

ECONOMIC IMPACT OF THE GROWING BURDEN OF MEDICAL DEBT

HEARING

BEFORE THE

COMMITTEE ON

BANKING, HOUSING, AND URBAN AFFAIRS

UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

ON

EXAMINING HOW WE CAN PROTECT AMERICANS FROM THE GROWING
BURDEN OF MEDICAL DEBT AND DEBT COLLECTOR HARASSMENT

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TUESDAY, MARCH 29, 2022

U.S. SENATE,
COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS,
Washington, DC.

The Committee met at 10 a.m., via Webex and in room 538, Dirksen Senate Office Building, Hon. Sherrod Brown, Chairman of the Committee, presiding.

OPENING STATEMENT OF CHAIRMAN SHERROD BROWN

Chairman BROWN. The Senate Committee on Banking, Housing, and Urban Affairs will come to order. Today's hearing is a hybrid format. Our witnesses will testify in person. Thanks to all five of you for making the effort to be here. Some of you came as far as from Cleveland, so thank you for that. The Members will participate, some in person, some virtually.

Think about watching a loved one rushed to the hospital in an ambulance, or learning you have a chronic disease that is going to require years of care and monitoring. These kinds of medical ordeals are some of the scariest moments in a family's life.

They can happen at any time, to anyone, without warning. Suddenly you are coordinating doctor's visits and calls with insurance companies. You are nervously checking your savings account. You are spending hours on interminable phone calls trying to get answers. And you are dealing with it all while worrying whether your husband or your mother or your child will make it out of the hospital, or whether their health problems will continue.

As the cost of prescription drugs rise, hospital bills skyrocket, and debt collectors start calling, families are forced to figure out how to make ends meet, instead of focusing on their health.

Families all over the country are telling us that.

We heard from Penelope Wingard, an after-school teacher from North Carolina, who lost her health coverage while battling breast cancer. When her medical bills began to pile up, her doctors eventually stopped seeing her. Soon after, Ms. Wingard had an aneurysm, in addition to vision loss, both of which required surgery. Because of the financial situation caused by her cancer diagnosis, Ms. Wingard was forced to wait and then seek care from a limited list of providers who were allowing sliding scale payments.

Debt collectors call her—they harass her—every single day. And now her credit is ruined because of her health.

Right now, Ms. Wingard needs additional testing to ensure her cancer has not returned, which has added an additional \$2,000 to

her debt. So instead of focusing on battling her illness, she has to figure out how to handle the debt collectors.

And Ms. Wingard is far from alone. In the United States, 43 million Americans hold \$88 billion dollars of medical debt on their credit reports, and this problem is growing. It can happen to anyone. Low-income families, Black and Hispanic households, veterans, young adults, and older Americans are hit particularly hard.

And debt collectors make this already exhausting experience worse. They call over and over, they make threats, and they even contact patients' employers.

Take, for example, Mindy Hedges, from Delaware County, Ohio. She has had type 1 diabetes since she was five. For most of her adult life, until the passage of the Affordable Care Act, she was unable to get health insurance because she had a preexisting condition.

After losing her business in the 2008 recession, her medical bills piled up, and she was unable to repay them. That is when the debt collectors started calling. And calling. And calling. And calling.

Ms. Hedges did her best. She tried to negotiate. She even begged for relief. But the harassment continued. At one point, she was even afraid to leave her house.

This harassment is part of the business model.

A counselor at a medical debt collection agency owned by a private equity firm had some choice words about harassing patients. They said they found the first 20 to 30 calls to be, quote, "highly effective."

If the calls do not work debt collectors often move on to even more aggressive tactics like litigation, forcing people to go through lengthy, expensive, and emotionally draining court proceedings, often while still battling cancer or grieving a loved one.

For patients, litigation can result in garnished wages or property liens. We even see people thrown in jail because they could not afford to pay. It is the return of debtor's prison. People in the United States of America today are in jail, right now, because of medical debt.

And of course, whenever we find suffering, Wall Street finds opportunity. Private equity firms are making inroads in the medical debt collection market. Between 2015 and 2016, one-third of all debt collection agency acquisitions were bought by private equity. Those firms exist purely to maximize investor profit, no matter the cost to society.

Maybe that is why private equity-owned debt collection agencies are responsible for an outsized number of consumer complaints, many concerning attempts to collect debt from people who do not owe them.

We must address the growing crisis of medical debt burdening American families.

President Biden and his Administration are working to remove barriers to medical debt forgiveness for veterans, and to make it easier and cheaper for them to get care. No one who served this country should be saddled with debt for illness or injuries incurred in the line of duty.

And the Biden administration has wasted no time in implementing the No Surprises Act, which took effect on January 1st.

This bipartisan law finally bans surprise medical bills. One way to prevent debt collector harassment is to protect people from debt in the first place.

The CFPB is also doing important work exposing the abuses Americans face while just trying to get health care. And after increasing scrutiny and pressure, the three credit reporting bureaus—Equifax, Experian, and TransUnion—all announced they would significantly change how medical collection debt is reported. These changes are expected to remove nearly 70 percent of medical debt in collections from credit reports. This is a positive first step, but just a step.

And this first step gets to a basic step that we too often ignore: medical debt does not correlate with credit risk. It correlates with illness.

It should be obvious—anyone can get sick. Anyone can get in a car accident. It has nothing to do with your ability to pay your bills—or at least it should not. No one should be forced into poverty, no one should be harassed by shady debt collectors because of a medical emergency or a sick family member.

We have taken important steps to protect Americans, but we can do more.

I am asking the CFPB to create an ombudsman position for consumer medical debt.

It is also why expanding Medicaid coverage to those who live in the 12 States that have refused to expand Medicaid under the Affordable Care Act is long overdue. I am appreciative of two Members of this Committee, Senator Warnock and Senator Ossoff, who are working to finally get this done, either here or in their State.

Of course, meeting these challenges cannot be done by the Government alone. Private industry must act. This country needs private institutions to meet their obligations of financial assistance and the No Surprises Act.

Today we are hearing from two advocates for consumers as well as one of my constituents, Robyn King, from Cleveland. Ms. King will tell her story of battling medical debt she never owed, after a nursing home cared for her mother.

I look forward to hearing more about how we can protect Americans from medical debt and debt collector harassment. No one should have their financial future ruined simply because they get sick.

Senator Toomey.

OPENING STATEMENT OF SENATOR PATRICK J. TOOMEY

Senator TOOMEY. Thank you, Mr. Chairman.

Pricing risk accurately is critical to the safety and soundness of financial institutions, and to consumers' ability to access affordable credit, because when borrowers default, lenders have to absorb the costs. That is why lenders generally look at information about credit history. It helps them estimate the risk of default and to price loans.

Lenders who cannot access information that they consider predictive of risk are likely to restrict their lending to the borrowers with the thickest credit files, seek out relevant proxies for the credit information they are not able to obtain, or increase the price of

loans to all borrowers in order to capture the uncertainty and the risk. This hurts all consumers, including low-income families and those without a long credit history. For all of those reasons, the Government should not suppress the reporting of accurate credit information.

Unfortunately, so-called consumer groups and allies have sought to remove information from credit reports and thereby make them less accurate. I am afraid such actions will have adverse unintended consequences.

Today's hearing title is the "Growing Burden of Medical Debt". It is an interesting but inaccurate title, because evidence suggests medical debt is actually falling, not growing.

According to the CFPB's own estimate, which the Chairman cited, medical debt in collections last year was \$88 billion. That is a nominal reduction of 10 percent over the last 3.5 years.

Another study showed that average medical debt in collection fell by 40 percent in the last decade. And that is despite the fact that over the same period medical spending increased 70 percent—and over 50 percent per capita. This is all illustrated on Chart 1 behind me.

Now there are likely many reasons for a decline in medical debt. A primary driver was the improving economy. After the tax reform in 2017, those with the lowest wages—those most likely to have medical debt—were making the biggest gains in income.

Another driver of the decline was the enactment of Obamacare and Medicaid expansion. Researchers estimate that for every \$25 spent on Medicaid expansion, medical debt in collections decreased \$1.

There are many aspects that have made me question the wisdom and efficacy of Medicaid expansion, including its cost and the lack of evidence that it improved health outcomes. But, unsurprisingly, if you are willing to spend massive amounts of other people's money, you can transfer individuals' debts onto the taxpayers. That is illustrated in Chart 2.

So all available evidence suggests there is no "growing" burden of medical debt. In fact, the scale of medical debt is often misunderstood. As illustrated in Chart 3, medical debt in collections represents less than 1 percent of all household debt. Two-thirds of medical debt collections are under \$500, and bankruptcy from medical debt is extremely rare, as illustrated in Chart 4—3/100ths of 1 percent of the population suffers bankruptcy each year as a result of a hospitalization.

And medical debt is not strictly an American phenomenon. Every health care system in the developed world includes out-of-pocket payments. According to the World Health Organization, even before Medicaid expansion, the likelihood that out-of-pocket expenses would exceed a quarter of one's income was roughly as rare in the United States, 0.8 percent, as Canada or the Ukraine, about 0.5 percent, and considerably rarer than in Italy, Spain, Korea, Switzerland, and other countries in the developed world.

Recently, credit reporting agencies announced changes that will reduce the amount of medical debt that appears on consumer credit reports going forward. Now, if a credit reporting agency decides to exclude this information, I do not think it is the Government's role

to meddle with such a decision. However, if credit reporting agencies had collectively decided the opposite—if every one of them had gotten together and decided they would begin at the same time to add consumers' medical debt information onto reports—I suspect the howls and protests about greed and collusion would have been deafening.

What appears to have occurred here was that a political campaign, which included the CFPB, bullied lenders and credit rating agencies into removing this information. This kind of misuse of power by the administrative state has grown all too common. It is an example of how Congress has become far too comfortable with the Executive branch seizing the Article I lawmaking authority of Congress.

We need to be careful that any actions considered to address symptoms—in this case debt from a health condition—do not make matters worse. This new credit reporting agency policy does not actually lower the cost of medical care. In fact, it will either raise costs or reduce access.

It may end up discouraging people from paying medical bills. That could lead to health care providers finding ways not to treat individuals without an obvious means to pay. And by eliminating one metric in a credit rating, it may cause credit rating agencies to use other metrics, or proxies, that are less accurate, which could actually hurt low-income populations more.

These kinds of downstream effects would not be shocking given that the entire effort to micromanage credit ratings is coming from an agency that has no expertise on complex medical billing and health care systems.

It should remind us that intervention into the market, no matter how noble advocates may think they are being, will have consequences, usually unintended consequences. And second, interventions should come after careful deliberation by the people's representatives, not diktats from unelected bureaucrats.

Thank you, Mr. Chairman.

Chairman BROWN. Thank you, Senator Toomey.

I will introduce today's five witnesses. Robyn King, a former second-grade teacher's assistant in Cleveland, now works part-time and volunteers when she is not caring for her family. Ms. King uses her voice to shed light on the terrible toll that medical debt is taking on average Americans.

Emily Stewart is the Executive Director of Community Catalyst, overseeing the direction of its advocacy of consumer health care rights and the organization's finances and operations. She has two decades of experience in health care advocacy.

Dr. Benedic Ippolito studies health care financing and the pharmaceutical market and its regulations and the effect of health care costs on the personal finances of Americans. He is a Senior Fellow in Economic Policy Studies at the American Enterprise Institute.

David Hyman is the Scott Ginsburg Professor of Health Law & Policy at Georgetown and is an adjunct scholar at the Cato Institute, a doctor as well as a lawyer. He served most recently as the Ross and Helen Workman Chair in Law and Professor of Medicine at the University of Illinois.

Berneta Haynes is a staff attorney at the National Consumer Law Center, working on a portfolio that includes consumer medical debt policy and energy policy. She recently published a report examining the intersection between the racial health gap and the racial wealth gap and harm of aggressive medical debt collection.

Thank you all for giving us your time and joining us today. I will begin with Ms. King. Welcome.

STATEMENT OF ROBYN M. KING, OF OHIO

Ms. KING. Good morning. It is an honor to be here today, and it is a privilege to be able to share my story with this Committee.

I am here to speak about my experience with medical debt. It is something that affects thousands and thousands of people in this country every year, and I know firsthand that the consequences of these burdens can be debilitating. I was lucky enough to get help from the attorneys at Legal Aid in Cleveland, but many people are not so lucky. For them and for others who have yet to be victimized, I share my story.

I am a mother with three children. I worked as a teacher's assistant for 10 years, and recently transitioned to working part-time at a Learning Center. I still volunteer with children and older adults in my spare time. I also am the youngest of six siblings who all cared deeply about our mom.

If you have ever brought a parent or loved one to a nursing home, knowing they will live out their final days there, knowing you are trusting all of their care and comfort to strangers, that is a day you will never forget. Because Mom was suffering from Alzheimer's and had difficulty understanding what was happening, my siblings and I decided I would be Mom's representative for the nursing home admission and sign all of the paperwork that allowed my mom to be admitted into the facility.

My mom's Social Security checks were used to pay for her portion of the nursing home bill, and Medicaid covered the rest. Knowing that my finances were already tight, I made sure to check the box on the nursing home admission form which said I did not agree to be personally liable if finances for my mom's medical care ran out. I have a household of my own to take care of and knew that I could not afford to pay any nursing home for my mom's medical expenses.

In November 2019, nursing home staff told me Mom's Medicaid needed to be reinstated, so I went to the office and filled out some more forms. I did not hear anything from them about Medicaid for months, so I assumed everything had been taken care of.

I was shocked when the nursing home told me, in May 2020 that Mom's Medicaid actually had not been reapproved and that I was now responsible for paying a huge bill. Why had they not told me this months ago? How could they have kept this information from me, when I always did everything the nursing home asked me to do? Maybe we could have figured out a way to prevent them from coming after me for this debt.

Because the nursing home took so long to tell me that Medicaid had stopped paying Mom's bills, the amount owed had grown huge. They were now trying to collect almost \$70,000. And while I tried

frantically to fix the situation, the nursing home started sending bills each month, every bill larger than the last.

My mom passed away on October 3, 2020. Just 2 days earlier I had received notice that I was being sued by the nursing home for close to \$80,000.

I never had time to grieve. I kept so much inside; the stress was unbearable. I thought, I will not be able to afford my mortgage, and I am definitely going to lose my house. I could face a garnishment of my paycheck and be forced to live on a reduced income when money was already tight to begin with. What will I tell my kids? What does it mean, to have this kind of judgment against you? How will that impact the rest of my life? At one point I even thought, I would rather be with my mom. I felt defeated. I had nothing to give.

The lawsuit made no sense to me since I told the nursing home that I would not be personally responsible for any of my mom's medical expenses. On my sister's advice, we called Cleveland Legal Aid. I am so grateful for my attorneys' help because they freed me from having to pay the nursing home debt with my own money.

The nursing home is still pursuing my mom's estate for what is owed, so it is still impacting my life. While I am not personally on the hook for the debt, they are still going after my family's assets.

I hope you can take action to protect people like me and not allow medical debt to upend people's lives. Medical care is not something we can opt out of. Getting sick or having a family member get sick should not force people to face crushing amounts of debt. I thought that I had done everything right in taking care of my mom, but without Cleveland Legal Aid I would have had an enormous judgment against me, and my family's financial future would have been devastated. There must be a better way to take care of each other and not leave people like me facing life-changing amounts of debt. There is just no excuse for this in America.

I hope that my testimony today will help turn my story into something positive. Thank you.

Chairman BROWN. Thank you, Ms. King.

Ms. Stewart of Community Catalyst, welcome.

**STATEMENT OF EMILY STEWART, EXECUTIVE DIRECTOR,
COMMUNITY CATALYST**

Ms. STEWART. Thank you. Good morning, Chairman Brown and Ranking Member Toomey and Members of the Committee. Thank you for having me.

Community Catalyst is a national nonprofit organization that is dedicated to building the power of people to build a health system that is rooted in race equity and health justice in a society where health is a right for all. For nearly 25 years we have worked at the forefront of local, State, and national conversations to make the health system more responsive to people, and over the course of that time one of the major takeaways from our work has been the deep connection, and troublesome connection, between people's health and their overall financial well-being.

There is no issue that shines a brighter light on this reality than the issue of medical debt. It is important to put medical debt into its context. Our health system is costly, it is imbued with inequity,

and this harms us all. Billing and collection is complicated and confusing, even to experts, but its patients, individual people who are put in the position of resolving that complexity, whether it be figuring out whether or not they were owed, they owed the bill to begin with, or navigating a dispute between their health plan and their health care provider.

There are many sources of medical debt, with the largest share from ER visits, dental care, and diagnostic tests, such as x rays and MRIs. It is such a concerning issue that 40 percent of Americans say that they are more fearful of medical debt than a serious illness. The Census Bureau estimates that 17 percent of U.S. households hold medical debt. There are other studies that have higher estimates, and it is entirely plausible that most people know someone who has been impacted.

In preparation for this hearing I decided to survey my siblings. I have seven of them. Five of us have had medical debt, in the thousands, ranging from ER visits, pregnancy-related care, and surprise bills.

Of course, medical debt impacts some more than others. People who are uninsured are more likely to have medical debt, and importantly, many of them are living in States that have not expanded Medicaid under the Affordable Care Act. And due to discriminatory barriers to affordable coverage and care, there is a disproportionate effect on people of color, with 27 percent of Black households and just under 19 percent of Latinx households reporting medical debt.

Families with children are far more likely to have medical debt than those without, and families with a member who has a disability are nearly twice as likely to have medical debt.

Medical debt can have a profound impact on people's health and well-being. Thirty-seven percent of people with medical debt have used up all their savings to pay off their bills, 31 percent took on new credit card debt, and 11 percent took out a mortgage against their income or another type of loan. People report reduced spending on food, clothing, and other household items.

It should come as no surprise that people with medical debt are much more likely to report experiencing stress, anxiety, and depression, and the COVID-19 pandemic has exacerbated the issue for many. For example, through our work with coalition partners in Illinois, a story surfaced of a man with work authorization in the State. He was rushed to the emergency room with COVID-19 complications and subsequently charged \$11,798. The hospital denied him any financial assistance, even though he was eligible under State law, and even though Federal assistance was already in place for COVID-19-related care. He paid over \$1,000 each month for a number of months because he was afraid that his bill would impact his immigration status or his ability to buy a home.

Whether a person's medical bill problem is alleviated or aggravated hinges on who holds the debt. Many hospitals offer extended payment plans directly to their patients, and, in fact, nonprofit hospitals are required to offer financial assistance under Federal community benefit standards. However, many people are unaware of these programs and not adequately informed of them upon receiving their first bill.

For many people the headache begins when the bills are sent to third-party collection agencies. These agencies are paid a percentage of the debt they collect, they typically report the accounts to the credit bureaus, and if not paid promptly they pursue legal action. Numerous press reports have detailed people having their wages garnished, bank accounts frozen, or liens put on their homes.

Medical debt can ruin people's credit rating, and to make matter worse, the data is often inaccurate or out of date. An analysis by CFPB showed that nearly two-thirds of collection complaints assert that the debt was never owed, never verified as the consumer's debt, already paid, or discharged in bankruptcy.

Proposals to address this issue are necessarily multifaceted, but there are a few to highlight. Senator Brown, Community Catalyst supports your proposal for a CFPB ombudsman to resolve medical debt complaints. It is important to also eliminate unpaid medical billing data on credit reports and to hold credit reporting agencies accountable for accurate data. It is important also to strengthen nonprofit community benefit standards, prohibit wage garnishments and liens on property, and to apply those protections to for-profit hospitals. Also, extending Medicaid coverage to people who are living in States that have yet to expand Medicaid.

Thank you for hearing this testimony, and I look forward to your questions.

Chairman BROWN. Thank you, Ms. Stewart. Dr. Ippolito.

**STATEMENT OF BENEDIC N. IPPOLITO, SENIOR FELLOW,
AMERICAN ENTERPRISE INSTITUTE**

Mr. IPPOLITO. Thank you very much for having me. I am going to echo some of the comments that we just heard.

Medical debt is different than other forms of consumer debt. A lot of consumers are not actively pursuing this debt. They are not taking on debt intentionally. More than that, I think it reflects these features of the health care system that attract justifiable criticism. It is very expensive. Billing is quite complex. And so certainly the extra attention that we pay to medical debt is certainly understandable.

That said, as policymakers consider the issue it is important to be able to begin with a firm grasp of the empirical reality surrounding medical debt in the United States.

I think many of us think of medical debts a reflecting tail events, those kinds of unexpected, catastrophic health shocks that can give rise to very large bills. And while those debts absolutely do exist, they do not, when you look at the data, appear to be representative of the typical experience in the United States.

Instead, medical debt is a very common phenomenon that seems to reflect actually much more typical common interactions with the health care system. So for example, about 16 or 17 percent of adult Americans have medical collections on their credit reports. The average medical collection itself is about \$300. I think for a lot of people that is relatively modest, and I do not mean modest in the sense that that is unimportant, but modest in the sense of the kind of bills that we know can happen in the health care system, certainly that we heard about today.

In aggregate, consumers owe about \$100 billion in medical collections alone. That number is a little higher if we include other forms of medical debt. About 92 percent of those medical collections, however, are never reported as paid on credit reports.

These debts can affect household finances in a few ways. Perhaps most centrally they can lower credit scores. That obviously makes it harder or more expensive for consumers to borrow. Many have called that practice into question, so it is worth considering what policy changes are warranted and what tradeoffs we might need to consider.

Obviously, credit scores are meant to summarize credit worthiness, so if they are not doing that accurately, if they are penalizing consumers for things they cannot control or otherwise are not predictive of their credit worthiness, those are the kinds of things we ought to address. And I think some medical debts clearly fit in that category. So for example, a medical debt that is initially incurred because of confusion over a billing process but is later repaid surely carries less predictive risk about future credit risk than a bill that is willingly incurred and then goes unpaid for a long time. So policies that, for example, would distinguish between things like paid versus unpaid medical collections certainly would help consumers who are inappropriately penalized in the current market.

Some obviously argue in favor of policies that go further and disallow the reporting of otherwise accurate medical collections. Indeed, the major credit bureaus have announced a policy that would do that for the majority of medical collections recently.

Those kinds of policies come with more potential unintended consequences that I do think are at least important to flag for policymakers who are interested in this area and are interested in these policies actually achieving their stated goals.

So in particular, while medical collections are certainly less predictive of some future repayment risk, that does not mean they are not predictive. So we have to think about, from the perspective of a lender there is a risk that they place some value on that is now not eliminated. It is obscured. So how are they going to respond to the fact that they cannot observe this anymore?

So I think there are a couple of potential ways. First, you might try and reweight. You might try and put more emphasis on other kinds of things that appear on credit records that are not medical collections but you think are indicative of a similar risk, other kinds of collections, other kinds of delinquencies, for example. It is not ex ante obvious that the distributional consequences of that kind of reaction are better than the status quo.

If they do not think they can find a clear proxy they may instead just increase the cost of borrowing across all consumers or, in some cases, you may change your lending habits, particularly in populations where you think there is a high unobserved risk and where it is harder to proxy. So for example, young consumers carry a lot of medical debt in the United States. They also tend to have thinner credit files. That is the kind of population where you may be more concerned about that kind of adverse reaction.

Finally, these tradeoffs, I think, sound a little bit academic or theoretically but they certainly are reminiscent of very real-world issues that we see, certainly in the health care market, where we

try and achieve similar things through regulatory redistribution. So for example, health insurance premiums cannot vary with health status or expected health expenditures. That obviously is motivated by equity concerns, and it has a similar flavor to what we are talking about today. We are trying to help people who have this unexpected health shock that they cannot necessarily prevent.

That said, it distorts pricing signals in the market and it creates a lot of instability. We constantly have to be vigilant over risk-pooling issues in these markets. We constantly have to be vigilant about unraveling incentives that distort the actual stability of the fundamental market itself. If the market is not stable, if we do not have insurance products that are readily available to consumers, that really attenuates the benefit of a lot of these policies.

And so that is not to say this is not an important topic and it is not worth addressing. It is to say, however, that there are important potential unintended consequences that we should be aware of and we certainly should emphasize.

I thank you for having me, and I look forward to the questions.
Chairman BROWN. Thank you, Dr. Ippolito. Professor Hyman.

STATEMENT OF DAVID A. HYMAN, SCOTT K. GINSBURG PROFESSOR OF HEALTH LAW & POLICY, GEORGETOWN UNIVERSITY LAW CENTER

Mr. HYMAN. Chairman Brown, Ranking Member Toomey, and other Members of the Committee, thank you for inviting me to speak to you. I am a professor at Georgetown where, among other classes, I teach consumer protection and a course entitled "How to Regulate", so this is very much something I think about a lot.

I am primarily a health law and policy person. I have also been the victim of identity theft and had to deal with medical bills for myself and my kids, so I think the difficulty of going fourth when we have got such a distinguished lineup of speakers is to say, "well, a lot of what I wanted to say has been said already" so I will focus on a couple of issues that have not been flagged yet.

