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# Conversations with Physicians and Frontline Health Care Workers about Medical Debt

Insights from Focus Groups

Prepared for Undue Medical Debt

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**PERRY  
UNDEM**

# Background.

*Undue Medical Debt* sponsored four focus groups to gain insight into how primary care providers think about and interact with the medical debt of their patients.

PerryUndem, a non-partisan research firm focusing on health care issues, conducted the focus groups and analyzed the results.

We spoke with physicians and frontline health care workers from different parts of the country and different health care settings to hear how they view health care costs, how they approach medical debt in their practices, whether they discuss medical debt with their patients, and how debt impacts the way patients approach their own care.

Following are details about the focus groups.

# Methods.

The four focus groups were held in March and April 2024. Here are details:

- Three of the focus groups were with primary care providers (family physicians, internists, hospitalists, nurse practitioners) who practice in different types of care settings and with diverse patient populations; and
- One group was held with primary care providers (family physicians and nurses) who are part of the *Communities Joined in Action (CJA)* network. CJA is a membership organization and includes health care providers committed to improving health and health care.
- Each focus group consisted of 6-8 participants and included a mix of age, gender, racial background, and geography.
- NOTE: This research only included a small sample of primary care providers. The insights from the focus groups are meant to raise issues and questions but not offer definitive research findings.

# Summary.

**1.**

**Physicians and frontline health care workers believe medical debt is a serious problem among their patients.** Many worry about the far-reaching impacts of debt. They believe debt has become a bigger problem in recent years.

**2.**

**Medical debt concerns are impacting how, when, and if their patients are seeking care and following prescribed treatments.** The study participants mention an increase in the number of patients who delay or skip medical care/appointments or who stop taking medications and participating in treatment as prescribed. Some also believe more of their patients are experiencing poorer physical and emotional health due to worries about – or experiences with – medical debt.

**3.**

**Many say their patients are increasingly opening up to them about medical debt and cost worries.** Many study participants (but not all) feel conversations around debt are now part of their job, and they generally view this as beneficial as it allows them to find ways to help patients manage care and costs.

#### 4.

**Most study participants say they try to do their part to reduce their patients' costs when they can.**

They prescribe generics or give free samples, they/their staff direct patients to resources that can help, they avoid prescribing unnecessary tests, they will join an appeal on their patients' behalf, and many say they delay or parse out some treatments until future appointments.

#### 5.

**But some physicians and frontline health care workers push back and say it is not their job to worry about their patients' medical debt.** Their job is to give patients the best care possible, not worry about their health coverage or financial problems. They also point to practical barriers – that they are too busy, see too many patients, work with too many health plans and drug formularies, and simply can't keep up with the specific details of their patients' health coverage. Some also explain they lack the staff, resources and tools to help their patients avoid high costs or debt – for example, the EMRs they use don't give real time cost or coverage information for the medications they prescribe.

## 6.

**Study participants feel many in the health system are to blame for high costs and the rise in medical debt.** Health insurers, pharmaceutical companies, and others in the health system are driving high costs and they feel there is little they can do to address this problem on a large scale. A few feel patients play a role too – by not enrolling in insurance or not doing enough research before getting care. Of note, we observed physicians and health care workers in the focus groups don't tend to see themselves as a cause of medical debt – it's others.

## 7.

**Despite their own perceived limitations to curb medical debt, many study participants say they want to help where they can.** They are on the side of their patients and want to help them avoid high costs and debt. To do this, some say they want tools that could make these conversations about costs/debt easier with patients as well as more assistance options for patients who struggle with costs. Right now, many feel they are improvising these discussions, that they lack information about resources that could help their patients, and on their own to solve problems.

## 8.

**There may be policies that physicians and frontline health care workers would support to address medical debt.** We only tested policy ideas in the last focus group with the CJA-affiliated physicians and health care workers, but they liked many of them. This suggests there may be broader physician support for some of these ideas. The ideas with the most support include:

- Require hospitals to screen all patients for their financial aid program before attempting to collect on a bill;
- Hire navigators (including those who speak languages other than English) to help patients access resources and financial aid programs;
- Give patients more time to pay back bills and at lower interest rates;
- Cap interest rates for medical debt;
- Ban aggressive debt collection practices including liens on people's homes;
- Delay reporting of medical debt to credit bureaus;
- Cap the amount a patient would have to pay on a debt in a year; and
- Make home foreclosures due to medical debt illegal.

