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# MEDICAL DEBT IN TENNESSEE

12 Options for State Policymakers



THE SYCAMORE INSTITUTE

BUILDING A STRONGER TENNESSEE THROUGH DATA AND RESEARCH



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Established in 2015, The Sycamore Institute is an independent, nonpartisan public policy research center for Tennessee. The organization's mission is to provide accessible, reliable data and research in pursuit of sound, sustainable policies that improve the lives of all Tennesseans.

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## SECTION 1

# Executive Summary

Medical debt is surprisingly common in Tennessee, appearing on one in four credit reports. It often results from circumstances tough to predict or control, and even small amounts can make it harder to get ahead. This summarizes our detailed report exploring 12 options for policymakers who want to prevent medical debt, help people manage their medical bills, and mitigate medical debt's negative effects on financial security, economic mobility, and health.

Our work on medical debt provides important background on how medical debt occurs, how it affects people's lives, who has it in and across Tennessee, and what can be done about it:

### **Medical Debt 101: How a Medical Bill Becomes Medical Debt**

<https://www.sycamoreinstitutetn.org/medical-debt-101/>

### **Medical Debt in Tennessee: Who Has It and Why Does It Matter?**

<https://www.sycamoreinstitutetn.org/medical-debt-tennessee/>

### **Medical Debt Across Tennessee's 95 Counties**

<https://www.sycamoreinstitutetn.org/medical-debt-tn-counties/>

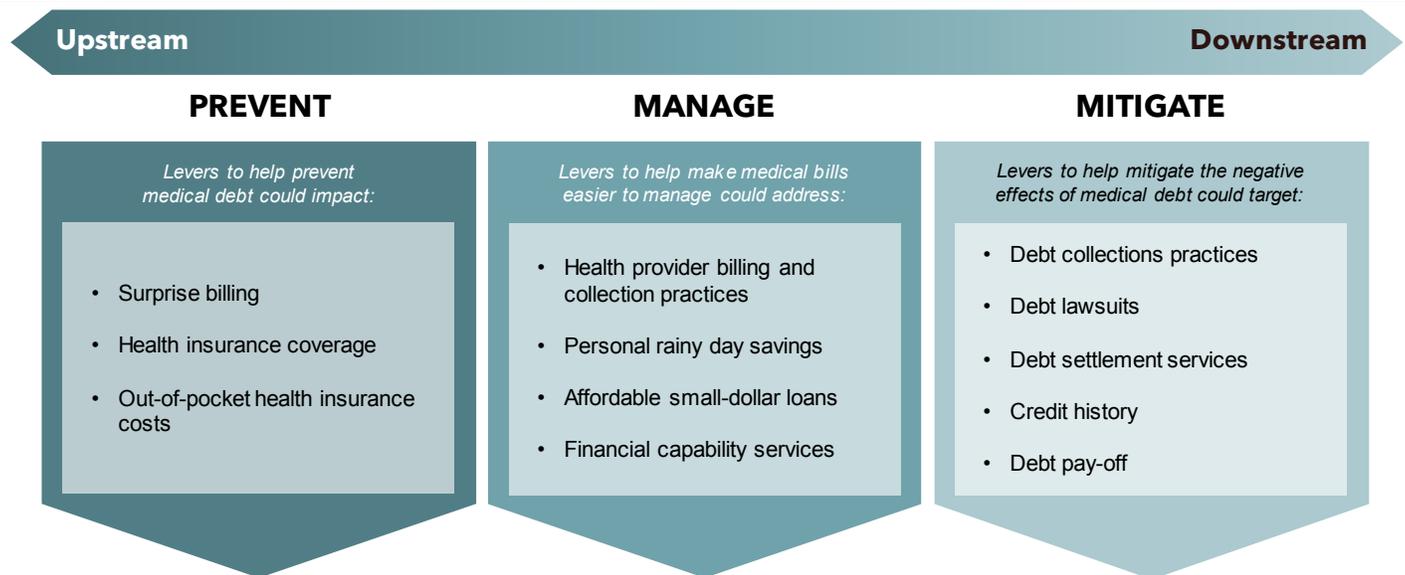
### **Medical Debt in Tennessee: 12 Options for State Policymakers**

<https://www.sycamoreinstitutetn.org/medical-debt-policy-options/>

## Key Takeaways

- The complexities of medical debt offer policymakers a wide range of opportunities to prevent the problem, help people manage it, and mitigate its effects.
- Prevent: Upstream policy levers that address surprise bills, access to coverage, and out-of-pocket insurance costs could help prevent many situations that cause medical bills to go unpaid.
- Manage: Midstream options that address provider billing, personal savings, and access to financial capability services and affordable, small-dollar lending could help make medical bills easier to manage.
- Mitigate: Downstream policy options that affect debt collection practices and lawsuits, risky debt settlement services, the use of credit history, and debt pay-off could help to mitigate the negative effects of medical debt.
- There is no silver bullet for medical debt. While some options listed here may have more impact than others, none would address every aspect of the problem by themselves.

**Figure 1. 12 Policy Levers to Address Medical Debt and Its Negative Effects in Tennessee**



Source: The Sycamore Institute

## Overview

**There are a range of state-level policy levers available to address medical debt and its effects on Tennesseans.** While not necessarily an exhaustive list, this report summarizes 12 potential areas that state policymakers may want to explore (**Figure 1**). This report discusses each option in more detail, including its trade-offs, the causes and effects of medical debt that it targets, and other key considerations.

**Our research suggests no single policy change would address every troubling aspect of medical debt in Tennessee and its downstream effects.** For example, getting more people enrolled in health insurance would make new medical debt less likely among those currently uninsured, but it would not affect existing debts or curtail surprise out-of-network bills for those with insurance. Tennesseans incur medical debt for many reasons, including circumstances that may be tough to predict or control, and the downstream effects on financial stability, economic mobility, and health range widely. Each option presented here addresses different aspects of this problem.

**Not all policy options are created equal.** Each one involves trade-offs, and some options may have more impact than others based on the specific causes and effects across Tennessee. The evidence also suggests that some options are more proven than others at achieving the intended goal. For example, health care price transparency efforts have long held the promise of lowering patients' out-of-pocket spending, but many experiments in this area have come with unintended consequences or fallen short of expectations.

## Upstream Options to Prevent Medical Debt

Upstream policy levers seek to prevent many situations that cause medical bills to go unpaid. Policies in this area could impact:

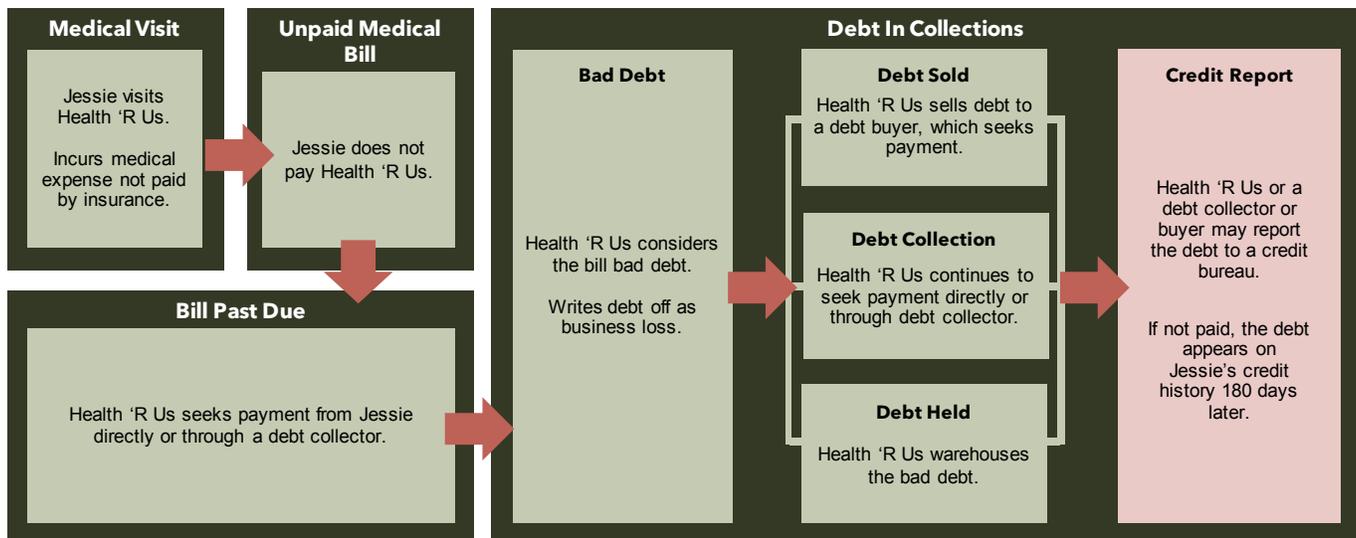
- **Surprise Bills** – Curtailing surprise bills may help prevent medical debts that result from unexpected bills when patients visit in-network or emergency facilities but get treated by out-of-network providers. Policymakers could require insurers to pay out-of-network providers a predetermined or arbitrated rate, or they could regulate how providers bill patients and/or contract with insurers.
- **Health Insurance Coverage** – Getting more Tennesseans enrolled in health insurance could help those individuals to better afford health care services and avoid medical debt. For instance, a state reinsurance program could make some private plans more affordable. Another example is exploring ways to address delays, lapses, and gaps in coverage for low-income Tennesseans.
- **Out-of-Pocket Health Insurance Costs** – Offering patients tools to minimize their out-of-pocket health insurance costs could help prevent medical debt by making some medical bills more affordable. High out-of-pocket insurance costs may mean that even insured individuals end up with unpaid medical bills. Reducing out-of-pocket costs could be challenging, but some states have explored using price transparency measures as a way to help patients better shop for health care.

## Midstream Options to Manage Medical Debt

Midstream policy approaches aim to help make medical bills easier to manage. These include efforts to address:

- **Provider Billing and Collection Practices** – Changing provider billing and collection practices could help prevent, manage, and mitigate medical debt. For example, new rules and oversight could facilitate patients' access to financial assistance, payment plans, or insurance coverage for which they might be eligible. It could also shed light on providers' use of extraordinary collection practices (see [Debt Lawsuits](#)).
- **Personal Rainy Day Savings** – Facilitating and incentivizing personal savings could reduce debt and promote financial stability by helping Tennesseans use their own resources to better weather unexpected expenses. For example, connecting Tennesseans without bank accounts to traditional financial services could remove obstacles to saving when funds are available.
- **Affordable, Small-Dollar Loans** – Increasing access to affordable, small-dollar loans could help some individuals to better manage unexpected medical expenses and avoid a cycle of debt. Alternative financial products like payday loans can be expensive but help people fill income gaps or pay for unexpected expenses like medical bills. Policymakers could explore ways to make these kinds of resources available at a lower cost to people who rely on them.
- **Financial Capability Services** – Improving access to services like financial literacy classes and one-on-one counseling and coaching could help people prepare for and manage debt if and when it occurs. For example, both Memphis and Nashville support financial empowerment centers that provide one-on-one financial counseling for people with low-incomes. Available data show that Nashville's center has improved financial outcomes for its clients.

