Only in America: Easing the Burden of Medical Debt

SPEAKERS
Heather Howard, Noam Levey, Eva Stahl

Heather Howard 00:02
Hi, and welcome to the Princeton Pulse Podcast. I'm Heather Howard, professor at Princeton University and former New Jersey Commissioner of Health and Senior Services. On campus and beyond, I've dedicated my career to advancing public health. That's why I'm excited to host this podcast and shine a light on the valuable connections between health research and policy. Our show will bring together scholars, policymakers, and other leaders to discuss today's most pressing health policy issues, domestically and globally. We'll highlight novel research at Princeton, along with partnerships aimed at improving public health and reducing health disparities. I hope you'll listen in as we put our fingers on the pulse and examine the power and possibilities of evidence informed health policy.

Heather Howard 00:54
On today's episode, we explore medical debt, a pervasive and uniquely American problem. Forty-one percent of US adults, or over 100 million people, are struggling to pay their medical or dental bills. How has this happened? Studies suggest that many Americans have insufficient health insurance coverage which has delayed or prevented care, worsened health outcomes, and increased financial hardship. My guests and I will delve into the latest research, the underlying drivers of medical debt, and its inequitable impact on low-income populations and communities of color. We'll also talk about what we can do to alleviate this growing burden, including federal and state policy responses. Here with me to discuss the issues are Noam Levey, a senior correspondent for KFF Health News, who has reported on this topic extensively, and Eva Stahl, Vice President of Public Policy at RIP Medical Debt, a nonprofit dedicated to strengthening communities by abolishing medical debt. Noam, Eva, welcome to the show!

Heather Howard 01:57
Noam, let me start with you. You've had a really interesting beat at KFF Health News. How do you describe it? And how did you come to it?

Noam Levey 02:10
Yeah, I mean, this is something I spent most of my career on at the LA Times. I came to KFF Health News specifically to cover medical debt because you can't cover health care in this country, which I've done for almost 15 years now, without coming across people who have trouble paying their medical bills. And it struck me that one of the things that we always focused on was the fact that people were having trouble paying their bills, but not looking as much at what that means for their broader lives. That's the story of debt. That's the story of all the sacrifices and the difficult choices that people are

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forced to make because they have some medical or dental bills hanging over their heads. What I've been doing for the last two years is looking at this horrible problem.

Heather Howard 03:02
Wow. We'll be sure to include some links to your really compelling reporting in the show notes because you really tell the policy story, but also the human story, right?

Noam Levey 03:13
Yeah, I know we'll get into all the numbers, but 100 million people is 100 million stories. We've talked to hundreds of people across the country from every walk of life, from every region, every income, race, you name it. And, you know, these are people who are living with the really gut-wrenching, heartbreaking consequences of medical bills. So yeah, it's pretty sobering.

Heather Howard 03:45
And, Eva, what about you? How did you come to this issue?

Eva Stahl 03:50
My background is actually in advocacy. I spent over a decade at a national consumer health advocacy organization called Community Catalyst, and lived through the Affordable Care Act -- birth and many revisions -- and really focused on affordability by supporting states in thinking about campaigns to expand coverage. Medical debt really is another doorway to affordability. So when this opportunity came up, I was approached by Allison Sesso, who leads RIP Medical Debt, and really wanted to think about how we could take the work to the next level and move upstream. We have these powerful stories from our beneficiaries. We wanted to think about how we could help build an ecosystem and create pressure for real policy change.

Heather Howard 04:41
So let's jump in. Eva, what is medical debt? Can you talk us through the mechanisms of how medical debt is accrued and how the burden is felt by individuals and families?

