

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-24)  
Patient Medical Debt  
(Resolution 710-A-23 and Resolution 712-A-23)  
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution 710-A-23 asked the American Medical Association (AMA) to work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state levels that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patient's employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23 asked the AMA to study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such a report to include recommendations to the House of Delegates to severely reduce the problem of medical debt.

An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid medical bills, totaling between \$195-220 billion. A 2021 Census Bureau analysis estimated that 15 percent of households in the United States owed medical debt. Medical debt is the leading cause of bankruptcy in the United States and can take many forms, including past due payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family or friends. Medical debt occurs widely across all demographic groups. Insurance coverage does not protect patients from incurring medical debt and debt is accrued both for patients with chronic medical conditions and as a result of unexpected acute events. Across the United States, approximately 50 million people are on a financing plan to pay off a medical or dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected may be kept by financing companies who often contract with physicians and hospitals to collect outstanding debt.

Medical financing products, such as medical credit cards and installment plans, can be offered to patients through hospitals or physicians' offices, but they are often serviced through third-party financial services companies. Historically, uninsured and low-income patients have been provided installment plans with zero or low interest rates directly from hospitals or physicians' offices where they received their care. Notably, as more physicians become employed, there is less control and awareness of the debt collection practices of their employers. In recent years, some hospitals and physicians' offices have partnered with financial service or private equity companies to offer more structured loan arrangements, which tend to charge market-level or higher interest rates.

In July 2023, the Biden Administration, the Consumer Financial Protection Bureau, the Department of Health and Human Services, and the Treasury Department issued a Request for Information on medical credit cards and other high-cost specialty financial products to understand their prevalence, patients' experience with them, and incentives driving physicians and other non-physician providers to offer these products.

The Council offers a series of recommendations to reduce patient medical debt.

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-24

Subject: Patient Medical Debt  
(Resolution 710-A-23 and Resolution 712-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee G

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1 At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution  
2 710-A-23, introduced by the Michigan delegation, asked the American Medical Association (AMA) to  
3 work with the appropriate national organizations to address the medical debt crisis by advocating for  
4 robust policies at the federal and state levels that prevent medical debt, help consumers avoid court  
5 involvement, and ensure that court involved cases do not result in devastating consequences to patient's  
6 employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23,  
7 introduced by the New Jersey delegation, asked the AMA to study the causes of medical bankruptcy in  
8 the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with  
9 such a report to include recommendations to the House of Delegates to severely reduce the problem of  
10 medical debt.

## 11 12 BACKGROUND

13  
14 An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid  
15 medical bills, totaling between \$195-220 billion.<sup>1</sup> Of this 100 million, approximately 20 million people  
16 owe money directly to their physician, hospital, or other non-physician provider.<sup>2</sup> The remaining 80  
17 million people reflect those that have other debts associated with their health care (i.e., credit card debt,  
18 loans from family and friends, etc.) The Consumer Financial Protection Bureau (CFPB) estimates that  
19 \$88 billion of total medical debt is reflected on Americans' credit reports.<sup>3</sup> A 2021 Census Bureau  
20 analysis estimated that 15 percent of households in the United States owed medical debt.<sup>4</sup> Medical debt is  
21 the leading cause of bankruptcy in the United States and can take many forms, including past due  
22 payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or  
23 collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family  
24 or friends.<sup>5</sup> Medical debt can often be masked as other forms of debt when someone falls behind on other  
25 expenses (i.e., food, housing, household goods) to pay down their medical bills.<sup>6</sup> Those with unaffordable  
26 medical bills are more likely to skip or delay needed care, cut back on basic household expenses, take  
27 money out of retirement or college savings, or increase credit card debt.<sup>7</sup>

28  
29 Medical debt occurs across demographic groups, but is more likely if a patient has disabilities, is in worse  
30 health, is poor or near poor, is Black, lives in the South, lives in a non-Medicaid expansion state, or is  
31 middle aged. Women are more likely to report having medical debt than men (11 percent vs. 8 percent),  
32 which is likely due to childbirth-related expenses and lower average incomes.<sup>8</sup>

33  
34 COVID-19 exacerbated several hardships associated with increased medical debt, including downstream  
35 effects of contracting COVID-19, losing employer-sponsored health insurance, or losing income. The  
36 Commonwealth Fund completed a study that found that half of all people ages 19-64 affected by