The first is you hear numbers thrown around, and those numbers vary widely. We have already heard figures ranging from \$89 billion to \$195 billion in medical debt. When you see a range that wide you should conclude that there is some uncertainty as well as variation in the way in which people are measuring things, and that is exactly what is going on here. Methodological choices and definitional uncertainty matter.

So the most common approach to quantifying the problem of unpaid medical debt involves looking at credit reports, and those credit reports flag certain things as coming from medical providers that are in collections. Now that is series of limitations that you ought to at least be aware of, because most of these studies involve data from a single credit reporting agency and the same information is not necessarily reported to all of the agencies.

Second, the accounts that are in collections are necessarily a subset of all accounts, particularly given the time lag in reporting. But the additional problem that is often not appreciated is the designation of medical debt obscures the reality that patients often use a variety of strategies to pay for their health care bills, including using traditional credit cards, using medical credit cards, taking

out home equity loans. And if those go into collections, even though they are attributable to an underlying medical cost, they will not be flagged as medical debt.

And the alternative approach uses surveys, including data gathered by the census, that has some advantages and some disadvantages, I am happy to talk about in the Q&A. But the short version is the numbers that you hear reflect a very specific set of assumptions about what does and does not count as medical debt.

The second point I want to make is that medical debt is a function or a result of multiple interactive factors. You can start with whether somebody receives health care or not, second, how much they are billed for it, third, how much is paid for or discounted off of that list price from various sources, and that includes insurance, it includes self-payment, it includes charity care policies. And all of those are moving parts that affect whether any given individual, with any given set of circumstances, has medical debt, and if so how much.

The third point I want to make is that modifications to credit reporting of medical debt may provide some relief, but as Dr. Ippolito already said, you should be wary of some of the unintended consequences. It is a solution to a symptom. It is not a solution to the underlying problem.

And that is the last point I want to end with and emphasize, which is the reason why we have medical debt is because health care in the United States is expensive. And if you want to address the problem of medical debt you should treat the underlying cause, i.e., the disease, rather than the symptom, and focus on ways of making health care less expensive.

I flagged two possible strategies but there are many others, one of which is pushing hospitals to more fully implement their charity care obligations, specifically nonprofit hospitals which have long had an obligation to do that under both State and now Federal law. I think to the extent hospitals are a major source of these bills that result in medical debt, that is going to be an important tool that already exists.

Second, I want to acknowledge that Congress has already taken an important step in addressing some aspects of medical debt with the No Surprises Act that both Dr. Ippolito and I helped consult on in the context of that legislation. And there are additional strategies as well.

But it is important to keep your eye on the ball. The ball here is high health care costs that result in these problems, and those problems are disproportionately borne by certain portions of the population.

Thank you very much for your attention.

Chairman BROWN. Thank you, Professor Hyman. Ms. Haynes, welcome.

**STATEMENT OF BERNETA L. HAYNES, STAFF ATTORNEY,
NATIONAL CONSUMER LAW CENTER**

Ms. HAYNES. Thank you. Chairman Brown, Senator Toomey, Members of the Committee, I appreciate the opportunity to testify on the economic impact of medical debt.

I provide my testimony today on behalf of the low-income clients of the National Consumer Law Center. We believe medical debt poses a severe problem disproportionately impacting Black and Latinx families. We ask that you provide consumer protections to prevent medical debt at the outset, and to shield consumers from harmful debt collection practices and long-term impacts on their well-being.

According to the CFPB, medical debt represents more than half of all debts in collection and remains a leading cause of bankruptcy. I live in Georgia, where I have worked directly with consumers and seen up close the real-life impacts of the medical debt crisis. Nineteen percent of Georgians have medical debt in collections, 17 percent of White Georgians and 21 percent of non-White Georgians.

Likewise, 17 percent of Ohioans have medical debt in collection, 17 percent of White Ohioans, 23 percent of non-White Ohioans. Similar disparities exist across the country.

Consumers with medical debt face aggressive debt collection. To avoid debt collection, families drain their savings, increase their credit card debt. They turn to deceptive financial products like medical credit cards and high-interest loans to pay off medical bills. Because medical debt often appears as other forms of debt in individual credit history, it likely has an even larger impact than data currently shows.

Aggressive debt collection takes so many forms. Hospitals sometimes turn bills over to third-party debt collectors who may use frequent, abusive, and harassing communication to pressure consumers to pay. Medical debt is consistently the most common type of debt about which people are contacted by debt collectors. Debt collectors contact Black households at twice the rate of White households, according to the FTC.

In some cases, health care providers, hospitals, and debt collectors file lawsuits against the consumer. They may use these lawsuits to seek liens against homes, garnish wages and tax refunds, seize bank accounts, and even seek civil arrest warrants when the debtor fails to appear for proceedings.

Between 2009 and 2018, hospitals in Maryland filed nearly 40,000 lawsuits that resulted in wage garnishment, often from their own employees, according to National Nurses United. Johns Hopkins alone sought over \$4 million in wage garnishment lawsuits between 2009 and 2018. It has a service area that is 45 percent Black.

The University of Virginia hospital system has a history of relying on property liens to collect unpaid medical bills, as Kaiser Health News reported in 2020. As a result of that expose, the system canceled decades of liens placed on low-income patients. VCU Medical Center in Richmond, a majority Black city, filed the most lawsuits of any single hospital from 2018 to 2020, according to researchers from Johns Hopkins.

Worse yet, the ACLU documented cases of arrest for medical debt in several States, including Maryland, Tennessee, and Arkansas. In Maryland, they observed the practice of patients being jailed for medical debts of less than \$1,000. The result of these

practices essentially revives debtor's prisons, which should be illegal in this country.

These debt collection tactics, for obvious reasons, put fear in consumers, harming not only their financial well-being but also their physical and psychological well-being. Consumers may forego or delay medical care because they fear medical debt, which can harm their physical health and lead to greater medical expenses in the future. Carrying debt and being subjected to these debt collection practices also causes psychological distress, increasing anxiety, depression, substance use disorders, and other mental health disorders. All these things can lead to greater medical bills and debt down the road—a vicious cycle.

So to address this epidemic of medical debt we ask that you focus on ways to prevent medical debt so that seeking health care does not send individuals into a financial tailspin. We ask that you consider consumer protections that address the racial disparities in medical debt, ban wage garnishment, bank account seizure, property liens, foreclosure of homes based on medical debt liens, and civil arrest warrants for medical debt; prohibit debt collection during health insurance appeals; end the practice of turning over medical debt to third-party collectors; prohibit providers and debt collection from reporting all medical debt to credit reporting bureaus; enacting universal publicly funded national single-payer health plan administered at the State and local levels.

There is more detail on these recommendations found in my written testimony. I do thank you for the opportunity to testify and I would love to answer any questions you have.

Chairman BROWN. Thank you, Ms. Haynes.

We will begin the questioning with Senator Warnock, who has been advocating for Medicaid expansion in Ms. Haynes' State, as she noted. Senator Warnock, you are recognized.

Senator WARNOCK. Thank you so very much, and it is good to see all of our witnesses, particularly Ms. Haynes from Georgia, and thank you, Mr. Chairman, for letting me go early due to my pre-siding obligations.

The Affordable Care Act allowed States to expand Medicaid to over 13 million Americans. This is transformational legislation for our country. But sadly, there are still 646,000 Georgians unable to access free and affordable health care because State politicians continue to prioritize politics over people.

I have been fighting for Medicaid expansion long before I came to the Senate, and when I arrived I fought really hard to get further incentives for Georgia to expand Medicaid, which we won in the American Rescue Plan, and the State continues. State politicians continue to refuse to expand Medicaid, a net loss to the State and certainly to the 646,000 Georgians in the Medicaid gap.

And that is why after that I introduced the Medicaid Saves Lives Act, which would give folks in States like Georgia access to health care, and I am fighting to close the coverage gap to ensure that everybody, everywhere, no matter your ZIP Code, has access to health care.

Ms. Haynes, do we tend to see more medical debt in States like Georgia that have not expanded Medicaid than States that have expanded Medicaid?

Ms. HAYNES. That is absolutely correct. Households in the South, the region with the highest concentration of Black folks, carry more medical debt than other regions. This is exactly the region, too, where Medicaid expansion has not really happened. Of the 12 States that have not expanded Medicaid, eight of them are in the South. That has left many people uninsured, particularly Black folks. Also many of those Southern States have a high percentage of for-profit hospitals too, that are not subject to the charity care provisions of the ACA.

But that said, the uninsured rate in the South is definitely connected to the lack of Medicaid expansion and connected to the increasing levels of medical debt in that region.

Senator WARNOCK. So you see a direct link between medical indebtedness in States like Georgia and its refusal to expand Medicaid.

Ms. HAYNES. Absolutely. The last State, I believe, said that Georgia has the fourth-highest or third-highest uninsured rate in the country. I have worked with clients directly in Georgia who are underinsured or uninsured, facing medical debt, and trying to figure out whether they need to file bankruptcy, trying to figure out how they can negotiate some sort of payment plan. It is definitely at crisis levels in States like Georgia.

Senator WARNOCK. Thank you. Medicaid expansion is something I am focused on, and I will keep pushing for that, but also capping the cost of prescription drugs would be helpful. According to the Kaiser Family Foundation nearly 1 in 10 adults, or roughly 23 million people, owe medical debt, and as of 2020, American families collectively owed over \$140 billion in medical debt. In Georgia, there is over \$120 million in medical debt for over 108,000 folks.

This is unacceptable. People should not have to choose between getting the prescription drugs they need and groceries. And this is why I introduced the Capping Prescription Drug Costs Act and the Affordable Insulin Now Act, which would cap out-of-pocket drug costs for Americans.

Ms. Stewart, how would proposals that cap out-of-pocket drug costs like mine alleviate, or help to alleviate the medical debt crisis in our country?

Ms. STEWART. Thank you, Senator Warnock, and Community Catalyst supports both pieces of your legislation. Thank you for that.

It is quite clear, based on the testimony of many people here, that it is underlying health care costs and people's inability to afford health care is a major driving factor. Kaiser Family Foundation also found that of people who have incurred medical bills that they cannot afford, 53 percent of them connect them to out-of-pocket prescription drugs costs. So absolutely, efforts like the one that you are undertaking with your bills would help the underlying issues and help alleviate the burden of medical debt.

Senator WARNOCK. And Kaiser has done work, as I recall, in the past on the impact of Georgia's refusal to expand Medicaid on the Georgia economy. It is a drag on people's health care. It is a drag on the Georgia economy. Is that correct?

Ms. STEWART. That is absolutely correct. There are many studies showing the connection between Medicaid expansion and improving overall economic well-being.

Senator WARNOCK. So we would do well to expand Medicaid in the 12 nonexpansion States or for us to have Federal legislation to make sure that folks in those States can access a Medicaid-like program, and we would do well to cap the cost of prescription drugs, a net gain for the Georgia economy and for people's health care.

Ms. STEWART. Absolutely, and it would help millions of people across the country.

Senator WARNOCK. Thank you so much.

Chairman BROWN. Thank you, Senator Warnock.

Senator Toomey is recognized.

Senator TOOMEY. Thank you, Mr. Chairman. Dr. Ippolito and Professor Hyman, let me address this question to the two of you. And I think you touched on this but I just want to be clear. Can credit reporting and debt collection policies actually solve the underlying problem of high or unexpected medical debt or would that require some health care policy change? Dr. Ippolito, you can go first.

Mr. IPPOLITO. Well, yes. So I guess I am going to echo something Professor Hyman said. But the challenge is that we are dealing with a clear symptom. Medical debt reflects something—it reflects something mechanical. A bill was not paid, obviously, but it reflects the fact that there was a bill that was potentially quite expensive and there was an inability to actually pay it.

So the challenge is if we are trying to address this as a banking system, if we are trying to address this through credit reporting changes, if we have not actually changed the underlying risk that the lenders are responding to, for example, in that case, then the lenders are going to respond some other way. We have to assume they are going to respond to the fact that there is some risk that they cannot observe. So clearly we are going to see some response, and that is where I worry more about the unintended consequences.

Senator TOOMEY. Professor Hyman.

Mr. HYMAN. Yes, I would echo that. I think you should think separately about the bills that have already been accumulated versus the bills going forward. But I do not think changes in credit reporting practices meaningfully change the debt that is owed, although they may change the visibility of that debt. And if you do not do something about the cost of health care you should expect future medical debt to compound itself rather than, as I said previously, addressing the root cause of the problem.

Senator TOOMEY. Right. And this is one of the reasons I am concerned that the CFPB seems to be running point on this. They have no authority to make changes to health care policy, they do not have any particular expertise in health care policy, and they certainly are not going to address the underlying problems.

Let's talk a little bit, if we could, about the effects of suppressing information. Now I understand that there might be categories of medical debt that may not be particularly predictive about a person's creditworthiness. I do not know, something like hospitaliza-

tion for a car accident is something that is obviously completely involuntary, extremely unusual, could be very expensive if you do not have insurance.

On the other hand, I think somebody—and, Dr. Ippolito, I believe it might have been you—pointed out that a very large majority of unpaid medical debt is under \$500, it is a few hundred dollars, which seems to suggest something closer to a more routine medical expense, and failure to pay that, maybe that tells us something different. Maybe that has a different predictive value with respect to creditworthiness.

Could you talk a little bit about the differences between different kinds of medical debt in terms of their predictive value and the unintended consequences that could emerge if that which has some predictive value is suppressed and is simply obscured to creditors?

Mr. IPPOLITO. Yes, I think there are two things there. So the first thing is you point to one of the big challenges when you look at the data on this topic is that the distribution of medical debt often does not look like what you are expecting, because I think so many of us are thinking car accident. It is the unavoidable thing that generates a huge bill. It is easy to understand how that generates a lot of debt.

But that really is atypical when you look at the credit profiles that the CFPB—

Senator TOOMEY. That is atypical.

Mr. IPPOLITO. That is atypical. Yes, that is right. The typical experience is the median medical collection is \$300–\$310, I believe, in 2020. Three-hundred-ten dollars can be generated in a lot of health care interactions that are not the catastrophic situations.

So I think your question speaks to the way I think about this topic, which is that we are seeing something that is an interaction between two things. One is there is a health care component, obviously, but there is also a personal finance component too. And so if you are seeing \$300 bills, \$200 bills, \$100 bills not getting paid, it is not completely obviously to me that the answer is, well, it is obviously a health care problem per se, obviously the cost point notwithstanding, it seems to me that we have a broader personal finance problem, that again, suppressing information on a credit panel is not going to get rid of that risk. It is just going to hide the risk. And we know people are going to respond because we see it in other markets. And so that is the core tension I see.

Senator TOOMEY. Professor Hyman, did you want to comment on that?

Mr. HYMAN. Yes. I would just add I think it is hard to infer much about the creditworthiness of a particular individual simply based on the size of the medical bill that they received, especially if you are looking at bills in isolation when, you know, a single encounter with a health care system can result in multiple bills, each of which might be in collection.

And so the dollar amount is informative of the distribution but it does not tell you that much about whether there has been an income shock or ability to repay has been affected or not. You need more information on that.

Senator TOOMEY. Thank you. Thanks, Mr. Chairman.

Chairman BROWN. Senator Warren, from Massachusetts, is recognized.

Senator WARREN. Thank you, Mr. Chairman.

So this is an important hearing. Medical debt is the most common form of debt on consumer credit records. It represents about 60 percent of all consumer debts listed on credit reports. It totals as much as \$140 billion. And for the nearly 1 in 5 Americans with medical debt in collections who are, by the way, disproportionately Black and Hispanic, it means facing aggressive and often predatory collection practices that can ruin your credit, garnish your wages, and drive you into bankruptcy. It also means that when it damages your credit score it drives up costs for mortgages, credit card, and other financial products.

Medical providers often outsource their debt collection to other businesses. In recent years, one of the big players to pop up in this space is—surprise, surprise—private equity. Giant private equity firms have slipped their tentacles across the health care industry, spending about \$750 billion over the last decade to buy up everything from hospitals to ambulances to the companies that bill patients and track them down to collect those debts.

Ms. Haynes, you are an expert on medical debt collection practices and their impact on families, so let me ask you. How would you characterize private equity's collection practices? Does it have a good track record of following the law and doing right by consumers?

Ms. HAYNES. Private equity hospitals and debt collection are as much a part of the problem in the medical debt crisis as the other players. They are very aggressive in their collection practices. They file lawsuits against patients. They harass them via phone, report their debt to CRAs, even when a debt is not owed. They are as big a player in the medical debt crisis as any other players in this crisis.

And I should say that these aggressive debt collection practices involving liens on homes are particularly damaging. Hospitals, once they actually seek a lien on a home, it can really damage the person's current asset value and their housing stability, ultimately.

Senator WARREN. All right. And I just want to underline one of the phrases you used in there—including when the debt is not even owed.

Ms. HAYNES. Yes.

Senator WARREN. I would like to know how much of those \$300 medical bills are not even actually owed.

But debt collection is an ideal business for private equity because their whole business model rests on squeezing companies and people dry. The standard playbook is to buy up a company, by loading it up with debt, squeeze the company to extract profits, then take the money and run after a few years.

In the medical debt collection business that means doing whatever it takes to collect as much money as possible from patients, and do it as fast as they can. So it is no wonder that private equity is gobbling up medical debt collection firms right and left, rolling them up into consolidated debt collection giants. In recent years, private equity has been behind as much one-third of the acquisitions of these companies.

Ms. Stewart, as the Executive Director of Community Catalyst, a consumer health advocacy center headquartered in Boston, you work to protect consumers across the country from predatory medical debt collections. In your view, is the consolidation of medical debt collectors under private equity ownership likely to be in consumers' best interests?

Ms. STEWART. Senator, as you noted the objective of private equity is, generally speaking, to make big profit and to attract investors. In the world of health care delivery, private equity has usually meant rising health care costs, particularly for people. So if past practice is a predictor of the future, it is highly unlikely that private equity consolidating medical collection practices is going to be a good thing for people.

Senator WARREN. Thank you. You know, medical debt is one of the biggest threats to families' financial security, and I am glad that the CFPB has taken steps to reduce this risk, including by pressuring the big three credit reporting agencies to clear up to 70 percent of medical debt from credit reports. This is going to boost scores for millions of Americans.

But we also need to crack down on the role that Wall Street private equity firms are playing in the medical debt crisis, whether that is providing care, billing, or debt collection. My Stop Wall Street Looting Act would better align incentives between private equity and the companies they take over in order to protect patients and their lives, financial and otherwise, and make sure that they are not ruined by corporate greed.

So I think this is an area we need to work on.

Thank you, Mr. Chairman.

Chairman BROWN. Thank you, Senator Warren.

Senator Tillis, from North Carolina, is recognized.

Senator TILLIS. Thank you, Mr. Chairman. Thanks to all the witnesses for being here.

I know there are some people that think the CFPB wading into this space makes sense. I am not one of them. I think we have seen their expansion of influence through the hostile takeover of the FDIC by the director. Now we see them wanting to move into the health care space. And I do think it is a problem we need to address. I just do not necessarily think that is the purview of this Committee to deal with it. If you listen to Senator Warnock, virtually every solution he had to this problem dealt with Committee subject matter outside of our jurisdiction.

Dr. Ippolito and Professor Hyman, Senator Toomey mentioned a few statistics. I just want to make sure that I am right and see if there are any other indicators we should be following. A little bit less than 1 percent medical debt is in collections. Is that right?

Mr. IPPOLITO. I am not sure what percent of medical debt in total.

Senator TILLIS. Yes. I think it is somewhere around 0.93 percent of all household debt, and only about 8 percent of that ultimately gets collected.

Now one number that I am curious about is that medical debt has reduced substantially, about 40 percent since 2009. You would logically think some of that tracks with the implementation of the Affordable Care Act and expansion of Medicaid. Are there any

other things that would have potentially contributed to the reduction in medical debt over that period of time?

Mr. IPPOLITO. Well, I mean, broadly speaking I am sure that the improved economy from about 2010 to now has to have improved part of what we are seeing there, and other outcomes on credit reports.

Senator TILLIS. Professor Hyman, when you were talking about if this credit reporting is no longer taken into account as a predictive indicator, I think you said something to the effect that lenders would somehow have to respond to that risk. What would that look like? Give me some examples of unintended consequences.

Mr. HYMAN. So, look, it is hard to make predictions, especially about the future, to quote Yogi Berra, or maybe it was Mark Twain. But in any event, you know, as I indicated in my written testimony, I would expect some increase in credit scores to happen. But the question would be whether credit agencies would make adjustments, as Dr. Ippolito indicated.

Senator TILLIS. Setting the bar for what may or may not be a good, or——

Mr. HYMAN. Exactly. Basically either modifying the formula to come up with numbers that actually match more closely the ability to repay, or moving the bar for what counted as a good risk versus a bad risk.

With my health care hat on, though, I would point out that there are potential follow-on consequences within the health care system, so health care providers may become less willing to take patients that are unable to pay in full at the time of service. And I would also expect, as I indicated in my written testimony, some increased consolidation, because larger providers are better able to weather this storm than a smaller, individual practice might be.

Senator TILLIS. What other significant potential unintended consequences can come from addressing the symptom versus some of the underlying problems that you mentioned in your opening testimony?

Mr. HYMAN. Oh, yes, I apologize for not addressing that. The other problem, of course, is this is a feedback loop indicating the problems with the American health care system, and it is no different than turning off the fire alarm. The fire is still going. You just no longer have the same evidence of the underlying problem, and you may not feel the same urgency to put the fire out.

Senator TILLIS. Ms. Haynes, I was more curious than anything. You mentioned that the Black and Hispanic communities are disproportionately hit by this. I think you also mentioned there are two times, or they are likely to be contacted twice as many times as a White person who may be in medical debt.

Have you looked at it along socioeconomic lines? Is there much disparity, for example, between a Black, Hispanic, and White poor family? So, do you understand the question?

Ms. HAYNES. Yes. That is actually a really good question. But the data shows that in ZIP Codes that are predominantly Black, no matter income, they are more likely to be contacted by debt collectors than White ZIP Codes and non-Black ZIP Codes. So actually the data does show that across incomes, Black folks are still more likely to be contacted by debt collectors.

Senator TILLIS. OK. Thank you. Thank you, Mr. Chair.

Chairman BROWN. Thank you, Senator Tillis.

I will ask my questions now, starting with Ms. King. In May 2020, you first received your alarmingly high bill—I know you have said some of this in your testimony—of \$69,000 from the nursing home that cared for your mother. In October 2020, shortly after her passing, the nursing home sued you for close to \$80,000.

What impact did this enormous amount of medical debt have on your life? Did you imagine you would ever be free of this?

Ms. KING. In that amount I could not. It was just really more than I could take in at that time. I was grieving. You know, my mom had just passed, and I was just trying to figure it all out, like how could they do this? I said I would not be responsible, and how am I getting sued.

So I had no idea how I would handle that, how I would take care of paying that amount, and what were they going to do to me. So no, I had no idea. It was unbelievable. I felt terrible, and it was tough. It was ridiculously tough.

Chairman BROWN. And fortunately you found legal services and they found you?

Ms. KING. I found legal services and they helped me.

Chairman BROWN. And Cleveland has a particularly good legal services, Legal Aid Society.

Ms. KING. Very much so. They are amazing.

Chairman BROWN. Thank you.

Ms. Stewart, as we pointed out, medical debt does not mean someone is a credit risk. It means they got sick. Accidents and sickness, as all five of our witnesses pointed out, can happen to anyone at any time, yet people with medical debt are harassed and often made to feel like a burden to society. Obviously, medical debt is not the fault of the person who gets sick.

My question is this. Would you say that our financial system treats medical debt like a moral failing?

Ms. STEWART. Yes, I would say that our financial system treats it as an individual moral failing, when it really is a failing of the financial system and the health system taken together. As we discussed during this hearing so far, the health care system is not regulated in terms of health care costs, and people are bearing the brunt of rising costs, being forced to pay higher deductibles, higher co-insurance.

And the financial system, in terms of billing and collection around medical debt does not take any of that into account, which is why we are really grateful at Community Catalyst that you are holding hearings like this to have conversations about systemic reforms that need to take place, both in the financial systems sector as well as the health systems sector.

Chairman BROWN. Thank you, Ms. Stewart.

My last question, Ms. Haynes. Under pressure, as you know, Equifax, TransUnion, and Experian just took an important step to wipe 70 percent of medical debt off credit reports. These changes will help the financial lives of millions of consumers. However, that means 30 percent is left, obviously. You have said in the past that medical debt is not predictive of credit risk. So since medical debt is not a good indicator of credit risk, should medical debt even be

part of a credit report? Should all medical debt be prohibited from being reported?

Ms. HAYNES. Yes. As I suggested in my recommendations in my testimony, ideally we should end the practice of turning over any debt to debt collectors, considering how involuntary and unpredictable debt from medical emergencies tends to be.

