

Medical Debt in Arkansas – from the ER to the Courtroom

Part of a series exploring issues from
the Community Foundation's
Aspire Arkansas report.

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May 2022

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The bills keep piling up...



Most of us have had a medical emergency or been close to someone who has. It may have led to a visit to the ER for small accidents or perhaps been a life-changing diagnosis. Regardless of the severity, we all get billed. And sometimes even the smallest medical bill can lead to financial ruin for the “working poor” — who we refer to as ALICE: Asset-Limited, Income Constrained, Employed.

The data from AspireArkansas.org — Arkansas Community Foundation’s source of online data on education, healthcare, families and communities — tells us that 26.5% of households in Arkansas have limited access to financial resources. And one-half of Arkansans don’t have more than \$2,000 in non-retirement savings. So when a medical emergency happens and the bills begin to pile up, families have to make tough choices — sometimes choosing between groceries or the medical bills. When collection agencies come calling, the fines and fees pile up creating crippling debt that is almost impossible to overcome, especially for ALICE families.

Medical debt has emerged as a crisis locally and nationally. As one answer to this crisis, the Community Foundation, along with the Winthrop Rockefeller Foundation, HOPE and other donors, raised more than \$225,000 to erase \$35 million in medical debt for 23,896 Arkansans in all 75 counties.

In this issue, we explore how the medical debt crisis in Arkansas can be addressed, along with personal stories of hardworking Arkansans who fell victim to the vicious cycle so hard to escape.

Best regards,

Heather Larkin
President and CEO



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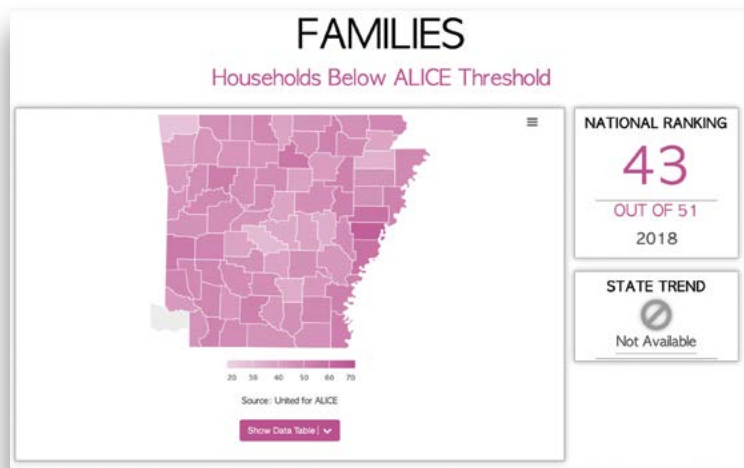
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President and CEO — Heather Larkin

Chief Communications Officer and
Editor — Jessica Hughes Ford

Contributors — Kim Dishongh and
Adena White



Find data on economic disparity online.

On the cover: Davey Ramirez of Hot Springs was misdiagnosed for months before having two surgeries for kidney stones. Then he broke his hand, requiring another surgery. Even with insurance, it will take 20 years to pay off all the debt.





The Face of Medical Debt in Arkansas

By Kimberly Dishongh



In 2020, Tony McDaniel was in an induced coma for six weeks due to COVID-19. Billing errors and previous medical debt turned into over \$20,000 worth of debt he is still working full time to repay.

Tony McDaniel's life has changed drastically in the last two years. He still enjoys watching sports and fishing, but his thoughts are often dominated by dialysis and medical debt. It's been a shock to his system.

"Especially when you're healthy and all of a sudden your life gets turned upside down, no fault of yours," said McDaniel.

McDaniel, of Little Rock, had hip replacement surgery during the summer of 2020 and was still healing when he caught COVID-19 in November of that year. "I went in the hospital on November 14, and I was doing OK for the first week, but the week of Thanksgiving, COVID attacked my kidneys and made my kidneys fail," he said. "I also had pneumonia so my lungs were affected."

His doctors started 24-hour dialysis to support his kidney function, put him in an induced coma and on a ventilator.

"I was in an induced coma for a month and a half," he said. "During that time, they accidentally nipped an artery checking something in my lungs. My wife was called twice to pull the plug on me. I was on a vent for four months and on ECMO [heart-lung bypass] for a month and a half."

McDaniel was released from the hospital in April and returned home in a wheelchair, with the hope that he could regain the ability to walk.

"Then I started getting these bills in the mail," he said.

He sorted through invoices, payment records and benefits explanations with the help of a social worker, and learned that the insurance he has through his employer had kicked in when he got sick but there were coding errors that didn't link all of his health issues to COVID which meant he hadn't met his deductible.

McDaniel had been paying toward previous medical debt when he was hospitalized. Those bills fell past due while he was sick and were turned over to collections. Those

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agencies weren't sympathetic to his plight.

"Nobody wanted to help me," McDaniel said.

His employer held his position while he was out, and he's back at work on a schedule limited by his continuing need for dialysis. Sometimes he doesn't feel well, but he goes to work anyway because he has upwards of \$20,000 in medical bills to pay.

"I'm stuck with this. I'm just dealing with this now," said McDaniel. "I'm trying to rebuild my credit because all that stuff that happened. You're steady dealing with it, and they're asking you for more and more. What am I supposed to do?"

"I've just been trying to work through it. I'm thankful to just still be here, but I feel like I'm being penalized because I got sick."

— Tony McDaniel

Crystal Collins' story is vastly different. Her daughter, JaKiah, was diagnosed with a Wilms tumor at the age of four. Upon JaKiah's admittance to Arkansas Children's, the family was assigned a financial counselor, who reviewed their insurance coverage and evaluated their ability to pay for medical care. The counselor helped them look for potential financial resources, including nonprofit assistance to Medicaid, TEFRA and the Arkansas Health Insurance Marketplace, as well as funds that helped cover gas, food and other expenses related to extended hospital stays and frequent clinic visits.

