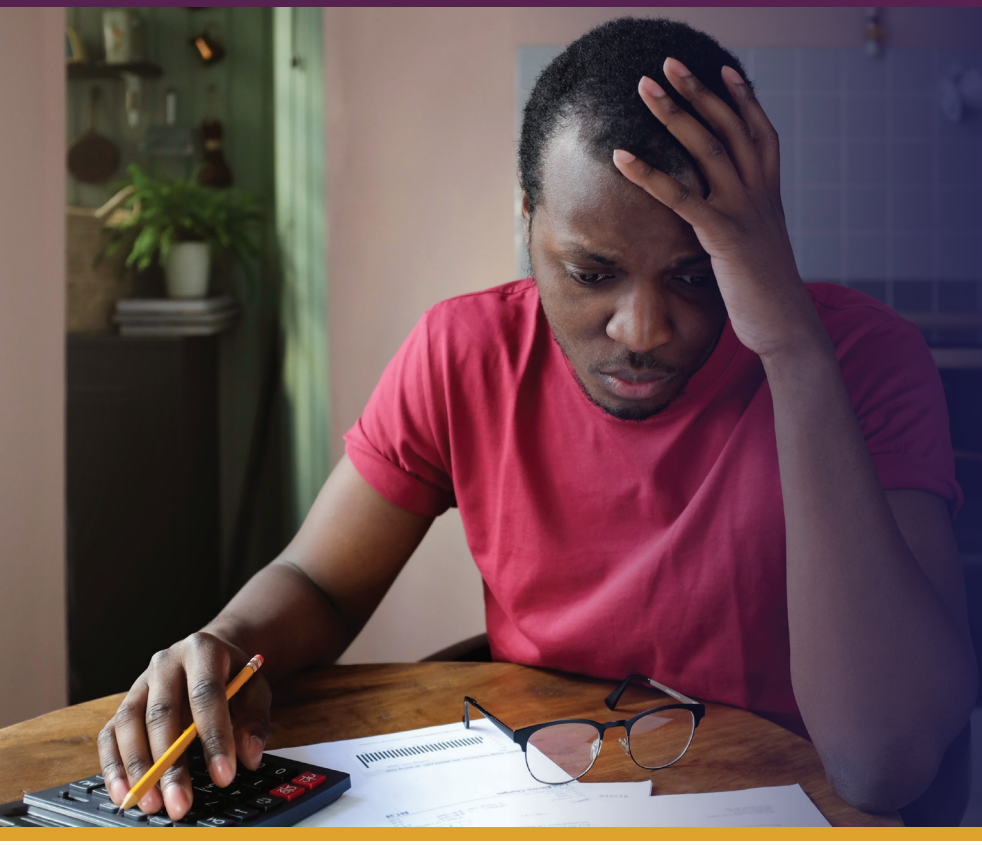


Medical Debt in Indiana

Summer 2022

Introduction

In February 2022, the Consumer Financial Protection Bureau (CFPB) released a report estimating that approximately 111 million delinquent medical bills (nearly 60.0% of all bills currently in collections) totaled $88 billion on Americans' credit reports.[1] The burden of medical debt is particularly acute in Indiana. The CFPB's recent report found that Indiana has the eleventh highest share of its population with a medical debt in collections (18.2% with $2.2 billion outstanding) in the United States and the highest among Midwest neighbors.[2] The Urban Institute provides comparable data with roughly one in six Hoosiers with medical debt in collections, and median amount in collections of $748.[3]

However, medical collections data alone do not convey the full scope and burden of medical debt itself. Collections do not reflect bills already paid or medical debt paid through other financing methods such as a credit card or personal loan, nor do they reflect the financial reality of the roughly 26 million Americans who do not have a credit score or report at all.[4] This makes the true picture hard to frame, providing challenges to researchers and policymakers.

Existing research on the prevalence of non-collections medical debt balances is only recently available. The Census Bureau estimates that approximately one in five households nationwide and one in four households with children under 18 have medical debt, with a median amount owed of $2,000.[5] Unfortunately, systemic disparities exist between those who bear the burden of medical debt among Black and Hispanic households, their White counterparts, and households with lower levels of educational attainment. Predictably, these households are also more likely to be uninsured, experience difficulty paying their mortgage or rent, and live in poverty.[6]

Consumer Financial Protection Bureau, Medical Debt Burden in the United States (Washington, DC: 2022)

Delinquent or high medical debt imposes a number of consequences not only on people's financial health, but on their physical and mental health as well. Barriers to credit or housing, wage garnishment, property liens, reduced access to health care services, and strains to mental health are a few of the adverse side effects explicitly linked to medical debt.[7] Addressing the rising level of debt and its associated consequences will require a comprehensive, systems-level solution. Research on the amount of medical debt in collections reveals a growing urgency to not only address how individuals and families acquire and manage medical debt, but also how to strengthen research methods that will provide a better understanding of the problem itself.

