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# THE RACIAL HEALTH AND WEALTH GAP

## IMPACT OF MEDICAL DEBT ON BLACK FAMILIES

By **Berneta L. Haynes**

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## INTRODUCTION

An alarming number of consumers struggle with medical bills in the United States, with medical debt representing 58% of all debts in collections.<sup>1</sup> Despite the aims of the Affordable Care Act (“ACA”), medical debt remains a looming crisis, disproportionately affecting Black households and communities.

- 62% of bankruptcies are related to medical debt<sup>2</sup>
- 1 in 3 Black adults have past-due medical bills, compared to fewer than 1 in 4 white adults<sup>3</sup>
- 17% of Black adults lack health insurance compared to 12% of white adults<sup>4</sup>

An array of issues contribute to the current medical debt crisis: rising healthcare costs,<sup>5</sup> lack of insurance, narrow insurance networks, surprise medical bills,<sup>6</sup> high out-of-pocket costs, high deductibles, and inaccessibility of charity care or financial assistance. Unlike other expenses, medical bills often arrive unexpected, sending families spiraling into a financial crisis. The situation worsens as medical bills go unpaid and end up reported to credit bureaus, harming consumer credit scores<sup>7</sup> that increasingly have become important for obtaining employment, housing, and other financial products. As a result, medical debt can lead to long-term financial insecurity.

Race contributes to whether households have medical debt, with 27.9% of Black households carrying medical debt compared to 17.2% of white non-Hispanic households.<sup>8</sup> Households in the South, the region with the highest concentration of Black people, carry more medical debt than households in the Midwest, West, and Northeast. Racial inequality underlies these disparities in medical debt. Due to structural racism in hiring and lending, Black adults are still more likely to be low-income and lack access to wealth-building vehicles (like homeownership) compared to white adults. This wealth disparity means medical bills are more likely to present a financial hardship for Black families than for white families. Furthermore, while people in general gained health insurance coverage after the passage and implementation of the Affordable Care Act, Black adults still remain more likely to be uninsured than white adults.<sup>9</sup> The problem is compounded by health risks (such as cancer, infant and maternal mortality, heart disease, etc.) that disparately impact

### Uninsured Atlanta Woman Slammed with 30k in Hospital Bills from Medical Emergency.

Venus Lockett suffered a mini-stroke while giving a presentation in 2016. Uninsured at the time and fearing a bill, she wondered if she should refuse an ambulance ride or insist upon going to a certain hospital. The paramedics took her to the closest hospital nearby and, after some tests, she was sent home. A month later, she received a \$26,203 medical bill with a request to pay in 20 days. It was the first bill of several, until she owed nearly \$30,000.

Source: [Georgia Watch](#) and Olga Khazan, “Americans Are Going Bankrupt From Getting Sick,” [The Atlantic](#), March 15, 2019.

Black families. Due to racial inequities in health and wealth, the medical debt crisis has impacted Black families more acutely than white families.

In its official regulatory plan, the Biden-Harris administration has signaled an interest in addressing “persistent disparities in health outcomes and access to care.”<sup>10</sup> However, the plan fails to explicitly acknowledge that structural and systemic racism underlies these disparities, which all fall disproportionately on Black families. An expressed commitment to tackling medical debt also remains conspicuously absent from the plan. As this report demonstrates, medical debt must be addressed as a racial justice issue that exacerbates the existing racial wealth and health gap facing Black families and communities. In recognition of the explicit role racism plays in medical debt and health disparities, advocates and leaders should take action to protect Black patients from unaffordable medical bills that trap families in a cycle of financial insecurity.

This report discusses the intersections between the racial health gap and racial wealth gap, “charity care” or hospital financial assistance programs, and the harms of aggressive medical debt collection. This report proposes policy solutions that have come from healthcare advocates, legal aid attorneys, racial justice organizations, academic researchers, and financial protection advocates.

## THE INTERSECTION BETWEEN THE RACIAL HEALTH AND WEALTH GAPS

The COVID-19 pandemic has exposed the reality of stark racial inequities and gaps in health, with Black people and other people of color more likely to become ill and die from COVID-19. Many factors contribute to the racial health gap and explain the disparate impact the pandemic has had on Black people: healthcare access inequities (including being underinsured or uninsured), disparities in vaccination and screening, chronic illnesses, low-wage jobs, and more.<sup>11</sup> While these disparities have become more transparent since 2020, the racial health gap extends beyond the pandemic and intersects with the racial wealth gap. Structural racism in healthcare was a core feature of Jim Crow segregation, and the legacy of that history persists, affecting Black people’s health outcomes and access to quality healthcare.

The *racial health gap* refers to the disparities in healthcare access, healthcare quality, and health outcomes of households across race.

The *racial wealth gap* refers to disparities in income, assets (including homes, savings, investments, etc.), and debts of households across race.

To provide a deeper understanding of the interaction between the racial health and wealth gap, this section will cover how medical debt affects the physical and mental health of Black families, and traps Black families in a cycle of debt.

## Jim Crow Segregation and Healthcare: A Brief History

Before the passage of the Civil Rights Act of 1964 and the enactment of Medicaid and Medicare, Jim Crow segregation permeated every institution in the United States, including hospitals. Passed in 1946 in response to a shortage of hospitals and healthcare facilities after the Great Depression and World War II, the Hospital Survey and Construction Act codified hospital segregation. Also known as the Hill-Burton Act, it authorized federal grants to states for hospital construction.<sup>12</sup> Although the Act created “the most comprehensive hospital and public health construction program ever undertaken”<sup>13</sup> in the United States, it came with a significant downside. The Act contained a separate-but-equal provision allowing for racial discrimination in healthcare facilities and service, a concession that resulted from pressure from Southern Senators.<sup>14</sup>

Due to this Jim Crow provision of the Hill-Burton Act, the number of hospitals increased around the country, but some Black communities still lacked access to hospitals altogether.<sup>15</sup> For Black communities in the South, the lack of hospitals willing to serve Black patients led to high rates of infant and maternal mortality because of home births.<sup>16</sup> Hospital segregation in the Northern cities occurred in a more subtle fashion but had similar consequences, including denial of care. For example, Black patients in the North were often sent to less suitable hospitals where they received lower quality healthcare.<sup>17</sup> Moreover, as the federal government created new health programs like Medical Assistance to the Aged (“MAA”) through the Kerr-Mills Act to benefit vulnerable populations, many states (especially those with significant Black populations) underfunded the program or declined to participate.<sup>18</sup>

The Kerr-Mills Act’s MAA program, implemented in 1960, provided federal grants to states to pay for medical services for indigent older adults.<sup>19</sup> But the program was slow to take off and by 1963 only thirty states had begun implementing Kerr-Mills programs,<sup>20</sup> with sixty percent of program participants residing in New York, Massachusetts, and California.<sup>21</sup> According to a report to the U.S. Senate in 1963, states such as Georgia, Louisiana, and Texas (with notably large Black populations) lacked a Kerr-Mills MAA program while many implementing states severely limited eligibility.<sup>22</sup> Therefore, despite the various efforts underway to rebuild the country’s healthcare system, Black communities remained less likely to benefit from these changes.

While the Hill-Burton Act rebuilt the country’s hospital system, it also further entrenched segregation in healthcare. However, the Act did not go unchallenged by desegregation advocates and civil rights activists. In fact, one successful challenge, *Simkins v. Moses H. Cone Memorial Hospital*, became important in the passage of Title VI of the Civil Rights Act of 1964. In 1963, the Fourth Circuit Court of Appeals ruled in *Simkins v. Moses H. Cone Memorial Hospital* that the separate-but-equal provision and the resulting regulations were unconstitutional.<sup>23</sup> The defendant hospitals appealed, but the U.S. Supreme court later declined to hear the case, making the appeals court decision final.<sup>24</sup> During the Senate floor debate on Title VI (intended to prohibit discrimination on the basis of race, color, or national origin in programs that receive federal financial assistance), proponents often cited the case as support for the

nondiscrimination goals of the bill. Desegregation advocates successfully challenged the separate-but-equal provision in the Hill-Burton Act, and the Senate passed the Civil Rights Act in 1964, but the battle was not over. Hospital segregation persisted because of the ineffectiveness of the department tasked with ensuring Title VI compliance with the Civil Rights Act.<sup>25</sup>

The turning point in hospital segregation occurred not with the Civil Rights Act of 1964 but with the establishment of Medicaid and Medicare in 1965. Lyndon B. Johnson signed into law Medicaid and Medicare, both subject to Title VI's nondiscrimination requirements, effectively forcing the immediate desegregation of hospitals all over the country. To receive Medicaid and Medicare federal funds, hospitals had to admit Black patients or face losing money.<sup>26</sup> In 1967, Johnson's assistant secretary of health reported that 95% of hospitals were admitting Black patients.<sup>27</sup>

While few other desegregation efforts worked as efficiently as Medicare and Medicaid did to eliminate hospital segregation,<sup>28</sup> structural racism still exists in healthcare and impacts the health and wellbeing of Black families. Hospitals may not outright exclude Black patients from care or officially separate Black patients from white patients anymore, but disparities in quality and access exist today. Indeed, nursing homes, where the primary payer is Medicaid, remain effectively segregated with Black older adults more likely than white older adults to end up in these homes.<sup>29</sup> A 2020 investigation found that Black older adults have a greater likelihood of living in the poorest quality nursing homes (and nursing homes that experience higher death rates from COVID<sup>30</sup>) and of being terminated from Medicaid.<sup>31</sup> Additionally, because expansion of Medicaid eligibility remains optional to the states rather than mandatory,<sup>32</sup> Black families living in non-expansion states<sup>33</sup> face higher uninsured rates than other demographic groups.<sup>34</sup>

Likewise, unresolved racial inequities exist in Medicare, with Black recipients reporting worse health and greater access problems than white recipients.<sup>35</sup> Although Jim Crow hospital segregation is largely a thing of the past, it has played a crucial role in the current health disparities, negative health outcomes, and healthcare quality and access issues in Black communities. This legacy of segregation and structural racism in healthcare underlies the racial health gap, impacting health outcomes and access to quality healthcare for Black people.

## **Medical Debt, a Key Consequence and Driver of the Racial Health Gap**

The “racial health gap” refers to disparities in healthcare access, healthcare quality, and health outcomes of households across race. What is the reality of the racial health gap in Black communities today?

In all areas of health, Black people experience worse outcomes, reduced healthcare access, and lower quality service from providers, compared to whites. Because of longstanding structural racism in healthcare, medical debt has a greater impact on

Black communities, exacerbating these health disparities in Black communities and widening the racial health gap.