And I should also add that the credit bureaus and the change that they made, while it is wonderful, there are a couple of categories of medical debt that is going to be removed from credit reports. A lot will still remain on people's credit reports. So debts of less than \$500, for instance, will be removed, debt that has been paid off. And that will help 15 percent of Americans. But if you look at the stats from the Urban Institute, the average medical debt Americans have in collections is \$797-\$854 for non-White communities. So those individuals will still be left on the hook and still see those debts in their credit histories.

Chairman BROWN. Thank you. With these changes in how medical debt is reported I think it is worth considering what next potential steps the CFPB and others might take to further lighten the medical debt burden.

Senator Ossoff, from Georgia, is recognized from his office.

Senator OSSOFF. I would like to extend a particular warm welcome to you, Ms. Haynes. Thank you for joining us and representing the State of Georgia.

I would like to begin with you as well and ask you, Ms. Haynes, based upon your knowledge—and then I am going to turn to Professor Hyman with the same question—how does the American experience of incurring massive debt because of a medical emergency, because you or a family member needs a medical procedure, how does that compare with the experience of folks in other wealthy countries around the world?

Ms. HAYNES. Well, as I noted in my testimony, in terms of the recommendations, enacting a publicly funded, universal, national single-payer plan, administrated at the State and local levels, would go a long way toward remedying this problem. In various countries outside of the United States they do have some version of a public option, a public-payer system. So I will not speak to that in any more detail because I would have to get back to you about how that would actually look.

But medical debt in this country is a uniquely American problem, and we need to address it as it stands currently.

Senator OSSOFF. Professor Hyman, in the course of your research, whether or not you have undertaken a formal comparative analysis with other countries, nevertheless, what is your impression, your reaction to the same question, how the American experience of medical debt contrasts with the experience of folks in other OECD or industrialized, advanced countries?

Mr. HYMAN. So thank you, Senator, for the question. That has not been the primary focus of my research, but my sense, based on having done this for quite a while, is that the United States is an outlier, to say the least, relative to other countries, in the cost of its health care system, which has predictable consequences for medical debt.

Other countries vary in their delivery systems as well as their financing, but the United States is, nonetheless, an outlier.

Senator OSSOFF. Thank you. Ms. Haynes, I spoke with a fellow Georgian named Felicia from Hogansville, who took care of her father after he recently suffered a stroke. The family faced steep medical bills. The impact of that debt has lowered her credit score and imposed a huge burden on the family. As a result, she was unable to take out a loan that was necessary for some home repairs. This is, of course, not an uncommon story.

Ms. Haynes, folks do not choose to incur medical expenses, for the most part. Correct?

Ms. HAYNES. That is correct. Medical debt tends to be very unpredictable and involuntary. It usually forces people to drive up their credit on credit cards, taking out personal loans. Medical debt really can throw people into a real financial tailspin.

Senator OSSOFF. And as a fellow Georgian, Ms. Haynes, you are well familiar with the ongoing saga of the State of Georgia's refusal to expand Medicaid under the Affordable Care Act, one of just 12 States that has made that decision. Eighty percent of medical debt is held by households with zero or negative net worth.

How could Medicaid expansion in the State of Georgia, which Senator Reverend Warnock and I have fought for, we delivered resources to make it an even better deal for the State of Georgia. Georgians are already paying Federal taxes at the same level as folks in other States but not getting this investment in public health, forcing low-income and middle-income Georgians into the emergency room instead of into preventative health care.

Ms. Haynes, in your opinion, what would be the impact of Medicaid expansion in Georgia on the burden of medical debt that is faced by so many of our fellow Georgians?

Ms. HAYNES. Yes. Thank you very much for that question. Georgia, as you know, has one of the highest uninsured rates in the country. It disparately impacts Black and Latinx families in Georgia. Expanding Medicaid would not only help in terms of the rural hospital closures that we have seen in Georgia that are directly connected to the lack of Medicaid expansion, but it would also help reduce the medical debt crisis that is facing many Black and Latinx Georgian families, by making sure that they are not lost within the coverage gap.

Senator OSSOFF. Thank you, Ms. Haynes.

Ms. Stewart, as has been discussed, Equifax, Experian, and TransUnion recently announced changes to the way that they score medical debt, and as I understand it now, medical collection debt under \$500 will not appear on consumer credit reports.

The average amount of medical debt, according to my staff's research, is approximately \$2,400, for those who are carrying it. So Ms. Stewart, how will the credit reporting agencies' announcement of this policy change impact individuals who have more than \$500 of medical debt?

Ms. STEWART. Thank you, Senator. Well, for people who have debt more than \$500 they will have an extra year to resolve the debt, so that is the good news of the policy. But beyond that, people with debt over \$500, it would not be removed from their credit

report, and that is something that we would encourage CFPB to pursue and explore.

Senator OSSOFF. Thank you all for your well-informed and concise questions, and Mr. Chairman, thank you for holding this hearing.

I will just close with this note. You know, it is a travesty that millions of Americans suffer not just from illness that they are unable to treat or prevent in the way that most of us would want and expect because they cannot get health insurance, but then the burden of debt, at these moments of stress and crisis for their families. We have widespread medical debt in this country. We have children with school lunch debt in this country. We have to stop burdening working people across the United States with debt for the necessities of life like food and health care. And I thank you, Mr. Chairman, for convening this hearing to shine a light on this issue.

Chairman BROWN. Thank you, Senator Ossoff.

Senator Cortez Masto, from Nevada, is recognized.

Senator CORTEZ MASTO. Thank you, Mr. Chairman. Thank you for holding this important hearing. And thank you to the panelists for joining us this morning.

One issue I want to raise here is the issue of medical debt in Indian Country. For generations the Federal Government has had a trust and treaty responsibility to provide care to sovereign Tribal nations, but the volume of medical debt across Tribal communities is evidence that we have fallen well short of meeting those obligations.

In 2019, the *New York Times* report found that Indian Health Services declined to pay medical bills for more than 500,000 patients, saddling them with more than \$2 billion in medical debt over the preceding 3 years.

Ms. Stewart and Ms. Haynes, how will these changes in reporting affect Native Americans? And I will start with Ms. Haynes.

Ms. HAYNES. Unfortunately I cannot speak to that particular issue, but if we are talking about federally held debt you may be aware of some of the changes related to federally held medical debt recently, that may go a long way toward helping consumers avoid some of that, the credit downfall of medical debt.

Senator CORTEZ MASTO. Thank you. Ms. Stewart.

Ms. STEWART. I would agree with Ms. Haynes. And just to highlight that one of the big issues with respect to medical debt and its impact on Native Americans is a lack of data, and that is something that Community Catalyst is really focused on making sure that there is more investment and disaggregated data so that there is much more clarity about the impact on Native American populations.

Senator CORTEZ MASTO. Thank you, because I sit on the Senate Indian Affairs Committee, and this is one area, and you just touched on it, is the lack of data. And because of the lack of data we are missing out on important services to our communities, including our Tribal communities across the country. And we really have to start focusing on those that are being left behind.

So let me jump to another area, which is the lack of communication I find here in some of this, and important information that needs to get out there that is not, at times.

In the recent CFPB report, it was illuminating because it said that 50 percent of Black respondents in a survey did not know that hospitals provide free and reduced-cost care for low-income patients. Now do we know what the level of awareness of these programs is among Spanish-speaking and other non-English-speaking communities? I mean, this is a travesty.

Let me just stop there and ask maybe Ms. King or Ms. Stewart or Ms. Haynes. I am concerned that the information is not getting out there. And we have a report here showing that members of our Black community are not getting it. What about those that have a language barrier? How do we ensure that they are getting access to this information that is going to be important for their health?

Ms. STEWART. I will start, Senator. Well first of all there are no requirements that hospitals, including nonprofit hospitals, that are, in fact, 501(c)(3) nonprofit organizations, proactively screen people for financial assistance programs (FAPs). There are responsibilities to make information publicly available, but for many, many people they report that they had no awareness that they were eligible for financial assistance.

For people for whom English is not their primary language and need language assistance that is really a very critical issue. And you can imagine how that issue is expounded when somebody has a language barrier. So it is deeply concerning overall, and especially concerning for people who face language barriers.

Senator CORTEZ MASTO. And what should we be doing about it? What can Congress do about this, to make sure this information gets out there?

Ms. STEWART. Well, there could be changes to the nonprofit community benefit standards to require nonprofit hospitals to proactively screen people for FAPs prior to billing them. In addition, there could be financial support for consumer assistance programs and other community-based organizations who could be available with resources to offer that kind of assistance to people.

Senator CORTEZ MASTO. Thank you. Yes, please.

Mr. HYMAN. Yes, I would just add that the Affordable Care Act included requirements for nonprofit community hospitals to develop a plan and report on the plan, but it did not include parallel requirements to disclose to patients, along with all the other things that they do disclose to patients, "Hey, we have a charity care program and here are the details on how you should apply for it."

So you could do that either with legislation or regulation, it seems to me, as a condition of participation.

Senator CORTEZ MASTO. Thank you. Yes, Ms. Haynes.

Ms. HAYNES. And I just wanted to add those great comments as well, that in addition to improving the FAP so that folks are required to screen patients before collecting, there is no right of action that patients have currently under the Affordable Care Act to enforce the FAP requirements. So allowing patients to actually enforce State and Federal FAP laws in court, to hold violating hospitals liable, would also go a long way toward improving this charity care.

Senator CORTEZ MASTO. Thank you. Thank you, Mr. Chairman. Chairman BROWN. Thank you, Senator Cortez Masto.

We will wrap the hearing up. Thank you to the five of you for being here.

As Senator Toomey's charts pointed out, the Affordable Care Act, especially its Medicaid expansion, not only improved the health of Americans, but it has also improved their financial health as well. Thanks to the ACA, States that expanded Medicaid programs—we know Georgia is an exception—but States that expanded Medicaid programs saw medical debt fall by 44 percent. Think of that, almost in half.

I would add, parenthetically, I know Senator Cortez Masto cares so much about this that the implementation of the child tax credit also dropped the poverty rate by about that number, 40 percent, for America's children.

The ACA Medicaid expansion helped reduce medical debt. Much more needs to be done. I look forward to working with colleagues in Congress and at the CFPB to reduce medical debt, including by creating a medical debt ombudsman. Americans should be able to focus on their health, not worry about their financial health, in, as Ms. King pointed out so well, those particularly difficult times.

To highlight the need for congressional action I will submit for the record three testimonials, from Mindy Hedges of Ohio, from Penelope Wingard of Senator Tillis' State, from Sloane Wesloh from Senator Toomey's State. Without objection, so ordered.

Chairman BROWN. Thanks to the witnesses. For Senators who wish to submit questions, these questions are due 1 week from today, on Tuesday, April 5th. To the witnesses, to the five of you, if you get questions submitted, please submit your responses for the record within 45 days from the day you receive them.

The hearing is adjourned.

[Whereupon, at 11:19 a.m., the hearing was adjourned.]

[Prepared statements, responses to written questions, and additional material supplied for the record follow:]

PREPARED STATEMENT OF CHAIRMAN SHERROD BROWN

Think about watching a loved one rushed to the hospital in an ambulance. Or learning you have a chronic disease that's going to require years of care and monitoring. These kinds of medical ordeals are some of the scariest moments in a family's life.

They can happen at any time, to anyone, without warning. Suddenly you're coordinating doctor's visits and calls with insurance companies. You're nervously checking your savings account. You're spending hours on interminable phone calls trying to get answers.

And you're dealing with it all while worrying whether your husband or your mother or your child will make it out of the hospital, or whether their health problems will continue.

As the cost of prescription drugs rise, hospital bills skyrocket, and debt collectors start calling, families are forced to figure out how to make ends meet, instead of focusing on their health.

Families all over the country are telling us that.

We heard from Penelope Wingard, an after-school teacher from North Carolina, who lost her health coverage while battling breast cancer. When her medical bills began to pile up, her doctors eventually stopped seeing her.

Soon after, Ms. Wingard had an aneurysm, in addition to vision loss, both of which required surgery. Because of the financial situation caused by her cancer diagnosis, Ms. Wingard was forced to wait and seek care from a limited list of providers who allow sliding scale payments.

Debt collectors call her—harass her—every single day. And now her credit is ruined because of her health.

Right now, Ms. Wingard needs additional testing to ensure her cancer has not returned, which has added an additional \$2,000 to her debt. Instead of focusing on battling her illness, she has to figure out how to battle the debt collectors.

And Ms. Wingard is far from alone.

In the United States, an estimated 43 million Americans hold \$88 billion dollars of medical debt on their credit reports, and this problem is growing. It can happen to anyone. Low-income families, Black and Hispanic households, veterans, young adults, and older Americans are hit particularly hard.

And debt collectors make this already exhausting experience worse.

They call over and over, they make threats, they even contact patients' employers.

Take for example, Mindy Hedges, from Delaware County, Ohio. She has had type 1 diabetes since she was 5-years old.

For most of her adult life, until the passage of the Affordable Care Act, she was unable to get health insurance because she had a preexisting condition.

After losing her business in the 2008 recession, her medical bills began piling up, and she was unable to re-pay them. That's when the debt collectors started calling. And calling. And calling. And calling.

Ms. Hedges did her best—she tried to negotiate, she even begged for relief. But the harassment continued. At one point, she was even afraid to leave her house.

That harassment is part of the business model.

A counsel at a medical debt collection agency owned by a private equity firm had some choice words about harassing patients—they said they found the first 20 to 30 calls to be, quote, "highly effective."

If the calls don't work, debt collectors often move on to even more aggressive tactics like litigation—forcing people to go through lengthy, expensive, and emotionally draining court proceedings, often while still battling cancer or grieving a loved one.

For patients, litigation can result in garnished wages or property liens. We even see people thrown in jail because they couldn't afford to pay. It's the return of debtor's jail. People in the United States of America today are in jail, right now, because of medical debt.

And of course, wherever we find suffering, Wall Street finds an opportunity.

Private equity firms are making inroads in the medical debt collection market. Between 2015 and 2016, one-third of all debt collection agency acquisitions were bought by private equity.

These firms exist purely to maximize investor profit, no matter the cost.

Maybe that's why private equity-owned debt collection agencies are responsible for an outsized number of consumer complaints—many concerning attempts to collect debt from people who do not owe them.

We must address the growing crisis of medical debt burdening American families.

President Biden and his Administration are working to remove barriers to medical debt forgiveness for veterans, and to make it easier and cheaper for them to get care.

No one who served this country should be saddled with debt for illness or injuries incurred in the line of duty.

And the Biden administration has wasted no time in implementing the No Surprises Act, which took effect on January 1st.

This bipartisan law finally bans surprise medical bills. One way to prevent debt collector harassment is to protect people from debt in the first place.

The Consumer Financial Protection Bureau is also doing important work exposing the abuses Americans face while just trying to get health care.

And after increasing scrutiny and pressure, the three credit reporting bureaus—Equifax, Experian, and TransUnion—all announced they would significantly change how medical collection debt is reported. These changes are expected to remove nearly 70 percent of medical debt in collections from credit reports. This is a positive first step.

And this first step by the credit reporting bureaus gets to a basic fact that we too often ignore: medical debt does not correlate with credit risk, it correlates with illness.

It should be obvious—anyone can get sick. Anyone can get in a car accident. It has nothing to do with your ability to pay your bills—or it shouldn't.

No one should be forced into poverty or harassed by shady debt collectors because of a medical emergency, or a sick family member.

We've taken important steps to protect Americans. But can we do more.

I'm asking the CFPB to create an ombudsman position for consumer medical debt. It's also why expanding Medicaid coverage to those who live in the 12 States that have refused to expand Medicaid under the Affordable Care Act is long overdue. I'm appreciative of two Members of this Committee, Sen. Warnock and Sen. Ossoff, who are working to finally get this done.

Of course, meeting these challenges cannot be done by the Government alone.

Private industry must act. This country needs private institutions to meet their obligations of financial assistance and the No Surprise Act.

Today we're hearing from two advocates for consumers, as well as one of my constituents, Robyn King, from Cleveland. Ms. King will tell her story of battling medical debt she never owed, after a nursing home cared for her mother.

I look forward to hearing more about how we can protect Americans from medical debt and debt collector harassment. No one should have their financial future ruined because they get sick.

PREPARED STATEMENT OF SENATOR PATRICK J. TOOMEY

Thank you, Mr. Chairman.

Pricing risk accurately is critical to the safety and soundness of financial institutions, and to consumers' ability to access affordable credit. Because when borrowers default, lenders have to absorb the costs. That's why lenders generally look at information about credit history—it helps them estimate the risk of default and price loans.

Lenders who cannot access information that they consider predictive of risk are likely to restrict their lending to the borrowers with the thickest credit files, seek out relevant proxies for the credit information they aren't able to obtain, or increase the price of loans to all borrowers in order to capture the uncertainty and risk.

This hurts all consumers, including low-income families and those without a long credit history. For all of those reasons, the Government should not suppress the reporting of accurate credit information.

Unfortunately, so-called consumer groups and allies have sought to remove info from credit reports and thereby make them less accurate. I'm afraid such actions will have unintended consequences.

Today's hearing title is the "Growing Burden of Medical Debt". It's an interesting but inaccurate title. Evidence suggests medical debt is actually falling, not growing.

According to the CFPB's own estimate, medical debt in collections last year was \$88 billion. That's a nominal reduction of 10 percent over the last 3.5 years.

Another study showed that average medical debt in collection fell by 40 percent in the last decade. Yet over the same period, medical spending increased 70 percent—over 50 percent per capita.

Now, there are likely many reasons for a decline in medical debt. A primary driver was the improving economy. After tax reform in 2017, those with the lowest wages—those most likely to have medical debt—were making the biggest gains in income.

Another driver of the decline was the enactment of Obamacare and Medicaid expansion. Researchers estimate that for every \$25 spent on Medicaid expansion, medical debt in collections decreased \$1.

There are many aspects that have made me question the wisdom and efficacy of Medicaid expansion, including its cost and the lack of evidence that it improved health outcomes. But, unsurprisingly, if you're willing to spend massive amounts of other people's money, you can transfer individuals' debts onto the taxpayers.

So all available evidence suggests there is no "growing" burden of medical debt. In fact, the scale of medical debt is often misunderstood. Debt in collections represents less than 1 percent of all household debt. Two-thirds of medical debt collections are under \$500. Bankruptcy from medical debt is extremely rare.

And medical debt is not strictly an American phenomenon. Every health care system in the developed world includes out-of-pocket payments.

According to the WHO, even before Medicaid expansion, the likelihood that out-of-pocket expenses would exceed a quarter of one's income was roughly as rare in the United States (0.8 percent) as Canada or the United Kingdom (0.5 percent), and rarer than in Italy (1.1 percent), Spain (1.8 percent), Korea (3.9 percent), or Switzerland (6.7 percent).

Recently, credit reporting agencies announced changes that will reduce the amount of medical debt that appears on consumer credit reports going forward.

Now, if a credit reporting agency decides to exclude this information, I don't think it's the Government's role to meddle with such a decision. However, if credit reporting agencies had collectively decided the opposite—that every one of them would begin at the same time to add consumers' medical debt info onto reports—I suspect the howls and protests about greed and collusion from the usual suspects would have been deafening.

What appears to have occurred here was that a political campaign, which included the CFPB, bullied lenders and credit-rating agencies into removing this information. This kind of misuse of power by the administrative state has grown all too common. And it's an example of how Congress has become far too comfortable with the Executive branch seizing the Article I lawmaking authority.

We need to be very careful that any actions considered to address symptoms—in this case debt from a health condition—don't make matters worse. This new credit reporting agency policy doesn't actually lower the cost of medical care. In fact, it will either raise costs or reduce access.

It may end up discouraging people from paying medical bills. That could lead to health care providers finding ways not to treat individuals without an obvious means to pay. And by eliminating one metric in a credit rating, it may cause credit rating agencies to use other metrics that are less accurate, which could actually hurt low-income populations more.

These kind of downstream effects wouldn't be shocking given that the entire effort to micromanage credit ratings is coming from an agency that has no expertise on complex medical billing and health care systems.

It should remind us that intervention into the market—no matter how noble advocates may think they are being—will have consequences. And interventions should come after careful deliberation by the people's representatives, not diktats from unelected bureaucrats.

PREPARED STATEMENT OF ROBYN M. KING

OF OHIO

MARCH 29, 2022

Good morning. It is an honor to be here today, and it is a privilege to be able to share my story with you, Members of the U.S. Senate Committee on Banking, Housing, and Urban Affairs.

I am here to speak about my experience with medical debt. It's something that affects thousands and thousands of people in this country every year, and I know firsthand that the consequences of these burdens can be debilitating. I was lucky enough to get professional legal help from the attorneys at Legal Aid in Cleveland, but many people are not so lucky. For them, and for others who have yet to be victimized, I share my story.

I am a mother with three children, my youngest still in high school. I worked as a teacher's assistant for 10 years, and recently transitioned to working part-time at a Learning Center. I still volunteer with children and older adults in my spare time. I'm also the youngest of six siblings who all cared deeply about our Mom.

If you've ever brought a parent or loved one to a nursing home, knowing they will live out their final days there, knowing you are trusting all of their care and comfort to strangers—that's a day you will never forget. I clearly remember walking into Jennings Nursing home, with the support of my five siblings, wondering if my mother, who had Alzheimer's, could grasp what was really going on. The group of us decided I would be Mom's representative for the nursing home admission agreement and sign all of the paperwork that allowed my Mom to be admitted into the facility.

My Mom's Social Security checks were used to pay for her portion of the nursing home bill, and Medicaid covered the rest. Knowing that my finances were already tight, I made sure to check the box on the nursing home admission form which said I did NOT agree to be personally liable if finances for my Mom's medical care ran out. I have a household of my own to take care of and knew that I couldn't afford to have the nursing home come after me for my Mom's medical care.

In November 2019, nursing home staff told me Mom's Medicaid needed to be reinstated, so I went to the office and filled out some more forms. I didn't hear anything from them about Medicaid for months, so I assumed everything had been taken care of.

When COVID hit and the world shut down, I was especially worried about how lonely Mom must be as there was no way for my siblings and me to continue visiting her as often as we normally did. But it was a shock when the nursing home told me in May 2020 that Mom's Medicaid actually hadn't been reapproved many months earlier and that I was suddenly on the hook for paying a huge bill.

They said, well, too bad, she is going to have to leave here and go somewhere else. But where else could she go, especially in the middle of the pandemic? Why hadn't they told me this months ago? How could they have kept this information from me, when I always did everything they asked me to do?

But because the nursing home took so many months to tell me that Medicaid had stopped paying my Mom's bills, the amount she owed had grown huge—the nursing home was trying to collect almost \$70,000 when I first learned of this issue. And while I tried frantically to fix the situation, the nursing home started chasing after me, sending bills each month in escalating amounts.

My Mom passed away on October 3, 2020. It was just two days before that, on October 1st, that I had received mail which said that I was personally being sued by the nursing home for close to \$80,000.

I never had time to grieve. I kept so much inside; the stress was unbearable. I thought, I won't be able to afford my mortgage—I am definitely going to lose my house. I could face a garnishment of my paycheck and be forced to live on a reduced income when money was already tight to begin with. What will I tell my kids? What does it mean, to have this kind of judgment against you, how will that impact the rest of my life? At one point I even thought—I'd rather be with my mother. I felt defeated. I had nothing left to give.

The lawsuit made no sense to me since I told the nursing home that I would not be personally responsible for any of Mom's medical expenses. On my sister's advice, we called Legal Aid—and it was just in time. I am incredibly grateful for my attorneys' help because they knew exactly what to do, they walked with me every step of the way, and they helped free me from the responsibility to pay the nursing home debt with my own money.

The nursing home is still pursuing my Mom's estate for what is owed. So—it's still impacting my life. While I'm not personally on the hook for the debt, they're still going after my family's assets.

As I stand here today, I cannot tell you how relieved I am to know I can keep my home, keep providing for my kids, keep my life as it is. There is no reason I should go into massive debt so that my mother could live out her final months in a safe and comfortable place, with her basic needs met. There is no reason my family's ability to build a better future for ourselves should be wiped out because my Mom got sick and we got her the medical care that she needed. There is just no excuse for this in America.

I want my story to shed light on what's happening to normal, everyday people in this country who are just trying to care for themselves and one another.

I hope you can take action to protect people like me and not allow medical debt to upend people's lives. Medical care, and end-of-life care especially, is not something we can opt out of. Getting sick or having a family member get sick should not force people to face crushing amounts of debt. I thought that I had done everything right in taking care of my Mom, but without the good fortune of having Legal Aid represent me, I would have had an enormous judgment against me, and my family's financial future would have been devastated. There must be a better way to take care of each other and not leave people like me facing life-changing amounts of debt.

I do still believe in the positive potential of every day, and I hope that today, you can help me turn my story into something positive. Thank you.

PREPARED STATEMENT OF EMILY STEWART

EXECUTIVE DIRECTOR, COMMUNITY CATALYST

MARCH 29, 2022

Good morning, Chairman Brown, Ranking Member Toomey, and Members of the Committee. Thank you for the opportunity to speak on the important issue of medical debt this morning.