## Figure 2. How a Medical Bill Becomes Medical Debt



Source: Adapted from Urban Institute (1)

## Downstream Options to Mitigate Medical Debt

**Downstream policy options could help mitigate the negative effects of medical debt.** Unpaid medical bills can become indistinguishable from most other types of consumer debt once they are purchased by a debt buyer (**Figure 2**). (2) For this reason, many of the downstream options address debt generally or offset the negative effects of bad debt. Actions in this area could affect:

- **Debt Collection Practices** – Reining in some debt collection practices could improve debt repayment outcomes and reduce debt-related stress among Tennesseans with unpaid medical bills. Policymakers could explore ways to revise existing rules for debt collectors, like expanding to whom the rules apply, limiting interest rates, and including new modes of communication.
- **Debt Lawsuits** – Addressing certain aspects of debt collection lawsuits could reduce some of the negative financial and legal fallout from medical debt. For example, national research suggests that many of these lawsuits go unchallenged. Policymakers could look at ways to expand access to legal representation or support tools for people to represent themselves.
- **Debt Settlement Services** – Greater oversight of debt settlement services could protect people looking for manageable ways to pay off their debts. Existing law provides protections for consumers using these services, but national cases show that many companies continue to engage in fraudulent practices. Tennessee policymakers could explore ways to add more protections while expanding access to less risky services like financial counseling.
- **Credit History** – Limiting how medical debt affects a person's credit history could address a potential significant obstacle to their financial stability and economic mobility. For example, state law already excludes medical debt from the information that can be used to set home and auto insurance terms and premiums. State lawmakers could consider additional limits for when medical debt can be reported to a credit bureau and how medical debt-related credit history information can be used.
- **Debt Pay-Off** – Paying off debts directly could reduce financial burdens on affected individuals and improve their economic security, potentially for less than the debt's face value. For example, one national nonprofit uses charitable donations to buy and forgive resold medical debt for low-income and financially insecure individuals.

## SECTION 2

# Preventing Medical Debt

**Upstream policy levers seek to prevent many situations that cause medical bills to go unpaid.** Policies in this area could impact:

- **Surprise Bills** – Curtailing surprise bills may help prevent medical debts that result from unexpected bills when patients visit in-network or emergency facilities but get treated by out-of-network providers.
- **Health Insurance Coverage** – Getting more Tennesseans enrolled in health insurance could help those individuals to better afford health care services and avoid medical debt.
- **Out-of-Pocket Health Insurance Costs** – Offering patients tools to minimize their out-of-pocket health insurance costs could help prevent medical debt by making some medical bills more affordable.

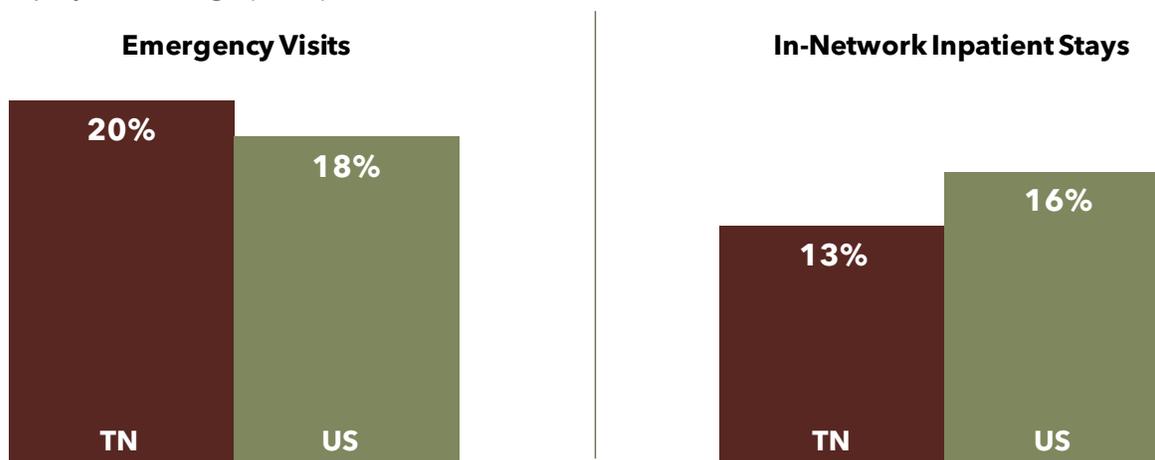
## Surprise Bills

**Curtailing surprise bills may help prevent medical debts that result from unexpected bills when patients visit in-network or emergency facilities but get treated by out-of-network providers.** These bills come as a surprise because patients often don't expect to face out-of-network charges at an in-network facility. At the same time, they may not have a meaningful choice over the specific provider or services for which they might receive a surprise bill.

**Surprise bills may be relatively common.** In 2017, about 20% of emergency room visits and 13% of in-network inpatient hospitalizations by Tennesseans enrolled in large employer plans resulted in an out-of-network bill (**Figure 3**). (3) According to two national studies, about half of ambulance rides in 2014 and two-thirds of air ambulance rides in 2017 by patients with private coverage involved an out-of-network provider. (4) (5)

### Figure 3. Many Emergency and In-Network Hospital Stays Can Result in Out-of-Network Bills

Emergency Visits and In-Network Inpatient Stays with an Out-of-Network Charge Among People with Large Employer Coverage (2017)



Source: The Kaiser Family Foundation's analysis of IBM Marketplace 2017 data (3)

**Emergency physicians and ancillary providers like anesthesiologists do not have to be in the same insurance networks as the hospitals where they work.** Under state law, most Tennessee hospitals cannot directly hire emergency physicians, anesthesiologists, radiologists, or pathologists. Research hospitals (e.g. Vanderbilt University Medical Center, University of Tennessee Medical Center) can employ any provider type but emergency physicians. (6) Laws on what is known as the "corporate practice of medicine" vary between states. (7) However, these types of providers often work for physician groups that contract with hospitals for services and with insurers for separate payment. As a result, they can be out-of-network even when a hospital where they work is in-network.

**The Affordable Care Act (ACA) and related regulations entitle emergency department physicians to a minimum insurance reimbursement even when they are out-of-network.** Emergency physicians are then allowed to bill patients for the remainder of their charges – a practice known as balance billing. (8)

**The current system creates a set of incentives that may drive up the costs for certain services.** Most providers are incentivized to join an insurance network by a promise of patient volume. However, there is less incentive to contract with an insurer when they can directly bill patients more for services over which the patient has little choice. These types of providers, however, may contract for network inclusion to avoid the hassle and administrative costs of billing patients directly. When they do join networks, they can often negotiate higher rates because of these market dynamics. (9) (10) (4)

## ***Current Surprise Bill Laws***

**Tennessee law requires in-network facilities to inform patients of the possibility that some providers may be out-of-network.** In-network providers must notify a patient before providing a service or, in the case of an emergency, within 12 hours of stabilizing the patient. If the proper notifications are not provided, an out-of-network physician is not allowed to balance bill a patient. (11)(12)

## ***Examples of Other Surprise Bill Strategies***

**State policymakers interested in addressing surprise out-of-network bills have a number of options that focus on either insurers or providers.**

### **Options for Insurer Regulations:**

- Require insurers to reimburse specific provider types for out-of-network bills at in-network facilities using either a defined benchmark (e.g. Medicare or in-network reimbursement rates) or a dispute-resolution process to determine an appropriate amount.
- Require insurers to pay for any balance bill amount above normal cost-sharing requirements. (4)

### **Options for Provider Billing and Contracting Regulations:**

- Require that hospitals bundle reimbursements to include all emergency and ancillary services in the rates that they negotiate with insurance plans. (9)
- Require that all providers that practice at a hospital contract with all the insurance plans with which the hospital contracts. (9)
- Set a maximum amount at which certain out-of-network providers can bill patients for services at an in-network facility. (9)
- Require that hospitals only contract with provider groups who are also in-network.
- Prohibit balance billing for out-of-network providers that receive any payment from an insurer.
- Require that out-of-network providers follow the same financial assistance policies as the hospitals at which they practice (see **Provider Billing and Collection Practices** beginning on page 15). (13)
- Remove legal restrictions on who hospitals may directly employ. (14)

**At least 25 states have some surprise billing protections on the books (Tennessee does not), and several have adopted comprehensive laws to address surprise billing.** The states with more comprehensive laws require insurers to reimburse out-of-network providers at emergency departments and in-network hospitals either by setting reimbursement benchmarks or establishing a dispute-resolution process. They also prohibit out-of-network balance billing by these providers. Most of these states also hold the patient harmless in the event of a billing dispute between an insurer and an out-of-network provider. (15)(16)

**The U.S. Senate is considering bipartisan legislation to address surprise billing at the national level.** The “Lower Health Care Costs Act,” as currently written, would set a benchmark for insurer payments to out-of-network providers. (17)(18) The bill passed a Senate committee in June 2019 and was awaiting action by the Senate as of August 2019.

## ***Surprise Bill Considerations and Trade-Offs***

**Shifting the current system’s incentives holds promise but comes with trade-offs.** For example, these approaches have the potential to address unexpected out-of-pocket costs while also reducing the health care costs associated with these services. However, some examples of the trade-offs and considerations involved in these options include:

- **Application** – State policymakers would have to decide what types of providers, facilities, and services any new requirements would apply to. National research on this topic suggests that unexpected out-of-network billing may be an issue across a range of settings and services. For example, a patient may be surprised to receive a bill for tests from an out-of-network laboratory ordered by and administered at an in-network physician office. (4)

- **Winners and Losers** – Nearly every approach would affect existing leverage, incentives, and costs in the affected insurer-provider relationships. For example, setting a relatively high insurance payment benchmark could drive up costs for insurers and premiums and create an even stronger disincentive for being in-network. At the same time, setting a relatively low benchmark could affect some of the current leverage that providers have in payment negotiations – ultimately affecting their bottom lines.
- **Patient Responsibility** – Different approaches involve different levels of patient responsibility. For example, some arbitration processes used in other states require that patients trigger the process, and they may still be responsible for balance bill payments at the end. Policymakers will want to consider the extent to which patients should be in the middle of disputes over out-of-network bills in the absence of meaningful choice over which providers to use.
- **Limitations of Federal Law** – State approaches that regulate insurance (i.e. required payment rates) would not apply to the largest source of health insurance coverage in Tennessee – large employer plans that are governed by the federal “ERISA” law. States can, however, regulate health care providers – including how they bill ERISA plans. (4)
- **Administrative Costs** – Any state-run arbitration processes could come with administrative costs.