### Health Disparities Affecting Black People

HEALTHCARE ACCESS	HEALTHCARE QUALITY	HEALTH OUTCOMES
More likely to be uninsured <sup>36</sup>	Lower quality care, whether insured or not <sup>37</sup>	Higher maternal mortality rates <sup>38</sup>
More likely to live in states with the highest uninsured rates <sup>39</sup>	Reliance on community clinics, outpatient care, and ERs <sup>40</sup>	Higher infant mortality rates <sup>41</sup>
Limited Medicaid access due to living in non-expansion states <sup>42</sup>	Less likely to receive health- and life-conserving treatments <sup>43</sup>	Highest mortality rate from heart disease and all cancers <sup>44</sup>
Lack of hospitals and healthcare providers <sup>45</sup>	More likely to receive less desirable treatments, like amputations <sup>46</sup>	Highest rates of onset, hospitalization, and death due to diabetes <sup>47</sup>

Medical debt affects communities of color disproportionately, with older Black adults 2.6 times more likely to carry medical debt than older whites.<sup>48</sup> In general, a third of Black adults have medical debt compared to less than a quarter of white adults.<sup>49</sup> 27.9% of Black households have medical debt compared to 17.2% of white households and 9.7% of Asian households.<sup>50</sup> Meanwhile, 6.2% of Black households have medical debt greater than 20% of their yearly income, compared to 4.4% of all households.<sup>51</sup> The biggest risk factors for incurring medical debt are lack of insurance and poor health, both of which are prevalent in Black communities (as well in Latiné, American Indian, and Alaska Native communities).<sup>52</sup> For example, uninsured households carry an average of \$31,947 in medical debt compared to \$18,827 among insured households.<sup>53</sup> While one-time accidents can lead to burdensome medical debt for insured and uninsured patients alike, most people tend to cite poor health and costly treatment for chronic conditions like heart disease, cancer, and diabetes as the cause of their medical debt.<sup>54</sup> Due to higher rates of chronic illnesses, lack of insurance and other disparities, Black adults struggle with medical debt more than other communities.

Medical debt not only stems from poor health but contributes to poor health outcomes,<sup>55</sup> creating a vicious cycle for Black people. Individuals struggling with medical debt report avoiding, delaying, or skipping necessary medical care,<sup>56</sup> and these practices are associated with not only worse health outcomes but also increased healthcare costs down the line. Avoiding and delaying healthcare is associated with late diagnosis of disease, lower rates of cancer screening, reduced survival rate from disease, and preventable health complications.<sup>57</sup> The sacrifices households with medical debt make do not stop at avoiding or delaying healthcare. Households with medical debt even report reducing spending on food in an effort to

manage their medical bills.<sup>58</sup> In short, people regularly put their health at greater risk to avoid medical debt or to pay off existing medical debt.

Carrying debt of any sort also causes psychological distress,<sup>59</sup> due to the fear of never being able to pay the debt or dealing with aggressive debt collectors. Debt collectors target Black people and people of color disproportionately, with these groups more likely to have debts in collection, more likely to be contacted by debt collectors, and more likely to be subject to collection actions (i.e. lawsuits, wage garnishment, judgments, etc.).<sup>60</sup> This stress increases an individual's risk of anxiety, depression, substance use disorders, and other mental health disorders.<sup>61</sup> Black adults are already more likely to experience feelings of sadness and hopelessness than white adults,<sup>62</sup> and medical debt potentially compounds this problem. In this sense, medical debt directly contributes to poor health outcomes in Black communities.<sup>63</sup> The physical and mental health impacts of carrying medical debt reinforce the racial health gap, worsening existing health disparities for Black people.

**In 2020, the Federal Reserve reported that the median net worth (all the assets an individual owns minus outstanding debts) of Black families was \$24,100 compared to \$188,200 for white families.**

## **Medical Debt Widens the Racial Wealth Gap**

Centuries of structural racism and discriminatory policies not only have contributed to a racial health gap, but also have left Black households with less wealth and resources to rely upon when financial pressures, like medical bills, arrive at their doorsteps. Black families have lower net worth than white families (even when controlling for income),<sup>64</sup> lower rates of homeownership, lower rates of participation in retirement plans, and much less in liquid emergency savings.<sup>65</sup> While whites hold more debt generally, Black families carry more student loan debt and costly debt like small-dollar loans (i.e. payday and car title loans), and higher credit card balances.<sup>66</sup> Debt, while not the single cause, reinforces this racial wealth gap.<sup>67</sup>

Medical debt in particular reinforces the racial wealth gap by locking Black families out of opportunities to build wealth. Aggressive medical debt collection practices include suits to garnish wages, property liens, and even civil arrest for unpaid medical bills, all of which disparately impact Black families.<sup>68</sup> To avoid these consequences, individuals often drain their short-term savings, increase their credit card debt, or dip into long-term savings accounts (retirement or college funds) to pay off burdensome medical bills.<sup>69</sup> Families sometimes turn to deceptive financial products, such as medical credit cards<sup>70</sup> and risky high-interest small dollar loans to pay medical bills.<sup>71</sup> In this way, medical debt directly widens the racial wealth gap.

Additionally, medical debt affects Black families' access to a key wealth-building vehicle: homeownership. Because medical debt often drags down credit scores,<sup>72</sup> individuals carrying medical debt may experience difficulty obtaining mortgage

loans. About 40% of people with medical debt report being denied a mortgage loan.<sup>73</sup> Some researchers also believe there may be a connection between medical debt and home foreclosure. In one community survey, 70% of respondents self-reported medical reasons (including illness, medical bills, and job loss due to illness) as a cause of their home foreclosure.<sup>74</sup> In particular, 23% of respondents reported having to divert money toward medical bills instead of the mortgage.<sup>75</sup> In a study examining medical debt and foreclosure in Tuscaloosa, Alabama, Black households were twice as likely as white households to have medical debt preceding foreclosure actions.<sup>76</sup> The study showed that medical debt presents a greater burden to Black families, corresponding to higher rates of foreclosure and susceptibility to mortgage default no matter where Black families lived.<sup>77</sup> Worse yet, some hospitals go as far as to seek liens on patients' homes for unpaid medical bills.<sup>78</sup> While more research is needed on the connection between medical debt and foreclosure, it is clear that medical debt affects financial stability and wealth-building opportunities, thereby widening the racial wealth gap.

## **“CHARITY CARE” AND FINANCIAL ASSISTANCE POLICIES PROVIDE INSUFFICIENT PROTECTION**

The Affordable Care Act (“ACA”) has gone a long way to tackle the problem of medical debt, including reducing the probability of bankruptcy.<sup>79</sup> However, these positive results primarily stem from the expansion of Medicaid under the ACA<sup>80</sup> rather than from the law’s “charity care” or financial assistance policy (FAP) requirements. Crucial deficiencies in the ACA’s financial assistance requirements warrant closer examination to understand why many patients still face burdensome and mounting medical bills.<sup>81</sup> To provide a clearer understanding of the inadequacies of charity care and FAPs in solving the medical debt crisis, this section will provide an overview of financial assistance requirements and spending, and an exploration of why charity care fails to protect Black patients.

### **A Glance at “Charity Care” Requirements and Spending**

The ACA requires all public and privately owned non-profit hospitals with 501(c) (3) status to provide community benefits, including financial assistance to low-income patients, to maintain their tax-exempt status.<sup>82</sup> Per the ACA requirements, non-profit hospitals must develop written financial assistance policies that inform patients of their options before the hospital uses aggressive methods to collect on unpaid medical bills.<sup>83</sup> Hospital FAPs must include eligibility criteria, the basis for costs charged to patients, instructions about how to apply for financial assistance, and any other information the hospital will use to determine eligibility for financial assistance.<sup>84</sup> If the hospital does not have a separate billing and collections policy, it must include in the FAP a description of actions the hospital will take to collect

on an unpaid bill.<sup>85</sup> The FAP must apply to all “emergency and other medically necessary” care the hospital provides.<sup>86</sup>

Notably, the requirements also state that before using any bill collection mechanisms a hospital must use multiple avenues<sup>87</sup> to make sure patients know about the FAP. The hospital must “widely publicize”<sup>88</sup> the FAP to all members of the community and make sure it is written in “plain language.”<sup>89</sup> While the ACA still allows hospitals to collect on unpaid bills, it requires hospitals to show they made a “reasonable effort” to inform patients about available charity care or financial assistance before using “extraordinary collection actions” (i.e. actions that require a legal or judicial process, selling the debt to a third-party, or reporting “adverse information” to credit reporting agencies).<sup>90</sup> Failure to comply with these financial assistance policy requirements under the ACA may result in loss of the hospital’s tax-exempt status.

Currently, hospital spending on charity care or financial assistance varies from hospital to hospital. In 2017, hospitals spent \$14.2 billion on financial assistance (\$9.7 billion to uninsured patients and \$4.5 billion to insured patients), while generating \$47.9 billion in net income.<sup>91</sup> Hospitals with the highest net incomes spent less of their income on charity care than hospitals with the lowest overall income; the least financially strong hospitals incurred losses due to their spending on charity care.<sup>92</sup> Additionally, hospitals in states that expanded Medicaid spent less on charity care than hospitals in non-expansion states.<sup>93</sup> Patient population differences may account for disparities in the provision of charity care (e.g. if fewer patients in the hospital’s service area need charity care, then it follows that the hospital will spend less on charity care, and vice versa). Overall, spending on charity care accounts for between 2% and 4% of expenses at private tax-exempt and government-owned hospitals.<sup>94</sup>

### **California Hospital Failed to Inform Eligible Patient of Charity Care Option and Sent Her to Debt Collections.**

Despite California’s mandate that general or acute care hospitals must provide free or discounted care to uninsured patients or income-eligible patients who have high medical costs, Monique Davis still found herself dealing with unmanageable medical bills after being diagnosed with a rare bone marrow disorder. Instead of informing her about financial assistance, staff at Memorial Care Hospital told her to borrow money from family members and pay out of pocket. Eventually, they sent her to collections.

“We started to receive numerous hospital bills in the mail, and phone calls. They would call me while I was still in the hospital, they would call my husband at work demanding payments. We were scared, felt alone and terrified. At times, I thought maybe it would be better if I had died, then my husband would not have the added stress and financial burden of me. . . . It was not until I contacted Public Law Center that I found out that I should have gotten help from the hospital to reduce my bill and offer me a payment plan.”

*Source:* Public Law Center.