The family qualified for TEFRA and made small monthly payments for that coverage. Throughout JaKiah's year-long cancer treatment, Collins only saw one hospital bill, totaling about \$100,000, covering her daughter's first hospital stay, surgery for the insertion of a port and her first chemo treatment.

"The balance was \$0," said Collins of Little Rock. "It said it was just for my records."

She was relieved to have dealt with financial responsibilities on the front end so she could focus on JaKiah, who is now a thriving 13-year old.

"Our language to the patient is, 'You focus on getting well, while our team focuses on addressing financial health,'" said Le'Kita Brown, vice president of Revenue Cycle for the state's only pediatric hospital. "Arkansas Children's is grateful for the multitude of community-based partners who come together to help address the needs of the patients and families we serve."



Crystal Collins and her daughter JaKiah worked with Arkansas Children's to create a plan to manage the debt for JaKiah's treatment.

Many Arkansans struggle with finding answers about their health as well as with associated finances.

Davey Ramirez of Hot Springs was misdiagnosed for months before experiencing almost unbearable pain while at work in June 2020. In the emergency room, he was told he had kidney stones and needed emergency surgery.

"I ended up having surgery the next day, and it all went without incident," he said. "Then I was stuck with this tremendous medical bill."

He had a second surgery to remove a stent put in during the first one. A few months later, he broke his hand and needed another surgery. "I think just the surgery to correct the damage done to my hand was like \$25,000," he said. "I had insurance, by the way. Even with that, I would have been paying this off for the next 20 years."

Ramirez negotiated a payment plan with the companies the hospital used to outsource billing and was getting two bills each month, one for \$92 and one for \$100. He works 40-60 hours a week as a contracted employee at an aluminum mill.

"I get overtime pay, and that's wonderful, but I'm not able to make it stretch very far after everything," said Ramirez, a single parent. "I applied for financial assistance and one was forgiven. But they're still taking the money out of my bank account, and I don't know why." He has tried to apply for help with the remaining bill but has been unable to figure out who to ask.

"It's been so confusing," he said. "I've had to call all these financial institutions to find out if they have received my



JaKiah was diagnosed with a Wilms tumor at the age of four. Financial counselors at Arkansas Children's helped her family access multiple resources for support and financial assistance.

paperwork, I get bounced around between four different people who don't want to take my call because they don't know anything, and then they defer me to someone else, and then those people send me to someone else." After taking time out of work to make calls — each lasting 40 minutes or more, including time on hold — he was told at one point that he would be reimbursed for payments he made, and he got several checks in the mail.

"They were in different amounts, like a couple were for \$200, and there was one that was \$16 and one for \$60 and some change," he said. "There was nothing attached, no letter or anything saying what they were for so I have a hard time telling what's been paid and what I still owe for. It's frustrating and confusing, and I don't know who has time to do all this."

"Beth," who asked that her full name not be used because she worries her business colleagues would perceive her as someone who simply can't pay her bills, understands Ramirez's struggle. Beth's former husband had long-term chronic health issues. They filed for bankruptcy after being overwhelmed by medical bills associated with his treatment and from her treatment for injuries sustained in a car accident.

"We were spending so much on his daily care, on just his regular maintenance meds, that when it came time for me to go to the hospital with an emergency situation on my feet, there was just no money," said Beth, who has worked for the same company for 23 years. "I had been putting money in my HSA [health savings account], but it was going out as quick as it could be put in. I was never able to save the money to even pay down the out-of-pocket expense, the deductibles and copays. There were always copays."

Beth was notified earlier this year that a bill she owed for foot surgery was part of a \$35.2 million medical debt payoff by philanthropic organizations — including Arkansas Community Foundation.

"I was surprised, number one, that the bill even existed," said Beth. "I was even more surprised that someone, out of the kindness of their heart, paid it for me. It literally blew my mind."

McDaniel hopes for a similar miracle. He makes less money than before he got sick because of his physical limitations. He is awaiting a kidney transplant, which will improve his quality of life but will also add to his debt load. And still the bills pile up.

Medical Debt — There Are No Villains

By Adena J. White

If there is one thing Kevin Ryan wants people to take away from the conversation around medical debt, it is that there are no villains.

“People seek out medical care because they need it. Providers are willing to provide medical care to save lives. Businesses have to generate an excess of revenue over expenses so they can stay open,” he said.

Ryan is currently associate dean for student and alumni affairs and an associate professor at the Fay W. Boozman College of Public Health at the University of Arkansas for Medical Sciences. Ryan obtained his Juris Doctor degree from the University of Arkansas at Little Rock William H. Bowen School of Law and works at the intersection of law and public health.

Throughout his career, Ryan has examined a series of issues that affect ALICE families, (meaning Asset-Limited, Income-Constrained, Employed) and the traditionally underserved. He considers it a privilege to be able to do so.

“This is far and away the absolute best job I’ve ever had in my life. I get to look at and learn about important issues that impact all of us and get to work with incredible teams of people trying to make things better.”

Ryan said the connection between personal bankruptcy filing and debt accrued through receipt of medical care is significant.

“People who file for bankruptcy, or debt reorganization, are required to roster out their debt,” Ryan explained. “When researchers have looked at and categorized these rosters, they found that debt related to medical care was the number one category year after year.”

Ryan said it is not always apparent in the research that medical debt is the leading driver of personal bankruptcy. This is because expenses related to medical care are often categorized as credit card debt. Upon further investigation, however, researchers determined that many people had used their personal credit cards to pay for medical expenses.

