive debt collection tactics, such as income garnishment or asset seizure, worsening financial instability and insecurity. It can be seen in Blavin, Braga, and Gangopadhyaya's research that these concerns regarding uninsured individuals with medical debt ring true. According to these authors, "People with medical debt are more likely to put off necessary medical care, struggle to pay for other necessities, and have an elevated risk of bankruptcy" (Blavin, Braga, Gangopadhyaya, 2022). Ultimately, my research indicates that the impact of medical debt, particularly among uninsured people, goes far beyond healthcare access and financial pressure. Blavin, Braga, and Gangopadhyaya's findings highlight the substantial impact of medical debt on people's health, financial stability, and overall well-being.

The significant impact that medical debt has on individuals was also reiterated by all of the participants. According to Cooper's (2022) research, adults with health insurance nevertheless owe money for medical expenses. As of June 2021, people owned $88 billion in medical debt on their credit reports, according to the Consumer Financial Protection Bureau (Cooper, 2022). This research correlates with what the participants expressed the emotional and financial burden medical debt causes on individuals who are insured and uninsured. Other studies highlight how medical debt and bankruptcy create financial hardships for working-age

cancer survivors. Cancer patients and their families in the U.S. are experiencing severe financial difficulty due to the escalating medical expenditures linked with the disease (Banegas, 2016). The literature and the respondents express that the weight of medical debt extends beyond financial pressure, infusing people's lives with anxiety, tension, and uncertainty. Medical debt can serve as a sharp reminder of the limitations and flaws of an insured person's coverage, causing financial stress and frustration. Meanwhile, uninsured people confront the additional problem of navigating healthcare costs without the safety net of insurance, and they frequently resort to desperate means to meet their financial commitments. Both existing literature and my research suggest that medical debt not only affects uninsured individuals but also insured individuals.

Respondents also noted that the healthcare system in the U.S. is a significant issue regarding medical debt. Addressing the interconnected concerns of uninsured people and cost shifting requires a multifaceted policy response aimed at increasing healthcare coverage, lowering uncompensated care costs, and promoting financial sustainability within the healthcare system. The participants shared that they believe policy debates and advocacy efforts such as Medicaid expansion, federal insurance premium subsidies, and regulations on provider billing practices on reducing uninsured rates, mitigating cost shifting can help alleviate the medical debt issue in the southeastern U.S. Five of the five participants believed that a large factor in why the southeastern U.S. struggles so much with medical debt is due to the large number of uninsured individuals and cost shifting. Cost shifting strategies in healthcare delivery systems in the southern states can be investigated and assessed for their impact on healthcare affordability, access, and medical debt accumulation across various demographic groups.

According to Kluender, Mahoney, and Wong's (2021) research the percentage of people with medical debt was highest in the South and in zip codes with the lowest income deciles, and it was more prevalent in lower-income neighborhoods in states where Medicaid was not expanded. The healthcare system is failing low income communities. Furthermore, the link between medical debt frequency and a lack of Medicaid expansion in some states implies that systemic issues in the healthcare system worsen financial difficulties for poor groups. While previous research on the relationship between the healthcare system and medical debt is limited, Kluender, Mahoney, and Wong's (2021) findings highlight the urgent need for more research into this vital topic. By investigating the structural barriers and systemic inequities within the healthcare system that contribute to medical debt, researchers can inform policy reforms and interventions aimed at creating a more inclusive, accessible, and affordable healthcare system for all people, regardless of socioeconomic status.

Furthermore, each participant noted the importance of a solution to help combat medical debt. Participants noted that coverage for individuals who suffered from a catastrophic event could be one solution as these are the events that bankrupt people. Each participant agreed that government intervention was necessary. Most said a bipartisan agreement surrounding healthcare could greatly help the issue, although it's unclear what specific policies could gain bipartisan support. The findings of Ahmadi, Kendall, Kessler, and Murdock, point to the importance of government intervention to help combat medical debts (Ahmadi, Kendall, Kessler, and Murdock, 2023). One participant shared the importance of medical debt forgiveness from non-profits like RIP Medical Debt, and each participant agreed that there needs to be changes regarding cost shifting in healthcare.

Overall, the similarities between the results of my research and the findings of previous studies help demonstrate the causes, consequences and solutions to medical debt in the South. Uninsured individuals, and the healthcare system in the U.S. significantly affect and add to the medical debt crisis in the south. That being said, the stigma surrounding medical debts, and the current state of Medicaid are barriers in the decision-making process. Efforts to eliminate medical debt must address each of these barriers.

Policy Recommendations

Helping reduce medical debt in the southeastern U.S. is a complex issue that will require government action and collaboration between many institutions. Based on the barriers and areas for improvement identified by the interview participants, I developed the following recommendations to help combat medical debt, especially in the southeastern U.S.

Simplification of the healthcare system in the U.S.

In Dr. Christian Briery's interview he shared about the simplification of the healthcare system and how a price list and a separate Medicaid account filled with X dollars for each American would be beneficial for patients. While a price list would be very beneficial for routine healthcare visits this would not be helpful regarding catastrophic events, such as getting diagnosed with cancer or having to have open heart surgery. Regarding the separate Medicaid account, this would also not be beneficial for catastrophic events as there would most likely not be enough money to cover one catastrophic event in this account.

