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Most Adults with Past-Due Medical Debt Owe Money to Hospitals

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Though the Affordable Care Act (ACA) substantially reduced medical debt and other indicators of financial distress, the challenge of medical debt persists (Caswell and Waidmann 2019; Kluender et al. 2021). More than 100 million adults have medical or dental bills they are paying off over time or that are past due, placing them at elevated risk of forgoing health care in the future, struggling to afford food and housing, and facing damaged credit and other financial hardships (CFPB 2022; Himmelstein et al. 2022; Lopes et al. 2022). To protect patients from these consequences, policymakers have increasingly focused on the role of hospital billing and collection practices in contributing to medical debt, with particular scrutiny directed toward nonprofit hospitals' provision of charity care.¹

Federal law requires nonprofit hospitals to establish financial assistance policies and determine if patients are eligible for charity care before engaging in certain actions to collect payment. But hospitals set their own eligibility criteria, and many patients who likely qualify for charity care do not receive it, with some facing aggressive debt collection tactics.² Moreover, for-profit and public hospitals and other health care providers are not subject to these requirements. In response, states have strengthened regulation of hospital financial assistance and debt collection practices and broadened consumer protections to cover all types of hospitals, and in some cases, other providers (Robertson, Rukavina, and Fuse Brown 2022; Stark and Bosco 2021). Understanding the experiences of people with past-due bills owed to hospitals and other providers can shed light on the potential for these policies to alleviate debt burdens.

Using June 2022 data from a nationally representative sample of adults ages 18 to 64 who participated in the Urban Institute’s Health Reform Monitoring Survey (HRMS), this brief examines past-due medical debt among adults and their families.³ It assesses the share of adults with past-due hospital bills and other medical debt and the actions taken by hospitals to collect payment or make bills easier to settle. The analysis focuses on the experiences of adults with family incomes below and above 250 percent of the federal poverty level (FPL), approximating the income cutoff used by many hospitals to determine eligibility for free and discounted care (Goodman et al. 2020). Key findings include the following:

- More than one in seven adults (15.4 percent) live in families with past-due medical debt. Nearly two-thirds of these adults have incomes below 250 percent of FPL.
- Nearly three in four adults with past-due medical debt (72.9 percent) reported owing at least some of that debt to hospitals, including 27.9 percent owing hospitals only and 45.1 percent owing both hospitals and other providers. Adults with past-due hospital bills generally have much higher total amounts of debt than those with past-due bills only owed to non-hospital providers.
- Most adults (60.9 percent) with past-due hospital bills reported that a collection agency contacted them about the debt, but much smaller shares reported that the hospital filed a lawsuit against them (5.2 percent), garnished their wages (3.9 percent), or seized funds from a bank account (1.9 percent).
- Though about one-third (35.7 percent) of adults with past-due hospital bills reported working out a payment plan, only about one-fifth (21.7 percent) received discounted care.
- Adults with incomes below 250 percent of FPL were as likely as those with higher incomes to experience hospital debt collection actions and to have received discounted care.

The persistence of medical debt highlights the ongoing challenges families face in obtaining affordable health care, including high prices for services, gaps in access to health insurance coverage, and inadequate protection against out-of-pocket costs for many people with high-deductible insurance plans. The concentration of past-due medical debt among families with low incomes and the large share who owe a portion of that debt to hospitals suggests that expanded access to hospital charity care and stronger consumer protections could complement coverage expansions and other efforts to mitigate the impact of unaffordable medical bills. The following sections provide context on federal and state policies related to hospital financial assistance and debt collection, present the survey results, and discuss policy implications. The survey data, methods, and limitations are described at the end of the brief.

Background: Federal and State Policies Regulating Hospital Charity Care and Debt Collection Practices

Federal regulation of hospital financial assistance and debt collection practices targets nonprofit hospitals, which make up nearly 6 in 10 community hospitals in the US.⁴ These hospitals must provide charity care and other community benefits to maintain their tax-exempt status.⁵ The ACA requires tax-exempt hospitals to establish and publicize written financial assistance policies (FAPs) for all emergency and medically necessary care provided by the facilities.⁶ The law further stipulates that tax-exempt hospitals must make “reasonable efforts” to determine whether patients are eligible for charity care before taking extraordinary collection actions, such as seeking wage garnishment.⁷ However, nonprofit hospitals determine their own charity care eligibility criteria, and FAPs are often difficult to find, use vague language, and have varying documentation requirements, income and asset limits, charges discounted, and services and providers covered (Fuse Brown 2015; Goodman et al. 2020; Goodman et al. 2022; Velasquez 2021).⁸ The lack of clear federal standards, inconsistent data collection, and limited enforcement mechanisms contribute to the challenges of overseeing compliance with ACA rules (GAO 2020).

