# When Hospitals and Doctors Sue Their Patients: The Medical Debt Crisis Through a New Lens


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Health Disparities Institute

**ISSUE BRIEF**

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UCONN HEALTH
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## ABOUT THE HEALTH DISPARITIES INSTITUTE

UConn established the Health Disparities Institute in 2011 as part of the Bioscience Connecticut initiative to enhance research and the delivery of care to minority and underserved populations in the state.

## MISSION

To reduce disparities by turning ideas shown to work into policies and actions.

## VISION

Everyone in Connecticut has an opportunity to enjoy good health and wellbeing.

## Context

Growing evidence suggests that medical debt is one of the most salient drivers of health disparities, decreased access to needed care and a leading contributor to growing economic inequality.[1] The problem of medical debt is not new. The magnitude of medical debt and its consequences on patients' financial situation, credit rating and other non-medical areas have been chronicled extensively.[2,3,4,5] However, insurance plans that transfer ever greater financial risk to patients and the consolidation of small practices into larger corporate entities are recent developments that are changing the context of the patient-provider relationship. These changes merit a fresh examination of medical debt. Such an examination is critical for patients living at the socioeconomic margin for whom medical debt poses a compounded risk for health inequities.

This Brief provides an overview of the complex problem of medical debt in America through a new lens, hospitals' and providers' law suits against their patients. Public records of litigation pursued by medical practices, hospitals or collection agencies against patients offers a unique window through which systemic factors as well as patients and provider behaviors surrounding medical debt can be examined and provide insights into possible solutions. We summarize the most current medical debt literature and offer some reflections on the impact of collection practices, including legal action, on patients' trust, continuity of care and overall quality of care.

We also consider the provider's perspective. Medical debt poses a considerable ethical dilemma for providers who must balance their dual responsibility of caring and advocating for their patients while protecting the fiscal integrity of their own medical practices.

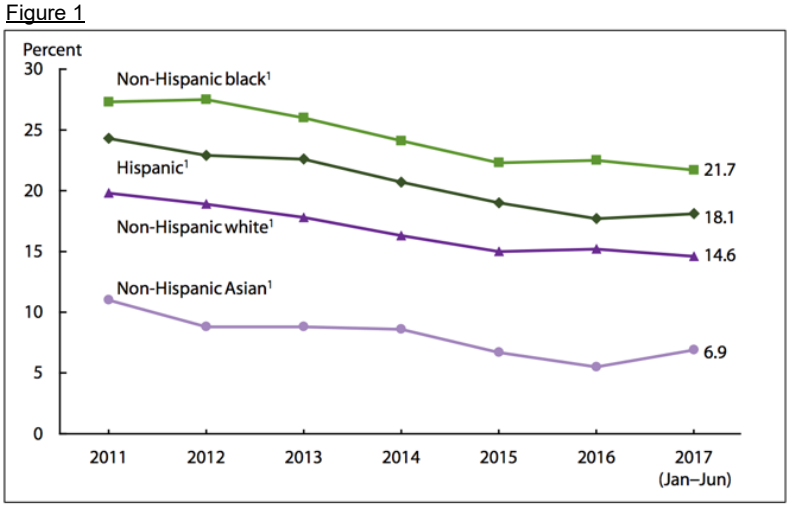
## Medical Debt: A National Perspective

Medical debt, unlike home mortgages, student loans or credit card debt is almost never voluntary. The need for preventive care, the presence of pain, chronic illness and the threat of disability or death demand services with no definable upper price boundaries in traditional economic constructs of supply and demand and other traditional market rules.[6] Under these conditions "what the market will bear" is an indefensible guiding principle for unfettered price escalation. The virtual absence of an effective legal framework to regulate healthcare price increases, a cultural aversion to mandatory price controls, and increased patient financial responsibilities (in the form of deductibles, co-pays, co-insurance and complex insurance rules that lead to costly errors), Americans face a perennial risk of incurring medical debt, despite insurance coverage and an otherwise comfortable income.