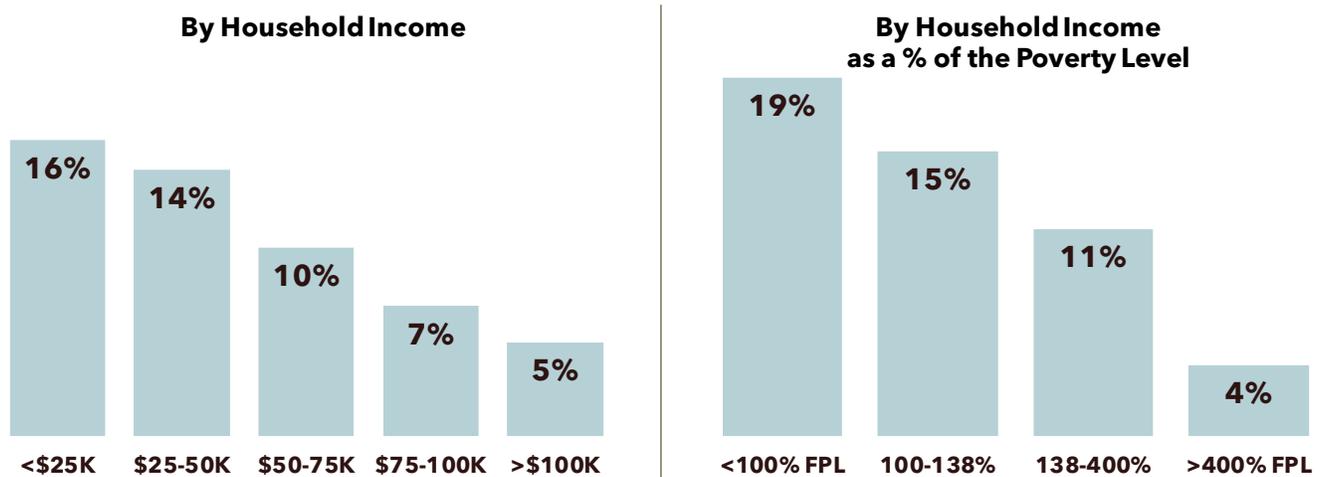
## Health Insurance Coverage

**Getting more Tennesseans enrolled in health insurance could help those individuals to better afford health care services and avoid medical debt.** Most health insurance is designed to provide financial protection against catastrophic health care costs. While [medical debt is common even among Tennesseans with health insurance](#), the uninsured are more likely than those with coverage to report having unpaid, past-due medical bills. (19) (20)

**Lower-income Tennesseans are less likely to be enrolled in coverage than higher-income Tennesseans (Figure 4).** In 2018, about [10.1% of all Tennesseans \(just under 670,000 people\) were uninsured](#) – ranging from 19.0% of Tennesseans living under the poverty line to 3.8% at 400% or more of poverty. (21)

### Figure 4. Lower-Income Tennesseans Are More Likely To Be Uninsured

Percent of Tennesseans without Health Insurance by Income Level (2018)



Source: 2018 American Community Survey 1-Year Estimates (21)

**Increasing enrollment in health insurance has the potential to reduce medical debt among newly enrolled individuals.** Numerous studies have found, for example, that ACA-related coverage expansions are associated with improvements in enrollees' financial health, including (22) (23) (24) (25) (26) (27) (28) (29) (30) (31) (32) (33):

- Fewer reported problems paying medical bills
- Fewer unpaid medical bills
- Lower debt balances
- Lower rates of medical debt
- Decreases in the amount of debt sent to collection
- Fewer bankruptcies
- Improved credit scores

### Examples of Coverage Strategies

**Politics aside, there are a number of potential strategies that could increase enrollment in comprehensive private health insurance.** Some examples include (34) (35):

- **High-Risk Pool/Reinsurance Program** – Policymakers could consider [a state-run high-risk pool or reinsurance program](#). Both approaches may be eligible for federal funding and could reduce premiums in the individual market. Lower premiums could make coverage more affordable for some currently uninsured Tennesseans.

- **State-Funded Subsidies** – People with incomes between 100-400% of poverty are eligible for federally-funded subsidies to purchase coverage in the [healthcare.gov Marketplace](https://www.healthcare.gov/marketplace). Those under 100% of poverty are not eligible for these subsidies and may or may not qualify for TennCare coverage. Policymakers could consider state-funded subsidies to help these individuals purchase private coverage.
- **Enrollment Assistance** – In recent years, the federal government has reduced its funding for navigators that provide outreach, education, and assistance to individuals looking for health coverage. (36) State policymakers could consider ways for the state to support its own outreach and enrollment assistance for uninsured Tennesseans.
- **Individual Mandate** – Congress repealed the penalty for the ACA’s individual mandate requiring that everyone enroll in coverage as part of tax reform legislation in December 2017. It appears the repeal has had a minimal impact on Marketplace enrollment between 2018 and 2019, but state policymakers could still consider implementing a state-level requirement for all Tennesseans to have coverage. (37)

**Another lever for increasing enrollment is TennCare, the state’s Medicaid program.** Potential strategies include implementing retroactive eligibility, taking steps to prevent delayed or lapsed coverage, expanding eligibility for the program under the ACA, or creating a “buy-in” option.

**TennCare is exempt from a federal law requiring three months of retroactive Medicaid eligibility for new enrollees.** (38) Implementing retroactive eligibility can be administratively challenging with managed care, in which private health insurance companies are paid a monthly fee to cover TennCare patients. However, waiving the requirement comes with a trade-off that may lead to more medical debt. (39) Without retroactive eligibility, for example, a TennCare-eligible mother who does not enroll until after an unexpected hospitalization would be responsible for the costs of that visit. If she cannot pay, the hospital would bear the immediate costs of uncompensated care, and she may bear a wide range of longer-term consequences from medical debt.

**TennCare could also explore steps that address delays or lapses in coverage that can lead to unpaid bills.**

Examples include more proactive efforts to encourage enrollment among those already eligible, partnerships with hospitals or providers to do eligibility screenings, and additional assistance with the application and/or eligibility reverification processes. (38)

**Tennessee has not expanded Medicaid eligibility under the ACA, so TennCare primarily serves populations required by federal law.** The ACA provides federal funding for states to expand Medicaid eligibility to all adults with incomes under 138% of poverty, which in 2019 amounts to about \$36,000 for a family of four. (40) Based on 2018 data, expansion would make about 230,000 uninsured Tennessee adults eligible for TennCare. As many as 167,000 of them have incomes under 100% of poverty and do not currently qualify for TennCare or ACA subsidies for private insurance (i.e. “the coverage gap”). (41)

**Some states are exploring a Medicaid “buy-in” option that would allow uninsured people to pay for Medicaid coverage out of their own pockets.** No state has yet enacted a buy-in option, but as of November 2018, at least three had authorized formal feasibility studies – Nevada, New Mexico, and Delaware. Proponents of the approach argue that, because of the efficiencies of most Medicaid programs, it could offer uninsured individuals an affordable, stable coverage option. (34) (42) (43) (35)

### ***Coverage Considerations and Trade-Offs***

**Some coverage options could have potential financial costs for the state.** For example, if Tennessee expanded TennCare eligibility to 138% of poverty the state would pay 10% of the long-term costs under current law (Tennessee pays about 35% of the costs of traditional TennCare enrollees). Tennessee’s share would have been an estimated \$191 million in 2019 (and the federal government’s \$786 million), depending on enrollment. (44) Past proposals anticipated using hospital assessments to pay the state’s costs. These costs may also be more manageable for the state than, for example, subsidizing private coverage for people under 100% of poverty, who are not eligible for federal subsidies.

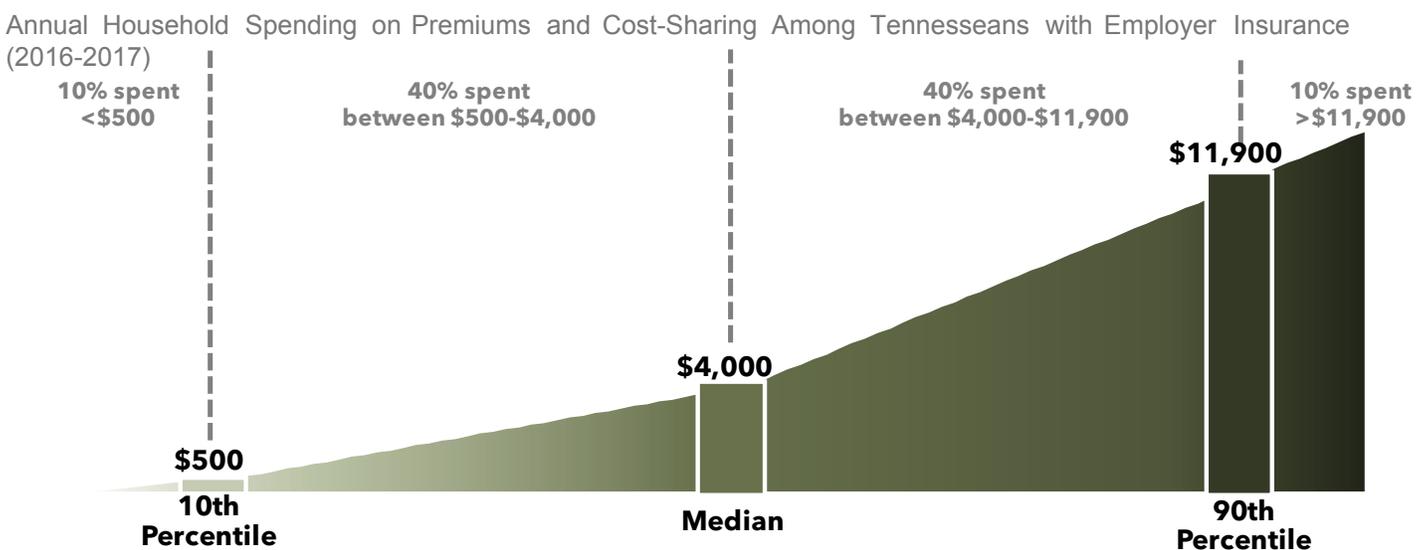
## Out-of-Pocket Health Insurance Costs

**Offering patients tools to minimize their out-of-pocket health insurance costs could help prevent medical debt by making some medical bills more affordable.** Health insurance coverage alone is not a cure-all for the problem of medical debt. Most insured individuals must cover some of their medical bills out-of-pocket to meet cost-sharing requirements like deductibles, co-pays, and co-insurance.

**Research suggests that some Tennesseans' out-of-pocket costs may be quite large.** According to a study of 2016-2017 data, half of Tennesseans with employer-sponsored insurance reported paying at least \$4,000 a year out of pocket for premiums and cost-sharing and 10% spent at least \$11,900 (**Figure 5**). (45) For context, \$4,000 represents about 8% of the median household income in Tennessee in 2017. (21)

**High out-of-pocket costs may mean people forgo care or end up with unpaid medical bills** – particularly if they have chronic health care needs. In a 2019 national survey of about 1,400 people with employer-sponsored plans, about 66% of those enrolled in a high-deductible plan said they would not be able to meet their full deductible without borrowing or going into debt. Among those with a chronic condition, 60% in high-deductible plans reported postponing or putting off care. (46)

### Figure 5. Half of Tennesseans with Job-Based Health Insurance Spent \$4,000 or More Out of Pocket in 2016-2017

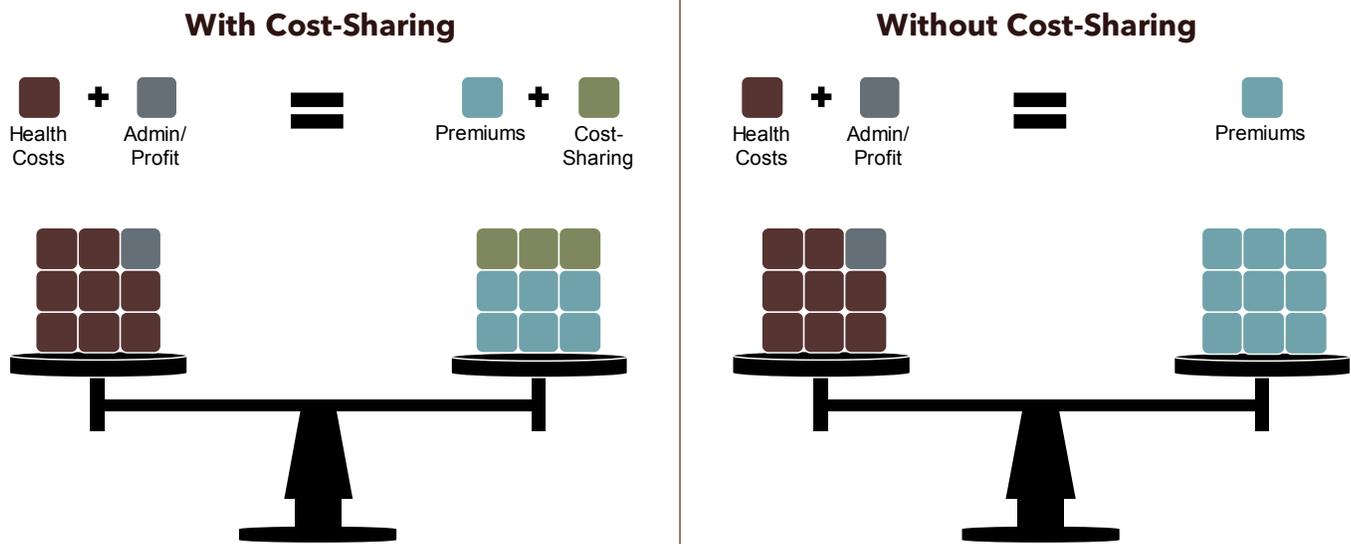


Source: The Commonwealth Fund's analysis of Current Population Survey data for 2016-2017 (45)

**Although cost-sharing requirements may be a burden for some families, they are intended to constrain the growth of health care costs.** Premiums generally spread the costs of [an insurance risk pool](#) evenly across all enrollees, whereas cost-sharing requires individuals to cover a greater share of their own spending. This is intended to create a disincentive for unnecessary utilization and incentive to make more informed care decisions.