Eva Stahl 04:58
Sure. It can be a little bit of a complicated workflow when you think about medical debt, and you really look under the hood. But essentially, when people can't pay their medical bills, and hospitals or providers have tried multiple times to request that those bills be paid, it moves through a cycle of collection, various cycles of collection, before it reaches a point where if they continue to go unpaid, that debt would either continue to be collected on through some extraordinary collection efforts, which we can talk about. Or one of those options might be to actually sell the debt. The hospital or provider can get to a point where they choose to either retire the medical bills and no longer collect on them and move on, or they might pursue additional collection tactics or sell to a debt buyer. That debt buyer then would continue to try and collect on those bills. And that is often referred to as a secondary debt market. But essentially, it reverberates through people's lives in multiple ways. It creates a lot of anxiety and stress for people from the onset. If you can't pay your medical bills, even when you have insurance for the parts that you're responsible for, it definitely creates a lot of anxiety, particularly in moments of distress. I think this is really well described through the number of stories about medical debt that I

hope people have seen. It [medical debt] also can affect people's credit. So one of those extraordinary collection tactics that we often talk about is that people's bills might be reported and affect their credit score. That means that it affects their daily choices about opportunities for work, opportunities for education, and even paying the bills that they have stacking up in their own household, whether those are utilities or rent or housing. So it really ripples through every part of your life, including whether or not you go back for care. And that's one of the most important parts of this story.

Heather Howard 07:01
Noam, you've written that this could be fueling the homelessness crisis. Right? Did I read that right from some of your reporting?

Noam Levey 07:10
Yeah, that's right. I think one thing that's important to understand about the breadth of medical debt is that a bill that isn't paid and ends up on somebody's credit score is one mechanism or way that medical debt can upend someone's life. And yes, in that respect, people with bad credit have a more difficult time renting an apartment. They have a more difficult time getting an auto loan. Some employers check people's credit scores, so it can be more difficult to get a job. So it becomes this weight that people carry around, which prevents them from advancing economically. But the other thing to keep in mind is that much medical debt is not necessarily on a credit report. In fact, less and less of it is. The debt manifests itself in other ways that can be just as damaging. For example, many people will put a medical bill that they can't afford on their credit card, and then they carry that credit card balance from month to month, usually at a very high interest. That, too, can affect their credit score and make it more difficult to do the things we were just talking about. People can be on a payment plan with a hospital or medical provider, where they're paying $100 or $200 a month, and that's affecting their ability to rent a larger home, to fix their home, to fix their car, even to get food. We did a poll here, as part of our research with our survey partners, and one of the things we found is that two thirds of people have said they'd cut spending on food, clothing, or other essentials as a result of carrying medical debt. I think one of the overarching and most disturbing things about this issue is that the health care system that's supposed to be taking care of people is forcing people to change the way they feed themselves.

Heather Howard 09:14
Eva, you mentioned before your work on the Affordable Care Act. Can you describe who's affected by this problem? Because it's not just people who are uninsured, right? It's also people who are what we call underinsured. Can you describe who that is?

Eva Stahl 09:30
Correct. It isn't just the uninsured. We've seen some tremendous gains in coverage, especially since the Affordable Care Act, and notably since the Inflation Reduction Act has increased subsidies for people to get access to coverage. Unfortunately, with high deductibles, people still can't afford to use that coverage. So when we say that people are underinsured, which is a term that's thrown around, the benchmark is usually spending more than 10% of your annual income on health care expenses. It's really about people having coverage, but then when they try to use it, they can't pay their medical bills. It's that individual responsibility component of insurance. You go the doctor and the insurance pays its part, but then you're left with the individual responsibility part, which is a deductible or out-of-pocket

costs, and you can't pay that. A number of those plans might be through the marketplaces. They also might be through high deductible health plans, which are increasingly popular because it's something that employers can offer that keeps premiums low but the plan has very high out-of-pocket costs. Sometimes that's paired with a health savings account, but not all employers contribute to those and they really benefit wealthier people more than anyone else. As we look at the data, we see that medical debt really hits hardest for people under 400% of the federal poverty level, and then you'll see a little bit of a shift moving downward because people tend to have more comprehensive coverage that they can afford to use.

Heather Howard 11:10
Noam, I'm coming back to you. 100 million people. Can you talk about how you arrive at that estimate of the number of people who are burdened by medical debt?

