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**for the Hearing**
**"What Can Congress Do to End the Medical Debt Crisis in America?"**

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Chairman Sanders, Ranking Member Cassidy, and members of the committee, thank you for devoting your valuable time to addressing medical debt for Americans. It is my honor to participate in today's hearing. Thank you for giving me the opportunity.

I am Ge Bai, a Certified Public Accountant, Professor of Accounting at The Johns Hopkins Carey Business School, and Professor of Health Policy and Management (joint) at The Johns Hopkins Bloomberg School of Public Health. My research expertise is in health care accounting, finance, and policy. I am affiliated with the Johns Hopkins Center for Health Services and Outcomes Research, Hopkins Business of Health Initiative, and Johns Hopkins Drug Access and Affordability Initiative. I served as a visiting scholar at the Health Analysis Division of the Congressional Budget Office from 2022 to 2023. I have published numerous research articles in leading academic journals regarding healthcare pricing, affordability, charity care, and medical debt.

My testimony has three sections: (1) identifying the root causes of medical debt, (2) analyzing policy approaches that address the symptoms of medical debt, and (3) discussing how to treat the root causes of medical debt. I aim to provide an objective, holistic, and evidence-based perspective on medical debt. The opinions expressed herein are my own and do not necessarily reflect the views of The Johns Hopkins University or any of its subsidiaries or affiliated entities.

**Section I: The Root Cause of Medical Debt: High Healthcare Prices**

The U.S. has a medical debt problem but not necessarily a medical debt crisis. In February 2024, the Peterson Center on Healthcare and KFF estimated that 8% of U.S. adults have medical debts, and 86% of medical debts are below $10,000.[1] The majority of patients with hospital medical debts already have health insurance coverage.[2] The primary root cause of medical debt is high healthcare prices. In fact, the difference in the healthcare spending gap between the U.S. and other developed countries is also caused mostly by higher prices in the U.S.[3] In 2022, U.S. healthcare spending reached $13,493 per person.[4]

High healthcare prices in the U.S. are the result of government policies that 1) detach patients from our healthcare dollars, and 2) tilt the playing field in favor of large players. Such policies produced uncompetitive healthcare markets with large players who capture the legislative and regulatory process on the one hand and powerless patients not controlling their dollars on the other. The results are high healthcare prices, medical debt, low health outcomes, and an intimate coalition between policymakers and industry interests that continuously channel taxpayers' money to healthcare industry interests.

1) Detaching Patients from Our Healthcare Dollars

As my colleagues and I wrote in our recent article published in JAMA Internal Medicine,[5] insurance creates value by insulating enrollees against major financial risks. In the meantime, insurance entails administrative expenses for processing, adjudicating, and paying claims, imposes administrative burdens on physicians (for health insurance only), and reduces beneficiaries' price sensitivity. When financial risk exposure is low, the cost of using insurance outweighs its benefit. This explains why car insurance does not cover oil changes, and home insurance does not cover faucet replacements. If they did, the premiums would be excessively high and make such plans unaffordable and unmarketable.

However, many government policies have been pursuing the broadening of insurance coverage scope. Today, U.S. health insurance covers many low-cost services and products that do not impose major financial risks, such as primary care visits and generic drugs. As pointed out by the Congressional Budget Office,[6] insurance benefit design limits consumers' price sensitivity, thus leading to high healthcare prices. High healthcare prices further entail high premiums, high

[1] https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states
[2] https://amp-theguardian-com.cdn.ampproject.org/c/s/amp.theguardian.com/us-news/2024/jan/11/hospital-debt-increase-people-with-insurance
[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.22.3.89
[4] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical
[5] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2814226
[6] https://www.cbo.gov/system/files/2022-09/58222-medical-prices.pdf

deductibles, and low discretionary income. As a result, patients are increasingly exposed and vulnerable to medical debt.

2) Tilting the Playing Field in Favor of Large Players

As recognized by the Congressional Budget Office, hospital consolidation, both horizontally and vertically, is an important driver of high healthcare prices.[6] This phenomenon is caused by government policies that created an uneven playing field, favoring large hospitals and compromising small, independent physician practices, hospitals, and alternative facilities (i.e., ambulatory surgery centers and imaging centers). Examples include the 340B drug pricing program,[7] site-based reimbursements,[8,9] restrictions on physician-owned hospitals,[10,11] the Stark Law,[12] certificate of need (CON) laws,[13] certificates of public advantage (COPA),[14] Medicaid payment policies,[15] and Disproportionate Share Hospital (DSH) payment policies.[16] Certain hospitals are protected by government-erected entry barriers and government-granted competitive advantages. Such market positions give these hospitals little reason to lower their prices.

