CONSUMER FINANCIAL PROTECTION BUREAU DECEMBER 2024

Medical Collections on Credit Reports in Native American Communities

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1. Introduction

Consumers rarely plan to take on medical debt, usually incurring it involuntarily due to an acute medical need. If a provider sends unpaid medical bills to collections, they can ultimately end up on consumer's credit records as a tradeline that includes the amount of the unpaid debt in collections.[1] These medical collections tradelines can in turn affect credit scores and limit consumers' ability to secure loans, housing, or employment, and even after the medical bill has been paid, the consumer still faces collections fees and charges.

This report examines medical debt in collections on credit records in areas where most residents are American Indian or Alaska Native. We first analyze credit records in the Consumer Credit Information Panel (CCIP) to understand the patterns of medical debt in collections for consumers in Native communities[2] as compared to the rest of the United States, and how features of the health care system relate to the prevalence and amount of this debt on credit reports. In the second part of this report, we present findings from interviews with Tribal leaders and members, health care administrators and subject matter experts. These interviews also highlight systemic issues in the health care system for Native consumers that result in medical debt collections that negatively impact Native consumers' financial lives, their health, and their communities.

Our analysis shows the following key findings:

- People in Native communities were almost twice as likely to have medical debt in collections on their credit records compared to the national average as of December 2023. This rate (about eight percent) was similar in other rural, high poverty tracts.
- The amount of medical debt in collections on credit reports is also higher in Native communities. Among consumers with medical debt collections tradelines in December 2023, the average total amount in medical collections on consumers' credit records was about $4,000 in Native communities, 33 percent higher than the national average and 28 percent higher than in other rural high poverty areas.

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[1] A "tradeline" is a specific account on an individual's consumer report. A medical debt collections tradeline includes information about an individual's allegedly unpaid medical bills. *See*, Camille Kirsch and K Eswaramoorthy, Market Snapshot: An Update on Third-Party Debt Collections Tradelines Reporting, February 2023, p. 4, https://files.consumerfinance.gov/f/documents/cfpb_market-snapshot-third-party-debt-collections-tradelines-reporting_2023-02.pdf.

[2] A note on terminology: We define "Native communities" and "majority-Native tracts" as census tracts where 50 percent or more of residents identify as American Indian or Alaska Native alone or in combination with other races in the American Community Survey.

- People in Native communities with medical debts on their credit records are more likely to have *only* these collections on their records, with no other types of tradelines. About 25 percent of credit records in Native communities contain only medical collections tradelines, as compared to the overall U.S. rate of about 15 percent.

- Factors over which a person has limited control influence the amount of medical debt in collections. One example is proximity to health care providers. The federal government provides health care to federally recognized Tribal members through the Indian Health Services (IHS) system. Federally or Tribally run facilities provide free care directly, but almost a third of majority-Native tracts lack a year-round IHS primary care facility. In 2023, medical debt tradelines were two and a half times more common on credit records in majority -Native census tracts without these facilities.

- The availability of public insurance is also related to the amount of medical debt in collections. In states that expanded Medicaid, half as many consumers in majority-Native areas had medical debt tradelines on their credit records as in non-expansion states. Native communities in a Medicaid expansion state that also had an IHS primary care facility saw the lowest incidence of medical debt in collections on credit reports, with a rate similar to the rest of the United States.

- Many medical collections for Native consumers are for bills that patients may not actually owe. Billing and administrative complications in the IHS system can result in delayed payments, errors, and confusion on the part of external providers. Consequently, providers often inappropriately bill patients for care that has been authorized for payment through the IHS system. Native consumers may be coerced into paying medical bills that they do not owe to avoid bad credit and any collections fees or interest charges. Even when bills are finally paid by IHS or the consumers themselves, consumers may still be stuck with these collections fees and charges.

- People in Native communities face a confusing and complex approval process, especially for specialty or emergency care in non-IHS facilities. This often results in unexpected medical bills.

- Medical debts affect both consumers' financial lives and their access to health care. Medical debt collections on credit reports were commonly reported to limit credit, impacting housing, education, and business development. Participants also reported limited access to health care providers, both individually and on a community level, due to payment delays and unpaid bills stemming from administrative hurdles. In some cases, providers refused individuals further treatment until the bills were resolved, and in other cases, providers refused to contract with Tribal health organizations due to difficulties in obtaining timely payment.

2. Characteristics of Native American Communities

Almost three million individuals report being only American Indian or Alaska Native in the United States, and 6.3 million report this race either alone combination with one or more races.[3] Race and ethnicity are not reported in the in the Consumer Financial Protection Bureau's (CFPB) Consumer Credit Information Panel (CCIP), which is used in the analysis for this report. Instead, we analyze medical debt in collections on consumers' credit reports in census tracts where a majority of residents report being American Indian or Alaska Native, either alone or in combination with other races. We refer to these areas as "Native communities," although many of the issues described also affect Native individuals living in other parts of the United States.

"Majority-Native" census tracts are identified as those where 50 percent or more of residents in the census tract report being American Indian or Alaska Native alone or in combination with other races in the American Community Survey, 2022. To disentangle the effects of the economic context of these tracts from issues specific to Native consumers, we compare patterns in medical collections on credit reports in these areas to those in rural comparison tracts. These rural comparison tracts are defined as those where 100 percent of residents live in rural areas, and at least 20 percent of individuals reside in households below the poverty line in the census tract. This threshold results in an average poverty rate and average median income that matches the majority Native tracts.

Majority-Native census tracts are all located on or very close to reservations or other Tribal lands. About 20 percent of all American Indian and Alaska Native individuals in the U.S. live in these tracts, but these communities are important political and cultural areas for many Native individuals. Lands in Indian country[4] often have complex jurisdictional issues stemming from mixes of trust and fee land, which create challenges for Tribal sovereignty and economic development. These areas are mostly located in the West, although there are also large Native communities in North Carolina and the upper Midwest.

Table 1 compares average characteristics of majority-Native census tracts to the rural comparison tracts and to the average U.S. census tract. These census tract characteristics are

[3] 2017-2021 ACS 5-Year Selected Population Tables (SPT) and American Indian and Alaska Native Tables (AI/ANT) Documentation.

[4] The term "Indian country" is a legal term which refers to reservations, trust lands, restricted fee lands, and other lands held by the federal government in trust for Indian Tribes. *See* https://www.justice.gov/archives/jm/criminal-resource-manual-677-indian-country-defined for a more comprehensive definition.

reported in the 2023 Census Bureau Planning Database, which is based on the 2017-2021 5-year American Community Survey.[5] Although Table 1 compares the tract averages, it is important to note that there is also significant variation across majority-Native tracts in some of these characteristics.

- On average across majority-Native tracts, 90 percent of residents live in rural areas, compared to less than a quarter in the average U.S. census tract.[6] Many are located far from population centers and have limited access to health care services.

- On average across majority-Native tracts, median household income is about 56 percent of the median household income in the average U.S. census tract. On average across these tracts, about one-third (32 percent) of individuals live in households with income below the poverty line, more than double the poverty rate of 14 percent in the average U.S. tract.

- Limited economic opportunities in many of these communities likely contribute to lower household incomes. On average, the unemployment rate in majority-Native tracts is 13 percent, more than double the average across all U.S. census tracts.

- Non-elderly individuals in these communities are much less likely have health insurance than in other areas. On average across majority-Native tracts, 29 percent of adults 19–64 do not have health insurance. This is 50 percent higher than the tract-level average in other rural comparison tracts and is almost two and a half times higher than the average across all U.S. census tracts. For children, the uninsurance rate (averaged across tracts) is more than three times as high in majority-Native tracts as in the U.S. as a whole: 16 percent for majority-Native tracts compared to 5 percent for all U.S. tracts).

[5] From https://www.census.gov/topics/research/guidance/planning-databases.html

[6] The ACS reports rural or urban status at the individual level, such that Census tracts vary in the percentage of residents residing in a rural area. A rural area is defined by the Census as a non-urbanized area, the smallest of which are urbanized clusters with at least 2,500 residents.

TABLE 1: CHARACTERISTICS OF MAJORITY-NATIVE CENSUS TRACTS, 2017-2021

Characteristic	Average across Majority-Native tracts	Average across Rural Comparison tracts	Average across All U.S. Census tracts
% Individuals residing in rural areas	89.8%	100%	22.5%
Median HH Income	$41,452	$41,411	$73,798
% Individuals in households below poverty line	31.7%	27.8%	14.0%
Unemployment rate, ages 16+	13.1%	8.4%	5.9%
% Individuals under 18	31.2%	22.7%	21.7%
% Individuals age 19–64 without health insurance	29.4%	19.7%	12.6%
% Individuals under 19 without health insurance	16.0%	7.6%	5.1%
Number of tracts	221	2,275	83,770

Source: 2023 Census Bureau Planning Database, https://www.census.gov/data/developers/data-sets/planning-database.html. Accessed Sept 5, 2024.

When medical debt is furnished to consumer reporting agencies (CRAs), it can have negative consequences for consumers' credit profiles and scores.[7] This issue is particularly salient in Native communities given the longstanding issues in credit markets in these areas. Native communities tend to be underrepresented in traditional financial services.[8] Residents are less likely to use mortgages and other types of traditional credit, particularly on reservations and Tribal lands. This is in part due to the complexities of property rights with mixtures of fee and trust lands[9], and consequently borrowers in these areas are more likely to have higher priced mortgage loans.[10] Credit limits for first-time borrowers are typically also lower if they reside in an area with a high share of Native consumers. [11] Consequently, medical debt collections reported on credit records can potentially have an outsized impact on consumers' credit records in Native communities, due to the already higher prices for and more limited access to credit.

[7] *See* Kenneth Brevoort and Michelle Kambara, Medical Debt and Credit Scores, Consumer Financial Protection Bureau Office of Research, Data Point, May 2014, https://files.consumerfinance.gov/f/201405_cfpb_report_data-point_medical-debt-credit-scores.pdf

[8] *See* Miriam Jorgensen and Randall K.Q. Akee, Access to Capital and Credit in Native Communities: A Data Review, Native National Institute, University of Arizona, (2017); Valentina Dimitrova-Grajzl, Peter Grajzl, A. Joseph Guse and Richard M. Todd, Consumer Credit on American Indian Reservations, 39 Economic Systems 518 (2015).

