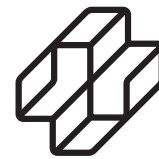


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Revenue Lost and Found: Debt Buying and Your Bottom Line

By Mikel J. Burroughs

Selling debt can affect your healthcare organization's bottom line in four key ways.

In this challenging economic climate of high unemployment and individuals increasingly struggling to pay medical bills, more healthcare organizations are employing a debt-selling strategy that recovers long-lost revenue yet remains sensitive to the financial strains of patients.

Selling all or a portion of these charged-off accounts after a primary collections agency has done its best job can have an immediate and significant impact on the bottom lines of healthcare organizations, generate funding for stalled projects, and open up new, predictable revenue streams.

"Having the option to recoup some of the monies that could potentially become losses improves our overall revenue cycle

management," said Jim Moake, operations CFO for IASIS Healthcare, a network of 15 acute care hospital facilities and one behavioral health hospital facility with a total of 2,848 beds. "However, the most impressive part of our debt-buying service is that it is able to take over these difficult accounts with minimal complaints from patients."

The action of selling self-pay and self-pay-after-insurance receivables to a debt buyer, although not a new concept, is still a sideline consideration for many hospitals, physicians' groups, first-responders, and behavioral health providers. This is due in part to the reluctance of some healthcare financial managers to shift away from traditional

INSIDE THIS ISSUE

Coding Q&A	4
Taking Notice of Observation Service Opportunities and Risks	5
2010 MAP Award Winner Profile: Danbury Hospital	6
Strategies for Simplifying Your Staff Training	7
Uninsured Young Adults with Cost-Related Access or Medical Bill Problems	8

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collections methods. They remain reliant on third-party agencies because they are long-held partnerships and allow health-care organizations to maintain control of patient accounts. The traditional thinking goes: If I don't sell the self-pay bad debt outright, I can monitor the accounts and ensure patients are not subjected to overly aggressive collections tactics.

Such concerns are valid and not to be discounted, but they don't take into account the protections and procedures used by a reputable debt buyer. A true debt-buying partner knows the importance of treating patients in a professional manner. In fact, the best debt buyers readily provide references and testimonials, adhere to Health Insurance Portability and Accountability Act (HIPAA) and Fair Debt Collection Practices Act (FDCPA) guidelines, go to painstaking lengths to minimize patient complaints, and allow providers to recall qualifying accounts without penalty.

Many hospitals are sitting on a growing pool of warehoused accounts receivables. After 120 days, these accounts won't get much more attention.

As the traditional debt-management paradigm shifts toward newer approaches, more healthcare financial managers are expected to use debt-selling tools to shape the revenue cycle. In fact, the best debt buyers will augment a healthcare organization's collections processes and function as one member of a three-way partnership—provider, collections agency, and debt purchaser—that maximizes the revenue cycle by keeping everyone competitive. As an added effect, some hospitals and groups, after incorporating a debt-selling strategy, see their liquidation rates improve because debtors see that even their older accounts will be pursued.

When weighing the debt-selling option, it's helpful to consider four examples of impact on a healthcare organization's bottom line.

Impact 1: One-Time Debt Sale to Test Waters

Many healthcare organizations are sitting on a growing pool of warehoused accounts receivables (A/R)—debts that likely went through an internal process, an early-out program, and one or more collections agencies within the first 120 days.

After 120 days, these accounts won't get much more attention. The collections industry is highly competitive and agencies typically are paid low rates—roughly 14 to 23 cents on every dollar collected. At these rates, uncollected A/R are a much less profitable prospect after four months, and agencies are much less able to put more resources into collecting the

debt. The result? At the 120-day mark, many agencies have only scraped the surface and recovered the easier balances through calls and letters. The more difficult balances remain uncollected.