This report discusses the health and social impacts of medical debt, explains how individuals become indebted, provides data about financially vulnerable Hoosiers and statewide trends, summarizes recent government and private action, and recommends policy solutions to address rising medical debt.

Health & Social Impacts of Medical Debt

"So **it's not just the medical debt** that you, kind of, have to worry about. It's a **fear** before the medical debt."

- Anna, South Bend

In a state looking to improve poor health outcomes, including through the existing work of the Governor's Public Health Commission, medical debt should be an essential area of focus because it both contributes to poor health outcomes and prevents individuals from accessing further treatment. Household debt – including medical debt – also negatively affects both physical and mental health. [8] A systematic review of literature finds that, in general, debt is associated with 2.5 to 8.5 greater odds of poor mental health. Research suggest mood, anxiety, and substance use disorders can be "driven by the experience of having difficulties repaying debt."[9] Qualitative research finds strong feelings of shame and failure associated with debt, which predict health conditions like high blood pressure, depression, and anxiety.[10] Exacerbating these conditions, overdue medical debt was linked to skipped or delayed medical care and lack of access to medications.[11]

Furthermore, both personal financial debt in general and medical debt in particular were shown to alter consumer spending, which leads to skipped housing payments, food insufficiencies, and delayed or diminished consumer purchases.[12] Conversely, expansions of Medicaid coverage were shown to decrease the percentage of individuals who report "very low food security" and the number of evictions.[13] Medical debt that goes into collections can exacerbate financial challenges and stress; overdue medical debt that is reported to credit bureaus damages credit scores and makes it more difficult to get loans, insurance, rentals, and jobs.[14] Individuals that lose medical debt lawsuits can have liens placed on their homes or wages garnished, adding to the strain on household finances.[15] The strain created by medical debt and its ancillary effects can also contribute to the deterioration of family relationships. Unsecured debt (debt that is not linked to an asset, like medical debt) is associated with higher rates of divorce across income levels.[16] In fact, couples may strategically divorce to avoid the consequences of medical debt and bankruptcy from harming both spouses.[17]

How Do Individuals and Families Accrue Medical Debt?

Preventing the harmful effects of medical debt requires an understanding of how individuals and families end up indebted. The United States has the highest per capita health care spending among comparable countries but with low access, equity, and outcomes. It stands out internationally for its decision not to provide universal health insurance coverage. While some countries also rely on private insurers, they use standardized benefits packages and low co-pays to improve efficiency and access to care.[18]

Prior to the pandemic, roughly one in twelve (8.4%) Hoosiers lacked insurance coverage – public or private.[19] Hoosier children accounted for 19.4% of the uninsured, and individuals in the 26 to 34 year age bracket made up the largest share of uninsured adults in Indiana.[20] According to the 2019 National Health Interview Survey, uninsured nonelderly adults report that barriers to insurance coverage include cost (73.7%), eligibility (25.3%), lack of desire for insurance (21.3%), difficulty or confusion (18.4%), plans not meeting need (18.0%), and a lost job (2.8%).[21] Individuals who delay or forgo medical care cite insurance coverage and financial reasons as top barriers to care.[22]

When they do not qualify for and seek out charity care, individuals who do not have insurance are billed directly by health care providers. Unsurprisingly, the uninsured tend to have larger medical debts than those who are insured. As if to underscore this point, a recent analysis of medical debt in collections found the highest concentration of medical debt in states that did not expand Medicaid.[23] The uninsured also tend to be charged more than the Medicare allowable amount for health care services.[24]

At the same time, those with health insurance are not always insulated from accruing significant medical debt either. In 2020, an estimated one in five adults was underinsured, meaning that even though they had insurance coverage, the cost-sharing requirements in their insurance plans (e.g. deductibles, co-pays) put their financial well-being at risk.[25] Eighty-five percent of covered workers have annual deductibles with an average of $1,669 for a single individual; this amount has increased by 68.4% over the last ten years.[26] Individuals can also be required to share costs on certain services – 68.0% of covered workers have coinsurance - and individuals may be hit with higher bills for receiving services that are not covered or are "out of network."[27]

> "He actually **had insurance** at the time. We actually thought he was having a heart attack and went to the ER. And even after our copays and the insurance,
> **we still owe about $4,000.**"
>
> - Mandy, Merillville

Certain medical needs or events are associated with higher household medical debt. Poor health and costly treatment for chronic conditions (heart disease, diabetes, cancer) are a common cause of medical debt; about 31.3% of households that have a member in fair or poor health have medical debt compared to 14.4% of those that do not.[28] Households in which a member experienced a hospital stay (31.3%) or in which a member had a disability (26.5%) were also much more likely to have medical debt than households that did not.[29]