\*California passed AB 1020 in 2021 to improve its charity care law and close these gaps.

## Charity Care Falls Short in Practice

While charity care or financial assistance policies help protect some uninsured or underinsured patients from burdensome medical debt, these programs fall short as hospitals do the bare minimum to satisfy the ACA's requirements and maintain their tax-exempt status. In practice, charity care policies fall short for several reasons:

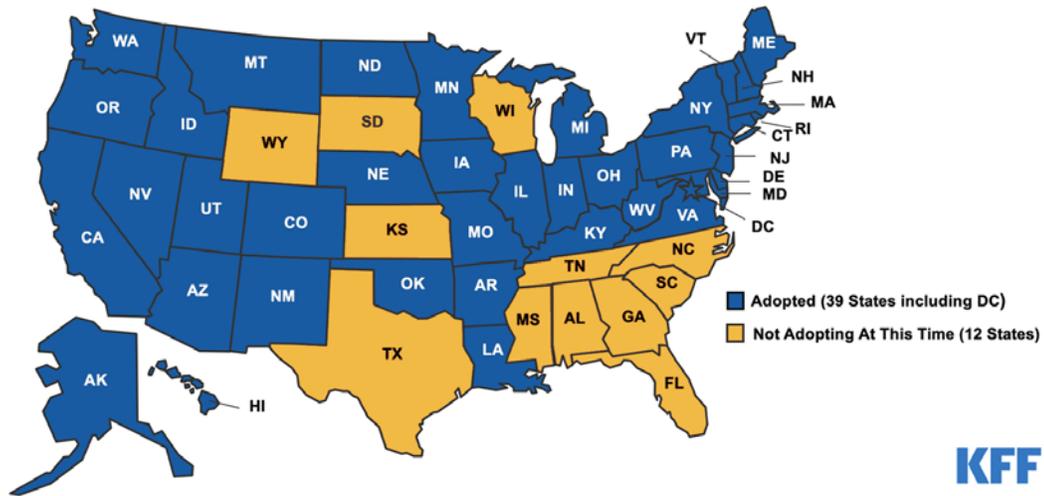
- Hospitals fail to inform patients of their eligibility for charity care before commencing debt collection;<sup>95</sup>
- Lack of specific guidelines and minimum eligibility criteria in the ACA's financial assistance policy requirements;<sup>96</sup> and
- Overall lack of effective implementation, enforcement, and oversight of charity care programs.

For-profit hospitals also are not subject to the ACA's financial assistance rules and represent a significant portion of hospitals around the country. In 2019, 50% of all hospitals in Texas were for-profit.<sup>97</sup> With the exception of just over a dozen states clustered primarily in the Upper Midwest and Northeast, at least ten percent of hospitals are for-profit and not required by federal law to provide financial assistance or charity care.<sup>98</sup>

Financial assistance or charity care should be available to fill in the coverage gaps left by Medicaid, subsidized insurance purchased through state or federal health insurance marketplaces, and other programs. But as described above, charity care itself leaves many gaps. Because of these failures in charity care, many individuals who ideally would be protected by the ACA's financial assistance requirements end up stuck with medical bills and debt. Leaving it up to hospitals to determine financial assistance application procedures, guidelines, and income eligibility requirements also creates glaring disparities where one hospital may provide an accessible and generous policy, while another may have an inaccessible and restrictive charity care policy.

This lack of specific guidelines and eligibility criteria leave Black people vulnerable for a few reasons. First, Black people are more likely to be uninsured. Second, hospitals with less generous eligibility requirements (e.g. restrictive income thresholds) tend to be located in Medicaid non-expansion states,<sup>99</sup> which are predominantly the Southern states (*see Figure 1*).<sup>100</sup> Third, Black people are more likely to reside in these Medicaid non-expansion states (*see Figure 2*).<sup>101</sup>

**FIGURE 1 STATUS OF STATE MEDICAID EXPANSION DECISIONS**



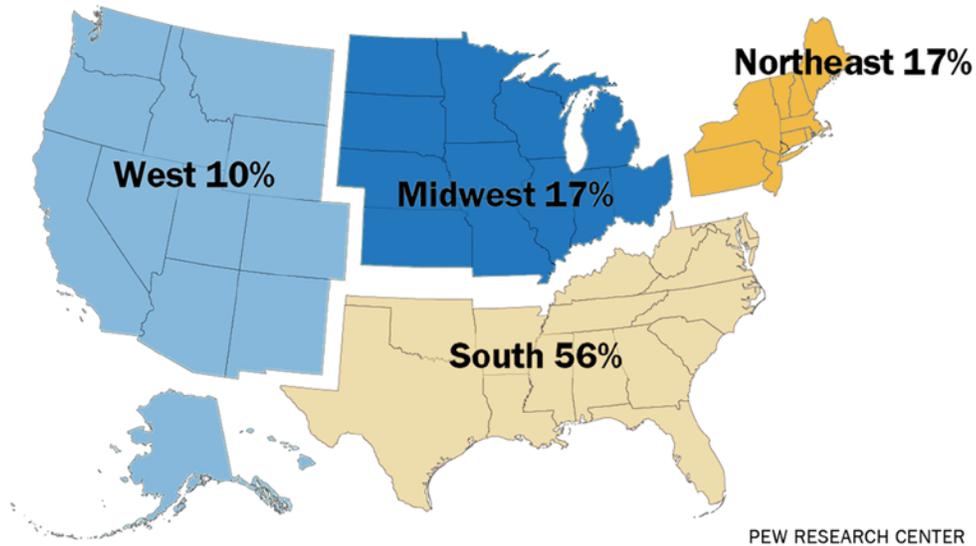
Courtesy of Kaiser Family Foundation.

Notes: Current status for each state is based on KFF tracking and analysis of state activity. See additional [state-specific notes](#).

Source: “Status of State Action on the Medicaid Expansion Decision,” KFF State Health Facts, updated February 24, 2022.

**FIGURE 2 MAJORITY OF THE U.S. BLACK POPULATION LIVES IN THE SOUTH**

Percent of U.S. Black population living in the \_\_\_\_, 2019



Courtesy of Pew Research Center.

Note: Figures may not add to 100% due to rounding. “U.S. Black population” refers to anyone who self-identifies as Black, inclusive of single-race Black, multiracial Black and Black Hispanic people.

Source: Pew Research Center tabulations of the 2019 American Community Survey (1% IPUMS).

While the ACA requires hospitals to provide financial assistance or charity care to keep their tax-exempt status, almost half of non-profit hospitals regularly bill patients who are income-eligible for assistance.<sup>102</sup> Hospitals sometimes give up trying to collect these bills and write them off as “bad debt,”<sup>103</sup> but that relief comes after the patient has suffered the financial consequences and stress of being in debt collections. For instance, of the bad debt that North Carolina non-profit hospitals billed in 2019, 11.9% to 28% should have been provided as charity care.<sup>104</sup> In 2020, 31% to 48% of bad debt billed to patients at North Carolina non-profit hospitals should have been provided as charity care.<sup>105</sup> This reality flies in the face of the ACA’s goals, namely the “reasonable effort” rule meant to protect patients from medical debt at the outset, not after the fact.<sup>106</sup> That hospitals are reporting billions in bad debt indicates that hospitals are neglecting to inform patients upfront about their financial assistance options and, therefore, not complying with the ACA’s “reasonable effort” rule.<sup>107</sup> It means the ACA’s financial assistance policy requirements are not working.

In addition, it is almost impossible to hold hospitals accountable for lack of compliance with the ACA’s financial assistance rules. As long as hospitals engage in some charity care and report it to the IRS, they can usually retain their non-profit tax-exempt status. The ACA provides no private right for a patient to sue a hospital for noncompliance with the FAP provisions. Only the IRS can enforce the financial assistance requirements of the ACA, and that enforcement is so far inadequate.<sup>108</sup>

This lack of enforcement and oversight is a recipe for exploitation that leaves patients who should qualify for charity care stuck in a medical debt trap while hospitals hit record revenues.<sup>109</sup> For example, between 2009 and 2018, Maryland non-profit hospital revenue and net income totaled \$147 billion and \$5.68 billion respectively; yet, in the last five years, the annual amount of charity care provided by these hospitals dropped by 36% or \$168 million.<sup>110</sup> As spending on charity care decreased and revenues increased, Maryland non-profit hospitals filed 145,746 medical debt lawsuits totaling approximately \$268 million (likely against many individuals who would have qualified for charity care).<sup>111</sup> A study showed a similar trend in nearby North Carolina, where the state’s non-profit hospitals have average revenues three times the national average and spend less on charity care than they avoid in taxes.<sup>112</sup>

Lack of enforcement and oversight, lack of notice to patients, and lack of specific guidelines and minimum eligibility requirements for hospital FAPs all snowball to limit the effectiveness of the ACA’s efforts to reduce the medical debt burden and protect patients from aggressive debt collection practices.

## THE HARMS OF AGGRESSIVE DEBT COLLECTION PRACTICES

While receiving a high medical bill is stressful enough, the problems mount when the bill is sent to debt collections. Medical debt is consistently the most common type of past-due bill about which consumers reported being contacted by debt collectors. In 2022, the Consumer Financial Protection Bureau reported that 58% of bills in collections and on people's credit records were medical bills in the second quarter of 2021.<sup>113</sup> As noted, Black people carry a disproportionate amount of medical debt compared to other racial groups. Debt collectors also contact Black people at a higher rate than other groups.<sup>114</sup> In fact, debt collectors contact Black households at twice the rate of white households, according to the Urban Institute.<sup>115</sup> Furthermore, the Federal Trade Commission found that areas where the Black population is 50% or more have a higher rate of debt collection complaints compared to areas that are majority nonblack.<sup>116</sup> Despite the ACA's credit and collection provisions, protections under the Fair Debt Collection Practices Act (FDCPA), and various state-based protections, aggressive debt collection remains a looming problem and medical debt is one of the leading triggers of this experience. Aggressive debt collection practices result in undue stress, loss of income and wages, liens on homes, and other long-term harm to financial stability.

To better understand the harms of aggressive debt collection practices and the role hospitals play in this problem, this section will provide an overview of consumer credit and collection protections under the ACA and the FDCPA, and an overview of common types of aggressive medical debt collection practices.