By contrast, a debt buyer stands ready to immediately pay a hospital or physician group extra liquidation dollars to own the debt. That's because the debt buyer's core business is to analyze the value of debt, purchase the debt, and revive the dormant accounts through specially trained staff, a network of legal partners, and proprietary technology. Because a debt buyer owns the accounts, it can throw more resources at them and work with account holders to find solutions for repayment and recovery of assets over a longer time horizon—as long as six years.

Moving earlier to sell debt is key for healthcare organizations because “fresher” debt garners a higher price from a debt buyer. The amount of liquidation dollars offered to own the account portfolio, however, will differ depending on how many third parties have tried to collect the debt, as well as hospital or group demographics, how the business performs, location, type of facility, and number of beds.

Before the sale takes place, a debt-buying partner should provide a free evaluation to analyze a designated portfolio either before or after it is placed with a primary or secondary agency. The focus is on purchasing accounts not currently being worked, including archived, out-of-statute, and written-off debts. With access to the basic information of a portfolio of self-pay accounts, a debt buyer should be able to make a bid in just a few days.

If the hospital agrees to sell, it can usually be paid the full sum in just a matter of days. The hospital then has a new

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Checklist: How to Select a Debt Buyer

In addition to thorough analysis of how your organization might benefit from a debt-selling strategy, it's important to give the selection of any debt-buying partner careful consideration by following this checklist.

- *Verify the debt buyer's experience.* Ask detailed questions to understand the company's history and level of industry experience.
- *Confirm that the debt buyer also services accounts.* Some debt buyers only purchase the debt and use independent collection agencies to service it. A suggested practice is to opt for a company that will both buy and service the paper.
- *Determine the best time to introduce the debt buyer into your revenue cycle.* Many facilities engage debt buyers when their accounts have reached "charged-off" status, having gone through an internal collections process, an early-out process, and typically through one or more collections agencies.
- *Determine the value and details of your debt.* How many accounts do you have? How old are they? Which ones should you sell to a debt buyer versus those to be collected by an agency?
- *Be willing to open your books and to provide comprehensive information.* The more information you are able to provide to debt buyers, the more completely they can evaluate your portfolio to provide the best pricing structure.
- *Ensure that your debt buyer adheres to mandates and regulations for patient privacy.* HIPAA and FDCPA, for example, are federal

regulations to protect the privacy and rights of patients. It is imperative that your debt buyer adheres to these regulations to ensure patients' rights are preserved. Have the debt buyer sign a business associate agreement before sharing files with the firm.

- *Investigate secure communications options provided by your debt buyer.* Options such as secure, read-only access to your billing system ensure added protection for you and your patients and save time for your staff. Additionally, investigate the debt buyer's systems and security procedures.
- *Evaluate how much cash flow you require, and in what time frame.* The collection process for a self-pay account can take days, months, even years. Working with a debt buyer can significantly accelerate cash flow and help you meet your needs sooner rather than later.
- *Determine whether you can repurchase accounts.* Positive patient relationships are key to your business. For your peace of mind, ask a potential debt buyer whether you can repurchase accounts at any time and for any reason, whether there is a cap on quantity, whether there is a price mark-up, and whether you can exchange for other valid accounts as opposed to paying for them in cash.
- *Ensure that the debt buyer operates nationwide or in the regions you require.* In addition to national regulations, many states have specific laws regulating debt collection. Make sure your debt buyer understands and operates within these parameters.

source of revenue for both immediate and long-term needs.

Impact 2: Shortening the Placement Cycle

When it comes to selling debt, a one-off business transaction is often how a healthcare organization tests the waters before diving into a more regular partnership. More healthcare organizations, however, are finding that partnering with a debt buyer to shorten the debt placement cycle can dramatically increase their self-pay account revenue. How? Instead of waiting for the primary agency to work the debt for a year, a healthcare organization can shorten the revenue cycle by selling the debt after four to six months. In doing so, it will be able to get a higher price for the accounts from the debt buyer. Otherwise, most bad debts will sit for five or six months past the 120-day mark. As they collect more dust, their value goes down.