More generally speaking, as the reimbursement policies and compliance requirements from government programs become increasingly complex, providers' burdens for administrative and regulatory compliance rise in accordance, creating a regressive environment detrimental to small providers. For example, as my colleagues and I documented in our study published in JAMA in 2023,[17] a large academic medical center spent substantial resources each year on quality metrics reporting, with many metrics having little incremental value. The relative quality-reporting burden on smaller providers would be even greater, creating an uneven playing field and increasing their tendency toward consolidation.

Many might blame markets for high healthcare prices in the U.S. However, Congress should recognize that markets may have been prevented by government policies from functioning properly in the first place. As the U.S. economy grows, we face mounting risks that arise from government policies that further detach patients from our healthcare dollars (either earned or subsidized), and tilt the playing field in favor of large providers. If Congress does not correct

[7] https://www.nejm.org/doi/full/10.1056/nejmsa1706475
[8] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812610
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7839635/
[10] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2820716
[11] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2806510
[12] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2776935
[13] https://www.justice.gov/archive/atr/public/press_releases/2008/237153a.htm
[14] https://www.ftc.gov/news-events/features/certificates-public-advantage-copas
[15] https://www.healthaffairs.org/content/forefront/medicaid-financing-requires-reform-north-carolina-case-study
[16] https://manhattan.institute/article/untangling-the-hospital-safety-net
[17] https://jamanetwork.com/journals/jama/fullarticle/2805705

these government policy failures, more Americans will be subject to medical debt and other negative consequences associated with high healthcare prices.

## Section II: Policy Approaches That Address the Symptoms of Medical Debt

Some policy approaches address the symptoms of medical debt by writing off medical debt for patients (i.e., medical debt relief) or banning medical debt from patients' credit reports.

1) Medical Debt Relief

In a pioneering study, a team of four economists from Harvard University, Stanford University, the University of Munich, and the University of California Los Angeles conducted randomized experiments involving more than 80,000 individuals with $169 million medical debt. They found "no improvements in financial well-being or mental health from medical debt relief, reduced repayment of medical bills, and if anything, a perverse worsening of mental health."[18] Those who received the largest amounts of medical relief experienced worsened mental health, especially regarding "feeling bad about self, like a failure, or let yourself or family down." Moreover, recipients of medical debt relief are less likely to pay subsequent medical bills. This phenomenon can motivate providers to erect access barriers for low-income patients, for example, requesting upfront payment before providing care, thus adversely affecting low-income patients, contrary to the intention of medical debt relief. Providers can also raise prices for commercially insured patients, further worsening patients' exposure to medical debt.

Medical debt relief involves providing alternative funding to providers to write off the existing medical bills. Unless it is done through private channels, such as philanthropy, the funding comes from taxpayers. Besides the aforementioned negative effects on patients, medical debt relief enacted through government policy would remove patients' price sensitivity, cause moral hazard, encourage fraudulent behavior, and motivate providers to inflate prices, thus channeling taxpayer dollars to providers in an unaccountable manner and causing medical debt and taxpayer burden to continuously escalate.

If the medical debt relief is based on predetermined rates, such as a multiple of Medicare rates, hospitals would intentionally encourage medical debt or discourage it by limiting access to low-income patients, depending on the relationship between the government-set rates and their specific collection rates. Such responses would adversely affect both patients and taxpayers. When fiscal constraints from public funding sources become binding, healthcare rationing will become inevitable, leading to severe consequences for all patients.

[18] https://www.nber.org/papers/w32315

Assuming grocery stores allow customers to take on grocery debt, and the government relieves the debt. Subsequently, more patients will take on grocery debt and receive the relief, and an increasing portion of groceries will be subject to government rate setting. Gradually, the variety and quality of groceries will drop because they can neither be influenced by nor need to be accountable to customers. Government medical debt relief will follow a similar pattern, bringing detrimental consequences to all Americans.

2) Banning Medical Debt from Credit Reports

An alternative approach that addresses the symptoms of medical debt is to remove it from patients' credit reports, as the Consumer Financial Protection Bureau (CFPB) proposed in June 2024. This approach aims to shield patients from negative consequences from unpaid medical bills in future borrowing activities. Like medical debt relief above, this approach discourages patients from paying medical bills and encourages providers to erect access barriers for low-income patients. Because providers in this case do not receive external funding to write off the outstanding medical bills, they will be under financial pressure to seek alternative ways to protect their revenue, such as requiring upfront payments and raising prices for commercially insured patients. Since large providers are less vulnerable than small providers, banning medical debt from credit reports will accelerate large providers' acquisitions of small providers, which would cause higher prices and worsen patients' exposure to medical debt.