While financial assistance programs and policies exist, so do barriers. These include health providers:

- never voluntarily offering charity care applications
- requiring or requesting that patients make partial payments, exhaust other sources of support, or liquidate assets
- using lengthy or difficult applications
- requiring detailed financial documentation, such as tax returns or bank statements
- requiring resubmission of documentation multiple times a year.[30]

When medical bills go unpaid, some hospital systems engage in damaging collection practices, including denying care until debts are satisfied, enlisting collection agencies to go after patients, damaging patients' credit reports, taking patients to court, garnishing wages, and placing liens on homes or property.[31]

Hoosiers' Medical Debt Balances & Collections

The full size and prevalence of medical debt in the United States is difficult to measure, given the lack of a centralized location where medical debt is reported and collected. While this presents challenges for a state-level analysis, this report leverages several unique resources that provide insight on medical debt among financially vulnerable Hoosiers as well as state- and county-level data on medical debt in collections.

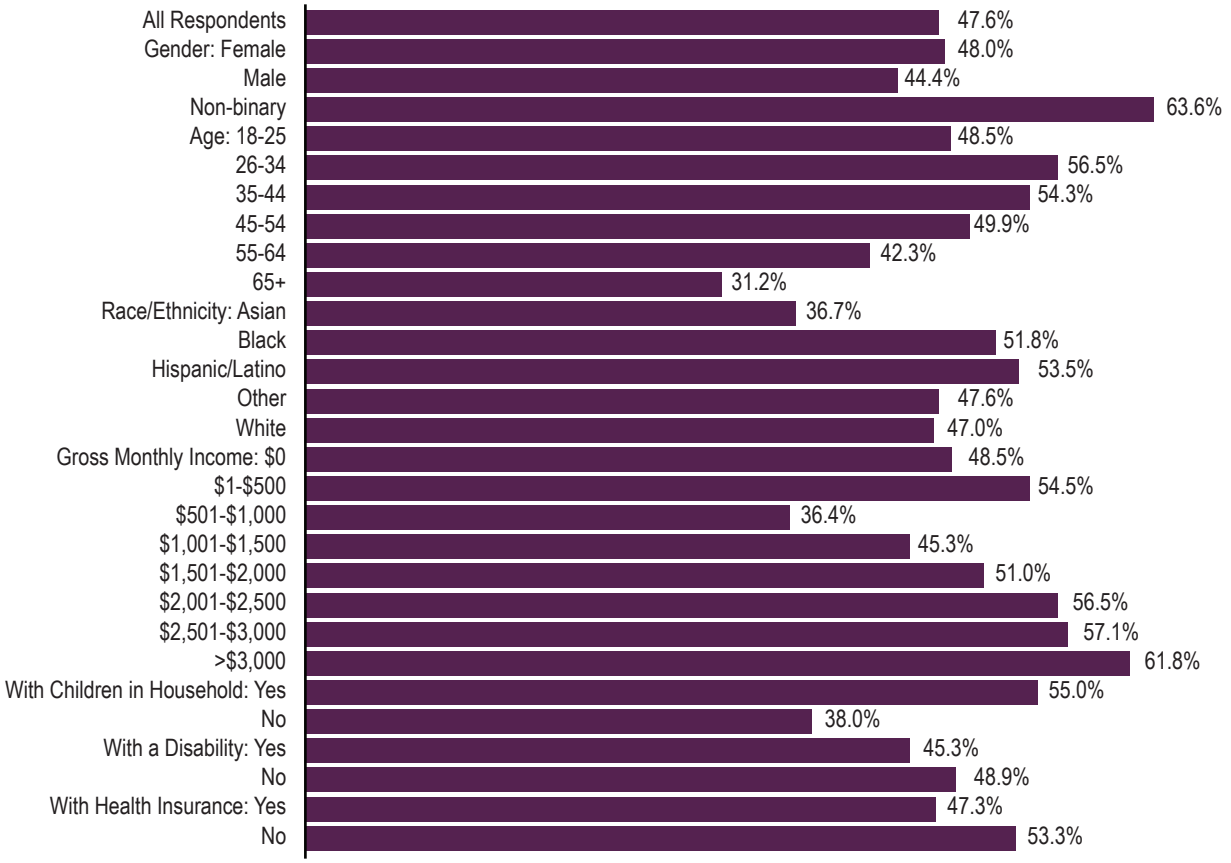
Medical Debt Balances[32]

During the fall of 2020 and the spring of 2021, the Indiana Community Action Association (INCAA), through its 22 local agencies covering all 92 Indiana counties, issued a survey to neighbors and clients to collect data on demographics, general well-being, COVID-19, and other key areas of interest. Survey respondents (5,822 total) were asked to identify both the type of debt (among six choices) and amounts (within specific ranges). Community Action clients are generally at or below 125% of the Federal Poverty Line (FPL) with some exceptions. Most notably, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and subsequent federal legislation raised this threshold to 200% FPL through December 3, 2021.[33]

A July 2021 brief by the Indiana Community Action Poverty Institute (formerly the Indiana Institute for Working Families) leveraging this data set found that nearly half (47.6%) of all survey respondents had medical debt outstanding.[34] Further analysis on those who reported a medical debt or a medical debt in collections is provided below.

