

The Operating Model and Financial Economics of U.S. Behavioral Health Outpatient Clinics

A California-Focused Case Study of Reimbursement Friction, Medical Debt, and the Business Case for Diaspora



Content:

- 01 Introduction:** Introduces the problem, context, and central argument of the paper.
- 02 Scope and Definition of the Market:** Defines the provider types and treatment settings included in the analysis.
- 03 Market Overview:** Reviews the size, composition, and treatment landscape of the market.
- 04 Operating Model:** Explains how behavioral health providers deliver care and generate revenue.
- 05 Financial Landscape:** Examines payer mix, reimbursement structure, and provider economics.
- 06 Denials, Underpayments, and Medical Debt:** Analyzes key forms of revenue leakage and patient payment risk.
- 07 Market Opportunity:** Frames the commercial opportunity through recoverable reimbursement loss.
- 08 Ideal Customer Profile:** Identifies the provider segment best suited for Diaspora's solution.
- 09 Limitations:** Notes the main data gaps and constraints in the analysis.

Abstract

Behavioral health providers occupy a clinically indispensable but economically unstable segment of the U.S. healthcare system. Unlike specialties whose economics are anchored in high-acuity procedures or relatively predictable unit reimbursement, behavioral health providers depend on recurring episodes of care, administrative execution, and the successful conversion of insurer adjudications and patient balances into cash. Although this paper centers on outpatient clinics, it also includes residential treatment centers because many of the core reimbursement frictions in behavioral health cut across both settings. National treatment-facility data show that outpatient care remains the dominant mode of service delivery in both mental health and substance use disorder treatment, while residential treatment continues to represent a meaningful and commercially relevant share of the market. In California, commercial behavioral health spending reached \$5.1 billion in 2023, with outpatient professional non-primary care representing the largest category overall, while residential and inpatient care together accounted for most substance use disorder spending. These differences matter because they show that behavioral health is not one market with one economic profile, but a collection of submarkets with distinct reimbursement dynamics. Across these settings, providers face fragmented payer rules, thin networks, rising out-of-network price differentials, administrative denials, and substantial patient balance exposure. In this environment, out-of-network and hybrid-network behavioral health providers, particularly substance use disorder and dual-diagnosis providers, face a concentrated form of reimbursement uncertainty that makes reimbursement intelligence and pre-service financial predictability economically valuable rather than merely operationally convenient.

INTRODUCTION

The central economic fact about behavioral health is that strong clinical demand does not automatically translate into reliable financial performance. The U.S. market for treatment of mental disorders is large: AHRQ’s Medical Expenditure Panel Survey estimated \$106.5 billion in treatment expenditures for adults with mental disorders in 2019, with ambulatory visits representing the largest spending category and private insurance, Medicaid, Medicare, and out-of-pocket spending all playing meaningful roles¹. Yet the revenue model behind those expenditures is unusually fragmented. Behavioral health providers often depend simultaneously on commercial insurance, Medicaid, Medicare, and direct patient payment, which means that provider revenue is assembled from multiple vulnerable components rather than from a single predictable reimbursement stream. A provider can therefore face robust patient demand and still experience weak cash realization if any one link in the chain—eligibility, authorization, adjudication, patient affordability, or collections—breaks down.

This problem is especially acute in behavioral health because out-of-network use is not merely incidental; it is unusually common relative to general medical care. One study of privately insured patients found that mental health service users were substantially more likely than general medical users to have at least one out-of-network contact². Other work found that, from 2007 to 2017, in-network adult psychotherapy prices fell while out-of-network prices rose, widening the price and cost-sharing gap between in-network and out-of-network care³. These patterns suggest that reimbursement opacity in behavioral health is not a side issue. It is built into how care is accessed and paid for. That is the deeper logic behind Diaspora’s business case: its relevance comes not simply from billing pain, but from the structural instability of the path from treatment to cash.

SCOPE AND DEFINITION OF THE MARKET

For purposes of this paper, “behavioral health outpatient clinics” functions as the organizing label, but the practical scope is broader. The analysis includes organized providers delivering mental health and substance use disorder care in outpatient, partial hospitalization, intensive outpatient, and residential settings⁴. This broader definition better reflects SAMHSA’s N-SUMHSS framework, which includes outpatient facilities, partial hospitalization/day treatment facilities, residential treatment centers for both children and adults, and other residential treatment settings within the same national behavioral health facility system. It also reflects the way patients often move across levels of care within the same treatment ecosystem, especially in substance use disorder and dual-diagnosis treatment.