**Detailed Insights.**

**Physicians and frontline health care workers in the focus groups believe medical debt is a growing problem.**

**Medical debt shows up many ways for their patients.** Patients will mention receiving confusing bills or multiple bills for one procedure, denial letters for services, their inability to pay their co-pays or deductibles, or their significant debt from being uninsured.

**They believe medical debt is getting worse.** This issue is coming up more frequently with their patients more than it did a few years ago. Those who have been in practice for longer are more likely to note these changes around debt. They say their patients raise issues of debt and cost concerns often; these problems do not feel isolated.

**While medical debt is a problem across their patient populations, some physicians/health care workers believe it is hitting some populations harder.** They say debt problems are more pronounced among younger people, communities of color, newer immigrants, and those with high deductible health plans or no insurance at all.



## IN THEIR OWN WORDS: DEBT AS A PROBLEM

People get really confused about bills, and my patients don't speak English and so every time they get a Medicaid denial letter, even though it might be covered by Medicaid, they bring it in and they're anxious about it and it causes them a lot of stress...a lot of my patients just can't pay it, but then it becomes an issue because then they need some other procedure done, and sometimes...hospitals don't want to do elective surgeries if you owe them a lot of money. And so I mean debt definitely becomes an issue. – Internist, Ohio

[Patients] just hold off until the absolute last minute and then that's what usually happens...that's how this medical debt happens because they're not going to a primary care. They're not going to a Federally Qualified Health Center, which they could afford...They have no clue how to get involved in a program or what is out there as far as services...and they incur these debts, but they don't know anything else. They're just not educated with the whole healthcare system. – CJA-affiliated registered nurse, California

I personally think that medical debt is runaway. I feel like, over my career, there's always been medical debt. Larger and larger percentages of the people, the patients, the people in general are adversely affected by medical debt and the magnitude of the debt is runaway, astronomical. – Family physician, West Virginia

Everything's more expensive and because everything is more expensive they are feeling that squeeze, and so we have to get so much more creative with our diagnostic ordering and medication... everybody's feeling it; and that's an area where it's definitely suffering, for sure. – Nurse practitioner, South Carolina

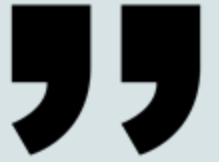
It seems like, for me it's intentional, I can't explain it otherwise, these insurance companies making their formularies so complicated, and not being transparent on what's covered. I think that's gotten worse and I think the consequence of that is patients are getting billed, because we're confused about what's covered, what's not covered. And yes, so I'm hearing more about patient's bills and medical debt. – Family physician, Pennsylvania

**Insurance is important, but even that isn't protection against medical debt.**

**Many acknowledge that having insurance doesn't mean patients are safe from debt.** They see many patients with health insurance who are struggling with debt because of high co-pays, lack of good prescription coverage, high deductibles, denial of services, hospital stays, etc. Debt is a problem across the board, and they feel it is only likely to get worse as these factors become more prevalent.

**Loss of insurance through Medicaid unwinding has made medical debt worse for some patients.** Some study participants mention the end of the public health emergency worsened cost pressures for vulnerable patients. They had patients who didn't know they needed to reapply for Medicaid; others received services without realizing they weren't covered until it was too late. Study participants also note that some patients who lost coverage put off care because of cost worries.

## IN THEIR OWN WORDS: INSURANCE COVERAGE



Unfortunately, health insurance is kind of a necessary evil these days, if you want to look at it that way...it's just every once in a while, you'll get that patient coming in and they're a self-pay and it just limits diagnostics, certain treatments and it makes the whole process a whole lot harder. On the flip side, there are those with health insurance with high deductibles, they're having a hard time fulfilling those deductibles. So it's difficult...you have to work it into every conversation with the patient essentially; What can we afford to do? What treatments are available to us? And it is absolutely as [much a] part of the treatment as I feel like the medicine is sometimes, just unfortunate. – Physician assistant, Montana

Even with their insurance they have trouble paying for their treatments like paying a copay for visits and it has this massive impact on the rate in which they show up at the office for... their treatment decisions, the medications. – Hospitalist, Mississippi