1 COVID-19 had medical debts or issues tangentially related to medical debt during the study period.  
2 COVID-19 hospitalizations and treatment also contributed to individuals' debt.<sup>9</sup>

3  
4 Besides negative financial impacts, other consequences patients face include being contacted by  
5 collectors or negative credit score impacts, which makes it difficult to buy a vehicle, get a job, or buy or  
6 rent a home. Additionally, there are consequences associated with care: one in seven adults with health  
7 care debt say they have been denied care due to unpaid medical bills.<sup>10</sup>

8  
9 *Causes of Medical Debt in the United States*

10  
11 According to a KFF study, 72 percent of patients with medical debt claim the bills were from an  
12 unexpected acute event while 27 percent of those with debt claim that the expenses built up over time  
13 from treatments for chronic conditions.<sup>11</sup> Conversely, the Commonwealth Fund reports that the source of  
14 debt for many people is chronic conditions and that about half of adults with debt said it was the result  
15 from treatment received for ongoing health problems.<sup>12</sup> The discrepancy in these findings indicates that  
16 medical debt clearly impacts both patients who experience a one-time acute care event and those with  
17 chronic medical conditions.

18  
19 Approximately 23 million people owe "significant" medical debt, which is considered to be anything  
20 \$250 or greater, according to both KFF and the Survey of Income and Program Participation.<sup>13</sup> In 2020,  
21 the average amount of medical debt was \$429.<sup>14</sup> Among single-person, privately insured households in  
22 2019, 32 percent did not have liquid assets over \$2,000 and among multi-person households, 20 percent  
23 did not have liquid assets over \$2,000. Sixteen percent of privately insured adults say they would need to  
24 take on credit card debt to meet an unexpected \$400 expense, while seven percent would need to borrow  
25 money from friends or family.<sup>15</sup>

26  
27 Adults who are uninsured for six months or more out of the year are more likely to report having  
28 significant medical debt. However, medical debt burden does not solely impact those without health  
29 insurance. Over 90 percent of Americans have some form of health insurance. Even those with private  
30 health insurance may have insufficient liquid assets to meet high deductibles or other cost-sharing  
31 expenses.<sup>16</sup> Many working age adults surveyed by the Commonwealth Fund said it was very or somewhat  
32 difficult to afford their health care, including 43 percent of those with employer-sponsored coverage, 57  
33 percent with Affordable Care Act (ACA) Marketplace or individual plans, 45 percent with Medicaid, and  
34 51 percent with Medicare.<sup>17</sup>

35  
36 Insurance coverage does not shield individuals from taking on debt. A substantial portion of people with  
37 insurance still have medical debt including 30 percent of people with employer-sponsored coverage, 37  
38 percent enrolled in an ACA Marketplace or individual plan, 21 percent covered by Medicaid, and 33  
39 percent covered by Medicare.<sup>18</sup> Among those in employer plans, those with low incomes especially  
40 struggled. Fifty-six percent of those with debt enrolled in employer-sponsored plans had incomes under  
41 200 percent of the federal poverty line (FPL) and reported difficulty in paying for their health care.<sup>19</sup>  
42 Additionally, those in employer-sponsored plans with incomes below 400 percent FPL reported much  
43 higher rates of delaying or forgoing needed care due to the cost. More than half of these individuals  
44 reported that their health problem had gotten worse as a result of skipping care.

45  
46 One concern with Medicaid specifically is estate recovery for those using Medicaid long-term care.  
47 Medicaid beneficiaries over the age of 55 that have used long-term services, such as a nursing home or  
48 home care, are subject to estate recovery after their death. State agencies will come after any assets,  
49 including the individual's home, in order to recoup the money spent on long-term care for the patient. In  
50 2019, states collected \$733 million in estate recovery, which is about 0.5 percent of Medicaid's total long-  
51 term care expenditures. Patient's families who do not have the assets to pay the expenses owed back to

1 Medicaid are often forced to sell the patient's home to cover the costs. These homes are often the last  
2 assets a family has and can further exacerbate existing poverty.<sup>20</sup>