Noam Levey 11:21
Sure. That number is a little bit higher than people may realize. And that's for a couple of reasons. One, as I mentioned earlier, medical debt was traditionally measured by looking at credit scores... looking at people's credit reports with TransUnion, Equifax, or Experian. People are probably familiar with these [organizations] that track people's debts. Sometimes, if you don't pay a medical bill, the hospital or other medical provider, or the debt collector, will report that to the credit score bureaus. And then it goes in the credit report. And then that data set is used, and people look at that and say, "Well, how many people in America who have a credit report have an unpaid medical debt?" The issue with that method is that it undercounts, by quite a lot, the number of people who go into medical debt. It doesn't count, for example, people who use their credit card to pay off a medical bill. That would be counted as credit card debt, not medical debt. So we asked people in the survey that we did, not only whether or not they had a bill that they couldn't pay, but if they were on a provider payment plan. I would argue that's also a form of debt. If you're paying off a medical bill over time, you're in debt, the same way that you would be in debt to your auto dealer, or you would be in debt for the refrigerator that you bought. We also ask people about credit cards. We asked them about loans that they may have taken out, sometimes from subprime lenders but also from their friends or family, which is a particularly corrosive form of being a debt. Maybe there is an expectation that you pay back your father, or your uncle, or your grandfather for that medical bill. Who knows? But you are borrowing, and when you put all that together, you get 41% of U.S. adults having some form of health care debt. That equates to about 100 million people. If you asked people if they've had any debt in the past few years, you would get an even higher number. More than half of them would report being in debt at some point.

Heather Howard 13:37
And this is uniquely American, right? A function of our system. Do you see this in any other country?

Noam Levey 13:46
[Medical debt] is so rare in other wealthy countries that they don't even measure it. If you try to find out how much medical debt there is in Germany, for example, you wouldn't be successful. As you might imagine, the German government tends to gather a lot of statistics, but this is not something that they track. And if you look in England, for example, where they do ask questions about being in debt for

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some kind of medical expense, the number is lower than the amount that people owe for gambling. This problem of medical debt just doesn't exist in any other industrialized, wealthy country.

Eva Stahl 14:21
Noam raises a really good point, which is that, you know, it's really important to have the pulse of what's happening. And the data is a problem. So that if we are centered on the issue of credit reporting, which we often have been, and many reports rely on this data to be able to illustrate the prevalence of medical debt, we have to acknowledge that it's inaccurate. There is so much debt out there that's not being recorded, and we have no systemic way to be able to understand the breadth of medical debt across the country because we just don't track it. We don't have good data for it.

Heather Howard 15:00
So, Eva, we've talked about the financial impact of this medical debt. But can you talk about the health impact? You were seeing people delaying care, and even being sometimes denied care. Can you tell us more about that?

Eva Stahl 15:16
There are a number of surveys that ask this question consistently, about people delaying care, forgoing care, and it is incredibly high. In a poll that we just did with the American Cancer Society and Leukemia Lymphoma Society, we found that close to 90% of people with medical debt delayed or forewent care in the last two years. So we know that medical debt is a deterrent to getting the care you need. That's highly concerning. When you look at the people who are carrying medical debt, you see people with chronic conditions, people in lower income brackets. These are the folks that are really carrying medical debt and also need access to health care. If we're burdening people with medical debt, then they're not going to see their doctor and get well. So it creates this endless cycle that affects people's health outcomes over the long run.

Heather Howard 16:10
Noam, I think you've also chronicled that sometimes providers won't provide care. What are you seeing on that front? Are hospitals saying that you can't make an appointment if you have an outstanding debt?

Noam Levey 16:22
It is a surprisingly frequent problem that people report. We found [in our survey] that one in seven people with medical debt said they had been turned away because of money they owe. And we looked at the kinds of policies that hospitals have to collect from people, what kinds of things they will do. Will they sue people? Will they sell patients' debt? Will they deny non-emergency care to patients with outstanding balances? We found that probably more than one in five hospitals have policies to turn people away with outstanding bills. They can't do that. To be clear, they can't do that. Hospitals can't turn people away who are having emergent medical condition, like people who show up in an emergency room after a car accident. But they can turn you away if you are a cancer patient and you need chemotherapy.

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Heather Howard 17:19
Even though hospitals often have charity care obligations? Eva, I know this is something you've worked on over the years.