These federal consumer protections do not apply to for-profit hospitals and most public hospitals. Evidence nonetheless suggests the nonprofit hospital requirements have limited impact (Bruch and Bellamy 2020; Herring et al. 2018). Nonprofit hospitals dedicate a smaller aggregate share of total expenses toward charity care than for-profit and public hospitals, and charity care spending among nonprofits varies widely, with the most financially successful hospitals spending less on charity care as a share of net income (Bai et al. 2021; Bai, Yehia, and Anderson 2020; Levinson, Hulver, and Neuman 2022). Nearly half of nonprofit hospitals report having bad debt⁹ owed by patients who would have likely qualified for charity care under their FAPs.¹⁰ Studies have also documented the extent to which nonprofit hospitals file lawsuits against patients and take other aggressive collection actions (Bruhn et al. 2019; Cooper, Hahn, and Mahoney 2021; Dunker and Benjamin 2020; Dunker and Benjamin 2022; Eliason, MacDougall, and Peterson 2022; National Nurses United 2020; Villagra et al. 2019).¹¹

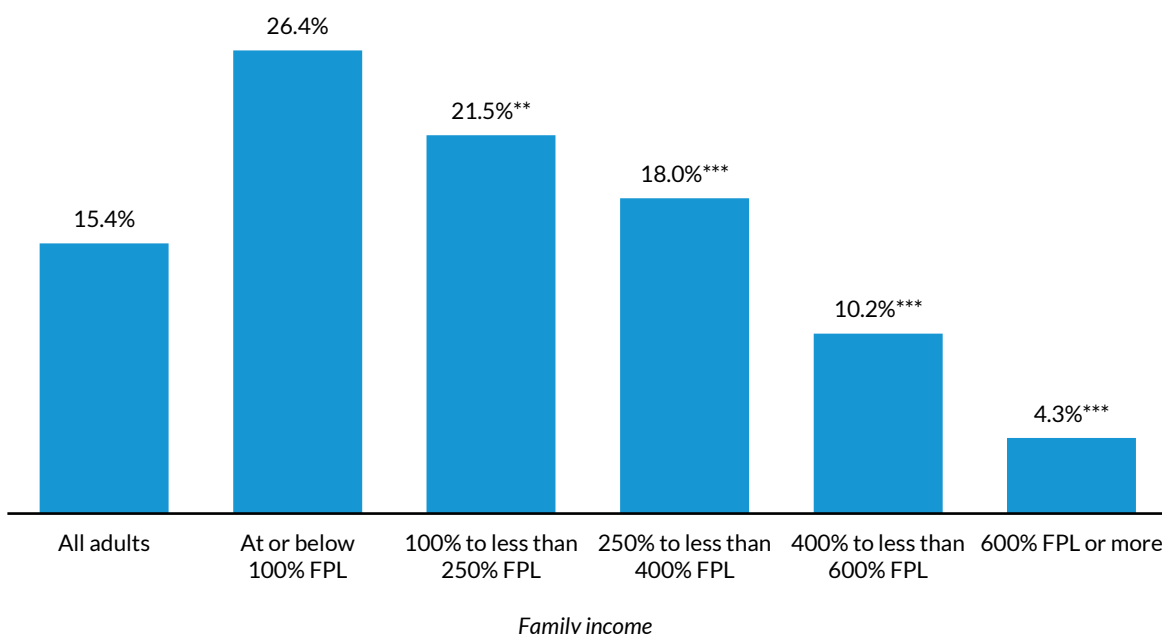
To address gaps in consumer protections, many states have enacted policies that go beyond federal rules. These include minimum criteria and mandatory screening for charity care eligibility for all hospital types (Stark and Bosco 2021).¹² For instance, states such as Illinois, Maryland, New Jersey, Oregon, and Rhode Island mandate free care for some or all patients with incomes below 200 or 250 percent of FPL and/or discounted care at higher income levels (Stark and Bosco 2021). States have also taken steps to restrict debt collection, such as prohibiting hospitals from placing liens on primary residences and limiting wage garnishment (Robertson, Rukavina, and Fuse Brown 2022). The next section offers insight on the potential of these policies to mitigate the impact of medical debt by presenting survey results on the experiences of adults with past-due medical debt owed to hospitals and other providers.

Results

More than one in seven nonelderly adults live in families with past-due medical debt, which is concentrated among families with low incomes.

Figure 1 shows that 15.4 percent of nonelderly adults reported that they or their families have unpaid medical bills that are past due. These include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing homes, or home care that may have been incurred in the past year or earlier years.

FIGURE 1
Share of Adults Ages 18 to 64 Reporting Past-Due Medical Debt, Overall and by Family Income, June 2022



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Source: Health Reform Monitoring Survey, June 2022.

Notes: FPL is federal poverty level.

*/**/*** Estimate differs significantly from adults with income at or below 100% FPL at the 0.10/0.05/0.01 level using two-tailed tests.