[9] Fee lands are ones where the owner holds the title and has control of it. The federal government holds the title to trust lands, not an individual, and typically tribes govern the use of this land.

[10] *See* Laura Cattaneo and Donna Feir, The Price of Mortgage Financing for Native Americans, 4 Journal of Economics, Race, and Policy 302 (2021); Elizabeth Laderman and Carolina Reid, Mortgage Lending on Native American Reservations: Does a Guarantee Matter?, 19 Journal of Housing Economics 233 (2010);

[11] *See* Valentina Dimitrova-Grajzl, Peter Grajzl, A. Joseph Guse, Richard M. Todd and Michael Williams, Neighborhood Racial Characteristics, Credit History, and Bankcard Credit in Indian Country, 60 Comparative Economic Studies 410 (2018).

Indian Health Services, an independent agency within the Department of Health and Human Services, has the responsibility to provide health care services to members of federally recognized Tribes. IHS is not an insurance program or an entitlement program Instead, Congressional appropriations fund clinics, health centers, and a few hospitals that are either directly operated by IHS, or by Tribes or Tribal organizations through self-determination contracts and self-governance compacts authorized in the Indian Self-Determination and Education Assistance Act (ISDEAA). [12] These facilities provide free direct care to eligible patients, although the available services vary. IHS also pays for specialized services or emergency care delivered by private providers through the Purchased/Referred Care (PRC) program. In these instances, IHS is the "payer of last resort," meaning that a patient's other public or private insurance makes payment first, with IHS covering any remaining charges.

Due to their generally remote nature, access to high-quality health care services is a major issue in many Native communities.[13] The COVID pandemic highlighted issues in access to care and disparities in outcomes. According to the Centers for Disease Control, American Indians and Alaska Natives had the highest rates of infection, hospitalization, and death compared to other races and ethnicities in the first year of the pandemic.[14] Even before the pandemic, the average American Indian or Alaska Native individual had a life expectancy five and one-half years shorter than the average American, and in 2020 American Indian or Alaska Native infant mortality rates were 60 percent higher than the overall rate in the U.S. [15] To the degree that issues of billing, coverage, and medical debt limit the ability of Native individuals to seek timely and appropriate care, this can exacerbate existing health disparities.[16]

[12] Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638, 88 Stat. 2203 (1975) (codified as amended at 25 U.S.C. §§ 450 et seq.).

[13] *See* Agency for Healthcare Research and Quality, National Healthcare Quality and Disparities Report, AHRQ Pub. No. 21(22)-0054-EF (2021).

[14] *See* Centers for Disease Control and Prevention, Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity (Nov. 22, 2021), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[15] *See* US Department of Health and Human Services, Indian Health Service, Indian Health Disparities: Fact Sheet, (October 2019).

[16] *See* Sara R. Collins, Shreya Roy, and Relebohile Masitha, Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer — Findings from the Commonwealth Fund 2023 Health Care Affordability Survey (Commonwealth Fund, Oct. 2023). https://doi.org/10.26099/bf08-3735

3. Analysis of medical debt collections tradelines

Previous CFPB research has found that medical debts in collections are less predictive of credit risk than other types of collections, [17] and that removal of this debt from consumer credit reports can improve access to credit and financial outcomes. [18] In part due to these concerns, the three nationwide CRAs made several changes to the treatment of medical debt in collections on consumer credit reports. Beginning in 2022, the CRAs increased the amount of time before unpaid medical collections were posted on consumers' credit records from 180 days to one year, and paid medical debts were removed from credit records. In 2023, unpaid medical collections below $500 were also removed from consumer credit records. [19]

Previous research has found that medical debt (as measured with collections tradelines on credit records) tends to be more common for people with low incomes and for Black and Hispanic consumers, [20] and that the removal of low-balance tradelines and paid collections left more medical debt in lower-income census tracts and for consumers with lower credit scores. [21] There is less information to date on the experience of Native individuals, however.

3.1 Share of consumers with medical collections on credit reports

Figure 1 shows that medical debt in collections disproportionately affects the credit records of individuals in Native communities, both before and after the reporting changes. In 2021, about 18 percent of consumers in majority- Native census tracts had a medical debt in collections on their credit record. This was five percentage points higher than the rate for other consumers in

[17] *See* Brevoort and Kambara, Medical Debt, supra note 3.

[18] *See* Consumer Financial Protection Bureau Office of Research, Early Impacts of Removing Low Balance Medical Collections, Data Spotlight, May 2024, https://www.consumerfinance.gov/data-research/research-reports/data-spotlight-early-impacts-of-removing-low-balance-medical-collections/

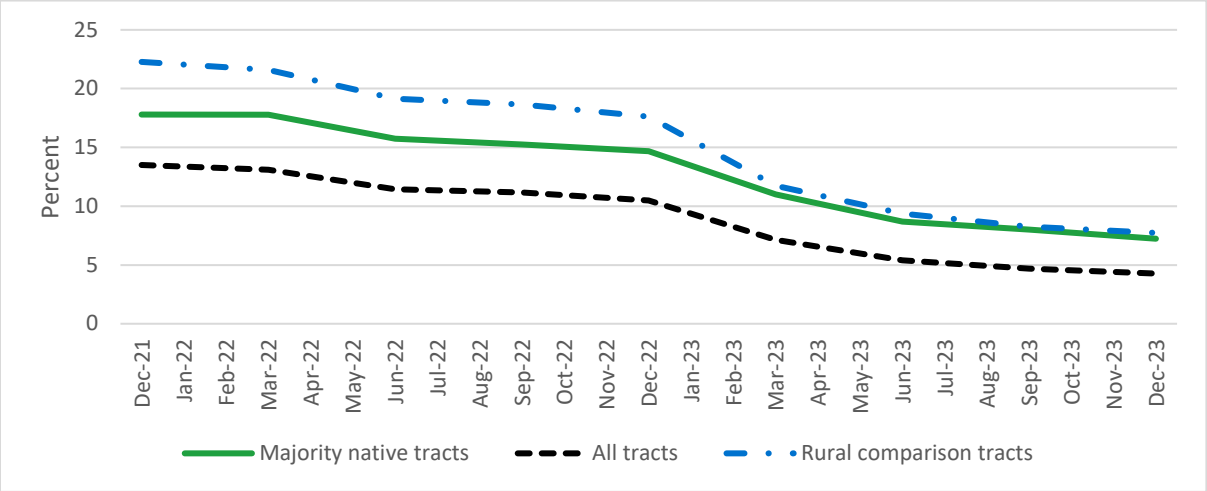
19 *See* Equifax, Experian, and TransUnion Remove Medical Debt Under $500 From U.S. Credit Reports, Business Wire (April 2023), https://www.businesswire.com/news/home/20230411005392/en/Equifax-Experian-and-TransUnion-Remove-Medical-Collections-Debt-Under-500-From-U.S.-Credit-Reports

[20] *See* Consumer Financial Protection Bureau, Medical Debt Burden in the United States, February 2022, https://www.consumerfinance.gov/data-research/research-reports/medical-debt-burden-in-the-united-states/

[21] *See* Ryan Sandler & Zachary Blizard, Recent Changes in Medical Collections on Consumer Credit Records, Consumer Financial Protection Bureau Office of Research, Data Point, Mar. 2024, https://www.consumerfinance.gov/data-research/research-reports/recent-changes-in-medical-collections-on-consumer-credit-records

the U.S. In December 2023, after the reporting changes, only about eight percent of credit records in majority-Native communities included medical debt, about double the roughly four percent rate in the U.S. as a whole, but similar to the rate in other economically comparable rural areas.

FIGURE 1: SHARE OF CONSUMERS WITH MEDICAL COLLECTIONS TRADELINES ON THEIR CREDIT REPORTS

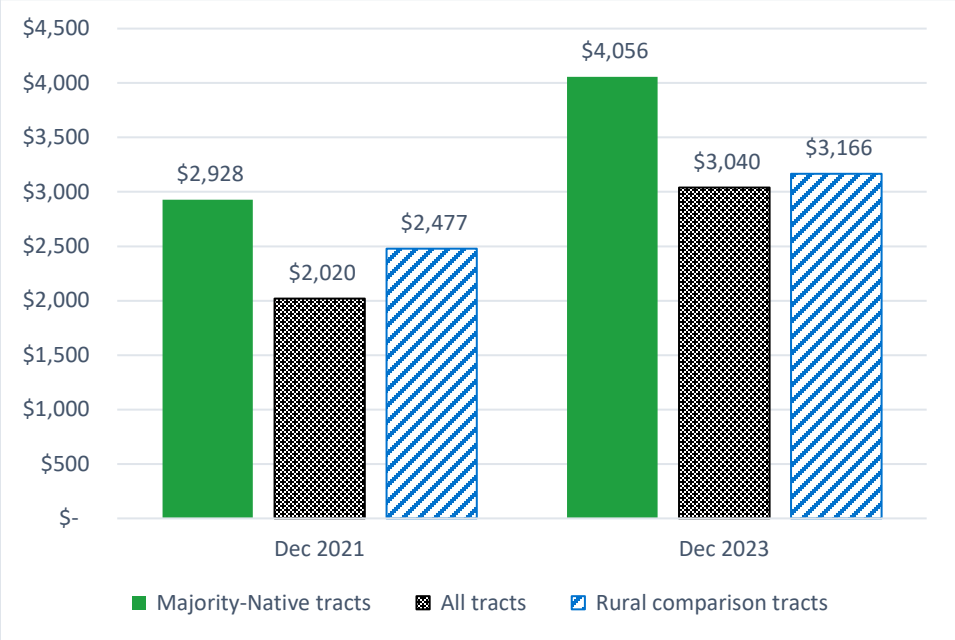


Source: CFPB Consumer Credit Information Panel (CCIP).

3.2 Average total medical collections tradelines

Figure 2 below shows average balances for consumers with medical debts on their credit record. As of December 2023, the average total balance was about $4,000 for consumers in Native communities, compared to about $3,200 in rural comparison tracts, and $3,000 for the entire U.S. Figure 2 shows this pattern of higher balances both before and after the 2022-2023 reporting changes that removed paid and low balance tradelines.

