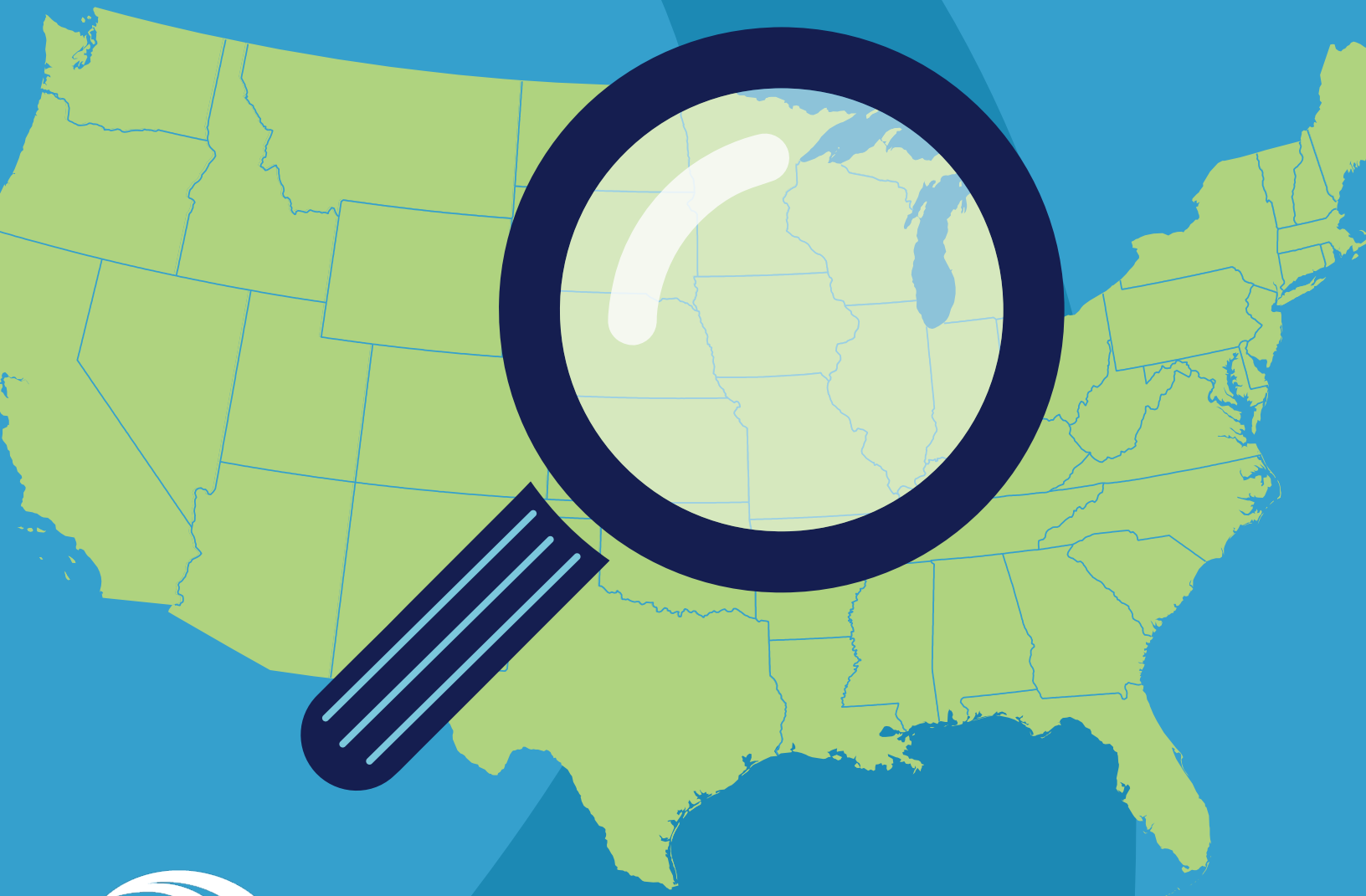
A Path Toward Ending Medical Debt: A LOOK AT STATE EFFORTS



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A Path Toward Ending Medical Debt:
A LOOK AT STATE EFFORTS

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Introduction

OVER THE PAST DECADE, millions of people across the nation received insurance coverage as a result of the Affordable Care Act (ACA). Despite this, many people remain uninsured, and many others can't afford their out-of-pocket cost sharing. In 2020, approximately one in four people reported having unpaid medical bills.[1] A recent study found medical debt in collection – which appears on people's credit reports – reached approximately $140 billion in 2020.[2] Nevertheless, this underestimates the problem since as not all medical bills are in collection, some are being paid using payment plans arranged with the provider and others put on credit cards.