3  
4 Medical debt is a uniquely American problem as nearly half of all working-age Americans struggle with  
5 health care costs.<sup>21</sup> The Commonwealth Fund compared the performance of the United States' health  
6 system to those of other high-income countries and ranked it last among 11 nations in several categories  
7 including access, efficiency, equity, and health outcomes.<sup>22</sup> Health expenditures per person in the United  
8 States totaled \$12,555 in 2022, which was over \$4,000 more than any other high-income nation. The  
9 average amount spent on health per person in comparable countries is about half of what the United States  
10 spends per person (\$6,651).<sup>23</sup> Americans also tend to be unhealthier than those in other countries.  
11 However, the comparison is limited due to the variance in health systems in each of the countries that  
12 were compared. America's global counterparts either have government health plans (i.e., Britain and  
13 Canada) or rely on subsidized private insurers (i.e., Germany and the Netherlands).<sup>24</sup> In addition, it would  
14 be unfair to compare the health care costs between America and its global counterparts due to the  
15 different tax burdens in each of these countries and how that impacts the total paid for health care. While  
16 the discrepancies between how these various systems work and serve patients may be of interest, this  
17 report specifically focuses on addressing American medical debt within the current health care system.

### 18 19 *Impact on Physicians*

20  
21 An article in the *AMA Journal of Ethics* states that physicians have a responsibility to reduce debt,  
22 especially given the impact of patients forgoing care if they are unable to pay. At a minimum, physicians  
23 should be aware of their institution's charity care policy or reduced bill payment options.<sup>25</sup> However,  
24 physicians cannot continue providing care to patients if they are not paid, especially those working in  
25 small private practices. Asking patients to pay outstanding and overdue bills is increasingly difficult if  
26 there are reduced financial consequences to patients who fail to pay. According to Medscape's 2022  
27 Physician Compensation Report, physicians react in the following ways when patients do not pay their  
28 outstanding bills: 43 percent continue to treat the patients and develop a payment plan; 13 percent send  
29 outstanding bills to third-party collection agencies; 12 percent continue to provide care and write off the  
30 balance; 25 percent choose other actions; and eight percent drop patients if they continue not to pay.<sup>26</sup>

31  
32 Physicians are encouraged to have an established payment policy, presented in writing to all patients.  
33 These agreements should be clear and easy for all patients to understand. When possible, physicians  
34 should try to collect payment at the time of service and provide transparent pricing to patients. This could  
35 include explaining that costs for prescribed services (e.g., tests, imaging, medications) are often dictated  
36 by the patient's insurance plan and out of the control of the prescribing physician. In the event that unpaid  
37 accounts need to be turned over to a third-party collection agency, physicians should be mindful to select  
38 agencies that charge reasonable fees, noting that some charge a fee that is 30 to 40 percent of the total  
39 amount of debt they collect.

40  
41 Physician responsibilities regarding patient medical debt and the cost of care are further codified in the  
42 following AMA Code of Ethics opinions: [11.1.1](#), [11.1.4](#), [11.2.1](#), [11.2.2](#), [11.2.4](#), and [11.3.3](#).

### 43 44 *Patient Financing Programs*

45  
46 Medical financing products, such as medical credit cards and installment plans, can be offered to patients  
47 through hospitals or physicians' offices, but they are often serviced through third-party financial services  
48 companies. Historically, uninsured and low-income patients have been provided installment plans with  
49 zero or low interest rates directly from hospitals or physicians' offices where they received their care.  
50 Notably, as more physicians become employed, there is less control and awareness of the debt collection  
51 practices of their employers. In recent years, some hospitals and physicians' offices have partnered with

1 financial service or private equity companies to offer more structured loan arrangements, which tend to  
2 charge market-level or higher interest rates. Some even target patients with low credit scores, while others  
3 target specific services, such as fertility treatments.  
4

5 Patient financing is a multi-billion-dollar business that includes private equity and banks buying patient  
6 debt from hospitals, physicians, and non-physician providers. Hospitals, physicians, and other non-  
7 physician providers, who have traditionally put patients in interest free payment plans, have embraced the  
8 patient financing model and have entered into contracts with these lenders. Many of these financing plans  
9 offer a promotional period where no interest is charged, but if a patient does not pay off the full amount  
10 owed during this time, interest is then charged. These loans can deepen inequities. For example, lower  
11 income patients without the means to make large monthly payments can face higher interest rates while  
12 wealthier patients who are able to take on larger monthly payments can secure lower interest rates.  
13 Additionally, patients with higher incomes can usually pay off the debt during the promotional period and  
14 avoid accruing any interest.<sup>27</sup>  
15