Eva Stahl 17:24
Yes. And I would add that part of it is stigma. That's what we hear from beneficiaries. We had a story a couple of weeks ago about someone that said, every time they drive by the hospital where they couldn't pay the bill, they felt anxiety and hot. They didn't want to go back there. So when they did need care, they drove farther away to a different setting to get access to the health care, because they were ashamed and embarrassed that they couldn't pay the bill at the first location. So that's part of it, too. How do we disrupt some of the stigma around medical debt, which we think is really important. But to your point around financial assistance, yes, it is an obligation through the Affordable Care Act that nonprofit hospitals provide a financial assistance policy. It is largely left to them to decide the contours of this financial assistance policy. It's supposed to reflect the community's need. How those are operationalized varies dramatically. Some hospitals that are larger institutions are able to screen presumptively and move people into financial assistance with greater efficiency and accuracy. But a lot of people fall through the cracks and find that these applications can be quite burdensome... that they're asking for too much information, and people can get stuck.

Heather Howard 18:44
So in terms of who gets stuck, you mentioned that it's largely people below 400% of poverty, but the data also show that it disproportionately affects communities of color, isn't that right? So in effect, it's exacerbating the racial wealth gap. Can you talk about that, Eva?

Eva Stahl 19:04
Sure. It does disproportionately affect households of color. And pairing that with not expanding Medicaid is hugely problematic. Part of what's driving the high debt numbers in some of these states is that they haven't expanded Medicaid. So when you have a huge swath of your population that has no access to coverage, under 138% of the federal poverty level, that means you're going to have to rely on charity care to fill those gaps. So you've got those two policies, or problems, working against each other sometimes when you're trying to make sure that people have access to care and coverage.

Heather Howard 19:44
This is all pretty staggering. But we shouldn't despair, right? Because in some ways, there's exciting policy innovation happening across the country on this front, and I'd love to explore it. Noam, if I could start with you, you've been chronicling what the Biden administration has been proposing to address medical debt? Can you help us understand what's happening at the federal level? We'll explore the issue at the state and local level as well, but let's start with what the Biden administration is doing.

Noam Levey 20:13
One of the things that's been really interesting to watch over the last couple of years is how the Consumer Financial Protection Bureau has taken a really intense in this issue. The Biden administration in general, and the White House specifically, has expressed concern and directed HHS to look at some of these issues, like how hospitals are providing financial assistance. But it is the

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CFPB, this agency that was kind of created out of the 2008/2009 financial crisis to deal with problematic mortgage underwriting and securitized mortgages and so forth, that has become the tip of the spear, if you will, for the federal government in addressing medical debt. And what they're doing is pretty interesting. Number one, they've started to look at the burgeoning industry of financing patients' medical bills. This is America. There's always a buck to be made somewhere in the process, right? You've got hospitals that are trying to collect from people, and people who can't pay their bills, and companies that are coming in and saying, "Oh, we'll take care of that business for you. We will service that loan, and we're going to tack on five or eight or 10, or 15 percent interest on top of that." So CFPB is looking at how that works. Because a lot of times patients don't understand what they're getting into. And there are some pretty unsavory kinds of ways that these lenders operate, frankly.

Noam Levey 21:48
And then the other thing that Eva mentioned earlier is looking very closely at how medical bills are reported to credit reporting agencies. It's called furnishing, and there's growing evidence, partly from CFPB itself, that shows that medical bills, or medical debt, isn't a particularly good predictor of people's overall credit worthiness. And so, if the point of having a ding on your credit score is to help a lender assess whether or not you're a good risk, and medical bills, unlike credit cards or auto loans or other kinds of bills, aren't so good at helping, then maybe medical bills shouldn't be on there at all. Just last month, CFPB announced that they wanted to look at actually issuing new regulations that would prevent medical bills from going onto people's credit scores, which would be a pretty major change and could potentially help millions of people get a job, or an auto loan, or rent an apartment. That would be pretty pathbreaking if they do that.

Heather Howard 22:53
But you seem to indicate that you expect opposition to those regulations from CFPB, right? This is just the start of the regulatory process.

Noam Levey 23:02
This is just the start. And yes, there are already indications that medical providers and, of course, the collection industry itself don't like this. Some of that opposition is just what you might expect when a government regulator steps into a space. Generally, the people who are playing in that space don't like the company. But there are some issues that they've raised as well, which are sort of interesting to think about, I think, because if you start taking away tools that providers use or think they need to use to collect from people, can you have unintended consequences? For example, is a hospital that can no longer report people who don't pay their bills, and can't get paid that way, going to demand that patients pay upfront? Or are they going to shuttle somebody off into a credit card or medical credit card more readily? And does that have unintended consequences? Those are sorts of things that will have to be explored further and balanced as this kind of rulemaking process goes forward.