**Reducing out-of-pocket costs presents trade-offs and could be challenging.** Unless ways are found to reduce underlying costs, limiting cost-sharing alone would help reduce medical debt and increase health care access and utilization for some with insurance by shifting those costs onto others – either through higher premiums or more taxpayer subsidies (**Figure 6**). The ACA, for example, provides federal funding to offset the costs of reducing cost-sharing requirements for certain low- and middle-income enrollees in private, individual market plans.

## Figure 6. Limiting Health Insurance Cost-Sharing Without Reducing Underlying Costs Could Drive Up Premiums



Source: The Sycamore Institute

### Cost Transparency Efforts

**Some states have explored all-payer claims databases (APCD) and other price transparency measures as a way to constrain both out-of-pocket costs and health care spending.** APCDs compile data across different payers (i.e. private insurers, Medicaid, Medicare) on reimbursements, utilization, and outcomes. APCDs can, for example, provide the foundational data needed to identify and test approaches that reduce costs and/or improve quality. (47) New Hampshire and Maine have also used their APCDs to create tools that allow the public to compare average prices across different hospitals for particular insurance carriers and procedures. (48) Existing Tennessee law and regulations establish the parameters for a state APCD, but they have not been implemented. (49) (50)

**The U.S. Senate is considering bipartisan legislation to establish a national APCD.** The “Lower Health Care Costs Act” would collect claims data from all states and authorize funding for states to establish and maintain their own APCDs. The bill passed a Senate committee in June 2019 and was awaiting action by the full Senate as of August 2019. (17)

**Price transparency tools hold some potential to affect out-of-pocket spending without cost-shifting in two ways.** First, these tools could provide opportunities for individuals to more actively make price-informed decisions in situations where they may have a choice. Second, they could also conceivably reduce the underlying cost trajectory of health care. For example, if significant numbers of patients begin to use lower-cost providers, spending may decline. In addition, if patients are drawn to lower-costs, providers may try to compete by lowering their prices. (51)

**Tennessee policymakers passed the “Right to Shop Act” in 2019 to increase insurers’ price transparency.** The new law requires insurers to provide shopping and decision support programs beginning in 2021 – including estimates on out-of-pocket spending. It also creates a framework under which insurers may voluntarily provide financial incentives to enrollees who use lower-cost providers. (52)

**The federal government began laying out new provider price transparency requirements this year.** In August 2019, HHS proposed new requirements for hospitals – including posting reimbursement rates negotiated with each health insurer for 300 “shoppable” services. (53) Proposed requirements for other types of providers and insurers had been expected by late September. (54)

## ***Cost Transparency Considerations and Limitations***

**Price transparency initiatives by insurers, employers, and other states have shown that there are challenges to using these tools to achieve the goal of lowering health care spending.** As Tennessee tracks the progress of its “Right to Shop Act” and considers new approaches, some considerations that have emerged from existing initiatives include:

- **Will patients use price transparency tools?** People may need stronger incentives to begin shopping for lower prices in health care, as research shows many existing price-transparency efforts are under-utilized by patients. For example, high deductibles and narrow networks are meant to encourage more and smarter shopping yet haven’t driven widespread use of these tools. In addition, patients with existing provider relationships may be less willing to switch in pursuit of lower costs. Another barrier may be that existing tools do not present information in a way that is useful and easy-to-use and understand. (51) (55)
- **What “price” will be provided?** The “price” of health care services can be defined in many ways – some more useful than others when trying to minimize out-of-pocket spending. For example, hospitals are already required to publish “chargemasters,” showing what they charge for various services. However, published charges do not necessarily reflect the actual amounts insurers pay to reimburse providers, which depend on negotiations and contracts. Price transparency tools may prove most useful when they show both reimbursement amounts and a person’s actual out-of-pocket costs under their insurance plan. (51) Even still, policymakers may want to consider the extent to which providers and insurers can then deviate from those prices once services are actually provided. (56)
- **Who would be responsible for providing price information?** Some states largely rely on insurance carriers to either report the data to a centralized entity like an APCD or (like Tennessee) provide tools themselves. Other states have taken a more scaled back approach that requires providers to give patients price estimates upon request. (51)
- **How much health care could a patient reasonably shop around for?** A host of factors may affect how much a patient can shop around. For example, not all services can be planned in advance (e.g. emergency or urgent care). In addition, patients may not have much choice of providers depending on their insurance plan’s network or what [health care facilities and resources are located nearby](#). One study (which considered some, but not all, of these factors) estimated that as much as half of out-of-pocket spending by individuals in employer plans in 2011 was considered “shoppable.” (57)
- **Could there be unintended consequences for health outcomes and costs?** Insurers have argued that price transparency would give lower-paid providers leverage to negotiate higher rates – driving up costs. Alternatively, it could also give higher-paying insurers leverage to negotiate lower rates – driving down costs. Other research has found that the incentives that make price transparency tools most attractive for patients (e.g. high cost-sharing) drive people to use less care rather than lower-priced care. (51) Some of these same incentives may also contribute to medical debt among the insured.
- **How much can states require of insurers?** In 2016, the U.S. Supreme Court limited states’ ability to require most large employer plans to participate in APCDs, which are governed by the federal ERISA law. As a result, any participation by these insurers would be voluntary. (58)
- **How much information do patients need to make meaningful choices?** There are many factors to consider beyond prices that might make a transparency tool or requirement meaningful – but not overly complex – for patients. For example, to what extent should it provide information about provider quality and outcomes? How would it show prices for a visit, procedure, or episode of care that may involve multiple providers, tests, and medical codes?

## SECTION 3

# Managing Medical Debt

**Midstream policy approaches aim to help make medical bills easier to manage.** These include efforts to address:

- **Provider Billing and Collection Practices** – Changing provider billing and collection practices could help prevent, manage, and mitigate medical debt. For example, new rules and oversight could facilitate patients' access to financial assistance, payment plans, or insurance coverage for which they might be eligible. It could also shed light on providers' use of extraordinary collection practices (see [Debt Lawsuits](#) beginning on page 30).
- **Personal Rainy Day Savings** – Facilitating and incentivizing personal savings could reduce debt and promote financial stability by helping Tennesseans use their own resources to better weather unexpected expenses.
- **Affordable, Small-Dollar Loans** – Increasing access to affordable, small-dollar loans could help some individuals to better manage unexpected medical expenses and avoid a cycle of debt.
- **Financial Capability Services** – Improving access to services like financial literacy classes, counseling, and coaching could help people prepare for and manage debt if and when it occurs.

## Provider Billing and Collection Practices

**Changing provider billing and collection practices could help prevent, manage, and mitigate medical debt** – including facilitating access to programs for which patients might be eligible and tempering some of the outside consequences of unpaid medical bills.

### *Current Provider Billing/Collection Laws*

**Current Tennessee law includes a handful of requirements governing certain health care providers' billing practices.** For example, hospitals, ambulatory surgery centers, and outpatient diagnostic centers may not charge uninsured patients more than 175% of the actual cost of providing services. (59) Additionally, certain primary care safety net providers (e.g. health departments, community clinics) provide free primary care services to uninsured adults ages 19-64 with low-incomes in exchange for state grant funding. All licensed health care facilities must also maintain and publicly post a concise charity care policy – although specifics are not laid out in law. (60)

**Current federal law requires that nonprofit hospitals and community health centers offer financial assistance policies based on ability to pay.** (61) (62) Community health centers are required to provide a sliding fee scale. (62) Under the ACA, nonprofit hospitals and any physician practices owned by nonprofit hospitals (63):

- Must make widely available a written financial assistance policy (FAP) that lays out eligibility and how to apply for free or discounted emergency and “medically necessary” care. (64)
- Cannot charge FAP-eligible patients any more for emergency and medically necessary care than the lowest amounts charged to insured patients. (65)
- Cannot take “extraordinary” steps (e.g. reporting the bill to a credit bureau, denying additional care until payment is received) without first trying to determine if a patient is FAP-eligible. A hospital may sell medical debts if the buyer agrees to abide by these conditions. (66)
- Could lose their federal tax-exempt status if they fail to meet these requirements. (67)

**Federal requirements for nonprofit hospitals are limited in reach and enforcement.** For example, they do not dictate the specifics of FAPs or apply to for-profit or government-owned hospitals or other providers. In addition, the burden is largely on patients to ask for information on a hospital's FAP. Patients also have no way to challenge a hospital's compliance. Because FAPs are tied to hospitals' tax-exempt status, the Internal Revenue Service (IRS) is responsible for enforcement. Data are not available on the extent to which these requirements are enforced. (68) (69)

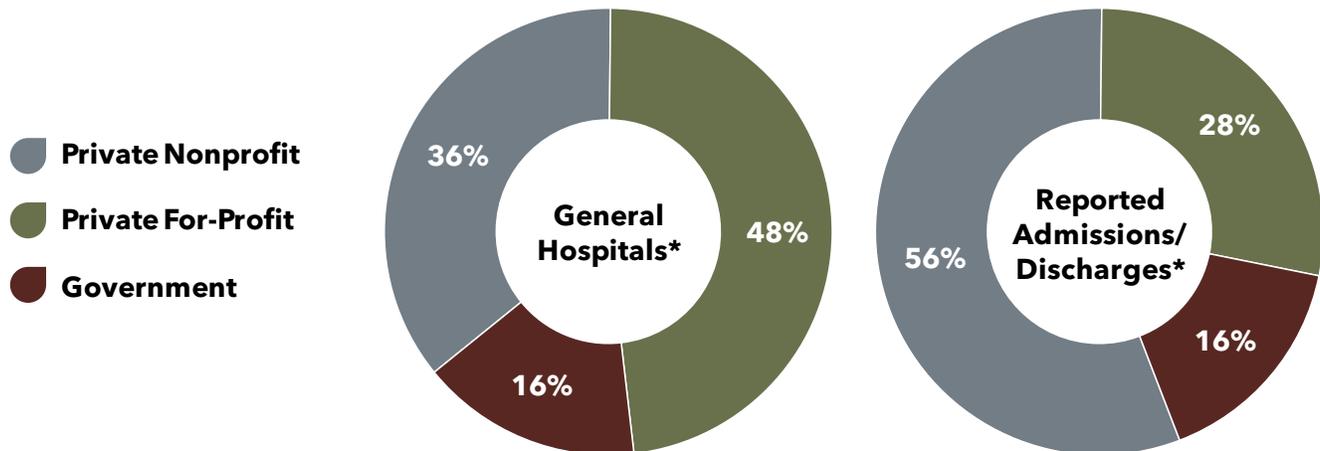
**The federal nonprofit requirements apply to some, but not all, Tennessee hospitals.** Nonprofit hospitals accounted for about 36% of all general hospitals in Tennessee in 2017 and were responsible for about 56% of hospital admissions statewide. Some of the remaining for-profit and government-owned hospitals do have FAPs, but they are not required to have or structure them in any particular way (**Figure 7**).