Despite being continuously insured millions of Americans have difficulty paying their medical bills. A 2018 Commonwealth Fund survey showed that 43% of adults had problems with medical bills or medical debt. The same proportion reported using up all their savings to pay their bills and receiving a lower credit rating as a result of their medical debt. Another 18% said they had delayed education or career plans. People with lower incomes were particularly affected, 37% said they were unable to pay.[7] In a Kaiser Family Foundation survey, 77% of insured and 64% of uninsured adults with medical debt reported cutting back on household expenses and vacation. Other measures included getting a second job or increasing work hours (42% insured and 40% uninsured), increasing their credit card debt (38% and 34%), borrowing money from family and friends (37%, 38%) and taking money out of their retirement or educational accounts (31%, 17%).[8] These data counter any potential claims that past-due medical debt stems out of "irresponsible" consumer behaviors.

Data from the National Health Interview Survey 2011-June 2017 showed that one year after the Affordable Care Act was signed into law, the number of Americans having problems with medical bills steadily decreased, but within each survey year, African-Americans and Hispanics under 65 years old were more likely than whites and Asians to have problems paying medical bills (Figure 1).[9]

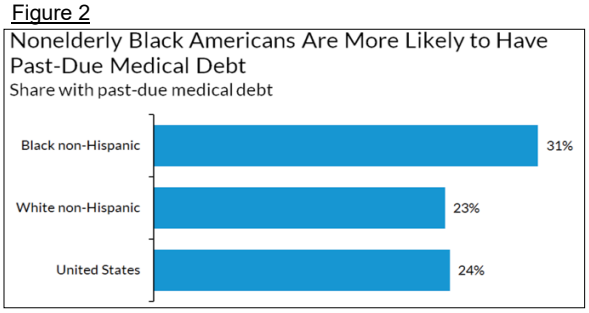
Figure 1




[1]Significant linear decrease from 2011 through June 2017 ($p < 0.05$).
NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2011–2017.

And compared to whites non-elderly African-Americans are more likely to have past-due medical debt (Figure 2).[3] The precise number of Americans who file for personal bankruptcy is a subject of ongoing debate with estimates ranging from 2% of all bankruptcies filed by adults 18-64 years olds[8] to 62% depending on the methodology applied.[10]
In his 2009 State of the Union Address President Obama acknowledged the crisis stating **that a medical bankruptcy occurred every 30 seconds**.[10] The proportion of medical debt that is recovered through a variety of means is not known.

Figure 2




*Source: McKernan, Braga, and Karas calculations from the 2015 National .*[3]