I would say high deductible insurances [are why people end up with medical debt]. They just can't afford it. They have to pay for their care up until like 3, 5, 7, 8,000 dollars, and so they just go into debt because of that and then they avoid treatment after that. – CJA-affiliated physician, Indiana

I just wanted to say also in my community, it's lack of insurance, or they don't know about resources or their resources like charity or all their financial assistance, they just don't know about it. So unless we educate them...while there's some other programs, especially for the ER or inpatient admission, they just don't worry about it. Because I feel like we have the population that worries about the bills and the ones that don't care. – Community health physician, Illinois

I think the problem is that insurance just really doesn't work for many people because of the cost, even when they have it. And so, it's hard to say that yes, they should get that, you should be insured when I know the reality is that it's not going to meet their needs. – CJA-affiliated physician, Maine

You can have insurance, but if you don't understand the type of insurance that you have it can be pretty useless and even harmful. Some of my patients have gotten private insurance off the Marketplace that had enormous deductibles and they didn't realize and then they get stuck with these huge bills that they didn't anticipate because they thought they had insurance. And it was partly because they didn't understand the type of insurance they were getting. – CJA-affiliated physician, North Carolina

## **Most physicians and frontline health care workers believe medical debt is harming their patients in a variety of ways.**

**More patients are delaying or skipping health care services.** Study participants say some of their patients are rationing medications or doing without them completely. Others say that some patients are not following through with specialist visits because they are worried about costs. A few physicians/health care workers told of instances when patients asked to be discharged early from a hospital or chose not to pursue a treatment because of costs.

**Some see a rise in patients not following through with prescribed medications and treatments.** Prescriptions are left at the pharmacy or patients are no-shows for certain treatments. Often these health care providers are not aware this happening until later on.

**There are impacts on health.** Study participants mention specific health issues that have worsened because patients were unable to keep up with needed medical services. They worry there are bigger public health effects of high rates of medical debt.

**Debt creates wider problems for many patients.** Some note that health-related costs create other financial concerns for patients around food insecurity, housing, etc., while a few mention the mental health toll of shame / embarrassment of debt. Pressures around debt are just not isolated to their health – the impacts ripple out into their lives.

## IN THEIR OWN WORDS: IMPACTS ON CARE



They're rationing their medication, especially diabetic medication. They're not taking it as prescribed. They're making it last longer. They're avoiding hospital care. I get pushed-back on a regular basis about ambulance transportation. So I think that could be summarized as, they're avoiding care. – Family physician, West Virginia

I've actually seen and heard some patients express shame...For example, they know that they've been told; hey, you need to follow back up in about three to six months so we can check on this particular condition that you have. And they'll say, I didn't want to come. I felt embarrassed. I have a \$600 bill with you. I don't want to come back. We don't stop them from coming, but it's the shame. There are those who really really care and they want to pay their debts and they don't want to be a bad citizen in society. – Nurse practitioner, South Carolina

I feel like it also affects their health, because they just don't seek the care that they need. So they either end up with no medication, no follow-ups, and when they come back...I had a patient maybe two years ago. He never went to the doctor he had diabetes and hurt his toe, so when he came, he needed to get it amputated because it was so bad. – Community health physician, Illinois

It's a huge deal. Even yesterday I had a patient [with] right lower quadrant pain, huge, huge, concern for appendicitis...and the first question was, if I just don't do anything about it or, maybe I'll sleep a little bit more today, is it going to go away, because I just don't have the money to go into the big city and get all the treatment for this. So it's something that definitely bothers me, and it's dangerous to my patients as well. – Physician assistant, Arizona

People define medical debt differently, but for people in Maine, for example, who live in really rural counties, I think it's fair to count transportation costs as medical debt...I've worked with cancer patients who have felt like [they] can't afford treatment, but a huge part of that was the transportation cost, logistics, needing help at home. – CJA-affiliated registered nurse, Maine

We've had patients with very early cancers who come back a year or two later with metastatic cancer, because they couldn't follow with oncology. We see patients in diabetic ketoacidosis who are supposed to follow-up, come back a month later in the same condition, because they couldn't follow-up. Yeah, that's a really common story in healthcare. – Internist, Utah



## IN THEIR OWN WORDS: IMPACTS ON CARE

I see that a good bit out here as well either not picking up their prescriptions or, I do have a few patients that have told me they end up kind of rationing out their prescriptions in order to save some money. So, you know medication that they should be taking twice a day they'll take maybe once every other day and then end up having more and more expensive issues pop-up down the road because of it. – Physician assistant, Arizona