### Existing Protections from Aggressive Debt Collection

*ACA Protections against "Extraordinary Collection Actions."* For consumers with medical debt, the ACA's "extraordinary collection actions" (or "ECAs") and "reasonable effort" rules offer some protections against aggressive debt collection. Per these rules, hospitals must not engage in extraordinary collection actions against a patient without first making reasonable efforts to determine the patient's eligibility for financial assistance.<sup>117</sup> ECAs include selling debt to a third party,<sup>118</sup> reporting adverse information to a credit bureau, denying care or requiring payment of past-due bills before providing care, and any actions that require a legal or judicial process (i.e. lawsuits, liens, civil arrest, wage garnishment, etc.).<sup>119</sup> Making a reasonable effort to determine FAP eligibility before using ECAs requires hospitals to provide the patient notice of either their presumptive eligibility or how to apply for eligibility.<sup>120</sup> For the presumptively eligible patients, the hospital must provide a reasonable time for the patient to apply for more generous assistance.<sup>121</sup> Likewise, the hospital must give any patients applying for financial assistance a reasonable time to complete the application and to rectify incomplete applications.<sup>122</sup> In general, at least thirty days before taking any ECAs, the hospital must provide written and

oral notice to the patient about ECAs the hospital will use, the option to apply for financial assistance, the deadline to apply, and plain language summary of the FAP.<sup>123</sup>

***FDCPA Debt Collection Protections.*** The FDCPA additionally offers protections from abusive, deceptive, or unfair behavior from debt collectors. In particular, the law prohibits debt collectors from contacting third parties (i.e. employers, friends, family, or coworkers) about a consumer's debt;<sup>124</sup> contacting the consumer at unusual or inconvenient times and places;<sup>125</sup> abusive conduct (i.e. harassing, threatening violence or harm, etc.);<sup>126</sup> making false threats of legal action;<sup>127</sup> and contacting the consumer after being told in writing to stop all contact.<sup>128</sup> Consumers have the option to file complaints with the Consumer Financial Protection Bureau ("CFPB"), the agency that enforces the FDCPA, if they feel a debt collector has violated their rights under the law. Consumers also have the right to file a lawsuit under the FDCPA. New protections under the FDCPA went into effect in 2021, giving consumers the ability to stop collection calls, placing limitations on call frequency, improving the notice consumers receive before debts are sent to credit bureaus, and requiring more information in debt collection notices.<sup>129</sup> Many states now have statutes that mirror the core provisions of the FDCPA.<sup>130</sup>

### **Types of Aggressive Medical Debt Collection Practices**

Although the ACA and FDCPA provide important protections against debt collection, aggressive debt collection practices remain a problem, especially for consumers with medical debt. Consumers struggling with unpaid medical bills face a range of troubling debt collection practices that affect everything from their finances to their housing and physical freedom.

To collect unpaid medical debts, hospitals and other medical providers frequently

### **Jackson Woman Sued for Medical Bill after Setting Up a Payment Plan with Hospital.**

After being diagnosed with breast cancer, Linda Burks of Jackson, Mississippi underwent surgery and a month of radiation therapy in 2016. She came out cancer-free but stuck with medical debt.

Although she was insured through her employer at the time, Linda still ended up slammed with medical bills from five different providers for their role in her cancer treatment. She set up a payment plan with St. Dominic Hospital. Yet, after a year of steady automatic payments, the hospital stopped billing her. She tried to find out why and asked the hospital to resume the payment plan. Instead, they sent her debt to collections. Debt collectors started calling her.

"They would call you every day if you didn't send them any money."

Eventually, the collectors sued her, and she's still paying down the debt. She stated that, because of her billing experiences, she never wants to go back to St. Dominic Hospital.

*Source:* Bologna, Giacomo, "St. Dominic Knew Patients Couldn't Afford Care. It Sued Them Anyway," MCIR, August 6, 2021.

place accounts with third-party collectors who may use frequent calls and other communications to pressure consumers to pay. Many facilities also authorize debt collectors to report alleged medical debts to credit bureaus.<sup>131</sup> As noted, these aggressive debt collection practices disproportionately affect communities of color and Black people, who are more likely than whites to have medical debt in collections<sup>132</sup> and experience contact with debt collectors.<sup>133</sup> Additionally, some medical providers file collection lawsuits on alleged medical debts. Once they obtain a judgment, providers may be able to use a variety of collection tools (depending on state law), including: seeking liens on homes, wage garnishment, tax refund garnishment, attachment and seizure of bank accounts, and even going so far as to seek civil arrest warrants when debtors fail to show up for court proceedings.

Non-profit hospitals,<sup>134</sup> the very hospitals subject to the ACA's restrictions against "extraordinary collection actions," filed the most lawsuits against patients between 2018 and 2020.<sup>135</sup> VCU Medical Center in Richmond, a majority Black city, filed the most lawsuits of any single hospital from 2018 to 2020; another hospital in Milwaukee, which has the largest black population in Wisconsin, was in the top three.<sup>136</sup> Wisconsin researchers found that lawsuits over unpaid medical bills increased by 37% between 2001 and 2018 in their state.<sup>137</sup> In data segmenting hospitals by revenue, Johns Hopkins University researchers found that many of the nation's top hospitals were suing patients for bills that averaged around \$1,842.<sup>138</sup> In other words, hospitals routinely used predatory and aggressive collection tactics to pursue unpaid bills that make up an insignificant portion of their overall revenue, less than 1% for some hospitals.<sup>139</sup>

Even at the onset of the COVID-19 pandemic when states declared public health emergencies, some hospitals continued suing patients for unpaid medical bills, going as far as seeking liens against patients.<sup>140</sup> Some hospitals use judgments against patients to secure liens on their homes, threatening the housing stability of indebted patients. In this sense, medical debt is not only associated with housing insecurity and foreclosure<sup>141</sup> but can be a direct cause of housing loss. A recent investigation by Kaiser Health News revealed that University of Virginia Hospital system has a history of relying on property liens to collect unpaid medical bills.<sup>142</sup> As a result of the investigation, the system announced in 2021 that it would cancel decades of liens placed on low-income patients for unpaid medical bills.<sup>143</sup> In New York, non-profit hospitals secured 4,880 liens in 2017 and 2018 on homes of patients who had unpaid medical bills.<sup>144</sup>

When a hospital secures a lien on a patient's home, in most states it gives the hospital the right to force sale of the home to satisfy the unpaid medical debt.<sup>145</sup> The lien stays on the home until the debt is paid or released.<sup>146</sup> In practice, the patient typically cannot sell the home until the lien is resolved; the lien clouds the title, preventing the patient from refinancing or obtaining a home equity loan.<sup>147</sup> In this sense, a relatively small hospital bill averaging less than \$2000<sup>148</sup> can end up costing a patient the value of their main asset, their home. Patients threatened with

foreclosure on liens placed after a judgment in a lawsuit to collect a medical debt may decide to file for bankruptcy protection.<sup>149</sup>

Hospitals also may seek garnishment of wages or other income to satisfy patient debt. Between 2009 and 2018, hospitals in Maryland filled nearly 40,000 lawsuits that resulted in wage garnishment, often from their own employees.<sup>150</sup> In Maryland, this practice disparately impacts Black communities. For example, Johns Hopkins sought over \$4 million in wage garnishment lawsuits between 2009 and 2018,<sup>151</sup> and has a community benefits service area that is 45% Black.<sup>152</sup> Likewise, the University of Maryland Medical System sought over \$10 million in wage garnishments during the same period<sup>153</sup> and has a community benefits service area that is 69.5% Black.<sup>154</sup> Like property liens, wage garnishments have long-term terrible consequences on families, increasing stress, and exacerbating financial insecurity.

To make matters worse, hospitals sometimes seek civil arrests against patients who fail to appear for court hearings. The ACLU documented cases of arrests for medical debts in several states, including Maryland, Arkansas, and Tennessee.<sup>155</sup> In Maryland, they observed a practice of patients being jailed for medical debts of less than \$1000.<sup>156</sup> In some cases, debt collectors made false threats of arrest for unpaid medical debts.<sup>157</sup> National Nurses United called for a ban on arrest warrants for medical debt in Maryland, and recent legislation enacted there has banned the practice.<sup>158</sup> Although the ACLU was not able to obtain data on racial disparities in civil arrest warrants, racial disparities in debt collection and in policing<sup>159</sup> should be explored further to determine whether civil arrests for medical debt disproportionately impact Black people.

Medical debt and these aggressive collection practices can lead patients to use other types of risky financial instruments, like credit cards and payday loans, to pay their medical debts. As Kaiser Family Foundation reported, medical debt often intersects with other types of debt. Kaiser found medical debt holders took the following actions to pay medical debts: 34% increased their credit card debt, 15% sought personal loans, and 13% borrowed from a payday lender.<sup>160</sup> These risky types of debt come with egregiously high interest rates; for instance, payday loans can have interest rates of over 600%.<sup>161</sup> As such, medical debt often traps people in a cycle of debt.

## **RECENT EFFORTS TO ADDRESS THE MEDICAL DEBT CRISIS**

To address the epidemic of medical debt, states and federal lawmakers have taken some steps during the past few years to improve hospital billing, protect consumers from debt collectors, and protect consumer credit reports. While these efforts do not specifically tackle the harms medical debt causes to Black communities, these efforts are a step in the right direction.