16 Across the United States, approximately 50 million people are on a financing plan to pay off a medical or  
17 dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected  
18 may be kept by financing companies who contract with hospitals to collect outstanding debt. Many  
19 hospitals are reluctant to share specific details on their agreements with these companies but have cited  
20 the need to offset the cost of offering financing options to patients as a reason why they enter into these  
21 partnerships.<sup>28</sup>  
22

23 If patients are unable to keep up with payments to the financing companies, their debt may be sent into  
24 collections or returned to the hospital or physician's office where further action may be taken. For  
25 example, one of these financing companies, AccessOne, returns patient accounts to the hospital if  
26 payments are missed. The hospital can then sue the patient, report them to credit bureaus, or take other  
27 collection action. Such actions could also include referring unpaid bills to the state revenue department,  
28 which can garnish tax refunds.<sup>29</sup> Medical credit cards may also be offered to patients. These accounts tend  
29 to charge patients interest rates higher than regular credit cards if patients are unable to pay their balances  
30 during the promotional period. In addition, when a patient uses a medical credit card, a physician's office  
31 may charge a fee at the time payment is disbursed. One such company, Alphaeon Credit, markets directly  
32 to ophthalmology, plastic surgery, dermatology, and dental practices. As an example, in the fine print of  
33 their offer to ophthalmology patients, Alphaeon Credit notes that "minimum payments are not guaranteed  
34 to pay the promotional plan balance within the promotional period...you may have to pay more than the  
35 minimum payment to avoid accrued interest charges." The annual percentage rate (APR) that a patient is  
36 charged if they do not pay off their balance within the promotional period is 31.99 percent, well above the  
37 average for a typical credit card.<sup>30</sup>  
38

### 39 *Hospital Charity Care*

40

41 Charity care is offered at most hospitals in the United States. Nonprofit hospitals must provide financial  
42 aid as a condition of their tax-exempt status, which is something that saves the hospitals billions of dollars  
43 each year. However, standards for aid vary widely across hospitals. Aid at some hospitals is limited to  
44 patients below the FPL, while at other hospitals, patients with incomes that are five to six times the FPL  
45 can receive assistance. Applying for aid can be complicated for patients, requiring lots of personal  
46 financial information and documentation. A Kaiser Health News analysis of tax filings found that nearly  
47 one half of nonprofit medical systems were billing patients with incomes low enough to qualify for  
48 charity care.<sup>31</sup>

1 Problems associated with charity care are important and closely related to the broader issue of patient  
2 medical debt. Notably, the Council will be preparing a report for the 2024 Interim Meeting specifically on  
3 charity care and any associated recommendations will be included in the forthcoming report.  
4

#### 5 *Recent Federal and State Efforts*

6

7 In July 2023, the Biden Administration, CFPB, the Department of Health and Human Services (HHS),  
8 and the Treasury Department issued a Request for Information (RFI) on medical credit cards and other  
9 high-cost specialty financing products to understand their prevalence, patients' experience with them, and  
10 incentives driving physicians and other non-physician providers to offer these products. In the RFI, the  
11 agencies cite that hospitals and financial service companies might not be making reasonable efforts to  
12 determine when a patient is eligible for financial assistance before offering a medical financing product.<sup>32</sup>  
13

14 Additionally, the RFI indicates that a typical APR for a medical credit card is 27 percent, while a typical  
15 consumer credit card has an average APR of about 16 percent. With medical credit cards, if a patient is  
16 unable to pay the balance within the no- or low-interest promotional period, the patient will then owe  
17 interest on the entire amount, not just the remaining balance. As a result, patients incurred a total of about  
18 \$1 billion in deferred interest on health care purchases between 2018-2020.<sup>33</sup>  
19

20 Although national credit reporting agencies agreed not to report medical debts that are less than a year old  
21 or under \$500 on Americans' credit reports, using a medical financing product can impact patient credit  
22 scores more directly through "[hard](#)" credit checks, increased credit line utilization, decreased account age,  
23 or eventual account closure.<sup>34</sup> A benefit for hospitals, physicians, and non-physician providers utilizing  
24 medical financing products is being paid within days of providing a service and not having to handle  
25 disputes, billing, or other administrative work.  
26