My name is Emily Stewart, I am the executive director of Community Catalyst, a national nonprofit organization with a mission to build the power of people to create a health system rooted in race equity and health justice and a society where health is a right for all.

While great progress has been made in expanding access to coverage and care since passage of the Affordable Care Act, more must be done to expand comprehensive coverage and make care affordable. Thirty million Americans remain uninsured¹ and many insured individuals face high deductibles and copayments if illness or injury strikes. When a person's medical bills exceed what they can pay, they are saddled with medical debt. There are many sources of medical debt, with the largest share arising from emergency room visits, hospitalizations, dental care, and diagnostic tests like x rays and MRIs.²

U.S. Census Bureau data estimate that 17 percent of U.S. households held at least \$195 billion in medical debt in 2019.³

Who has medical debt? To start, the uninsured. More than one-third of people with no insurance have medical debt. Many of them are living in States that have not expanded Medicaid. People in these States also have a greater number of accounts being sent to collection when compared to residents of Medicaid expansion States.⁴

Additionally, 22 percent of insured people have outstanding medical bills.⁵ This means just about anyone is at risk of incurring medical debt, especially as insurance deductibles, copayments and coinsurance increase year after year.

Some people are at greater risk. As a result of discriminatory barriers to affordable coverage and care, there is a disproportionate effect on people of color, with nearly 27 percent of Black households and just under 19 percent of Latinx families having medical debt.⁶ In addition, households with income of less than 133 percent of the Federal poverty level are more likely to have problems paying medical bills. Families in households with children are far more likely to have medical debt than those with no children in the household. Families in which a member has a disability are nearly twice as likely to have medical debt as those families in which no family member has a disability.⁷

Medical debt problems result from inadequate insurance, complicated insurance claim procedures and opaque billing and collection systems. People with medical debt often are forced to exhaust their savings to pay for medical bills, and consequently reduce their spending on food, clothing, and other household items, borrow money from friends or family members, or take on additional debts.⁸ Thirty-seven percent of people with medical debt or billing problems used up all their savings to pay their medical bills, 31 percent took on new credit card debt, and 11 percent took out a mortgage against their home or took out another type of loan to pay their medical bills.⁹

Many others saddled with high medical debt delay needed care to avoid incurring more bills.¹⁰ The implications of this problem were made obvious over the past 2 years, as we have encouraged people to seek testing and treatment for COVID-19. Living with outstanding medical bills also creates health problems, causing stress that can lead to poor physical and mental health.¹¹

How do people hold debt? We know that medical debt comes in various forms: money owed directly to hospitals and providers; bills owed providers that are being pursued by third-party collection agencies; payments for care that has been charged to credit cards; loans from companies that specialize in financing medical debt; and medical accounts that have been purchased by debt buyers. Unfortunately, we do not know precisely the amount of debt in these different categories.

Some medical debt is masked as credit card debt. Several studies have found that one-third of those with credit cards have ongoing credit card debt because of medical bills.^{12 13} Analysis of payment patterns conducted by the JPMorgan Chase Institute illustrates the lingering effects of medical debt. They found that younger families are more likely to take on revolving credit card debt and older adults have elevated

levels of credit card debt one year after making a medical payment of \$1,500 or more.¹⁴

In recent years we have seen a growing number of financial service firms that partner with providers on loans or payment plans. There are medical credit cards, often with high interest rates.¹⁵ Other companies claim to partner with hospitals or providers to offer flexible low-interest patient loans.¹⁶ Some issue patients a health care payment card to be used at any time for health-related expenses.¹⁷

Who owns medical debt? Who holds the debt can make a huge difference in whether a person's medical bill problem is alleviated or aggravated. Many hospitals and providers offer extended payment plans, with no interest, directly to their patients. Nonprofit hospitals are obligated to provide charity care or financial assistance, but many people are unaware of these programs. The Washington State Office of the Attorney General recently filed lawsuits against two Washington hospitals alleging that employees were trained using scripts that gave patients the impression that they were expected to pay for their care, failing to notify them that they were eligible for financial assistance.¹⁸

There are many stories we could share; here are two from partner organizations:

This story is from our Illinois partners (Illinois Coalition for Immigrant and Refugee Rights, Mujeres Latinas en Accion, Southwest Suburban Immigrant Project, Mano a Mano Family Resource Center, Legal Council for Health Justice and Enlace Chicago)—A noncitizen patient with work authorization, became ill with COVID-19 complications, was rushed to the emergency room and billed \$11,798. The hospital denied the patient any financial assistance even though State law should have permitted the patient a full discount, and Federal assistance programs were in place for COVID-19-related services. The patient paid over \$1,000 out-of-pocket over a few months out of fear that the bill would impact his immigration status and ability to buy a home.

And this story is from our New Mexico partners (New Mexico Center on Law and Poverty, Casa de Salud and Forward Together)—A pregnant patient was told the cost to deliver a baby was \$10,000, but she was never informed of financial assistance or Medicaid options. Instead, she planned to sell her personal belongings until a family member got involved and helped her apply for Medicaid. She later received a bill for an ultrasound. A nurse told her it should be covered, but the unpaid bill showed up on a credit check three years later, which severely damaged her ability to buy a house.

For many people, the headaches begin when bills are sent to third-party collection agencies. These agencies are paid a percentage of the debt they collect. They typically report the accounts to the credit bureaus and, if not paid promptly, pursue legal action.

Private equity firms are also getting into the medical bill collection space. These companies are investing heavily in updating and scaling their collection services through technology. It is reported that there has been a surge in demand from hospitals for their services and that these companies are very profitable and attractive for investors.¹⁹ This will likely make it even more difficult for patients to negotiate reasonable payment plans directly with their local hospitals and providers.

Is the debt even owed? Medical debt can ruin an individual's credit rating. Research from the Consumer Financial Protection Bureau (CFPB) found that 58 percent of collection accounts on credit reports are medical bills. These accounts are reported by third-party collection agencies; they often lack accurate or updated information from the original health care provider. While the CFPB estimates that \$88 billion in medical collections sit on consumer credit reports, other estimates range from \$81 billion to \$140 billion.²⁰

Many medical collection amounts are fairly low-dollar value. Sadly, a high proportion of reported accounts are for disputed bills. Analysis of collection complaints submitted to the CFPB found that nearly two-thirds (63 percent) of complaints assert that either the debt was never owed, not verified as the consumer's debt, already paid, or discharged in bankruptcy.²¹ One complainant stated that "that agency had me served with court papers. for medical bills. They had already been paid in full by my insurance company." Another said the collector "garnished my husband's check for almost \$300 for bills we did NOT owe!"

CFPB research has found medical collections are less predictive of future consumer credit performance than nonmedical collections. This has been acknowledged by the credit scoring industry and has resulted in changes to some scoring models.

These revised scoring models either give less weight to medical collections or ignore paid collections when calculating scores. Given this, we welcome the CFPB's investigation of whether medical collections should be eliminated from credit reports altogether.

What are debt collection practices? Third-party collection agencies, acting on behalf of hospitals and other providers, often pursue lawsuits. Legal actions include garnishing wages, putting liens on patients' homes and bank accounts, and even issuing civil arrest warrants for people who do not comply with repayment terms.

Numerous press reports have detailed people having their wages garnished or bank accounts frozen.²² One report found that more than one-quarter of the top 100 hospitals, based on patient revenue, sued patients for medical bills between 2018 and 2020.²³ In New York State, 55 hospitals had sued over 4,000 patients since the pandemic began, including the State's largest health system, which sued more than 2,500 patients during this time period.

For-profit hospitals have also been aggressive in using lawsuits to collect from patients. Despite receiving \$700 millions of dollars in COVID-19 relief funds, one for-profit chain filed thousands of lawsuits against patients struggling to pay their bills. In the early days of the pandemic, they garnished the wages of one patient making roughly \$850 a month for a \$9,000 bill resulting from an emergency visit due to food poisoning that had occurred two years before.²⁴ Even publicly owned, governmental hospitals, took legal action, with one West Virginia hospital being responsible for close to 18,000 lawsuits.²⁵ Early on in the pandemic in 2020, one family was surprised that their debit card was declined while purchasing groceries. They later learned that their bank account was locked due to medical debt owed to a hospital.²⁶

It may be shocking to learn that people can even end up going to jail due to medical bills. Yes, medical debtor prison is a possibility. One Kansas family incurred \$70,000 in bills from their son's leukemia treatment and the mother's seizures related to Lyme disease. After the father missed a court appearance about these bills, and was unable pay bail set at \$500, he was sent to jail.²⁷ In an incident from another Kansas hospital, a women spent six hours in jail, paying a \$250 bond, which went toward the judgement obtained for her medical bills. A lawyer then warned that if the judge issued another warrant for her arrest, bond the next time would be set at \$500.²⁸ An Idaho woman, who was unaware that she owed \$950 from care received years before, only learned of it when deputies arrived at her door. "They handcuffed me and took me down to the jail to put me in booking." They held her briefly until reaching the collection attorney who worked out a \$20 per month payment plan, as the woman didn't make enough money for her wages to be garnished. She said it was the first time she had ever been to jail and that she was terrified.²⁹

Recommendations

1. Extend Medicaid coverage to protect residents of States that have not yet expanded Medicaid.
2. Strengthen nonprofit hospital Section 501r protections to prohibit wage garnishments and liens on primary residences, require more generous financial assistance and extend protections to include the services of any provider of care in a hospital or health system.
3. Extend Section 501r protections to for-profit hospitals and health systems.
4. Promote cross-agency collaboration to facilitate patients' access to insurance coverage and FAPs of health care providers.
5. Provide funding to State consumer assistance programs to assist people in identifying coverage and resolving medical debt problems.
6. Encourage the Department of Health and Human Services to:
 - a. Include a requirement in the No Surprises Act (NSA) final rule that providers must screen uninsured patients for public insurance programs and hospital financial assistance in addition to providing good faith estimate of the cost of services.
 - b. Monitor the NSA implementation to ensure that patients are not billed, nor coerced into paying amounts exceeding those allowed under this law.
7. Extend protections through funding COVID-19 testing and treatment for uninsured people.
8. Establish an ombudsman office within the Consumer Financial Protection Bureau to resolve complaints involving medical collections and credit reporting and require the office to issue annual reports.
9. Support the CFPB's actions to:

- a. Hold credit reporting companies accountable for having reasonable procedures in place to assure that medical debt information is accurate and taking action against furnishers who report inaccurate information.
- b. Conduct additional research on medical billing collection practices and their impact on patients and families.
- c. Determine whether policies should be implemented to eliminate unpaid medical billing data on credit reports altogether.

Thank you for the opportunity to testify and I welcome your questions.

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PREPARED STATEMENT OF BENEDIC N. IPPOLITO
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Medical Debt in the United States

Senate Committee on Banking, Housing, and Urban Affairs

Benedic Ippolito

March 29, 2022

Medical debts are unlike many other forms of debt. Individuals may not choose to incur them as they do with other financial obligations. Moreover, they reflect broader features of the U.S. health care system that attract justifiable criticism. Health care is expensive and insurance coverage incomplete. In the extreme, some segments of the health care market work particularly poorly and systematically generate unexpected balance bills that likely represent some of the most vexing medical debts.¹ Taken together, it is understandable that medical debts attract particular attention.

In my testimony, I will first summarize facts about medical debts in the United States, with particular attention paid to medical collections—one important type of medical debt which reflects health care bills that have been unpaid and sent to a collections agency. I will then outline the mechanisms through which these types of debts can affect individual personal finances more broadly. Finally, I will discuss the relative merits of policy proposals that would seek to reduce the influence of these debts, with an emphasis on recent developments in credit reporting. I will emphasize a few key points.

First, while some medical debts surely reflect unexpected health shocks, many likely do not. Medical collections average roughly \$300 and are most common among populations where health care utilization is relatively low (notably younger adults). These empirical realities are important for understanding the causes of debt and merits of potential interventions. In particular, they suggest that many medical debts likely reflect an interaction between the generally high cost of health care and relatively tenuous financial state of some consumers.

Second, medical debt on credit profiles can affect consumers' financial health by raising their cost of borrowing or by causing them to divert resources from other obligations. However, real world empirical evidence suggests that policies which starkly reduce medical debt have inconsistent effects on broader financial health. In part, this likely reflects the low repayment rates and persistence of medical debt on credit profiles and is helpful for forecasting the potential effects of policy interventions.

Finally, policymakers should note that efforts to reduce the influence of medical collections will incentivize lenders to adjust behavior in ways that may threaten the intended goals of a policy. I outline a few margins on which compensatory behavior is most likely and discuss their potential impacts on lending markets.

The state of medical debt in the United States

Medical debt is a common form of personal debt in the United States. Roughly 16-18 percent of credit reports include medical collections—bills from health care providers which have gone unpaid,

¹ Eg., Hyman, D., & Ippolito, B. N. (2019). Solving surprise medical billing. *AEI Economic Perspectives*.

sent to a collection agency, and reported to a national credit reporting agency—on which Americans owe roughly \$88 billion.² The total value of medical collections on credit profiles has, however, fallen over the last decade or so.³

In my testimony, I will place particular emphasis on medical debts in collections. This is a very important form of medical debt that can be clearly and objectively measured. It has also been the focus of considerable research and is the focus of recent policy changes by credit bureaus. However, medical collections are not an exhaustive measure of total medical debt. Consumers might, for example, finance a health care bill on their credit card and be unable to pay the resulting balance (this would instead manifest in other outcomes, like higher credit card utilization). Surveys which ascertain information about medical debts more broadly often indicate higher debt levels. For example, one recent survey indicated that consumers held at least \$195 billion in medical debt.⁴

Characterizing the relative importance of medical debts in household finances depends, in part, on the relevant context. On one hand, medical collections represent a small portion of aggregate household debt levels, which total over \$15 trillion (or \$4.5 trillion in non-mortgage debt).⁵ Medical collections, however, are common when compared to debts of similar types. Notably, medical collections represent a slight majority of all collection tradelines on consumer credit profiles.⁶

While these aggregate data are useful, understanding the composition of individual debts is important for clarifying the likely causes and consequences of medical debt.

In short, medical collections are likely more common and more modestly sized than many might imagine. In particular, while some collections can be in the thousands of dollars, the median individual medical collection averages just over \$300 (figure 1). Combined with the relatively large share of consumers who incur such collections, the data suggest that many medical debts in collections are incurred from relatively “typical” interactions with the health care system rather than rarer catastrophic events.

² While precise estimates vary across studies, results are broadly consistent. The CFPB (2022) estimates \$88 billion in collections. Batty, Gibbs, and Ippolito (2018) estimate that 16 percent of consumers had medical collections on their credit report, which totaled \$81 billion in 2016. Kluender, Mahoney, and Wong (2021) estimate a prevalence of 17.8% and a total value of \$140 billion (the larger dollar estimate largely owing to a bigger implied universe of credit accounts). Slightly earlier analysis from the CFPB indicated that 19.5 percent of consumer credit reports contained a medical collection. See Consumer Financial Protection Bureau. 2022. Medical Debt Burden in the United States. Batty, M., Gibbs, C., & Ippolito, B. (2018). Unlike medical spending, medical bills in collections decrease with patients' age. *Health affairs*, 37(8), 1257-1264. Kluender, R., Mahoney, N., Wong, F., & Yin, W. (2021). Medical Debt in the US, 2009-2020. *JAMA*, 326(3), 250-256. Consumer Financial Protection Bureau. 2014. Consumer credit reports: A study of medical and non-medical collections.

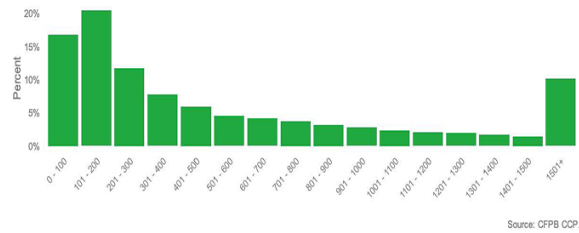
³ E.g., Kluender, R., Mahoney, N., Wong, F., & Yin, W. (2021).

⁴ Rae, M., Claxton, G., Amin, K., Wager, E., Ortaliza, J., and Cox, C. 2022. The burden of medical debt in the United States.

⁵ Federal Reserve Bank of New York. Quarterly report on household debt and credit 2021:Q3

⁶ CFPB (2022)

Figure 1: Distribution of medical collections balances in consumer credit panel, 2020.
Reproduced from CFPB (2022).

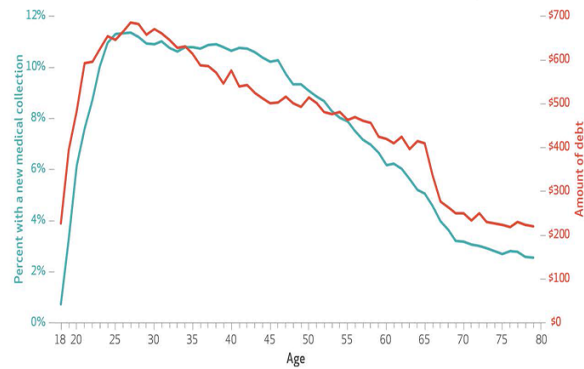


Distribution of medical collections balance amounts (in dollars) in the CFPB's Consumer Credit Panel as of 2020.

In addition, the distribution of medical debt is highly uneven across geography and individuals. Notably, the highest frequency of medical collections is found among relatively young adults (figure 2), where health care expenditures are lower but where other important factors, like assets, are as well. Heterogeneity in insurance coverage across people and places clearly plays a role in these trends but does not fully explain observed debt patterns.⁷

⁷ E.g., Goldsmith-Pinkham, P., Pinkovskiy, M., & Wallace, J. (2021). The Great Equalizer: Medicare and the Geography of Consumer Financial Strain. Working paper. Batty, M., Gibbs, C., & Ippolito, B. (2022). Health insurance, medical debt, and financial well-being. *Health Economics*.

Figure 2: Percent of consumers with any new medical collections and the median size of their debt, by age, 2016. Reproduced from Batty, Gibbs, and Ippolito (2018).



SOURCE Authors' analysis of data for 2016 from the Consumer Financial Protection Bureau's Consumer Credit Panel. **NOTE** Medical collections are defined as outstanding bills that have been reported to a nationwide credit reporting agency as a collection, with an original creditor classification code for medical or health care.

The role of medical debts in broader personal finances

The presence of medical debts, particularly when included on credit reports, can have important implications for consumers. Perhaps most directly, collections can enter negatively into credit scoring models. The appearance of a new medical collection can thereby reduce a consumer's credit score and affect their ability and cost of borrowing.

The credit consequences of medical debts are larger in settings where lenders employ older credit scoring models which typically give more weight to medical collections. Newer credit models treat medical debts less punitively in a few ways. Many newer models no longer include medical collections which were ultimately paid under the assumption that consumers who do so represent a lower credit risk than those who do not (this is a particularly sensible assumption if lenders believe some portion of these debts reflect individuals' confusion over appropriate payment of a health care bill).⁸ In addition, unpaid medical collections are often given less weight than in prior models. This is meant to reflect the fact that medical collections are less predictive of future credit risk than non-medical collections.⁹ The distinction between how medical collections are treated across credit models is likely to be particularly important to individuals with otherwise clean reports.

⁸ For empirical evidence in support of this see Brevoort, K. P., & Kambara, M. (2015). Are all collections equal? The case of medical debt. *Journal of Credit Risk*, 11(4).

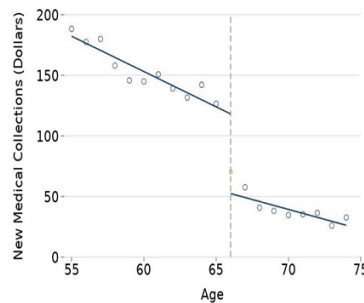
⁹ Brevoort and Kambara (2015).

However, many lenders do not use the latest credit models and may even employ their own. Indeed, FICO Score 8, which does not distinguish between medical and non-medical collections, is one of the most common models currently used.¹⁰ Thus, medical collections may still have a direct effect on credit scores for a substantial portion of consumers.

Recent empirical work has helped to clarify how medical debts in collections affect consumers' finances in real-world settings by studying natural experiments which have first-order effects on the prevalence of medical collections. These papers typically investigate settings in which populations experience stark changes in insurance coverage and ask how credit outcomes change afterwards.

For example, several studies have made use of the increase in insurance coverage owing to Medicare eligibility at age 65. These studies show that the drop in uninsurance causes a reduction in the amount of medical collections incurred by consumers.¹¹ For example, Batty, Gibbs, and Ippolito (2022) show that the mean dollar value of medical collections incurred per year falls by \$63, or 56 percent, following Medicare eligibility (figure 3).

Figure 3: Mean dollar value of medical collections, 2013. Reproduced from Batty, Gibbs, and Ippolito (2022)



Note: Mean dollar value of medical collections, 2013. RD estimate: $-\$63^{***}$. Figure and regression discontinuity estimate are generated from evaluating Equation (2) linear polynomial in age. We omit consumers who turn 66 in a year when calculating polynomials on either side, but we illustrate the age 66 value in our figures as a red circle. Data are from the CFPB CCP for 2013 (1,279,844 observations). $*p < 0.05$, $**p < 0.01$, $***p < 0.001$.

That said, credit data indicate little evidence that these reductions in medical collections trigger broad improvement in other financial outcomes measured on credit reports. Batty, Gibbs, and Ippolito (2022) finds that outcomes not directly tied to health care bills—like credit scores, credit card utilization, the dollar value of non-medical collections, rate at which consumers become more delinquent on debt, public records, or bankruptcy filings—hardly change around the age 65

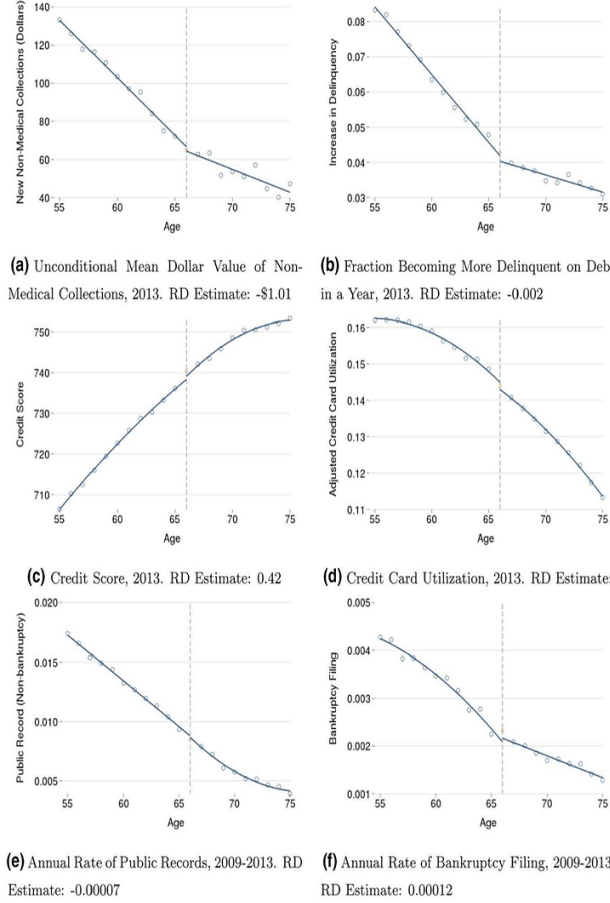
¹⁰ <https://www.ficoscore.com/education>

¹¹ Batty, M., Gibbs, C., & Ippolito, B. (2022). Health insurance, medical debt, and financial well-being. *Health Economics*. Goldsmith-Pinkham, P., Pinkovskiy, M., & Wallace, J. (2021). The Great Equalizer: Medicare and the Geography of Consumer Financial Strain. Working paper. Caswell, K. J., & Goddeeris, J. H. (2020). Does Medicare reduce medical debt? *American Journal of Health Economics*, 6(1), 72-103.

threshold (figure 4). These results were similar when looking at areas where one would expect the largest effect sizes (e.g., places where insurance coverage was low at baseline). In other words, the large reduction in the value of medical collections on credit reports does not seem to translate to general improvements in other credit outcomes on average.

These data provide important context for the empirical link between medical collections and other credit outcomes at the population level. Of course, they do not rule out the possibility that individuals or smaller groups of consumers benefit in these circumstances and they cannot speak to outcomes which are not included in credit data.

Figure 4: Non-medical collections outcomes, surrounding age 65 Medicare eligibility.
 Reproduced from Batty, Gibbs, and Ippolito (2022).



Note: This figure shows CFPB CCP outcomes on credit reports that are not directly related to medical care. Delinquencies are any increase in delinquency status conditional on at least 30 days of delinquency on installment or revolving credit accounts. Observations range from 1,182,390 to 5,948,142.