### *Provider Lawsuits*

**Like all creditors, health care providers have the right to sue people for unpaid bills.** Lawsuits may help providers ensure patients meet their financial obligations, which affects providers' ability to keep costs down and pay their own bills. However, some have questioned whether and to what extent nonprofit hospitals should be able to sue patients for unpaid bills. (70) (71) (72) (73) (74) (75) (76) (77) These suits may be cause for concern for several reasons, such as if providers speedily resort to legal action. They can also greatly add to a debt burden through attorney's fees, court costs, and interest and result in wage or asset seizure (see **Debt Lawsuits** section beginning on page 30).

## Figure 7. 2 in 3 General Hospitals in Tennessee Are Not Subject to Federal Nonprofit Billing Rules

Licensed Tennessee Hospitals by Ownership Status (2017)



Note: Data do not reflect any hospital closures or changes in ownership since the data were reported for 2017.

\*Excludes specialty, exclusively children's, veterans, and psychiatric hospitals.

Source: The Sycamore Institute's analysis of 2017 Joint Annual Report data from the TN Dept. of Health

**Shelby County court data and other anecdotal evidence suggest the practice may be relatively common in at least some parts of Tennessee, including Shelby County and the Tri-Cities.** Ballard Health, a nonprofit hospital system in Upper East Tennessee, filed nearly 6,000 lawsuits against patients in a recent one-year period, which has reportedly strained the budget of at least one local court system.<sup>(78)</sup> (171) Sycamore also analyzed publicly-available data for Shelby County's General Sessions court from January 2018 through June 27, 2019 <sup>(79)</sup>. We found **(Figure 8)**:

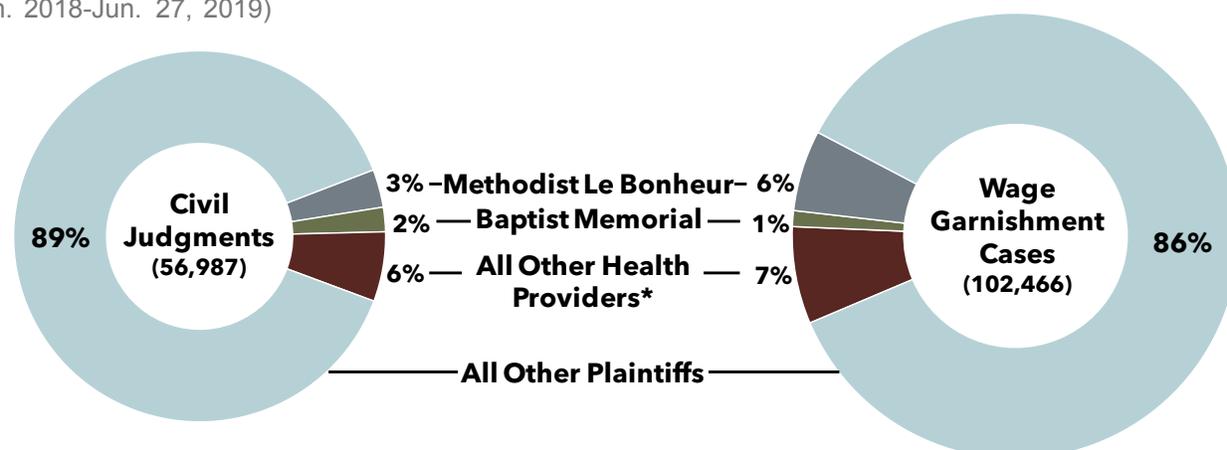
- Of 56,987 civil judgments made during this period, at least 11.8% (6,752) were filed by health care providers (e.g. hospitals, physician groups).
- Judgments in favor of health care providers ranged from a low of just under \$2 to a high of nearly \$33,000. The median judgment was \$2,115.
- Cases brought by health care providers during this period dated as far back as January 2011.
- 46% (3,099) of the provider cases were brought by the area's two largest health systems, Methodist Le Bonheur (1,887 cases) and Baptist Memorial (1,212). Both are nonprofits.
- Providers also accounted for 14,293 active wage garnishment cases – 14% of all garnishment cases in this period. Of these, Methodist accounted for 6,015 and Baptist for 1,332.

In the wake of a June 2019 media report, Methodist suspended lawsuits against patients as part of a review of its collection practices and financial assistance policies. <sup>(75)</sup> <sup>(80)</sup> As of September 2019, Methodist had also forgiven the debts of more than 6,500 patients. <sup>(81)</sup>

**There are limits to what the available data can tell us about provider lawsuits in Tennessee.** Most go through county-level General Sessions civil courts, meaning any available data must be requested on a county-by-county basis. Also, what data is available does not include important context. Examples of details that are not known include how soon after initial billing the provider filed suit, what resources the patient had, if the patient qualified for an FAP or other coverage, and if a payment plan was offered.

## Figure 8. Health Care Providers Are the Plaintiff in 1 in 10 Civil Judgments in Shelby County Court

Shelby Co. General Sessions Court Civil Judgments and Wage Garnishments by Plaintiff Type  
(Jan. 2018-Jun. 27, 2019)



\*Includes 102 hospitals, outpatient clinics, physician staffing groups, ambulance services, and individual providers identified using a search of key terms.

Source: The Sycamore Institute's analysis of data from the Shelby Co., TN General Sessions court (79)

### Examples of Other Provider Billing/Collection Strategies

Tennessee policymakers could explore ways to build on existing state and federal provider billing and collection requirements. Potential approaches could include (13) (68) (82) (83):

- Further Research** – Policymakers may want to look closer at the extent to which Tennessee's health care providers are complying with existing laws. Providers' use of extraordinary collection practices (e.g. lawsuits) may also warrant further review to better understand the context for providers and the impact on patients.
- Additional Providers** – Policymakers could apply the federal FAP requirements to more health care provider types. For example, they could include for-profit hospitals, ambulatory surgery centers, and providers that work in these settings.
- More Specific FAP Requirements** – State-level policy could articulate more specific requirements around FAPs, education, and screening. For example, lawmakers could define income and asset eligibility standards for free and discounted care and lay out benchmarks for how much individuals can be charged. They could also require providers to proactively screen uninsured patients for coverage or FAP eligibility before providing and/or billing for services. It could also define for how long a patient is to remain eligible for the FAP (e.g. the life of the debt).
- Payment Plans** – New policy could require health care providers to proactively offer payment plans to those eligible for FAPs and/or before charging interest, taking collection actions, suing, and/or turning unpaid bills over to debt buyers or credit bureaus. They could also lay out payment plan requirements and limits (e.g. minimum durations, maximum payments as a share of income). State policy could also set a maximum interest rate for medical debt.
- Collection Actions** – State policy could set limits for when and how providers can resort to collection actions like lawsuits or credit bureau reporting. For example, policies could set a specific grace period or prohibit these actions while health insurance billing disputes or appeals are underway. The state could also apply its debt collector regulations to health care providers. Under current law, creditors and their subsidiaries are exempt from the rules summarized in the section on [Debt Collection Practices](#) beginning on page 28.

- **Enforcement** – Policymakers could increase oversight of existing state and federal rules and any new state requirements by, for example, tracking compliance, allowing patients to file complaints, and taking enforcement actions. They could also explore the extent to which lawsuit judgments that include additional fees and interest are consistent with state law that limits certain provider charges to uninsured patients.

### ***Provider Billing/Collection Considerations and Trade-Offs***

**One important consideration is how different options may affect providers' revenues and any resulting unintended consequences.** Some strategies could conceivably increase revenues in some cases. A payment plan, for example, could increase the likelihood that a patient pays at least some of their bill when they otherwise may pay none of it. However, if new requirements have the effect of decreasing revenues, unintended spillover effects could include greater financial distress for providers or higher costs for other patients as providers attempt to offset their losses.

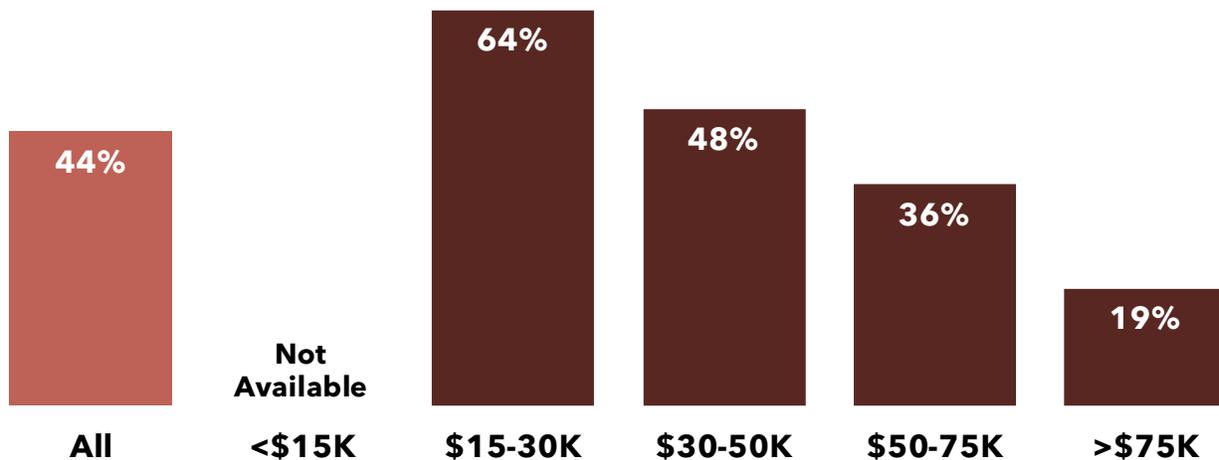
**Changes may come with other trade-offs as well.** For example, additional requirements could create new administrative burdens for providers – some of which use third-party contractors to handle billing and collection. Some may also view new regulations as an overreach. Nonprofit hospitals and community health centers, for example, are reasonably expected to provide a public benefit because they receive tax subsidies via their nonprofit status. Some may believe that the same expectations should not apply to other types of providers.

## Personal Rainy Day Savings

**Facilitating and incentivizing personal savings could reduce debt and promote financial stability by helping Tennesseans use their own resources to better weather unexpected expenses.** For some, even a small unexpected medical bill could lead to medical debt. A 2017 survey by the FDIC estimated that 56% of Tennessee households had saved for an emergency or unexpected expense in the last year – 44% had not (**Figure 9**). (84) In a national 2018 survey by the Federal Reserve, 39% of adults said they would have trouble covering an unexpected \$400 expense. (85)

### Figure 9. Over 40% of Tennesseans Have No Personal Rainy Day Savings

Percent of Tennesseans Who Have Not Saved for Unexpected Expenses or Emergencies in the Past 12 Months by Household Income (2017)



Data are not available where the sample size was too small to produce reliable estimates.

Source: 2017 FDIC National Survey of Unbanked and Underbanked Households (84)

### Current Incentives for Personal Rainy Day Savings

**Many federal policies already create incentives for long-term savings and asset-building.** Tax incentives, for example, allow people to deduct mortgage interest and retirement savings, and capital gains are taxed at a lower rate than other income. These incentives, however, may not encourage the kind of savings that help people weather short-term unexpected expenses, and they do not always help lower- and moderate-income families who are less likely to have savings and may have low tax rates and little-to-no income tax liability.