27 In addition to the RFI, in September 2023, CFPB released a notice that it is developing a rule to bar credit  
28 reporting companies from including medical debt in consumer credit reports. CFPB is seeking to prohibit  
29 lenders from using medical collections information when evaluating a borrower's application. The agency  
30 plans to issue a Notice of Proposed Rulemaking in 2024,<sup>35</sup> which was not available at the time that this  
31 report was written. As of November 2023, CFPB released a notice stating that it is taking steps to ensure  
32 medical debt collectors follow the law, including the Fair Debt Collection Practices Act and the Fair  
33 Credit Reporting Act. Specifically, these steps include supervision and enforcement efforts, reminding  
34 entities about their obligations, support for state-level action, and education and outreach. Although the  
35 Fair Debt Collection Practices Act limits how aggressive debt collectors can be by restricting the ways  
36 and times they can contact debtors, it does not limit or prohibit the use of legal remedies like wage  
37 garnishment or foreclosure.<sup>36</sup> Further, the Fair Debt Collection Practices Act currently only applies to  
38 debt collectors and does not include hospitals or other health care entities.  
39

40 In addition to recent federal efforts, several states have created policies to protect patients from the  
41 consequences of having medical debt. A detailed overview, including maps of which states fall into each  
42 category can be found [here](#).<sup>37</sup>  
43

44 A summary of recent state actions include:

- 45 • Charging interest on medical debt
  - 46 ○ Eight states have laws prohibiting or limiting interest on all medical debt.
  - 47 ○ Some states have set a ceiling for interest on all medical debt. Others prohibit charging
  - 48 interest to patients who are at or below 250 percent FPL and are ineligible for public
  - 49 insurance programs.

- 1     • Regulations on sending medical bills to collections
    - 2         ○ Thirty-seven states do not regulate when a hospital can send a bill to collections.
3         ○ However, unlike hospitals, debt collectors do not have a relationship with patients and  
4         ○ can be more aggressive when collecting on the debt.
5         ○ Connecticut prohibits hospitals from sending bills of certain low-income patients to  
6         ○ collections and Illinois requires hospitals to offer a reasonable payment plan first.7         ○ Maryland and Colorado require hospitals to report debt collection actions with  
8         ○ demographic data and New Mexico and Colorado extended the requirements that are  
9         ○ applicable to nonprofit hospitals to urgent care clinics, freestanding Emergency  
10         ○ Departments, and outpatient clinics.<sup>38</sup>
- 11     • Sale of medical debt
  - 12         ○ Maryland, New Mexico, and Vermont prohibit the sale of medical debt while California  
13         ○ and Colorado regulate debt buyers instead. California prohibits debt buyers from  
14         ○ charging interest and Colorado prohibits them from foreclosing on a patient's home.
15         ○ California also recently restricted when hospitals could sell patient debt or report patients  
16         ○ to credit bureaus.<sup>39</sup> Debt collection is prohibited for 180 days, regardless of financial  
17         ○ status.<sup>40</sup>
- 18     • Liens and foreclosures
  - 19         ○ Thirty-three states do not limit hospitals, collection agencies, or debt buyers from placing  
20         ○ a lien or foreclosing on a patient's home to recover unpaid medical bills. However,  
21         ○ almost all states provide a homestead exemption, which protects some equity in a  
22         ○ patient's home from being seized during bankruptcy.
23         ○ Eleven states prohibit or set limits on liens and foreclosures for medical debt.
- 24         ○ New York and Maryland fully prohibit both liens and foreclosures because of medical
- 
- 25         ○ debt, while California and New Mexico only prohibit them for certain low-income
- 
- 26         ○ populations.
- 27     • Wage garnishment
  - 28         ○ Under federal law, the amount of wages garnished each week may not exceed the lesser  
29         ○ of 25 percent of the employee's disposable earnings or the amount by which an  
30         ○ employee's disposable earnings are greater than 30 times the federal minimum wage.
31         ○ Twenty-one states exceed the federal ceiling for wage garnishment.
- 32         ○ New York fully prohibits wage garnishment to recover medical debt for all patients, yet
- 
- 33         ○ California only extends protections for certain low-income populations.34         ○ New Hampshire does not prohibit wage garnishment, but it does require the creditor to
- 
- 35         ○ keep going back to court every pay period to garnish wages, which significantly limits
- 
- 36         ○ creditors' ability to garnish wages in practice.