FIGURE 2: AVERAGE TOTAL MEDICAL COLLECTIONS TRADELINES ON CONSUMERS' CREDIT REPORTS



Source: CFPB Consumer Credit Information Panel (CCIP).

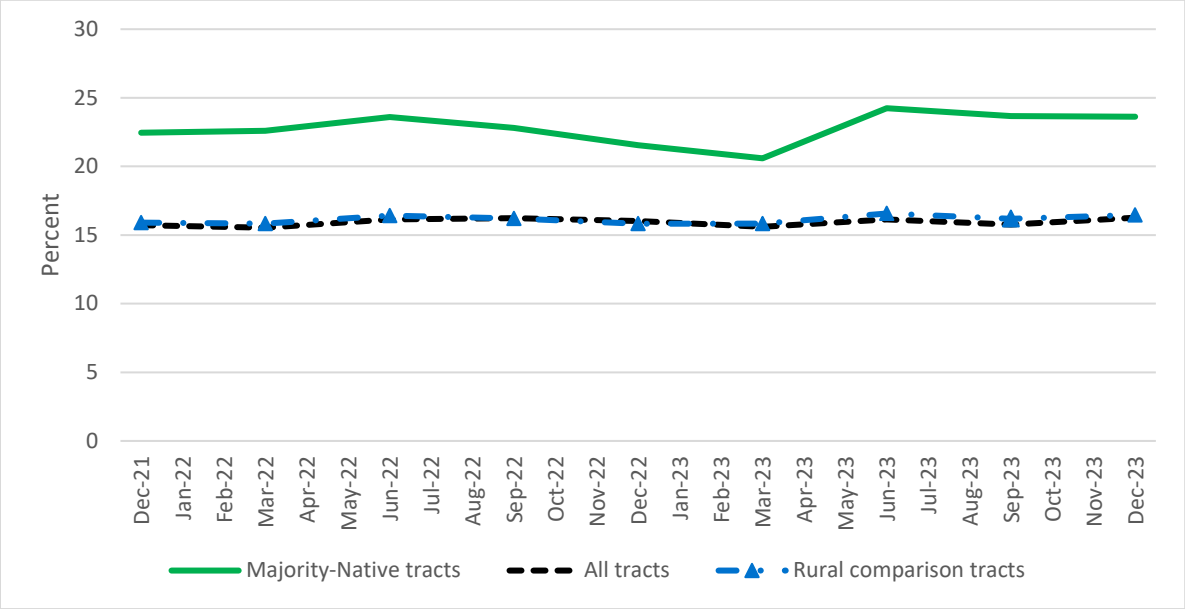
The higher probability of reported medical collections tradelines and higher balances in Native communities is particularly striking, given that many residents are eligible for free medical services through IHS. Section 7, below, discusses the prevalence of billing, reimbursement, collections, and other issues that lead to significant medical debts even for these eligible individuals.

3.3 Consumers with medical debt collections and no other credit record items

Consumers in majority-Native tracts who have medical debt in collections on their credit records are more likely to lack any other items on their credit records. This is shown in Figure 3 below.

Figure 3 shows that from December 2021 through December 2023, about 23 percent of consumers in majority-Native tracts with medical debt in collections had *only* this item on their credit records, lacking any other forms of reported tradelines. In both the comparison rural tracts and for consumers in the U.S. as a whole, this rate was about 15 percent.

FIGURE 3: FRACTION OF CONSUMERS WITH MEDICAL DEBTS WHO HAVE NO OTHER ITEMS ON CREDIT RECORD



Source: CFPB Consumer Credit Information Panel (CCIP).

4. Access to IHS facilities

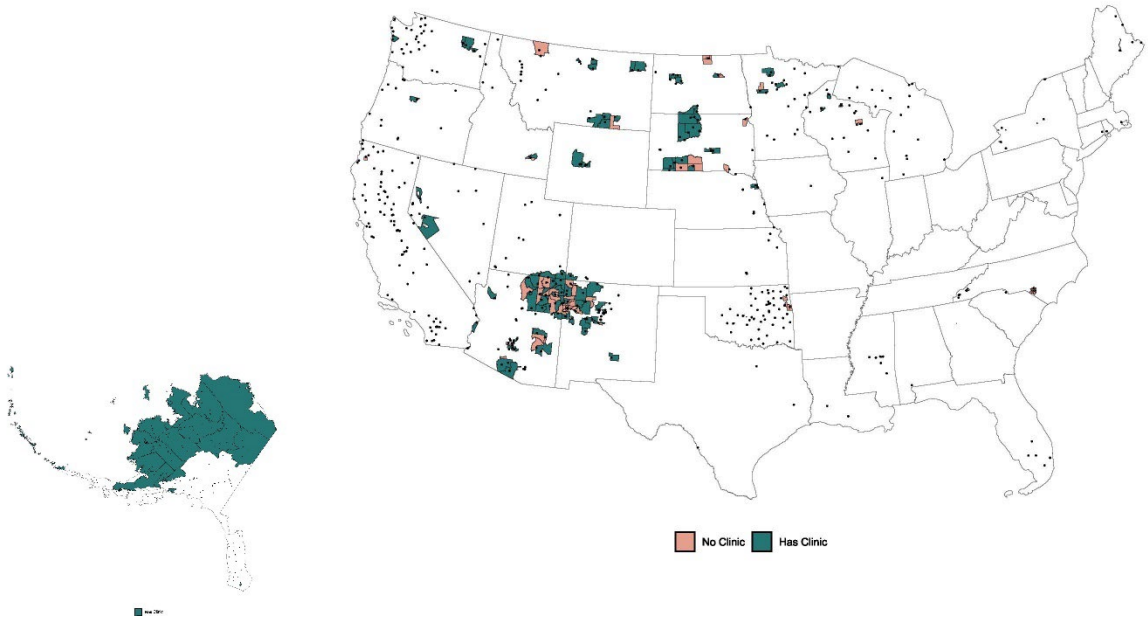
Many Tribal population centers contain an IHS or Tribally operated primary care facility that is available to treat individuals year-round. Individuals are eligible for free care at IHS facilities if they are an enrolled member of a federally recognized Tribe or a direct descendent of a member.[22] Children of eligible members are also covered, as well as women pregnant with an enrolled member's child. Tribes may also choose to cover spouses of eligible members. Depending on the facility, non-eligible individuals may also be able to obtain care, although they would be billed for the services.

Figure 4 shows the locations of year-round IHS primary care facilities in 2022. Shaded areas indicate census tracts with majority-Native individuals. Census tracts that contain a facility are in teal; tracts without a facility are in pink. (Some communities without a facility may offer

[22] These and other eligibility standards are outlined in the IHS Indian Health Manual https://www.ihs.gov/ihm/pc/part-2/chapter-1-eligibility-for-services/

services periodically, and these temporary locations are not included in the map.) In 2022, about a third (32%) of majority-Native census tracts did not contain a primary care facility in the IHS system. This can result in significant travel times for people seeking care in an IHS facility**.** The list of Census tracts and whether or not they contained an IHS clinic in 2022 is found in Appendix A.

FIGURE 4: IHS PRIMARY CARE FACILITIES AND MAJORITY-NATIVE TRACTS

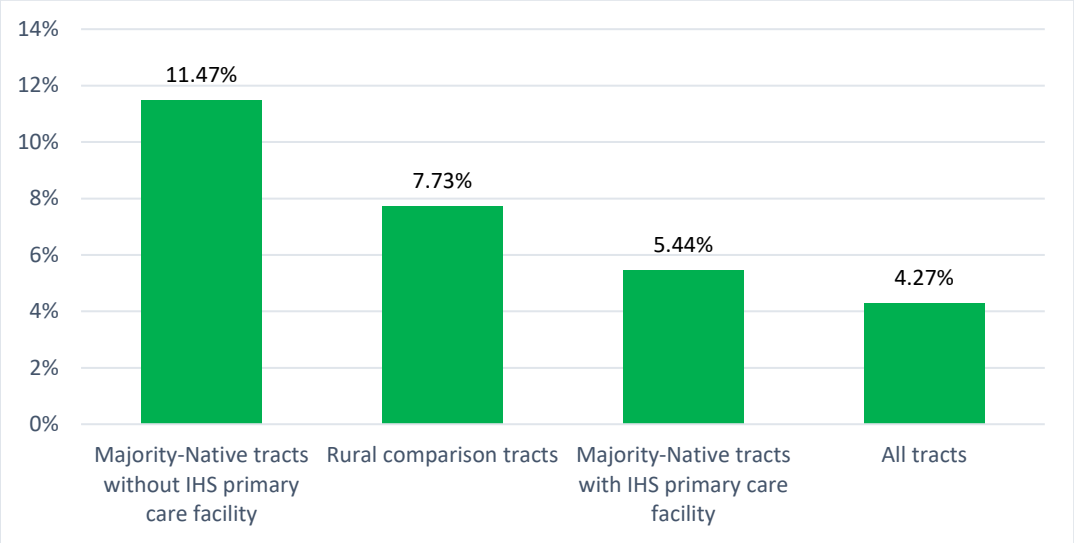


Dots indicate IHS system year-round primary care facility open in 2022, including both IHS and Tribally operated facilities. Tracts in green contain IHS primary care clinics; tracts in blue do not. Note that some of the clinic dots fully cover small tracts.

Source: 2020 Census tracts with IHS primary care facilities are identified using the longitude and latitude as reported in IHS listing of facilities.

Figure 5 below shows that proximity to a year-round primary care IHS facility is related to the prevalence of medical debt in collections on credit reports. The figure shows that in majority-Native tracts that contain an IHS facility, about five percent of credit records have a medical debt in collections, similar to the rate for the U.S. as a whole and lower than in other rural comparison tracts. However, in majority-Native tracts that lack a standing IHS primary care facility, almost 12 percent of credit records contain medical debts in collections.

FIGURE 5: SHARE OF CONSUMERS WITH MEDICAL COLLECTIONS TRADELINES ON THEIR CREDIT REPORTS Q4 2023



Source: CFPB Consumer Credit Information Panel (CCIP). Tracts with IHS primary care facilities are identified using the longitude and latitude as reported in the IHS listing of facilities.