**Other policies can encourage savings for both long-term asset-building and short-term rainy day needs.** Assets for Independence programs offer low-earners financial education, connections to bank services, and a personal savings match for specific investments (e.g. home buying, college). Their goal is long-term self-sufficiency and asset-building, but they also incentivize (without a match) savings for unforeseen expenses. A randomized evaluation of two programs' first year found participants saved more than they otherwise would have. Participants also had more overall liquid assets, less material hardship (e.g. trouble paying for housing, utilities, or health care), less use of alternative check-cashing, and gains in self-reported financial security. (86) Longer-term evaluations of similar programs found mixed results on use of the funds for their intended purpose – building assets. (87)

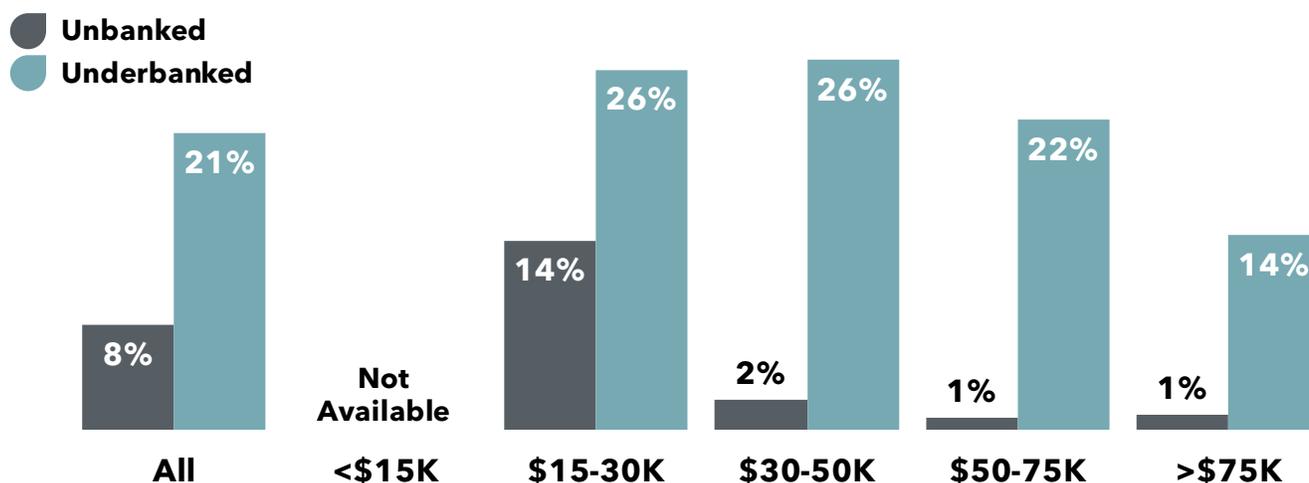
## Examples of Other Incentives for Personal Rainy Day Savings

Other strategies could also incentivize rainy day savings for low- and moderate income families. Examples include:

- **Tax-Time Savings Accounts** – New York, New Jersey, Texas, Oklahoma, and other states have offered programs that reach out and provide a savings match during tax time when many people get refund checks. (88) (87) (89) Evaluations of these various programs found that they were successful at encouraging modest savings among low-wage workers. (90)
- **Employer-Based Accounts** – Employers could offer nonretirement savings accounts that allow individuals the flexibility to withdraw and use funds when needed. Public policy could support these accounts by, for example, allowing for automatic enrollment. (91)
- **Financial Education** – Financial education programs could offer tools and knowledge to help people save for unexpected expenses (see **Financial Capability Services** section beginning on page 25).
- **Traditional Banking Services** – Connecting unbanked and underbanked Tennesseans with traditional banking services could remove obstacles to saving when funds are available. (87) A 2017 FDIC survey estimated 7.5% of Tennessee families are unbanked (i.e. they do not use traditional banking services), and another 21% were underbanked (i.e. they use traditional banking and alternative products like payday loans or check cashing services) (**Figure 10**). (84) Over 20% of households making under \$30,000 were unbanked, according to 2013-2017 estimates. (92)
- **Asset Testing** – Eligibility for many public programs depends on both income and assets. It is conceivable that these asset limits may create a disincentive for some lower-income families to set aside even small amounts for a rainy day, although the available evidence is mixed. (93)

## Figure 10. Lower-Income Tennesseans Are Less Likely to Use Traditional Banks

Percent of Tennesseans Who Are Unbanked or Underbanked by Household Income (2017)



Underbanked includes individuals with a bank account who have also accessed alternative financial services like payday loans or check cashing.

Data are not available where the sample size was too small to produce reliable estimates.

Source: 2017 FDIC National Survey of Unbanked and Underbanked Households (84)

### ***Personal Rainy Day Savings Considerations and Trade-Offs***

**If policymakers want to encourage personal rainy day savings, there are trade-offs and considerations to weigh.** For example, many of the strategies outlined above may be difficult to evaluate and, where evaluated, have generated mixed results. Approaches that incentivize behaviors may also have greater outcome variation than other, more direct types of public assistance. (94)

**Any new incentives should also account for the behaviors and motivations that influence financial decision-making.** While low- and moderate-income individuals may have fewer resources to set aside, research suggests it is possible for them to save. Effectively helping Tennesseans save for a rainy day will, however, require careful attention to behaviors and motivations. The emerging fields of behavioral economics and behavioral psychology, for example, are helping to inform how programs can be better implemented to achieve the most effective and efficient results. (95)

## Affordable Small-Dollar Loans

**Increasing access to affordable, small-dollar loans could help some individuals to better manage unexpected medical expenses and avoid a cycle of debt.** Today, most low-dollar lending is available only through alternative financial services (AFS), which meet a need for many families but come with high costs. Policymakers could consider ways to reduce the cost of these services while expanding access to lower-cost options.

**Alternative financial products include services provided outside federally-insured banks – such as money orders, check cashing, payday lending, flex loans, and tax refund loans.** Their use is associated with reduced ability to meet basic needs, poor health outcomes, and financial insecurity. (96) In some cases, the interest and fees that accrue can exceed the amount originally borrowed.

**Groups that are more likely to have medical debt are also more likely to use AFS.** Lower-income households, black and Hispanic households, and households with volatile incomes and lower levels of education are more likely to use AFS. (97)

**People often rely on small dollar loans to fill income gaps or pay for unexpected expenses like medical bills.**

While costly, AFS fill a need for many Tennesseans. Many banks do not provide small dollar loans, and AFS users report that these products are easier to qualify for than bank loans and more convenient to access. (98)

Two broad approaches to this problem include more regulation of alternative financial services and increasing access to lower-interest, small-dollar lending options.

### *Regulating Alternative Financial Services*

Examples of approaches to more stringently regulate AFS include:

- **Capping Interest Rates** – Some states cap the annual percentage rate (APR) on payday and installment loans at 36%, which limits both the initial interest rate and any other associated fees or charges. A 36% max APR has effectively eliminated payday lending in these states, as these unsecured loans to high-risk borrowers are no longer profitable. (96) (99) The profitability of payday lending relies on repeat borrowers who roll over their loans multiple times. (100) (101)

Tennessee has separate laws for two types of similar products – deferred presentment services (i.e. payday lending) and flex loans. Payday loans are capped at \$500 and 31 days, and fees are capped at 15%. (102) According to three separate estimates, these caps work out to an average APR of over 400%. (103) (104) (105) Flex loans are capped at 24% interest with no limit on fees. (106) One analysis estimated that a \$500 six-month installment loan in Tennessee could have a max APR with fees of 94%. (107)

- **Prohibiting Certain AFS Products** – As of May 2019, five states and the District of Columbia expressly prohibit payday lending. (108) While the prohibition eliminates within-state access, consumers can use online services or travel to other states that allow the products. (109) (99)

**State regulation of alternative financial services may have unintended consequences for consumers and businesses.** Some considerations include:

- **Substitution of Services** – Reducing the supply of a product does not necessarily reduce the demand. Consumers who lose access to one financial product may simply switch to another. For example, if people cannot access payday loans, they may use online options, flex loans, or auto-title loans to meet their needs instead. (110) (111)
- **Offsetting Price Increases** – In response to caps on interest rates, lenders may increase fees or change other loan terms to remain profitable. (110) (111)

- **Innovation** – Heavy regulation may incentivize lenders to innovate, with positive and negative results. While some innovations could lead to services that are both profitable and improve customers' financial well-being, lenders may also find creative ways to avoid regulations and keep operating more or less as before. (110)
- **Decreased Access to Credit** – Lenders may leave the market entirely and stop offering financial services to consumers who need them. Consumers may suffer from a lack of financial options that meet their needs. (111)

### ***Examples of Strategies to Expand Affordable, Small-Dollar Loans***

**Reducing the supply of AFS without providing alternatives could have unintended consequences for people who rely on these services.** (109) (96) Low-income customers are not profitable to many banks because they take out smaller loans and are a higher credit risk compared to higher-income customers. (112) Policies that seek to provide access to credit and lending should consider the needs of these consumers and the business needs of lenders.

**Community Development Financial Institutions (CDFIs) may offer a way to expand access to affordable small-dollar loans.** CDFIs are private entities that leverage federal funding with private investment to provide credit, capital, and other financial services to communities underserved by traditional financial institutions. While 23 CDFIs in Tennessee made over 280,000 loans and investments in 2018 totaling \$11.2 billion, many people do not have access to them. (113)

Examples of ways that states can encourage the expansion of CDFIs include: (114)

- **Financial Support** – The federal government provides grants to CDFIs to help underwrite the administrative costs of making loans and helping borrowers obtain them. These grants give CDFIs financial support during times of economic stress and help them provide resources to their clients that they may not be able to otherwise. (115) Some states are creating and funding their own grant programs based on the federal model.
- **Access to Capital** – CDFIs can more flexibly meet their borrowers' needs when they have access to low-cost debt. States have used a variety of mechanisms – general appropriations, bonds, and special purpose funds – to provide CDFIs with low-cost, long-term debt.
- **Sharing Credit Risk** – CDFIs lend to riskier clients than traditional banks. Sharing the credit risk with other entities helps a CDFI to serve their target populations and remain a sustainable business. States have shared credit risks with CDFIs by creating pooled loan loss reserves and providing loan guarantees and funding for loan loss. The federal State Small Business Credit Initiative is one source of funding for loan guarantees. (116)
- **Tax Incentives and Credits** – States often provide tax credits for donating to CDFIs or investing in CDFI-financed projects. Fourteen states have modeled their tax credits on the federal New Markets Tax Credit (NMTC) Program. The NMTC Program lets Community Development Entities (CDE), like CDFIs, offer tax credits to private investors in exchange for equity. CDEs can then use that equity capital to make loans and investments. (117)
- **Licensing and Regulation** – CDFIs work with consumers, homebuyers and owners, and small businesses, so they are subject to many state laws and regulations. Compliance can at times be a challenge due to the groups CDFIs serve. For example, applying bank lending rules to CDFIs can make underwriting and risk management difficult since they serve riskier populations with less volume than traditional banks. As a result, some states modify or exempt CDFIs from certain licensing and regulatory requirements.