Evidence surrounding the enactment of the Affordable Care Act's (ACA) "under 26" provision reveals broadly similar results.¹² The most compelling real-world evidence that medical debt reductions can spurn broader personal financial improvements comes from Medicaid. Studies show a clear reduction in medical collections following Medicaid expansions¹³ and identify improvements to some outcomes like credit scores.¹⁴

The somewhat inconsistent link between medical collections and other credit outcomes likely reflects multiple factors. Importantly, the context of studies varies. Studies that focus on Medicaid, for example, may be more likely to find broader financial benefits because Medicaid comes with extremely low cost sharing (thus, should mechanically eliminate most bills) and targets those with particularly low incomes. Still, large-scale interventions like Medicare eligibility or the ACA's dependent coverage provision are very useful for understanding these relationships in very large swaths of the population.

Characteristics of medical collections themselves may also play an important role in understanding these results. Conditional on being sent to collections and reported on a credit report, medical bills are rarely repaid. Batty, Gibbs, and Ippolito (2022) show that only about eight percent of medical collections are ever reported as paid on a credit report (figure 5). This repayment rate is also consistent with medical collections representing a relatively low priority form of debt for consumers with competing obligations (a decision that is likely rational given constraints and is often recommended by consumer groups).¹⁵ Rather than remaining on credit records until they must be removed (after seven years) most stop being reported much earlier. The majority are no longer reported within seven months of first appearing on a credit record.

This low repayment rate and relatively short persistence mute one key channel through which reductions in medical collections could trigger broader improvements to personal finances. If consumers were diverting resources to pay these obligations, then their removal would directly free up money for other purposes. If they were relatively unlikely to do that, however, this channel is attenuated.

It is important to note that these data cannot speak to potentially important non-financial consequences of medical debt, including the costs associated with collections activity itself or if patients are reluctant to seek care out of concern for potential debts.

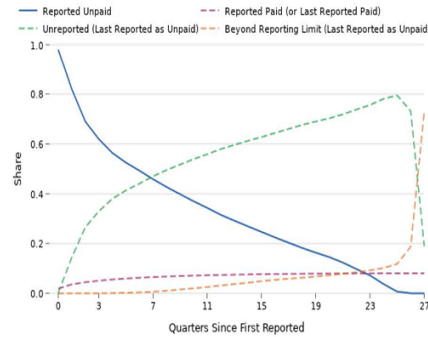
¹² Batty, M., Gibbs, C., & Ippolito, B. (2022). Health insurance, medical debt, and financial well-being. *Health Economics*.

¹³ E.g., Miller, S., Hu, L., Kaestner, R., Mazumder, B., & Wong, A. (2021). The ACA Medicaid Expansion in Michigan and financial health. *Journal of Policy Analysis and Management*, 40(2), 348-375. Brevoort, K., Grodzicki, D., & Hackmann, M. B. (2020). The credit consequences of unpaid medical bills. *Journal of Public Economics*, 187, 104203. Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J. P., Allen, H., Baicker, K., & Oregon Health Study Group. (2012). The Oregon health insurance experiment: evidence from the first year. *The Quarterly journal of economics*, 127(3), 1057-1106.

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¹⁵ *Dealing with medical debt: Consumer advice from NCLC*. Dealing with Medical Debt: Consumer Advice from NCLC | NCLC Digital Library. (2018, May 17). Retrieved March 23, 2022, from <https://library.nclc.org/dealing-medical-debt-consumer-advice-nclc>

Figure 5: Persistence of medical collections on credit reports. Reproduced from Batty, Gibbs, and Ippolito (2022).



Note: This figure shows the status of medical debt in collections that was incurred in 2011 through the first half of 2013 by quarter since it was first reported on a consumer's credit record in the CFPB CCP. The solid blue line represents the share of those medical collections that are still reported as unpaid. This share falls over time as bills are reported as paid (purple dashed line), they reach the seven year reporting threshold (orange dashed line), or they have not been paid but are no longer reported to the consumer reporting agency for other reasons (green dashed line).

Implications for potential and forthcoming policy changes

There are a host of policy changes that could affect the prevalence of medical debt or its influence on household finances. In this section, I consider a non-exhaustive list and emphasize potential tradeoffs that policymakers should consider.

Addressing underlying causes of medical debt

At a mechanical level, policies that aim to reduce the amount of unpaid medical bills must either reduce health care bills or increase the rate at which consumers' pay them. The suite of policies to do that is, of course, very broad. Health care reforms that reduce health care costs, expand insurance, or simplify health care billing processes, would typically lower the rate of medical debt. This is also true of policies that aim to reduce the prevalence of unexpected bills that might give rise to the most unavoidable sources of medical debt, like the No Surprises Act.

A full consideration of the merits of policy changes along these lines is beyond the scope of this testimony, but I will emphasize a few conceptual points. Efforts to lower health costs come with inevitable tradeoffs. Even if health markets exhibit some level of inefficiency, expenditures rarely purchase nothing of value. Policies should aim to balance the benefit to consumers stemming from lower health costs with general equilibrium effects on other outcomes, like quality of care. As a general rule, policies that lower health costs by targeting sources of inefficient spending—like reducing consolidation incentives, eliminating open-ended subsidies that contribute to price insensitivity, and so on—are likely to increase welfare the most.

It is also important to understand that the incidence of unpaid medical bills does not fall entirely on consumers, but also on health care providers.¹⁶ Thus, much of the value of policies that increase payment of bills (e.g., increasing insurance coverage or lowering cost sharing) will be borne by health care providers. Policymakers should weigh these transfers in light of others that already exist to partly compensate for this lack of payment (e.g., Disproportionate Share Hospital payments).

The suite of policies that would affect consumers' personal finances in advance of receiving health care bills is perhaps even broader, involving tax policy, unemployment insurance, productivity growth, and much more.

Increasing the accuracy of medical collections included on credit reports

The purpose of credit modeling is to provide information about credit worthiness of potential borrowers. If some medical collections on reports are inaccurate or likely convey no meaningful information about credit risk, there is an argument for changing how these debts are reported.

There are at least two settings in which medical collections are likely to convey relatively little information about credit worthiness. First, consider bills that initially go unpaid as a result of a consumer's confusion over billing practices, but that are later paid. The lack of payment in these cases may not fully reflect credit risk. Policies that allow lenders to distinguish these types of collections should improve signals of credit worthiness. In addition, if bills are regularly being reported on credit reports before potential uncertainty over payment is resolved, one could justify further delaying their appearance on credit records as a way to accomplish similar goals.

Recent changes announced by the major credit bureaus would enact changes along these lines.¹⁷ Specifically, they would require that unpaid medical collections not appear on credit reports for at least a year (up from the current standard of six months from date of first delinquency). In addition, they would remove medical collections that have been paid. Although one could argue in favor of simply identifying collections that have been paid (as some newer credit models do), these changes generally work towards the appropriate goal of improving signals about credit risk.

Restricting reporting of accurate unpaid medical collections

There are other proposals that would seek to limit the ability to observe medical collections even if they likely represent valid bills. This includes the recently-announced decision by the main credit bureaus to suppress medical collections that are under \$500 beginning in 2023. Policymakers should consider how lenders might respond to such a change and whether that would meaningfully affect the desired goals.

Medical collections may be less predictive of future repayment risk than other collections, but that does not imply they contain no predictive value. Indeed, the predictive power of medical collections is likely to be higher in a setting where other policies have reduced the noise associated with this flag (i.e., policies mentioned above that reduce the presence of medical collections which are likely to convey little value about credit worthiness). Moreover, it is notable that many lenders still use models which place meaningful weight on medical collections. That fact is consistent with the theory

¹⁶ Garthwaite, C., Gross, T., & Notowidigdo, M. J. (2018). Hospitals as insurers of last resort. *American Economic Journal: Applied Economics*, 10(1), 1-39.

¹⁷ Andriotis, A. March 18, 2022. Most Medical Debts to Be Removed From Consumers' Credit Reports. *Wall Street Journal*.

that they view those debts as informative. Thus, disallowing the reporting of this debt does not eliminate the perceived source of risk, but rather, obscures it. There are a few ways lenders might respond in this setting.

First, if lenders believe medical collections held predictive power over future repayment, they may seek to place more emphasis on other entries on credit reports that they believe carry similar information. For example, one might place higher weight on non-medical collections or other delinquencies, raising the cost of borrowing for consumers with those flags on their credit reports. It is not immediately obvious that raising the cost of borrowing for consumers with these flags would have preferable distributional consequences than the status quo (of course, if an alternative flag was highly correlated with medical collections, then similar consumers would be impacted).

If lenders do not think that they can proxy for the obscured source of risk they may consider alternative responses. One option would be to raise the cost of borrowing relatively evenly across all consumers. This would essentially represent a financial transfer from consumers without medical collections to those with them. Another alternative would be to adjust lending behavior in populations where risk is perceived to be high and unobservable. For example, consider younger adults who have some of the highest rates of medical collections on credit reports and are often building credit (thus have thinner files). If lenders believe there is a significant risk that is concentrated in this population, and it is not feasible for them to model it, they may view this group as a generally higher credit risk and be more reluctant to loan to them.

It is important to note that these types of regulatory redistribution efforts are not without precedent. Within health care markets policymakers have often intentionally distorted price signals in an effort to achieve certain kinds of cross subsidization. For instance, regulations often limit how much health insurance premiums can vary with expected health costs of individuals. This is motivated by equity concerns and the inherently unexpected nature of many illnesses and health care utilization. But these efforts have triggered responses by insurers who must price products in the face of imperfectly observable risk. This can destabilize markets for insurance as insurers seek to avoid higher risk enrollees (e.g., this can contribute to “death spiral” type incentives). While distinct from the policy setting under consideration here, this illustrates the kind of dynamic responses policymakers should be attentive to when considering this type of policy change.

Finally, policymakers should be cognizant of potential feedbacks to the provision of health care. By design, eliminating unpaid medical collections from consumer credit profiles reduces the costs of unpaid bills to consumers. Mechanically, this also reduces the incentives for consumers to pay such bills, particularly in cases where they are unlikely to visit the same provider multiple times. If this incentive is salient to consumers, it has the potential to affect rates of payment and alter providers’ willingness to treat patients who are perceived to be of higher non-payment risk. Access to health care is a first-order element of consumer wellbeing in this market. Efforts to reduce medical debts are, in part, motivated by concerns that medical debts, themselves, may dissuade consumers from seeking care in the first place. Thus, this margin is worth particular attention as policymakers seek ways to address medical debts.

PREPARED STATEMENT OF DAVID A. HYMAN
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MARCH 29, 2022

I have organized my testimony around four key points:

1. Quantifying medical debt involves both methodological choices and definitional uncertainty.
2. Medical debt is a function of multiple interactive factors.
3. Modifications to credit reporting of medical debt may provide some relief but is also likely to have unintended consequences.
4. Medical debt is a symptom of a larger problem, which will not be solved by changes in credit reporting practices. If we want to fix the problem of medical debt, we should be focusing on making health care cheaper.

Quantifying Medical Debt: Methodological Choice and Definitional Uncertainty

Researchers have generally used credit reports to generate estimates of total medical debt, based on bills from medical providers that are unpaid and have been sent to a collection agency and reported to a credit reporting agency. There are good reasons to use this approach; credit reports are objective sources of quantifiable information, and if an account is labeled as coming from a medical provider, it is unlikely to be attributable to nonmedical debt.

According to a recent report by the CFPB using this approach, about 20 percent of credit reports include such “medical collections,” totaling approximately \$88 billion.¹ Other estimates use the same approach.² These studies indicate that medical debt is not evenly distributed across the population, and a modest number of outliers are responsible for a heavily disproportionate share of total medical debt. The same studies find that higher medical debt is more likely among certain subgroups of the population.

There are several distinct problems with using this credit report-based approach to determining the amount of medical debt—let alone evaluating whether there are any time trends in the total amount of medical debt.

All of these studies are based on data from a single credit reporting agency, and all three employ the same definition of medical debt (i.e., a medical bill that is sent to collections). The first problem is that not all medical debt that is sent to collections is reported to all three credit reporting agencies—so reliance on a single agency will predictably miss at least some amount medical debt. The second problem is that not all medical debt is sent to collections—so reliance on collections data will predictably miss some medical debt as well. The third problem is that not all debt attributable to medical evaluation and treatment is reported as medical debt. For example, patients can pay some of their medical bills (including deductibles and copayments at the point of service) with a traditional credit card. Alternatively, they can use a credit card designed and marketed to cover health care expenses.³ Finally, they can tap other sources of funds, such as home equity loans, to pay medical bills. If any of these accounts ever go to collection, they will be treated by researchers as nonmedical debt.⁴ For all these reasons, research that relies on collections data will predictably underestimate total medical debt.

An alternative approach relies on survey data. For example, Rae et al. (2022) use data from the U.S. Census Survey of Income and Program Participation (SIPP) to

¹CFPB, “Medical Debt Burden in the United States (2022)”, at <https://www.consumerfinance.gov/dataresearch/research-reports/medical-debt-burden-in-the-united-states/>.

²See, e.g., Raymond Kluender, et al. “Medical Debt in the United States, 2009–2020”. 326 *JAMA* 250–256 (July 20, 2021), <https://jamanetwork.com/journals/jama/article-abstract/2782187> (estimate of \$140 billion); Michael Batty, Christa Gibbs, and Benedic Ippolito. “Unlike Medical Spending, Medical Bills in Collections Decrease with Patients’ Age”, 37 *Health Affairs* 1257–1264 (July 25, 2018), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0349> (estimate of \$81 billion).

³For several examples of such products, see Bankrate, “Best Credit Cards for Medical Expenses”, <https://www.bankrate.com/finance/credit-cards/should-you-have-a-medical-credit-card/>.

⁴For a discussion of how such these strategies affect the amount of reported medical debt in the context of bankruptcy filings, see Melissa B. Jacoby and Mirya R. Holman, “Managing Medical Bills on the Brink of Bankruptcy”, 10 *Yale J. Health Pol’y L. Ethics* 239 (2010).

evaluate medical debt.⁵ They arrive at a much higher figure (\$195 billion) than the studies based on credit reports. Surveys have their own issues involving validity, including whether the sample size is sufficient, and whether respondents can accurately recall and report information. For these reasons, Rae, et al. (2022), note that “[t]he total amount of medical debt is difficult to estimate with any precision. While surveys capture a larger share of people and more types of medical debt than analysis of credit reports, there are challenges in capturing data from people who owe high levels of debt.”⁶ That said, like the studies based on credit reports, Rae, et al. (2022), also find that medical debt is highly concentrated, with large sums owed by a relatively modest number of individuals: “0.3 percent of adults account for well more than half of the total medical debt.”⁷

To sum up, researchers have used various strategies to quantify medical debt, and have arrived at figures ranging from \$81 billion to 195 billion. This range of figures is the result of different methodological choices, data (un)availability, and definitional uncertainty.

Medical Debt Is a Function of Multiple Interactive Factors

The amount of medical debt that is incurred is a function of the billed cost of care, less any discounts and payments (including insurance, charity care write-offs, and direct payment by the patient). This formula means the amount of medical debt incurred by any given patient is affected by multiple factors, including how much care they receive; the list price of the care that is rendered; whether the patient has insurance; whether the care is provided in-network or not; the “generosity” of applicable insurance coverage (i.e., how large the deductibles and copayments are); the “generosity” of provider charity care policies and whether they pursue patients for balance bills; and the amount of any payments made by the patient at the time of service.

This list makes clear how many moving parts there are associated with any given episode of medical debt, as well as the potential interactions of each of those parts. For example, people who don’t consume health care won’t have medical debt, even if they don’t have insurance—or have insurance with large copayments and deductibles. People who do consume health care but have “rich” insurance coverage (i.e., insurance with no copayments or deductibles) are unlikely to end up with material medical debt. Patients who receive care from a retail clinic are less likely to have material medical debt than those who always go to a hospital emergency department. Patients who receive care from in-network providers are less likely to end up with material medical debt than those who receive care from out-of-network providers. Patients who receive care from a hospital with a robust charity care policy are less likely to have material medical debt than those who receive care from a hospital that has a more restrictive charity care policy. Patients who receive care from a provider that does not balance bill are less likely to have material medical debt than those who receive care from a provider that aggressively seeks to collect balance bills. And so on.

Credit Reporting and Medical Debt

Until recently, credit reporting agencies reported medical debt like any other form of debt. In the last week, Equifax, Experian, and Transunion have all announced changes in how they will handle medical debt. In general, these changes involve (i) deferring the reporting of medical debt that is in collections until a year has passed (for debt that exceeds \$500); (ii) not reporting medical debt that is in collections if

⁵ Matthew Rae, et al., “The Burden of Medical Debt in the United States”, KFF Issue Brief, Mar. 10, 2022, <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/> (\$195 billion). Other researchers have used similar strategies. See, e.g., U.S. Census Bureau, “Who Had Medical Debt in the United States?” (Apr. 7, 2021), <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>; Liz Hamel, et al., “The Burden of Medical Debt: Results From the Kaiser Family Foundation/New York Times Medical Bills Survey”, (Jan. 5, 2016), <https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey/>; Robin A. Cohen and Jeannine S. Schiller, “Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates From the National Health Interview Survey”, 2011–June 2015, National Center for Health Statistics; (Dec. 2015), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/probs-paying-medical-bills-jan-2011-jun-2015.pdf>; Sara R. Collins, et al., “Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings From the Commonwealth Fund Biennial Health Insurance Surveys”, 2001–2007, <https://www.commonwealthfund.org/publications/fund-reports/2008/aug/losing-ground-how-loss-adequate-health-insurance-burdening>.

⁶ Rae, et al., supra note 5.

⁷ Id.

the amount owed is less than \$500; and (iii) removing information on collection of medical debt from credit reports if the debt has been paid off.⁸

It remains to be seen how credit rating scores will be affected by these changes, or by other possible changes to credit reporting practices regarding medical debt. There are reasons to expect that individuals with modest medical debt may experience an increase in their credit rating, affecting their ability to obtain credit on favorable terms. Depending on the details of credit scoring and adjustments made in response to the elimination of most medical debt from credit reports, the increase in credit rating may be temporary. Alternatively, even if the credit rating bump is persistent, the meaning of any given credit score to issuers may change as well.

There are likely to be other follow-on consequences as well. At the margin, changes in credit reporting may make some patients less willing to pay their medical bills. Nonhospital providers are likely to adapt by restricting available appointments to those who can pay in full at the time of service, or otherwise limiting access to care to patients unable to pay in full at the time of service—the very group of patients whom this change in credit reporting aims to help.⁹ I would also expect more consolidation on the delivery side of the market, as small groups and individual providers come under increasing financial pressure. There will doubtless be other unintended consequences.

Solving the Problem of Medical Debt

Medical debt is a symptom of a larger problem—the American health care system is too expensive. Attempting to solve the problem of medical debt with tweaks to the credit reporting system is the equivalent of treating a symptom instead of the underlying disease.

Congress has already taken a big step to address the problem of medical debt with the No Surprises Act, although disagreement about implementation has already resulted in litigation.¹⁰ There is no shortage of additional ideas on how to make health care less expensive, although there is considerable disagreement on which ideas are worth pursuing. One strategy that should not be controversial is ensuring nonprofit hospitals are providing sufficient charity care to justify the sizeable tax exemption they receive.¹¹ Another strategy that should not be controversial is to encourage the use of lower-cost providers (including retail clinics and paraprofessionals) when the requisite services are within their scope of expertise. There is also considerable price variation among providers for a variety of shoppable medical services—creating obvious opportunities for lowering health care spending, as long as there is sufficient pricing transparency.¹² I have spelled out other ideas for making American health care cheaper in my academic work and am happy to discuss those issues further if there is interest and time.¹³

PREPARED STATEMENT OF BERNETA L. HAYNES

STAFF ATTORNEY, NATIONAL CONSUMER LAW CENTER

MARCH 29, 2022

Summary

Chairman Brown, Ranking Member Toomey, and Members of the Committee, thank you for inviting me to testify today regarding consumer medical debt. I offer

⁸Jessica Merritt, “Most Medical Debt May Soon Vanish From Credit Reports”, *U.S. News Money*, Mar. 25, 2022, <https://money.usnews.com/credit-cards/articles/most-medical-debt-may-soon-vanish-from-credit-reports>.

⁹Hospitals that receive Medicare are subject to EMTALA, and may not deny evaluation and treatment based on insurance status or ability to pay.

¹⁰See Katie Keith, “Court Sets Aside Key Parts of No Surprises Act Rule”, *Health Aff.* Feb. 24, 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220224.298748/>.

¹¹Ge Bai and David A. Hyman, “Nonprofit Hospitals’ Community Benefits Should Square With Their Tax Exemptions. They Often Don’t”, *StatNews* (Feb. 17, 2022), <https://www.statnews.com/2022/02/17/nonprofit-hospitals-not-earning-tax-exemptions/>; Ge Bai and David A. Hyman, “Tax Exemptions for Nonprofit Hospitals: It’s Time Taxpayers Get Their Money’s Worth”, *StatNews* (Apr. 5, 2021), <https://www.statnews.com/2021/04/05/tax-exemptions-nonprofit-hospitals-bad-deal-taxpayers/>.

¹²John Jiang, Martin A. Makary, and Ge Bai, “Commercial Negotiated Prices for CMS-Specified Shoppable Radiology Services in U.S. Hospitals”, 302 *Radiology* (Nov. 30, 2021), <https://doi.org/10.1148/radiol.2021211948>. See also Melanie Evans, “Some Hospitals Charge up to 10 Times More for Medical Scans Than Others, Study Finds”, *Wall St. J.* Nov. 30, 2021, <https://www.wsj.com/articles/some-hospitals-charge-up-to-10-times-more-for-medical-scans-than-others-study-finds-11638284400>.

¹³Charles Silver and David A. Hyman, “Overcharged: Why Americans Pay Too Much for Health Care” (Cato, 2018).

my testimony here on behalf of the low-income clients of the National Consumer Law Center.¹

The National Consumer Law Center is a nonprofit organization working for economic justice for low-income consumers and other vulnerable populations. We work with thousands of legal services, Government and private attorneys, as well as community groups and nonprofit organizations, from all States who represent low-income and older adults on consumer issues. As a result of our daily contact with these advocates, we have seen many examples of the damage wrought by medical debt. It is from this vantage point that we supply these comments.

An alarming number of consumers struggle with medical bills in the United States, with medical debt representing more than half of all debts in collection.² Black and Latino consumers, who are more likely to be uninsured and underinsured, carry significant medical debt.³ Among Black households, 27.9 percent carry medical debt, compared to 17.2 percent of White non-Hispanic households.⁴ 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.

Recently, the Big Three credit bureaus (Equifax, Experian, and TransUnion) announced changes to how they will report medical debt; the changes will result in the removal of nearly 70 percent of medical bills from credit reports.⁵ When medical bills go unpaid and end up reported to credit bureaus, it harms consumer credit scores⁶ 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. For this reason, more work is necessary to remove all medical debts from credit reports.

Because medical debt brings with it the threat of aggressive collection practices, many individuals take risky measures to avoid medical debt collection. Individuals often drain their short-term savings, increase their credit card debt,⁷ or dip into long-term savings accounts (retirement or college funds) to pay off burdensome medical bills.⁸ Families sometimes turn to deceptive financial products, such as medical

¹This testimony was written by Berneta L. Haynes, with editorial review by Lauren Saunders, Carolyn Carter, April Kuehnhoff, and Jenifer Bosco. For further discussion and policy solutions, see Berneta Haynes, “The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families”, National Consumer Law Center (March 2022), available at <https://www.nclc.org/images/pdf/medical-debt/RacialHealth-Rpt-2022.pdf>.

²“Medical Debt Burden in the United States”, Consumer Financial Protection Bureau (February 2022), available at <https://files.consumerfinance.gov/f/documents/cfpb-medical-debt-burden-in-the-united-states-report-2022-03.pdf>.

³Andre 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/>. See also Neil Bennett, Jonathan Eggleston, Laryssa Mykyta, and Briana Sullivan, “19 Percent 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>.

⁴Neil Bennett, Jonathan Eggleston, Laryssa Mykyta, and Briana Sullivan. “19 Percent 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>. Households in the South, the region with the highest concentration of Black people, also carry more debt than households in the Midwest, West, and Northeast.

⁵On March 18, 2022, the Big Three credit bureaus (Equifax, Experian, and TransUnion) announced changes to how they report medical debt; the changes will result in the removal of nearly 70 percent of medical bills from credit reports. See Anna Maria Andriotis, “Most Medical Debts To Be Removed From Consumers’ Credit Reports”, *Wall Street Journal* (March 18, 2022), available at <https://www.wsj.com/articles/most-medical-debts-to-be-removed-from-consumers-credit-reports-11647604803?reflink=desktopwebshare-permalink>.

⁶Michael Best, Jenifer Bosco, and Chi Chi Wu. “Don’t Add Insult to Injury: Medical Debt and Credit Reports”, NCLC (November 2019), available at <https://www.nclc.org/images/pdf/debt-collection/report-dont-add-insult-nov2019.pdf>.