As shown in Figure 1, female and non-binary respondents were more likely to have medical debt than male respondents. The prevalence of medical debt was highest among middle-aged respondents with roughly half of all respondents between the ages of 26 and 54 having some form of medical debt. However, individuals age 65 and older were the least likely to have medical debt, likely due to enrollment in Medicare. Disparities among low-income Black Hoosiers compared to their White counterparts are present (51.8% vs. 47.0%), which is predictable given a long, documented list of health disparities by access, quality, and outcomes between Black and White families.[35] Additionally, well over half of all households with children had medical debt, although the survey did not ask if debt was from care provided to the adult or child.

Figure 1: Respondents with Medical Debt by Selected Characteristics



Overall, respondents tended (40.0%) to have medical debt balances between $1,000 and $10,000 (Table 1). However, nearly a fifth (17.4%) of respondents had more than $10,000 in medical debt. While the survey was limited to financially vulnerable Hoosiers generally at or below 125% FPL, there was little deviation in median gross monthly incomes and the amount of debt. For example, respondents who reported more $10,000 in medical debt had a median income of $1,279 compared to $1,459 for those with less than $500.

Table 1: Distribution of Medical Debt Balances by Selected Characteristics

Category	Subcategory	Less than $500	$500-$1,000	$1,000-$10,000	More than $10,000
All Respondents		21.9%	20.7%	40.0%	17.4%
Gender	Female	22.2%	20.8%	40.3%	16.7%
	Male	20.2%	19.0%	39.2%	21.7%
	Non-binary	0.0%	42.9%	0.0%	57.1%
Age	18-25	23.0%	18.8%	46.7%	11.5%
	26-34	18.6%	25.9%	40.8%	14.8%
	35-44	18.8%	18.1%	41.4%	21.7%
	45-54	17.6%	18.5%	43.8%	20.1%
	55-64	25.3%	18.8%	36.9%	19.0%
	65+	36.8%	21.4%	31.3%	10.5%
Race/Ethnicity	Asian	0.0%	27.3%	36.4%	36.4%
	Black	21.3%	25.7%	34.9%	18.2%
	Hispanic or Latino	16.6%	22.7%	45.9%	14.9%
	Other	18.3%	17.5%	46.8%	17.5%
	White	22.4%	19.9%	40.5%	17.2%
With Children in Household	Yes	19.4%	21.5%	41.9%	17.2%
	No	26.6%	19.2%	36.5%	17.7%
With a Disability	Yes	22.7%	18.6%	38.5%	20.2%
	No	21.5%	21.8%	40.8%	15.9%

Table 2 provides the distribution of medical debt balance by health insurance type and coverage. Uninsured persons are more likely to postpone care, go without care at all, or lack access to preventative care.[36] Because of these factors and due to the lack of care partly subsidized by insurance, it is unsurprising that uninsured respondents without health insurance had higher balances than those with insurance.

Given that the general Medicaid eligibility in Indiana for adults (133% FPL) and children (158% FPL) covers those in the survey population (at or below 125% FPL), there is clearly work to be done to ensure that all those who are eligible for Medicaid are enrolled and covered.[37] Additionally, while individuals and families reported debt balances and coverage under a Medicaid program, the survey did not identify when the debt was accrued.

Table 2: Medical Debt Balances by Health Insurance Type & Coverage

Health Insurance Type & Coverage	Less than $500	$500-$1,000	$1,000-$10,000	More than $10,000
Employer	21.0%	18.7%	43.2%	17.2%
Marketplace	28.6%	21.4%	31.0%	19.0%
Medicaid	20.2%	20.8%	41.6%	17.3%
Medicare	28.3%	22.2%	32.4%	17.1%
TRICARE or VA Benefits	14.3%	42.9%	35.7%	7.1%
With Health Insurance	22.4%	20.9%	39.5%	17.2%
Without Health Insurance	13.2%	16.7%	49.3%	20.8%

Medical Debt in Collections

While data are limited on the total medical debt outstanding, consumer credit reports provide valuable insight on the amount of total delinquent debt. In February 2022, the CFPB published research showing $88 billion in medical debt collections on consumer credit reports nationwide, including $2.2 billion in Indiana.[38] The CFPB's report also found that Indiana has the eleventh highest share of its population with a medical debt in collections (18.2%) and the highest compared to Midwest neighbors (Illinois, Kentucky, Michigan, and Ohio).