## 37 38 AMA POLICY AND ADVOCACY

39  
40 AMA policy is limited on the issue of patient medical debt directly. Tangentially related policies address  
41 uncompensated care, controlling costs of care, price transparency, patient cost-sharing generally, and  
42 expanding coverage and improving affordability of coverage.

43  
44 Policy D-155.987 states that our AMA: 1) encourages physicians to communicate information about the  
45 cost of their professional services to individual patients, taking into consideration the insurance status of  
46 the patient or other relevant information where possible; 2) advocates that health plans provide plan  
47 enrollees or their designees with complete information regarding plan benefits and real time cost-sharing  
48 information associated with both in-network and out-of-network provider services or other plan designs  
49 that may affect patient out-of-pocket costs; 3) will actively engage with health plans, public and private  
50 entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for

1 patients and physicians, and help ensure that entities promoting price transparency tools have processes in  
 2 place to ensure the accuracy and relevance of the information they provide; 4) will work with states and  
 3 the federal government to support and strengthen the development of all-payer claims databases; 5)  
 4 encourages electronic health record vendors to include features that assist in facilitating price  
 5 transparency for physicians and patients; 6) encourages efforts to educate patients in health economics  
 6 literacy, including the development of resources that help patients understand the complexities of health  
 7 care pricing and encourage them to seek information regarding the cost of health care services they  
 8 receive or anticipate receiving; and 7) will request that the Centers for Medicare & Medicaid Services  
 9 expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

10  
 11 Policy H-165.846 states that our AMA supports the following principles to guide in the evaluation of the  
 12 adequacy of health insurance coverage options: a) any insurance pool or similar structure designed to  
 13 enable access to age-appropriate health insurance coverage must include a wide variety of coverage  
 14 options from which to choose; b) existing federal guidelines regarding types of health insurance coverage  
 15 (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program regulations) should  
 16 be used as a reference when considering if a given plan would provide meaningful coverage; c) provisions  
 17 must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health  
 18 insurance coverage and meeting cost-sharing obligations; and d) mechanisms must be in place to educate  
 19 patients and assist them in making informed choices, including ensuring transparency among all health  
 20 plans regarding covered services, cost-sharing obligations, out-of-pocket limits, and lifetime benefit caps,  
 21 and excluded services. Policy H-165.846 also advocates that the Early and Periodic Screening,  
 22 Diagnostic, and Treatment program be used as the model for any essential health benefits package for  
 23 children and that the AMA: a) opposes the removal of categories from the essential health benefits (EHB)  
 24 package and their associated protections against annual and lifetime limits, and out-of- pocket expenses;  
 25 and b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their  
 26 associated protections against annual and lifetime limits.

27  
 28 Policy D-180.979, which comes from CMS Report 9-A-19, states that the AMA will: 1) support the  
 29 development of sophisticated information technology systems to help enable physicians and patients to  
 30 better understand financial obligations; 2) encourage states and other stakeholders to monitor the growth  
 31 of high deductible health plans and other forms for cost-sharing in health plans to assess the impact of  
 32 such plans on access to care, health outcomes, medical debt, and provider practice sustainability;  
 33 3) advocate for the inclusion of health insurance contract provisions that permit network physicians to  
 34 collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the  
 35 time of service; and 4) monitor programs wherein health plans and insurers bear the responsibility of  
 36 collecting patient co-payments and deductibles.

37  
 38 Policy H-373.996 states that our AMA supports the principles contained in the Medical Debt Relief Act  
 39 as drafted and passed by the US House of Representatives to provide relief to the American consumer  
 40 from a complicated collections process and supports medical debt resolution being portrayed in a positive  
 41 and productive manner.

42  
 43 Policy H-160.923 states that our AMA: 1) supports the transitional redistribution of disproportionate  
 44 share hospital payments for use in subsidizing private health insurance coverage for the uninsured; 2)  
 45 supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose  
 46 of supporting physicians that treat large numbers of uninsured patients, as well as the Emergency Medical  
 47 Treatment and Active Labor Act-directed care; and 2) encourages public and private sector researchers to  
 48 utilize data collection methodologies that accurately reflect the amount of uncompensated care (including  
 49 both bad debt and charity care) provided by physicians.