As soon as I hear medical debt I start to think, okay this patient is probably not going to get their mammogram, they're probably not going to get colon cancer screening. If they have a lot of debt and they're worried about accumulating more, they're certainly just not going to do preventive care. So that's where my mind goes with that. – Internist, Indiana

## **Some have patients who have been denied services because of debt.**

**Some study participants mention instances where patients have been turned away because of outstanding debt.** They talk about patients who cannot go back to a specialist because of previous bills. Study participants do not feel this is happening often, but they acknowledge some patients put off needed care because specific doctors are denying care until their debt is cleared. Others mention that some patients just avoid follow-ups because they are embarrassed about outstanding debt.

**While instances of denied services were limited, it speaks to the larger systemic issues we know exist.** Study participants say their institutions / practices have different approaches to patients with debt – and usually it does not involve turning patients away. But they are aware of situations where this happens. And, they recognize it is probably happening more than they realize (even if they aren't doing it themselves).



## IN THEIR OWN WORDS: DENIED SERVICES BECAUSE OF DEBT

I personally have seen people turned away...they don't put it on the doctor to do that or the provider. In other words, no we don't refuse their care, but they don't make it past the front door. – Family physician, West Virginia

The copays with the specialists are often a problem as well. So I'll have somebody that definitely needs to see a cardiologist, but they have a bill there and they're either too embarrassed to go back or they're not allowed to go back until that bill is paid or balance is paid. So that causes a lot of issues with these specialty copays. – Nurse practitioner, South Carolina

I've seen other places like eye care, say, which we don't have. And people who have eye care needs, but have accumulated debt can't be seen at those facilities. – CJA-affiliated physician, Maine

When a patient comes to our clinic and they haven't paid their bills, the front desk will ask them to first pay out before they can [be seen] and if they cannot, they are denied the visit. – Family physician, California

## **Many say they talk to their patients about medical debt and costs concerns.**

**Debt conversations are becoming a bigger part of their appointments.** These physicians and frontline health care workers say they are talking about debt more than they have in the past. It is weighing on the minds of their patients – and is becoming a frequent subject during appointments.

**Some proactively have conversations with patients about debt / cost of services.** These study participants say they initiate debt / costs discussions with patients in hopes of helping their financial situation – as well as ensuring they stick with a care plan. They feel it is part of their job at this stage, especially as cost pressures continue to increase. They want to make sure patients are not jeopardizing their health because of cost and debt worries.

**Other study participants are discussing debt, but it tends to be driven from the patient-side and not always a comfortable conversation.** Some of these study participants are less comfortable talking about finances, so they lean on resources in their practice such as nurses, front office staff, financial counselors, social workers, or EMR cost suggestions. They wait on patients to bring up cost concerns, and then try to help them find solutions. But, it does not feel natural for them and some feel it isn't really their place to insert cost into care discussions.

**Some physicians and frontline healthcare workers don't feel it's their role to address medical debt with their patients.**

**Some study participants push back on having conversations about debt at all.** They list different reasons they don't talk about these issues: they are too busy, see too many patients, or their appointments are too short. Others say they work with so many health plans and drug formularies – and they simply can't keep up with the specific details of their patient's health coverage. From their point of view, these factors make it too difficult / not worthwhile to have conversations about debt with their patients. A few feel it simply isn't their job; they think their time is better focused on delivering quality health care.

**Some explain they lack the resources to help anyway.** For example, a few study participants say the EMRs they use don't give real-time cost information. So, they wouldn't be able to provide patients with accurate / helpful data to guide decisions around cost / care.