5. State Medicaid expansions

Lack of insurance can be an important contributor to medical debt, and American Indian or Alaska Native individuals have the highest uninsured rate among racial and ethnic groups.[23] Even for IHS-eligible individuals, health insurance coverage affects the probability of medical debt, given that IHS is budget-limited. While recent budgets have increased, IHS appropriations have historically been reported to be insufficient to meet the demand for medical services,[24] with one recent U.S. Department of Health and Human Services report estimating that

[23] *See* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Health Insurance coverage and access to care among American Indians and Alaska Natives: recent trends and key challenges (2024). Accessed at https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-AI/AN

[24] These issues are longstanding, as noted in Donald Warne and Linda B. Frizzell, American Indian Health Policy: Historical Trends and Contemporary Issues, 104 American Journal of Public Health 263 (2014); Thomas D. Sequist, Theresa Cullen, Kenneth Bernard, Shimon Shaykevich, E. John Orav & John Z. Ayanian, Trends in Quality of Care and Barriers to Improvement in the Indian Health Service, 26 Journal of General Internal Medicine 480 (2011).

appropriations are about half of current need in Native communities.[25] According the Government Accountability Office, IHS per capita spending was half of Medicaid's level, and even less than per-capita spending for the Veterans Health Administration, Medicare, and for federal prisoners.[26]

Limited funds can limit specialty or emergency care from private providers accessed through the PRC program. When the PRC budget is set at an amount lower than the demand, specialty care is rationed by priority ranking. As the Indian Health Manual notes, "[l]imitations of funds, facilities, or staff may result in services not being available to all persons who come within the scope of the program."[27]

Health insurance is therefore essential for most Native consumers to obtain needed care.[28] Medicaid is an important insurance source for many Native individuals, with 40 percent of non-elderly American Indian or Alaska Native individuals covered through Medicaid in 2022, compared with 36 percent through employer-provided insurance.[29] As of November 30, 2023, 28 percent of consumers in majority-Native census tracts lived in states that had not expanded Medicaid to low-income adults, or where the expansion had not yet be implemented (North Carolina, South Dakota, Wisconsin, and Wyoming). South Dakota did not expand Medicaid until July 1, 2023, and given that credit reporting agencies do not report medical debts until they have been in collections for a year, as of December 2023 consumers in South Dakota would also not have medical debt tradelines that came from periods after the Medicaid expansion.

Figure 6 shows medical debt in collections based on the Medicaid expansion status of the state at the time collections were posted for December 2021 through December 2023. The states included in each group are the same throughout the period. However, Oklahoma expanded Medicaid on July 1, 2021. While Oklahoma is classified as an "expansion" state in this graph, it is worth noting that some consumers in Oklahoma may have still had collections on their credit reports that stemmed from medical care delivered prior to the expansion. No states with majority-Native tracts changed their Medicaid expansion status during the period of this graph,

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[25] *See* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2022). How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives (Report No. HP-2022-21). Accessed at https://aspe.hhs.gov/reports/funding-ihs

[26] *See* Government Accountability Office, Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs, GAO-19-74R (2018).

[27] https://www.ihs.gov/ihm/pc/part-2/chapter-1-eligibility-for-services/#2-1.5A Note that the FY 2023 budget included a significant increase in funds.

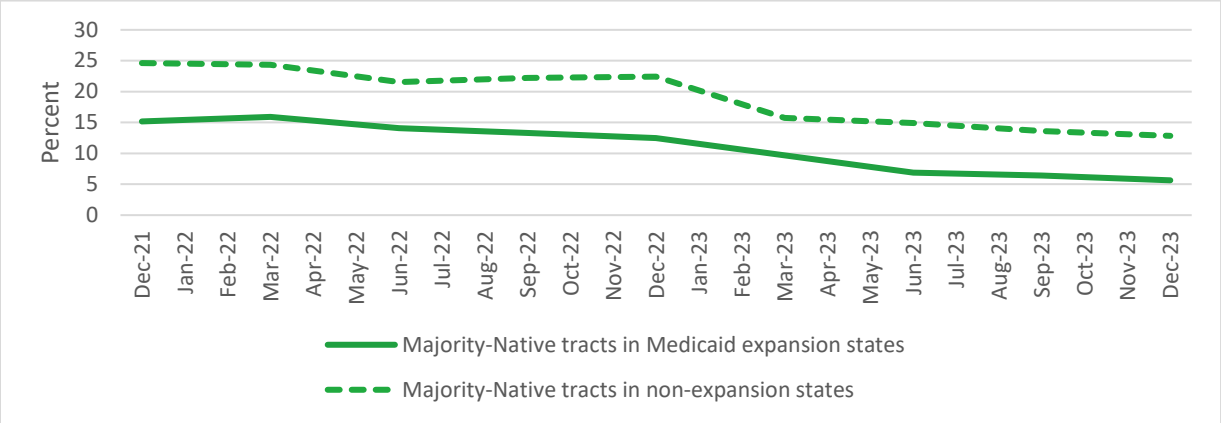
[28] *See* Renuka Bhaskar and Brett J. O'Hara, Indian health service coverage among American Indians and Alaska Natives in federal Tribal areas, 28 Journal of Health Care for the Poor and Underserved 1361 (2017).

[29] *See* Assistant Secretary for Planning and Evaluation, Health Insurance coverage, supra note 18.

with the exception of South Dakota, which occurred too late to affect any of the collections reported by December of 2023.

Figure 6 shows that in Medicaid expansion states, about five percent of consumers in majority-Native tracts had medical debts in collections in 2023, compared to 12 percent in majority-Native tracts in non-expansion states. This shows that the share of consumers with medical collections tradelines on their credit reports is lower in Native communities located in Medicaid expansion states.

FIGURE 6: SHARE OF CONSUMERS WITH MEDICAL COLLECTIONS TRADELINES ON THEIR CREDIT REPORTS, BY STATE MEDICAID EXPANSION.



Source: CFPB Consumer Credit Information Panel (CCIP). Medicaid expansion states come from the **KFF Status of State Medicaid Decisions**.[30]

Indian Health Service facility access and Medicaid expansions also operate synergistically. As a "payer of last resort," IHS covers remaining balances after other public or private insurance coverage is exhausted. Since 2014, IHS facilities have billed Medicaid for direct care services, receiving $1.3 billion in FY2024.[31] If more patients in an IHS area are covered by Medicaid or other insurance, the same budget can accommodate more direct or PRC care.[32] Medicaid expansions have been associated with expanded services at federally and Tribally operated facilities and in the PRC program.[33]

[30] https://www.kff.org/status-of-state-medicaid-expansion-decisions/

[31] Indian Health Service, Fiscal Year 2025 Justification of Estimates for Appropriations Committees (2024). Accessed at https://www.ihs.gov/ofa/division-of-budget-formulation/congressional-justifications/

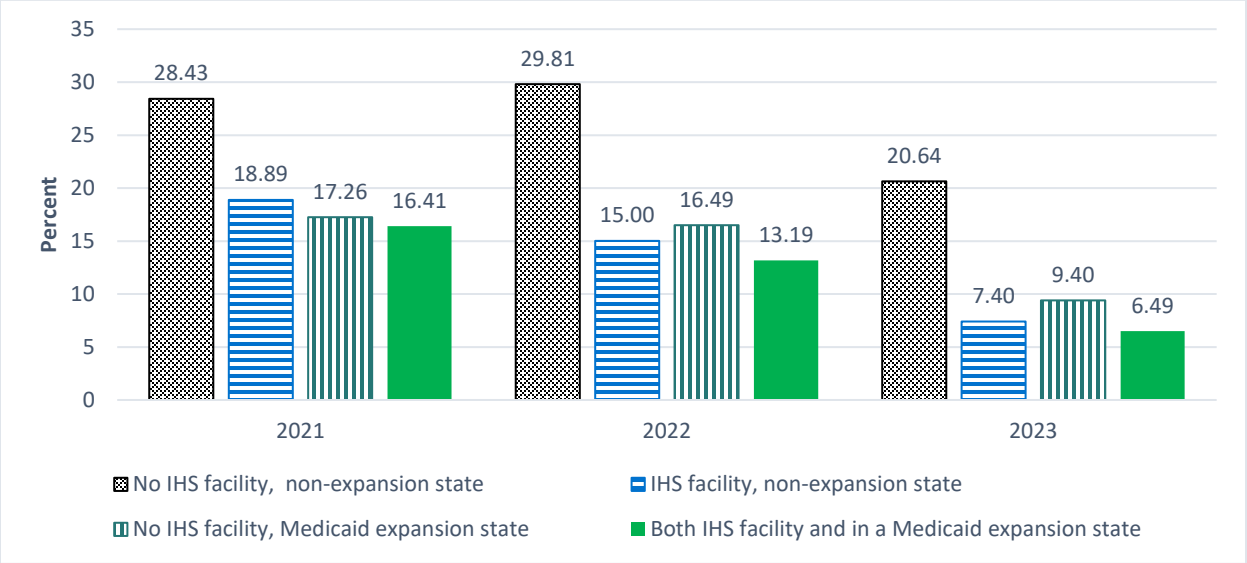
[32] The impact of the ACA and Medicaid expansion is discussed in more detail in Gina Kruse, Victor A. Lopez-Carmen, Anpotowin Jensen, Lakotah Hardie & Thomas D. Sequist, The Indian Health Service and American Indian/Alaska Native Health Outcomes, 43 Annual review of public health 559 (2022).

[33] *See* General Accounting Office, Indian Health Service Facilities Reported Expanded Services Following Increases in Health Insurance Coverage and Collections (2019), https://www.gao.gov/assets/gao-19-612.pdf

Figure 7, below, points to the synergistic relationship between IHS and Medicaid. In majority-Native census tracts without an IHS facility in non-expansion states, 28 percent of credit reports had medical debt in collections in 2021, dropping to 20 percent in 2023. Areas with either Medicaid expansion or an IHS primary care facility showed lower medical debt rates. In Native communities *both* with an IHS facility and in a Medicaid expansion state, only 5.4 percent had medical debt in collections on their credit reports. This pattern persisted through credit reporting changes.