Medical debt affects people across socioeconomic and demographic backgrounds. Yet, individuals who are Black, Indigenous and people of color (BIPOC), and other historically oppressed and excluded populations are disproportionately burdened by medical debt and also experience longer-lasting consequences – such as reduced ability to build wealth, and less access to medical care, housing stability, employment opportunities and education – compared with their white counterparts.[3] According to 2017 Census data from the Survey of Income and Program Participants (the most current available data), 19 percent of households had medical debt. However, nearly 28 percent of Black households and just under 22 percent of Latinx families had medical debt in comparison to 17 percent of white families.[4]

Certainly, the problem has deepened during the COVID-19 pandemic. From big cities to small towns, millions of people have experienced income loss due to work hour cuts, and have

INDIVIDUALS WHO ARE BLACK, INDIGENOUS AND PEOPLE OF COLOR (BIPOC) ARE DISPROPORTIONATELY BURDENED BY MEDICAL DEBT.

struggled to cover usual household expenses such as food, rent or mortgage, car payments, medical expenses, or student loans.[5] The situation has become dire for millions of others who lost their jobs and health insurance coverage during this time.[6&7] Still, many hospitals and other providers, despite receiving federal COVID-19 relief funds,[8] continue their aggressive billing and collection practices, suing patients and garnishing their wages or putting liens on their home or cars for outstanding medical bills.[9&10]

This brief aims to provide a policy framework to support state and local health advocates, and policymakers, who are looking for ways to address medical debt and aggressive billing and collection practices. It also includes key advocacy considerations to ensure a winning campaign to put in place protections that will help curb medical debt. It is intended as a grounding document to complement a series of case studies describing successful campaign strategies to pass medical debt protections that have recently been put in place in a number of states.

Key Drivers of Medical Debt

MEDICAL DEBT IS PERSONAL DEBT a patient accumulates over time as a result of the inability to pay off their medical bills. There are many factors that drive medical debt. They include, but are not limited to: poor health status and low income; lack of health insurance coverage; high out-of-pocket cost sharing; complicated and confusing insurance adjudication process; unfair billing and collection practices.

POOR HEALTH STATUS AND LOW INCOME

Medical debt often arises from unexpected and unavoidable illnesses and injuries. People with income below 133 percent of the federal poverty level are more likely to have problems paying medical bills than those with higher income.[11] The problem is even worse for individuals and families where a member has a disability. These families are nearly two times more likely to have medical debt than those families where with no disabled member.[12]

Racial inequity in health status intensifies medical debt and its impacts on historically oppressed and excluded populations. Decades of structural racism continue to segregate neighborhoods and inhibit equitable access to preventive health care, often forcing people from low-income BIPOC communities to live in places that negatively affect their health.[13&14] As a result, they experience high rates of chronic health conditions such as asthma, diabetes, heart disease and obesity, and associated high health care needs. With limited financial resources, many people can't afford high out-of-pocket cost expenses for necessary ongoing health care services.[15]

LACK OF HEALTH INSURANCE COVERAGE

Despite gains resulting from the ACA, approximately 30 million people in the United States lack health insurance coverage.[16] U.S. health care has historically, and up to the present, been beset with racist polices that create barriers or outright exclusion for specific population groups from accessing public health insurance programs.[17] As a result, many of the uninsured people are immigrants and low-income people of color.[18&19] In the 12 states that continue to refuse to expand Medicaid, eight are in the South, a region that has long been scarred by overt structural racism and health inequities. Compared to states that have expanded Medicaid, non-expansion states have higher levels of medical debt, as well as a greater number of accounts being sent to collection.[20] This means that all of the nearly 2.2 million people in the Medicaid coverage gap – that is, living in states that have made the decision not to expand Medicaid – are among the hardest

> PEOPLE WITH INCOME BELOW 133% OF THE FEDERAL POVERTY LEVEL ARE MORE LIKELY TO HAVE PROBLEMS PAYING MEDICAL BILLS THAN THOSE WITH HIGHER INCOME.