The prevalence of past-due medical debt declines as family income rises. More than one in four (26.4 percent) adults with incomes below 100 percent of FPL—about \$13,600 for a single adult and \$23,000 for a family of three—reported past-due medical debt, as did more than one in five (21.5 percent) with incomes between 100 and 250 percent of FPL and just under one in five (18.0 percent) with incomes between 250 and 400 percent of FPL. Past-due medical debt was less common among

those with incomes between 400 and 600 percent of FPL (10.2 percent) or at or above 600 percent of FPL (4.3 percent), but it still affected a notable share of the population at those income levels.

Though less than half of all adults (43.2 percent) had family incomes below 250 percent of FPL, nearly two-thirds of adults reporting past-due medical debt (65.1 percent) had incomes below this threshold (data not shown).¹³

The survey data also highlight inequities by race, ethnicity, and disability status, which is consistent with previous studies of medical debt (Bennett et al. 2021; Lopes et al. 2022; Karpman, Martinchek, and Braga 2022). Black and Hispanic/Latinx adults were more likely to report past-due medical debt than white adults (25.9 percent and 19.1 percent versus 12.8 percent; data not shown).¹⁴ Adults with disabilities were more than twice as likely as those without disabilities to have past-due medical debt (29.1 percent versus 12.5 percent; data not shown).

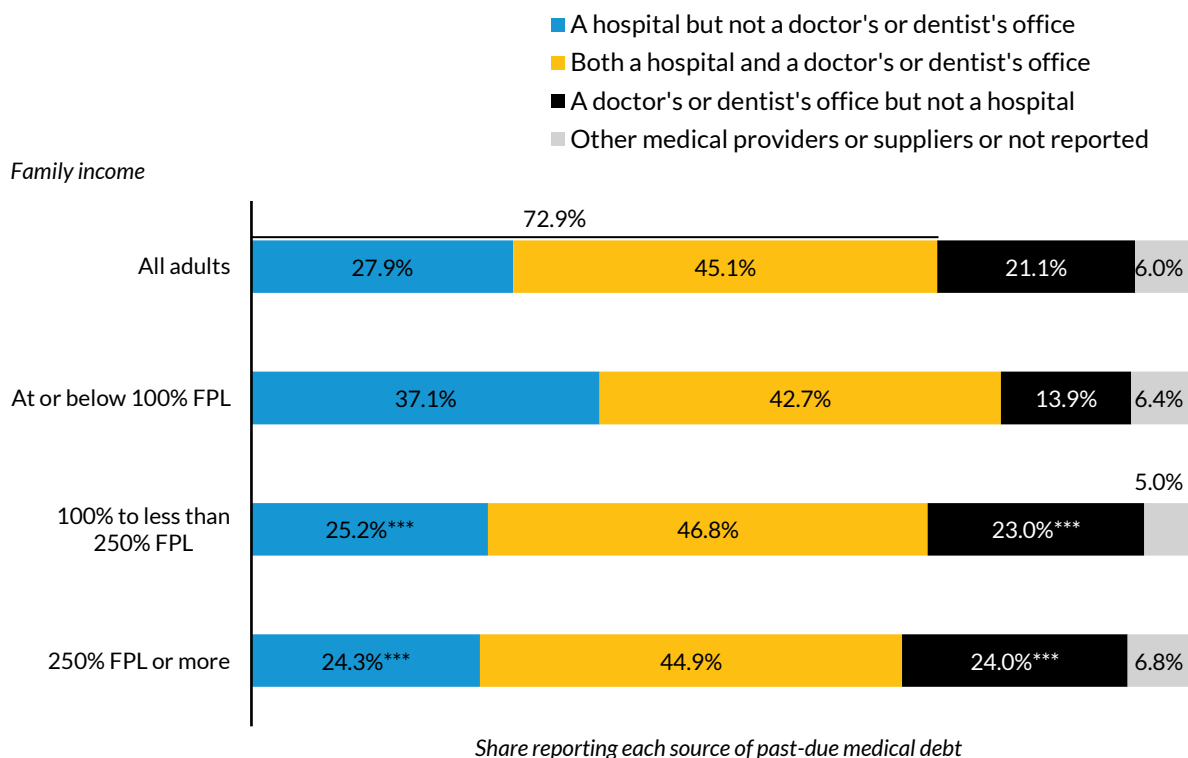
Nearly three in four adults with past-due medical debt owe at least some of that debt to hospitals.

Figure 2 shows that 72.9 percent of adults with past-due medical debt owed some or all of their debt to hospitals. This includes 27.9 percent of adults who only owed debt to a hospital and 45.1 percent who owed to both a hospital and a doctor or dentist. The latter group may include adults who incurred medical debt during separate visits to a hospital and a non-hospital provider or from the same hospital visit (i.e., in which the patient received separate bills from the hospital and a physician). Another 21.1 percent reported past-due bills from a doctor or dentist but not a hospital, and 6.0 percent owed other types of medical providers or suppliers or did not report the source of their debt.

The share of adults who owed at least some of their past-due medical debt to hospitals was even higher among adults with the lowest incomes. About 8 in 10 adults with medical debt and income below 100 percent of FPL (79.7 percent) owed some or all of their debt to hospitals, compared with about 7 in 10 adults with incomes between 100 and 250 percent FPL (71.9 percent) or at or above 250 percent of FPL (69.2 percent).