## IN THEIR OWN WORDS: INITIATING DEBT CONVERSATIONS



I feel like it comes up if they feel like it's going to affect their credit. If they feel like it's going to affect them, they want to do something about it. They want to apply for financial assistance because they feel like it's going to go to collections. – Community health physician, Illinois

I was going to bring that up. I'd say in terms of frequency for my patients, it's probably about 50% will bring up medical debt on their own. I have a pretty even split between kind of, a lot of retirees out here, a lot of military retirees. Tri-care is a pretty easy thing to deal with, but my undocumented [patients], the other 50% medical debt pretty much comes up in every conversation and so, about 50% and it's usually by them. – Physician assistant, Arizona

If a patient, for example with an acute asthma and needs admission, if you tell the patient hey, you need to be admitted. Oh, doc, I don't want to go to hospital, I can't afford all those bills. That's the immediate response we get from most of the patients because they're worried about, the future bills that they get from hospitals, different people. So they even want to postpone the treatment, or go for a different way or a less aggressive way. – Hospitalist, Michigan

It depends on the patient because everyone that's on my caseload, we do a social determinants of health, it's like a questionnaire. So that kind of gets them kind of talking about things. And then we do a needs assessment. So in their needs assessment, we ask about income, health insurance, things like that. So that that kind of opens the door. So for some people, they'll just be more like forthcoming in saying; you know what, I have all these bills and I don't know what to do, and that kind of leads to another conversation. – Community health physician, Michigan

I would say I'm usually the one initiating it. As soon as I'm meeting with the patient on my screen, I'll see what kind of healthcare they have, what their health insurance coverage is. So if it's Medicaid I essentially, I don't bring it up too much...but, if I see they do have a private insurance, I ask them, especially if we're going to be ordering a CT or an MRI or something like that, and I'll say if you don't mind, let's talk about your healthcare coverage and where you're at in your deductible and those conversations. – Physician assistant, Montana

## **Trust and care setting play a role in who is having these conversations.**

**Study participants feel patients are more comfortable discussing debt if they have built trust.** Those who have been in practice longer, do home visits, or work in smaller / rural settings seem to have formed stronger bonds with patients over time. And, they feel this connection / trust allows them to discuss more sensitive topics such as medical debt / financial insecurity. These study participants also talk about the extra work (i.e., longer appointments, follow-ups, connecting with resources, etc.) they do to help these patients navigate these issues.

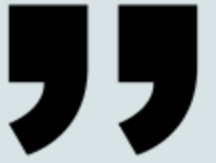
**Some believe provider setting also makes a difference.** These study participants acknowledge that primary care providers / family physicians / long-term specialists are more likely to discuss debt with patients than others – especially those in a hospital setting.

**Physicians and frontline health care workers say they have some patients who don't want to talk about debt or costs.**

**When the patient is reluctant to raise costs concerns, physicians and other health care workers say they don't want to force the conversation.** They think some patients are embarrassed or feel stigma around debt. Others feel patients would prefer to talk with administrative staff or handle things themselves instead of speaking with them about debt and costs.

**Still, many study participants say patients are more assertive around cost conversations than they used to be.** They feel many patients have to be more pro-active because they are financially strained. Study participants believe these patients have no choice but to consider costs and potential / ongoing debt when thinking about services. This seems like the new reality as patients feel it is necessary that they advocate for themselves – not just about type of care but also cost of care.

## IN THEIR OWN WORDS: DEBT CONVERSATIONS AND TRUST



I go to patient's homes, so I practiced for many years in an office; and it's a different experience when you go into their homes and actually see things like food insecurity and hoarding...when they come to an office or to a hospital, they're putting on their best, if they can. When you go to their homes and you can see their dogs, and their family, and all of that, you see what's transgressing in those situations. – Family physician, Michigan

I have a long patient relationship with my patients in the rural community. I mean, I've been seeing these people for years and they tend to trust me. And if I say usually why something's needed and they can do it, they'll do it...They're usually pretty open with me as well. – Nurse Practitioner, South Carolina

With patients, they trust me and they bring me the bill personally because they can't get through anywhere else. It's a 45 minute wait with the billing office. They get conflicting information, there's nothing else, the insurance company they wait on the phone for two hours and get nowhere. So, they trust me because I'm their physician, and there's no other option except bring it up with me, which is kind of depressing. – Family physician, Pennsylvania

It may not always be debt, but as much as just cost. So like, if I see that someone hasn't filled their meds and they haven't been taking things consistently, I really like to ask just a direct question like; are you having trouble affording your medication...it's very different whether someone's forgetting to take their meds versus can't afford it. And so I like to know what the reason is behind noncompliance. And then I really try to bring up the conversation in that if you ever can't afford a medication that I give you, please let me know because there are alternatives. – Internist, Ohio

I think our patients are very appreciative when we talk to them and they feel we're showing empathy towards them and they'll open up more also, you know. – Hospitalist, Illinois