⁷“The median credit card balance from health expenditures among African American middle class households that carry the expense on their credit card is \$933. The median indebted African American household with medical debt on their credit cards carries 11 percent of their total credit card debt due to medical expenses.” See Catherine Ruetschlin and Dedrick Asante-Muhammad. “The Challenge of Credit Card Debt for the African American Middle Class”. Demos and NAACP (Dec. 2013), available at <http://www.demos.org/sites/default/files/publications/CreditCardDebt-Demos-NAACP-0.pdf>.

⁸This 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), available at <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

credit cards⁹ and risky high-interest small-dollar loans to pay medical bills.¹⁰ In a recent survey by the American Cancer Society, 7 percent of respondents reported taking out a loan to pay their medical debt.¹¹ As such, medical debt can show up as other types of debt in individual credit histories.

Hospitals and other medical providers frequently place accounts with third-party collectors, who may use frequent calls and other communications to pressure consumers to pay. Black people in particular are more likely to be contacted by debt collectors over medical debt. In fact, debt collectors contact Black households at twice the rate of White households, according to the Urban Institute.¹² The Federal Trade Commission found that areas where the Black population is 50 percent or more have a higher rate of debt collection complaints compared to areas that are majority nonblack.¹³ Despite the credit and collection protections under the Affordable Care Act (ACA), 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 experiences with debt collectors.

In some cases, 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. For example, a recent investigation by Kaiser Health News revealed that the University of Virginia Hospital system has a history of relying on property liens to collect unpaid medical bills.¹⁴ 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.¹⁵ Between 2009 and 2018, hospitals in Maryland filed nearly 40,000 lawsuits that resulted in wage garnishment, often from their own employees.¹⁶ Furthermore, the ACLU documented cases of arrests for medical debts in several States, including Maryland, Arkansas, and Tennessee.¹⁷

Recommendations

To address the epidemic of medical debt, policy advocates and lawmakers should focus on ways to prevent medical debt at the outset, not after the fact, to protect consumers from harmful debt collection practices and long-term impacts on their

⁹National Consumer Law Center, *Collection Actions* (5th ed. 2020), 9.4.4.1, updated at <https://library.nclc.org/node/2436706?s=care%20credit>. In 2021, the Consumer Financial Protection Bureau received complaints against medical credit card companies for a variety of reasons, including overcharge of interest and lack of notice of fees, conditions, or contract terms.

¹⁰Hamel, 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), available at <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

¹¹Four percent of respondents indicated they took out a payday loan or refinanced their home to pay medical bills. See “Survivor Views: Cancer and Medical Debt”, American Cancer Society (Feb. 2022), available at <https://www.fightcancer.org/sites/default/files/national-documents/survivor-views-cancer-debt-0.pdf>.

¹²Michael 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), available at <https://www.urban.org/sites/default/files/publication/98919/the-well-being-and-basic-needs-survey-1.pdf>. See also National Consumer Law Center, *Fair Debt Collection* (10th ed. 2022), 1.3.1.5, updated at <https://library.nclc.org/fdc/01030105-0>.

¹³Despite similar rates of default and late payments, 71 percent of Black middle-income households received calls from debt collectors compared to 50 percent of White middle-income households. See Catherine Ruetschlin and Dedrick Asante-Muhammad. “The Challenge of Credit Card Debt for the African American Middle Class”. Demos and NAACP (Dec. 2013), available at <http://www.demos.org/sites/default/files/publications/CreditCardDebt-Demos-NAACP-0.pdf>. See also Raval Devesh. “Which Communities Complain to Policymakers? Evidence From Consumer Sentinel”. Federal Trade Commission (July 2018), 20, available at <https://www.ftc.gov/system/files/documents/reports/which-communities-complain-policymakers-evidence-consumer-sentinel/working-paper-336.pdf>.

¹⁴Jay Hancock. “UVA Health Still Squeezing Money From Patients—By Seizing Their Home Equity”, Kaiser Health News (Oct. 19, 2020), available at <https://khn.org/news/uva-health-property-liens-patient-medical-debt/>.

¹⁵Jay Hancock. “UVA Health Will Wipe Out Tens of Thousands of Lawsuits Against Patients”, Kaiser Health News (April 20, 2021), available at <https://khn.org/news/article/uva-health-will-wipe-out-tens-of-thousands-of-lawsuits-against-patients/>.

¹⁶“Preying on Patients: Maryland’s Not-for-Profit Hospitals and Medical Debt Lawsuits”. National Nurses United (Feb. 2020), 9, 17, available at <https://www.nationalnursesunited.org/preying-on-patients>.

¹⁷“A Pound of Flesh: The Criminalization of Private Debt”. American Civil Liberties Union (2018), 45, available at https://www.aclu.org/sites/default/files/field_document/022118-debtreport.pdf.

financial wellbeing. Policymakers also should provide consumer protections that address the racial disparities in medical debt. The following solutions would go a long way toward addressing the medical debt crisis:

- **Strengthen Protections Against Aggressive Debt Collection.** Prohibit aggressive debt collection by banning wage garnishment, bank account seizure, property liens, foreclosure of homes based on medical debt liens, and civil arrest warrants (also referred to as body attachments or capias warrants) for medical debt.
- **Prohibit Collection of Medical Debt During Health Insurance Appeals.** Require debt collectors to cease collection of alleged medical debts when they are advised that a health insurance appeal is pending or otherwise informed that the consumer is seeking to resolve the account with the insurer.
- **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 all medical debt to credit reporting bureaus.¹⁸ Short of total prohibition, exclude disputed debt and require screening for financial assistance.
- **Improve Protection of Funds Needed for Necessities for All Types of Debt.** As medical debt is often converted into credit card and other types of debt, we sorely need to increase the Federal protection against wage garnishment and to adopt a new Federal protection for a base amount of funds in bank accounts.¹⁹ Currently, under Federal law, only \$217.50/week in wages are fully protected—not even the poverty level, and there is no general Federal protection for bank accounts; in many States, collectors can completely empty out bank accounts.²⁰

Please see the attached reports and materials for more policy recommendations to protect people from burdensome medical debt: *The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families*²¹ and NCLC's recent letter to the CFPB regarding medical debt.

Conclusion

Issues related to medical debt cut across a variety of areas of financial regulation (credit reporting, debt collection, and regulation of lending products, etc.), and thus the solutions must be broad and cross-cutting. Urgent policy solutions are needed to reduce consumer medical debt and ensure that health care never throws anyone into a cycle of financial insecurity.

Thank you for the opportunity to testify today. I would be happy to answer your questions.

¹⁸To 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), available at <https://www.nclc.org/images/pdf/debt-collection/report-dont-add-insult-nov2019.pdf>.

¹⁹See NCLC, "A Free Stimulus To Support Struggling Families and the Economy: First Suspend, Then Reform, Wage and Bank Account Garnishment" (Jan. 2021), <http://bit.ly/Wage-Garnish-Stimulus-2021>; Center for Responsible Lending, "Protect Against Abusive Debt Collection: Working Families Need Wage Protection and a Chance to Save" (Feb. 2021), <https://www.responsiblelending.org/sites/default/files/nodes/files/research-publication/crl-garnishment-memo-feb2021.pdf>.

²⁰See NCLC, "No Fresh Start in 2021: Will States Let Debt Collectors Push Families Into Poverty as Pandemic Protections Expire?" (Nov. 2021), <https://www.nclc.org/issues/report-still-no-fresh-start.html>.

²¹Berneta Haynes, "The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families", National Consumer Law Center (March 2022), available at <https://www.nclc.org/images/pdf/medical-debt/RacialHealth-Rpt-2022.pdf>. See also Chi Chi Wu, Jenifer Bosco, and April Kuehnhoff, "Model Medical Debt Protection Act", National Consumer Law Center (September 2019), available at <https://www.nclc.org/images/pdf/medical-debt/model-medical-debt-protection-act-082017.pdf>.



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March 22, 2022

Director Rohit Chopra
Consumer Financial Protection Bureau
1700 G Street, NW
Washington, DC 20552

RE: Additional actions the CFPB should take to protect consumers with medical debt

Dear Director Chopra:

Thank you for the recent announcements and guidance regarding reporting and collection of alleged medical debts by the Consumer Financial Protection Bureau (CFPB).¹ We believe that these strong actions, along with the CFPB's clear expression of ongoing concerns, directly led to last week's announcement by the nationwide consumer reporting agencies (CRAs) that they will be adopting changes resulting in the removal of nearly 70% of debt collection items from credit reports.²

We are writing to highlight important additional actions that the CFPB should take to protect and assist consumers with medical debts in collection.

Medical Debt Ombuds

We encourage the CFPB to create a medical debt ombuds similar to the role that already exists within the Bureau for student loans. Issues related to medical debt cut across a variety of areas of financial regulation, including: credit reporting, debt collection, and regulation of lending products. This office should ensure a cross-disciplinary focus on medical debt within the Bureau

¹ Consumer Fin. Protection Bur., [Medical Debt Burden in the United States](#) (Feb. 2022); Consumer Fin. Protection Bur., Bulletin 2022-01: [Medical Debt Collection and Consumer Reporting Requirements in Connection with the No Surprises Act](#); Jim Rice, Consumer Fin. Protection Bur., [New VA rule relieves financial distress for thousands of veterans with medical bills](#) (Feb. 7, 2022).

² Joint Press Release, [Equifax, Experian, and TransUnion Support U.S. Consumers With Changes to Medical Collection Debt Reporting](#) (Mar. 18, 2022).

and also coordinate work with other federal agencies on related issues. It should also focus on racial disparities in medical debt³ and center these disparities in the Bureau's work to address medical debt and consumer protections. Finally, the ombuds should be empowered to resolve consumer complaints to the CFPB involving credit reporting and debt collection over medical debts.

Credit Reporting

The CFPB should prohibit reporting of *all* medical debt collection items by the nationwide CRAs, given the lack of predictiveness of medical debt; the unexpected and involuntary nature of medical bills; and the complicated, dysfunctional nature of medical billing in the United States.⁴ Short of a total prohibition, the CFPB should:

- **Require Screening for Financial Assistance:** Before a medical debt owed to a nonprofit hospital can be reported by a CRA, both the collector/furnisher and CRA should be required to ensure that the consumer was screened for eligibility for financial assistance as required by the regulations issued under the Affordable Care Act.⁵ The same screening should be required for consumers who reside in states with their own financial assistance laws.⁶
- **Exclude Disputed Medical Debt:** If a consumer disputes a medical debt on the basis that it should have been paid by an insurer or other third-party payer, the collector should not furnish the debt to CRAs and the CRAs should not report it until any insurance or other appeals have been exhausted and the consumer given time to pay the debt after exhaustion. Given the complexity and dysfunction in medical billing, if the consumer disputes the debt as incorrect, the debt should not be reported at all until the CFPB medical debt ombuds resolves the dispute.

Debt Collection

- **Information about Financial Assistance.**
 - Require debt collectors to include notice about any financial assistance policy in their communications with consumers.

³ See, e.g., Berneta L. Haynes, National Consumer Law Center, [The Racial Health and Wealth Gap: Impact of Medical Debt on Black Families](#) (Mar. 2022); Urban Institute, [Debt in America: An Interactive Map](#) (Mar. 31, 2021) (showing 17% of individuals in communities of color have medical debt compared to 13% of individuals in predominantly white communities).

⁴ Cf. Michael Best, et al., National Consumer Law Center, [Don't Add Insult to Injury: Medical Debt & Credit Reports](#) (Nov. 2019) (summarizing state protections).

⁵ 26 C.F.R. § 1.501(r) et seq.

⁶ For a list of such laws, see Andrea Bopp Stark and Jennifer Bosco, National Consumer Law Center, [An Ounce of Prevention: A Review of Hospital Financial Assistance Policies in the States](#) (Nov. 2021); National Consumer Law Center, Collection Actions § 9.4.3 (5th ed. 2020), updated at www.nclc.org/library

- Require debt collectors to provide notice about any financial assistance policies when consumers indicate that they are experiencing financial hardship - even if the consumer does not specifically ask about financial assistance.
 - Prohibit misrepresentations about financial assistance or the consumer's eligibility for such assistance.
- **Disputes.** Clarify that a consumer claim that an alleged medical debt should be covered by insurance is a dispute under the Fair Debt Collection Practices Act.⁷ Require debt collectors to cease collection of alleged medical debts when they are advised that an insurance appeal is pending or otherwise informed that the consumer is seeking to resolve the account with the insurer.
- **Credit Parking.** During CFPB supervisory visits and in response to consumer complaints, investigate compliance with Regulation F requirements⁸ to provide notice prior to furnishing collection tradelines. Bring enforcement actions when violations are identified. Strengthen Regulation F to increase the likelihood that consumers will actually receive notices from debt collectors that comply with notice requirements before credit reporting.⁹
- **Communications about Credit Reporting.** The CFPB should issue guidance to debt collectors to clarify that threats to report medical debts during the one year credit reporting pause or for amounts smaller than \$500 to credit bureaus violate the FDCPA since credit bureaus will no longer be displaying such amounts on consumer credit reports.¹⁰
- **Collection Calls.** Put meaningful limits on collection calls and make those limits per consumer and not per account. The current presumptive call limits in Regulation F¹¹ are 7 calls in 7 days *per account in collection*. Consumers with medical debts frequently have multiple accounts in collection, which may result in high volumes of collection calls. For example, a consumer with five medical accounts in collection could receive up to 35 calls in a 7-day period under Regulation F.

⁷ See [15 U.S.C. § 1692e\(8\)](#) (prohibiting debt collectors from "[c]ommunicating or threatening to communicate to any person credit information which is known or which should be known to be false, including the failure to communicate that a disputed debt is disputed."); [15 U.S.C. § 1692g\(b\)](#) ("If the consumer notifies the debt collector in writing within the thirty-day period described in subsection (a) . . . that the debt, or any portion thereof, is disputed . . . the debt collector shall cease collection of the debt, or any disputed portion thereof, until the debt collector obtains verification of the debt or a copy of a judgment . . . and a copy of such verification or judgment . . . is mailed to the consumer by the debt collector.").

⁸ [12 C.F.R. § 1006.30\(a\)](#).

⁹ See NCLC, [Comments Re: Debt Collection Practices \(Regulation F\) Delay of Effective Date](#) (May 19, 2021) (highlighting consumer protection concerns related to oral delivery of validation notice and provision of validation notice in an initial electronic communication).

¹⁰ Joint Press Release, [Equifax, Experian, and TransUnion Support U.S. Consumers With Changes to Medical Collection Debt Reporting](#) (Mar. 18, 2022).

¹¹ [12 C.F.R. § 1006.14\(b\)\(2\)\(i\)\(A\)](#).

- **Default.** Clarify when a medical debt is “in default”¹² and issue guidance to so-called “early out” or “first-party collectors” to clarify when they are covered under the Fair Debt Collection Practices Act.

Credit

- **Prohibit Deferred Interest Promotions.** One of the biggest uses of deferred interest promotions is for medical expenses.¹³ Deferred interest is an inherently deceptive product and its use for medical necessities make the abuses of the product even worse.
- **General Purpose Credit.** Research the use of general purpose credit products (e.g., credit cards, payday loans, home equity loans, etc.) to better understand what percentage of such credit is incurred to pay for medical debts. Also research indirect use of credit to pay for other expenses (e.g., rent, food, childcare, etc.) where consumers are attempting to pay medical bills.
- **Medical Credit.** Research credit card and loan products that specifically target consumers paying for medical expenses. Research should investigate the business models of specific medical credit and medical loan products. Provide guidance about how to avoid consumer harms. Bring enforcement actions or collaborate with other agencies as needed to bring enforcement actions against actors that are outside of CFPB jurisdiction.
- **Hidden Debt Buying.** Clarify that entities engaging in debt buying under the guise of providing buy now pay later or other types of credit are debt buyers covered by the Fair Debt Collection Practices Act and Regulation F. Bring enforcement actions where appropriate.

Collaboration with Other Federal Agencies

- **Internal Revenue Service.** Advocates who represent clients directly have reported that low-income patients who should be eligible for hospital financial assistance often cannot access this assistance, and may face collection actions and lawsuits for debt that should have been reduced or forgiven by the non-profit hospital. These observations have been supported by analyses of hospital financial assistance and spending on

¹² The definition of “debt collector” in the Fair Debt Collection Practices Act excludes “any person collecting or attempting to collect any debt owed or due or asserted to be owed or due another to the extent such activity . . . (iii) concerns a debt which was not in default at the time it was obtained by such person.” [15 U.S.C. § 1692a\(6\)\(F\)\(iii\)](#).

¹³ Consumer Financial Protection Bureau, [The Consumer Credit Card Market](#) 104 (December 2017) (about 15% of deferred interest purchases are healthcare services; superprime cardholders concentrate spending on home improvement purchases, but subprime and deep subprime tend to make more of their purchases for healthcare); Chi Chi Wu, National Consumer Law Center, [Deceptive Bargain: The Hidden Time Bomb of Deferred Interest Credit Cards](#) (Dec. 2015).

community benefits.¹⁴ The CFPB should meet with the team at the Internal Revenue Service that is responsible for compliance with non-profit hospital financial assistance rules, pursuant to the Affordable Care Act and 26 CFR 1.501(r). The agencies should consider issuing joint guidance regarding the duty of nonprofit hospitals to provide financial assistance to low-income patients, and the hospitals' responsibility to refrain from credit reporting or collection activity until after eligibility for financial assistance has been determined. Otherwise, those who collect or report those debts for the hospitals may be in violation of the FDCPA, since the correct amount of the debt has not been established.

- **Department of Defense.** Civilians who receive care at military hospitals may face significant medical debt and government debt collection efforts.¹⁵ The CFPB should support ongoing efforts¹⁶ to protect consumers from the burden of medical debt collection for procedures at military hospitals and encourage the adoption of additional reforms similar to those implemented by the Department of Veterans Affairs.¹⁷

Thank you for your time and attention. We look forward to the opportunity to discuss these ideas with the appropriate staff at the CFPB. Please contact April Kuehnhoff at akuehnhoff@nclc.org with any questions about this letter.

Sincerely,

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¹⁴ E.g., Kaiser Health News, [Patients Eligible For Charity Care Instead Get Big Bills](#) (Oct. 14, 2019); Department of the State Treasurer of North Carolina, [N.C. Nonprofit Hospitals Bill the Poor](#) (Jan 26, 2022).

¹⁵ Jared Bennett and Olga Khazan, The Atlantic, [America's Most Powerful Medical-Debt Collector](#) (Feb. 10, 2020); [Letter from Representative Joaquin Castro to Chairman Adam Smith and Ranking Member Mac Thornberry](#) (March 31, 2020).

¹⁶ Joint Base San Antonio, [BAMC launches initiatives to help alleviate billing concerns](#) (Sept. 1, 2021).

¹⁷ Department of Veterans Affairs, [VA establishes new threshold for reporting benefit and medical debt](#) (Feb. 2, 2022).



THE RACIAL HEALTH AND WEALTH GAP

IMPACT OF MEDICAL DEBT
ON BLACK FAMILIES

By Berneta L. Haynes

National Consumer Law Center®

March 2022



ABOUT THE NATIONAL CONSUMER LAW CENTER

Since 1969, the nonprofit National Consumer Law Center® (NCLC®) has used its expertise in consumer law and energy policy to work for consumer justice and economic security for low-income and other disadvantaged people in the United States. NCLC's expertise includes policy analysis and advocacy; consumer law and energy publications; litigation; expert witness services, and training and advice for advocates. NCLC works with nonprofit and legal services organizations, private attorneys, policymakers, and federal and state government and courts across the nation to stop exploitative practices, help financially stressed families build and retain wealth, and advance economic fairness.

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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.¹ 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 debt²
- 1 in 3 Black adults have past-due medical bills, compared to fewer than 1 in 4 white adults³
- 17% of Black adults lack health insurance compared to 12% of white adults⁴

An array of issues contribute to the current medical debt crisis: rising healthcare costs,⁵ lack of insurance, narrow insurance networks, surprise medical bills,⁶ 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 scores⁷ 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.⁸ 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.⁹ 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.”¹⁰ 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.¹¹ 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.¹² Although the Act created “the most comprehensive hospital and public health construction program ever undertaken”¹³ 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.¹⁴

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.¹⁵ 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.¹⁶ 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.¹⁷ 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.¹⁸

The Kerr-Mills Act’s MAA program, implemented in 1960, provided federal grants to states to pay for medical services for indigent older adults.¹⁹ But the program was slow to take off and by 1963 only thirty states had begun implementing Kerr-Mills programs,²⁰ with sixty percent of program participants residing in New York, Massachusetts, and California.²¹ 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.²² 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.²³ The defendant hospitals appealed, but the U.S. Supreme court later declined to hear the case, making the appeals court decision final.²⁴ 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.²⁵

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.²⁶ In 1967, Johnson's assistant secretary of health reported that 95% of hospitals were admitting Black patients.²⁷

While few other desegregation efforts worked as efficiently as Medicare and Medicaid did to eliminate hospital segregation,²⁸ 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.²⁹ 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 COVID³⁰) and of being terminated from Medicaid.³¹ Additionally, because expansion of Medicaid eligibility remains optional to the states rather than mandatory,³² Black families living in non-expansion states³³ face higher uninsured rates than other demographic groups.³⁴

Likewise, unresolved racial inequities exist in Medicare, with Black recipients reporting worse health and greater access problems than white recipients.³⁵ 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 ³⁶	Lower quality care, whether insured or not ³⁷	Higher maternal mortality rates ³⁸
More likely to live in states with the highest uninsured rates ³⁹	Reliance on community clinics, outpatient care, and ERs ⁴⁰	Higher infant mortality rates ⁴¹
Limited Medicaid access due to living in non-expansion states ⁴²	Less likely to receive health- and life-conserving treatments ⁴³	Highest mortality rate from heart disease and all cancers ⁴⁴
Lack of hospitals and healthcare providers ⁴⁵	More likely to receive less desirable treatments, like amputations ⁴⁶	Highest rates of onset, hospitalization, and death due to diabetes ⁴⁷

Medical debt affects communities of color disproportionately, with older Black adults 2.6 times more likely to carry medical debt than older whites.⁴⁸ In general, a third of Black adults have medical debt compared to less than a quarter of white adults.⁴⁹ 27.9% of Black households have medical debt compared to 17.2% of white households and 9.7% of Asian households.⁵⁰ Meanwhile, 6.2% of Black households have medical debt greater than 20% of their yearly income, compared to 4.4% of all households.⁵¹ 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).⁵² For example, uninsured households carry an average of \$31,947 in medical debt compared to \$18,827 among insured households.⁵³ 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.⁵⁴ 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,⁵⁵ creating a vicious cycle for Black people. Individuals struggling with medical debt report avoiding, delaying, or skipping necessary medical care,⁵⁶ 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.⁵⁷ 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.⁵⁸ 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,⁵⁹ 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.).⁶⁰ This stress increases an individual's risk of anxiety, depression, substance use disorders, and other mental health disorders.⁶¹ Black adults are already more likely to experience feelings of sadness and hopelessness than white adults,⁶² and medical debt potentially compounds this problem. In this sense, medical debt directly contributes to poor health outcomes in Black communities.⁶³ 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),⁶⁴ lower rates of homeownership, lower rates of participation in retirement plans, and much less in liquid emergency savings.⁶⁵ 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.⁶⁶ Debt, while not the single cause, reinforces this racial wealth gap.⁶⁷

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.⁶⁸ 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.⁶⁹ Families sometimes turn to deceptive financial products, such as medical credit cards⁷⁰ and risky high-interest small dollar loans to pay medical bills.⁷¹ 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,⁷² individuals carrying medical debt may experience difficulty obtaining mortgage

loans. About 40% of people with medical debt report being denied a mortgage loan.⁷³ 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.⁷⁴ In particular, 23% of respondents reported having to divert money toward medical bills instead of the mortgage.⁷⁵ 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.⁷⁶ 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.⁷⁷ Worse yet, some hospitals go as far as to seek liens on patients' homes for unpaid medical bills.⁷⁸ 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.⁷⁹ However, these positive results primarily stem from the expansion of Medicaid under the ACA⁸⁰ 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.⁸¹ 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.⁸² 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.⁸³ 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.⁸⁴ 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.⁸⁵ The FAP must apply to all “emergency and other medically necessary” care the hospital provides.⁸⁶

Notably, the requirements also state that before using any bill collection mechanisms a hospital must use multiple avenues⁸⁷ to make sure patients know about the FAP. The hospital must “widely publicize”⁸⁸ the FAP to all members of the community and make sure it is written in “plain language.”⁸⁹ 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).⁹⁰ 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.⁹¹ 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.⁹² Additionally, hospitals in states that expanded Medicaid spent less on charity care than hospitals in non-expansion states.⁹³ 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.⁹⁴

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

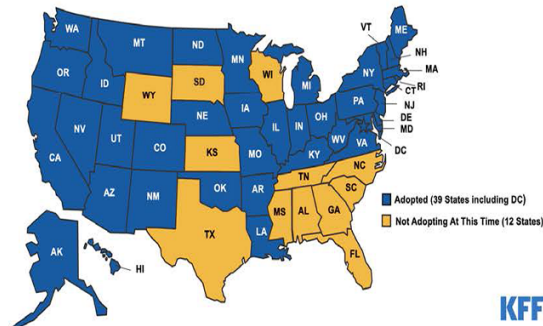
While charity care or financial assistance policies help protect some uninsured or underinsured patients from burdensome medical debt, these programs fall short as hospitals do the bare minimum to satisfy the ACA's requirements and maintain their tax-exempt status. In practice, charity care policies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

- Hospitals fail to inform patients of their eligibility for charity care before commencing debt collection;⁹⁵
- Lack of specific guidelines and minimum eligibility criteria in the ACA's financial assistance policy requirements;⁹⁶ 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.⁹⁷ 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.⁹⁸

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,⁹⁹ which are predominantly the Southern states (*see Figure 1*).¹⁰⁰ Third, Black people are more likely to reside in these Medicaid non-expansion states (*see Figure 2*).¹⁰¹

FIGURE 1 STATUS OF STATE MEDICAID EXPANSION DECISIONS

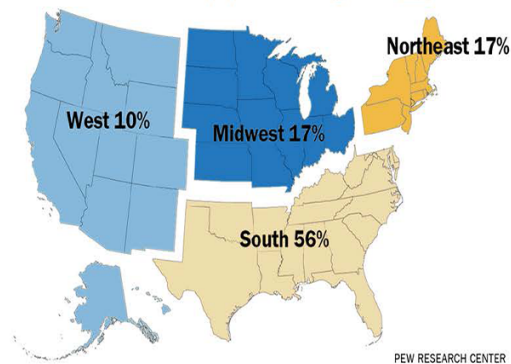
Courtesy of Kaiser Family Foundation.