## Recently Passed Laws Improving Hospital Billing Practices

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
<p>No Surprises Act of 2020 (Federal)  <i>House Resolution 133, passed and enacted</i>  <i>Amended 42 U.S. Code § 300gg–19a</i></p>	<p>Key protections:<sup>162</sup></p> <ul style="list-style-type: none"> <li>■ Prohibits balance billing for emergency services and certain services provided by out-of-network providers at in-network facilities, including by air ambulances</li> <li>■ Enables insurers and providers to settle payment disputes among themselves via a dispute resolution process</li> </ul>
<p>Surprise Billing Consumer Protection Act of 2020 (Georgia)  <i>House Bill 888, passed and enacted</i>  <i>O.C.G.A. § 33-20E-1 et seq.</i></p>	<p>Key protections:<sup>163</sup></p> <ul style="list-style-type: none"> <li>■ Prohibits surprise billing in emergency situations and when a patient receives scheduled services at an in-network facility</li> <li>■ Requires patients to give consent before receiving out-of-network services</li> <li>■ Enables insurers and providers to settle payment disputes among themselves via a dispute resolution process</li> </ul>
<p>Balance Billing Protections, 2019 (Texas)  <i>Senate Bill 1264, passed and enacted</i>  <i>28 Tex. Admin. Code §§ 21.4901–29.4904</i></p>	<p>Key protections:<sup>164</sup></p> <ul style="list-style-type: none"> <li>■ Prohibits balance billing in emergencies or when the patient did not have a choice of doctors for medical services</li> <li>■ Requires patients to give consent before receiving out-of-network services</li> <li>■ Enables insurers and providers to settle payment disputes among themselves via a dispute resolution process</li> </ul>

## Recently Passed Laws Protecting Consumers from Aggressive Medical Debt Collection

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
<p>Medical Debt Protection Act of 2021, Maryland  <i>Senate Bill 514 and House Bill 565, passed unanimously and enacted</i>  <i>Md. Code Ann. Health–Gen. § 19-214.1</i></p>	<p>Key protections:<sup>165</sup></p> <ul style="list-style-type: none"> <li>■ Prohibits hospitals from requesting arrest warrants against patients</li> <li>■ Prohibits hospitals from requesting a lien against a patient’s home</li> <li>■ Protects patients eligible for financial assistance against wage garnishment and adverse credit reporting</li> <li>■ Requires hospitals to check patient eligibility for financial assistance before filing lawsuits</li> <li>■ Requires hospitals to refund any money and seek to vacate a judgment if patients are later deemed eligible for financial assistance within 240 days of billing</li> <li>■ Requires hospitals to annually report details about charges, out-of-pocket costs, debt collections, and lawsuits against patients</li> </ul>

(continued)

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
<p>Medical Debt Protection Act of 2021, Nevada <i>Senate Bill 248, passed and enacted Nev. Rev. Stat §649.005 et seq.</i></p>	<p>Key protections:<sup>166</sup></p> <ul style="list-style-type: none"> <li>Requires 60-day notification to “medical debtor” before a collection agency can take debt collection actions</li> <li>Prohibits collection agency from taking civil actions for medical debts of less than \$10,000 or charging fees of more 5% of the debt</li> <li>Specifies that voluntary payment made by a medical debtor to a collection agency is not an admission of liability for the medical debt and is not a waiver of any defenses to the collection of the medical debt</li> </ul>
<p>Patient’ Debt Collection Practices Act of 2021, New Mexico <i>Senate Bill 71, passed and enacted NM Stat § 57-32-1 to 57-32-10</i></p>	<p>Key protections:<sup>167</sup></p> <ul style="list-style-type: none"> <li>Prohibits collection actions against indigent patients, and any collection actions must be terminated upon a determination that the patient is indigent</li> <li>For medically necessary care, the healthcare facility must verify whether the patient has health insurance and, if the patient is uninsured, screen them for all available public insurance, public programs that assist with health care, and for the facility’s FAP</li> </ul>
<p>Health Care Debt and Fair Billing Act of 2021, California <i>AB 1020, passed and enacted Cal. Civ. Code §§1788.14, 1788.185, 1788.52, 1788.58; Cal. Health &amp; Safety Code §§127400 to 127444</i></p>	<p>Key protections:<sup>168</sup></p> <ul style="list-style-type: none"> <li>Patients with “high medical costs” (i.e. patients whose family income is 400% of the federal poverty level or lower) are eligible for hospital charity care or discount policies</li> <li>Requires the hospital to wait 180 days before reporting a debt to the credit bureaus</li> <li>During the 180-day wait, the hospital must determine the patient’s eligibility for financial assistance or confirm that the patient failed to respond to its offer of financial assistance</li> </ul>

### Current Laws Mandating Comprehensive FAPs for Non-Profit and For-Profit Hospitals<sup>169</sup>

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
<p>California, <i>Cal. Welf. &amp; Inst. Code §§ 16900 to 16996.2; Cal. Health &amp; Safety Code §§ 127400 to 127466</i></p>	<p>Key protections:<sup>170</sup></p> <ul style="list-style-type: none"> <li>Hospitals must offer free or discounted care to uninsured patients who are at or below 350% of the federal poverty level</li> <li>Hospitals must offer free or discounted care to underinsured patients with “high medical costs”<sup>171</sup></li> </ul>
<p>Connecticut, <i>Conn. Gen. Stat. §§ 19a-7d, 19a-509b, 19a-649, 19a-673</i></p>	<p>Key protections:<sup>172</sup></p> <ul style="list-style-type: none"> <li>Hospitals must screen patients for FAP eligibility</li> <li>Hospitals may not collect more than the cost of providing the service from uninsured patients with an household income at 250% of the federal poverty level or below</li> </ul>

(continued)

STATE LAWS	IMPORTANT CHANGES AND PROTECTIONS
<p>Illinois, <i>Hospital Uninsured Patient Discount Act</i>, 210 Ill. Comp. Stat. §§ 89/1 to 89/20</p>	<p>Key protections:<sup>173</sup></p> <ul style="list-style-type: none"> <li>Free care available for uninsured patients with family income at 200% or below the federal poverty level and who receive “medically necessary health care services” exceeding \$150 at a hospital other than a rural or “critical access” hospital</li> <li>Rural or “critical access” hospitals must provide free care for uninsured patients with family incomes at 125% or below the federal poverty level who receive “medically necessary health care services” exceeding charges of exceeding \$300</li> </ul>
<p>New Jersey, <i>N.J. Stat. Ann. §§ 26:2H-18.58; N.J. Admin. Code § 10:52-11.8, 11.1</i></p>	<p>Key protections:<sup>174</sup></p> <ul style="list-style-type: none"> <li>Hospitals must provide financial assistance to patients with incomes below 200% of the federal poverty level</li> <li>Hospitals must provide financial assistance to patients with incomes between 200% and 300% of the federal poverty level, if their medical expenses are more than 30% of their annual income, their individual assets are no more than \$7,500, and family assets are no more than \$15,000</li> <li>For patients with incomes less than 500% of the federal poverty level, hospitals cannot charge them more than 15% above the Medicare payment rate</li> </ul>

### Federal Medical Debt Legislation (introduced but not yet adopted)<sup>175</sup>

NAME OF LEGISLATION	IMPORTANT CHANGES AND PROTECTIONS
<p>COVID-19 Medical Debt Collection Relief Act (Federal) <i>Senate Bill 355, introduced in 2021</i></p>	<p>Key protections:<sup>176</sup></p> <ul style="list-style-type: none"> <li>Temporarily suspends all extraordinary collection actions<sup>177</sup> by health care providers of medical debt until to the end of the pandemic or 18 months after enactment of the bill</li> <li>Suspends repayment plans for medical debt and ensures reasonable forbearance and repayment options</li> <li>For debt incurred due to COVID-19 testing and treatment: one-year extension of federal and state health insurance appeal deadlines, no accrual and collection of fees and interest related to these debts, and no extraordinary collection actions</li> <li>Liability for hospitals and debt collectors that fail to comply</li> </ul>
<p>Medical Debt Relief Act of 2021 (Federal) <i>Senate Bill 214 and House Resolution 773, introduced in 2021</i></p>	<p>Key protections:<sup>178</sup></p> <ul style="list-style-type: none"> <li>Prohibits credit reporting agencies from adding medical debt information that is fully paid or settled, or is less than one year old</li> <li>Requires debt collectors to notify a consumer before reporting the debt to a credit bureau</li> </ul>

## CONCLUSION

The above-noted state and federal policy efforts are important first steps in tackling the medical debt crisis, but more robust solutions are needed. More importantly, lawmakers should prioritize relief for Black families because of the severe and disproportionate impact of medical debt on them. Among other things, this requires focusing on the states where Black people are heavily concentrated and focusing on ways to prevent medical debt at the outset not after the fact. A range of solutions are necessary to address the medical debt crisis and close the racial health and wealth gap.

### Our Recommendations

- **Strengthen Protections Against Aggressive Debt Collection.** Prohibit aggressive debt collection (or “extraordinary collection actions”) by banning wage garnishment, bank account seizure, property liens, foreclosure of homes based on medical debt liens, and civil arrest warrants for medical debt.
- **Crack Down on Third-Party Debt Collection.** End the practice of turning over medical debt to third-party collection agencies.
- **Protect Patient Credit Reports.** Prohibit providers and debt collectors from reporting medical debt to credit reporting bureaus.<sup>179</sup> At a minimum, states should limit providers and debt collectors from reporting medical debts to credit bureaus until one year has passed after the initial billing.
- **Improve Charity Care or FAP Requirements.** Improve the ACA by expanding comprehensive FAP requirements to include all non-profit and for-profit health care facilities, ambulatory surgical centers, and outpatient clinics. Broaden income eligibility requirements to cover uninsured and insured patients, require providers to screen all patients for FAP eligibility, and require reasonable notice to patients before taking debt collection actions. Allow patients to enforce state and federal FAP laws in court to hold violating hospitals liable.
- **Expand Medicaid<sup>180</sup> in Holdout States.** Create a federal program that allows the Centers for Medicare and Medicaid Services to offer a Medicaid-like plan to those eligible in holdout states, especially since Black patients are more likely to live in these states.<sup>181</sup>
- **Increase Hospital Debt Collection Transparency.** Mandate annual public reporting of debt collection practices by healthcare providers. Require healthcare providers and hospitals to publicly disclose how often they take collection actions against patients to satisfy unpaid debts. Require hospitals to provide demographic data (including racial/ethnic backgrounds, zip codes, etc.) of patients against whom they take collection actions.
- **Center Medical Debt in Reparations for Racial Justice.** Incorporate medical debt cancellation and Medicaid expansion into a larger strategy toward reparations for racial injustice. Closing the racial wealth gap by addressing debt (including

medical debt) requires a reparations package for Black people. Closing the racial health gap requires making diseases and conditions that disproportionately affect Black patients key health priorities for Medicaid programs.

- **Cancel Medical Debt.** Discharge medical debt incurred through care at facilities operated by the federal government, including Veteran’s Administration hospitals and clinics, as well as hospitals run by the Department of Defense and the Department of Health and Human Services. Discharge medical debt incurred through care at facilities operated by state and local governments. For privately-held medical debt (debt incurred for care at non-profit and for-profit facilities), states, municipalities, and the federal government should purchase medical debt from debt collectors and healthcare providers at discounted rates (avoiding a financial windfall for debt collectors) and discharge these debts.
- **Single-Payer Universal Healthcare.** Enact a universal publicly-funded national single-payer health plan administered at the state and local levels, with comprehensive lifetime benefits, including dental, vision, mental health care, substance use disorder treatment, prescription drug coverage, and hospice and long-term care.<sup>182</sup>

Although more exploration of medical debt as a racial justice issue is needed, many resources are available for advocates, policymakers, and community members interested in pushing for greater protections against the medical debt trap. NCLC’s *Don’t Add Insult to Injury: Medical Debt and Credit Reports* provides an overview of the crisis of medical debt and potential reforms to protect consumer credit reports. For more information on financial assistance policies and how to make them more effective, see NCLC’s *An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States*. Additionally, NCLC’s *Model Medical Protection Act* offers language policymakers can use to build on existing state policies and guide the development of new policies to protect consumers from medical debt. In recognition that medical debt is a racial justice issue, advocates and policymakers should target medical debt solutions to Black communities and households.