FIGURE 2

Source of Past-Due Medical Debt Among Adults Ages 18 to 64, Overall and by Family Income, June 2022



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Source: Health Reform Monitoring Survey, June 2022.

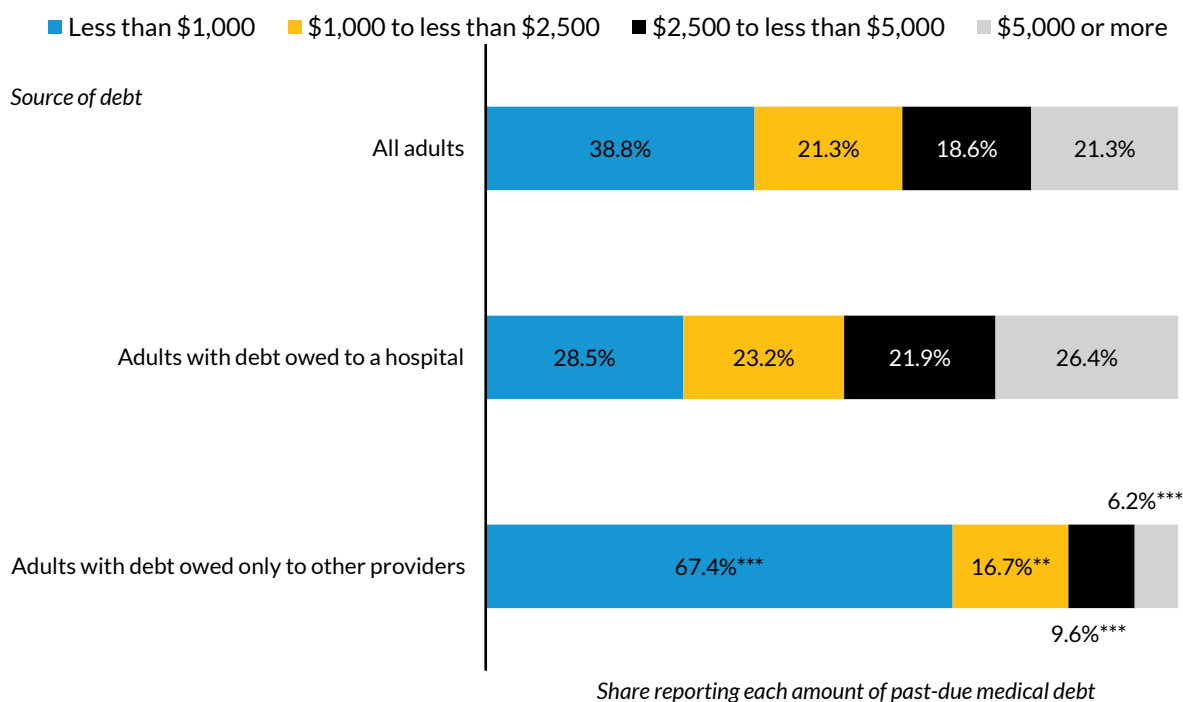
Notes: FPL is federal poverty level. Adults with past-due medical debt owed to hospitals and/or doctor's or dentist's offices may also have debt owed to other medical providers or suppliers.

*/**/** Estimate differs significantly from adults with income at or below 100% FPL at the 0.10/0.05/0.01 level using two-tailed tests.

Adults with any past-due hospital bills were more likely to have much higher total amounts of medical debt than adults who only had past-due bills from non-hospital providers (figure 3). More than two-thirds (67.4 percent) of adults with past-due medical debt owed only to non-hospital providers had debt amounts of less than \$1,000 in total, and a relatively small share (6.2 percent) owed \$5,000 or more. In contrast, less than one-third (28.5 percent) of adults who owed a hospital had total past-due debt amounts of less than \$1,000, and over one-quarter owed \$5,000 or more (26.4 percent). This difference may reflect several factors, including higher overall service use, higher-cost procedures, and less predictability in anticipated costs among those with hospital debt. Debt amounts were slightly lower among adults with past-due bills owed to hospitals and no other providers compared with adults owing both a hospital and another type of provider (data not shown).

FIGURE 3

Amount of Past-Due Medical Debt Among Adults Ages 18 to 64, Overall and By Source of Debt, June 2022



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Source: Health Reform Monitoring Survey, June 2022.

Notes: Adults with past-due medical debt owed to hospitals may also have debt owed to doctor’s or dentist’s offices and other medical providers or suppliers. Estimates are not shown for adults who did not report the source of the medical debt. Adults who did not report the amount of medical debt are excluded from the denominator of estimates.

*/**/** Estimate differs significantly from adults with past-due medical debt owed to a hospital at the 0.10/0.05/0.01 level using two-tailed tests.