Figure 7 shows that medical collection tradelines are most common in areas that lack both an IHS facility and are in a non-expansion state. In majority-Native tracts in these areas, the share of consumers with medical collections on their credit reports was 28.43 percent in 2021. However, in tracts with an IHS facility and in a non-Medicaid state the share was 18.89 percent; in tracts in Medicaid expansion states but without an IHS facility, the share was 17.26 percent, and tracts with both an IHS facility and in a Medicaid expansion state the share was 16.41 percent. In 2022, the corresponding shares were 29.81, 15.00, 16.49, and 13.19 percent, respectively. In 2023, the shares were 20.64, 7.4, 9.4, and 6.49 percent, respectively.

FIGURE 7: SHARE OF CONSUMERS WITH MEDICAL COLLECTIONS TRADELINES ON THEIR CREDIT REPORTS, BY MEDICAID AND IHS FACILITY



Source: CFPB Consumer Credit Information Panel (CCIP). Medicaid expansion states come from the **KFF Status of State Medicaid Decisions.**[34]

[34] https://www.kff.org/status-of-state-medicaid-expansion-decisions/

6. Billing, collections, and reimbursement issues

To understand the aspects of the health care system in Native communities that lead to medical debts on consumers' credit reports and the impacts of these debts, the CFPB interviewed a range of stakeholders from January through September 2024.[35] These included Tribal leaders, councils, and members; current and former IHS officials; administrators of Tribal health organizations; administrators at Native Community Development Financial Institutions (CDFIs), and other subject matter experts. We also identified relevant consumer complaints using keyword searches that included the phrases "Tribe," "Tribal," "Indian," "Native American," any of the names of the federally recognized Tribes, and "IHS." In these interviews and complaints, there were common patterns that led to medical collections that incorrectly ended up on credit records, despite being eligible for IHS reimbursement.

One of the most striking issues that emerged was the consistent report that many Native consumers ended up with medical debts in collections for bills that Native consumers should not owe. The Indian Health Care Improvement Act (IHCIA) statement of liability makes clear that collections are prohibited for approved services:

> *[A] patient is not liable for services that have been authorized for payment by a PRC program carried out by the IHS or a Tribal health program. Providers are prohibited from collecting any payments for these services from the patient, whether directly or through referral to an agent for collection.*[36]

However, as the preceding analysis shows, medical debts in collections are more common in Native communities than in other parts of the country. While direct care provided at IHS facilities is free, eligible individuals often need emergency or specialty care from non-IHS providers through the PRC system. Though approved PRC care should have zero out-of-pocket costs, consumer complaints and stakeholder feedback indicate that patients often experience payment delays, with bills sent to collections before IHS payment. Some of this feedback reported that providers at times incorrectly bill patients above PRC rates, despite legal prohibitions. Other contributing factors identified in complaints and interviews included system

[35] The CFPB interviewed a total of 28 people during 11 interview events, including six (6) individual interviews, four (4) group interviews, and one focus group.

[36] Indian Health Service Manual §§ 2.3.21-2.3.22 (2023), https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.9A.

complexity, non-IHS providers' unfamiliarity with billing procedures, and IHS budget constraints, all of which can result in medical bills ultimately appearing on credit records.

6.1 The approval and payment process for care from external providers is difficult to navigate

Obtaining PRC approvals and payments for care from private providers requires multiple steps: patients must verify that they meet strict eligibility requirements [37] and get approval based on medical priority and available PRC funds.[38] In an emergency, patients must notify IHS within 72 hours and the PRC committee must determine the situation to have been truly "emergent."[39] Once care from an external provider has been approved, the provider receives a "purchase order" (PO) referral that authorizes the care and notifies the provider that IHS (or Tribal authority) will pay.[40] Finally, the provider should bill IHS or the Tribal authority rather than the patient; the claim is sent to the fiscal intermediary for verification, claims processing, and payment; and, finally, the provider is paid.

According to stakeholders, this process often fails at various points. When this happens, providers may bill patients directly and may send unpaid bills to collections. Even if IHS eventually pays, consumers often must pay added collection fees and interest. These administrative issues are long-standing. In 2000, the IHCIA highlighted these problems, mandating that IHS conduct a study to assess payment delays, examine impacts on credit histories, and determine the most efficient and effective means of improving the PRC payment system and ensuring the development of consumer protection policies to protect against aggressive billing practices.[41]

6.2 Providers often hold patients responsible for PRC authorized care

Although the federal IHCIA states that, "[p]roviders are prohibited from collecting any payments for these services from the patient," consumers and Tribal authorities consistently reported that patients are asked by private healthcare providers to assume financial responsibility by signing a standard patient waiver indicating that the patient will be responsible

[37] https://www.ihs.gov/prc/eligibility/requirements-eligibility/

[38] https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care/

[39] https://www.ihs.gov/prc/eligibility/requirements-notification/

[40] An IHS PRC purchase order is an IHS-843-1A form, also known as an "Order for Health Services", that the IHS issues to a provider when authorizing a patient for medical services under the Purchased/Referred Care (PRC) program.

[41] *See* Indian Health Care Improvement Act § 219, Pub. L. No. 94-437, 90 Stat. 1400 (codified as amended in scattered sections of 25 U.S.C.).

for the bill. In many cases, that patient waiver then becomes the basis for the medical provider or their debt collector to demand payment for services from these patients, despite the express prohibition in the IHCIA.

It may be that in some of these cases, the provider is not aware that patients should not be responsible for bills. According to the IHS Manual, providers should be notified that an authorized patient "is not liable for the payment of any charges or costs associated with the provision of such services" within five days of the claim.[42] However, according to one subject matter expert, "it has traditionally been . . . hit or miss whether those documents go out in a timely manner or at all." This may contribute to confusion on the part of providers about who is liable, or providers simply may not be complying with the IHCIA, perhaps in the hope of receiving more timely payment. In the words of one Tribal council member:

> *The health provider [makes] you sign [a form on the] day of treatment, saying that you're responsible for the debt that will be incurred if they see you. That takes [the] liability off IHS at that point because you sign that form. It should have been referred back to the IHS. That needs to be addressed.*[43]

According to another Tribal council member:

> *Changing a name from a Tribal member on the bill to making IHS the responsible payer on the bill [would solve this]. … If a bill came in it would automatically go to IHS and they'd have to be the responsible payer for it, not the Tribal member.*[44]

Furthermore, consumers frequently report, and IHS officials confirm, that providers will "balance bill" patients for charges above the approved rate, even though providers are prohibited from billing patients. In one example from a complaint submitted to the CFPB, the person who filed the complaint described how his wife had purchased hearing aids from an external provider, who then billed the Tribal health organization for $5,500. The Tribal health organization paid the provider the contract rate of $4,200 and informed the provider and the complainant's wife that she had no financial responsibility to the provider, per the terms of the contract. Nevertheless, the provider billed the complainant's wife for the $1,300 balance, claiming it did not recognize the validity of the Tribal health organization's plan.[45]

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[42] Indian Health Service Manual §§ 2.3.21-2.3.22 (2023), supra note 28.

[43] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[44] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[45] Complaint on file with the CFPB.

6.3 Provider payments can be delayed for long periods

According to the IHS Manual, "[t]he Service shall pay a completed contract care service claim within 30 days after completion of the claim."[46] However, the claims process is even more complicated than typical medical claims processing because of the multiple parties involved. Before charges can be approved, the fiscal intermediary who processes the claims must verify that the patient has used all other sources of insurance first, including any insurance for which they might be eligible, such as Medicaid. They also must verify that the other insurers have made payments. Approval is also contingent on ensuring that charges comply with any vendor agreements and prices.[47]

Subject matter experts reported a wide range of administrative issues that led to delayed payments . These included difficulties in correcting inaccurate information about other sources of insurance that the patient had, inaccurate information about contracts with vendors or prices for services, delays in payments by other insurance providers, and record systems that were outdated.

These issues are difficult to resolve. Even in a large Tribally run organization with the staffing to work with fiscal intermediaries, there are numerous and continual challenges in securing payment. One Tribal health organization administrator reported, "[i]t is the most discouraging, time-consuming aspect of some of my team's job. And it just feels like we never win. We never can get this stuff resolved."[48]

In nearly every interview, lengthy payment delays were noted as a commonplace occurrence. These delays impact consumers and all parties involved, as noted in one interview with a Tribal health organization:

> *In the case of this patient, [the fiscal intermediary] told us (the Tribal health organization) that there was no Medicaid EOB (explanation of benefits) on file. We had sent it to them multiple times. We re-sent it to [the FI] back and forth in the case of this patient in particular . . .. We did not know this patient was sent to collections until they*

[46] Indian Health Service Manual §§ 2.3.21-2.3.22 (2023), supra note 28.

[47] https://www.ihs.gov/prc/prc-rates-information/

[48] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B1.

contacted us . . . it took seven months for us to resolve this . . . the patient in the interim was sent to collections.[49]

Similarly, one subject matter expert reported:

Hospital providers, professionals, insurance companies don't really understand or take the time to understand [how the IHS system works]. Payment is delayed or denied. Even when it is provided, trying to get those bills paid can be extremely complicated, cumbersome. The patient has very little input into that process because it is really done at the federal agency level of Indian Health Service or the Tribes.[50]

Claim processing frequently takes long periods of time, and patients and health organizations reported significant difficulties in resolving outstanding billing and payment issues. One large Tribal health organization that contracted health services with IHS described several hundred actively pending claims with the fiscal intermediary, some of which had been pending for multiple years.

Another Tribal organization documented thousands of purchase orders (the IHS authorizations for care from an external provider) that were unpaid over a period of multiple years:

In 2018 [and 2019], we had about over 2,000 purchase orders that weren't paid. They were just left open. [In] 2020, we probably had about 3,000 plus. There was one year, I think 2022, we had over 6,000. . . [Currently], we have over 7,000 purchase orders [that are unpaid].[51]

6.4 Delays in payments can lead to collections

Payment delays frequently result in providers sending the debt to a collections agency. In many cases, consumers only became aware of the unpaid debt after it had been sent to collections. Numerous complaints submitted to the CFPB, accounts from Native consumers, and examples from providers describe these common situations. One example even involved a high-ranking IHS official, who was notified of the existence of IHS medical debt on her credit record during a pre-employment federal security clearance check:

I became the Indian Health Service Director [of one of the 12 IHS regions] . . . One of the requirements of a Senior Executive Service position is you have to go through a

[49] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B1.