## ENDNOTES

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36. Signe-Mary McKernan, Steven Brown, and Genevieve M. Kenney. “Past-Due Medical Debt a Problem, Especially for Black Americans.” *Urban Institute*, 2017, available at [www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans](http://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans). See also U.S.

Department of Health and Human Services Office of Minority Health, available at <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61>.

37. Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael McCleary. “Residential Segregation and Disparities in Healthcare Services Utilization.” *Medical Care Research and Review* (April 2012), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3387667/>.
38. Black pregnant individuals are more likely to die giving birth than white pregnant individuals. See Emily E. Peterson, Nicole L. Davis, David Goodman, and Shanna Cox, et al. “Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States 2007–2016.” *Centers for Disease Control and Prevention* (Sept. 2019), available at [https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s\\_cid=mm6835a3\\_w](https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s_cid=mm6835a3_w).
39. Black people are concentrated in the South, the region with the highest uninsured rates. See U.S. Census Bureau, available at <https://www.census.gov/newsroom/press-releases/2021/uninsured-health-coverage-rates-decline.html>.
40. Jamila Taylor. “Racism, Inequality, and Health Care for African Americans.” *The Century Foundation* (Dec. 2019), available at <https://tcf.org/content/report/racism-inequality-health-care-african-americans/?session=1>.
41. “Infant Health Mortality and African Americans.” U.S. Department of Health and Human Services Office of Minority Health, available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>.
42. Black people are more likely to live in states that did not expand Medicaid. In those states, Black people and other people of color are most likely to fall within the coverage gap—they earn too much to qualify for Medicaid but not enough to be eligible for premium tax credits under marketplace plans. See Rachel Garfield and Kendal Orgera. “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid.” *Kaiser Family Foundation* (March 2019), available at <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.
43. Even after controlling for factors like class, access to health insurance and services, health behaviors, and comorbidities, studies show that providers are much less likely to deliver effective treatments to Black patients. See Khiara M. Bridges. “Implicit Bias and Racial Disparities in Health Care.” *American Bar Association, Human Rights Magazine*, 43(3), available at [https://www.americanbar.org/groups/crsj/publications/human\\_rights\\_magazine\\_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/](https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/).
44. “Cancer and African Americans.” U.S. Department of Health and Human Services Office of Minority Health, available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=16>. See also “Heart Disease and African Americans.” U.S. Department of Health and Human Services Office of Minority Health, available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19>.
45. Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael McCleary. “Residential Segregation and Disparities in Healthcare Services Utilization.” *Medical Care Research and Review* (April 2012), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3387667/>. See also Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan, and Rachael McCleary. “Residential Segregation and the Availability of Primary Care Physicians.” *Health Services Research* (December 2012), 47(6), 2353–76, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3416972/>.
46. Khiara M. Bridges. “Implicit Bias and Racial Disparities in Health Care.” *American Bar Association, Human Rights Magazine*, 43(3), available at [https://www.americanbar.org/groups/crsj/publications/human\\_rights\\_magazine\\_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/](https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/).
47. “Diabetes and African Americans.” U.S. Department of Health and Human Services Office of Minority Health, available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18>.

48. Jacqueline C. Wiltshire, Keith Elder, Catarina Kiefe, and Jeroan J. Allison. "Medical Debt and Related Financial Consequences Among Older African American and White Adults." *American Journal of Public Health* (2016), 106(6), 1086-91, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4880274/>.
49. Signe-Mary McKernan, Steven Brown, and Genevieve M. Kenney. "Past-Due Medical Debt a Problem, Especially for Black Americans." *Urban Institute*, 2017, available at [www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans](http://www.urban.org/urban-wire/past-due-medical-debt-problem-especially-black-americans).
50. Like Black households, households with someone of Latiné origin also were more likely to have medical debt than other households. See Neil Bennett, Jonathan Eggleston, Laryssa Mykyta, and Briana Sullivan. "19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away." *United States Census Bureau*, 2021, available at <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>.
51. Andre M. Perry, Joia Crear-Perry, Carl Romer, and Nana Adjeiwaa-Manu. "The racial implications of medical debt: How moving toward universal health care and other reforms can address them." *Brookings Institution* (Oct. 2021), available at <https://www.brookings.edu/research/the-racial-implications-of-medical-debt-how-moving-toward-universal-health-care-and-other-reforms-can-address-them/>.
52. Id. See also Neil Bennett, Jonathan Eggleston, Laryssa Mykyta, and Briana Sullivan, "19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away." *United States Census Bureau*, 2021, available at <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html> ("8.5% of households not fully insured reported high medical debt burden compared with 2.9% of households that were fully insured . . . households with members in fair or poor health were also more likely to suffer high medical debt burden (9.4%) than their healthier counterparts (2%), as the medical care costs of those in worse health may be higher").
53. While having insurance reduces an individual's risk of medical debt, insured individuals also risk medical debt due to surprise billing. See Andre M. Perry, Joia Crear-Perry, Carl Romer, and Nana Adjeiwaa-Manu. "The racial implications of medical debt: How moving toward universal health care and other reforms can address them." *Brookings Institution* (Oct. 2021).
54. Hamel, Liz, et. al. "The Burden of Medical Debt: Results from the Kaiser Family Foundation/ New York Times Medical Bills Survey." *Kaiser Family Foundation* (Jan. 2016). Also, in a survey of people with "serious illness," over 50% of respondents reported experiencing "dire financial consequences" related to their care, despite 9 out of 10 of them being insured. See Eric Schneider, Melinda Abrams, Arnav Shah, Corinne Lewis, and Tanya Shah. "Healthcare in America: The Experience of People with Serious Illness." *The Commonwealth Fund* (Oct. 2018), 5.
55. Debt is a chronic stressor and, particularly, "persistent high debt" is associated with worse health, even among those who have paid down their debt over time. See Adrienne Frech, Jason Houle, and Dmitry Tumin. "Trajectories of unsecured debt and health at midlife." *SSM Population Health* (Sept. 2021), Vol. 15.
56. Hamel, Liz, et. al. "The Burden of Medical Debt: Results from the Kaiser Family Foundation/ New York Times Medical Bills Survey." *Kaiser Family Foundation* (Jan. 2016).
57. Pranav M. Patel, Shipra Singh, and Ishmael Tagoe. "Association of Social Risks With Avoiding or Delaying Health Care and With Emergency Department Visits: Evidence From 2017 Ohio Medicaid Assessment Survey." *American Journal of Managed Care* (March 2021), 27(3).
58. Hamel, Liz, et. al. "The Burden of Medical Debt: Results from the Kaiser Family Foundation/ New York Times Medical Bills Survey." *Kaiser Family Foundation* (Jan. 2016).
59. National Consumer Law Center, *Fair Debt Collection* (9th ed. 2018), 1.3.1.3.
60. National Consumer Law Center. "Racial Disparities in Consumer Debt Collection."
61. Id.
62. "Black and African American Communities and Mental Health." *Mental Health America*.

63. Brianna Wells. [“Solving the Medical Debt Crisis.”](#) *The Greenlining Institute* (March 2021), 6.
64. “Wealth is the sum of resources available to a household at a point in time; as such it is clearly influenced by the income of a household, but the two are not perfectly correlated. Two households can have the same income, but the household with fewer expenses, or with more accumulated wealth from past income or inheritances, will have more wealth.” See Kriston McIntosh, Emily Moss, Ryan Nunn, and Jay Shambaugh. [“Examining the Black-white wealth gap.”](#) *Brookings* (Feb. 2020). See also Neil Bhutta, Jesse Bricker, Andrew C. Chang, et. al. [“Changes in U.S. Family Finances from 2016 to 2019: Evidence from the Survey of Consumer Finances.”](#) *Federal Reserve* (Sept. 2020).
65. Neil Bhutta, Andrew C. Chang, Lisa J. Dettling, and Joanne W. Hsu. [“Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances.”](#) *Federal Reserve* (Sept. 2020).
66. Christian Weller and Lily Roberts. [“Eliminating the Black-White Wealth Gap Is a Generational Challenge.”](#) *Center for American Progress* (March 2021).
67. Neither indebtedness nor income alone explain the racial wealth gap, as white families have a higher total debt load and even higher income Black families still have less wealth than similarly-situated white families. See Kriston McIntosh, Emily Moss, Ryan Nunn, and Jay Shambaugh. [“Examining the Black-white wealth gap.”](#) *Brookings* (Feb. 2020).
68. National Consumer Law Center, *Fair Debt Collection* (9th ed. 2018), 1.3.1.5. See also Elisabeth R. Benjamin and Amanda Dunker. [“Discharged into Debt: Medical Debt and Racial Disparities in Albany County,”](#) *Community Service Society* (March 2021), (*finding that in Albany County, New York those most burdened with hospital lawsuits were communities of color, low-income communities, and those without insurance*).
69. This is true for uninsured and insured individuals alike. See Hamel, Liz, et. al. [“The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey.”](#) *Kaiser Family Foundation* (Jan. 2016).
70. National Consumer Law Center, *Collection Actions* (5th ed. 2020), 9.4.4.1.
71. Hamel, Liz, et. al. [“The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey.”](#) *Kaiser Family Foundation* (Jan. 2016).
72. “In calculating a consumer’s credit score, the most commonly used credit scoring models treat medical debts the same as any other debt . . .” See Michael Best, Jenifer Bosco, and Chi Chi Wu. [“Don’t Add Insult to Injury: Medical Debt and Credit Reports,”](#) *NCLC* (November 2019).
73. Brianna Wells. [“Solving the Medical Debt Crisis.”](#) *The Greenlining Institute* (March 2021), 6.
74. The survey involved a roughly even spread of respondents from Florida, Illinois, California, and New Jersey; 64% were white, 18% were Black, 8% were Latiné, and 7% were Asian. See Christopher Tarver Robertson, Richard Egelhof, and Michael Hoke. [“Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures.”](#) *Health Matrix: Journal of Law and Medicine* (2008), 18(65), 65-104.
75. *Id.*
76. The study showed Black families in Tuscaloosa owed significantly less debt overall than white families, but Black families owed substantially more in medical debt than white families. See Bronwen Lichtenstein and Joe Weber. “Losing Ground: Racial Disparities in Medical Debt and Home Foreclosure in the Deep South.” *Family and Community Health* (2016), 39(3), 178-187.
77. “The intersectionality of poorer health status, medical debt, and mortgage default offers a partial explanation for the decline in African American homeownership in Tuscaloosa County and perhaps helps to explain widening racial disparities in homeownership at the national level.” *Id.*
78. Elisabeth R. Benjamin and Amanda Dunker. [“Discharged into Debt: Nonprofit Hospitals File Liens on Patients’ Homes,”](#) *Community Service Society* (November 2021). See also [“Preying on Patients: Maryland’s Not-for-Profit Hospitals and Medical Debt Lawsuits.”](#) *National Nurses United* (Feb. 2020), 4.