Most adults with past-due medical debt owed at least \$1,000, and more than one in five owed at least \$5,000, results that are consistent with other recent surveys (Bennett et al. 2021; Lopes et al. 2022). Adults with incomes below 100 percent FPL were more likely than higher-income adults to have debt of at least \$5,000 (data not shown), perhaps because of their higher uninsurance rates and more limited protection against high medical bills resulting from inadequate coverage: 40.8 percent of adults at this income level incurred debt only during periods with insurance, 37.1 percent incurred debt only during periods without insurance, and 22.1 percent incurred debt during periods with and without insurance.

Overall, 63.5 percent of adults with past-due medical debt incurred their debt only during periods with insurance, 20.5 percent incurred debt only during periods without insurance, and 16.0 percent incurred debt during periods with and without insurance (data not shown). The share of adults who had health insurance coverage at the time they incurred medical debt is largely unchanged from nearly a

decade ago, highlighting the incomplete protection against high out-of-pocket medical expenses that many people receive from their coverage (Karpman and Long 2015).

Most adults with past-due hospital bills had their debt referred to a collection agency, even adults with incomes below 250 percent of FPL.

More than 6 in 10 adults (60.9 percent) with past-due hospital bills reported that the hospital had a collection agency contact them about the debt (table 1). This share did not differ significantly by family income. Adults with incomes below 100 percent of FPL and between 100 and 250 percent of FPL were roughly as likely to report being contacted by a collection agency as adults with incomes above 250 percent of FPL.

TABLE 1

Actions Taken by Hospitals to Collect Payment for Past-Due Medical Bills from Adults Ages 18 to 64, Overall and By Family Income, June 2022

	All adults	At or below 100% FPL	100% to less than 250% FPL	250% FPL or more
Had a collection agency contact the respondent or family	60.9%	60.7%	63.8%	57.5%
Filed a lawsuit against the respondent or family	5.2%	7.6%	4.2%	4.5%
Garnished wages	3.9%	4.0%	4.7%	2.9%
Seized funds from a bank account	1.9%	2.3%	2.0%	1.5%
Sample size, adults with any debt owed to a hospital	1,192	324	554	314

Source: Health Reform Monitoring Survey, June 2022.

Notes: FPL is federal poverty level. Respondents could report more than one action to collect payment.

Smaller shares of adults with past-due hospital bills reported that the hospital filed a lawsuit against them (5.2 percent), garnished their wages (3.9 percent), or seized funds from a bank account (1.9 percent). Even though these actions were much less common than having collection agencies seek to recover payment, the estimated shares of adults reporting these actions represent hundreds of thousands of adults and their families affected by aggressive debt collection practices. Though adults with incomes below 100 percent of FPL were more likely than adults at higher income levels to report being sued, these differences were not statistically significant.

Though about one-third of adults with past-due hospital bills reported working out a payment plan, fewer received discounted care.

Just over one in three adults with past-due hospital bills (35.7 percent) reported that the hospital made those bills easier to pay by working out a payment plan allowing them to make partial payments over

time (table 2). Payment plans were less common among adults with incomes below 100 percent of FPL than among adults with incomes between 100 and 250 percent of FPL or incomes at or above 250 percent of FPL (24.7 percent versus 36.8 percent and 43.6 percent). However, the financial protection consumers received from these payment plans was unclear. For instance, medical credit cards with high interest rates could lead to increased debt.¹⁵

TABLE 2

Actions Taken by Hospitals to Make Past-Due Medical Bills Easier to Pay for Adults Ages 18 to 64, Overall and by Family Income, June 2022

	All adults	At or below 100% FPL	100% to less than 250% FPL	250% FPL or more
Worked out a payment plan to accept partial payments over time	35.7%	24.7%	36.8%***	43.6%***
Offered discounted care	21.7%	23.7%	20.2%	21.7%
Negotiated to lower the bill amount	15.3%	16.3%	14.0%	16.1%
Reduced bills through a financial assistance program	12.1%	13.3%	12.5%	10.7%
Offered help with applying for Medicaid	5.8%	9.2%	6.9%	1.8%***
Sample size, adults with any debt owed to a hospital	1,192	324	554	314

Source: Health Reform Monitoring Survey, June 2022.

Notes: FPL is federal poverty level. Respondents could report more than one action to make bills easier to pay.

*/**/** Estimate differs significantly from adults with income at or below 100% FPL at the 0.10/0.05/0.01 level using two-tailed tests.

A smaller share of adults, 21.7 percent, reported receiving some form of discounted care in which the hospital reduced the amount they owed; this group included 15.3 percent who negotiated a lower bill amount and 12.1 percent who reported that the hospital reduced their bills through a financial assistance program. Adults with incomes below 250 percent of FPL were as likely as adults with incomes above that level to report receiving financial assistance. The results suggest that most of the lower-income adults with past-due hospital bills were not eligible for charity care, were eligible but unaware it was available or did not apply successfully, or received care from a hospital without a financial assistance policy. Only 5.8 percent of adults with past-due hospital bills reported that the hospital offered to help them apply for Medicaid, including 9.2 percent of adults with incomes below 100 percent of FPL.