KEY DRIVERS OF MEDICAL DEBT

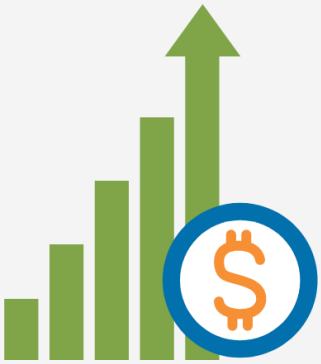
- Poor health status and low income
- Lack of health insurance coverage
- Unfair billing and collection practices
- Complicated and confusing insurance adjudication process
- High out-of-pocket cost sharing

THE RESULTS

- One in four people reported having unpaid medical bills
- People with medical bills in collections experience high levels of stress, anxiety, and poor health

MEDICAL DEBT CAN RUIN CREDIT

40% of people with medical bill issues received a lower credit score rating. In 2020, more than $140 billion in medical debt was reported on consumer credit reports as unpaid medical bills in collection



MEDICAL DEBT STRAINS FINANCIAL HEALTH

- 37% of people with medical bill issues used up all their savings to pay for their medical bills
- 31% of people with medical bill issues took on credit card debt
- 26% of people said they were unable to pay for basic necessities such as food, rent, and heat due to medical debt or an issue with a medical bill

hit with medical debt. Sixty percent of them are people of color.[21]

Ample evidence shows that uninsured people are often forced to juggle paying for essential needs like food, rent, utilities, and medical care. To make matters worse, when uninsured individuals need medical care, they are frequently asked to pay upfront for the full cost of care – often two to four times what health insurers and public programs actually pay for hospital services – before they can see a doctor.[22] This puts them at an even greater risk of financial strain due to medical bills.

HIGH OUT-OF-POCKET COST SHARING

Medical debt is a result of a broken health care system. For too many people, having health insurance coverage does not adequately protect them from medical debt. According to a 2019 survey, six in ten people who reported difficulties of paying medical bills were covered by health insurance but could not afford to pay the required cost-sharing, including copays, deductibles, or coinsurance.[23] Deductibles, in particular, have sharply risen since 2006. Across all workers enrolled in employer-sponsored insurance plans with a deductible, the average deductible amount for a single coverage jumped from $584 in 2006 to $1,644 in 2020.[24]

A fundamental factor contributing to high out-of-pocket cost sharing is the high – and generally unregulated – price charged for health care services. Compared to other high-income countries, the U.S. has much higher prices across a range of health care services.[25] This problem is exacerbated by a steady increase in provider market power. In the past two decades, the U.S. has witnessed accelerating trends in hospital-physician integrations and mergers of hospitals. There is little evidence that provider integration reduces costs or improves quality of care. Instead, consolidation enables dominant hospitals and large physician group practices to leverage their monopoly power to negotiate higher prices for their services.[26] In response to the rapid increase in health care prices, health insurers and the employers purchasing coverage through them, have shifted the cost to patients by imposing higher deductibles, copayments, and coinsurance, as well as restricting access by offering limited benefit packages and/or restricting doctor and hospital choices by narrowing networks through which their members access care.

EVIDENCE SHOWS THAT UNINSURED PEOPLE ARE OFTEN FORCED TO JUGGLE PAYING FOR ESSENTIAL NEEDS LIKE FOOD, RENT, UTILITIES, AND MEDICAL CARE.

COMPLICATED INSURANCE ADJUDICATION PROCESS

The medical billing process, which involves interactions between patients, providers, and insurers, is confusing. In many cases, patients are unable to differentiate between a medical bill and an explanation-of-benefits statement. Medical bills are often rife with errors. Studies from programs that work with individuals seeking assistance with their medical bills have found that in 2016 the medical billing error rate for their clients was close to 75 to 80 percent.[27]

In 2018, the Centers for Medicare and Medicaid Services (CMS) found the billing error rate in Medicare Fee-for-Service claims was 8.5 percent, which was caused by simple coding errors, double billing, up-coding and insufficient documentation.[28] The end result is patients receiving bills for services that should have been covered by insurance, due to coding errors such as providers failing to include required prior authorization paperwork or using incorrect billing codes. In such scenarios, insurers might delay or deny payments to providers. Insurers might also deny claims for services provided to patients if they determine that these services are not medically necessary. If unchallenged, patients might be asked to cover the full cost of these services.

THE COMPLICATED BILLING PROCESS RESULTS IN PATIENTS BEING CONFUSED OR UNSURE ABOUT WHO IS RESPONSIBLE FOR PAYING THE BILLS AND WHETHER THEY SHOULD SEND THE PAYMENT.