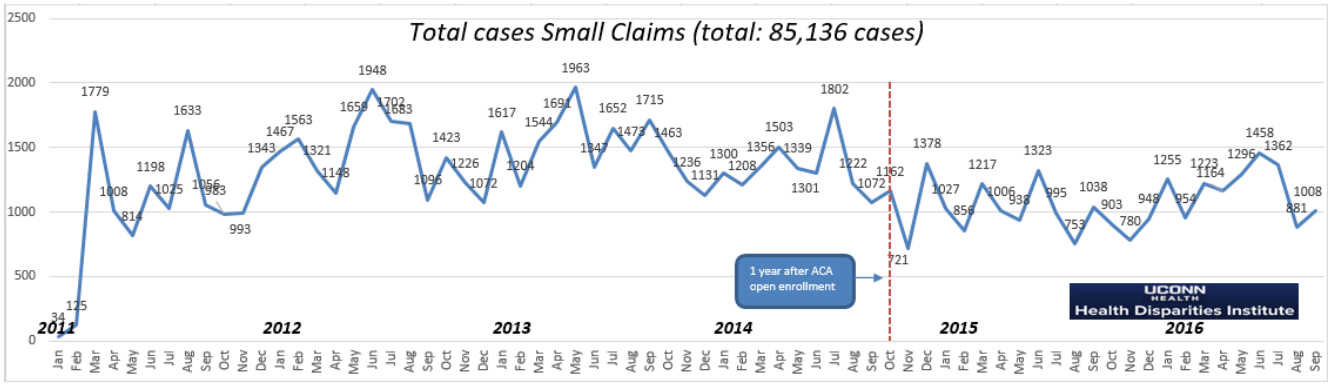
## Efforts to Mitigate Medical Debt

In the context of medical treatment, one author [11] defined "financial toxicity" as "…the objective financial consequences of cancer, as well as the subjective financial burden." This concept has attracted increasing attention beyond the cancer community. Financial toxicity is linked with "…clinically relevant patient outcomes, including health-related quality of life (HRQOL)[12]; symptom burden[13]; compliance[14]; and, most recently, survival[15]." How awareness of financial toxicity is molding providers' every-day decisions is not clear. Providers have long ago recognized the ethical and practical problems associated with medical debt[16] and a plethora of palliative measures such as charity care policies, sliding scales provisions, and gradual payment schemas have been implemented to ameliorate its impact. Many of these provisions are encoded in states' and federal laws that justify the non-profit status of some healthcare systems. Moreover, many states have developed elaborate "Health Care Affordability Standards", establishing household income level thresholds that would render healthcare affordable, yet medical debt remains a significant burden for insured and underinsured low- and middle-income families, racial/ ethnic minorities and the uninsured.

## Hospitals and Doctors Suing Patients

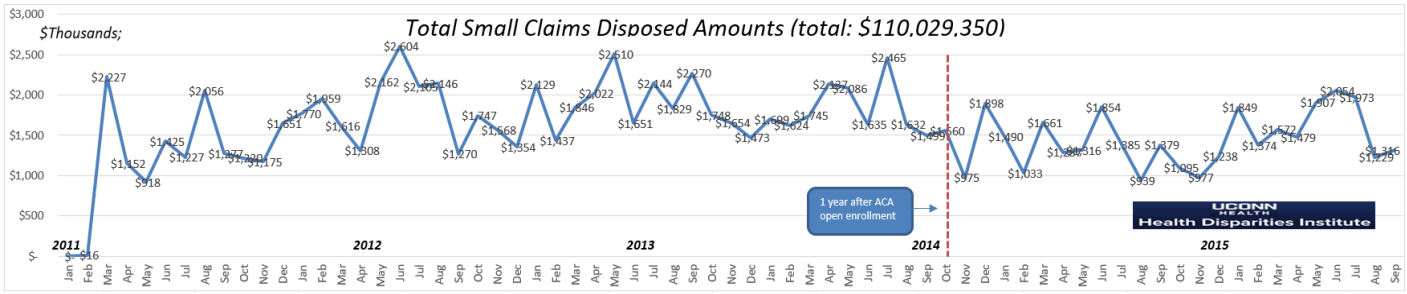
In Connecticut between 2011 and 2016, physician practices, hospitals or collection agencies combined initiated 81,136 lawsuits in small claims courts, up to $5,000 per claim, against their patients to recover outstanding medical debts (Figure 3).

Figure 3




The total outstanding debt over the same period was $110,029,350 (Figure 4).[17] The court disposition favored the plaintiffs in 99% of the cases. More than 50% of patients did not show up for their court hearing.

Figure 4



These numbers exclude similar litigation activity in the superior court system for medical debt over $5,000 per claim which typically requires the defendant to have legal representation. While these figures do not represent the number of unique defendants or the actual amount of debt recovered or attempted to recover, they do expose the magnitude of the medical debt problem and raise important questions that have received relatively little attention by the medical community, policy makers or the public at large.

Despite significant protections conferred by the Affordable Care Act, increases in the price of healthcare services, consolidation of healthcare delivery and insurance assets and widespread adoption of high deductible plans are converging to inflict real harm to families' health and financial wellbeing. Medical debt is the most proximate cause of that harm, especially to low-income racial/ethnic minorities and the uninsured.

**The impact of collection practices including legal actions against patient on the patient-physician relationship.**

The ethical tension for physicians has always been acknowledged and is explicitly embedded in the Hippocratic Oath taken by thousands of graduating medical students:

> *"I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."*

Absent data on the consequences of providers' aggressive collection practices or lawsuits precludes drawing any conclusions about the impact of litigation on patients' trust, continuity of care and overall quality of care. And lacking a compelling narrative of how debt and litigation ricochets across every aspect of family life obscures the search for effective remedies. The Kaiser Family Foundation survey of 100 patients referenced above offered some insightful perspectives about the impact of medical debt but none of those patients reported having had the traumatic experience of being sued. The Health Disparities Institute is designing a large study with broad demographic representation to address the issue. It would seem logical that a law suit against a patient would have adverse consequences on a patient's trust. We could also hypothesize that physician agency, "I am your advocate", could also be eroded in the presence of medical debt and the experience of litigation. There is currently no information about the number of patients with past-due debt that voluntarily or involuntarily discontinue their relationship with their physician. Data is also lacking on the impact of provider-initiated law suits on the patient's quality of care. Studies have shown that aggressive debt restitution tactics (short of litigation) by providers, hospitals or their proxies can have a negative effect on a patient's health-seeking behavior[18], result in forgone medical care[19], decreased medication adherence[20], and negatively impact mental and physical health.[21] Real patient harm caused by unaffordable healthcare is reflected in the excess morbidity and premature mortality statistics among racial and ethnic minorities, the uninsured and the underinsured.[22] However, statistics present an abstract, anonymous picture that fails to elicit strong emotions among providers, patients, policy makers or the public at large. A law suit, on the other hand, is a personal, direct and often an emotionally charged event. Providers faced with a medical malpractice law suit have expressed a range of emotions including anxiety, fear, frustration, remorse, self-doubt, shame, betrayal and anger.[23] The emotional impact may have long-lasting consequences such as increased use of defensive medicine and viewing every patient as a potential plaintiff.[24] In-depth studies describing the emotional impact on patients sued by their providers, the impact on providers or their corporate employers as the originator of the lawsuit or the fallout of such action on the future patient-provider relationship are lacking. The details of those events are the missing narrative.

## A Physicians' Perspective

A 2009 survey of primary care physicians medical specialists, surgeons, psychiatrists and other specialties showed that up to 89% of physicians believed that all Americans should receive medical care regardless of the ability to pay.[25] However, another survey of primary care physicians (PCPs) in 2010 showed that a majority of the PCPs surveyed would be willing to withhold medical care from patients if they did not pay their bills.[26]

The advent of high deductible plans has increased the dollar amount and duration of" "accounts receivables" or uncollected insurance invoices or patients' bills in outpatient clinics. Since computer automation has accelerated rather than delayed insurance claims processing, most of the blame for growing accounts receivables has been pegged on high deductible insurance plans but seldom on the galloping price increases of pharmaceuticals, medical products and services. In a primary care setting growing accounts receivables can lead to cash flow problems and threaten the financial performance of a typical low-margin operation. In small medical practices where physicians are intimately involved in the day-to-day business aspects of their office and know their patients well, the choice of how to proceed can be heart wrenching; either send to a collection agency, initiate litigation, forgive the debt or something in between. All the alternatives are painful. In these situations, the physician in a small practice is the

decider of what to do. Familiarity with the patient, compassion and professionalism are all activated when a physician makes the decision. However, solo or small physician practices are decreasing steadily. Between 1983 and 2014, the percentage of physicians practicing alone fell from 41% to 17%. Over the same period, the percentage of physicians in practices with 25 or more doctors grew fourfold (5% to 20%). The trends include hospitals and even insurance companies buying physician practices. As medical practices consolidate into larger corporate entities and decisions about debt recovery falls on non-medical professionals in finance departments far removed from the patient. The uncoupling of the acts of caring and billing patients, removes the provider ethical burden of balancing their dual obligation to their practice and their patients.

Expert practice management consultants' recommendations aimed at averting bad debt is to charge the visit to the patient's credit card. "*We would much rather have that patient make payments to their own credit card than to us,"* stated an office manager. This measure transfers the potential debt to the credit card company that typically charges high interest rates. Patient advocates, on the other hand advise patients to avoid liquidating a medical debt using their credit card because they also forego special consumer protections explicitly designed for medical debt but not for credit card debt.

This overview of the medical debt crisis is an urgent call to action for a more in-depth examination of the problem and for implementation of solutions.

## Conclusions

1. Medical debt is a silent crisis that harms patients and their families, especially African-Americans, Hispanics and people with low income.
2. Enhanced consumer protections and a more transparent judicial process in cases of litigation against patients for past-due medical are needed.
3. Providers, hospitals or their corporate representatives suing patients or offloading their debt to collection agencies is a complex problem with financial, ethical and legal dimensions that need further examination and effective policy solutions.
4. The transition of medical practices from solo/small medical practice to large corporate organizations threaten traditional covenants of the patient-provider relationship. These changes have not been reconciled the medical code of ethics and professionalism.

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