Actions taken by doctors or dentists followed similar patterns as actions taken by hospitals: referring debt to collections agencies was the most common method of collecting payment and working out a payment plan was the most common method of making bills easier to pay (data not shown).

Discussion

These findings highlight the persistent challenge of medical debt, the role of hospitals as a key source of that debt, and the gaps in health insurance coverage, hospital financial assistance policies, and federal and state consumer protections that leave many families exposed to bills they cannot afford to pay. More than one in seven nonelderly adults, predominantly those with low incomes, reported that they or their families have unpaid medical bills that are past due. Nearly three-quarters of these adults owed some or all of their debt to hospitals, and those who did had the largest total debt amounts.¹⁶ Most adults with past-due hospital bills had their debt referred to a collection agency, and few received discounted care, including adults whose incomes may have been low enough to qualify for charity care if it was available.

These findings underscore the shortcomings of current federal policies, which target only nonprofit hospitals and demonstrate limited efficacy, and they suggest that expanding access to free or discounted hospital care has the potential to help reduce risks of incurring medical debt, given the income profiles of debt-holders and the providers they owe. To that end, it will be important to assess the impact of new state consumer protections, including policies that establish minimum eligibility criteria for charity care that apply to both uninsured and underinsured patients, require screening for charity care eligibility as well as Medicaid and other public coverage, establish standards for presumptive eligibility screening,¹⁷ and restrict aggressive debt collection practices for all types of hospitals.¹⁸ Some of these policies condition efforts to collect payment on ensuring that eligible patients receive screening for financial assistance, for instance, by prohibiting referral of debt to collections before patients are screened for charity care or requiring hospitals to provide refunds to patients who should have qualified for charity care, as with policies in Maryland (Robertson, Rukavina, and Fuse Brown 2022). States are also taking different approaches to tailoring requirements based on hospital size or financial performance¹⁹ and to enforcing these policies.²⁰

Federal legislative and regulatory efforts could build on state-level protections by clarifying and strengthening community benefit standards for nonprofit hospitals, expanding consumer protections to other hospitals and health care providers, increasing standards and oversight of aggressive collection practices, and improving reporting of charity care and collection actions (Fuse Brown 2015; Gee and Waldrop 2022; GAO 2020; Velasquez 2021). For instance, the Strengthening Consumer Protections and Medical Debt Collection Act would establish a national database of extraordinary collection actions by health care providers and debt collectors.²¹

Policies to strengthen regulation of hospital charity care and debt collection practices may also complement other proven strategies to reduce medical debt, such as expanding Medicaid under the ACA. Eleven states have not expanded eligibility for their Medicaid programs to adults with incomes up to 138 percent of FPL,²² a group that is at the greatest risk of incurring medical debt. If all of these states expanded Medicaid, more than 3 million people would gain coverage, sharply reducing their exposure to high medical bills (Buettgens and Ramchandani 2022). Additional policies to reduce uninsurance rates and improve health care affordability for people insured with public and private coverage may be

needed to sustain recent progress in reducing the prevalence of medical debt (Holahan and Simpson 2022; Karpman, Martinchek, and Braga 2022). These policies include increasing Marketplace cost-sharing reductions, tying premium subsidies to the cost of gold plans to help consumers purchase coverage with a higher actuarial value, and modifying or eliminating the firewall that prevents people with access to employer-sponsored plans that are deemed affordable from qualifying for Marketplace subsidies. It will also be important to monitor enforcement of new protections against balance billing under the No Surprises Act.

Efforts to reduce medical debt have the potential to address inequities in health and financial well-being and improve long-term health outcomes, given the disproportionate burden of medical debt among people of color, people who are in poor health, adults with disabilities, families with low incomes, and parents living with dependent children (Bennett et al. 2021; Haynes 2022; Karpman, Martinchek, and Braga 2022; Lopes et al. 2022). As federal and state policymakers consider new strategies to alleviate this burden, further research will be needed to assess how these strategies affect medical debt and associated outcomes for the population at large and for vulnerable groups.

Data and Methods

Survey Data

This analysis draws on data from the June 2022 round of the Urban Institute’s Health Reform Monitoring Survey. Launched in 2013, the HRMS is a nationally representative, internet-based survey of adults ages 18 to 64 that provides timely information on health insurance coverage, health care access and affordability, and other health topics. For each round of the HRMS, a stratified, random sample of nonelderly adults is drawn from Ipsos’s KnowledgePanel, the nation’s largest probability-based online research panel. Members of the panel are recruited from an address-based sampling frame covering approximately 97 percent of US households, including those without internet access. If needed, panel members are given internet access and web-enabled devices to facilitate their participation.