All of these problems result in patients being confused or unsure about who is responsible for paying the bills and whether they should send the payment. All too often, providers send the bills to collection agencies, due to a lack of payment.[29]

UNFAIR BILLING AND AGGRESSIVE COLLECTION PRACTICES

As mentioned above, uninsured patients often have to pay unfairly high prices for the health care services they receive. To make matters worse, some health care providers refuse to provide additional care to patients with unpaid medical bills.[30&31] Although many hospitals have financial assistance programs, and non-profit hospitals are required to have them, many patients are not aware of whether such a program exists at the facility where they received care. Patients are often unable to negotiate to lower their bills or establish a reasonable repayment plan – all of which contributes to the ongoing problem of unaffordable cost.

Aggressive collection practices further exacerbate the problem of unmanageable medical bills. Taking legal action against patients with outstanding bills is all too common. One study conducted found that hospitals (including for-profit, non-profit, and safety-net hospitals) use extraordinary patient billing practices to sue patients over unpaid medical bills.[32] Between 2018 and 2020, they were responsible for nearly 39,000 lawsuits and other court actions against patients.[33] These legal actions are typically taken by debt collection agencies working on behalf of a hospital. After legal action is taken, many patients are unaware they are being sued and do not appear in court. Many of the patients who attend the proceedings do not have legal representation in court.[34] 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.[35] Collection agencies also typically report medical debt to credit bureaus, showing up as derogatory accounts that reduce credit scores. Some providers even sell medical accounts outright to debt buyers, and when this is done, they generally lose control over the legal actions that are used to collect on the bills.

Ramifications of Medical Debt

Medical debt has damaging effect on patients' health and financial wellbeing. People with medical bills in collections experience high levels of stress, anxiety, and poor health.[36] Many of those burdened with medical bills often delay or forgo needed medical care in order to avoid incurring even more bills they can't afford. Based on an analysis of a financial assistance program for low-income patients at Kaiser Permanente hospitals in Northern California, researchers found a sharp increase in doctor visits and prescription refills among Kaiser Permanente enrollees after receiving hospital financial assistance in the form of debt forgiveness and reduced cost sharing.[37]

Families with lower incomes, credit problems, lacking liquid financial assets, or equity investments are more vulnerable to the drag that medical debt has on their economic security and quality of life.[38] Medical debt can exacerbate financial problems by lowering credit ratings, making it more difficult to obtain loans or even take advantage of job opportunities. With its significant financial consequences, medical debt can be viewed as a major and growing contributor to the cycle of economic and health inequity.[39]

Shortfall In Federal Protections Against Medical Debt and Unfair Hospital Billing and Collections

Recent press attention has focused on non-profit hospitals pursuing aggressive billing and collection practices against patients. For example, one study found that 55 hospitals in New York State had sued over 4,000 patients since the pandemic began in March of 2020, including the state's largest health system Northwell Health, which sued more than 2,500 patients during this time period. It was only after the lawsuits were exposed in The New York Times that Northwell Health announced it was rescinding all these lawsuits.[40&41] These aggressive medical debt collections clearly defy what Congress intended under the ACA. Additionally, it is disconcerting that hospitals and health systems that received COVID-19 relief funds have continued to sue patients, even during the declared public health emergency. A CNN investigation found that while many hospitals ceased filing such lawsuits, the Community Health Systems, a for-profit chain, filed at least 19,000 lawsuits over allegedly unpaid medical bills since the pandemic began, despite generating $448M in profits and receiving COVID-19 relief funds.[42]

Non-profit hospitals in the U.S. have a long-standing obligation to provide community benefit in exchange for savings that result from their tax-exempt status. Under the ACA, the IRS was directed to establish Section 501(r),[43] requiring new community benefit, including establishing and publicizing financial assistance programs for low-income patients. In addition, hospitals are prohibited from charging patients who are

eligible for financial assistance more than the amounts generally billed to insured patients. Finally, before engaging in extraordinary collection actions,[44] hospitals must make reasonable efforts to determine whether a patient is eligible for financial assistance.