The complexity of the healthcare system in the U.S. adds greatly to the difficulties people confront when seeking healthcare services and managing medical bills. Simplifying the healthcare system is critical for increasing access to care, lowering administrative costs, and

tackling the underlying causes of medical debt. To accomplish this objective there can be many steps taken. First, the healthcare billing process needs to be simplified. By streamlining billing procedures between healthcare providers and insurers, administrative operations can be made more efficient. Standardized billing practices, electronic billing systems, and dependable health information technology platforms can improve the accuracy, transparency, and timeliness of billing and payment transactions, lowering the likelihood of billing errors and disputes that contribute to medical debt.

Next, expanding access for affordable health insurance will help not only the uninsured but the insured as well. Expanding access to affordable health insurance coverage for the uninsured and underinsured is critical for streamlining the healthcare system and minimizing inequities in access to care. To ensure comprehensive and equitable access to healthcare services for all Americans, policymakers should consider measures to broaden eligibility criteria for public insurance programs such as Medicaid and Medicare, and strengthen affordability protections for marketplace insurance plans.

Finally, cost shifting should be decreased and price transparency should be promoted. Cost shifting in healthcare can be considerably reduced by enacting comprehensive reforms targeted at tackling the underlying reasons for high healthcare costs and enhancing system efficiency. One strategy is to enhance transparency in healthcare pricing and billing systems, allowing patients to make more informed decisions about their healthcare options and decreasing unexpected medical expenses. Furthermore, steps to reduce the overall cost of healthcare services, such as negotiating cheaper pricing for prescription drugs and medical procedures, can relieve patients' financial burdens and prevent cost shifting from healthcare providers to patients and insurers. In addition, investing in preventative care and population health efforts can help

reduce the need for costly medical interventions and hospitalizations, ultimately lowering healthcare costs.

Improving pricing transparency in healthcare services and prescription pharmaceuticals might help customers make more informed healthcare decisions and better manage their medical expenses. Individuals can better estimate out-of-pocket spending and prevent surprise medical bills, which add to medical debt, if healthcare costs and treatment options are made plain and accessible.

Expanding medical debt relief programs at both the state and federal levels

Expanding medical debt relief programs and nonprofits is a crucial part in alleviating the burden of medical debt and promoting financial stability for individuals and families. Therefore the government should allocate funding at the state and federal level to help expand medical debt reduction programs, like RIP Medical Debt. These programs can provide immediate financial aid to people suffering exorbitant medical expenditures, allowing them to avoid bankruptcy and achieve financial stability. To make sure that the programs are running effectively, systems would need to be implemented for continuous evaluation and monitoring of medical debt alleviation initiatives in order to assess their effectiveness, identify areas for improvement, and assure responsibility. There is also a significant lack of public knowledge about medical debt relief programs, so launching public awareness campaigns to raise knowledge about medical debt relief programs would be beneficial as well. It would also encourage people to seek help if necessary. Using a variety of communication platforms, such as traditional media, social media, and community outreach activities, we would be able to reach hundreds of thousands of individuals and lessen the stigma associated with obtaining financial assistance for medical expenditures. Individuals struggle to keep up with medical bills which causes them shame,

stress, and anxiety. People with problematic medical debt often delay or forgo seeking needed healthcare services due to fears about incurring more medical bills. Empowering people to seek help without shame or judgment is critical in creating a caring and inclusive atmosphere in which everyone may receive the care they require without fear of financial ruin. With the implementation and expansion of more medical debt relief programs the south can push towards getting rid of its residents' high medical debts.

Chapter 7: Conclusion

Many regions, but particularly the Southern United States struggles with medical debt. Proximate causes include the fact that there are more uninsured (and underinsured) individuals living in this area and that many states have chosen not to expand Medicaid under the Affordable Care Act. Through interviews with five professionals with experience and knowledge of medical debt, I identified barriers that lead to the causes, consequences and solutions to medical debt in the southeastern U.S.

This study reinforces the findings of existing research that identify the causes, consequences and solutions to medical debt, especially in poor regions of the South. Still, many of the participants I interviewed noted that the high rate of uninsured individuals could be a key factor in explaining why the Southeastern U.S. struggles significantly with medical debt.

To address these barriers, I offer two policy recommendations. First, expanding medical debt relief programs at both the state and federal levels, and second, advocating for the simplification of the healthcare system in the U.S. If these recommendations were implemented it could have tremendous positive effects on individuals, families, and the healthcare system as a whole.

Additionally, I have organized a fundraiser in collaboration with RIP Medical Debt to raise funds aimed at relieving medical debt burden for residents of Mississippi. I plan to partner with this independent, 501(c)(3) organization, RIP Medical Debt, to raise awareness and donations to eliminate these obligations.

While admittedly a bold initiative, it is my intention to help eliminate the outstanding debt of those Missippians in poverty or working poor for fiscal year 2024 . I plan to share this research with my contacts at RIP Medical Debt and send them to U.s. Senators and Congressmen

in hopes of providing a helpful resource for eliminating medical debt. This research focuses only on the causes, consequences and solutions to medical debt in the South. Future research could involve interviews with Congressmen and Senators to determine what policies they could craft to eliminate medical debt or create a solution for the looming issue. Conducting interviews with political officials would give useful information on the legislative landscape and the viability of taking policy measures to address medical debt.

Taking action to address the causes, repercussions, and solutions of medical debt in the South is critical for maintaining financial stability, enhancing healthcare access, and reducing regional inequities. Legislators and healthcare professionals can help to reduce the impact of medical debt on individuals and communities in the South by implementing specific measures to increase healthcare coverage, strengthen healthcare infrastructure, promote price transparency, support medical debt relief programs, and advocate for policy change. By taking comprehensive action to address the underlying causes and consequences of medical debt, we can build a more equitable and accessible healthcare system that supports financial security and well-being for all Americans.

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