The CFPB's report also found that Indiana has the **eleventh highest** share of its population with a medical debt in collections (18.2% with $2.2 billion outstanding) and the **highest among Midwest neighbors.**

INCAA's survey of financially vulnerable Hoosiers asked respondents about debts in collections, including credit cards, medical debt, and loans (payday, student, auto, and personal installment). Approximately a third (30.6%) of respondents had a medical debt in collections, with 59.3% of those individuals (18.2% of all respondents) having only medical debt in collections. Table 3 summarizes the prevalence of medical debt in collections by selected characteristics.[39]

Table 3: Respondents with Medical Debt in Collections by Selected Characteristics

Category	Subcategory	Medical Debt in Collections
All Respondents		30.6%
Gender	Female	31.3%
	Male	26.1%
	Non-binary	18.2%
Age	18-25	32.9%
	26-34	38.0%
	35-44	37.3%
	45-54	33.9%
	55-64	25.8%
	65+	14.4%
Race/Ethnicity	Asian	26.7%
	Black	31.7%
	Hispanic or Latino	34.3%
	Other	32.5%
	White	30.3%
With Children in Household	Yes	36.9%
	No	22.5%
With a Disability	Yes	31.0%
	No	30.4%
Health Insurance Type	Employer	42.8%
	Marketplace	32.9%
	Medicaid	30.4%
	Medicare	24.0%
	TRICARE or VA Benefits	29.7%
Health Insurance Coverage	With Health Insurance	30.2%
	Without Health Insurance	38.1%

A broader view of medical debt in Indiana that leverages additional consumer-level credit records finds that Indiana has one of the highest proportions of its population with a medical debt in collections (16.0%).[40] Indiana ranks tenth in the country for proportion of the population from communities of color with a medical debt in collections (25.3%) with a median amount of $736. Table 4 compares Indiana to neighboring states. [41]

Indiana ranks tenth in the country for proportion of the population **from communities of color** with **medical debt in collections (25.3%)**.

Table 4: Medical Debt in Collections - Indiana Compared to Neighboring States

	Share with Medical Debt in Collections:			*Median Medical Debt in Collections:*			*Share without Health Insurance Coverage:*		
State	*All*	*Communities of Color*	*Majority White Communities*	*All*	*Communities of Color*	*Majority White Communities*	*All*	*Non-White*	*White*
Indiana	16.0%	25.3%	14.9%	$748	$736	$753	8.0%	10.7%	7.4%
Illinois	13.6%	19.9%	11.5%	$641	$645	$641	6.8%	10.1%	5.4%
Kentucky	17.1%	37.0%	16.5%	$491	$570	$479	5.6%	8.3%	5.2%
Michigan	12.6%	18.5%	11.7%	$440	$443	$439	5.4%	6.8%	4.9%
Ohio	14.9%	20.6%	14.2%	$607	$654	$598	6.2%	8.2%	5.7%

Source: Urban Institute; U.S. Census Bureau

A closer look at some of Indiana's largest counties, where disaggregated data are available, demonstrates acute racial disparities in health insurance coverage and medical debt delinquency. Appendix 1 provides similar data across all 92 Indiana counties. While balances are fairly similar, communities of color are more likely to be uninsured and have a medical debt in collections.

Table 5: Medical Debt in Collections in Select Indiana Counties

	Share with Medical Debt in Collections:			*Median Medical Debt in Collections:*			*Share without Health Insurance Coverage:*		
County	*All*	*Communities of Color*	*Majority White Communities*	*All*	*Communities of Color*	*Majority White Communities*	*All*	*Non-White*	*White*
Allen	14.9%	29.7%	11.9%	$872	$952	$850	8.0%	11.4%	7.1%
Lake	15.3%	25.8%	9.2%	$738	$758	$640	6.9%	9.5%	5.2%
Marion	20.9%	25.0%	18.1%	$705	$653	$769	9.8%	11.2%	8.9%
St. Joseph	12.4%	15.2%	11.2%	$488	$369	$480	7.6%	11.2%	6.5%
Indiana	16.0%	25.3%	14.9%	$748	$736	$753	8.0%	10.7%	7.4%

Source: Urban Institute; U.S. Census Bureau

CFPB Consumer Complaint Database

The CFPB's Consumer Complaint Database contains valuable data that illustrate how medical billing, repayment, and collections affect consumers after receiving medical care or treatment. While the data cannot be used to draw broad trends in the marketplace (as it is not a statistical sample), it can help in understanding mismatches between consumer expectations and actual experiences.[42] Data represent complaints that the CFPB forwarded to companies.

Even with these limitations in mind, medical debt does represent a noticeable share of all complaints filed by Hoosiers. As of April 27, 2022, four percent of all complaints filed by Hoosiers were related to medical debt.[43] Using the Center for Disease Control's COVID-19 timeline, a third of all medical debt complaints by Hoosiers were filed since the start of the pandemic.[44] Figure 2 provides the top five medical debt collections complaints submitted by Hoosiers.