The above financial assistance requirements represent positive steps towards protecting low-income patients. However, there are limitations. First, these requirements apply to only non-profit hospitals, not to for-profit or government-run hospitals, which make up more than 40 percent of all hospitals in the country.[45&46] Second, they do not set minimum eligibility standards for financial assistance, but merely require hospitals to have written policies. As a result, some hospitals have limited assistance to only those patients with no insurance and extremely low incomes, excluding patients with any form of health insurance coverage regardless of the difficulty that their policy's out-of-pocket expenses impose on them. Others have adopted policies with burdensome application requirements, seeking financial documents that many patients are unable to provide. Third, while these requirements limit what can be charged to patients who qualify for assistance, the framework for calculating the charges too often results in unaffordable bills. Fourth, instead of banning non-profit hospitals from pursuing extraordinary collection actions for low-income patients with outstanding medical debt, the federal rules only require hospitals to make a good-faith effort to give patients an opportunity to apply for financial assistance and to notify patients about the potential ramifications for falling behind on bills. Furthermore, IRS 501(r) rules do not apply to providers other than hospitals, such as physician practices, dental practices, ambulance services, and laboratory and diagnostics providers.[47]

State Actions on Fair Hospital Billing and Medical Debt Collections

Given the limitations in federal rules that leave many patients and their families vulnerable to financial and health-related consequences, many states have stepped up to fill the gap.[48&49] In 2021, as of the date this report was issued, policymakers in at least 12 states have taken actions:

- Eight states* – California, Colorado, Connecticut, Illinois, Maryland, Minnesota, Nevada, and New Mexico – have successfully amended existing medical debt protections or enacted new laws. Some state and local advocates drew on parts of the Model Medical Debt Protection Act developed by the National Consumer Law Center,[50] and advocated for laws to improve equitable access to care and fair billing for all.
- Several other states including New York, Ohio, Texas, and Vermont introduced legislation this year.

To better assess state protections, Community Catalyst staff and partnering state and local health advocates from more than a dozen organizations in five states have co-designed five equity-focused principles for hospital medical billing and collection policies, which include: Equity, Transparency, Affordability, Inclusivity

* This brief does not look into legislation passed in Connecticut (SB 683) and Minnesota (HF 6).

and Accountability.[51] In general, medical debt protections that were enacted into law in eight states this year include the following requirements for health care providers:

- Screen and provide free or discounted care to low-income patients regardless of their immigration status.
- Clearly notify all patients about hospital policies regarding financial assistance programs, billing, and collections.
- Limit hospital charges and extraordinary collection practices.
- Comply with reporting requirements that aim to explore disparities.
- Solicit feedback from patients and patient advocates on notification of patient's rights.

Though some are stronger than others, as demonstrated below, all the protection measures newly enacted in California, Colorado, Illinois, Maryland, Nevada, and New Mexico reflect at least one of the five equity-focused principles. Click here for a summary chart.

Below are a few state examples of how these new protections bring to light the five equity-focused principles.

PRINCIPLE 1: EQUITY

To ensure that policies on financial assistance, billing and collections do not discriminate against patients based on their age, gender, race, disability, health status, language, immigration status, sexual orientation, or religious affiliation.

KEY MEASURES:

- Expand eligibility for hospital financial assistance programs by removing barriers based on income or immigration status
- Take further actions to ensure racial justice and advance health equity

STATE EXAMPLES: In general, the states that amended their existing laws or enacted new laws requiring hospitals to provide free or discounted care for their residents under a certain income threshold and to remove barriers for immigrants, regardless of their status to access hospital vital services.

For instance, ***California*** passed Assembly Bill 1020 into law to raise the income level for financial assistance from 350% of the poverty level to 400%. In ***Maryland,*** under the newly enacted law (Senate bill 514 and House Bill 565), hospitals are required to calculate income eligibility for free care (to patients with family income at or below 200% of the poverty level) or reduced-cost care "*at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial hospital bill is provided, in accordance with the mission and service area of the hospital.*" Maryland also clearly prohibits hospitals from using patient's citizenship or immigration status as an eligibility requirement for financial assistance; or withholding financial assistance or denying a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

In ***Illinois,*** Senate Bill 1840 was passed into law requiring hospitals to screen all uninsured Illinois residents with income below or at 200 percent of the federal poverty line for public health insurance programs and hospital financial assistance programs. Senate Bill 1840 requires hospitals to make free and discounted care more accessible to immigrants and their families regardless of their status by defining Illinois residents as "*any person who lives in Illinois and who intends to remain living in Illinois indefinitely*." In addition, hospitals are required to describe activities that aim to address health disparities, advance

health equity, and improve community health through their community benefit plans.

PRINCIPLE 2: TRANSPARENCY

To ensure that patients clearly understand their rights and have access to the support they need when applying for financial assistance.