“Medical debt impacts so many people, so many families, and it is definitely disproportionately represented in lower-income folks,” Ryan said. “And, more importantly, it affects people who are working, and who — in many cases — are working multiple jobs to make ends meet.”

Ryan has been part of several teams that have studied ways to expand health insurance coverage. The studies have found that, just like the majority of people with medical debt, most of the people who were uninsured tended to work several jobs.

“These are not people just sitting at home. These are people

who are working hard with several different jobs,” Ryan said. “And all of a sudden, an adverse life event occurs — there’s an accident, there’s an unexpected injury of some type, or they develop a disease. These are not events someone can plan for.”



Kevin Ryan

The patient then seeks care for the health issue and is faced with the full cost of the bill if they are uninsured. Ryan said even those who are covered by health insurance may be responsible for a costly bill. According to the Kaiser Family Foundation, two-thirds of medical debts are the result of a one-time or short-term medical expense arising from an acute medical need.

To demonstrate how easily medical debts can accrue, Ryan painted a scenario using heart disease as an example, which is the leading cause of death in the United States. Heart disease, which includes coronary artery disease and heart attacks, costs the U.S. about \$363 billion each year, according to the Centers for Disease Control and Prevention.

“Imagine you begin experiencing chest pains and are taken to the emergency room by ambulance. The doctor and nurses place an electrocardiogram and administer life-saving clot-buster medication. They conduct an angiogram during your five-day hospital stay, and you are discharged.

“Hypothetically speaking, let’s say the bill was \$100,000. Your good insurance pays 80% of it, but you still have a debt of \$20,000. The vast majority of people don’t have \$20,000. That can be devastating to a fully insured family with two working adults.”

Lower-income, single-parent households are affected disproportionately. Ryan said if they work multiple jobs or work a shift outside of normal business hours, they may not have the ability to take themselves or their children to a doctor, which could increase the likelihood of costly trips to the emergency room for routine care. Additionally, the federal Emergency Medical Treatment & Labor Act ensures public access to emergency services regardless of ability to pay, making the emergency room the only option for those without health insurance.



Ryan said even if you do not subscribe to the idea that we are “our brother’s and sister’s keeper,” everyone should care about medical debt. It affects the cost of the entire health care system, and everyone ends up paying more.

“We pay more because the system isn’t rational. The system isn’t as balanced as it should be,” Ryan said. “We should care not only because it’s the right thing to do but because it affects all of our bottom lines.”

On March 18, 2022, the three nationwide credit reporting agencies — Equifax, Experian and TransUnion — announced that effective July 1, 2022, paid medical collection debt will no longer be included on consumer credit reports. In addition, the time period before unpaid medical collection debt would appear on a consumer’s report will be increased from 6 months to one year. In the first half of 2023, Equifax, Experian and TransUnion will also no longer include medical collection debt under at least \$500 on credit reports.

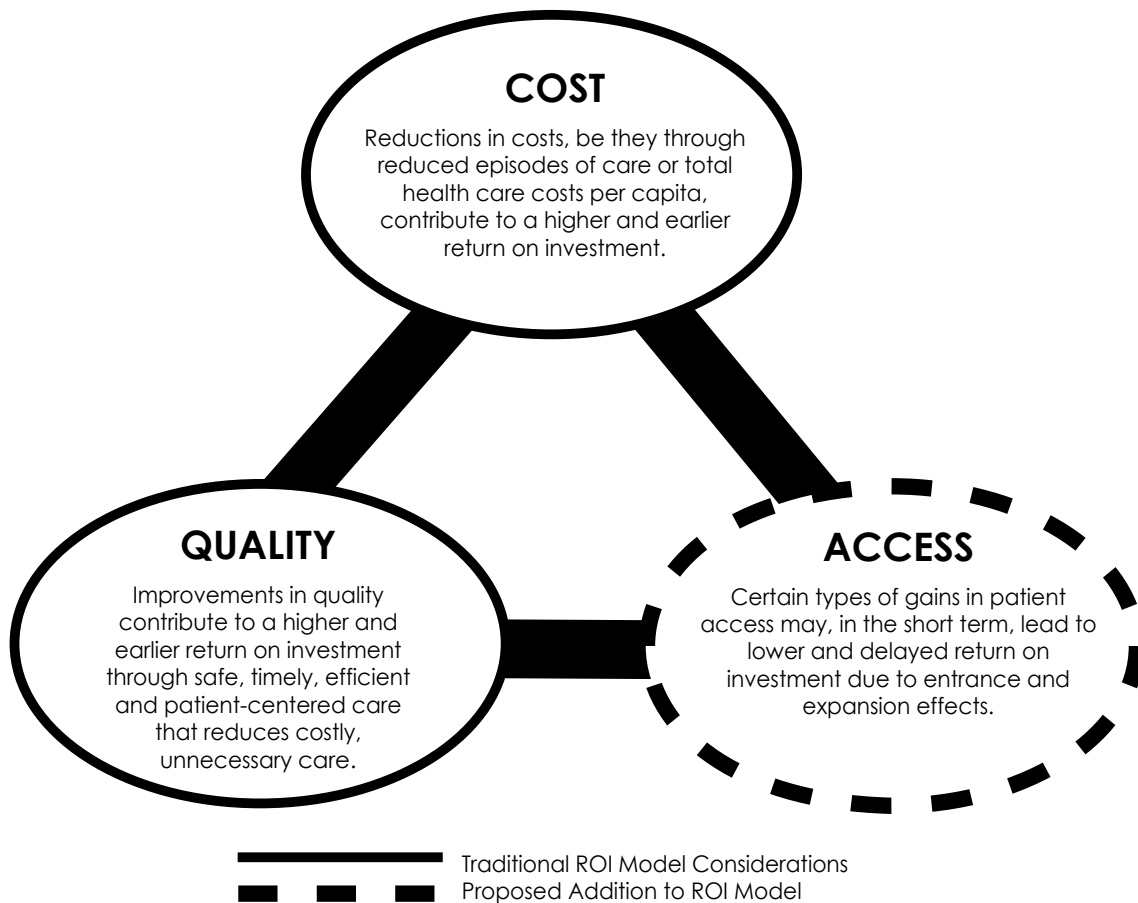
Ryan said that while the credit reporting agencies’ recent

decision to change medical collection debt reporting is an important step in ensuring medical debt does not negatively impact one’s credit score, there are some limitations.