Ideally, a healthcare organization enters into a "forward-flow" agreement with a debt buyer. These agreements are becoming much more common and allow the provider group or hospital to sell its delinquent receivables on an ongoing basis, often as they reach the one-to-six-month threshold post "early out."

This process creates a more predictable cash flow and alleviates the buildup of bad debt going forward. It also reduces administrative work, and therefore, valuable hours for providers.

Impact 3: Testing ROI of Traditional Collections Versus Debt Selling

Some CFOs and other healthcare financial managers further define their debt-selling strategies by using a champion-challenger test to determine whether traditional collections or debt selling has the greatest impact on processes and cash flow.

To do so, a healthcare organization would place equal amounts of debt with its primary collections agency and its debt buyer for a set period of time—say 12 months. It would then compare the advantages and return each partner delivers over time and how each approach affects internal processes and staff.

For example, the hospital pays the collections agency contingency fees over a 12-month period, with fees varying depending on the hospital's location and demographics. The net liquidation, gross recovery, and net dollars also are spread over 12 months. In addition, after several months, the debt may need to be placed with a secondary agency for a higher service fee or returned as uncollectible.

By contrast, a debt purchaser is paid nothing by the hospital. It essentially buys the placement on day one, and the

hospital receives cash right away. With an additional revenue-sharing program, the hospital may receive additional dollars over the life of the purchased portfolio if the debt buyer hits certain targets in a specified period of time.

In addition to those considerations, the hospital should weigh the impact over the 12-month sample period of working with the collections agency on remittance detail and day-to-day operations, versus the impact of monthly self-pay money from the debt purchaser that requires minimal day-to-day operations.

For many managers, the test comes down to the value of money trickling in over several years versus the value of money today. Often, the winner is money in hand today. The debt buyer is essentially

Debt selling is a powerful option for maintaining revenue-cycle stability.

putting more cash quicker into the hospital's pocket. This makes an immediate impact on the revenue stream and allows the facility to fund ongoing operations or invest in improvements.

Impact 4: Debt Buyer as Revenue-Sharing Partner

Sometimes, a revenue-sharing relationship between a healthcare organization and a debt buyer is possible on the back end of a successful asset recovery process. Such an agreement becomes an option when a debt buyer purchases debt for the right price, can successfully revive the dormant accounts, and after several years, can reciprocate the hospital or group by paying out additional revenues. Such revenue-sharing agreements are not part of a set program but are individually determined at the time the debt is priced.

Even so, the revenue-sharing agreement is a strong example of how a debt-selling partnership can provide benefits on several different levels. It also shows how

a debt buyer's aim, ultimately, is to be a true partner along with the primary collections agency in the successful management of a hospital's or group practice's revenue cycle.

One thing is certain: With falling collections rates and rising medical debt, economic pressures are mounting for revenue cycle managers. In response, hospital CFOs, directors of patient accounts, business managers, and other healthcare financial managers alike are exploring all available tools to optimize the revenue streams and support the core mission of delivering high-quality patient care.

In that regard, debt selling is a powerful option for maintaining revenue-cycle stability and funding a healthcare organization's progress, even in these shaky economic times. ☎

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Coding Q&A

By Jennifer Swindle

Q: We recently had a claim rejected for a patient who returned to surgery to address an infection two weeks after gall-bladder surgery on the grounds that the second operation was within the 90-day global period for the initial surgery. In what cases may a second surgery within the 90-day period be billed, and how should it be coded?

A: There are three circumstances under which a second surgery within the global period may be billed. Each should be reported with a specific

modifier to ensure that the procedure is not included in an ongoing global period.

Treatment of postoperative complications requiring an unplanned return to the operating room is one, and it may apply in your case. Such a procedure should be billed with modifier 78 to indicate it is unplanned but related to the initial surgery.