This definitional choice is analytically important for two reasons. First, SAMHSA's facility counts are best understood as a conservative measure of the organized treatment landscape, not as a complete census of every behavioral health practice, because the survey excludes individual private practitioners and small group practices that are not licensed as clinics or centers⁵. Second, the survey's mental health and substance use facility categories are not mutually exclusive: facilities that provide both types of services can appear in analyses specific to both mental health and substance use disorder treatment. That means the market should not be interpreted as a cleanly segmented set of non-overlapping provider categories. For Diaspora, this matters because the company's opportunity is not confined to one narrow facility type. It sits at the intersection of organized care settings, recurring treatment episodes, and reimbursement ambiguity across levels of care.

03

MARKET OVERVIEW: U.S. AND CALIFORNIA BEHAVIORAL HEALTH OUTPATIENT CLINICS

At the national level, the behavioral health treatment system is overwhelmingly outpatient in delivery but not exclusively outpatient in economic importance. SAMHSA's 2024 N-SUMHSS state profiles report 14,091 mental health treatment facilities nationwide, with 12,015 offering less-than-24-hour care; those settings accounted for 95.4% of reported mental health clients⁶. At the same time, the same system included meaningful residential and other 24-hour treatment capacity, which means that outpatient dominance in volume should not be mistaken for complete economic dominance across all behavioral health segments. In California, SAMHSA reported 1,204 mental health treatment facilities in 2024. Substance use disorder facilities are reported separately, with California's state profile listing 1,495 substance use treatment facilities and 90,954 clients in treatment on the survey date. Those two facility counts are not directly additive, because some facilities provide both mental health and substance use disorder treatment.

A more nuanced reading of this landscape is that behavioral health is too broad a category to be economically meaningful on its own. The commercial profile of general mental health care is not the same as that of substance use disorder treatment. California's HCAI data brief makes this distinction especially clear. In 2023, total commercial behavioral health spending in California reached \$5.1 billion, and outpatient professional non-primary care was the single largest service category at 43% of spending⁷. Yet the composition of substance use disorder spending looked very different: residential and inpatient care together accounted for 60% of commercial SUD spending, compared with 13% of mental health spending. This means that while outpatient care dominates the behavioral health system overall, the economic center of gravity in SUD is much more concentrated in higher-acuity settings. For Diaspora, that distinction is crucial. Its initial wedge is not simply behavioral health. It is a narrower slice of behavioral health in which episode size, reimbursement complexity, and financial stakes per patient are all materially higher.



A second nuance is that out-of-network exposure is not evenly distributed across behavioral health settings. National claims research found that the out-of-network share of spending for behavioral health facilities rose sharply from 12.6% in 2008–2010 to 34.4% in 2014–2016⁸. The growth was particularly pronounced in residential substance abuse facilities, where out-of-network spending rose from 11.6% to 44.3%, and in non-residential substance abuse facilities, where it rose from 5.3% to 42.8%. These figures matter because they show that out-of-network reimbursement is not confined to a small fringe of behavioral health. It is increasingly concentrated in the very segments—especially substance use treatment and residential care—where reimbursement is hardest to predict and where the financial stakes per episode are highest.

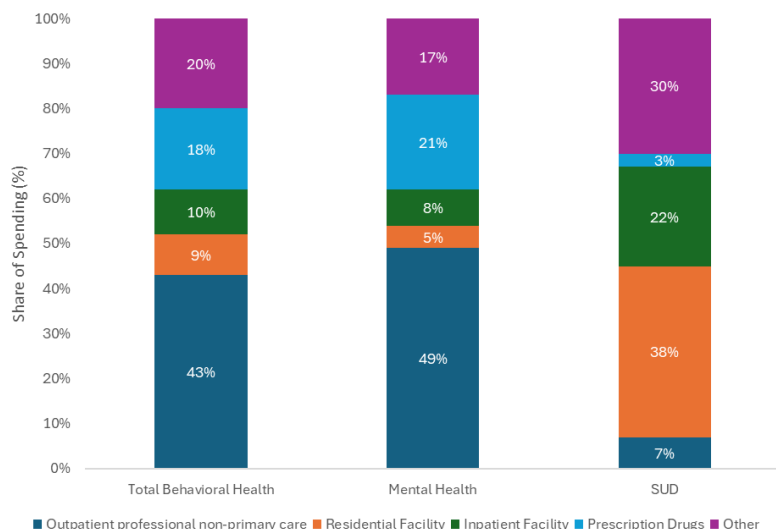


Figure 1. California Commercial Behavioral-Health Spending

In 2023, California commercial behavioral-health spending totaled \$5.1 billion. Outpatient professional non-primary care accounted for 43% of total behavioral-health spending, while residential and inpatient care accounted for 60% of SUD spending.