The June 2022 round of the HRMS had a sample size of 9,494 adults, including oversamples of adults in low- and moderate-income households, nonwhite and Hispanic/Latinx adults, and young adults. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population, based on benchmarks from the Current Population Survey and the American Community Survey. Participants can take the survey in English or Spanish, and the survey takes a median of 15 minutes to complete. The margin of sampling error, including the design effect, for the full sample of adults in the 2022 survey is plus or minus 1.2 percentage points for a 50 percent statistic at the 95 percent confidence level.

Key Measures and Analysis

To estimate the prevalence of past-due medical debt, we asked all respondents the following question:

Do you or anyone in your family currently have any unpaid medical bills that are past due? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care. This could include medical bills owed directly to health care providers or paid with a credit card or personal loan. The bills can be from earlier years as well as this year.

In a preceding question, we defined the family as the respondent, their spouse or partner, and any of their children or stepchildren under age 19 who live with them. The question on past-due medical debt draws partially on wording used in a question from the National Financial Capability Study conducted by the FINRA Investor Education Foundation.²³

Respondents who reported having past-due medical debt were asked a series of follow-up questions about the amount they owed for past-due bills; whether their past-due bills were owed to a hospital, general or specialist doctor's office, dentist's office, and/or another health care provider; and actions taken by hospitals and by doctor's or dentist's offices to make the bills easier to pay or to collect payment. The full survey questionnaire is available on the Urban Institute website.²⁴

The analysis for this brief focused on the experiences of adults with past-due medical debt at three income levels: at or below 100 percent of FPL (about \$13,600 for a single adult and \$23,000 for a family of three in 2022); between 100 and 250 percent of FPL (\$13,600 to \$34,000 for a single adult and \$23,000 to \$57,600 for a family of three); and at or above 250 percent of FPL. These income levels are relevant to state policies aimed at protecting consumers from medical debt, some of which require free care for some or all patients with incomes below 200 or 250 percent of FPL (Stark and Bosco 2021). In addition, most tax-exempt hospitals use income cutoffs of 200 or 250 percent for determining eligibility for free or discounted care under their financial assistance policies (Goodman et al. 2020).

Limitations

Limitations of this analysis include coverage and nonresponse bias, which are only partially mitigated by the survey weights. Certain groups are not represented or underrepresented in the survey, including people who do not speak English or Spanish, have low literacy, are homeless, or live in institutional settings. There may be measurement error in self-reported past-due medical debt, particularly for debt not incurred recently, which may or may not have been written off as bad debt by providers. Some respondents may have misreported having past-due hospital debt if they received services during a hospital visit from providers who were not employed by the hospital. Annual family income reported at the time of the survey may not reflect income at the time services were received.

Because the survey only asked adults with past-due medical debt about actions taken by providers to make bills easier to pay, receipt of charity care by adults without past-due medical debt, which may have prevented them from incurring such debt, was not observed. It is also not known whether hospitals from which respondents have past-due bills are nonprofit, for-profit, or government hospitals; whether

they have financial assistance policies; or whether the respondent or their family would have been eligible for charity care at the time they received services.

Notes

- ¹ The IRS defines charity care as free or discounted health services provided to people who meet the hospitals' financial assistance criteria and are unable to pay for the services. See Internal Revenue Service, "[Instructions for Schedule H \(Form 990\)](#)," November 9, 2021, accessed November 10, 2022.
- ² Nonprofit hospitals are required to report information related to community benefits to the IRS using Schedule H (Form 990). This includes a reasonable estimate of bad debt expenses that could be attributed to patients who likely would have qualified for charity care under the hospital's financial assistance policy but for whom insufficient information was obtained to determine eligibility. Hospitals have flexibility in the methodology to estimate this amount, such as "record reviews, an assessment of financial assistance applications that were denied due to incomplete documentation, analysis of demographics, or other analytical methods." See Internal Revenue Service, "[Instructions for Schedule H \(Form 990\)](#)," November 9, 2021, accessed November 10, 2022, and Jordan Rau, "[Patients Eligible for Charity Care Instead Get Big Bills](#)," *Kaiser Health News*, October 14, 2019.
- ³ The sample for the Health Reform Monitoring Survey does not include adults ages 65 and older, who are less likely than nonelderly adults to have medical debt (Karpman, Martinchek, and Braga 2022). Previous studies have found access to Medicare at age 65 significantly reduces the risk of medical debt (Caswell and Goddeeris 2020).
- ⁴ American Hospital Association, "[Fast Facts on US Hospitals, 2022](#)," accessed November 10, 2022.
- ⁵ Public hospitals are also exempt from taxes and subsidized by tax revenue (Bai et al. 2021), including some that are tax exempt under 501(c)(3) of the tax code, which defines requirements for charitable organizations to qualify for tax exemption. See Internal Revenue Service, "[Charitable Hospitals—General Requirements for Tax-Exemption Under Section 501\(c\)\(3\)](#)," updated July 15, 2022, accessed November 11, 2022, and Internal Revenue Service, "[Section 501\(r\) Reporting](#)," updated July 15, 2022, accessed November 11, 2022. For further background on the community benefit standard for tax-exempt hospitals, see "[Nonprofit Hospitals' Community Benefit Requirements](#)" (James 2016).
- ⁶ FAPs must describe eligibility criteria for charity care, how amounts charged to patients are calculated, how patients can apply, actions that may be taken to collect payment, and providers covered by the FAP. Hospitals must publicize the FAP by making the policy, application form, and a plain-language summary widely available on a website; providing paper copies upon request; notifying patients, visitors, and community members; and translating FAP documents into the primary spoken languages of community members with limited English proficiency. See Internal Revenue Service, "[Financial Assistance Policy and Emergency Medical Care Policy—Section 501\(r\)\(4\)](#)," updated July 15, 2022, accessed November 11, 2022.
- ⁷ Extraordinary collection actions include selling medical debt to a third party, reporting delinquent debt to credit bureaus, denying care to patients because of nonpayment, and legal actions against the patient such as filing lawsuits, garnishing wages, attaching or seizing bank account funds, placing a lien on the patient's property, or causing a patient to be arrested. See Internal Revenue Service, "[Billing and Collections—Section 501\(r\)\(6\)](#)," updated July 15, 2022, accessed November 11, 2022. Though it is illegal to arrest an individual for nonpayment of debt, patients with a medical debt collection judgment against them may be arrested for failing to attend a court hearing or produce requested financial information (Andres et al. 2021).
- ⁸ In addition to provisions related to FAPs and billing and collections, the ACA requires nonprofit hospitals to conduct community health needs assessments every three years and develop implementation strategies for meeting those needs. The ACA also requires nonprofit hospitals to limit charges for emergency and medically necessary care for FAP-eligible patients to amounts generally billed to insured patients.