**Examples of other strategies that may boost access to affordable, small-dollar loans for people who use alternative financial services include:**

- **Alternative Data Sources for Credit Underwriting** – People who use AFS are more likely than others to have a credit card application declined. (118) Some credit card companies and mortgage lenders have begun using rent, utility payments, and bank account history (e.g. income and expenses) to gauge creditworthiness. (110) These alternative methods could help people with very little credit history gain access to and build their credit history. However, depending on the details, it could also further restrict access to credit for those with unpaid bills and debts. (119)
- **Employer-Based Small-Dollar Loans** – Data suggest that workers who face financial issues are more likely to be stressed and in worse health, which can lead to lower on-the-job productivity. (120) Although not widely used, some employers have partnered with financial institutions to provide short-term loans to help improve the financial health of their workers. The loans are usually repaid via payroll deductions. (121) There may be ways state policy can support this approach, but close monitoring is needed to assess how these loans (and any related or wraparound services) benefit both employers and employees without feeding the cycles of financial insecurity and debt often tied to AFS. (110)
- **More Research** – The majority of research in this area has focused on the needs and motivations of people who use AFS. There is less understanding of the needs of lenders and the overall small-dollar lending market. A clearer picture of both could help state policymakers identify additional solutions that meet the needs of both consumers and lenders. (110)

## Financial Capability Services

**Improving access to services like financial literacy classes, counseling, and coaching could help people prepare for and manage debt if and when it occurs.** Financial capability services aim to give individuals the knowledge, skills, and resources to effectively manage their finances. This section focuses on financial literacy, counseling, and coaching, but other examples range from free tax preparation assistance to credit building. (122)

### *Financial Literacy*

**Financial literacy education generally involves group workshops or classes intended to teach basic financial concepts.** (122) Policymakers could consider whether and how to apply lessons from existing financial literacy efforts to specifically address the issue of medical debt.

**Individuals with higher levels of financial knowledge are less likely to have past-due medical debt and to use alternative financial services (AFS),** like high-cost payday or flex loans. (123) (124) People with low financial literacy are more likely to misunderstand the cost of borrowing, misinterpret annual percentage rates, and have higher debt-to-income ratios. While financial illiteracy correlates with having medical debt and using AFS, correlation is not causation. (123)

**Financial education contributes to many positive financial outcomes but may not significantly reduce medical debt.** For example, state-mandated high school financial education classes are associated with higher credit scores and lower credit card and auto loan delinquency rates four years after graduation. (125) (126) However, they do not appear to have a significant impact on medical debt. (124) In 2013, Tennessee became one of 23 states requiring high school students to complete a financial education course. (127)

**The positive effects of financial literacy interventions also decrease over time.** When considering retirement savings, for example, a high school class may be less effective than financial education when a person has the chance to enroll in a work-sponsored retirement plan. (128)

**Financial literacy interventions have been found to be less effective among people with low-incomes.** (128) Research suggests this occurs because people with lower incomes often have different stressors when making decisions, different social and economic environments, and less room for financial error. They also often have different financial opportunities and choices. For example, this group is less likely to have a bank account, which may lead to greater use of check cashing and money order services with higher transaction fees. (92) (129)

### *Financial Counseling*

**Financial counseling is a one-on-one intervention meant to help someone manage a specific situation – for example, to purchase a home or handle a debt.** (122) Policymakers could consider how to build on limited but successful programs already operating in Tennessee.

**Financial empowerment centers (FECs) are an effective way to provide financial counseling and improve financial outcomes for people with low-incomes.** FECs are run by local governments and provide free, individual-level financial counseling. They combine education, personalized solutions, payment plan negotiations, professionally trained counselors, and coordination with other social services. (130) Clients who attend multiple sessions are the most likely to see improved outcomes.

**Tennessee has two FECs located in Nashville and Memphis.** While data on the Memphis FEC is not yet available, the Nashville FEC has shown positive results. Of the 1,700 Nashville clients who attended multiple sessions between 2013-2015: (130)

- 38% increased their credit score
- 32% increased their amount in savings
- 32% established a credit score
- 27% decreased their amount of debt

### ***Financial Coaching***

**Financial coaching is a one-on-one intervention aimed at improving financial behavior and achieving longer-term financial goals.** (131) Policymakers could consider whether financial coaching may be an avenue for preventing and addressing medical debt in Tennessee.

**Evidence suggests that financial coaching may help people improve their finances, but the results are mixed.**

One 2015 experimental evaluation of two programs found that they improved participants' money management, debt loads, and self-perceptions of financial-well-being. However, results were more mixed around savings behaviors, credit scores, and financial knowledge. The approach may also be more expensive than other methods of helping people set and work towards financial goals (e.g. financial education). (131)

## SECTION 4

# Mitigating Medical Debt

**Downstream policy options could help mitigate the negative effects of medical debt.** Unpaid medical bills can become indistinguishable from most other types of consumer debt once they are purchased by a debt buyer. (2) For this reason, many of the downstream options address debt generally or offset the negative effects of bad debt. Actions in this area could affect:

- **Debt Collection Practices** – Reining in some debt collection practices could improve debt repayment outcomes and reduce debt-related stress among Tennesseans with unpaid medical bills.
- **Debt Lawsuits** – Addressing certain aspects of debt collection lawsuits could reduce some of the negative financial and legal fallout from medical debt.
- **Debt Settlement Services** – Greater oversight of debt settlement services could protect people looking for manageable ways to pay off their debts.
- **Credit History** – Limiting how medical debt affects a person’s credit history could address a potential significant obstacle to their financial stability and economic mobility.
- **Debt Pay-Off** – Paying off debts directly could reduce financial burdens on affected individuals and improve their economic security, potentially for less than the debt’s face value.

## Debt Collection Practices

**Reining in irresponsible debt collection practices could improve debt repayment outcomes and reduce debt-related stress among Tennesseans with unpaid medical bills.** Examples include harassment or abuse, misrepresenting how much someone owes, using inaccurate information about debts, and inappropriate threats of legal action or jail time. These practices can create unnecessary additional stress and force some individuals into unfavorable or unaffordable settlements. (2)

### Current Debt Collection Rules

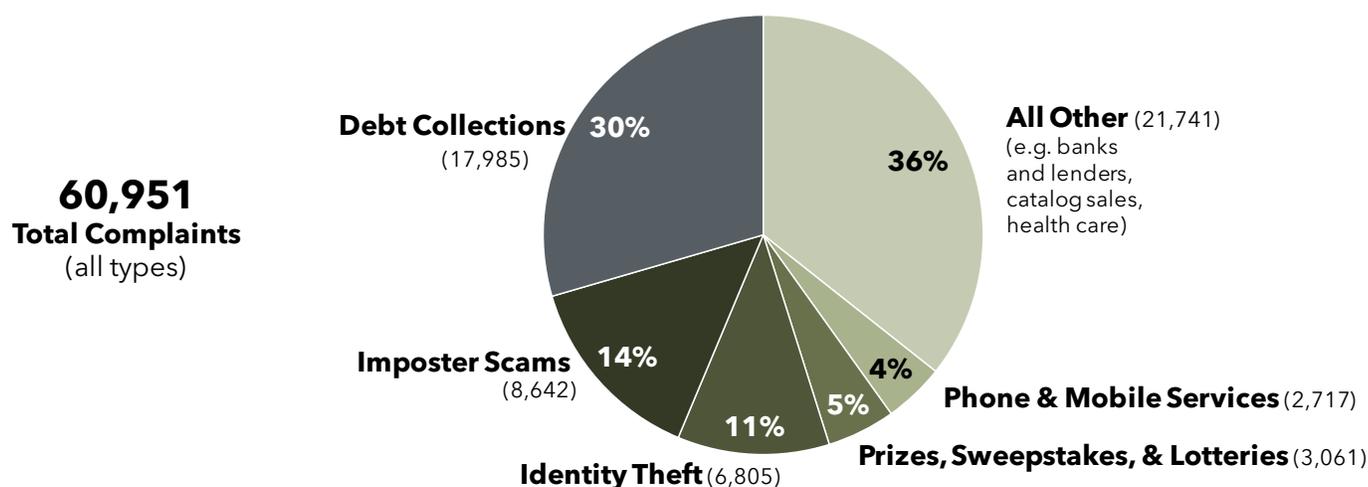
**Both state and federal rules govern what debt collectors can do.** The Consumer Financial Protection Bureau (CFPB) and the Federal Trade Commission (FTC) jointly enforce the federal Fair Debt Collection Practices Act. (132) At the state level, the Tennessee Collection Services Board issues licenses and oversees debt collectors. State and federal rules are largely consistent. For example:

- Debt collectors are generally barred from contacting people at inconvenient times or places (e.g. after 9pm) or after someone asks to no longer be contacted.
- Collectors cannot threaten violence, use profanity, or repeatedly call with the intent to annoy.
- Collectors are not allowed to make false or misleading statements about, for example, who they are or the legal status of a debt. (133)
- If a collector violates any of these state rules, they can have their license revoked and be fined up to \$1,000 per violation (134)(135)

**Despite these regulations, the FTC fielded nearly 18,000 complaints from Tennesseans about debt collectors in 2018 (Figure 11).** Debt collectors were the state’s top complaint, beating out the next two categories combined – imposter scams (8,600) and identity theft (6,800). (136) Tennesseans primarily complained about repeated calls, receiving calls after making a stop request, and collectors making false statements about debts or misrepresenting who they are. (137)

## Figure 11. Tennesseans Made Nearly 18,000 FTC Complaints about Debt Collectors in 2018

Tennesseans’ Complaints to the Federal Trade Commission (FTC) by Type (2018)



Source: Federal Trade Commission (136)

**Since debts can be resold multiple times, basic information may be wrong or missing – which contributes to troubling collection practices and outcomes.** A 2013 study by the FTC found that debt collectors rarely had and/or shared basic info like to whom the debt was originally owed, whether it had been disputed, and how much was principal, interest, or fees. (138) In a national 2015 CFPB survey, over half the people contacted by a collector in the previous year said the debt was not theirs or was for an inaccurate amount. (139) These situations can lead to harassment or legal action for debts a person may not owe or that have already been paid. (2)

**The CFPB proposed updates to federal rules for debt collectors in May 2019.** The proposal clarifies how debt collectors can use newer technologies like email, text, and social media to contact consumers and creates a weekly seven-call limit for each specific debt. It also requires collectors to provide certain information to verify debts and prohibits them from suing or threatening to sue over debts that are past the statute of limitations (called “zombie debts,” see [Debt Lawsuits](#) section beginning on page 30). (83) (140) Some critics believe the proposed rule should go farther to, for example, prohibit voicemails and sending important notices via email, as well as putting stricter limits on phone calls, texting, email, and social media. (141)

### ***Examples of Other Debt Collection Strategies***

**Tennessee policymakers could explore ways to revise existing rules for debt collection in Tennessee.** Examples of areas for consideration include:

- **Applicable Parties** – Neither federal law nor Tennessee’s rules apply to all parties that collect debt. State rules, for example, do not apply to lawyers, entities collecting debt on their own behalf (e.g. a hospital), or entities who are subsidiaries or affiliated firms of those entities (e.g. the billing subsidiary of a hospital). (135)
- **Interest Rate Limits** – Debt buyers and collectors often tack additional fees and interest onto the original amounts when they seek payment. Policymakers could consider setting limits on these additional costs. A new Washington state law, for example, limits the maximum interest rate that can be charged on medical debt prior to a court judgment. (83)
- **Charity Care Eligibility** – State policymakers could tie debt collecting to any provider charity care policies. For example, Washington’s new law also requires collection agencies to offer itemized statements for medical debts that note if the patient was eligible for charity care. (83)
- **Other Updates** – Tennessee’s rules could be updated to address some of the same issues broached in CFPB’s proposed rule – for example, the use of newer communication methods, specific limits on making contact, and information verification requirements.