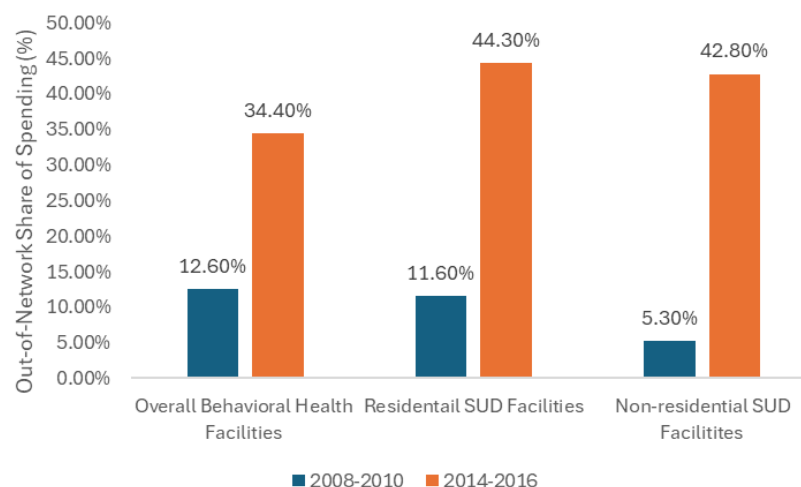


Figure 2. Out-of-Network Spending in Behavioral-Health Facilities

Out-of-network spending increased sharply between 2008–2010 and 2014–2016 across behavioral-health facilities overall, with especially large increases in residential and non-residential substance-abuse facilities.



OPERATING MODEL OF THE BEHAVIORAL HEALTH OUTPATIENT CLINIC

The behavioral health provider is best understood as a labor-intensive recurring-care business with unusually high administrative sensitivity. In outpatient settings, revenue depends on clinician supply, scheduling efficiency, no-show management, documentation, coding, authorization where required, and the successful adjudication of repeated claims. In residential settings, revenue depends on many of the same variables, but the financial stakes are amplified by longer lengths of stay and larger claims per patient episode. Unlike procedural specialties, where a single intervention may anchor a significant portion of revenue, behavioral health providers typically rely on the repeated conversion of lower-dollar professional services or multi-day treatment episodes into collectible cash. This makes the business relatively light in physical capital but highly exposed to revenue-cycle friction.

That recurring-care model has two strategic implications. First, operational execution and financial performance are tightly coupled. A missed authorization, coding error, or misread benefit summary does not merely reduce reimbursement on one claim; it can destabilize an entire episode of care. Second, patient affordability matters more in behavioral health than the phrase *patient responsibility* might suggest on paper. Behavioral health treatment often requires repeated visits or extended engagement over time. As balances accumulate, the practical distinction between a valid receivable and collectible cash becomes increasingly important. In that sense, behavioral health is not just a clinical services business. It is an administrative conversion business in which the provider must repeatedly translate medically appropriate treatment into payments that are actually realizable.

Public company reporting illustrates the shape of this model. LifeStance, one of the largest outpatient mental health platforms in the country, reported 8,040 clinicians, 9.0 million visits, and \$1.424 billion in 2025 revenue, alongside \$157.7 million in adjusted EBITDA, or 11.1% of revenue⁹. Those figures imply a scaled business with large visit volume but only modest margin relative to revenue, suggesting that even at national scale the sector's economics depend more on disciplined execution than on exceptionally wide reimbursement spreads. This is a useful benchmark not because LifeStance represents every clinic, but because it shows how operationally sensitive the outpatient behavioral health model remains even when scale advantages are present.