Figure 2: Top CFPB Medical Debt Collections Complaints in Indiana

Source: Authors' calculations using data from the Consumer Financial Protection Bureau

Recent Action to Address Medical Debt

Despite persistent challenges and issues related to access to care, health insurance coverage, and the costs of treatment, a number of recent developments should help alleviate some of the pain associated with medical debt.

No Surprises Act

In late 2020, Congress passed and the President signed into law an omnibus bill that funded the federal government through Fiscal Year 2021 and included important provisions to help address some surprise billing issues for out-of-network services.[45] Surprise billing typically occurs when a patient receives medical treatment or service that is not entirely covered by their health insurance policy.[46] The difference between the cost of care and the amount the insurance company pays is picked up by and billed to the consumer – known as balanced billing. Effective January 1, 2022, the No Surprises Act went into effect, protecting many consumers from a market failure in elective care.[47] Broadly, the new law provides protections to all commercially insured patients (group health plan or group or individual insurance coverage), and prevents out-of-network providers from billing more than what is permissible for in-network, cost-sharing amounts. This includes: (1) emergency services; (2) post-stabilization care until a patient can be safely moved to an in-network facility; (3) air ambulance transports; and (4) out-of-network services ordered by in-network facilities unless a consent process is filed.[48]

Indiana Legislative Leaders

Indiana House Speaker Todd Huston and Senate President Pro Tempore Rodric Bray issued a joint letter to health insurance companies and nonprofit healthcare systems in late 2021 to address Indiana's disproportionally high medical costs.[49] While the leaders did not provide a specific legislative solution, they indicated that statutorily reducing healthcare prices would be an option if carriers and systems did not provide a viable alternative. The industries' proposed solutions are currently under review by the legislative leaders.[50]

Nationwide Credit Reporting Agencies[51]

In March 2022, Equifax, Experian, and Transunion, announced changes to their credit reporting practices that will remove 70.0% of all medical debt collections from consumer credit reports. Effective July 1, 2022, the agencies will remove paid medical collections from credit reports and increase the time period before an unpaid collection appears on a report from six months to one year. The agencies will take an additional step by no longer reporting medical debt collections under $500 on credit reports starting in the first half of 2023. However, further steps need to be taken to address the remaining 30.0% of medical debt collections on consumer credit reports. The agencies have not provided a timeline for how long it will take them to implement these changes. Given this is a private action, it should be noted that the agencies could reverse course at any time and it is uncertain if this is a permanent policy.

Federal Executive Action[52]

In April 2022, the White House announced a number of new actions across several federal agencies that should help reduce the pressures stemming from medical debt. Some of these include:

- Department of Health & Human Services (HHS) will research and evaluate how billing practices affect affordability of medical care, and the impact this has on household medical debt. This evaluation will be used in HHS' grant making and any findings or potential violations will be shared with enforcement agencies.
- CFPB will build on its existing enforcement authority as it relates to protecting consumers under the newly enacted No Surprises Act.[53] The agency will work to hold credit reporting companies and debt collectors accountable by determining if certain medical debt data should be reported on credit reports. The CFPB will also build out consumer education resources related to medical billing with a specific focus on ways financially vulnerable consumers can access assistance.
- The Department of Agriculture, Department of Veterans Affairs, and the Small Business Administration are each taking steps to eliminate medical debt as an underwriting factor in credit and loan programs, respectively. The Office of Management and Budget will provide consistent guidance on ways these federal agencies and others can eliminate medical debt in underwriting practices.

Policy Recommendations[54]

Lawmakers should take the following steps to ensure equitable and proper access to healthcare while ensuring the most financially vulnerable Hoosiers can access care without the fear of financial collapse.

(1) Promote continuous, high-quality coverage.

During the pandemic, enrollment in Medicaid and Children's Health Insurance Program (CHIP) grew by over 300,000 Hoosiers (20.5%).[55] This enrollment spike was likely due to financial hardship that made many individuals and families eligible and the removal of some restrictions that allowed the state to capture additional federal funds.[56] A continuous coverage requirement prohibited the state from terminating coverage until after the public health emergency ended.[57] The state took an additional step by temporarily waiving all premiums. Indiana should address eligibility barriers for Medicaid enrollment and coverage that were temporarily lifted during the pandemic, including by eliminating premium payments altogether.