“I am appreciative of what Equifax, Experian and TransUnion are doing. I think it’s a step in the right direction,” Ryan said. “However, the debt has to be paid before it will be removed from credit reports. While some families are able to eventually do that, it will take years for many ALICE families to pay off large amounts of medical debt.”

“People deserve a healthcare system that they can access when it’s needed to receive the proper quality of care in an affordable way. As a society, we’re all made better by having that system in place.

“I remain convinced that there’s some bipartisan way to fix it. I just know that somehow as a society if we grapple with it long enough, and get the right people involved in the discussion, we’ll be able to figure it out.”



Potential solutions to alleviating medical debt must consider the “iron triangle” model for health care reform, which includes cost, quality and access. These solutions can only be realized when people and organizations with differing and often conflicting points of view come together.

Solutions: National and Local Efforts to Address Medical Debt



Neil Sealy is the executive director at Arkansas Community Institute, the state's largest grassroots organization organizing low-income and working families statewide to fight for social and economic justice.

Medical debt is a barrier for 37 percent of Arkansans. That is a disheartening statistic, but the future need not be bleak. National and local experts are tackling the problem strategically in hopes of creating a better tomorrow.

"These aren't mistakes those individuals made. This isn't where an individual has taken out a loan," said Signe-Mary McKernan vice president for labor, human services and population and population codirector of the Opportunity and Ownership Initiative at the Washington, D.C.-based Urban Institute. "People need to have quality health insurance, and policies that support wealth building instead of stripping wealth from people."

McKernan lauded the passage of Medicaid expansion in Arkansas, which allows more low-income Arkansans to get health insurance coverage.

"There is strong research that shows personal financial improvements in states that expand their Medicaid programs

so residents are less likely to have new medical debt in collections, and they're more likely to have improved credit scores and reduced bankruptcy filings," she said.

Neil Sealy is the executive director of the Arkansas Community Institute, a membership organization of working families with low to moderate income. Arkansas Community Institute has made recommendations for simplifying the application process for Medicaid, including hiring state workers to facilitate enrollment.

"The other piece related to medical debt is looking at court cases, beginning in Pulaski County District Court, and then we're going to other counties, to see what's happening, and reaching out to people in the community who have debt," he said. "We're hoping to get them talking about what they're experiencing so we can look for ways we might be able to help them."

Sealy, citing instances of people paying off medical debt from hospitals but still being pursued by collections agencies, said the debt collection process needs to be streamlined. Medical debt that goes to collections results in



lower credit scores, and subprime credit scores make many things more expensive, from buying a house to repairing a car. Making minimum payments to avoid this debt spiral is, of course, key.

“Our research has shown that even a small amount of emergency savings can help families be resilient,” McKernan said. “Families that had non-retirement savings, a cushion of as little as \$350 to \$749 were less likely to be evicted, were less likely to miss housing or utility payments after a job loss or a health issue or a large income drop.”

Joanna Ramani, managing director at the Aspen Institute Financial Security Program in Washington, D.C., is interested in looking at ways to eliminate the ways people end up in debt in the first place as well as how to get them out of it.

“We want to stop the spigot of debt from building,” she said. “But even if you did all of that today — like if tomorrow, we fully changed the healthcare model — you still would have a bunch of people sitting in the debt they already accrued, and we can’t forget about them.”

RIP Medical Debt, a nonprofit organization formed by two former debt collections executives, buys medical debt for charitable reasons rather than for profit, said RIP spokesman Daniel Lempert.

“It’s for individuals who are 400 percent or below the federal poverty level or for individuals who have medical debt that is 5 percent or more of their gross annual income,” said Lempert. “We go high and low anywhere we can to get access to those specific debts, and we’ll purchase them from debt collectors and debt collection agencies.”

Lempert said that for every \$1 donated, RIP can erase \$100 of medical debt. Lempert said the organization has raised enough money to abolish \$6.6 million for over 3.5 million families.

“It really stretches the donor’s dollar a lot further,” said Lempert.

Organizations that set up funds to buy medical debt at a reduced price and forgive patients’ bills are promising and important, said Ramani, but they aren’t a perfect solution.

“They put a lot of pressure on the private sector for donations and in some ways the responsibility hasn’t changed off of the person who had the health need because they still have to find a source where someone’s going to help them,” she said.

In the same way patients are counseled about physical care as they go home after a hospital stay, the same could be done for finances. Financial coaches could work directly with patients to ensure that patients are enrolled in federal or state healthcare programs and connected with available resources.

“It’s almost unconscionable to let this person who’s been through a traumatic health event out into the world again without counseling them on how they will help with their financial side, the same way you wouldn’t let them back out into the world without counseling them on what to do about their health,” said Ramani. These are important steps, she said, for the good of families as well as for communities.

“It is real and documented and evidence-based that even if you don’t care about a single family, the fact that there are so many families in communities in Arkansas means that as a state, the economic development and the financial costs of the state is high,” said Ramani. “For that reason alone, you should care about it.”