[50] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B2.

[51] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

> *very extensive background check. . . . The investigator called me and said, "Ma'am, you should have told us that you are in a collection with a collection agency." And I said, "I am? But, what for?" [After determining that the collection was for a medical bill for an approved procedure awaiting payment from PRC funds], he said, "But ma'am, aren't you the head of Indian Health Service?" And I said, "Well, certainly as an IHS recipient of care, I get no special treatment."*[52]

Furthermore, once a bill ends up in collections, it can be difficult to correct even after payment has been made. This appears to be due in part to the complexity of the system. One subject matter expert suggested a partial explanation:

> *When [the fiscal intermediary or IHS sees] a purchase order that was made in 2018 and they don't have a bill on the record because they already turned it over to debt collectors, that's a real issue. So then they close that purchase order, thinking that it's closed, ...yet the bill still remains out there.*[54]

> Earlier this year, I checked my credit and noticed that there [were]medical bills on my [credit] report from [three years prior] …. The medical bills … should have been taken care of by Indian Health Services. [IHS] said they paid what was given to them, but the doctors billed me separately. I had no idea they could do that….This is severely hurting my credit and I have no idea how to get this resolved. [53]

The difficulties of resolving debt erroneously sent to collections agencies were mentioned frequently. For example, one consumer mentioned continuing to receive bills from a debt collector for her son's emergency room visit even after her Tribal health organization had paid the provider's bill.[55] Another example by a subject matter expert and Tribal member:

[52] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part A" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A3.

[53] Consumer Complaint 2711063, https://www.consumerfinance.gov/data-research/consumer-complaints/search/detail/2711063.

[54] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B2.

[55] Consumer Complaint 2349885, https://www.consumerfinance.gov/data-research/consumer-complaints/search/detail/2349885

> *I had a bill [for] $10.15 that they were trying to collect. [A] year later, I was still …spending time on the phone. They would agree that it had been paid, and then I'd get the bill [again]. …They just keep after you."*[56]

As seen in a number of these accounts, many patients report paying bills preemptively, when they can, to avoid debt going to collections. In the words of one subject matter expert:

> *Individuals would get medical bills and if they had the means, oftentimes they would just pay them out of pocket because they had no faith that the bill would get paid. And they didn't want to see damage to their credit.*[57]

However, stakeholders reported a lack of a formal process for getting reimbursement in these situations. One Tribal council member stated that:

> *We discussed [the reimbursement process when a Tribal member preemptively pays] with [senior leaders at] Indian Health Services, and they don't have a mechanism for reimbursing membership. …There are a lot of our Tribal membership that have paid just so that they don't have that on their debt. …We had an elder … in his late 70s, early 80s, wandering around the community picking up cans to recycle, to help pay his hundred and something dollar debt he couldn't afford.*[58]

The issues from comments and complaints were pervasive and were consistently reported across many geographic regions of the country.

6.5 Collections result in consumer fees and charges even after IHS payment

When patients are wrongly held liable for bills they do not owe, and those bills are sent to collections due to delayed payments, the collection agency imposes additional fees and interest charges.

> *When IHS or whoever doesn't pay their medical bill, there [are]s administrative fees applied to that, and interest. [Those fees and interest are] not considered part of the original billing, and [are] not taken off [the credit record when the bill is eventually*

[56] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part A" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A3.

[57] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B2.

[58] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

paid]. IHS [will] only pay for the original bill, which sometimes is a lot smaller than all the other fees applied on top of that. [Tribal council member][59]

These extra costs continue to impact consumers, even after the original debt has been eliminated or settled.

6.6 Administrative issues lead to bills patients had understood were covered

All of the above breakdowns in the system can lead to medical debt, even in cases where IHS has given approval for PRC services from a private provider. In other cases, patients act in good faith to obtain approvals, but end up with bills that are later denied coverage.

> When my youngest daughter was born we did have a purchase order through IHS. We were sent to the OBGYN and they said that the baby's coming like right now. I called IHS back, asked if I needed a new purchase order. They said 'no, the one you have is fine.' So we went in. My wife had the baby and then it was months later before we got contacted by a collection agency. We hadn't even received a bill, I don't know where those were going….I just ended up paying because I didn't want to mess with it, so I just paid it. [Tribal council member][60]

One common situation relates to the notification requirements for emergencies. As noted above, IHS must be notified of a medical emergency within 72 hours,[61] and the care must be determined to be "emergent." Tribal members reported many instances where a patient thought they had complied with the requirements, but still ended up with large bills.
In other cases, patients who went to an emergency room for care were denied payment because the situation was later deemed not to be an emergency. One subject matter expert and Tribal member reported that:

If you're in pain, you make the decision to go [to an emergency room] and then IHS just will decide whether it was emergent or not. And if they decide that it wasn't, that you could have waited, then they'll deny payment.

[59] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B2.

[60] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[61] In some cases, like with individuals over 65, patients have 30 days to give notification. Notification requirements can be found here: https://www.ihs.gov/prc/eligibility/requirements-notification/

And then all of a sudden you have accrued all of this cost even if you've acted in really good faith. [Subject matter expert and Tribal member][62]

Another common occurrence is when a patient is approved for specialty care, but due to administrative errors or miscommunication, other related care is later ruled to not be covered. A Tribal council member reported that:

When people go to IHS and get a referral out for a [purchase order], they go to a doctor - say like a cancer specialist - and they order labs, they order other tests. They're not told to get other [purchase orders] for those other services. And so, without that knowledge, those Tribal members get charged. And sometimes IHS won't pay it, because they said you never established a [purchase order] for those other services.[63]

These kinds of errors and payment denials are reported to be very common when care requires multiple treatments, even when patients are diligent about compliance:

We have another Tribal member that's been going through chemotherapy. She had a mastectomy done. She did a spreadsheet, she did documentation. She had email. She recorded conversations on all her [purchase order]s with IHS. She documented every conversation so that she wouldn't have to pay a bill. … All her [purchase orders] were approved with all her providers and IHS, and she's now she got a $16,000 bill. IHS won't pay for her chemotherapy. She even provided all the proof to IHS and they still won't pay her bill.[64]

Patients also face hurdles in verifying eligibility for services. While IHS clinics may treat any member of a federally recognized Tribe, PRC care is only approved for current residents of (or full-time students from) a federally recognized reservation or nearby PRC Delivery Area.[65] Residents must be able to prove that they have lived in the area for over 180 days. Stakeholders report challenges in verifying eligibility for individuals who were living with family members or for other reasons did not have utility bills or rental agreements in their own names.

Moreover, because IHS is the payer of last resort, individuals are required to use any private or public insurance (e.g., Medicaid, Medicare, or the VA) for which they are eligible.[66] Stakeholders reported that even if an individual is not eligible for Medicaid, they must apply and be denied to

[62] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part A" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A3.

[63] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[64] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[65] Purchased/Referred Care Delivery Areas are counties that includes all or part of a reservation or sharing a boundary with a reservation, and the states of Alaska, Nevada, and Oklahoma (42 CFR §136.22).

[66] https://www.ihs.gov/prc/eligibility/requirements-alternate-resources/

verify that they were deemed ineligible. Coverage of out-of-pocket costs or PRC are not approved even if a patient has a purchase order if the patient does not use these other resources. Many patients who have largely relied on direct care services from an IHS facility may not have applied for Medicaid previously. In one striking example, an elderly patient living in a remote area had an emergency, but died before the application could be completed. The Tribal health organization described the difficulties in this situation:

> *We just needed a wet signature [meaning that the application could not be faxed or emailed, but needed to be signed and mailed in] . . . No wet signature and she passed away and now the family has $695,000 worth of debt just because she didn't sign. . . It's just nauseating because … efforts were made [for] a very sick individual . . . . That "wet signature" thing is a major deal for us in [remote locations]. . . we have to literally [mail] the application to the person and [have them] send [the completed paperwork] back to us in a [place] where the US Postal Service is unreliable. They go weeks and weeks without mail [and] we can't fax [or] email, it actually has to be pen and paper.*[67]

Patients and their families can face serious consequences if they cannot navigate the application process during these types of medical emergencies.

6.7 Patient approvals impacted by access to clinics or IHS staffing and budget limitations

Finally, one significant frustration expressed by many Tribal consumers is that patients may need care but are unable to get the necessary approval in time. Individuals may end up with medical bills for expenses that could have been reimbursable if they had received timely care and appropriate referrals.

Lack of proximity to a clinic, temporary clinic closures during COVID,[68] and staffing issues can all contribute to limiting access to an IHS provider who can make a timely referral for specialist care. Data from both 2018 and 2021 show that IHS facilities had 20 to 30 percent employment vacancy rates for doctors, physician assistants, and nurses,[69] resulting in long wait times and otherwise limiting patients' abilities to obtain provider referrals.[70]

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[67] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B1.

[68] *See* Elayne J. Heisler, COVID-19 and the Indian Health Service (Congressional Research Service 2020), https://crsreports.congress.gov/product/pdf/IN/IN11333.

[69] *See* U.S. Department of Health and Human Services, How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives HP-2022-21 (2022). Accessed at https://aspe.hhs.gov/reports/funding-ihs.

[70] *See* Government Accountability Office, Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies GAO-18 (2018); US Department of Health and Human Services, Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care, OEI-06-14-00011, (2016).