For me, a huge one is just building rapport. I think unlike a lot of people here, I don't have 15-, 10-minute appointments and all that stuff. Sometimes I can spend an hour with people, so building rapport is huge. And in that time, I've found that really explaining the why we're getting something. Maybe it doesn't make it more affordable, but it makes it at least a little bit more palatable. – Physician assistant, Arizona



## IN THEIR OWN WORDS: DEBT CONVERSATIONS AND PROVIDER SETTING

I think having the medical debt discussion or financial concerns discussion in an inpatient setting is different than an outpatient setting. I think people probably feel a little bit more under duress to do what is being recommended on the inpatient setting versus an outpatient setting and potentially be more willing to compromise in terms of what needs to get done on an outpatient setting. So I think it's a little bit of a different discussion. – Hospitalist, Virginia

Now I've switched over to direct primary care, that is one of the main focuses. [Patients] come to me because they're concerned about bills and they want to save money. And so, I do have discussions with them quite a bit and I have a longer time to spend with them, typically 30 minutes to an hour. – CJA-affiliated physician, Indiana

## **Physicians and frontline health care workers feel there is a lot of blame to go around for medical debt – but don't tend to see themselves as a cause.**

**Some blame health insurance and prescription drug companies most for rising costs.** They specifically mention the growth of high deductible health plans as another factor in increasing medical debt.

**Some also feel the lack of cost transparency makes it harder for patients to choose wisely when it comes to health care.** Others point out health costs differ significantly depending on region / area, which makes it even harder for patients to know what care will cost.

**Some think non-English speakers find it harder to navigate the health care system and avoid high costs.** They see these patients as more vulnerable to medical debt – and less aware of financial assistance programs that could help.

**A few also bring up the role of patients in debt.** Some talk about patients who decide not to get health insurance because they are young and healthy (and then get hit hard when something bad happens). Others think that patients do not do enough research about the cost of care before seeking costly treatments.

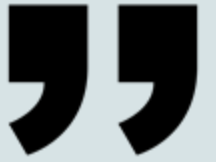
**They don't mention themselves as a cause of medical debt.** Rather, they see other parts of the health system – including patients – to be driving high costs and debt. They feel they have little power in this system and believe they have little control over costs.

**Most feel they can help on an individual patient level, but larger change is out of their hands.**

**Most study participants feel they have some power to help individuals with debt / costs, but they are limited beyond that.** Most feel they can make an impact with specific patients through conversations, checking insurance coverage, giving information on assistance programs, etc.

**But this does not address the overarching debt problems.** Study participants feel larger change needs to happen on the federal / state level to tackle high health care costs and the rise in medical debt

## IN THEIR OWN WORDS: THEIR POWER



I can make a difference within my practice. I don't think I can make a difference on a national or state level...I have an intimate relationship with my patients. There's a trust level there, and I'm running a business, so I have some level of knowledge of budgeting and economics, and a lot of people don't know how to budget their money. They are uneducated, and they're in a low socioeconomic area, and they get money, and they go out and spend it. I mean, they can't pay their rent and then they lose their home. So I'm able to speak with those people in a family way. – Family physician, Michigan

Yes and no. I mean, the big thing would be again, know what I can prescribe my patients and make sure it's cheap, it's affordable and it's something they can pick up. So that's kind of a big thing. And then when we just [think] nationally, I don't think I can do much, unfortunately. – Family physician, Pennsylvania

The thing is, as clinicians in our clinical role we don't, we have very limited ability to really do anything about the status quo aside from commiserate with our patients, and make good choices as well, but we're not changing the pricing and or anything really. – Internist, Utah

Your debt is your debt. So I mean we can try to reduce further expenditures by prescribing differently, but your debt is your debt. And with the Epic flag if I were to be told that the patient who I'm about to see is in a lot of debt, I'm not sure what I would say. I'm not sure I would say anything besides acknowledging that that's painful and might affect their behaviors and what not. We're not in a position to do anything about it. – Internist, Utah

Sometimes it's the doctors. Ordering a lot of unnecessary testing is a big one...you know maybe repeat labs that aren't needed, imaging that isn't needed. We rely so much on the test to tell us how to diagnose sometimes that we don't need it, and I think that also drives up a lot of costs. – Nurse practitioner, South Carolina