In cases where a more extensive procedure is undertaken because an initial less extensive procedure was not successful, the second

surgery may be billed. It should be reported with modifier 58 to indicate it is a staged or related procedure.

A surgery unrelated to the initial surgery may also be billed within the global period of the first surgery. Modifier 79 should be reported with the second surgery to indicate that it is unrelated to the first procedure.

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Send your coding questions to Carole Bolster at cbolster@hfma.org.

Taking Notice of Observation Service Opportunities and Risks

Recent pressures from the Medicare Recovery Audit Contractors and various third-party payers have increased the sense of urgency that hospital leaders feel about getting observation programs established.

The issues surrounding the development of a strong program include:

- > Ever-changing Medicare and fiscal intermediary guidance
- > Differing requirements among various payers
- > Case management staffing and training
- > Lack of structured physician advisory and review processes

All of these issues make the admission decision challenging. Frequently, the billing for observation services has been difficult because of weak documentation, including unclear admission orders, a lack of negotiated observation rates for managed care payers, and insufficient system infrastructure for ensuring that all Medicare requirements are met.

The starting point for compliant patient billing is the physician's decision to admit the patient to observation level of care. Case management's role in this process is to ensure that the patient's medical necessity supports this level of care and that all documentation is complete. This typically means using standard industry guidelines as a screening tool. Often, the case management evaluation of the patient, the industry guidelines, and the physician's order may not agree. Where such disagreements occur, the physician adviser and the utilization committee should be involved to resolve the issue while the patient is in house.

As hospitals have implemented observation programs, external pressures to increase the number of patients placed into observation have increased significantly. Both governmental and other payers have implemented recovery programs based on medical necessity, primarily focusing on short-stay inpatient cases that may have been appropriately handled as observation

stays. At many hospitals, these pressures have resulted in an overcorrection and an overutilization of observation services.

Some of the related pitfalls regarding the increased utilization of observation services include the artificial increase in the hospital's case mix indexes (CMI) and increased length of stay on inpatient cases. The CMI issues may further exacerbate the government's notion that the hospitals are increasing coding, when in fact the CMI increase is simply a result of removing the low DRG weight cases from the calculations. Given Medicare's recent reduction in the payment levels related to what was historically called DRG creep, this issue may have a significant impact on the hospitals' future payments as well. Additionally, hospitals need to be concerned about the financial and public relations impact on the patient of billing what appears to be an inpatient service as outpatient. Finally, evidence supports that the readmission rate for observation care is relatively high, raising the question of the impact of observation programs on clinical quality.

To ensure compliant billing and avoid the observation volume creep being experienced at many hospitals, the best practices include following distinct physician-driven pathways. The factors to be considered in physician level of care assignment per the Centers for Medicare & Medicaid Services regulations are individualized, not driven solely by time of encounter or diagnosis category.

Observation services also can offer a significant opportunity to hospitals that have yet to implement programs and begin billing for the service appropriately. Observation revenue

typically exceeds \$1,000 per case compared with outpatient billing without observation. Many managed care contracts call for observation per diems comparable to inpatient per diems. If the inpatient care is going to be denied due to lack of medical necessity, hospitals should have a comprehensive plan in place to capture the optimum observation revenue.

As with most things, the key to implementing an effective observation service is developing a comprehensive process that is driven by physician decision making related to level of care assignment. ☞

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Danbury Hospital

This month, 2010 MAP Award-winning Danbury Hospital describes the impact of its emphasis on clean claims.

Back in 2002, staff on the billing and collections side of the revenue cycle at Danbury Hospital were spending way too much time cleaning up claims.

"Bills were being returned because a member was not on file—one of the easiest problems to eliminate. There were denials because a diagnosis wasn't appropriate for the services provided. We were getting denials from Medicare because we didn't have advance beneficiary notices. There was a tremendous amount of rework on the back end," recalls Mary Brannigan-Lowe, director of patient access and financial services for the 371-bed teaching hospital located in southwest Connecticut.