The most common situation, though, is when a health care provider has determined the care is medically necessary, but coverage is denied due to rationed PRC budgets. As the IHS states, "Unfortunately, PRC funds often are not sufficient to pay for all needed services. When this happens, the [PRC] committee considers each individual's medical condition to rank cases in relative medical priority. *Cases with imminent threats to life, limb, or senses are ranked highest in priority*. . . . Specific services authorized within relative medical priorities may vary from time-to-time in response to changing supply and demand, especially to stretch diminished funds over the remainder of the fiscal year."[71]

In many interviews with subject matter experts, the "life or limb" priority ranking was listed as a common limitation on other needed care:

> *So they say it's life or limb, so if you're not life or [limb or] you cannot get referral for additional care . . . the joke is you get Tylenol or ibuprofen or a band aid, but you don't get the care that you need to address the issue.*[72]

In fiscal year 2020, IHS-operated PRC programs denied or deferred about $1.1 billion in services. This does not include PRC denials in Tribally managed programs, which are not required to report this information.[73]

As a result of denied or deferred PRC services – even for services that might have been approved for coverage absent a rationed PRC budget – an individual patient may incur the cost of obtaining care privately or may delay obtaining needed care. One common frustration was that patients end up with debts for care that could have been approved at an earlier point in the fiscal year, before the PRC budget limit was met:

> *[At] the end of the fiscal year, … July or August or September, …medical debt can accrue in part because . . . people get themselves into these situations, where they're going to be asked to pay for something that they need. They don't have… easy access to third party coverage and they can't get the service at home.*[74]

Another subject matter expert stated:

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[71] IHS provides PRC resources for patients at https://www.ihs.gov/forpatients/prc/. One of those resources is the PRC Patient Process for Authorization for Payment Diagram, from which this quote is taken (emphasis added). Accessed September 30, 2024.

[72] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part A" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A5.

[73] U.S. Department of Health and Human Services, Indian Health Service: Fiscal Year 2023 Justification of Estimates for Appropriations Committees (2024). The FY 2023 President's Budget proposal significantly increases funds to cover the "Level of Needed Funds" over the 5-year period from FY 2024 to FY 2028.

[74] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part A" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A2.

> *You're kind of stuck with just the appropriation that's given to IHS for your facilities. We have heard stories for years about how… there's enough to get people through an IHS service delivery unit through like 3/4 of the year and then they don't really have any more money left. So there's a lot of rationing of care. And then … at the end of a year, …you have a big problem. What are you going do? You're going to end up at the urgent care…, and you're not going to be able to pay."* [75]

Throughout, respondents described these difficult choices about whether to incur medical debts to obtain more timely care.

7. Impacts of medical debt on Native individuals and communities

To better understand the impacts of medical debt, we interviewed Tribal leaders and Tribal council members, administrators at Native CDFIs, health care administrators, and other subject matter experts. These participants spoke about ways that Tribal members' financial lives are affected by medical collections on their credit reports. They also described the way medical debts affected access to health care services and how the fear of medical debt led to avoidance of medical providers. Furthermore, participants identified downstream effects on Native communities, both from economic impacts and from the ways that health care providers respond to payment delays and other difficulties in the health care system for Native patients.

7.1 Impacts on consumers' financial lives

Medical debt's potential impact on credit scores, with the associated limited access to credit,[76] is a particularly salient concern in Native communities. As discussed in Section 6 Native consumers may feel compelled to pay bills when they can, even when they have authorization to get them covered by IHS, to prevent the debt from being sent to collections and to protect their credit from collections being furnished to CRAs. Interview participants frequently reported how

[75] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part A" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A4.

[76] *See* Alyssa Brown and Eric Wilson, Consumer Credit and the Removal of Medical Collections from Credit Reports, Consumer Financial Protection Bureau Office of Research, Data Point, April 2023, https://www.consumerfinance.gov/data-research/research-reports/consumer-credit-and-the-removal-of-medical-collections-from-credit-reports/

medical debt that ends up in collections had significant effects on access to credit, housing, education, and business development, with one Tribal council member stating:

> *The impacts are compounded severely . . . you cannot get a consumer loan. You actually cannot be on any boards that require you to have good credit. You cannot go to school and get financial aid. So everything is attached to that, their collections.*[77]

Medical collections tradelines can lead to credit impacts for any consumer in the U.S. However, as noted, consumers in Native communities with medical debt tradelines are more likely to have credit records that *only* include these collections than consumers in other areas. The disproportionate economic vulnerability in Native communities can also lead medical collections to have particularly acute impacts on families and communities:

> *There [are] Tribal members throughout the reservation that it impacts their credit history to the point where they aren't able to qualify for a rental unit. So then they're left homeless, living out of their vehicles and living with relatives. It's very disheartening. [Tribal council member]*[78]

A Native CDFI administrator reported that medical debts can limit community development through impacts on entrepreneurship and employment:

> *One of the applications [funded by the Native CDFI] was to pay off a Native woman's medical debt so she could start a business that would employ 15 people. They just needed to pay off that [medical] debt. It was $50,000, and it was because she had fallen and messed up her knee . . . the IHS wouldn't cover it. [She got] the grant, and she paid off the debt. . . that's just a story of how the community is now gonna benefit, right? There's 15 jobs. That's a lot of jobs anywhere.*[79]

7.2 Impacts on access to health care services

Many stakeholders and Tribal members described how common it was for community members to avoid obtaining medical care because of the fear that it would result in collections:

> *There [are] a lot of Tribal members that . . . get referred to care, they get a bill, and then pretty soon that's turned over to debt collectors, and then they have the penalties, and they just stop seeking [healthcare] services. You know that really is the result here.*

[77] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[78] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[79] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A1.

I think it's more common here and in Tribal communities. . . . people are being referred out for the purchased referred care with IHS, most of them are specialty care. They're chronic conditions. And then people just stop going [for medical care]. A lot of our elders will stop going …because of fear of … getting these bills with penalties, with interest, you know, and they're stacking up.[80]

One health official tied the issue of medical debt in collections to the prevalence of untreated COVID in their community:

You just stay home and tough [COVID] out and that means you don't get an early diagnosis. The likelihood that you'll die is greater because the earlier you get diagnosed, the better the outcome is. …No one wants to get tortured by collection agents. And so, you know, this has very devastating consequences. [IHS health administrator][81]

In other cases, patients sought care but were denied it because of unpaid medical bills, or had to pay for care themselves in order to be treated:

I arrived at the provider [with a new] referral and they said "I'm sorry we can't see you because you have an outstanding medical debt with another provider." And at that time, I had dislocated my spine in three places, my lower lumbar, and I was using a walker to get around. [Then] the second provider wouldn't see me. So finally I just said "I need this [medical treatment]. I need to be taken care of, I need to be seen." I ended up paying out of pocket quite a few thousand dollars and tapping into my retirement to get this taken care of. That really personally affected me.[82]

In some cases, stakeholders reported that medical providers in the area chose to not deliver care to eligible patients because of the payments and delays:

[Providers] actually won't contract with our Tribe because these bills aren't being paid. What happens to our relationships that we have with the medical providers who will no longer do business with us? [Tribal council member][83]

Similarly, one Tribal council member noted:

[80] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[81] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 01/24/2024 to 03/18/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant A5.

[82] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

[83] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

> *We live in a rural and isolated community, so we don't have a lot of vendors in our community. [When we] lose our vendors, including the hospitals . . . sometimes they've stopped services in middle of treatment plans. [One Tribal member] was 80 or 90 years of age and she had nine teeth pulled and in middle of it they stopped services and her teeth were getting infected. She got an abscess or something, probably a critical condition where she couldn't eat. She was down to 90 pounds. She was an elder and they had just stopped services right in the middle of the treatment plan. The same thing with people with chronic diseases.*[84]

This impact of medical debt – preventing providers from offering services to patients – is especially damaging in areas with few medical providers.

Even when individuals made efforts to ensure that medical bills had been paid or were going to be reimbursed, these debts reduced patients' access to providers, their willingness to seek medical care, and the availability of providers in the community. More broadly, the interview respondents consistently reported that medical debt collections on credit reports limited access to credit, affecting Tribal members' housing, education, employment and entrepreneurship.

8. Conclusion

Native communities have been disproportionately affected by medical debt in collections, and levels of medical debt were often related to breakdowns in the health care system in the areas where American Indian and Alaskan Natives live. People in Native communities were almost twice as likely to have medical debt in collections on their credit records compared to the national average, and the average amount of debt in collections was about 33 percent higher than the national average. Medical debt was also related to factors over which a person has limited control, such as the availability of year-round primary care facilities in the IHS system and the expansion of state Medicaid.

Analysis of complaints and reports from health care providers, Tribal officials, and other key stakeholders indicates that problems with billing, reimbursement, and credit reporting are common and pervasive for Native consumers. Many Native consumers have bills sent to collections even when they have been approved for payment by the IHS system and the consumer is not responsible for these bills. These inaccurate collections are due to many factors: delayed payments, external providers' lack of familiarity with the IHS system, inappropriate balance billing, administrative errors, and complex third-party billing. People in Native

[84] Unstructured Moderated Stakeholder Interviews "Native American Medical Debt Interviews, Part B" (via Microsoft Teams) conducted 06/27/2024 to 09/25/2024, by Susan Kerbel and Christiana Stoddard, n=5, Participant B3.

communities face a particularly confusing and complex process, especially when seeking specialty or emergency care provided in a non-IHS facility. This results in bills for care that patients had understood would be covered, or for care that was not authorized due to rationed budgets.

Medical collections also lead to many adverse impacts on American Indian and Alaska Native consumers. Many of these consumers report paying medical bills that they do not owe to avoid bad credit and collections fees and charges, while others are unaware of the collections until a credit or employment background check. As with other parts of the U.S., medical collections have negative effects on employment, housing, credit, and education, but these downstream effects are particularly acute given the economic vulnerability in Native communities.

The CFPB will continue to monitor developments related to medical debt in Native communities, including issues related to medical debt on credit reports.

APPENDIX A: MAJORITY NATIVE CENSUS TRACTS

The following is the list of Census tracts used in the analysis where a majority of residents self-identified as American Indian or Alaska Native, either alone or in combination with other races, in the American Community Survey in 2022.