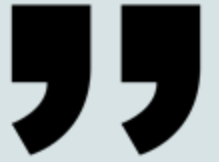
When I'm prescribing a medication and I already know it is a high copay because of previous experiences, because the pharmacy or the patient called us. So I tell them it's a high copay, and if they can afford it or not and we try to find an alternative drug by pharmacy or if we have a sample, we try to give that to the patient. – Family physician, California

## **Some physicians and frontline health care workers look for ways to help their patients manage costs or reduce their medical debt.**

**They use a number of strategies to help patients.** This includes prescribing generic or alternative drugs which are cheaper; giving free samples when available; deciding against ordering tests that aren't as necessary / urgent; pushing off services until the next appointment (especially with uninsured patients); helping them appeal a health insurer decision or fight a denial; suggesting programs that could help with costs such as GoodRx or helping them access manufacturer discounts.

**Some also try to connect patients with resources within their practice / larger system.** This can involve connecting patients with financial counselors or administrative staff that can answer questions. Some also try to leverage resources like charity care that could offer some level of relief.

## IN THEIR OWN WORDS: RESOURCES / HELPING PATIENTS



When we said discharge planning on day one, when the patient comes in, I have the social worker text me, could you put in an order for the patient to go back to nursing home or if they need it? So they start looking into it from day one. So I think that makes things very easy. So sometimes if patients have to pay out-of-pocket too, and that's not an option, we start, way ahead of their discharge to find some other options or family members or caregivers, whatever we can. – Hospitalist, Illinois

A lot of patients struggle with affording their medications. So we're spending time during their appointment looking up like manufacturer coupons, and signing them up for different programs and things of that nature. So it's vital, but like was already said, it does definitely doesn't cover everything that patients need for care. – Family physician, Georgia

It's more hospital driven. So I think it's if a patient has a concern, I think we just tell them that you can talk to the financial people about payment plans or to discuss your bill. It's the same thing. It would be more like a patient's like, oh my gosh, look at this bill. And a lot of times, again, I'll send them to the social worker and then she will tell them; you can go to these finance...to the hospital and discuss it. – Certified Midwife, Texas

We always send test strips down before we start anything, especially upon discharge so we know what it will cost. We also have pharmacist whose sole job it is to run all the medications to make sure that copays are reasonable and if they're not, they provide alternatives. So they come and talk to the patient about what their options are and if things are not affordable then we have alternatives for them. And we have a whole team that kind of handles that on the inpatient side of things. – Hospitalist, Virginia

I know we have financial screeners, I'm just not intimately involved with their process. When somebody gets admitted they do look at that, and especially if they've come to the hospital before and they have had difficulty paying. They have people that will approach them and discuss with them various options, including payment plans and other financial hardship forms that they can fill out. I'm just not involved with that and personally, I think it's for the best. – Hospitalist, Virginia

I think the flip side of that is certainly you can ask the [social determinants of health] questions, but if you don't have resources or a plan or a way to help people in this area, then how are you really helping them by even asking. – Internist, Indiana



## IN THEIR OWN WORDS: RESOURCES / HELPING PATIENTS

I always give them cards. Yeah, I have Good Rx, which is like we get it sometimes and I just give it to my patients at the time of discharge so that they have that option, and they are more aware. Some of them are not just aware of it, or it could be just simply making them aware that it exists. – Internist, Michigan

For medication sometimes we have a discount card from the manufacturers so they can get one year of refills free or something, so we have that. And they sometimes drop us the samples because they are introducing this new medication and they know it is expensive because they still need to get contract with their different insurances. – Family physician, California

The more comorbidities a person has, the more medications they're taking, the more visits they have to do with me. Like a person with diabetes, has to see me every three months, technically. And the more specialist ideally, they would see. But often patients who have trouble with affordability, I just don't refer them, and I just deal with it by myself. – CJA-affiliated physician, North Carolina

I think for me, medication's a big one. I would love to have more help with medication, especially when you get into this drug. You can get three months free with this coupon and this scanning and that type of thing and go to this pharmacy and avoid that pharmacy. Like there's just no way we can remember all that. So that would be helpful. Meds for me are a big one. – Nurse practitioner, South Carolina

When I'm making my care plans with patients, give them option A, option B, option C. That I think when I was trained it was sort of like treat every patient the same no matter what, without a cost-conscious mentality, is one of those schools of thought. But I think in my space I sort of say here's option A, option B, option C and I give general frameworks of; we could do a CAT scan or we could wait a weekend, you know, this is the relative cost burden of that, of waiting and potentially having an issue, or we get this up front and we'll know the answer now. – CJA-affiliated physician, Washington

**Few physicians or frontline health care workers in the focus groups have received any training or guidance on medical debt. They seem open to help on this issue.**

**Most say they are improvising.** When cost/debt worries arise, most study participants say they feel on their own to solve them. Simply having the discussion with their patients can be hard for some physicians/health care workers. A few, though, have had training / presentations from social workers / counselors about issues of debt and cost which helps.