1 Policy H-165.838 states that the AMA is committed to working with Congress, the Administration, and  
2 other stakeholders to achieve enactment of health system reforms that include the following seven critical  
3 components: health insurance coverage for all Americans; insurance market reforms that expand choice  
4 of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps;  
5 assurance that health care decisions will remain in the hands of patients and their physicians, not  
6 insurance companies or government officials; investments and incentives for quality improvement and  
7 prevention and wellness initiatives; repeal of the Medicare physician payment formula that triggers steep  
8 cuts and threaten seniors' access to care; implementation of medical liability reforms to reduce the cost of  
9 defensive medicine; and streamline and standardize insurance claims processing requirements to  
10 eliminate unnecessary costs and administrative burdens.

## 11 DISCUSSION

12  
13  
14 Medical debt is a huge burden on many Americans across all demographic groups. Patients face negative  
15 outcomes associated with debt, including worse health outcomes, stress from being contacted by debt  
16 collectors and negative credit score impacts, and the downstream effects of difficulty getting a job or  
17 buying or renting a home.

18  
19 Medical debt is accrued by patients with long-term, chronic conditions, as well as those with acute  
20 conditions or those suffering from an accident. Insurance coverage does not automatically protect patients  
21 from debt. Even with insurance coverage many patients struggle with high cost-sharing and deductibles  
22 offered by their insurance plans. Improved patient education on the cost of care and plan details could  
23 help patients better prepare for unexpected medical costs. Both insured and uninsured patients have  
24 reported delaying or forgoing needed care due to costs, further exacerbating health concerns.

25  
26 The growth of high-deductible health insurance plans, which are increasingly offered to patients, have  
27 been shown to require deductibles too high for many Americans. In 2021, the average annual deductible  
28 for a single worker with employer-based coverage was over \$1,400, which is almost four times greater  
29 than it was in 2006. Family deductibles can exceed \$10,000.<sup>41</sup> Out-of-pocket maximums also prove to be  
30 too high for many Americans. For example, although the ACA caps out-of-pocket spending for those on  
31 Marketplace plans, in 2024, the out-of-pocket maximum for those on a Marketplace plan is \$9,450 for an  
32 individual and \$18,900 for a family.<sup>42,43</sup>

33  
34 Many patients are unaware of reduced cost options offered by their hospital or physician's office. These  
35 plans should be easy for patients to access and should be discussed with patients at the time of payment.  
36 This includes sharing details about interest rates, timelines for payment, and anything else that may  
37 impact the patient financially. While physicians should be aware of the charity care policy in their office  
38 or institution, it must be understood that physicians cannot continue providing care to patients if they are  
39 not paid. This is made more difficult if penalties are reduced for patients who are unable or unwilling to  
40 pay their bills. The Council believes that physicians have the opportunity to educate patients on the  
41 charity care policy offered by their institution but should be mindful when partnering with third-party  
42 collection agencies, especially those who place wage garnishments and property liens on low-wage  
43 patients. If possible, physicians should try to handle debts with patients directly, by requiring payment  
44 prior to providing services (for non-emergent care), offering flexible payment plans, or forgiveness of  
45 debt altogether. Additionally, if a patient's medical bill is part of an ongoing dispute, hospitals and  
46 physicians should try to refrain from sending this bill to collections or to a third-party collection agency  
47 until the dispute is resolved.

48  
49 The Council believes that recent efforts by the Biden Administration, CFPB, HHS, and Treasury  
50 Department to explore the causes of and solutions to medical debt provide the AMA with an opportunity

1 to support amendments to laws, such as the Fair Debt Collection Practices Act, to strengthen standards  
2 and provide additional clarity to patients about medical billing.

3  
4 Several states, counties, and cities have taken a creative approach to managing medical debt for their  
5 residents. For example, New York City and Cook County (Chicago) in Illinois have recently partnered  
6 with RIP Medical Debt, a nonprofit organization that purchases and forgives medical debt from low-wage  
7 individuals. At the time that this report was written, Cook County and RIP Medical Debt have used \$12  
8 million of federal funds granted by the American Rescue Plan to forgive up to \$1 billion in medical debt  
9 for residents.<sup>44</sup> New York City is also partnering with RIP Medical Debt and investing \$18 million to  
10 purchase and forgive \$2 billion in medical debt for approximately half a million New York residents.<sup>45</sup> To  
11 qualify for relief in both Cook County and New York, a resident must have an annual household income  
12 below 400 percent FPL or have medical debt equal to five percent or more of their annual household  
13 income. Other states and cities are exploring similar grants and partnerships. The AMA has an  
14 opportunity to be further educated on these and other initiatives to reduce medical debt for patients and  
15 explore ways to support the missions of these organizations.