2020 Census Tract Number	State	County	IHS clinic in 2022
2016000100	Alaska	Aleutians West Census Area	Yes
2050000100	Alaska	Bethel Census Area	Yes
2050000200	Alaska	Bethel Census Area	Yes
2050000300	Alaska	Bethel Census Area	Yes
2070000100	Alaska	Dillingham Census Area	Yes
2070000200	Alaska	Dillingham Census Area	Yes
2122000100	Alaska	Kenai Peninsula Borough	Yes
2122001200	Alaska	Kenai Peninsula Borough	Yes
2158000100	Alaska	Kusilvak Census Area	No
2164000100	Alaska	Lake and Peninsula Borough	No
2180000100	Alaska	Nome Census Area	No
2180000200	Alaska	Nome Census Area	No
2185000100	Alaska	North Slope Borough	No
2185000200	Alaska	North Slope Borough	No
2188000100	Alaska	Northwest Arctic Borough	No
2188000200	Alaska	Northwest Arctic Borough	No
2198940100	Alaska	Prince of Wales-Hyder Census Area	No

2290000100	Alaska	Yukon-Koyukuk Census Area	No
2290000200	Alaska	Yukon-Koyukuk Census Area	No
2290000300	Alaska	Yukon-Koyukuk Census Area	No
2290000400	Alaska	Yukon-Koyukuk Census Area	No
4001942600	Arizona	Apache County	No
4001942700	Arizona	Apache County	No
4001944000	Arizona	Apache County	No
4001944100	Arizona	Apache County	No
4001944201	Arizona	Apache County	No
4001944202	Arizona	Apache County	No
4001944301	Arizona	Apache County	No
4001944302	Arizona	Apache County	No
4001944901	Arizona	Apache County	No
4001944902	Arizona	Apache County	No
4001945001	Arizona	Apache County	No
4001945002	Arizona	Apache County	No
4001945100	Arizona	Apache County	No
4005002102	Arizona	Coconino County	No
4005942201	Arizona	Coconino County	No
4005942202	Arizona	Coconino County	No
4005944900	Arizona	Coconino County	No
4005945000	Arizona	Coconino County	No

4005945100	Arizona	Coconino County	No
4005945200	Arizona	Coconino County	No
4007940200	Arizona	Gila County	No
4007940400	Arizona	Gila County	No
4009940500	Arizona	Graham County	No
4012940300	Arizona	La Paz County	No
4013940700	Arizona	Maricopa County	No
4013941000	Arizona	Maricopa County	No
4013941200	Arizona	Maricopa County	No
4013941300	Arizona	Maricopa County	No
4015940400	Arizona	Mohave County	No
4017940008	Arizona	Navajo County	No
4017940010	Arizona	Navajo County	No
4017940011	Arizona	Navajo County	No
4017940012	Arizona	Navajo County	No
4017940013	Arizona	Navajo County	No
4017940014	Arizona	Navajo County	No
4017940015	Arizona	Navajo County	No
4017940100	Arizona	Navajo County	No
4017940301	Arizona	Navajo County	No
4017940302	Arizona	Navajo County	No
4017942300	Arizona	Navajo County	No

4017942400	Arizona	Navajo County	No
4017942500	Arizona	Navajo County	No
4019940800	Arizona	Pima County	No
4019941000	Arizona	Pima County	No
4019941100	Arizona	Pima County	No
4021941200	Arizona	Pinal County	No
4021941300	Arizona	Pinal County	No
6023940000	California	Humboldt County	No
6025940000	California	Imperial County	No
8083941100	Colorado	Montezuma County	No
13089021204	Georgia	DeKalb County	No
16005940000	Idaho	Bannock County	No
16011940000	Idaho	Bingham County	No
23019940000	Maine	Penobscot County	No
27005940000	Minnesota	Becker County	No
27007940001	Minnesota	Beltrami County	No
27021940002	Minnesota	Cass County	No
27087940300	Minnesota	Mahnomen County	No
28099940100	Mississippi	Neshoba County	No
30003940400	Montana	Big Horn County	No
30003940500	Montana	Big Horn County	No
30003940600	Montana	Big Horn County	No

30003940700	Montana	Big Horn County	No
30005940100	Montana	Blaine County	No
30005940200	Montana	Blaine County	No
30035940200	Montana	Glacier County	No
30035940400	Montana	Glacier County	No
30041940300	Montana	Hill County	No
30085940001	Montana	Roosevelt County	No
30085940002	Montana	Roosevelt County	No
30087940400	Montana	Rosebud County	No
31173940100	Nebraska	Thurston County	No
31173940200	Nebraska	Thurston County	No
32021970800	Nevada	Mineral County	No
32031940200	Nevada	Washoe County	No
35001940602	New Mexico	Bernalillo County	No
35001940700	New Mexico	Bernalillo County	No
35006941500	New Mexico	Cibola County	No
35006945800	New Mexico	Cibola County	No
35006946100	New Mexico	Cibola County	No
35031940301	New Mexico	McKinley County	No
35031940302	New Mexico	McKinley County	No
35031940500	New Mexico	McKinley County	No
35031943500	New Mexico	McKinley County	No

35031943601	New Mexico	McKinley County	No
35031943602	New Mexico	McKinley County	No
35031943701	New Mexico	McKinley County	No
35031943702	New Mexico	McKinley County	No
35031943801	New Mexico	McKinley County	No
35031943802	New Mexico	McKinley County	No
35031943803	New Mexico	McKinley County	No
35031943903	New Mexico	McKinley County	No
35031943904	New Mexico	McKinley County	No
35031943905	New Mexico	McKinley County	No
35031943906	New Mexico	McKinley County	No
35031943907	New Mexico	McKinley County	No
35031944000	New Mexico	McKinley County	No
35031945201	New Mexico	McKinley County	No
35031945202	New Mexico	McKinley County	No
35031945300	New Mexico	McKinley County	No
35031945400	New Mexico	McKinley County	No
35031945602	New Mexico	McKinley County	No
35031945701	New Mexico	McKinley County	No
35031945702	New Mexico	McKinley County	No
35031946001	New Mexico	McKinley County	No
35031946002	New Mexico	McKinley County	No

35031946003	New Mexico	McKinley County	No
35035940000	New Mexico	Otero County	No
35039941000	New Mexico	Rio Arriba County	No
35043011200	New Mexico	Sandoval County	No
35043940200	New Mexico	Sandoval County	No
35043940600	New Mexico	Sandoval County	No
35043940700	New Mexico	Sandoval County	No
35043940900	New Mexico	Sandoval County	No
35045000503	New Mexico	San Juan County	No
35045000504	New Mexico	San Juan County	No
35045000506	New Mexico	San Juan County	No
35045942801	New Mexico	San Juan County	No
35045942802	New Mexico	San Juan County	No
35045942803	New Mexico	San Juan County	No
35045942900	New Mexico	San Juan County	No
35045943000	New Mexico	San Juan County	No
35045943100	New Mexico	San Juan County	No
35045943201	New Mexico	San Juan County	No
35053940000	New Mexico	Socorro County	No
35061940300	New Mexico	Valencia County	No
36009940000	New York	Cattaraugus County	No
36029940000	New York	Erie County	No

36033940000	New York	Franklin County	No
36037940100	New York	Genesee County	No
36063940001	New York	Niagara County	No
36067940000	New York	Onondaga County	No
37099940200	North Carolina	Jackson County	No
37155960202	North Carolina	Robeson County	No
37155960302	North Carolina	Robeson County	No
37155960402	North Carolina	Robeson County	No
37155960403	North Carolina	Robeson County	No
37155960404	North Carolina	Robeson County	No
37155960501	North Carolina	Robeson County	No
37155960502	North Carolina	Robeson County	No
37155960503	North Carolina	Robeson County	No
37155960601	North Carolina	Robeson County	No
37155960602	North Carolina	Robeson County	No
37155960701	North Carolina	Robeson County	No
37155960702	North Carolina	Robeson County	No
37155961801	North Carolina	Robeson County	No
37155961802	North Carolina	Robeson County	No
37155962002	North Carolina	Robeson County	No
37173940100	North Carolina	Swain County	No
38005940100	North Dakota	Benson County	No

38005940200	North Dakota	Benson County	No
38053940100	North Dakota	McKenzie County	No
38055940100	North Dakota	McLean County	No
38061940300	North Dakota	Mountrail County	No
38061940400	North Dakota	Mountrail County	No
38079941800	North Dakota	Rolette County	No
38079951600	North Dakota	Rolette County	No
38079951700	North Dakota	Rolette County	No
38079951900	North Dakota	Rolette County	No
38085940800	North Dakota	Sioux County	No
38085940900	North Dakota	Sioux County	No
40001376800	Oklahoma	Adair County	No
40001376900	Oklahoma	Adair County	No
40001377000	Oklahoma	Adair County	No
40015162102	Oklahoma	Caddo County	No
40021978201	Oklahoma	Cherokee County	No
40041376100	Oklahoma	Delaware County	No
40109980001	Oklahoma	Oklahoma County	No
40109980003	Oklahoma	Oklahoma County	No
40109980008	Oklahoma	Oklahoma County	No
41031940000	Oregon	Jefferson County	No
46007941200	South Dakota	Bennett County	No

46017940200	South Dakota	Buffalo County	No
46023940200	South Dakota	Charles Mix County	No
46031941000	South Dakota	Corson County	No
46031941100	South Dakota	Corson County	No
46041941500	South Dakota	Dewey County	No
46041941700	South Dakota	Dewey County	No
46071941200	South Dakota	Jackson County	No
46085940100	South Dakota	Lyman County	No
46095940300	South Dakota	Mellette County	No
46102941000	South Dakota	Oglala Lakota County	No
46102941100	South Dakota	Oglala Lakota County	No
46102941200	South Dakota	Oglala Lakota County	No
46109940400	South Dakota	Roberts County	No
46109940800	South Dakota	Roberts County	No
46121940100	South Dakota	Todd County	No
46121940200	South Dakota	Todd County	No
46137941600	South Dakota	Ziebach County	No
49037942000	Utah	San Juan County	No
49037942100	Utah	San Juan County	No
53009940000	Washington	Clallam County	No
53019940000	Washington	Ferry County	No
53027940000	Washington	Grays Harbor County	No

53045940000	Washington	Mason County	No
53047940100	Washington	Okanogan County	No
53065941000	Washington	Stevens County	No
53073940002	Washington	Whatcom County	No
55003940000	Wisconsin	Ashland County	No
55078940101	Wisconsin	Menominee County	No
55078940103	Wisconsin	Menominee County	No
55078940104	Wisconsin	Menominee County	No
55113940001	Wisconsin	Sawyer County	No
55113940002	Wisconsin	Sawyer County	No
55125940000	Wisconsin	Vilas County	No
56013940100	Wyoming	Fremont County	No
56013940202	Wyoming	Fremont County	No