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.¹⁰² Hospitals sometimes give up trying to collect these bills and write them off as “bad debt,”¹⁰³ 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.¹⁰⁴ In 2020, 31% to 48% of bad debt billed to patients at North Carolina non-profit hospitals should have been provided as charity care.¹⁰⁵ 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.¹⁰⁶ 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.¹⁰⁷ 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.¹⁰⁸

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.¹⁰⁹ 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.¹¹⁰ 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).¹¹¹ 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.¹¹²

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 2021.¹¹³ 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.¹¹⁴ In fact, debt collectors contact Black households at twice the rate of white households, according to the Urban Institute.¹¹⁵ 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.¹¹⁶ 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.¹¹⁷ ECAs include selling debt to a third party,¹¹⁸ 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.).¹¹⁹ 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.¹²⁰ For the presumptively eligible patients, the hospital must provide a reasonable time for the patient to apply for more generous assistance.¹²¹ Likewise, the hospital must give any patients applying for financial assistance a reasonable time to complete the application and to rectify incomplete applications.¹²² 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.¹²³

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;¹²⁴ contacting the consumer at unusual or inconvenient times and places;¹²⁵ abusive conduct (i.e. harassing, threatening violence or harm, etc.);¹²⁶ making false threats of legal action;¹²⁷ and contacting the consumer after being told in writing to stop all contact.¹²⁸ 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.¹²⁹ Many states now have statutes that mirror the core provisions of the FDCPA.¹³⁰

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.¹³¹ 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 collections¹³² and experience contact with debt collectors.¹³³ 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,¹³⁴ the very hospitals subject to the ACA's restrictions against "extraordinary collection actions," filed the most lawsuits against patients between 2018 and 2020.¹³⁵ 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.¹³⁶ Wisconsin researchers found that lawsuits over unpaid medical bills increased by 37% between 2001 and 2018 in their state.¹³⁷ 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 \$1,842.¹³⁸ 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.¹³⁹

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.¹⁴⁰ 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 foreclosure¹⁴¹ 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.¹⁴² 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.¹⁴³ In New York, non-profit hospitals secured 4,880 liens in 2017 and 2018 on homes of patients who had unpaid medical bills.¹⁴⁴

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.¹⁴⁵ The lien stays on the home until the debt is paid or released.¹⁴⁶ 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.¹⁴⁷ In this sense, a relatively small hospital bill averaging less than \$2000¹⁴⁸ 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.¹⁴⁹

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.¹⁵⁰ In Maryland, this practice disparately impacts Black communities. For example, Johns Hopkins sought over \$4 million in wage garnishment lawsuits between 2009 and 2018,¹⁵¹ and has a community benefits service area that is 45% Black.¹⁵² Likewise, the University of Maryland Medical System sought over \$10 million in wage garnishments during the same period¹⁵³ and has a community benefits service area that is 69.5% Black.¹⁵⁴ 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.¹⁵⁵ In Maryland, they observed a practice of patients being jailed for medical debts of less than \$1000.¹⁵⁶ In some cases, debt collectors made false threats of arrest for unpaid medical debts.¹⁵⁷ National Nurses United called for a ban on arrest warrants for medical debt in Maryland, and recent legislation enacted there has banned the practice.¹⁵⁸ Although the ACLU was not able to obtain data on racial disparities in civil arrest warrants, racial disparities in debt collection and in policing¹⁵⁹ 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.¹⁶⁰ These risky types of debt come with egregiously high interest rates; for instance, payday loans can have interest rates of over 600%.¹⁶¹ 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
No Surprises Act of 2020 (Federal) <i>House Resolution 133, passed and enacted</i> <i>Amended 42 U.S. Code § 300gg-19a</i>	Key protections: ¹⁶² - Prohibits balance billing for emergency services and certain services provided by out-of-network providers at in-network facilities, including by air ambulances - Enables insurers and providers to settle payment disputes among themselves via a dispute resolution process
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>	Key protections: ¹⁶³ - Prohibits surprise billing in emergency situations and when a patient receives scheduled services at an in-network facility - Requires patients to give consent before receiving out-of-network services - Enables insurers and providers to settle payment disputes among themselves via a dispute resolution process
Balance Billing Protections, 2019 (Texas) <i>Senate Bill 1264, passed and enacted</i> <i>28 Tex. Admin. Code §§ 21.4901–29.4904</i>	Key protections: ¹⁶⁴ - Prohibits balance billing in emergencies or when the patient did not have a choice of doctors for medical services - Requires patients to give consent before receiving out-of-network services - Enables insurers and providers to settle payment disputes among themselves via a dispute resolution process

Recently Passed Laws Protecting Consumers from Aggressive Medical Debt Collection

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
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>	Key protections: ¹⁶⁵ - Prohibits hospitals from requesting arrest warrants against patients - Prohibits hospitals from requesting a lien against a patient's home - Protects patients eligible for financial assistance against wage garnishment and adverse credit reporting - Requires hospitals to check patient eligibility for financial assistance before filing lawsuits - 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 - Requires hospitals to annually report details about charges, out-of-pocket costs, debt collections, and lawsuits against patients

(continued)

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
Medical Debt Protection Act of 2021, Nevada <i>Senate Bill 248, passed and enacted</i> <i>Nev. Rev. Stat §649.005 et seq.</i>	Key protections: ¹⁶⁶ - Requires 60-day notification to "medical debtor" before a collection agency can take debt collection actions - Prohibits collection agency from taking civil actions for medical debts of less than \$10,000 or charging fees of more 5% of the debt - 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
Patient' Debt Collection Practices Act of 2021, New Mexico <i>Senate Bill 71, passed and enacted</i> <i>NM Stat § 57-32-1 to 57-32-10</i>	Key protections: ¹⁶⁷ - Prohibits collection actions against indigent patients, and any collection actions must be terminated upon a determination that the patient is indigent - 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
Health Care Debt and Fair Billing Act of 2021, California <i>AB 1020, passed and enacted</i> <i>Cal. Civ. Code §§1788.14, 1788.185, 1788.52, 1788.58; Cal. Health & Safety Code §§127400 to 127444</i>	Key protections: ¹⁶⁸ - 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 - Requires the hospital to wait 180 days before reporting a debt to the credit bureaus - 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

Current Laws Mandating Comprehensive FAPs for Non-Profit and For-Profit Hospitals¹⁶⁹

NAME OF LAW	IMPORTANT CHANGES AND PROTECTONS
California, <i>Cal. Welf. & Inst. Code §§ 16900 to 16996.2; Cal. Health & Safety Code §§ 127400 to 127466</i>	Key protections: ¹⁷⁰ - Hospitals must offer free or discounted care to uninsured patients who are at or below 350% of the federal poverty level - Hospitals must offer free or discounted care to underinsured patients with "high medical costs"¹⁷¹
Connecticut, <i>Conn. Gen. Stat. §§ 19a-7d, 19a-509b, 19a-649, 19a-673</i>	Key protections: ¹⁷² - Hospitals must screen patients for FAP eligibility - 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

(continued)

STATE LAWS	IMPORTANT CHANGES AND PROTECTIONS
Illinois, <i>Hospital Uninsured Patient Discount Act</i> , 210 Ill. Comp. Stat. §§ 89/1 to 89/20	Key protections:¹⁷³ - 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 - 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
New Jersey, <i>N.J. Stat. Ann. §§ 26:2H-18.58; N.J. Admin. Code § 10:52-11.8, 11.1</i>	Key protections:¹⁷⁴ - Hospitals must provide financial assistance to patients with incomes below 200% of the federal poverty level - 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 - For patients with incomes less than 500% of the federal poverty level, hospitals cannot charge them more than 15% above the Medicare payment rate

Federal Medical Debt Legislation (introduced but not yet adopted)¹⁷⁵

NAME OF LEGISLATION	IMPORTANT CHANGES AND PROTECTIONS
COVID-19 Medical Debt Collection Relief Act (Federal) <i>Senate Bill 355, introduced in 2021</i>	Key protections:¹⁷⁶ - Temporarily suspends all extraordinary collection actions¹⁷⁷ by health care providers of medical debt until to the end of the pandemic or 18 months after enactment of the bill - Suspends repayment plans for medical debt and ensures reasonable forbearance and repayment options - 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 - Liability for hospitals and debt collectors that fail to comply
Medical Debt Relief Act of 2021 (Federal) <i>Senate Bill 214 and House Resolution 773, introduced in 2021</i>	Key protections:¹⁷⁸ - Prohibits credit reporting agencies from adding medical debt information that is fully paid or settled, or is less than one year old - Requires debt collectors to notify a consumer before reporting the debt to a credit bureau

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.¹⁷⁹ 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 Medicaid¹⁸⁰ 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.¹⁸¹
- **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.¹⁸²

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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2. Kimberly Amadeo. "Do Medical Bills Really Bankrupt America's Families?" *The Balance*, 2019.
3. Signe-Mary McKernan, Steven Brown, and Genevieve M. Kenney. "Past-Due Medical Debt a Problem, Especially for Black Americans." *Urban Institute*, 2017.
4. *Id.*
5. Greg Iacurci. "1 in 3 workers saw higher health costs this year, survey finds," *CNBC* (Oct. 7, 2021). See also *CMS National Health Expenditure Data*, (projecting an annual growth rate of 5.4% in national health spending between 2019 and 2028).
6. A new federal law, the [No Surprises Act](#), protects consumers from most surprise medical bills. Surprise medical bills occur when insured patients inadvertently receive care from out-of-network hospitals, physicians, or other providers. The No Surprises Act, H.R. 3630, effectively eliminates surprise billing in most emergency and non-emergency situations. The law went into effect in January 2022. See H.R. 3630. See also Karen Pollitz, "[No Surprises Act Implementation: What to Expect in 2022](#)," *Kaiser Health News* (Dec. 10 2021).
7. Michael Best, Jenifer Bosco, and Chi Chi Wu. "Don't Add Insult to Injury: Medical Debt and Credit Reports," *NCLC* (November 2019).
8. 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. Households in the South, the region with the highest concentration of black people, also carry more debt than households in the Midwest, West, and Northeast.
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10. Department of Health and Human Services. *Statement of Regulatory Priorities for Fiscal Year 2022*.
11. L. R. Fortuna, M. Tolou-Shams, B. Robles-Ramamurthy, and M. V. Porche. "Inequity and the disproportionate impact of COVID-19 on communities of color in the United States: The need for a trauma-informed social justice response." *Psychological Trauma: Theory, Research, Practice, and Policy*, 2020, 12(5), 443-445.
12. Emily A. Largent. "Public Health, Racism, and the Lasting Impact of Hospital Segregation." *Public Health Reports* (November 2018), 133(6), 715-20.
13. V.M. Hoge. "The Hospital Survey and Construction Act." *Social Security Bulletin*, 1946, 9(10), 15-17.
14. *Id.*
15. This was particularly true in the Southern states, where Black communities often had no hospital they could turn to for healthcare. See Steve Sternberg. "[Desegregation: The Hidden Legacy of Medicare](#)," *US News* (July 2015).
16. Steve Sternberg. "[Desegregation: The Hidden Legacy of Medicare](#)," *US News* (July 2015).
17. *Id.*
18. LaShyra T. Nolan, Adam L. Beckman, and Emma Sandoe. "How Foundational Moments In Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities." *Health Affairs* (Sept. 1, 2020).
19. Edward Berkowitz. "Medicare and Medicaid: The Past as Prologue," *Health Care Financing Review* (2005), 27(2):11-23.
20. *Id.*

21. Judith D. Moore and David G. Smith. "Legislating Medicaid: Considering Medicaid and its Origins," *Health Care Financing Review* (2005-2006), 27(2):45-52.
22. Medical Assistance for the Aged, the Kerr-Mills program, 1960-1963: A Report by the Subcommittee on Health of the Elderly to the Special Committee on Aging, United States Senate, p. 10-11.
23. Steve Sternberg. "Desegregation: The Hidden Legacy of Medicare," *US News* (July 2015).
24. *Id.*
25. *Id.* "In summer 1965, staff members of the US Commission on Civil Rights visited 39 hospitals to determine the effect of the Civil Rights Act and regulations on segregation of patients in hospitals. Only 13 of the 39 hospitals were found to have achieved any substantial degree of desegregation."
26. Beth Duff-Brown. "Desegregating Hospitals: How Medicare's architect forced hospitals to admit Black people," *Stanford Medicine* (2021), Issue 1.
27. *Id.* See also David Barton Smith. "Eliminating Disparities in Treatment and the Struggle to End Segregation," *Commonwealth Fund* (Aug. 2005), Pub. No. 775. Smith noted that after the implementation of Medicare, "more than 1,000 hospitals quietly and uneventfully integrated their medical staffs, waiting rooms, and hospital floors in less than four months."
28. Emily A. Largent. "Public Health, Racism, and the Lasting Impact of Hospital Segregation," *Public Health Reports* (November 2018), 133(6), 715–20.
29. LaShyra T. Nolan, Adam L. Beckman, and Emma Sandoe. "How Foundational Moments In Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities," *Health Affairs* (Sept. 1, 2020).
30. Nursing homes where a significant portion of the residents are Black and Latiné have been impacted more by COVID-19 than majority-white nursing homes. See "The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes," *New York Times* (June 14, 2021).
31. The study identified the "lowest-quality" nursing homes as those with "lower nurse staffing ratios, more serious regulatory deficiencies . . ." See Rebecca J. Gorges and Tamara R. Konetzka. "Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US," *JAMA Network* (2021), 4(2).
32. In an unprecedented move in 2012, the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius* struck down as unconstitutional the ACA's mandatory Medicaid eligibility expansion.
33. Black people are most concentrated in the South, with 56% living in the region as of 2019, according to the Pew Research Center. See Christine Tamir, Abby Budiman, Luis Noe-Bustamente, and Lauren Mora. "Facts about the U.S. Black Population," *Pew Research Center* (March 25, 2021), available at <https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population/#~:text=In%202019%2C%20there%20were%2046.8%20million%20people%20who,36.2%20million%20Black%20Americans.%20Black%20Americans%20are%20diverse>.
34. Of the 12 states that have not expanded Medicaid, 8 of them are in the South or "Black Belt." See "Status of State Medicaid Expansion Decisions: Interactive Map," *Kaiser Family Foundation* (Nov. 2021), available at <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.
35. Nancy Ochieng, Juliette Cubanski, Tricia Neuman, Samantha Artiga, and Anthony Damico. "Racial and Ethnic Health Inequities and Medicare," *Kaiser Family Foundation* (Feb. 2021), available at <https://www.kff.org/medicare/report/racial-and-ethnic-health-inequities-and-medicare/>.
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. See also U.S.

- Department of Health and Human Services Office of Minority Health, available at <https://www.minorityhealth.hhs.gov/omh/browse.aspx?vi=3&lvld=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.
 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?vi=4&lvld=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/.
 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?vi=4&lvld=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?vi=4&lvld=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/.
 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?vi=4&lvld=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.
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. 2016), 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," *MCI* (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. §§ 69/1 to 69/20.
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

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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**RESPONSES TO WRITTEN QUESTIONS
OF SENATOR MENENDEZ FROM BERNETA L. HAYNES**

Q.1. Removing cleared medical debt from consumer credit reports is a good first step, but as the sheer amount of medical debt indicates, it isn't so easy for families to clear up their medical debt.

What are some of the challenges people face in trying to clear their medical debt?

A.1. As discussed in my written testimony,¹ consumers trying to clear their medical debt face significant challenges, including lack of disposable income or savings to pay the debts, obstacles accessing charity care, and harassment and aggressive behavior from debt collectors.

As the Consumer Financial Protection Bureau (CFPB) has indicated, medical debt disproportionately impacts lower-income consumers,² individuals who are less likely to have emergency savings or disposable income to weather a medical bill. The Kaiser Family Foundation reported that consumers with medical bills are less likely than those without medical bills to have a checking or savings account, a retirement account of any kind, or any type of investments or stocks.³ Furthermore, these consumers often reported loss of income due to illness.⁴ In an effort to clear their medical bills, these consumers may turn to deceptive and risky financial alternatives (credit cards, high-interest small-dollar loans, medical credit cards,⁵ etc.), taking an already precarious financial situation from bad to worse.⁶

Ideally, charity care or FAPs should help protect some uninsured or underinsured patients from burdensome medical debt. In practice, however, these programs fall short as many hospitals do the bare minimum to satisfy the Affordable Care Act's (ACA) requirements for their tax-exempt status. Charity care policies fall short for several reasons:

- Hospitals fail to inform patients of their eligibility for charity care before commencing debt collection;⁷

¹Testimony of Berneta L. Haynes on "Economic Impact of the Growing Burden of Medical Debt" before the United States Senate Committee on Banking, Housing, and Urban Affairs, Mar. 29, 2022, available at <https://www.banking.senate.gov/imo/media/doc/Haynes%20Testimony%2023-29-22.pdf>.

²"Medical Debt Burden in the United States", Consumer Financial Protection Bureau (February 2022), p. 15, available at <https://files.consumerfinance.gov/f/documents/cfpb-medical-debt-burden-in-the-united-states-report-2022-03.pdf>.

³Hamel, 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), available at <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

⁴Id.

⁵National Consumer Law Center, Collection Actions (5th ed. 2020), 9.4.4.1, updated at <https://library.nclc.org/node/2436706?s=care%20credit>.

⁶This 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), available at <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

⁷Jordan Rau. "Patients Eligible for Charity Care Instead Get Big Bills". Kaiser Health News (Oct. 14, 2019), available at <https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills/>.

- Lack of specific guidelines and minimum eligibility criteria in the ACA's FAP requirements;⁸
- Gaps in hospital FAPs, which exclude many providers; and
- Overall lack of effective implementation, enforcement, and oversight of charity care programs.

Patients struggle to access charity either due to lack of information, narrow eligibility guidelines, and onerous application or documentation requirements. Lack of enforcement and oversight, lack of notice to patients, and lack of specific Federal guidelines and minimum eligibility requirements for hospital charity care programs all snowball to limit the effectiveness of the ACA's efforts to reduce the medical debt burden and help people clear their medical bills.

As the debt lingers, patients face aggressive debt collectors,⁹ which can lead to wage garnishment, seizure of bank accounts, and even liens against property. Medical debt is consistently the most common type of past-due bill about which consumers reported being contacted by debt collectors.¹⁰ To avoid aggressive debt collection, individuals lucky enough to have any short-term or long-term savings accounts often drain their savings to pay off burdensome medical bills.¹¹ As noted, families sometimes turn to deceptive financial products that can worsen their financial situation.¹² In effect, the risky measures families often take to clear a medical debt and avoid debt collection further trap them in a cycle of financial insecurity.

Q.2. One in four Millennials and Gen-Z members with medical debt skipped rent or mortgage payments because of their debt. Those missed payments can negatively affect their credit score for years.

What are some other ways that medical debt can have a lasting effect on credit scores? What can be done to mitigate or expunge these secondary effects?

A.2. As discussed above, to manage their medical debt, patients often put medical bills on credit cards, take out risky high-interest loans, and turn to medical credit cards, all of which can harm their credit scores and increase the likelihood of bankruptcy. According to the CFPB, patients can sometimes see significant drops in their

⁸ 26 CFR §1.501(r)-4. See also Jordan Rau. "Patients Eligible for Charity Care Instead Get Big Bills". Kaiser Health News (Oct. 14, 2019), available at <https://khn.org/news/patients-eligible-for-charity-care-instead-get-big-bills/>.

⁹ In 2022, the Consumer Financial Protection Bureau reported that 58 percent of bills in collections and on people's credit records were medical bills in the second quarter of 2021. "Medical Debt Burden in the United States", Consumer Financial Protection Bureau (February 2022), available at https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf. 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, available at https://files.consumerfinance.gov/f/documents/201701_cfpb_Debt-Collection-Survey-Report.pdf (finding Medical debt, credit card debt, and student debt led the list of types of debt that led to interaction with debt collectors).

¹⁰ "Consumer Experiences With Debt Collection: Findings From the CFPB's Consumer Survey of Consumer Views on Debt", Consumer Financial Protection Bureau (January 2017), p. 5, available at https://files.consumerfinance.gov/f/documents/201701_cfpb_Debt-Collection-Survey-Report.pdf.

¹¹ 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), available at <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

¹² 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), available at <https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/>.

credit scores due to small unpaid medical debts.¹³ One consumer reported to the CFPB that she saw her credit score drop 94 points due to an unpaid medical debt of about \$120.¹⁴ Worse yet, consumers reported only finding out a medical debt had affected their credit report when they were in the process of making a major purchase. For example, one consumer stated that when she was trying to buy a house she found out about a medical debt that had harmed her score.¹⁵ To address this issue, the CFPB issued Regulation F in 2020 (effective November 30, 2021), requiring debt collectors to notify consumers before reporting the debt to a credit reporting agency. Moreover, even after a consumer has paid to have a medical debt removed from their credit report, it may continue to harm their credit score; some changes recently announced by the major credit bureaus include removing paid medical debts from credit reports.¹⁶

Consumers may file bankruptcy due to medical debt. In a recent survey of bankruptcy filers between 2013 and 2016, most respondents indicated medical debt as a reason for their bankruptcy.¹⁷ Bankruptcy may impact credit scores for up to 10 years, as limited by the Fair Credit Reporting Act.¹⁸ This is particularly troubling because credit scores increasingly have become important for obtaining employment, housing, and other financial products.¹⁹

Recently, the Big Three credit bureaus (Equifax, Experian, and TransUnion) announced changes to how they will report medical debt.²⁰ The credit bureaus announced that, beginning in July, they will remove medical debt that has been paid off. After March 2023, they will remove unpaid medical debt less than \$500. Going forward, they will wait a full year before adding new unpaid medical debts to credit reports. These changes will remove nearly 70 percent of medical debt from credit reports, helping many of the 15

¹³ Consumer Financial Protection Bureau. “Complaint Bulletin: Medical Billing and Collection Issues in Consumer Complaints”, April 2022, p. 18, available at https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf.

¹⁴ Consumer Financial Protection Bureau. “Complaint Bulletin: Medical Billing and Collection Issues in Consumer Complaints”, April 2022, p. 18, available at https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf.

¹⁵ Consumer Financial Protection Bureau. “Complaint Bulletin: Medical Billing and Collection Issues in Consumer Complaints”, April 2022, p. 22, available at https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf.

¹⁶ See Consumer Financial Protection Bureau. “Complaint Bulletin: Medical Billing and Collection Issues in Consumer Complaints”, April 2022, p. 23, available at https://files.consumerfinance.gov/f/documents/cfpb_complaint-bulletin-medical-billing_report_2022-04.pdf; citing a consumer who paid to have a medical debt removed, but it was never removed and the debt continued affecting their credit score, preventing them from obtaining a mortgage.

¹⁷ Himmelstein, et al. “Medical Bankruptcy: Still Common Despite the Affordable Care Act”, *American Journal of Public Health* (March 2019), available at <https://ajph.apha.org/doi/abs/10.2105/AJPH.2018.304901>.

¹⁸ “Medical Debt Burden in the United States”, Consumer Financial Protection Bureau (February 2022), p. 28–29, available at https://files.consumerfinance.gov/f/documents/cfpb-medical-debt-burden-in-the-united-states_report_2022-03.pdf.