- ⁹ Bad debt includes uncollectible charges that hospitals recorded as revenue but wrote off due to patients' failure to pay. See Internal Revenue Service, "[Instructions for Schedule H \(Form 990\)](#)."
- ¹⁰ Rau, "[Patients Eligible for Charity Care Instead Get Big Bills](#)."
- ¹¹ Michelle McGhee and Will Chase, "[How America's Top Hospitals Hound Patients with Predatory Billing](#)," *Axios*; Noam N. Levey, "[Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours?](#)" *Kaiser Health News*, December 21, 2022.
- ¹² Michael Ollove, "[New Safeguards in Maryland and Other States May Help Those Who Are Drowning in Medical Debt](#)," *Stateline*, Maryland Matters, August 29, 2022; Innovation for Justice, "[Medical Debt Policy Scorecard Report](#)," May 2022.
- ¹³ Because adults reported annual family income for the 12 months prior to the survey, it may differ from their income at the time the debt was incurred, particularly if they worked less and had lower earnings because of their illness.
- ¹⁴ *Black adults* and *white adults* refer to adults who are not Hispanic/Latinx.
- ¹⁵ Noam Levey, "[How Banks and Hospitals Are Cashing In When Patients Can't Pay for Health Care](#)," *NPR*, November 17, 2022.
- ¹⁶ These results are consistent with previous surveys showing that past-due medical debt is concentrated among families with low incomes and that hospitals are the source of a significant portion of medical debt (Karpman and Caswell 2017; Lopes et al. 2022; Rae et al. 2022).
- ¹⁷ MD. Health—General Code Ann. § 19-214.1 (2021).
- ¹⁸ Innovation for Justice, "[Medical Debt Policy Scorecard Report](#)."
- ¹⁹ For instance, a 2022 law in Washington State established different financial assistance standards for large hospitals and health care systems (Tier 1) and smaller, independent hospitals (Tier 2). See Washington State Office of the Attorney General, "[Washington State Charity Care Law](#)," accessed December 21, 2022. A 2021 Maryland law gives the state's Health Services Cost Review Commission some discretion in establishing family income thresholds for charity care based on hospitals' patient mix and financial condition. See MD. Health—General Code Ann. § 19-214.1 (2021). Other states have established minimum levels of community benefit spending based on the value of hospitals' tax exemptions, revenues, or operating margins (Atkeson and Higgins 2021; Singer, Wilson, and Carare 2022).
- ²⁰ Susan Kelly, "[Providence Targeted by Oregon Consumer Protection Probe](#)," *Healthcare Dive*, October 17, 2022; Sheila Phillips, "[State Attorneys General Against Medical Debt](#)," *Community Catalyst*, September 8, 2022.
- ²¹ S. 5150—Strengthening Consumer Protections and Medical Debt Transparency Act. 117th Congress (2021–2022).
- ²² Kaiser Family Foundation, "[Status of State Action on the Medicaid Expansion Decision](#)," updated November 9, 2022, accessed November 10, 2022.
- ²³ FINRA Investor Education Foundation, "[2021 National Financial Capability Study State-by-State Survey Instrument](#)," accessed November 10, 2022.
- ²⁴ Urban Institute, "[Health Reform Monitoring Survey: Survey Resources](#)."

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