Heather Howard 24:04
Eva, you're at RIP Medical Debt. I bet a lot of our listeners are not aware of the really interesting model that you follow. Tell us how you buy down and relieve people of their medical debt. Then we'll explore where you're doing it.

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Eva Stahl 24:17
The model is really flipping the script of the debt buyer. And the founders of the organization actually were two debt buyers. Part of it was to approach, as a debt buyer would, the purchase of a portfolio of debt at a very low price. Debt is cheap. So when you go to a hospital or provider, which is a little bit of an evolution of our model. We started just buying from the secondary debt market... buying from other debt buyers that had bought these big portfolios of patient files of debt and hoping to be able to collect on some of it. So buying it at a very low price. We would buy those portfolios of debt and use fundraised dollars to match with it, and then send people letters saying that they no longer owe this debt, which has been abolished. We've actually evolved quite a bit over the past five years. Now our goal is actually to work with both providers and hospitals, because we want to get closer to when those medical bills go unpaid. We're mitigating the harm of medical debt, many of the harms we've talked about, very focused on how people delay care and their mental health. By purchasing the debt from those entities, from hospitals and providers, it's the same type of model as buying portfolios of debt for pennies on the dollar. For every dollar you donate, you can abolish $100 worth of medical debt, on average. We bring in all that debt, and we send out letters to let people know that that their debt has been abolished. In those letters, there's an invitation, with a QR code, to actually come back to us and be a part of our community, to engage with us and tell us their stories. We have an in-house anthropologist who collects all these stories and tracks trends of the stories over time, so that we really can begin to understand the experience of medical debt for people across the country. In terms of policy work, that's what really drives our agendas... listening to our beneficiaries and creating a feedback loop.

Heather Howard 26:31
So the reason medical debt is so cheap is because there is an expectation is that they won't be able to recoup the debt.

Eva Stahl 26:37
Exactly.

Heather Howard 26:38
So they're torturing people and not even recovering the debt.

Eva Stahl 26:41
The debt is cheap because there has already been a lot of work to try to collect on the debt. And many of these people don't have the ability to pay. So it's pennies on the dollar.

Heather Howard 26:54
I was very excited to see that Governor Phil Murphy in New Jersey included $10 million in his state budget, using Covid relief funds, to propose a partnership with RIP Medical Debt. Tell us about that. I think they've estimated that could buy down a billion dollars worth of debt in New Jersey.

Eva Stahl 27:18
Yeah. We started in Cook County, Chicago, using American Rescue Plan Act funds. They approached us and asked, “Hey, this is a crazy idea, but could we do this?" That was our first government contract.

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And the way that it works is it sort of opens up a line of credit that we can draw down, to go and purchase debt from hospitals and providers in the state or in the community. And then leverage those dollars for that great return on investment, and let folks know that their debt has been abolished. Usually that's done over a number of years as we develop partnerships with providers in the community that want to participate.

Heather Howard 28:02
So you started with Cook County, but I think you've also done Pittsburgh and Toledo, and now hopefully New Jersey. Washington, DC is doing this, right? Is it largely governmental agencies? I think I've also seen that you're partnering with faith-based organizations sometimes.

Eva Stahl 28:20
That's how we started. Largely, they've been grassroots campaigns from the beginning. You have a lot of faith-based groups that like to raise funds and abolish debt. Individuals can raise funds and abolish debt. Students groups can, too. You can start your own campaign and be a philanthropist. That is the approach. The government work is relatively new for us. We're working with about 30 different localities or states now that are interested in doing this work. It's really in response to the growing narrative around medical debt, and reducing the stigma and the shame around it - a general acknowledgement that this is not the fault of the individual; this is the fault of the system. We just did polling showing that large majorities of people, regardless of background, firmly believe that this is not the fault of the individual. And that is a really important story that needs to be told. Because people need to understand that this is not their fault, that we have a broken health care financing system.