Signe-Mary McKernan



Joanna Ramani



Daniel Lempert

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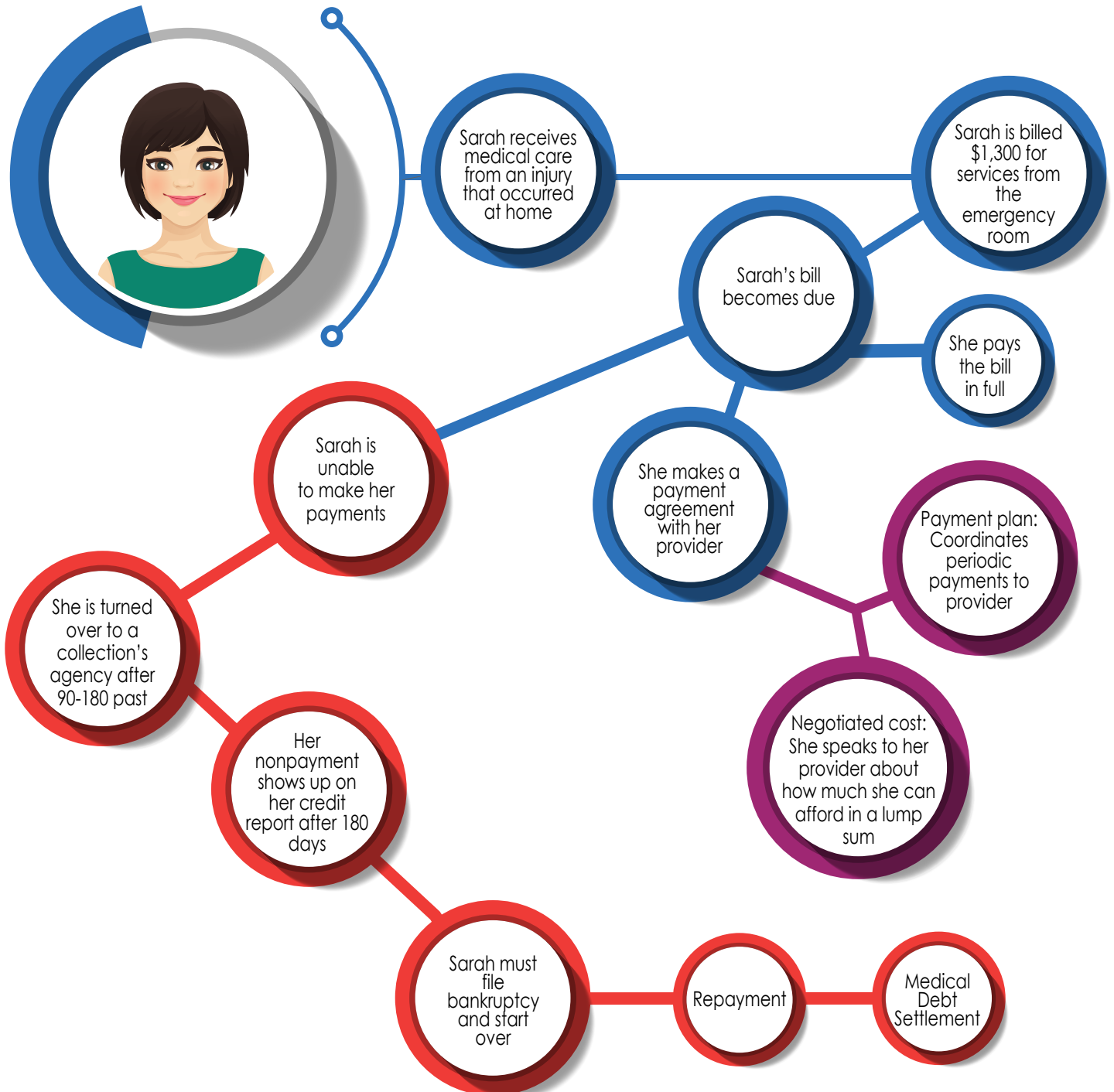
A Journey through Medical Debt