FINANCIAL LANDSCAPE OF U.S. AND CALIFORNIA BEHAVIORAL HEALTH OUTPATIENT CLINICS

The most important financial distinction in behavioral health is not between charges and reimbursement alone, but between nominal revenue and realized cash. FAIR Health’s consumer materials on in-network and out-of-network care explain the core mechanics clearly¹⁰. In-network providers agree to contracted rates and accept those rates as payment in full, subject to patient cost-sharing. Out-of-network providers, by contrast, are paid based on the insurer’s allowed amount or a plan-specific reimbursement methodology, and patients may owe not only higher deductibles and coinsurance but also the difference between the insurer’s allowed amount and the provider’s actual charge. In practice, then, out-of-network revenue is split into at least three uncertain components: insurer payment, patient cost-sharing, and the balance between the provider’s billed charge and the plan’s allowed amount. That structure is especially destabilizing in behavioral health because repeated visits or longer treatment episodes can generate cumulative patient responsibility that is technically owed but increasingly difficult to collect.

The trendline has moved in a direction that intensifies this problem. A Health Affairs study of psychotherapy claims from 2007 to 2017 found that average in-network adult psychotherapy prices fell from \$98.10 to \$84.47, while out-of-network prices rose from \$123.30 to \$148.64³. Over the same period, the ratio of out-of-network to in-network prices rose from 1.28 to 1.76, and patient cost-sharing gaps widened as well. This pattern suggests a strategic paradox in behavioral health reimbursement: out-of-network positioning can support higher nominal prices, but it can also amplify patient balance exposure and collection risk. For providers, the relevant question is therefore not just whether out-of-network care reimburses more on paper. It is whether it yields more realizable cash after denials, underpayments, and patient affordability constraints are taken into account.

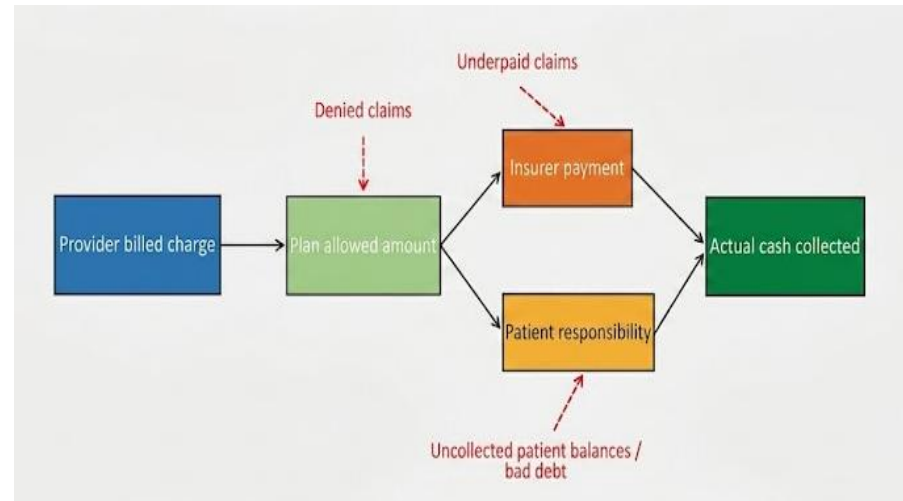


Figure 3. The Behavioral-Health Revenue Path from Charge to Collected Cash
Out-of-network reimbursement often depends on a plan’s allowed amount rather than the provider’s billed charge, leaving patients responsible for deductibles, coinsurance, and potentially the difference between charges and allowed amounts.



California’s public financing structure adds another layer of complexity. DHCS’s behavioral health fee schedule materials explicitly state that Mental Health Plans and DMC-ODS counties negotiate rates with and reimburse their individual providers, and those providers are not required to be reimbursed at the posted state fee-schedule amounts¹¹. That means even in public behavioral health reimbursement, the posted rate is not the same as the provider’s actual economic reality. This matters because it reinforces a broader point: behavioral health payment is often negotiated, layered, and difficult to infer from public schedules alone. The opacity problem Diaspora is trying to solve is therefore not limited to commercial PPO claims. It is a structural feature of the broader behavioral health financing environment.

06

DENIALS, UNDERPAYMENTS, AND MEDICAL DEBT

A deeper analysis of behavioral health revenue leakage should distinguish among three different failure points. The first is *adjudication failure*: the claim is denied or underpaid by the insurer. The second is *estimation failure*: treatment begins without a reliable forecast of likely reimbursement and patient responsibility. The third is *conversion failure*: the patient balance is valid on paper but never turns into cash. These failures are related but analytically distinct, and the business case for Diaspora is strongest when framed as a tool that addresses the second failure point before it cascades into the third.