79. In particular, Medicaid Expansion under the ACA improved credit scores, reduced medical debt balances, lowered number of medical bills being sent to collections, and reduced bankruptcy filings. See Kyle J. Caswell and Timothy A. Waidmann. [“The Affordable Care Act Medicaid Expansions and Personal Finance.”](#) *Medical Care Research and Review* (2019), 76 (5), 538, 562.
80. Id. Additionally, while the ACA’s marketplace subsidies and cost-sharing reductions lowered the probability of burdensome medical bills among low-income adults, these measures did not reduce the financial burden for middle-income adults. See also Liu, Charles, et. al. [“The Affordable Care Act’s Insurance Marketplace Subsidies Were Associated With Reduced Financial Burden For US Adults.”](#) *Health Affairs* (March 2021), 40(3).
81. See also Andrea Bopp Stark. [“An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States.”](#) *National Consumer Law Center* (Jan. 2020).
82. 26 C.F.R. § 1.501(r)-4.
83. 26 C.F.R. § 1.501(r)-4.
84. 26 C.F.R. § 1.501(r)-4.
85. 26 C.F.R. § 1.501(r)-4.
86. 26 C.F.R. § 1.501(r)-4.
87. This includes offering paper copies of the FAPs as part of intake or discharge, “conspicuous notice” on billing statements, and “conspicuous public displays” in ERs and admissions areas. See 26 C.F.R. § 1.501(r)-4.
88. 26 C.F.R. § 1.501(r)-4.
89. “Plain language” is defined as language that is “clear, concise, and easy to understand.” See 26 C.F.R. § 1.501(r)-1(b)24.
90. 26 CFR § 1.501(r)-6.
91. Ge Bai, Farah Yehia, and Gerard F. Anderson. [“Charity Care Provision by US Non-profit Hospitals.”](#) *Jama Internal Medicine* (2020), 180(4).
92. Id. The least financially strong hospitals lost 15.8% of total overall net income due to spending on charity care.
93. Id.
94. [Report to Congress on Private Tax-Exempt, Taxable and Government-Owned Hospitals.](#) Internal Revenue Service, Department of Treasury (March 2020), 4. Since 2013, charity care spending has fallen significantly. See Dan Diamond. [“How hospitals got richer off Obamacare.”](#) *Politico* (July 17, 2017).
95. A 2015 study showed that just 44% of hospitals provided patients notice of financial assistance eligibility before seeking debt collection. See Sayeh S. Nikpay and John Z. Ayanian. “Hospital Charity Care — Effects of New Community-Benefit Requirements.” *New England Journal of Medicine* (Oct. 2015), 373, 1687-1690.
96. 26 C.F.R. § 1.501(r)-4. See also Jordan Rau. [“Patients Eligible For Charity Care Instead Get Big Bills.”](#) *Kaiser Health News* (Oct. 14, 2019).
97. Kaiser Family Foundation. [“Hospital Ownership by Type.”](#)
98. Kaiser Family Foundation. [“Hospital Ownership by Type.”](#)
99. Hospitals in states that did not expand Medicaid have less generous FAPs or charity care policies, such as more stringent income eligibility requirements to qualify for free and discounted care. See Sayeh S. Nikpay and John Z. Ayanian. “Hospital Charity Care — Effects of New Community-Benefit Requirements.” *New England Journal of Medicine* (Oct. 2015), 373, 1687-1690.
100. [“Status of State Medicaid Expansion Decisions: Interactive Map.”](#) *Kaiser Family Foundation* (Nov. 2021). Many of these Southern states (particularly, Texas, Florida, Louisiana, and Tennessee) also have a significant percentage of for-profit hospitals that are not required to provide charity care. See [“Hospital Ownership by Type,”](#) *Kaiser Family Foundation*.

101. See Christine Tamir, Abby Budiman, Luis Noe-Bustamente, and Lauren Mora. [“Facts about the U.S. Black Population,”](#) *Pew Research Center* (March 25, 2021).
102. Jordan Rau. [“Patients Eligible For Charity Care Instead Get Big Bills.”](#) *Kaiser Health News* (Oct. 14, 2019).
103. “Bad debt” refers to bills not paid in full or unlikely to be paid in full by the patient or insurance. According to a Kaiser Health News analysis of IRS reports from non-profit hospitals, the hospitals had given up on collecting an estimated \$2.7 billion in bills from patients who would have qualified for charity care. Id.
104. [“NC Nonprofit Hospitals Bill the Poor,”](#) *North Carolina State Health Plan, National Academy for State Health Policy* (Jan. 26, 2022). For more information about how non-profit hospitals often bill patients who are otherwise eligible for charity care, see Selena Simmon-Duffin. [“When Hospitals Sue For Unpaid Bills, It Can Be ‘Ruinous’ For Patients.”](#) *NPR* (June 25, 2019).
105. [“NC Nonprofit Hospitals Bill the Poor,”](#) *North Carolina State Health Plan, National Academy for State Health Policy* (Jan. 26, 2022), available at <https://www.shpnc.org/what-the-health/nc-nonprofit-hospitals-bill-poor>.
106. As noted, the ACA requires hospitals to make a “reasonable effort” to inform patients about available charity care or financial assistance before using “extraordinary collection actions.” 26 CFR § 1.501(r)-6.
107. 26 CFR § 1.501(r)-6. See also Jordan Rau. [“Patients Eligible For Charity Care Instead Get Big Bills.”](#) *Kaiser Health News* (Oct. 14, 2019). (“ . . . several hospitals whose practices were highlighted in news reports this year for aggressively suing patients admitted to the IRS they knew many unpaid bills might have been averted through their financial assistance policies”).
108. The IRS issues reports to Congress, can take action but other than some sporadic media reports it’s not clear how much enforcement activity takes place.
109. Dan Diamond. [“How hospitals got richer off Obamacare.”](#) *Politico* (July 17, 2017).
110. [“Preying on Patients: Maryland’s Not-for-Profit Hospitals and Medical Debt Lawsuits.”](#) *National Nurses United* (Feb. 2020), 4, 7.
111. [“Preying on Patients: Maryland’s Not-for-Profit Hospitals and Medical Debt Lawsuits.”](#) *National Nurses United* (Feb. 2020), 4. State advocates took action to try to improve the situation for Maryland patients and hope the new Medical Debt Protection Act, passed in 2021, will reduce patient medical debt.
112. Johanna F. Still. [“‘Profits over patients’: Study finds charity care lackluster for non-profit hospitals that enjoy tax-exempt status.”](#) *Port City Daily* (Oct. 28, 2021).
113. [“Medical Debt Burden in the United States,”](#) *Consumer Financial Protection Bureau* (February 2022). See also [“Consumer Experiences with Debt Collection: Findings from the CFPB’s Survey of Consumer Views on Debt.”](#) *Consumer Financial Protection Bureau* (Jan. 2017), 5, 21 (finding Medical debt, credit card debt, and student debt led the list of types of debt that led to interaction with debt collectors).
114. Catherine Ruetschlin and Dedrick Asante-Muhammad. [“The Challenge of Credit Card Debt for the African American Middle Class.”](#) *Demos and NAACP* (Dec. 2013).
115. Michael Karpman, et al. [“The Well Being and Basic Needs Survey: A New Data Source for Monitoring the Health and Well-Being of Individuals and Families,”](#) *Urban Institute* (Aug. 28, 2018). See also National Consumer Law Center, *Fair Debt Collection* (10th ed. 2022), 1.3.1.5.
116. Despite similar rates of default and late payments, 71% of Black middle-income households received calls from debt collectors compared to 50% of white middle-income households. See Raval Devesh. [“Which Communities Complain to Policymakers? Evidence from Consumer Sentinel.”](#) *Federal Trade Commission* (July 2018), 20.
117. 26 C.F.R. § 1.501(r)-6(a)
118. Exceptions apply, as explained in 26 C.F.R. § 1.501(r)-6(b)(2).
119. 26 C.F.R. § 1.501(r)-6(b)