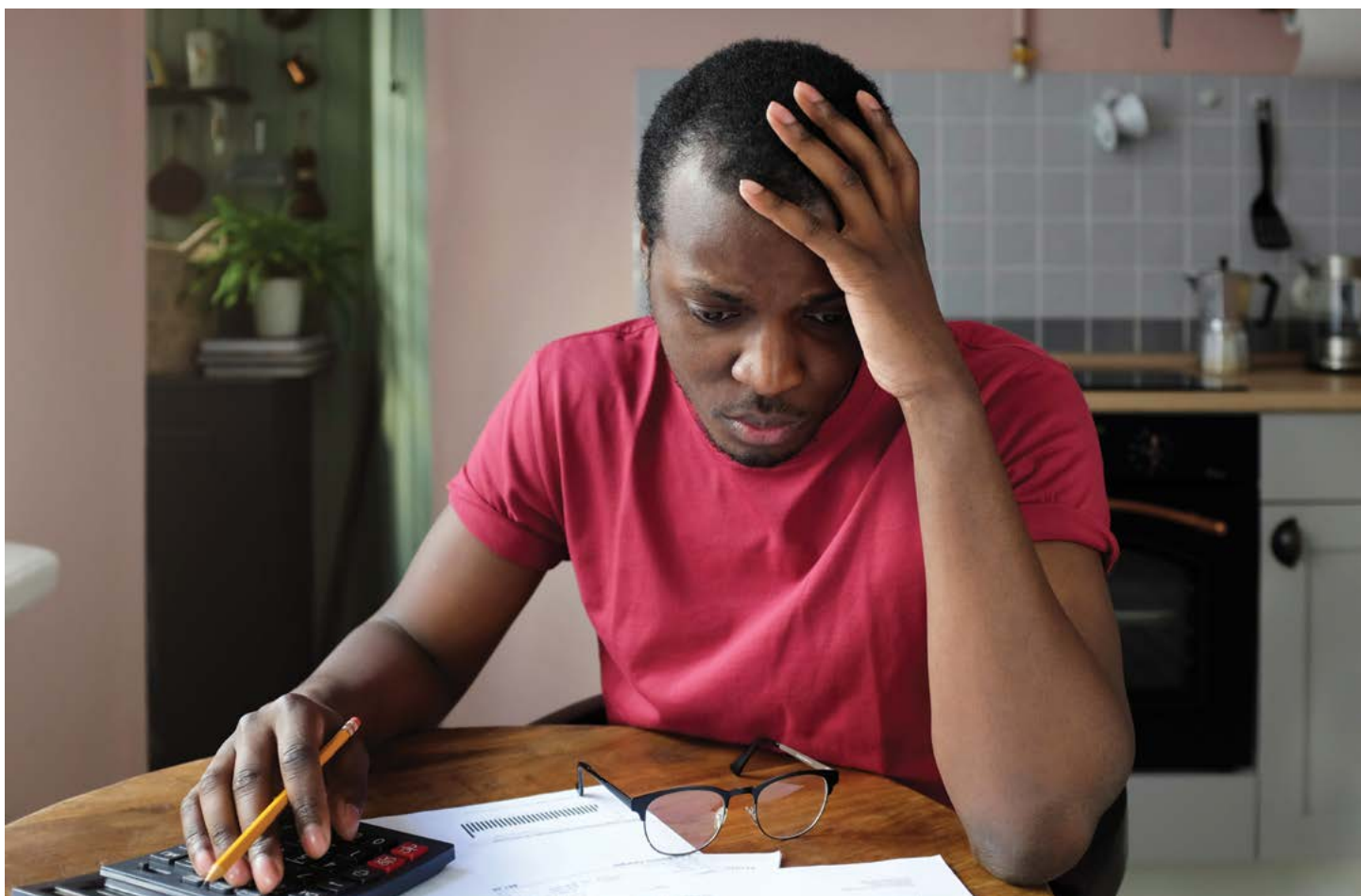
How does a medical bill become a debt?

Meet Sarah. She is a Certified Nursing Assistant at a local nursing home. Sarah makes \$27,000 a year and gets her insurance through a private carrier from the Affordable Care Act. Her deductible is \$3,000.

Sarah is a single mother with two children, works full time and utilizes all human services benefits that she qualifies for such as SNAP benefits, daycare vouchers and WIC for her children.

She has approximately \$250 discretionary income a month.





A Nationwide Problem

In April, a new report from the Consumer Financial Protection Bureau “Medical Debt Burden in the United States” was issued, which elevates medical debt as a larger problem nationwide. Some findings from the report:

- The Consumer Financial Protection Bureau's research shows \$88 billion in medical debt on consumer credit records as of June 2021. The total amount of medical debt in collections in the U.S. is likely higher, since not all medical debts in collections are furnished to consumer reporting companies.
- Most medical debt on consumer credit reports are under \$500
- Past-due medical debt reported to consumer reporting companies can appear on a person's credit reports and lower their credit scores. This may reduce their access to credit and make it harder to find a home or a job.
- Medical debt collections are less predictive of future payment problems than other debt collections are. Certain newer credit models take this into account, but some widely-used models still weight medical and nonmedical collections equally.
- Black and Hispanic people, and young adults and low-income individuals of all races and ethnicities, are more likely to have medical debt than the national average. As a result, these populations may be more heavily impacted by outdated credit models that overestimate the predictiveness of medical debt. Older adults and veterans are also heavily impacted by medical debt. Additionally, medical debt is more prevalent in the Southeastern and Southwestern U.S.
- Medical bill amounts can be unpredictable and often vary widely based on patient and provider characteristics. Uninsured and out-of-network patients are often charged prices that are much higher than what in-network insurers pay — even though the uninsured may have little ability to pay. The prices charged to uninsured and out-of-network patients sometimes significantly exceed providers' costs. Markups are especially high for emergency care, and for-profit investor-owned hospitals charge higher average markups.

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How Can The Medical Debt Crisis Be Addressed?



The Arkansas Asset Funders Network, Arkansas Community Institute, Arkansas Community Foundation and Hope Policy Institute joined together in January 2022 for an announcement highlighting the escalating debt issues in Arkansas and a set of recommendations for addressing the issue. Moderated by Talk Business and Politics host Roby Brock, the event provided an overview of medical debt and court costs

and described how debt cycles disproportionately harm lower income communities, ALICE households and people of color. A cohort of policy analysts, nonprofit leaders and representatives from the private sector developed a series of recommendations and action steps for policy makers and funders to affect change for the medical debt crisis.

CONTRIBUTORS TO THE RECOMMENDATIONS

Abby Hughes Holsclaw
Senior Director, Asset Funders Network

Karen Murrell
Program Officer, Special Projects,
Asset Funders Network

Neil Sealy
Executive Director, Arkansas Community Institute

Calandra Davis
Senior Policy Analyst, Hope Policy Institute

Diane Standaert
Sr. Vice President, Policy and Advocacy
Hope Policy Institute



RECOMMENDATIONS AT THE FEDERAL LEVEL:

- Implementing the No Surprises Act, which increases consumer protections for those receiving medical care from out-of-network providers. Under the No Surprises Act, which is slated for implementation in 2022, patients will only be required to pay the in-network cost-sharing amounts when they receive emergency care or when they unknowingly receive non-emergency care from an out-of-network provider at an in-network facility.
- Increasing attention to the harms of medical debt by the Consumer Financial Protection Bureau. Specifically, the Bureau could act to limit medical debt reporting on credit reports; create and publish new data on the impact of medical debt on consumers, particularly in communities of color; and increase consumer safeguards against debt collectors and healthcare providers.
- Broadening federal protections that limit wage garnishment by hospitals.