National denial evidence underscores the instability of adjudication itself. KFF’s analysis of 2024 HealthCare.gov claims found that insurers denied 19% of in-network claims and 37% of out-of-network claims¹². Although those figures are not behavioral-health-specific, they are highly relevant because Diaspora’s initial target segment sits precisely where out-of-network reimbursement is common. Massachusetts HPC findings point in the same direction: the overall commercial denial rate was 20.4% in 2024, institutional outpatient claims had a 23% denial rate, professional mental health claims had a 10% denial rate, and the vast majority of denials were administrative rather than strictly clinical. That distinction matters because administrative denials are more amenable to better intake, verification, documentation, and reimbursement workflow—exactly the areas where predictive financial intelligence can matter most.



Underpayment and patient balance exposure then turn insurer opacity into a provider collections problem. In a 2022 *Psychiatric Services* study, half of families using out-of-network behavioral health care in employer-sponsored insurance experienced balance billing¹³. Among those families, mean annual balance billing was \$861, with materially higher amounts at the upper end of the distribution. This is not a trivial side effect. It means that even when care is delivered and coverage exists, the provider may still be depending on a residual patient payment stream that is both hard to predict and hard to collect. In that setting, bad debt is not merely a collections metric. It is often the downstream symptom of an upstream estimation problem.

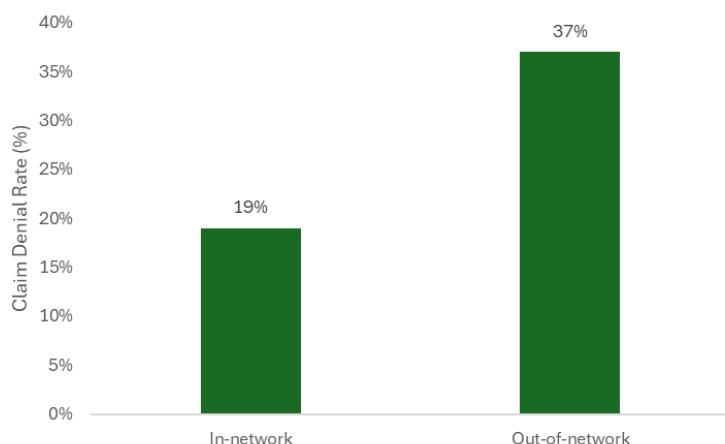


Figure 4. In-network vs. Out-of-network Claim Denial Rates
 Based on HealthCare.gov qualified health plan claims in 2024, insurers denied 19% of in-network claims and 37% of out-of-network claims.

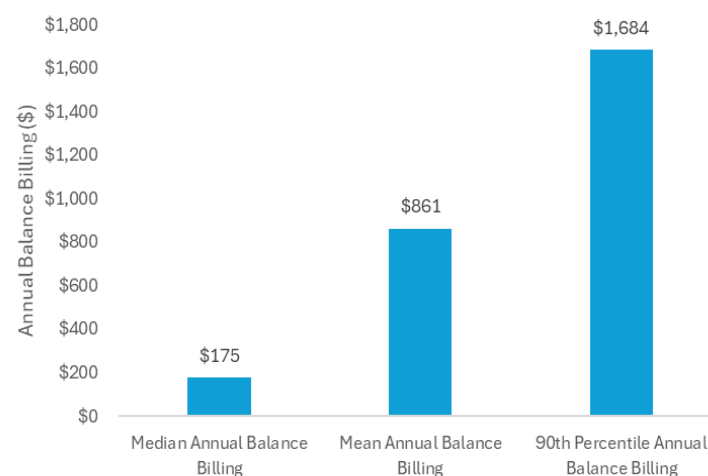


Figure 5. Patient Balance Exposure in Out-of-network Behavioral Health
 Among family-years with any balance billing for out-of-network behavioral health care, the mean annual balance-billing amount was \$861, the median was \$175, and the 90th percentile was \$1,684.