Heather Howard 29:22
The poll you did is very interesting. It shows that there's a lot of confusion about our health care system. People have trouble navigating it. So we'll put that in the show notes, too. In New Jersey, it's projected that $10 million will reduce a billion dollars in debt. People don't even have to apply, right?

Eva Stahl 29:50
That's correct. People can't apply. It's a little bit like the lottery. We partner and purchase that debt in bulk, and then people receive those letters. Our goal is that they know this program exists. So they open the letters. One thing we didn't really talk about is that when people get a lot of unpaid medical bills, or any kind of a debt-related bills, they don't open their mail. Part of it is that sense of isolation that goes with the mental health stress issues associated with medical debt. Our goal is to get people to open these letters and let them know that this debt has been abolished.

Heather Howard 30:01
Noam, I think there is research that you've written about indicating that people with debt have triple the incidence of mental health conditions, such as anxiety, stress, or depression.

Noam Levey 30:35
In fact, there's some interesting research out in Washington State, looking at people with medical debt who have cancer. They actually found that similarly situated cancer patients who have medical debt will die more quickly.

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Heather Howard 31:00
What's it like to cover these kinds of initiatives? Have you talked to people who've gotten the letter in the mail saying their debt has been erased?

Noam Levey 31:06
Yes. People are excited to get out from it. Earlier this week, I got an email from someone who is in her mid 50s, who had cancer when she was in her 20s. Twenty-five years and six months after she first went into debt, she paid off the last of her medical debts. She has lived with this debt for her entire adult life.

Heather Howard 31:53
Only in America. Given the underlying structural reasons for this debt, do you worry, Eva, that the people whose debt you're buying off, who might have a chronic condition, start accruing more debt the next day? You've dramatically improved their lives, but I guess that's why you opened by saying you also see the policy advocacy role.

Eva Stahl 32:13
That's exactly right. A lot of the letters and responses we get are about knowing that other people care enough to donate and get them out of this debt. It is really meaningful to them. We had a lovely interview the other day, where the beneficiary said that she keeps the letter on her desk to remind herself that other people care. Yes, it is only a blip. It's just a little bit of help, depending on the size of the bill and the circumstances of the person. But the greater hope here is that we are lifting voices and creating an ecosystem where we are generating pressure to bring stakeholders to the table to begin to solve the problem. Because there are numerous stakeholders that need to do that in order to solve it.

Heather Howard 32:58
So what does that look like? How do we actually address the cost in the health care system?

Eva Stahl 33:03
It's so many things. We look across three domains. It's really about how are we making sure that insurance works. High deductible health plans are crushing people. So are the high costs of health care. There's also the domain of how are we making sure that financial assistance is actually working for people. It's a sliver of help for people within the larger system of medical debt, but it's a really important one, particularly for low income people. And then how are we transforming the debt collection space so that people aren't harmed? We know the inequitable practices that are associated with that.

Heather Howard 33:41
And Noam, what about you? How do you see the tractability of the issue? Are you hopeful now, after being on this beat?

Noam Levey 33:46
That's hard to say. In some respects, yes. I think the excesses of the medical debt collection industry are getting overdue attention. And the shortcomings of the financial assistance and insurance structures to protect people are finally getting some much needed attention. I'm encouraged when I see what's happening at the state level in places like Colorado and Maryland, Oregon, and Washington. There are generally positive developments that are happening out there.

Noam Levey 33:46
You mean what those states are doing on costs and expanding?

Noam Levey 33:52
Yes, some of that. But even more specifically, on protecting people from medical debt and limiting what hospitals and other providers can and can't do. I think we could all agree, for example, about whether or not it is appropriate for a medical provider to put a lien on somebody's house. I would argue that's a debatable proposition. And maybe that's not something our medical system ought to be doing. But where I'm more worried is that, at the end of the day, as long as people are in health insurance plans that require them to pay 1000s of dollars out of pocket, before their insurance protection kicks in, people are going to continue to go into debt. Particularly at a time when so many people have chronic illness, these health plans and the way we have this system structured is a recipe for continuing the debt problem. I wish there was more discussion of that sort of underlying problem, which obviously is much more complicated, but that gets at the underlying prices that all the providers charge in our system. That's, I think, where we need to go.