¹⁹ Michael Best, Jenifer Bosco, and Chi Chi Wu. “Don’t Add Insult to Injury: Medical Debt and Credit Reports”, NCLC (November 2019), available at https://www.nclc.org/images/pdf/debt_collection/report-dont-add-insult-nov2019.pdf.

²⁰ “Consumer Advocates Cheer Removal of Most Medical Debt From Credit Reports”, National Consumer Law Center (March 18, 2022), available at <https://www.nclc.org/media-center/consumer-advocates-cheer-removal-of-most-medical-debt-from-credit-reports.html>.

percent²¹ of Americans with medical debt on their credit report and mitigating some of the harm to credit scores. But the remaining 30 percent of medical debt on credit reports will continue to harm the most vulnerable consumers, such as those facing catastrophic illness who cannot afford to pay. It will disproportionately impact consumers of color. Data from the Urban Institute shows that the median medical debt Americans have in collections is \$797, and \$854 among non-White communities.²² Individuals with more than \$500 in medical debt, many of them non-White, will still see medical debt on their credit reports. More needs to be done to protect the consumers, disproportionately non-White, who will not be covered by these changes.

For this reason, Congress needs to act to protect patient credit scores from medical debt. Specifically, Congress should ban providers and debt collectors from reporting medical debt for medically necessary services to credit reporting bureaus. At a minimum, Congress or the States should codify the reforms by the three major credit bureaus to limit providers and debt collectors from reporting medical debts to credit bureaus until one year has passed after the initial billing. The CFPB and FTC should strengthen Regulation F, including investigating compliance with Regulation F notice requirements, to ensure that consumers receive notices from debt collectors before credit reporting.

Q.3. A study from Johns Hopkins found that 26 of the 100 hospitals with the highest revenue, many of which are nonprofit or Government run, filed nearly 39,000 court actions against patients from 2018 to 2020. These actions include lawsuits, wage garnishments, and personal property liens.

What can be done to combat the use of abusive debt collection practices by hospitals?

A.3. 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 often place accounts with third-party collectors who may use frequent calls and other communications to pressure consumers to pay. These aggressive debt collection practices disproportionately affect communities of color and Black people, who are more likely than Whites to have medical debt in collections²³ and experience contact with debt collectors.²⁴ Additionally, some medical providers file collection lawsuits on alleged medical debts. Once they obtain

²¹ “Debt in America: An Interactive Map”. Urban Institute (Dec. 2020), available at https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_med.

²² *Id.*

²³ 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. See also “Debt in America: An Interactive Map”. Urban Institute (Dec. 2020), available at https://apps.urban.org/features/debt-interactive-map/?type=medical&variable=perc_debt_med.

²⁴ 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), available at https://www.urban.org/sites/default/files/publication/98919/the_well-being_and_basic_needs_survey_1.pdf.

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. Here is a quick glance at the problem:

- Nonprofit hospitals,²⁵ the very hospitals subject to the ACA's restrictions against "extraordinary collection actions," filed the most lawsuits against patients between 2018 and 2020.²⁶
- 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' homes.²⁷ In New York, nonprofit hospitals secured 4,880 liens in 2017 and 2018 on homes of patients who had unpaid medical bills.²⁸
- Between 2009 and 2018, hospitals in Maryland filed nearly 40,000 lawsuits that resulted in wage garnishment, often from their own employees.²⁹
- The ACLU documented cases of arrests for medical debts in several States, including Maryland, Arkansas, and Tennessee.³⁰ In Maryland, they observed a practice of patients being jailed for medical debts of less than \$1,000.³¹

Some States have taken steps during the past few years to address aggressive medical debt billing practices. In 2021, Maryland passed the Medical Debt Protection Act, which prohibits hospitals from requesting arrest warrants against patients and from requesting a lien against a patient's home; the Act also protects patients eligible for financial assistance against wage garnishment and adverse credit reporting.³² Similarly, Nevada's Medical Debt Protection Act that passed in 2021 prohibits a collection agency from taking civil actions for medical debts of less than \$10,000 or charging fees of more than 5 percent of the debt, and requires 60-day notification to the patient before a collection agency can take debt collec-

²⁵"Hospitals by Ownership Type". Kaiser Family Foundation, available at <https://www.kff.org/bf5afc7/>.

²⁶Michelle McGhee and Will Chase. "How America's Top Hospitals Hound Patients With Predatory Billing". Axios, Johns Hopkins University, available at <https://www.axios.com/hospital-billing>.

²⁷Froedtert 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), available at <https://www.propublica.org/article/some-hospitals-kept-suing-patients-over-medical-debt-through-the-pandemic>.

²⁸Elisabeth R. Benjamin and Amanda Dunker. "Discharged Into Debt: Nonprofit Hospitals File Liens on Patients' Homes", Community Service Society (November 2021), available at <https://www.cssny.org/publications/entry/discharged-into-debt-nonprofit-hospitals-file-liens-on-patients-homes>.

²⁹"Preying on Patients: Maryland's Not-for-Profit Hospitals and Medical Debt Lawsuits". National Nurses United (Feb. 2020), 9, 17, available at <https://www.nationalnursesunited.org/preying-on-patients>.

³⁰"A Pound of Flesh: The Criminalization of Private Debt". American Civil Liberties Union (2018), 45, available at https://www.aclu.org/sites/default/files/field_document/022118-debtreport.pdf.

³¹"A Pound of Flesh: The Criminalization of Private Debt". American Civil Liberties Union (2018), 45, available at https://www.aclu.org/sites/default/files/field_document/022118-debtreport.pdf ("including cases in which people were arrested in cases involving debts of \$217.50 and \$230 owed to an addiction service provider").

³²See Senate Bill 514, available at <http://mgaleg.maryland.gov/2021RS/bills/sb/sb0514T.pdf>. See also House Bill 565, available at http://mgaleg.maryland.gov/2021RS/fnotes/bil_0005/hb0565.pdf.

tion actions.³³ These laws, as well as similar legislation passed in New Mexico³⁴ and California³⁵ in 2021, are great starting points and illustrate what legislators can do to solve the problem of aggressive medical debt collection. At the Federal level, Congress should:

- ***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.
- ***Protect Patient Credit Reports.*** Pass H.R. 2537³⁶ and H.R. 2547,³⁷ prohibiting providers and debt collectors from reporting medical debts for medically necessary procedures to credit reporting bureaus. At a minimum, Congress should pass companion bills H.R. 773³⁸ and S. 214,³⁹ which would codify the reforms announced by the three major credit bureaus.
- ***Cancel Medical Debt and Pass Single-Payer Universal Health Care.***
 - Discharge medical debt incurred through care at facilities operated by the Federal Government, including U.S. Department of Veterans Affairs hospitals and clinics, as well as hospitals run by the Department of Defense and the Department of Health and Human Services. For privately held medical debt (debt incurred for care at nonprofit and for-profit facilities), the Federal Government should purchase medical debt from debt collectors and health care providers at discounted rates (avoiding a financial windfall for debt collectors) and discharge these debts.
 - 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.⁴⁰

³³ See Senate Bill 248, available at <https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/7770/Text>. The collector can still sue in small claims court, limiting the value of this provision.

³⁴ 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, available at <https://www.nmlegis.gov/Legislation/Legislation?Chamber=S&LegType=B&LegNo=71&year=21>. See also “New Mexico Patients’ Debt Collection Practices Act Signed by Governor”. ACA International (Apr. 7, 2021), available at <https://www.acainternational.org/news/new-mexico-patients-debt-collection-practices-act-signed-by-governor/>.

³⁵ See AB 1020, available at https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB1020.

³⁶ See H.R. 2537 (Rep. Tlaib), Consumer Protection for Medical Debt Collections Act, available at <https://www.congress.gov/bills/117/congress/house-bill/2537>.

³⁷ See H.R. 2547 (Rep. Waters), Comprehensive Debt Collection Improvement, available at <https://www.congress.gov/bills/117/congress/house-bill/2547>.

³⁸ See H.R. 733 (Rep. Porter), Medical Debt Relief Act of 2021, available at <https://www.congress.gov/bills/117/congress/house-bill/733>.

³⁹ See S. 214 (Sen. Merkley), Medical Debt Relief Act of 2021, available at <https://www.congress.gov/bills/117/congress/senate-bill/214>. See also S. 355 (Sen. Van Hollen), COVID-19 Medical Debt Collection Relief Act of 2021, available at <https://www.congress.gov/bills/117/congress/senate-bill/355>.

⁴⁰ 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), avail-

For additional guidance, see NCLC's "Don't Add Insult to Injury: Medical Debt and Credit Reports",⁴¹ which provides an overview of the crisis of medical debt and potential reforms to protect consumer credit reports. NCLC's "Model Medical Protection Act"⁴² also offers language policymakers can use to build on existing State policies and guide the development of new policies to protect consumers from medical debt.

able at <https://www.brookings.edu/research/the-racial-implications-of-medical-debt-how-moving-toward-universal-health-care-and-other-reforms-can-address-them/>.

⁴¹ Available at https://www.nclc.org/images/pdf/medical-debt/Rpt_Ounce_of_Prevention.pdf.

⁴² Available at <https://www.nclc.org/images/pdf/medical-debt/model-medical-debt-protection-act-082017.pdf>.

ADDITIONAL MATERIAL SUPPLIED FOR THE RECORD
STATEMENT SUBMITTED BY MINDY HEDGES

Senate Committee on Banking, Housing, & Urban Affairs
Testimony - Consumer Medical Debt
March 29, 2022
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Chairman Brown, Ranking Member Toomey, and the Majority and Minority members of the Senate Committee on Banking, Housing and Urban Affairs, thank you for inviting me to speak to you today about consumer medical debt.

My name is Mindy Hedges. I live in a rural Ohio community, 50 miles north of Columbus Ohio.

I came here today to explain to you the difficulty of having a pre-existing condition and medical debt because of it. I am hopeful you will be able to help find a solution to assist those of us who have had difficulty making ends meet because of the excessive costs of medical supplies, insurance and testing in our country for those of us with chronic illnesses.

I am a Type 1 diabetic and have had diabetes since the age of 5, going on 62 years. If you look around this room, I would bet that most of you have someone in your family or a neighbor or close friend who is also

diabetic, and has gone through some of what I will be telling you about.

The daily cost for a Type 1 diabetic is so tremendous that many can't afford the cost of their medication that keeps them alive, or the instrument that puts that medication into their system. And for many, including me, this debilitating disease puts many of those people in debt. My yearly out-of-pocket costs for my diabetic supplies and medications costs me over \$8,000 per year, WITH INSURANCE.

So, here's the beginning of my story. When I first opened my company in 1990, and started to hire employees, I wanted to get them health insurance. I started to look for coverage around 1992, when our business was growing. When I started to search for it, many companies would not even quote because I, as the owner, had a pre-existing illness. I offered my staff the opportunity to get health insurance on their own, and my company would pay for ½ of the premium. Not ideal, as this type of coverage costs a company way more than a group health plan.

After several years of this type of benefit, we were getting bigger, and I tried again to get insurance. We were again turned down, with the same answer. I then took myself out of the coverage pool and got an insurance company to quote. When they did, however, they made a mistake and had me in the quote. Thankfully, Ohio's law at that time stated that if a company quoted on an insurance coverage policy, they were bound by that quote and could not back out, although they

tried. Every year I was worried that this insurance would drop my company because of my condition, so it held us bound to the first and only company that made a mistake and had to cover us, no matter how they raised their premiums.

I had to close my business in 2009 because of the horrible recession. My husband also worked in my company, so we were both unemployed and without insurance. This was pre-Affordable Care Act, and I was getting quite a few phone calls about insurance coverage, as the insurance brokers stalk the unemployment lists online. All I had to say, when they first called and identified themselves, was that I was a Type 1 diabetic. Most of them hung up without another word.

Only one told me that if they did quote, it would be somewhere between a \$2,000 - \$5,000 in a premium payment per month, but they still wouldn't quote on it or offer us insurance. Both of us were on unemployment so these costs were more than we had every month to spend on our mortgage and food. In addition, my pharmaceuticals, including insulin and insulin pump supplies, cost around \$700 per month. Our only decision was to not have insurance.

One of my friends studied to be an actuary and went over all the figures with me. She suggested that I pay for my pharmacy needs out of pocket, which was less expensive than insurance. She said that Ohio's hospitals cannot reject any person from major medical care if I or my husband needed hospitalization. Lots of tears and lots of

thinking only gave us one option -- no insurance until the Affordable Care Act was passed! I thankfully had some friends and neighbors who were supplying me with some pump supplies so we didn't have to buy them.

We barely survived. And then the medical bills came, with very little money to pay for them. We had collectors calling but tried hard to hold them off every month. I negotiated, I begged, I even called the pharmaceutical companies that manufactured my insulin – there were only two companies at the time - to see if they had a fund set up for those of us who were having difficulty during this terrible recessionary period. After trying to reach 5 different people at one company, I gave up. I finally reached someone at the 2nd company's Community Relations' department, who told me they didn't have any fund like that, and I would have to pay their cost of around \$500 per bottle. The same insulin, in Canada, sold for \$25 at the time. And both of these companies made a profit of over \$60 billion the year prior! We had over \$9,000 in debt, which we are still paying small monthly payments on. I have \$90 left to pay. But the emotional and physical harm the collection agencies cause were immeasurable. I lost weight, couldn't eat, and didn't want to leave the house because I was afraid of getting accosted for money. I knew better, but they were relentless.

When the Affordable Care Act was approved, I signed on right away. They were so kind, caring, and helpful. We got a tax abatement, which made our premium affordable.

I want to explain about how diabetes is increasing, and the debt it causes for American families. Here are some important statistics about this debilitating and expensive disease:

- Approximately 1.84 million Americans will have type 1 diabetes. By 2050, 5 million people are expected to be diagnosed with type 1 diabetes. An estimated 64,000 people are diagnosed with type 1 diabetes each year. 200,000 people under the age of 20 years old have this illness, which is uncurable, but possibly can be treatable, with medications and durable medical equipment.
- In 2021, 37.3 million Americans—about 1 in 10—have both type 1 and type 2 diabetes.
- Of the 37.3 million, about 1 in 5 people with diabetes don't know they have it.
 - 96 million American adults—more than 1 in 3—have prediabetes.
 - More than 8 in 10 adults with prediabetes don't know they have it.
- In 2019, about 1.4 million new cases of diabetes were diagnosed.
- For adults with diagnosed diabetes, it is the number one cause of heart failure, blindness, and kidney failure, as well as amputation of feet and legs. It is a disease that causes many body functions to eventually fail, which costs an excessive amount of money, if not controlled.
 - 69% had high blood pressure, and 44% had high cholesterol.

- 39% had chronic kidney disease, and 12% reported having vision impairment or blindness.
- Diabetes was highest among Black and Hispanic/Latino adults, in both men and women.

Diabetes and diabetes-related health complications can be serious and costly.

- The average diabetic spends \$16,750 a year on medical care, or about \$10,000 a year more than people without diabetes. The cost of diabetes medications, which account for most of that total, rose 52.8% between 2014 and 2016, compared to an 18.8% cost increase for all other drugs.
- The seventh leading cause of death in the United States, diabetes costs a total estimated \$327 billion in medical costs and lost work and wages.
- People with diagnosed diabetes have more than twice the average medical costs that people without diabetes have.
- There are \$16 billion in type 1 diabetes-associated healthcare expenditures and lost income each year.
- Preliminary data from T1 International's 2018 access and supply survey that says 1 of every 4 US respondents have rationed insulin due to cost.
 - Roughly a quarter of diabetic patients dependent on insulin skimp or even skip doses altogether.
 - According to a Commonwealth Fund study, uninsured Americans with diabetes are more likely to be using older, less costly (and less effective)

formulations of insulin compared to those with private insurance or Medicaid. Sixty-eight percent of uninsured patients pay the full list price for insulin, while 9% of privately insured and 3% of Medicaid beneficiaries do. Consequently, the uninsured are much more likely to report being unable to afford prescription medicines, by a 38% to 10% margin.

I am so thankful that this Senate Committee is hearing testimony on Medical Debt. Please take into account that part of this debt is the cost of insurance. Diabetics, and others with chronic illnesses, cannot go uninsured, or without coverage that helps us buy pharmaceuticals and durable medical equipment like the insulin pump and pump supplies. These are necessities that keep us alive. There are no alternatives. Our lives and whether we can eat, pay our mortgages or rents, or pay medical bills, are in your hands.

STATEMENT SUBMITTED BY PENELOPE WINGARD

My name is Penelope Wingard, and I live in Charlotte, North Carolina. My life changed forever in February of 2013 when I was diagnosed with stage two breast cancer. Hearing the news was shattering. As the doctor continued to speak, I felt like it was a dream – someone else's life. I was placed on Medicaid (Breast/Cervical Cancer Medicaid) and was able to receive the treatment I needed. I went through chemotherapy, which was extremely hard on my body. During the chemo, I was rushed to the hospital, feeling dizzy, with a headache. I was devastated to find out that I had a brain aneurysm, which would have to be dealt with, and then, a few years later I would be facing another life-altering medical condition. Dealing with my health issues was stressful and scary enough, but unfortunately, I would soon also be worrying about the financial burden of medical debt, as well as trying to figure out how I was going to pay for my ongoing treatments and medicines. This added anxiety was completely unnecessary, and downright cruel.

My chemo ended in August 2013 and ahead of me was surgery for the breast cancer followed by surgery for the aneurysm. Following the breast cancer surgery, I had to have radiation treatment which took such a terrible toll on my body, that I had to stop the treatment twice because the burns and blisters were so painful. I went every day for 3 months. At this point I didn't think anything could be worse than chemo, but this was. I leaned heavily on my family which took a toll on their lives.

February 2014, the day after my last radiation treatment, my Medicaid stopped. There was no warning, it just stopped, and because North Carolina has not expanded Medicaid, I found myself uninsured. My oncologist refused to treat me because I could no longer pay. My surgeon would no longer see me because I had no insurance. I had to start all over again as if it was the first day of my diagnosis. I found a new oncologist who is seeing me with no payment, but I owe him thousands of dollars for continuing my treatment. As far as the brain aneurysm – I had to have surgery twice because the first surgery failed. The first surgery was covered, but the second one wasn't, and my medical debt was growing. Also, the doctor I was seeing for the aneurysm would no longer see me because I didn't have insurance.

Then in 2016, I found myself facing another medical emergency. Out of the blue, my vision became extremely blurry, especially when I woke up. I just thought I needed glasses, so my aunt set up an appointment with an ophthalmologist. She paid for this appointment out of her pocket, again since I had no insurance. I knew something was wrong when he referred me to a specialist, but I didn't know it was going to affect my life forever. I had to have corneal transplants in both eyes because I was losing my vision. The surgeries were 3 months apart. I had no insurance, so I had to find programs that would help me with this cost. I did have the surgery, but I will have to be on eye drops for the rest of my life to maintain my vision.

As my medical bills grew, and my health problems continued, I felt hopeless. I had to rely on my family, especially one aunt to help me pay my bills. Until this day, she doesn't pick up the phone or speak to me because she thinks that I am calling her to ask her help to pay my medical bills or for medicine. It has cost her a lot and I have no way of

paying her back. Getting sick and struggling with medical debt, doesn't just destroy your health, it can destroy your family. It can destroy your relationship and your friendships. It destroys your credit. My credit report is filled with medical debt. It is probably about \$50,000, and all because I had the audacity to get sick, and I can't afford health coverage. I can't buy a house, or lease a car, or get something else financed. There are times I can barely afford food or other necessities. This medical debt is ruining my life, breaking my spirit, and will continue to do so unless I can pay it off.

I get calls from bill collectors every week and have for years. They talk down to me, and it borders on harassment, which is incredibly stressful. One person threatened to seize my property, which thankfully they can't do because it is not in my name.

No one asks to get sick, and I am certainly not alone in this experience.

All across America people are suffering and are much worse off than me. I have been lucky enough to survive breast cancer, to not go blind, to get my aneurysm dealt with (for now). But because I remain uninsured it is difficult for me to get my mammogram every 6 months like I need to, or get the aneurysm checked every year, which I am supposed to. Sometimes I can find programs that help, but that takes hours of my time, and it is not always successful. Any treatment I do get means more medical debt, which makes me think twice about getting the care that I need. It's almost like you're a walking time bomb. We should have a country where if you do get sick, you shouldn't have to worry about how you will pay for treatment or medicines.

The top four credit agencies have just announced that they will now delay adding medical debt to your credit report. This is a good start, but it is not enough. We are the only developed country that allows our people to go broke because they got sick. Medical debt should be forgiven, which would allow people to focus on healing. In North Carolina, we should expand Medicaid as soon as possible to ensure more people, especially those with low incomes can get health insurance. If North Carolina, and the other 11 non-expansion states won't do it, the federal government should offer a federal coverage gap solution. But those are temporary band-aids on a gaping wound. What the American people need is a universal single-payer system that prioritizes health and wellness over the bottom line and covers everyone equitably.

We can and must do better. The United States of America should prioritize achieving universal health coverage for everyone and should be investing resources into creating a healthier and more productive population.

STATEMENT SUBMITTED BY SLOANE WESLOH

Written Testimony of Sloane Wesloh
regarding
“Economic Impact of the Growing Burden of Medical Debt”
for the U.S. Senate Committee on Banking, Housing, and Urban Affairs
March 29, 2022

When I was diagnosed with type 1 diabetes at age 12, I was told that my life wouldn't look much different than before: I'd need to take injections and test my glucose levels, but my doctor was adamant that this diagnosis wouldn't change me. Unfortunately, factors outside of the biological realm, including treatment cost, are often overlooked in considering the burden of disease.

Nearly 10 years later, at the counter of a CVS pharmacy in Pittsburgh, PA, I attempted to pick up a prescription for a one-month supply of insulin: for me, that was one bottle of insulin. The pharmacist leaned over the counter and whispered, “Do you know how expensive this is?” gesturing to the \$829.22 flashing on the register. I was confused: how could it be this expensive even with my insurance? It was the first time that I walked away from the counter without my prescription, slinking to the ground in the corner of that pharmacy to pull up my bank account details. It was just after the first of January; the \$800 in rent I paid monthly had nearly drained my bank account.

As a type 1 diabetic in this situation, you have very little choice as to how to make your next move. Your body requires insulin 24/7 regardless of food or activity. There is no waiting until your next paycheck. There is no waiting until you have a better job or a more stable financial situation, or perhaps until a friend can loan you the money. If there is no insulin in your fridge, you risk developing acute complications, such as diabetic ketoacidosis (DKA). DKA is a dangerous state of metabolic acidosis induced by hyperglycemia, which can occur when the body does not have enough insulin. It can rapidly develop from flu-like symptoms to coma and even death. It is the startling reality of life with type 1 diabetes that rationing or restricting insulin entirely can lead to devastating outcomes in a matter of just a few days. This harsh reality perpetuates a cycle of debt.

Sitting in the corner of that CVS, I called my parents and tried to figure out how to afford this bottle of insulin. Since it was the start of a new year, the deductible on my insurance plan had just reset and I needed to pay fully out of pocket until it was met. I put the charge on a credit card with an APR of 22.24%. The situation played out for the next few months until my deductible was met, and I spent the rest of the year working to pay off the debt and its accumulating interest. But deductibles reset each January and thus so, too, do cycles of damaging debt. By the next January, my financial situation wasn't much improved, but type 1 diabetes is a chronic condition which will never go away. I found myself back at the pharmacy, an \$800 bottle of insulin on the counter. In this story, there is no choice to exit the cycle of debt. It is life or death.

The story that I have told comes from a place of privilege, as an individual with health insurance and the ability to put out of pocket healthcare costs on credit cards. It highlights the heterogeneity of medical debt. Medical debt can rear its head as the burden of an unexpected large cost: an ambulance bill or a surgery, reasons patients often turn to crowdfunding sources such as GoFundMe to avoid debt. Sometimes, though, the burden of medical debt is a weight accumulated over months and years; a process of give-and-take. This slow build-up of medical debt is often part of

the burden of living with a chronic condition like type 1 diabetes. Dependent on medications like insulin and the supplies required for its administration, patients may have no choice but to pay using whatever means are available. Life with a chronic condition should not entail a choice between debt and the potential for complication or death. Unfortunately, because of our expensive healthcare system, patients are forced to make this decision every day.

The burden of choice between debt and complication due to the inability to access treatment is untenable. Making steps to protect consumers from debt is a necessary endeavor. But medical debt is a symptom of the unsustainable cost of our healthcare system. Removing the burden of the patient's choice between debt and complication means addressing the issue of truly affordable and accessible healthcare head-on.

I thank you for the opportunity to share my story. Countless others are living this story and stories like it each day. In pharmacies across the US, people are walking out without the medications they so desperately need, or they might be walking out with a one month supply and bundle of debt. COVID-19 is only increasing the number of people who will experience medical debt and specifically medical debt affiliated with chronic disease. To address the burden of this debt requires not only protection for consumers, but broader changes to the affordability of our healthcare system to prevent debt from becoming a choice between life or death.