The medical debt literature strengthens this interpretation. A 2025 *Health Affairs Scholar* study estimated that 36% of U.S. households had medical debt in 2024, 21% had a past-due medical bill, 23% were paying a medical bill over time, and 15% had been contacted by someone other than their provider to collect a medical debt¹⁴. Separately, a 2025 *JAMA Health Forum* study found that adults with medical debt were far more likely to forgo mental health care because of cost than adults without medical debt, while a 2024 *JAMA Psychiatry* study found that medical debt was more common among adults with depression and anxiety than among those without those conditions¹⁵. Taken together, these findings suggest that medical debt is not only a consumer-finance issue. In behavioral health, it is also an access, retention, and revenue-cycle issue. Once patient responsibility outruns realistic affordability, the provider is not simply holding a receivable; it is holding a growing probability of disengagement, nonpayment, and weaker lifetime value per patient episode.

California's legal environment softens some consumer harms without eliminating provider risk. Beginning in 2025, most medical debt can no longer appear on California credit reports¹⁶. That may reduce some downstream consequences for patients, but it does not solve the provider's core problem: a balance assigned to the patient is still not the same thing as cash collected. If anything, the policy shift may make it even more important for providers to prevent unmanageable balances from arising in the first place rather than relying on downstream collection tactics. That strengthens the strategic logic for a product focused on pre-service predictability rather than post hoc recovery alone.

07

MARKET OPPORTUNITY FOR DIASPORA

Diaspora's market is best understood not as the full behavioral-health market, but as the reimbursement-leakage layer within that market. The relevant opportunity is the portion of provider revenue that is lost to avoidable denials, disputable underpayments, and preventable bad debt. This framing is more appropriate than sizing the company against total behavioral-health spending, because Diaspora does not create demand for treatment; rather, it stabilizes the conversion of existing treatment demand into collectible revenue.



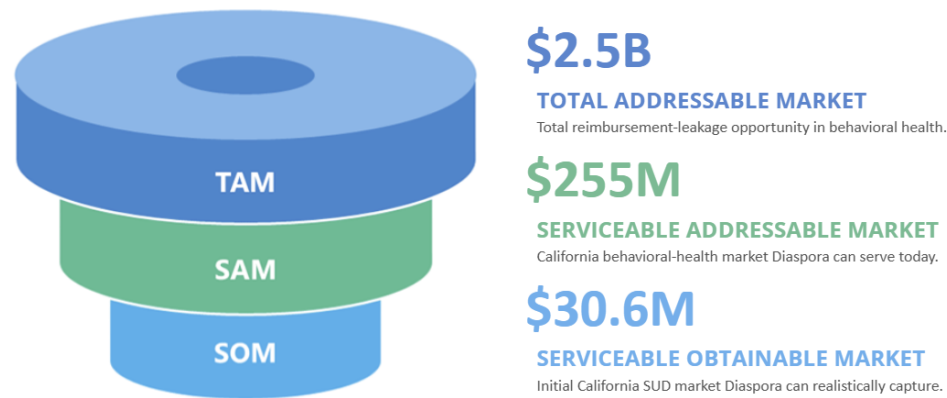


Figure 6. Diaspora Market Opportunity

TAM, SAM, and SOM are midpoint estimates based on a 5% reimbursement-leakage assumption. TAM uses national MEPS spending data; SAM and SOM use California HCAI commercial behavioral-health spending data.

At the national level, a useful TAM proxy is the portion of behavioral-health spending most exposed to the reimbursement and affordability problems Diaspora addresses: private insurance plus out-of-pocket spending for adult mental disorder treatment. MEPS reports \$33.9 billion in private-insurance spending and \$15.6 billion in out-of-pocket spending in 2019, for a combined base of approximately \$49.5 billion¹. Applying a conservative 3%–7% leakage assumption yields an estimated national reimbursement-leakage TAM of roughly \$1.5 billion to \$3.5 billion annually, with a midpoint of \$2.5 billion. This is best interpreted as a planning proxy rather than a precise census, since MEPS captures adult mental disorder spending rather than the entire behavioral-health universe, but it provides a grounded estimate of the revenue base most relevant to Diaspora’s model.

For SAM, the cleanest serviceable market is California commercial behavioral health. HCAI reports that California commercial behavioral-health spending reached \$5.1 billion in 2023⁷. Applying the same 3%–7% leakage assumption produces a California behavioral-health SAM of approximately \$153 million to \$357 million annually, with a midpoint of \$255 million. This is a stronger SAM definition than California mental health alone because it preserves a clean nesting structure for Diaspora’s expansion across both mental health and substance use treatment, while still aligning with the company’s state-based go-to-market focus.