Brannigan-Lowe and others at the hospital at that time had been reading about the advantages of transferring back-end revenue cycle processes to the patient access area. But she, her CFO, the COO, and the hospital president wanted to move beyond admitting and preregistration and take the revenue cycle directly into the clinical departments. "That's where the revenue cycle really starts. If you can get the information you need for a clean claim from the clinical department the first time out, you get paid the first time out. So we were looking for greater accountability from our clinical departments in coding, registration, verification, and eligibility," she says.

Making the Case for Centralization

Shifting accountability to the clinical departments meant centralizing revenue cycle

Charging denials back to the department makes a big difference because the denials hurt the department's financial performance.

functions in the patient financial services department. Clinical departments were reluctant at first because they didn't want to lose any staff. "The departments would say, 'They are my staff. They are multiskilled. They also file and answer the phone and do other things,'" she says.

Brannigan-Lowe started making the case for centralization by conducting a full-scale prebill review. She asked three FTEs to analyze every single bill, not just to find claims issues, but also to look for insurance verification and eligibility information. She then tracked and publicized errors by department to show who was doing a good job and who wasn't. "Once the clinical departments realized they weren't doing very well and they didn't really want to devote more resources to deal with patient registration, verification, and eligibility, they said, 'We'll give you the staff. You can consolidate ours with yours,'" she says.

Brannigan-Lowe added punctuation to the argument for centralization by charging denials back to the clinical departments. "Anything that says 'denied' is sent back to the clinical department, and the department has so many days to respond to tell us whether we should appeal the denial or whether a diagnosis or a code needs to be corrected. Charging denials back to the department makes a big difference because the denials hurt the department's financial performance," she says.

Fostering Collaboration

Staff and administration at Danbury Hospital have worked hard to foster strong and collaborative relationships between the patient financial services department and the clinical departments. It's all about communication and teamwork," says Brannigan-Lowe. "The clinical departments are not afraid to call us if they have a question. I don't hesitate to call the COO or one of the vice presidents of operations if I have a

problem with a department. Within minutes, we are all in a room together sharing issues and concerns and brainstorming better processes."

The hospital's business operations unit, in particular, helps keep channels of communication open. Unit staff routinely advise clinical departments, particularly the high-cost, high-volume areas such as radiology and cardiology, on charging and coding. "We also have an extremely strong coding staff who work along with patient financial services and the clinical departments to make sure we are not going to be dealing with a problem after the fact. They also notify us of any patterns of problems," she says.

Since Danbury Hospital started measuring key performance indicators in 2005, it has seen its A/R greater than 90 days drop from a high of 31 percent to 11 to 12 percent today. Its credit balance, which was well over \$1 million, now averages \$250,000. The return-to-provider error rate from Medicare is less than 1 percent.

None of this would have been possible without support from executive leadership. "You can't make the changes we've made and get the results we get today without a commitment from the top. Our president, COO, and CFO have been committed to improving our revenue cycle process by making our clinical departments accountable and by incorporating the revenue cycle in all performance evaluations. Everyone from the top of the administration down to the staff knows this is important," Brannigan-Lowe says. ☺

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Strategies for Simplifying Your Staff Training

Binders containing tasks and policies and training sessions for staff can improve patient financial services office operations.

Have you ever wondered how to take some of the stress out of your day-to-day operations or help your patient financial services staff work more efficiently? These tips for simplifying your staff training can help you reach those goals.

Prepare a Binder of Tasks and Policies

Each work station should have a binder that lists the tasks each staff member performs and includes relevant policies. The binders help to simplify and organize training for new employees. The binders should be reviewed yearly to ensure that the processes are still valid and in place.

The value of using policy and procedure manuals for staff training cannot be overstated. Policies can be as simple as how to check in a patient, or more detailed, such as how to use an advance beneficiary notice (ABN) manual. Policies are needed not only to provide operating parameters for staff, but also to help you accomplish necessary tasks when staff members are unavailable.