**Most want more resources and training on medical debt.** Study participants acknowledge that the need to have medical debt discussions and frank conversations about costs/affordability is not going away anytime soon and many want to get better at them. Most would welcome additional resources or help.

**But a few reiterate this simply should not be their job.** They became doctors to provide care for patients, not to help them with their finances. This frustration boils up across the groups. While most acknowledge medical debt and affordability concerns are a reality in health care today (and isn't likely to change), they still feel it falls outside of their job description / mission.



## IN THEIR OWN WORDS: TRAINING

We teach the residents as they do their continuity clinic. So like this comes up, obviously, as they're seeing patients in my clinic, and so we're walking them through that, and one of the things we actually evaluate them on is, are they taking into account cost of, who their insurer is when they're talking about what they're ordering and doing and stuff like that. But I do feel like it's not formal. I don't think they're getting lectures on it, but as they're rotating through our clinic, at least the people and at my institution and all the different FQHCs, they are getting some training in that. – Internist, Ohio

I was just going to say simply I've had no training on this in med school or residency in any form, in a lecture or small groups setting at all. – Family physician, Pennsylvania

I feel like I shouldn't have to be doing this, but I know that I have to do this. I'm a biller, I'm an accountant, I'm, you know, I'm a private practice physician, so I'm running all of this stuff. I don't want to do any of that. I just want to do the medicine, but here I am. – Family physician, Michigan

I've never seen any [resources] anywhere, and I've been in multiple places. So...you just teach yourself. Because I've been slapped with those bills and you want to educate other people. But no, I've never seen any tools, ever. – CJA-affiliated registered nurse, Ohio

**We tested policies to address medical debt in the focus groups with CJA-affiliated physicians and frontline health care workers. Many of these ideas received strong support.**

**These CJA participants are especially supportive of ideas that focus on curbing interest rates, delaying credit reporting, and giving patients more time to pay back bills.** Policy ideas that directly help patients seem to have the most appeal. They like ideas that could lessen the pressure to pay back bills quickly or reduce the financial burden if patients have to carry some debt.

**But they were less supportive of ideas that could be seen as potentially impacting their practices.** They had questions about policies such as: making all health care providers offer charity care, establishing uniform criteria for financial assistance, etc. Some are unsure how these policies would work and whether it could impact their own practices. They do not oppose these ideas, but they want more information to alleviate these concerns.

# Policy ideas tested...

## Policies They Support

- Have advocates or navigators, including those who speak different languages, available to help patients complete financial assistance forms and access other resources to help lower their medical debt.
- Give patients more time to pay back bills and at a lower interest rate.
- Cap the interest rate allowed to be charged for medical debt.
- Ban aggressive collection practices such as suing people, taking their assets (i.e., homes, cars, etc.) or garnishing people's wages.
- Place limits on extreme debt collecting efforts like liens on patients' homes.
- Delay reporting of unpaid medical debts to credit bureaus until one year after a patient is billed.
- Cap the amount a patient would have to pay in a year (for example, a limit of \$2,300) towards their medical debt.
- Make hospitals screen a patient, both the insured and uninsured, for its financial aid program before attempting to collect on a bill (i.e., ensure those who are eligible for financial support can get it).
- Make home foreclosures due to medical debt illegal.

## Policies That Raise Questions

- Require all hospitals and their health providers to offer charity care (i.e., free or discounted health services for people who meet a criteria for assistance).
- Establish a uniform criteria for who can access hospital financial assistance (i.e., patients with SNAP / food stamps, people who are experiencing homelessness, and people with Affordable Care Act (ACA) / state marketplace plans).
- Make more health care providers offer financial aid programs.

**PERRY  
UNDEM**