Indiana should expand the use of ex parte determinations and redeterminations for Medicaid. Programs, most notably the Supplemental Nutrition Assistance Program (SNAP), have qualifications that almost completely mirror the qualifications for Indiana Health Coverage Programs. Using this as a mechanism for eligibility determinations across programs would ensure more initial coverage for eligible Hoosiers, as well as less loss of coverage during the redetermination process.[58]

In addition to ex parte determinations, consideration should be given to reach potentially eligible Hoosiers with information about and enrollment assistance with Indiana Health Coverage Programs and the Healthcare.gov Marketplace. Potential pathways for this would be a health coverage navigator referral opt-in on Indiana forms such as unemployment insurance, SNAP, Temporary Assistance for Needy Families (TANF), and Child Care Development Fund (CCDF) voucher applications.

Indiana is also just one of a handful of states that has not eliminated the five-year waiting period for lawfully residing immigrant children and pregnant women to be eligible for Medicaid and CHIP.[59] Approximately, 4,513 to 5,961 children and 481 to 635 pregnant women in Indiana lack coverage due to this rule remaining in place.[60]

(2) Create more accessible and inclusive Financial Assistance Policies (FAPs).

Indiana is one of only a handful of states that does not require all hospitals (nonprofit and private) to provide FAPs nor does the state mandate the eligibility standards for patients who need assistance.[61] Generally, very low-income patients are eligible for financial assistance for very severe medical conditions at nonprofit Indiana hospitals.[62]

> "One of the first things I did was reach out to the hospital, but this was before he lost his job, so at the time they said we didn't qualify. I tried applying after he lost his job, but at that point **they were like, oh, we've already sent it over** even though **we didn't get any letter from collections**, they had already sent it over to collections."
>
> - Mandy, Merriville

Lawmakers should require all nonprofit and private hospitals adopt robust FAPs. This includes expanding free care to Hoosiers at or below 200% FPL (at the minimum) and discounted care through a sliding scale pricing model between 200% and 600% FPL. Providers should be required to screen patients for eligibility so that every eligible patient receives assistance, and assistance should be available to those who are insured and uninsured. FAPs must be transparent, clear, and advertised in multiple ways to ensure patients have full access to the resource. Additionally, payment plans should be available for eligible patients, and include repayment terms that any debt less FAP assistance does not exceed five percent of their income. FAPs should include provisions that allow patients to apply for assistance retroactively.

(3) Strengthen consumer protections that prevent abusive practices.

Currently, medical debts in dispute or under review can be placed as delinquent or in collections on a consumer's credit report. This means consumers are subject to collections practices and adverse credit impacts even when they may not owe anything at all. Federal or state legislation that prohibits such practices until outstanding claims are resolved, including a waiting period after resolution, ensures patients are billed the correct amount and do not pay more than required or risk their credit health. Lawmakers should take an additional step and codify the policies recently adopted by the three national credit agencies as well as prohibit reporting on medical debt for at least one year.[63]

"Sometimes I think the lawmakers don't know how critical a problem this [medical debt] is. Do you understand that this is going on?

I mean, I feel like this subject is really like, you know, black and white. There's not a whole lot of gray areas, so people tried to make gray area, you know? But these are **people's lives we're talking about**. They have families and families want them to be here. This **should not be one of the decisions that every American has to face**."

- Charissa, Gary

Additionally, Indiana has one of the worst state exemption laws in the country, providing Hoosiers and their families with little protection from seizure by creditors, debt buyers, and collectors.[64] These laws do not provide any explicit safeguard for those with medical debt, which further jeopardizes financial security. Indiana lawmakers should take basic steps to protect Hoosiers' financial security by prohibiting foreclosure of a family or individual's home due to a medical debt. The easiest way would be to exempt a home from collection arising from a delinquent medical debt. At the very least, Indiana lawmakers could update and reform the homestead exemption ($22,750 as of March 1, 2022) to preserve a more adequate value of consumer's home and prevent debt collectors from executing a lien until the home sells. [65] Similarly, lawmakers should raise the wage garnishment threshold to preserve a sustainable wage. Current state law protects only $217.50 per week (30 times the minimum wage) from garnishment, with limited exceptions. For Hoosiers experiencing a medical emergency that they cannot afford, further pain and suffering should be prevented by exempting wages altogether from medical debt collections, especially if the patient is eligible under FAP income thresholds.

(4) Provide legal remedies for violations of the law.

In addition to strong FAPs and consumer protections, legal remedies to consumers should be available to address providers and collectors who violate the law. This includes authorizing the state Attorney General to enforce FAPs and consumer protections while also investigating complaints and imposing penalties on violators. Indiana lawmakers should also provide a private right of action to consumers that would provide a pathway to collect associated damages or injunctive relief. A private right of action could provide more timely justice that would offset inadequate enforcement or frequent violators.

(5) Collect and publish data on medical debt collection.

Indiana lawmakers could take an important step in understanding the size and prevalence of medical debt collections by requiring hospitals to submit an annual report to the Indiana Department of Health Consumer Services and Health Care Regulation Commission (or other applicable agency) on collections activities filed against consumers.