To prepare the binders, work with staff members individually to see how they accomplish tasks and to determine ways to streamline the process. Write down each task that staff members perform, and outline how the task is to be accomplished.

The sample policy at www.hfma.org/rcs spells out who is responsible for a task and how the task is to be accomplished.

Policies help staff members “own” their tasks and give them a means to accomplish those tasks. They are great resources to ensure consistent training.

Training

Next, host training sessions with staff, get their input regarding how to improve processes, and cross-train staff on how each task is done. Training sessions help staff members understand what their coworkers need to accomplish and how they can help.

Communication is the key to success. Training staff is time-consuming, but taking a systematic approach simplifies the process.

More comprehensive training is required for large transitions, such as electronic medical record or ICD-10 implementation. For major training, you need to assess work flow and determine the best methods of training. Some employees may require more individual attention. Some might need training to bring their computer skills up to speed. And those transitioning into ICD-10 coding who have limited knowledge of anatomy or medical terminology may need refresher courses before receiving other training.

Another important point is that people have different learning styles. People depend on their senses to process information, and they tend to use one of their senses more than the others. The three most common learning styles are visual, auditory, and kinesthetic.

Visual learners prefer to see how to do things rather than talk about them. Most people are visual learners.

Auditory learners can often follow directions precisely after being told only once

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See a sample policy for small balance write-offs at www.hfma.org/rcs.

or twice what to do. Some auditory learners concentrate better when they have music or white noise in the background, or retain new information better when they talk it out.

Kinesthetic learners typically learn best by doing. They are naturally good at physical activities, such as sports and dance. They enjoy learning through hands-on methods. They typically like how-to guides and action-adventure stories. They might pace while on the phone or take breaks from studying to get up and move around. Some kinesthetic learners seem fidgety, having a hard time sitting still.

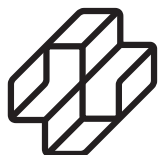
Training Will Enhance Office Operations

It’s important to provide your staff with consistent, comprehensive training. As you train them, consider their individual needs and learning styles. With proper training, your office will operate more smoothly and efficiently. ☺

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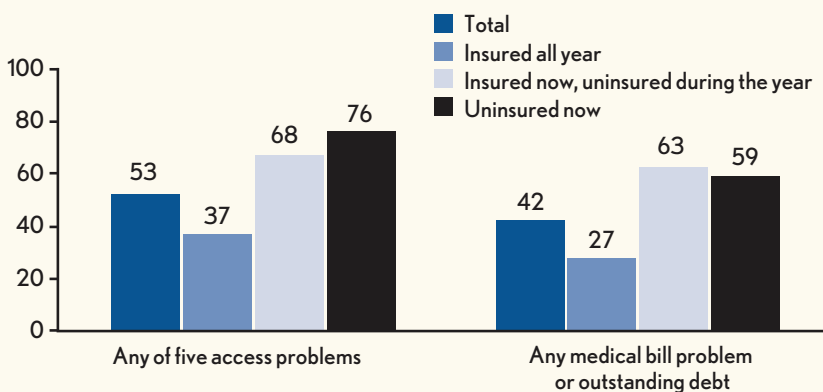
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Figures at a Glance

Uninsured Young Adults with Cost-Related Access or Medical Bill Problems

Access problems include not filling a prescription; skipping a medical test, treatment, or follow-up; having a medical problem but not seeing a doctor or going to a clinic; not seeing a specialist when needed; and delaying or not getting needed dental care. Medical debt or bill problems include not being able to pay medical bills, being contacted by a collection agency, changing way of life to pay medical bills, and medical bills/debt being paid off over time.

Percentage of adults ages 19-29 reporting cost-related access problems or medical bill or debt problems:



Source: Collins, S.R., and Nicholson, J.L., *Rite of Passage: Young Adults and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, May 2010).