RECOMMENDATIONS AT THE STATE LEVEL:

- Enacting comprehensive legislation to protect consumers from surprise (out-of-network) medical bills.
- Centering medical debt elimination and protections in COVID-19 recovery plans.
- Regulating and expanding hospital-based financial assistance programs.

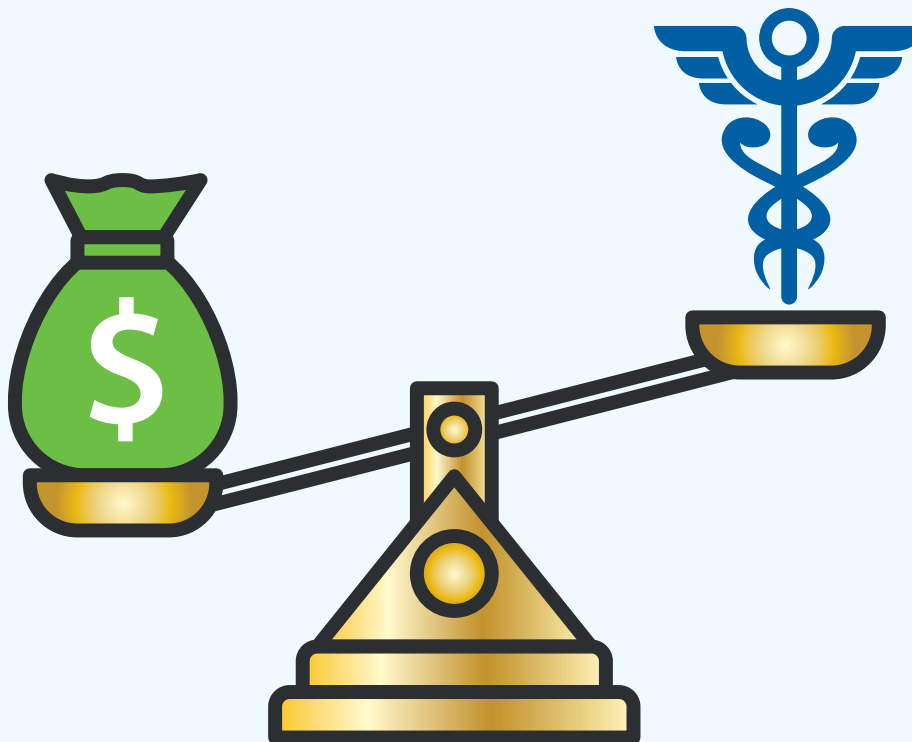
- Providing state-level protections from abusive medical debt collection practices, limiting reporting of medical debt to credit report agencies, and limiting the amount of interest that can be charged on medical debt.

HOSPITALS CAN LESSEN THE BURDEN OF MEDICAL DEBT BY:

- Ensuring that information about hospital-based assistance is prominently displayed at all points of patient contact and that employees are trained to tell patients about assistance programs.
- Actively creating payment plans or offering other options for patients rather than sending returned checks to collection agencies or district courts.

RECOMMENDATIONS FOR FUNDERS:

- Increasing access to legal representation for debt collection cases, either directly or through support for advocacy organizations.
- Funding advocacy and research that identifies the specific changes needed to increase racial equity in the medical and courts systems and supporting pilot initiatives.
- Working with the state bar association to increase legal aid or pro bono representation for debt collection cases.
- Exploring employer-sponsored legal counseling as part of employee benefit packages. Models for this, sometimes called Judicare, are in operation around the country.



Racial Disparities Contribute to Medical Debt for Arkansans

by Bill Bynum, CEO, HOPE Enterprise Corporation



Bill Bynum

“Now, we are using our voice to join with others in calling for changes that will benefit Arkansans across the state.”

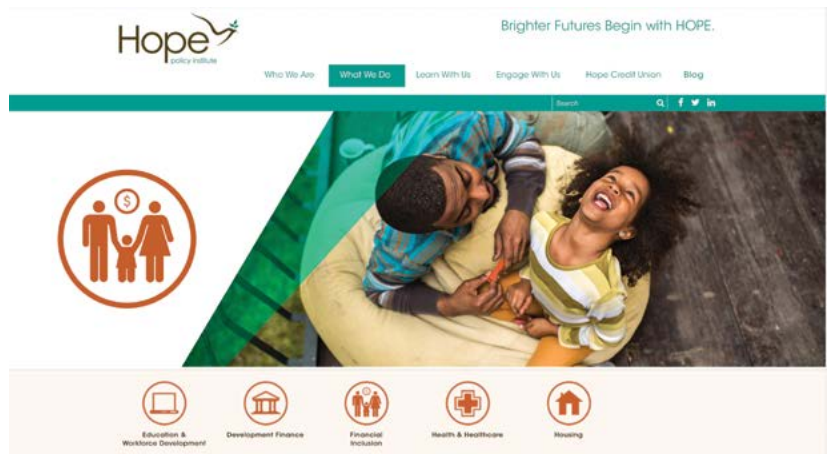
— Bill Bynum

Anchored in the America's Deep South, HOPE is a financial institution owned and led by women and people of color and a policy center that works to open doors to the American Dream. HOPE sees how medical debts push doors to opportunity further out of reach every day.