Areas of Further Research

This report does not explore how best to address the existing $88 billion in delinquent medical debt on Americans' credit reports. Broad-based cancellation, forgiveness, or relief could be challenging given that private companies hold this debt. However, existing research is limited on the most efficient and equitable solution to this problem.

Appendix 1: Medical Debt Collections & Health Insurance Coverage by Indiana County			
County	Share with Medical Debt in Collections	Median Medical Debt in Collections	Share without Health Insurance Coverage
Indiana Total	16.0%	$748	8.0%
Adams	11.9%	$1,164	19.5%
Allen	14.9%	$872	8.0%
Bartholomew	10.6%	$427	7.8%
Benton	18.9%	$750	9.1%
Blackford	14.2%	$1,236	5.1%
Boone	13.2%	$979	4.6%
Brown	12.4%	$460	8.6%
Carroll	19.8%	$1,143	9.6%
Cass	28.3%	$1,380	8.2%
Clark	21.5%	$605	6.5%
Clay	19.2%	$938	4.8%
Clinton	22.0%	$1,425	9.7%
Crawford	23.1%	$883	7.3%
Daviess	11.4%	$727	25.6%
Dearborn	14.8%	$740	5.0%
Decatur	18.9%	$985	5.9%
DeKalb	20.9%	$1,274	7.1%
Delaware	15.0%	$495	7.5%
Dubois	9.0%	$1,204	4.3%
Elkhart	14.2%	$803	15.0%
Fayette	14.7%	$474	8.2%
Floyd	18.9%	$548	4.7%
Fountain	19.1%	$1,030	10.1%
Franklin	16.7%	$526	7.2%
Fulton	19.2%	$886	10.0%
Gibson	14.4%	$910	4.9%
Grant	21.4%	$1,229	7.7%
Greene	14.2%	$833	6.3%
Hamilton	8.8%	$593	4.2%
Hancock	14.2%	$898	5.8%
Harrison	17.0%	$742	6.2%
Hendricks	13.5%	$702	5.8%
Henry	12.3%	$692	6.8%
Howard	19.1%	$859	6.9%
Huntington	13.0%	$1,239	6.6%
Jackson	17.7%	$1,575	8.2%
Jasper	12.7%	$739	5.7%
Jay	18.0%	$904	10.3%
Jefferson	23.8%	$1,012	8.0%
Jennings	20.4%	$998	10.4%
Johnson	15.7%	$817	6.1%
Knox	18.1%	$1,031	7.9%

Kosciusko	13.8%	$799	10.8%
LaGrange	11.7%	$803	42.6%
Lake	15.3%	$738	6.9%
LaPorte	11.8%	$710	7.3%
Lawrence	18.4%	$689	7.3%
Madison	18.8%	$527	8.1%
Marion	20.9%	$705	9.8%
Marshall	13.2%	$612	12.3%
Martin	12.8%	N/A	5.6%
Miami	17.3%	$687	8.5%
Monroe	11.6%	$590	6.3%
Montgomery	14.7%	$708	8.2%
Morgan	18.5%	$922	6.1%
Newton	13.9%	$966	6.6%
Noble	18.9%	$891	9.9%
Ohio	20.4%	N/A	7.2%
Orange	17.0%	$455	7.6%
Owen	19.5%	$750	10.9%
Parke	19.8%	$500	13.5%
Perry	18.3%	$752	4.8%
Pike	15.0%	$842	3.9%
Porter	8.8%	$624	5.3%
Posey	11.2%	$458	5.0%
Pulaski	16.1%	$1,303	7.2%
Putnam	20.9%	$997	5.0%
Randolph	17.7%	$551	9.1%
Ripley	13.7%	$659	7.6%
Rush	25.1%	$1,384	9.6%
St. Joseph	24.4%	$746	7.6%
Scott	21.9%	$1,098	7.4%
Shelby	14.2%	$830	6.6%
Spencer	12.4%	$488	3.5%
Starke	17.0%	$703	6.6%
Steuben	20.2%	$1,228	7.3%
Sullivan	14.9%	$594	9.2%
Switzerland	18.8%	N/A	12.3%
Tippecanoe	15.9%	$1,115	6.5%
Tipton	16.0%	$685	8.6%
Union	11.4%	N/A	7.9%
Vanderburgh	16.2%	$734	7.8%
Vermillion	16.4%	$681	5.1%
Vigo	18.8%	$666	7.0%
Wabash	13.0%	$522	8.2%
Warren	15.2%	N/A	4.5%
Warrick	11.9%	$850	3.8%
Washington	22.3%	$692	9.0%
Wayne	12.8%	$391	11.4%
Wells	7.9%	$631	5.5%
White	22.8%	$1,110	8.4%
Whitley	11.5%	$748	7.4%

*N/A = data unavailable due to small sample size.

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