Heather Howard 35:58
Eva, that's a good place to conclude. What's next for RIP Medical Debt? It sounds like you're expanding your network of where you're going to be working to buy down debt. What else?

Eva Stahl 36:10
We've been thinking a lot about how to better partner. When we go into a locality or state, how are we also identifying and dovetailing the abolishment approach with other services and supports? If you recognize medical debt as a social determinant of health, it should be part of that general system of support. How do we fit in to those places? We're looking at how we can continue building some of those partnerships and thinking collaboratively with those groups about how to leverage abolishment in a way that we can make sure people are connected to navigators, and they understand what coverage is and what financial assistance pathways could look like. So that's a lot of where our focus will be as we try to move it upstream.

Heather Howard 36:55
Noam, what's next on your horizon, on your beat?

Noam Levey 37:00
We have a few stories in the works, kind of looking at problems with medical debt collection and also debt industry -- what happens when people's medical bills get out there in the sometimes seedy world of medical debt collection. We're also looking further at the inadequacy of the financial assistance

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structure that hospitals have in place. If you go to one hospital, you're going get assistance. If you turn right at the light and go to another one, maybe you get sued and your wages are garnished. How is the patient supposed to know? That system is not working. So we're looking at some of that, and we're hoping to spotlight a few hopeful places, too, where various players in our health care space are figuring out ways to do this a little bit better. Hopefully that can point the way forward to some positive change.

Heather Howard 37:53
It's interesting. On this podcast, we usually have a researcher and a policymaker. Noam, on your front, you're neither, but you're both in some ways because your reporting is driving policymaking. And it sounds like the communication strategy you all pursue -- of lifting up these stories -- is really important to driving that policy change you're seeking, right?

Eva Stahl 38:15
Yes. The stories are really central to being able to amplify the problem. And it definitely has people talking. I think that is a hopeful space, where you see the Biden administration talking, and you have a lot of states that are taking action, as well as a lot of interested advocacy groups that are now taking up this issue as well.

Heather Howard 38:38
Well, that's an optimistic note on which to end. So let me thank you both. This was a terrific discussion. Anything we missed? Any substantive stuff that you would want to address?

Noam Levey 38:49
I guess one other thing. I don't know whether this fits in at all, but maybe you would agree with this. One of the hopeful things that I also see happening around the country -- less in Washington but out in the state legislators and state government around the country, this is sort of an unusually bipartisan issue. Not always. But we've lived for the last 15 years with health care being sort of Democrats and Republicans who aren't even talking the same language. But you see both Democrats and, interestingly, Republicans and a lot of states taking an interest in addressing medical debt. I think part of that is because people think about medical debt as something different than buying the TV or the Mercedes.

Eva Stahl 39:39
I was going to say there's such a strong sentiment. People really recognize that people are trying to pay their medical bills. There's this sense that individuals are making an effort to work, to pay their bills on time, and yet they're still getting into medical debt. Why is it that when you're doing everything right, you're still losing? That kind of fair question. And it's interesting. If you look at the end of the poll, at those 12 policies, across political affiliation, the numbers are high, right? They're like 80 plus percent support. So I do think there is this growing drumbeat. I don't think it's as easy to find collective support on the decision makers part? Will lawmakers actually agree and come together to solve the problem? But there definitely is pressure for them to do that. And it's reminiscent of the No Surprises Act, where you're going to feel the heat if you don't start to deal with this for people.

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Heather Howard 40:53
So that's a really important and hopeful note. When pretty much everything else in health care is politically fraught, to have found something on which people can agree. I was struck last year by Arizona's ballot initiative that would have capped medical interest rates on medical debt at 3%. It passed three to one, at the same time that every other election in the state is by a whisker.

Heather Howard 41:22
Well, thank you both. I hope this was fun for you, and we'll see you in person. Be well. Thanks, guys.

Heather Howard 41:48
Thank you for listening to the Princeton Pulse Podcast, a production of Princeton University's Center for Health and Wellbeing. The show is hosted by me, Professor Heather Howard, produced by Aimee Bronfeld, and edited by Alex Brownstein with additional support from Madison Linton. We invite you to subscribe to the Princeton Pulse Podcast on Apple Podcasts, Spotify, or wherever you enjoy your favorite podcasts.

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