16  
17 Medical debt impacts many patients in the United States, causing negative health outcomes from delayed  
18 or denied care to stress from financial pressures from unpaid bills. When possible, the Council believes  
19 that physicians should support patient education on the cost of care, including potential downsides for  
20 alternative options for paying down debt, such as high interest rates or penalties for missing payments  
21 with third-party collection agencies. Understanding both the serious issue of medical debt for patients and  
22 that physicians need to be paid to continue providing care, physicians should be thoughtful when  
23 navigating this issue by encouraging patients to be informed about their insurance coverage and to take  
24 advantage of charity care when they qualify to reduce the burden of the cost of their care.

## 25 26 RECOMMENDATIONS

27  
28 The Council on Medical Service recommends that the following recommendations be adopted in lieu of  
29 Resolution 710-A-23 and Resolution 712-A-23, and the remainder of the report be filed:

- 30  
31 1) That our American Medical Association (AMA) encourage health care organizations to manage  
32 medical debt with patients directly, considering several options including but not limited to  
33 discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt  
34 altogether, before resorting to third-party debt collectors or any punitive actions. (New HOD  
35 Policy)
- 36  
37 2) That our AMA support innovative efforts to address medical debt for patients, including sliding-  
38 scale, interest-free payment plans before collection or litigation activities and public and private  
39 efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation. (New  
40 HOD Policy)
- 41  
42 3) That our AMA support amending the Fair Debt Collection Practices Act to include hospitals and  
43 strengthen standards within the Act to provide clarity to patients about whether their insurance  
44 has been or will be billed, which would require itemized debt statements to be provided to  
45 patients, thereby increasing transparency, and prohibiting misleading representation in connection  
46 with debt collection. (New HOD Policy)
- 47  
48 4) That our AMA opposes wage garnishments and property liens being placed on low-wage patients  
49 due to outstanding medical debt at levels that would preclude payments for essential food and  
50 housing. (New HOD Policy)

- 1 5) That our AMA support patient education on medical debt that addresses dimensions such as:
- 2 a. Patient financing programs that may be offered by hospitals, physicians offices, and other
- 3 non-physician provider offices;
- 4 b. The ramifications of high interest rates associated with financing programs that may be
- 5 offered by a hospital, physician’s office, or other non-physician provider’s office;
- 6 c. Potential financial aid available from a patient’s hospital and/or physician’s office; and
- 7 d. Methods to reduce high deductibles and cost-sharing. (New HOD Policy)

Fiscal Note: Less than \$500.

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## **Relevant AMA Policy Patient Medical Debt**

### **Price Transparency, D-155.987**

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide enrollees or their designees with complete information regarding plan benefits and real-time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economic literacy, including the development of resources that help patients understand the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.  
(CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19; Reaffirmation: A-23)

### **Adequacy of Health Insurance Coverage Options, H-165.846**

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
  - a. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
  - b. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
  - c. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
  - d. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.  
(CMS Rep. 7, A-07; Reaffirmation: I-07; Reaffirmation: A-09; Reaffirmed: Res. 103, A-09; Reaffirmation: I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19)

### **Health Plan Payment of Patient Cost-Sharing, D-180.979**

Our AMA will: (1) support the development of sophisticated technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.  
(CMS Rep. 09, A-19)

### **Exclusion of Medical Debt that Has Been Fully Paid or Settled, H-373.996**

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.  
(Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20)

### **Offsetting the Costs of Providing Uncompensated Care, H-160.923**

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.  
(CMS Rep. 8, A-05; Reaffirmation: A-07; Modified: CMS Rep. 01, A-17)

### **Health System Reform Legislation, H-165.838**

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
  - a. Health insurance coverage for all Americans
  - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
  - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
  - d. Investments and incentives for quality improvement and prevention and wellness initiatives
  - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
  - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
  - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
  6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
  7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
  8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
    - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
    - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
    - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
    - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
    - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
    - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
  9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicates our AMA's position based on AMA policy.
  10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
  11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
  12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
  13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
- (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, hA-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23)