For SOM, the most realistic initial obtainable market is California commercial SUD, particularly providers operating with out-of-network or hybrid-network reimbursement exposure. HCAI reports that 12% of California commercial behavioral-health spending in 2023 was for SUD, implying an SUD spending base of approximately \$612 million⁷. Applying the same 3%–7% leakage assumption yields an initial SUD reimbursement-leakage pool of roughly \$18 million to \$43 million annually, with a midpoint of \$30.6 million. This is the strongest SOM because it reflects Diaspora’s actual beachhead: a narrower segment in which residential and inpatient care account for most spending, reimbursement is more opaque, and the dollar exposure per patient episode is materially higher than in lower-acuity behavioral-health settings.

Under this framework, Diaspora’s strategic logic becomes clearer. The company’s broad opportunity lies in behavioral-health reimbursement instability, but its initial obtainable market lies in the narrower part of the California SUD landscape where out-of-network use, larger episode sizes, and patient balance exposure overlap most sharply. That makes the company’s early market smaller than the overall behavioral-health market, but also more economically concentrated and more closely aligned with the product’s value proposition.

08

IDEAL CUSTOMER PROFILE

Diaspora’s initial ICP is a *California behavioral-health operator that provides SUD and dual-diagnosis treatment across outpatient and/or residential settings, serves a meaningful share of commercially insured PPO/POS patients, and bills a meaningful portion of care out of network or on a hybrid-network basis*⁸. What defines this customer is not simply that it operates in behavioral health, but that it manages recurring or extended treatment episodes in a reimbursement model where insurer payment, allowed amounts, and patient responsibility are all difficult to predict before care begins. In practical terms, Diaspora is best suited to organized regional operators for whom reimbursement mistakes create material annual leakage, but who are still too operationally lean to have robust payer analytics or pre-service reimbursement intelligence in-house.



This framing also helps explain why some providers are better initial targets than others. A fully in-network, low-acuity therapy practice may still face administrative friction, but its reimbursement path is comparatively more standardized. By contrast, a hybrid-network SUD provider or residential operator faces a more volatile combination of authorization risk, allowed-amount uncertainty, patient balance exposure, and higher-dollar episodes. The commercial attractiveness of Diaspora’s wedge therefore comes not from serving the broadest possible behavioral health audience, but from serving the part of the market where reimbursement uncertainty is most concentrated and most economically consequential.

09

LIMITATIONS

This analysis still faces important data limitations. Public facility counts are stronger on provider inventory and service setting than on provider-level economics. Public expenditure datasets, such as MEPS and HCAI, are useful for understanding payment flows and market composition, but they do not provide clinic-level income statements. Public company data, such as LifeStance’s disclosures, are valuable for illustrating scaled outpatient economics, but they are not representative of every independent clinic or residential operator. Most importantly, standardized public data on behavioral-health-specific bad debt, write-offs, and collections performance remain sparse. That means the paper can describe the structure of the problem with more precision than it can quantify the average provider’s exact leakage rate.

At the same time, that limitation is analytically revealing rather than fatal. The scarcity of standardized leakage data suggests that many providers operate in a market where reimbursement instability is materially important but poorly benchmarked. For a company like Diaspora, that means the opportunity may include not only solving financial problems, but also making them legible. In that sense, lack of public precision around bad debt and underpayment is not only a research constraint; it may also be evidence of an unmet managerial need inside the market itself.



Conclusion

The behavioral health market is best understood not as a simple story of growing demand, but as a story of demand colliding with reimbursement instability. Outpatient care dominates the delivery system, but residential treatment remains economically important, especially in substance use disorder care. Across both settings, providers operate in a revenue model that depends on repeatedly converting treatment episodes into collectible cash under conditions of fragmented payer rules, frequent out-of-network use, administrative denial risk, and patient affordability constraints. The key problem is therefore not merely low reimbursement. It is instability in the path from treatment to cash.

Within that broader landscape, out-of-network and hybrid-network SUD and dual-diagnosis providers appear to be the strongest initial customers for Diaspora because they sit where three pressures overlap most sharply: high reimbursement opacity, high episode-level financial stakes, and high patient balance risk. Framed this way, Diaspora is not merely a billing tool or a workflow convenience. It is a financial intelligence layer for a segment of healthcare in which uncertainty itself is one of the core economic problems.

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