### ***Debt Collection Considerations and Trade-Offs***

**Each of these strategies could affect creditors’ and collectors’ ability to hold people responsible for their financial obligations.** Policymakers will need to find a balance between tackling the issues that concern them and protecting access to affordable credit for people seeking to build wealth or weather financial emergencies and instability.

## Debt Lawsuits

**Addressing certain aspects of debt collection lawsuits could reduce some of the negative financial and legal fallout from medical debt.** This section primarily focuses on debt collection lawsuits in general. See [Provider Billing and Collection Practices](#) beginning on page 15 for more specific information on debt lawsuits brought directly by health care providers.

### *Current Debt Lawsuit Practices*

**Debt collectors and creditors are allowed to sue people in civil court for unpaid bills.** In Tennessee, an individual can be sued for up to six years after the last payment was made on an outstanding debt. (142) The state's Circuit and Chancery courts and county-level General Sessions courts share jurisdiction over debt collection lawsuits. Debt collection suits are most often brought in General Sessions courts, which have jurisdiction over claims of less than \$25,000.

**If a court rules in a collector's favor, it determines a settlement that can include the debt along with court costs, attorney's fees, and interest.** Any settlement is subject to a pre-determined post-judgment interest rate set by state law. (143) Collectors can use a number of tools to recoup settlements, including garnishing wages and seizing assets. (2) (144) There is no time limit in Tennessee for enforcing civil judgments, but they must be renewed by a judge every 10 years. (145)

**Technically, one can be jailed in Tennessee for failing to pay a court-ordered debt settlement, though it is not clear how often this occurs.** State law allows the jailing of people who fail to follow a civil court's order. This could include not appearing in court for a hearing, not providing required documentation, or not meeting the payment requirements in a court's judgment. (146) A 2018 study found cases of arrest warrants and jail time for debt in Tennessee. (146)

**There is limited data available on the number of debt collection lawsuits in Tennessee, but national studies suggest they may make up a large volume of civil court cases.** For the state's Circuit and Chancery courts, debt and contract-related cases combined made up about 10% of non-domestic civil cases in FY 2018. (147) Caseload data are not readily available for Tennessee's General Sessions courts. Nationwide, however, a 2016 study found that 24% of non-domestic civil litigation in state courts was for debt collection. (144)

**National studies highlight several aspects of debt collection lawsuits that may merit attention from policymakers,** including:

- **Intimidation** – Some collectors reportedly use threats of legal action and jail time as an intimidation tactic, even when there may be no legal basis for a lawsuit. (2)
- **"Zombie Debt"** – Debt collectors may mislead people with threats to sue for debts older than the six-year statute of limitations. Consumer advocates often call these "time-barred" or "zombie" debts. If payments are made on such debts, the six-year clock can reset. (144) (2)
- **Notification** – Individuals may never receive clear or proper notification of a lawsuit. Similarly, they may not receive notification of a default judgment for which they are responsible.
- **Unchallenged Lawsuits** – Nationally, most debt lawsuits go unchallenged. In a 2015 CFPB survey, about 15% of Americans contacted by a debt collector in the past year reported being sued. Of those, only about 26% attended the court proceeding. (139) Some reasons people may not attend include lack of notice or legal representation, receiving incorrect or misleading information, confusion about the alleged debt, and income, job, or travel constraints. (2) (144) When people don't show up, courts often issue default judgments. (2)

- **Legal Representation** – There is no guaranteed right to legal representation in civil suits, and many people who do challenge them are unrepresented. (144) (2) In a 2016 national study of debt lawsuits, about 84% of defendants had no legal representation. (144) This often gives debt collectors an advantage, as non-lawyers may not have the expertise to challenge the plaintiff's allegations. (144) Plaintiffs often drop cases when defendants are represented. (2)
- **Inaccuracies** – Some studies have reported that suits can be brought based on inaccurate or incomplete information about the debt. (2) (144)
- **Added Costs** – On top of the original debt and any fees and interest that accrue pre-lawsuit, court settlements often add attorney's fees, court costs, other reimbursable expenses, and post-judgment interest. In default judgments, interest can significantly inflate this new total without the defendant being aware.

### ***Examples of Debt Lawsuit Strategies***

**Policymakers could consider a number of strategies to address these aspects of debt lawsuits**, such as:

- **Time Limits** – Policymakers could modify the six-year statute of limitations, prohibit the six-year clock from resetting, and/or limit the time available to enforce judgments. (148)
- **Stronger Notification Requirements** – Policymakers could revise notification rules for lawsuits and associated proceedings to, for example, expand notification requirements to include email, require proof of notification, and assess penalties for failing to properly notify. (144) (148)
- **Documentation Standards** – Procedural court reforms could strengthen the documentation and evidentiary burden in lawsuits, such as proving the statute of limitations has not expired and establishing a mandatory documentation standard. (2) (149) (148) (144)
- **Support Legal Representation** – Policymakers could provide financial resources to expand access to legal representation for low- and moderate-income individuals. (2) (144) (150)
- **Tools for Self-Representation** – Policymakers could also explore ways to make it easier for people to represent themselves. For example, plain-language legal forms, better online and phone access to court staff, online dispute resolution, and technology-based tools could help laypeople navigate the legal system. (151) (152) (153) (154) (155)
- **Provide Judicial Support** – Policymakers could look at ways to help judges better assess claims, especially in cases where the defendant is not present or legally represented. (144)
- **Limit Costs** – New policies could limit recoverable attorneys' fees and post-judgment interest by, for example, limiting interest rates, providing a grace period, or allowing for exceptions in certain circumstances (148) State policies could also set specific wage and asset protections for lower-income workers (e.g. limit garnishment to some multiple of the minimum wage). (148)
- **Limit Arrests** – New policies could prohibit the use of civil arrest warrants in certain circumstances. (148)

### ***Debt Lawsuit Considerations and Trade-Offs***

**Some of the options above may offer greater protection from abuse than others, and each could affect plaintiffs' ability to bring legitimate lawsuits.** Ensuring that people in debt meet their financial obligations can help mitigate increases in the costs of credit (or health care) for others. The best approaches will likely find a balance between reining in the most troubling practices and preserving access to affordable credit. Policymakers should carefully consider the available evidence for each option and weigh any potential for unintended consequences. For example, the use of technology to help people navigate litigation should be monitored for unexpected effects. (153)

## Debt Settlement Services

**Greater oversight of debt settlement services could protect people looking for manageable ways to pay off their debts.** Services that promise to renegotiate payment terms with creditors (often referred to as debt management, debt settlement, or debt relief services) are not free of risk or cost. Some require a person to first default on a loan or debt, which can drive up its cost, lead to collection actions by the creditor, and/or hurt the individual's credit history. These services do not always guarantee a more favorable outcome than if people negotiate on their own and can involve costly fees (e.g. 20-25% of the debt). (156) (157)

**Existing Tennessee law provides some protections for consumers using debt settlement services.** For example, these services cannot use deceptive or scare tactics to attract customers. They cannot misrepresent the services or the outcomes they can realistically offer. They also cannot enroll clients who have not first received credit counseling or who cannot afford a debt management plan. (158) (159)

**National cases found that some debt management companies have engaged in fraudulent practices that violate state and federal laws.** (160) For example, recent settlements with the largest debt management company in the U.S. show that the company failed to inform borrowers that it was barred from even negotiating with several major creditors and misrepresented its fees and the outcomes it could get for clients. (161) (162)

**Tennessee policymakers could explore ways to add more consumer protections while expanding access to less risky services.** For instance, the state laws mentioned above do not apply to attorneys and do not limit what debt settlement services can charge. (158) (159) Policymakers could also consider ways to expand access to nonprofit credit and financial counseling services that have smaller risks and costs (see [Financial Capability Services](#) section beginning on page 25). (156)

## Credit History

**Limiting how medical debt affects a person's credit history could shrink a potentially significant obstacle to financial stability and economic mobility.** Credit history can be either a gateway or a barrier to financial health. Poor credit history may make it harder and more costly to secure a job, housing, and access to credit – including forms of debt like home and business loans that can help build wealth.

**Medical debt on Tennesseans' credit histories is common and has far-reaching effects, yet it is not always an accurate reflection of one's will or ability to pay.** (163) [In 2016, medical debt hurt the credit history of 24% of Tennesseans.](#) Yet, a 2014 national study found that half of people with medical debt on their credit history had an otherwise clean credit report. (164) Some entities have begun excluding medical debt when they review credit histories, but the practice isn't required or widespread. (165) (166) Credit agencies also withhold medical debt from credit histories for 180 days after it is reported to allow time for insurers, providers, and patients to resolve any billing disputes. (167)

**State lawmakers could consider additional limits for when medical debt can be reported to a credit bureau and how medical debt-related credit history information can be used.** For example, policymakers could require health care providers to screen patients for charity care or other program eligibility before reporting past-due bills to the credit bureaus (see [Provider Billing and Collection Practices](#) section beginning on page 15). Currently, state law excludes medical debt from the information that can be used to set home and auto insurance terms and premiums. (168) Policymakers could build on this to exclude medical debt from other types of credit screenings (e.g. employment, housing, utilities).

## Debt Pay-Off

**Paying off resold medical debts could reduce financial burdens on affected individuals and improve their economic security, potentially for less than the debt's face value.** For example, one national nonprofit (R.I.P. Medical Debt) uses charitable donations to buy and forgive resold medical debt for low-income and financially insecure individuals. Debt can be bought and sold by debt collectors and sellers multiple times – often at increasingly cheaper prices. As a result, R.I.P. Medical Debt can buy portfolios of unpaid medical debt for a fraction of the value of the outstanding bills and then forgive them. (169) (170) Tennessee could explore ways to similarly facilitate debt forgiveness for Tennesseans (e.g. with direct or administrative support).

**This “if all else fails” approach is less likely than other strategies to create systemic change.** Erasing a debt provides one-time relief but does not alter the underlying circumstances that generated it. In addition, debts that are bought and sold multiple times before being erased have likely had numerous negative effects that may outlive the debt itself. In addition, it could be hard to target funds for specific individuals or types of individuals. As a result, this approach may be best suited for catching people who fall through the cracks even after policymakers have implemented other strategies outlined in this report.

## SECTION 5

# Parting Words

Each policy option could help improve Tennesseans' financial security, economic mobility, and health by addressing one or more aspects of medical debt. The complexities and unique features of medical debt mean there is no single answer that addresses every aspect of the problem and its downstream effects in Tennessee. As policymakers consider the details of each strategy as discussed in the full report, they will have to balance the trade-offs and potential for unintended consequences inherent in every public policy decision.

Medical debt is surprisingly common in Tennessee, appearing on one in four credit reports. It often results from circumstances tough to predict or control, and even small amounts can make it harder to get ahead. This report explores 12 options for policymakers who want to prevent medical debt, help people manage their medical bills, and mitigate medical debt's negative effects on financial security, economic mobility, and health.

Our work on medical debt provides important background on how medical debt occurs, how it affects people's lives, who has it in and across Tennessee, and what can be done about it:

### **Medical Debt 101: How a Medical Bill Becomes Medical Debt**

<https://www.sycamoreinstitutetn.org/medical-debt-101/>

### **Medical Debt in Tennessee: Who Has It and Why Does It Matter?**

<https://www.sycamoreinstitutetn.org/medical-debt-tennessee/>

### **Medical Debt Across Tennessee's 95 Counties**

<https://www.sycamoreinstitutetn.org/medical-debt-tn-counties/>

### **Medical Debt in Tennessee: 12 Options for State Policymakers**

<https://www.sycamoreinstitutetn.org/medical-debt-policy-options/>

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