According to the Urban Institute, one in five of Arkansans have medical debt in collections — higher than the national average. The data reveals wide racial disparities, with 19% of people in white communities impacted compared with 23% of people in communities of color. Mounting medical debt and the disparities within it stem from a long history of policy decisions. According to ProsperityNow, Arkansas has the second highest rate of people in liquid asset poverty, meaning they cannot cover three months of basic expenses in the face of unexpected loss of income. It has the highest liquid asset poverty rate for Black households, with 74% in liquid asset poverty.

Mounting medical debts exacerbate these conditions, as it siphons off resources that people could otherwise use to build savings or wealth for the future. One HOPE member, who makes \$2,200 a month, requested a modification on her mortgage because she was being garnished \$447 per month for repayment of her medical debt after it was sold to a third-party. This means the original medical provider is no longer trying to seek repayment but yet the borrower will be hounded for years by other debt collectors. Another member had come to HOPE shortly after he had sold his truck to pay for medical bills, resulting in him walking a 10-mile, four hour round trip. Thankfully, we were able to get him into a car loan, even with a low credit score. Ultimately, getting sick should not lead to a lifetime of financial ruin.

As a lender, HOPE is doing what it can to discount medical debt when making decisions about providing access to capital that people need to build wealth for the future. Now, we are using our voice to join with others in calling for changes that will benefit Arkansans across the state. We urge others to do the same. Leaders in philanthropy, in particular, can use your voice and your power to make investments for change to prevent debt from serving as a barrier for Arkansas's economic mobility. It is vital that the recommendations included in this publication be weighed and considered by policy makers and community leaders in Arkansas.





DEBT ERASED FOR ARKANSANS IN 2022

\$225,000

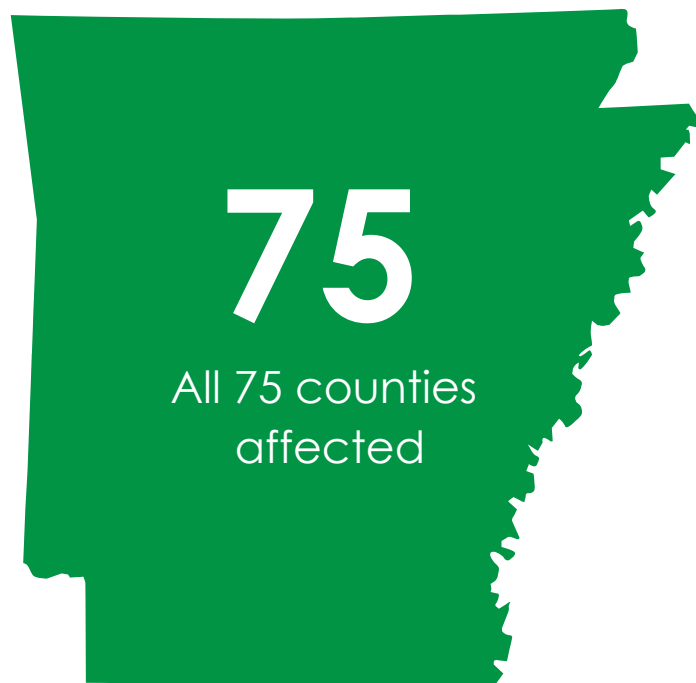
raised by private funders

\$35 million

of medical debt relieved

23,896

Arkansans had debt erased



This effort was an initiative of Arkansas Community Foundation, HOPE Policy Institute and the Winthrop Rockefeller Foundation.

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policy institute

winthrop
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RIP Medical Debt (RIP) coordinated the payments and purchased medical debts in large, bundled portfolios for a fraction of their face value. Recipients were randomly chosen based on who qualified and account availability. Those selected for debt abolishment received a letter notification from RIP.



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5 Allied Drive, Suite 51110
Little Rock, AR 72202
501-372-1116 • FAX 501-372-1166
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A Practice with Compassion

Danna F. Gear, M.D., is a radiologist and founding partner of The Breast Center, a MANA Clinic in northwest Arkansas. The physicians of MANA hold the MANA Fund with Arkansas Community Foundation. Started to recognize a colleague, the fund supports a benevolence fund for employees facing personal emergencies, and the Murray T Harris scholarship fund assisting students in healthcare fields such as radiology technology and nursing.

In her practice, Dr. Gear sees patients struggling to pay for and navigate the medical system, especially following a cancer diagnosis. “We see patients with and without insurance struggling with medical debt. Many insured patients have high deductibles” said Gear. “Many choose plans with high deductibles because they can’t afford larger monthly premiums. A few thousand dollars of medical debt (before meeting their deductible) can be impossible for many to pay.”

A cancer diagnosis can be overwhelming. “Many people don’t know what to do, much less how they’ll pay for it.” she said.

“At the Breast Center, patients are seen regardless of their ability to pay,” said Gear. Unfortunately, if a patient does not make an attempt to pay their bill, it may be sent to collections. “We offer to set up payment plans. Paying as little as \$5-10 per month keeps an account from being turned

to a collection agency. The system really isn’t fair. A \$100 account sent to a collection agency can snowball.”

Gear and her husband have a donor-advised fund with the Community Foundation directed primarily to organizations serving patients with medical needs, like Washington Regional Medical Foundation. “I love what WRMF does.

Among many things, through their Cancer Support Home, they provide a ‘navigator’ to patients to help them with whatever they need — childcare, transportation or sometimes simply having their hand held during a difficult treatment.”

As a doctor and fundholder, Gear understands the connection between philanthropy and support for cancer patients. “I’m trying to be more intentional about my charitable giving. The Community Foundation helps me with that. Through our local Philanthropy Club, I am learning more about local nonprofits,” she said. “I just wish I’d started sooner.”



Danna F. Gear, M.D.