120. 26 C.F.R. § 1.501(r)-6(c)
121. 26 C.F.R. § 1.501(r)-6(c)(2)
122. While providing a 120-day wait period before initiating any ECAs, notify the patient about the option to apply for FAP and give the patient a reasonable time to rectify any incomplete application so that the hospital can determine whether the patient is eligible for assistance. See 26 C.F.R. § 1.501(r)-6(c)(3).
123. 26 C.F.R. § 1.501(r)-6(c)(4)
124. 15 U.S.C. § 1692b and 15 U.S.C. § 1692c(b)
125. 15 U.S.C. § 1692c(a)(1) and 15 U.S.C. § 1692c(a)(3)
126. 15 U.S.C. § 1692d
127. 15 U.S.C. § 1692e
128. 15 U.S.C. § 1692c(c)
129. April Kuehnhoff. “[Comprehensive New FDCPA Regulation F Takes Effect November 30](#),” *National Consumer Law Center* (Sept. 24, 2021).
130. For example, the Illinois Collection Agency Act (225 Ill. Comp. Stat. § 425), Rosenthal Fair Debt Collection Practices Act in California (Cal. Civ. Code §§ 1788 to 1788.33), Florida Consumer Collection Practices Act (Fla. Stat. Ann. § 559.52), and Massachusetts Consumer Debt Collection Act (MGL c. 93A). See also National Consumer Law Center, *Collection Actions* (5th ed. 2020), 9.4.
131. Medical debt appeared on 43 million credit reports, according to the latest findings from the CFPB. See “[Medical Debt Burden in the United States](#),” *Consumer Financial Protection Bureau* (February 2022).
132. Signe-Mary McKernan, Steven Brown, and Genevieve M. Kenney. “[Past-Due Medical Debt a Problem, Especially for Black Americans](#).” *Urban Institute*, 2017. See also “[Debt in America: An Interactive Map](#).” *Urban Institute* (Dec. 2020).
133. Michael Karpman, et al. “[The Well Being and Basic Needs Survey: A New Data Source for Monitoring the Health and Well-Being of Individuals and Families](#),” *Urban Institute* (Aug. 28, 2018).
134. “[Hospitals by Ownership Type](#).” *Kaiser Family Foundation*.
135. Michelle McGhee and Will Chase. “[How America’s top hospitals hound patients with predatory billing](#).” *Axios, Johns Hopkins University*.
136. Id. According to researchers from Johns Hopkins University, VCU Medical Center filed 17,806 lawsuits between 2018 and 2020. It was among the 10 hospitals that make up 97% of all lawsuits filed against patients during the period.
137. Zack Cooper, James Han, and Neale Mahoney. “[Hospital Lawsuits Over Unpaid Bills Increased By 37 Percent in Wisconsin From 2001 To 2018](#),” *Health Affairs* (Dec. 2021), 40:2.
138. Caitlin Owens. “[America’s biggest hospitals vs. their patients](#).” *Axios* (June 14, 2021). See also Michelle McGhee and Will Chase. “[How America’s top hospitals hound patients with predatory billing](#).” *Axios, Johns Hopkins University*.
139. For Maryland hospitals, one study showed the amount of medical debt sought in lawsuits represented 0.18 percent of operating revenues. See “[Preying on Patients: Maryland’s Not-for-Profit Hospitals and Medical Debt Lawsuits](#).” Even payment plans do not always protect patients from medical debt lawsuits. See Giacomo Bologna. “[St. Dominic Knew Patients Couldn’t Afford Care. It Sued Them Anyway](#),” *MCIR* (Aug. 6, 2021).
140. Froedtert Health System in Milwaukee filed more than 100 lawsuits from mid-March through July, after the governor declared a public health emergency on March 12, 2020. See Jenny Deam. “[Some Hospitals Kept Suing Patients Over Medical Debt Through the Pandemic](#).” *ProPublica* (June 14, 2021).
141. As noted, a study in Tuscaloosa showed Black families in foreclosure were twice as likely as white families to have medical debt judgments. See Bronwen Lichtenstein and Joe Weber.

- "Losing Ground: Racial Disparities in Medical Debt and Home Foreclosure in the Deep South." *Family and Community Health* (2016), 39(3), 178-187.
142. Jay Hancock. "[UVA Health Still Squeezing Money From Patients—By Seizing Their Home Equity](#)," *Kaiser Health News* (Oct. 19, 2020).
143. Jay Hancock. "[UVA Health Will Wipe Out Tens of Thousands of Lawsuits Against Patients](#)," *Kaiser Health News* (April 20, 2021).
144. Elisabeth R. Benjamin and Amanda Dunker. "[Discharged into Debt: Nonprofit Hospitals File Liens on Patients' Homes](#)," *Community Service Society* (November 2021).
145. *Id.*
146. *Id.*
147. *Id.* As Benjamin and Dunker note, these medical debt liens therefore sully the title of the home and reduces the value of what is often a patient's main asset, their home.
148. *Id.*
149. With the exception of New Jersey, Pennsylvania, and Maryland, all states have homestead exemptions that protect a debtor's home. Some states even protect the homestead from liens resulting from medical debts, by prohibiting the execution of the lien during the lifetime of the debtor, the debtor's spouse, or certain dependents. See National Consumer Law Center, [Collection Actions](#) (5th ed. 2018), 15.2.1 and 15.2.6.
150. "[Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits](#)." *National Nurses United* (Feb. 2020), 9, 17.
151. "[Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits](#)." *National Nurses United* (Feb. 2020), 38. Notably, Johns Hopkins denied more than 40% of all their charity care applications ("*In our report "Taking Neighbors to Court: Johns Hopkins Hospital Medical Debt Lawsuits" and our review of Johns Hopkins Bayview's practice of suing its patients, we found a number of victims of lawsuits with reported incomes below the thresholds required for charity care*").
152. [The Johns Hopkins Hospital Fiscal Year 2017 Community Benefits Report Narrative](#), 8-9.
153. "[Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits](#)." *National Nurses United* (Feb. 2020), 38.
154. [University of Maryland Community Benefit Report Fiscal Year 2017](#), 9.
155. "[A Pound of Flesh: The Criminalization of Private Debt](#)." *American Civil Liberties Union* (2018), 45.
156. "[A Pound of Flesh: The Criminalization of Private Debt](#)." *American Civil Liberties Union* (2018), 45 ("*including cases in which people were arrested in cases involving debts of \$217.50 and \$230 owed to an addiction service provider*").
157. An elderly woman in Ohio reported receiving calls from a debt collector who falsely claimed to be with the prosecutor's office and threatened her with a fake arrest warrant for her unpaid medical bills. See "[A Pound of Flesh: The Criminalization of Private Debt](#)." *American Civil Liberties Union* (2018), 34.
158. "[Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits](#)." *National Nurses United* (Feb. 2020), 4. See also Senate Bill 514 and House Bill 565.
159. ACLU found that arrests for debt usually result from police stops for traffic violations, vehicle equipment violations, other minor traffic and vehicle infractions, and searches of public housing residents related to people with open warrants. See "[A Pound of Flesh: The Criminalization of Private Debt](#)." *American Civil Liberties Union* (2018), 11.
160. Hamel, Liz, et. al. "[The Burden of Medical Debt: Results from the Kaiser Family Foundation/ New York Times Medical Bills Survey](#)." *Kaiser Family Foundation* (Jan. 2016).
161. Megan Leonhardt. "[Payday loans can have interest rates over 600%—here's the typical rate in every U.S. state](#)." *CNBC* (Feb. 16, 2021). Additionally, in the handful of states where these loans are restricted or banned, other high-interest loans like car title or "title pawn" loans are

- available and clustered in low-income communities. *See also* Audrey Xu and Samuel Hammond. “[Expand Medicaid, Crush “Predatory Lenders”—How Medical Debt Fuels Financialization.](#)” *Niskanen Center* (Aug. 9, 2021).
162. 42 U.S. Code § 300gg–19a
  163. “[Office of Commissioner of Insurance and Safety Fire Posts Final Surprise Billing Regulations.](#)” *Georgia Office of Commissioner of Insurance and Safety Fire* (Dec. 30, 2020).
  164. “[How Texas protects consumers from surprise medical bills.](#)” *Texas Department of Insurance*.
  165. *See* [Senate Bill 514](#). *See also* [House Bill 565](#).
  166. *See* [Senate Bill 248](#).
  167. The protections are enforced by the state attorney general and patients may file a complaint against a health care facility, third party provider, or medical creditor that violates a provision of the law. *See* [Senate Bill 71](#). *See also* “[New Mexico Patients’ Debt Collection Practices Act Signed by Governor.](#)” *ACA International* (Apr. 7, 2021).
  168. *See* [AB 1020](#).
  169. This chart is a sample of the most comprehensive state financial protection laws around the country. For a full list, see Andrea Bopp Stark. “[An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States.](#)” *National Consumer Law Center* (Jan. 2020).
  170. The law applies to acute care hospitals. *See* Cal. Welf. & Inst. Code §§ 16900 to 16996.2 and Cal. Health & Safety Code §§ 127400 to 127466.
  171. “High medical costs” refer to annual out-of-pocket costs that exceed 10% of the patient’s family income for the prior 12 months or a lower level determined by the hospital per the hospital’s financial assistance policy. *See* Cal. Health & Safety Code §§ 127400 to 127466.
  172. The law applies to hospitals with “bed funds.” *See* Conn. Gen. Stat. §§ 19a-7d, 19a-509b, 19a-649, 19a-673.
  173. The law applies to all hospitals. *See* 210 Ill. Comp. Stat. §§ 89/1 to 89/20.
  174. The law applies to acute care hospitals. *See* N.J. Stat. Ann. §§ 26:2H-18.58; N.J. Admin. Code § 10:52-11.8, -11.1.
  175. While not included in the chart, efforts to protect veterans’ credit reports from medical debt should be noted. Senate Bill 2155, for example, prohibits medical debt that should have been reported to Veterans Affairs from being reported to credit bureaus. *See* Patrick Campbell and Brian Lavin. “[New protections for servicemembers and veterans alert.](#)” *Consumer Financial Protection Bureau* (Feb. 7, 2019). Additionally, in 2015 a multistate settlement with Equifax, Experian, and Transunion required the credit bureaus to wait 180 days before reporting medical debt on credit reports; the credits were applied to consumers nationwide in 2017. *See* Michael Best, Jenifer Bosco, and Chi Chi Wu. “[Don’t Add Insult to Injury: Medical Debt and Credit Reports.](#)” *National Consumer Law Center* (Nov. 2019).
  176. *See* [Senate Bill 355](#).
  177. These extraordinary collection actions include selling the patient’s debt to a third party, denying care or requiring payment of debt before providing medically necessary care, reporting adverse information to the credit bureaus, and taking actions that require a legal or judicial process (liens, garnishment, etc.). *See* 26 C.F.R. § 1.501(r)-6.
  178. *See* [Senate Bill 214](#). *See also* [House Resolution 773](#).
  179. To date, Minnesota is the only state that prohibits hospitals and debt collectors from reporting medical debts to credit bureaus. For a discussion, see Michael Best, Jenifer Bosco, and Chi Chi Wu. “[Don’t Add Insult to Injury: Medical Debt and Credit Reports.](#)” *National Consumer Law Center* (Nov. 2019).
  180. We recognize that Medicaid is not a cure-all for solving the medical debt crisis in Black communities. For example, inadequacies in Medicaid particularly affect Black nursing home residents and their families (when Medicaid refuses to pay a portion of the costs associated with the recipient’s care, nursing homes often sue family members to collect the debt). In

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addition to expanding Medicaid, advocates should push to strengthen the current program by opposing efforts to limit eligibility, implement work requirements, and shorten the 90-day retroactive coverage period.

181. Advocates should consider how to craft policies that authorize local governments to expand Medicaid to those eligible under the ACA. The Cover Now Act, a bill proposed by Texas congressional Democrats in 2021, would allow local government to implement their own Medicaid expansion programs. See [H.R.3961](#), 117th Congress (2021-2022).
182. For an overview of single-payer systems and why this type of public system can address racial disparities in medical debt, see Andre M. Perry, Joia Crear-Perry, Carl Romer, and Nana Adjeiwaa-Manu, "[The racial implications of medical debt: How moving toward universal health care and other reforms can address them](#)," Brookings Institution (Oct. 2021).



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