Banning medical debt from credit reports is intended to make it easier for patients with medical debt to access credit. It is important to note that lenders must assess borrowers' creditworthiness before lending money. When credit reports no longer contain complete information, lenders will discount the usefulness of the credit reports and resort to alternative measures to mitigate their risk exposure, such as zip code or other demographic or geographic profiles. These alternative measures are noisy and can inadvertently harm all low-income patients who fit into the profile of high-risk borrowers by limiting their access to affordable credit, regardless of their actual creditworthiness.

In sum, policy approaches that address the symptoms of medical debt can suppress medical debt in the short run but are counterproductive eventually, harming the very patients they intend to assist. All low-income individuals will face greater barriers to accessing both healthcare and credit, regardless of whether they actually deserve lower borrowing costs.

## Section III: Treating the Root Cause of Medical Debt: High Healthcare Prices

As described in Section I, high healthcare prices in the U.S. are primarily caused by government policies that 1) detach patients from our healthcare dollars, and 2) tilt the playing field in favor of

large players. Therefore, only policies that focus on fixing these problems have the potential to relieve medical debt for Americans in the long run.

1) Patients Control Our Healthcare Dollars

Nobody cares when spending others' money. To obtain competitive pricing and better health, individuals must possess sufficient agency. Plan sponsors should be allowed to bundle an essential plan (including full coverage of routine immunizations) with a substantial cash contribution to beneficiaries' health savings accounts (HSAs). Such plans would have much lower premiums than plans with more comprehensive coverage, thus enabling cash contributions to HSAs. To protect patients who are seriously ill or financially disadvantaged, HSAs should be allowed to receive government subsidies and tax-deductible cash transfers from private organizations and individuals to purchase healthcare products and services including stop-loss coverages. The scope of HSAs should be expanded to cover various health-improving activities, allowing individuals the flexibility to receive and make contributions (with tax benefits) and use them for self-directed purposes to address their own health needs.

By acting as both the user and the payer, patients will be unshackled from insurance restrictions, able to flexibly choose providers without facing insurance-based access barriers and keep savings to themselves. This ultimate bargaining power, possessed by consumers everywhere outside of healthcare, will force providers to compete to offer affordable prices and attractive services that patients want and like. This approach also protects patients from major financial exposure, overcomes insurance-induced access barriers to providers, and enables patients to benefit directly from provider competition, thus alleviating medical debt.

Some might worry that patients without insurance coverage would be subject to exorbitant prices. However, academic research has found that cash prices are often lower than the median commercial negotiated rates for hospital services.[19,20,21] Providers offer competitive prices because they avoid insurance complexities and face price-sensitive patients who actively shape the provider's reputation. Competitive cash prices have also been observed for generic prescription drugs, for which the complex reimbursement process adjudicated by pharmacy benefit managers contracted with insurance companies often leads to higher insurance prices compared to purchasing through cash-pay platforms.[22,23,24] Patients, plan sponsors, and providers would be better off using cash-pay channels to transact on common routine services and products.

[19] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00977?journalCode=hlthaff.
[20] https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2787285
[21] https://jamanetwork.com/journals/jamasurgery/article-abstract/2817652
[22] https://www.acpjournals.org/doi/10.7326/M22-0756
[23] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2781810
[24] https://www.acpjournals.org/doi/10.7326/M23-0644

Moreover, factors beyond healthcare influence 90% of mortality variance.[25] Most individuals earn good health and low exposure to medical debt through continuous favorable decision making and investments of time and effort. Patients' control of our healthcare dollars mitigates the moral hazard created by third-party payers, allows patients to benefit directly and personally from lower healthcare spending, incentivizes responsible health-enhancing behaviors, encourages human capital development, and improves health, thus reducing vulnerability to medical debt.

2) Level the Playing Field for Providers

The most effective force to reduce prices, improve quality, and create value for consumers is competition. Congress should level the playing field and unshackle physicians and alternative facilities to enable them to compete fairly with dominant providers. The regulatory restrictions mentioned in Section I (2) should be removed, including the 340B drug pricing program, site-based reimbursements, restrictions on physician-owned hospitals, the Stark Law, certificate of need (CON) laws,[26] certificates of public advantage (COPA),[27] Medicaid payment policies,[28] and Disproportionate Share Hospital (DSH) payment policies.[29]

Competition causes all providers to voluntarily and continuously innovate, leading to lower prices, higher quality, and expanded access. Without competition, incumbent providers would have little incentive to innovate and instead focus on strengthening regulatory capture and further expanding market power through consolidation to protect their financial interests. Therefore, leveling the playing field by removing anticompetitive regulations will invite physician practices and alternative facilities to instill competition in the hospital market. As a result, patients will access improved quality, lower cost of care, and lower exposure to medical debt.

3) Price Transparency

As my colleagues and I wrote in a recent article in Health Affairs Forefront, "perhaps the most important federal bipartisan agreement in the past two years has been the recognized need to improve healthcare price transparency."[30] Price transparency enjoys broad public support.[31] The bipartisan legislation currently being considered in the Senate, "Health Care Prices Revealed and Information to Consumers Explained Transparency Act" (S.3548), contains excellent provisions

[25] https://www.annfammed.org/content/17/3/267
[26] https://www.justice.gov/archive/atr/public/press_releases/2008/237153a.htm
[27] https://www.ftc.gov/news-events/features/certificates-public-advantage-copas
[28] https://www.healthaffairs.org/content/forefront/medicaid-financing-requires-reform-north-carolina-case-study
[29] https://manhattan.institute/article/untangling-the-hospital-safety-net
[30] https://www.healthaffairs.org/content/forefront/congress-has-opportunity-deliver-health-care-price-transparency-american-people
[31] https://www.kff.org/mental-health/poll-finding/kff-health-tracking-poll-december-2022/

that promote competition among providers and depress healthcare prices, thus directly relieving the threat of medical debt.[32]

Importantly, S.3548 requires providers to disclose actual discounted cash prices and accept discounted cash prices as payment in full from any patient, without regard to the patient's insurance status or plan type. These non-discriminatory prices enable self-insured employers and unions to directly contract with providers and design benefits referenced at such prices.[33] These provisions would allow providers to benefit from timely payments and lowered administrative complexity associated with third-party collection and allow workers to benefit through lower premiums and higher take-home wages, reducing American workers' exposure to medical debt.

Price transparency is also critical to ensuring billing integrity and the legitimacy of medical debt. With the disclosure of prices at the provider-plan level—as required in S.3548, patients with medical debt can compare and verify the amount of their medical debt, which reduces patients' risk of facing erroneous amounts that exceed the actual amount negotiated by their insurance plan or the discounted cash price offered.

4) Transparency on Charity Care Eligibility and Tax Exemption Value for Nonprofit Hospitals

Nonprofit hospitals are exempt from paying federal and state income tax, sales tax, and property tax. They also issue tax-free bonds to reduce their cost of borrowing and receive charitable contributions that are tax-deductible for donors.[34] To maintain their tax-exempt status, nonprofit hospitals must provide charity care (i.e., financial assistance) to low-income patients, with the eligibility criteria determined by the hospitals themselves. Patients who receive charity care face no or discounted medical debt. Although hospitals are required to widely publicize charity care policies, some eligible patients may still be unaware and subsequently face unnecessary medical debt. Congress may consider requiring hospitals to ensure patients' awareness of charity care policies.

Congress should also consider requiring hospitals to disclose their estimated tax exemption value. This would facilitate the understanding of hospitals' tax exemption value and the assessment of generosity in their charity care policy and provision (currently disclosed on Form 990 and Medicare Cost Report). I provided more background and details regarding this policy recommendation in my testimony at the House Ways and Means Committee Oversight Subcommittee on April 24, 2023.[34]

[32] https://www.congress.gov/bill/118th-congress/senate-bill/3548/cosponsors
[33] https://www.healthaffairs.org/content/forefront/federal-legislation-and-state-policy-efforts-promote-access-and-use-discounted-cash
[34] https://docs.house.gov/meetings/WM/WM06/20230426/115817/HHRG-118-WM06-Wstate-BaiG-20230426.pdf

It is worth emphasizing that each hospital has its unique operating situation and many face financial challenges. Uniform quantitative requirements determined at the federal level, such as setting a minimum dollar amount requirement, can threaten the financial viability, encourage report manipulations, reduce incentives to provide charity care, and put upward pressure on commercially insured patients, which in turn raises patients' risk exposure to medical debt.

**Section IV: Conclusion**

To fundamentally addressing medical debt, Congress should (1) allow individuals to benefit directly and personally through the control of our own healthcare dollars, (2) remove regulations that tilt the provider playing field that foster consolidation, (3) codify price transparency, and (4) ensure patients' awareness of charity care eligibility.

Such patient-centered policies would expand choice, promote competition, and initiate a virtuous cycle: Americans benefit from lower prices, less medical debt, better care quality, and improved health; employers gain flexible and affordable options to fund or purchase healthcare for workers; physicians, relieved from administrative complexities, focus on care delivery and innovation; national healthcare spending stabilizes; and innovations in medicine, care delivery, and insurance design continuously improve quality and reduce costs.

The energy to initiate and strengthen this virtuous cycle springs from the demand to access better and cheaper healthcare on the buy side and the desire to innovate and achieve returns on the sell side. Congress should unleash American dynamism in healthcare for the benefit of all.

Thank you again for giving me the opportunity to participate in this hearing. I would be pleased to answer any questions you may have.