KEY MEASURES:

- Provide clear notices on financial assistance, billing & collections
- Proactively screen patients for public insurance programs and hospital financial assistance programs
- Provide assistance regarding patient's applications and complaints/appeals

STATE EXAMPLES: Robust requirements on hospital financial assistance and strong medical debt protections are somewhat irrelevant if patients don't understand their rights. Transparency is an area in which many states have made progress this year. Most of the states with new laws have requirements related to translation, visibility, accessibility and clarity of hospital financial assistance, billing, and collection policies.

For instance, ***Colorado*** enacted House Bill 21-1198 requiring health care facilities to screen each uninsured patient for public health insurance programs, the Colorado Indigent Care Program and hospital financial assistance programs. To improve the transparency of the screening process, health care facilities must *"use a single uniform application developed by the state department of health care policy and financing (HCPF)." In addition, health care facilities must use standardized notification of patient's right, which is described as follow: "a written explanation of a patient's rights that is written in plain language at a sixth-grade reading level and translated into all languages spoken by ten percent or more of the population in each county of the state and [posted] in all required languages on the HCPF's website."*

Similarly, in addition to requirements on clear notices on financial assistance, billing and collections, ***Illinois*** requires hospitals to include in their financial assistance application form *"language that directs the uninsured patient to contact the hospital's financial counseling department with questions or concerns, along with contact information for the financial counseling department, and shall state: "Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General." A website, phone number, or both provided by the Attorney General shall be included with this statement."*

PRINCIPLE 3: AFFORDABILITY

To ensure that hospital policies improve patients' health and economic stability rather than imposing financial burdens on them.

KEY MEASURES:

- Avoid excessive charges and/or interest rates
- Work with patients to develop a reasonable repayment plan
- Prohibit collection practices that impoverish patients

STATE EXAMPLES: Many states also improved their fair medical pricing and collection laws to limit the amount hospitals may charge patients, prohibit hospitals from taking certain extraordinary collection actions against patients, or restrict hospitals from imposing excessive interest rates.

For instance, ***Colorado*** sets new limits on hospi-

tal bills, which go into effect on July 1, 2022. The new limits will apply for every state resident at or below 250 percent of the federal poverty level who does not qualify for discounted hospital care under the Colorado Indigent Care Program. The limits will apply to bills from hospitals as well as to bills from "hospital-based providers" – providers that provide care in a hospital setting but that bill separately from the hospital (e.g., radiologists and anesthesiologists). Under the new requirements, the Colorado Department of Health Care Policy and Financing will set and publish the maximum amount that hospitals and hospital-based providers can charge uninsured patients for services and these rates will have to approximate rates paid by public payers. Additionally, monthly charges from hospitals and hospital-based providers will not be able to exceed a certain percentage of a qualified patients' monthly income – specifically hospitals will not be able to bill for more that 4 percent of monthly income each month and hospital-based providers will not be able to bill for more than 2 percent of monthly income per month. Finally, the patient's bill must be treated as paid in full after the billed amount is paid, or after the patient makes 36 payments, whichever happens earlier. The 4 percent / 2 percent standard and the 36-month payment limit protect both uninsured patients and insured patients with cost-sharing obligations.

Regarding restrictions on collections, under the newly enacted ***California*** law, hospitals are restricted from selling a patient's debts unless the patient is found ineligible for financial assistance or that the patient has not responded to attempts to collect on the bill or applied for financial assistance for 180 days. Additionally, hospitals must *"include contractual language in the sales agreement in which the debt buyer agrees to return, and the hospital agrees to accept, any account in which the balance has been determined to be incorrect due to the availability of a third-party payer, including a health plan or government health coverage program, or the patient is eligible for charity care or financial assistance."*

Similarly, ***Maryland*** prohibits hospitals from taking certain extraordinary collection actions, including but not limited to: *requesting a lien against a patient's primary residence; taking action that causes a court to issue a body attachment or an arrest warrant against a patient; requesting a writ of garnishment of wages if the patient is eligible for free or reduced-cost care; seeking legal action against a patient on a debt owed until establishing and implementing a hospital-patient mutual agreement on a repayment plan that complies with guidelines developed by the Health Service Cost Review Committee.*

In ***Nevada,*** Senate Bill 248, signed into law in June 2021, amends the definition of medical debt to mean "any debt owed for goods or services provided by a medical facility, a provider of health care or a provider of emergency medical services." Under this definition, the law applies to all medical debt – including the financing or an extension of credit – for goods and services provided by medical facilities. Debt collection agencies are required to provide written notice to the patient who owes medical debt at least 60 days before any collection action is taken.

New Mexico passed Senate Bill 71 into law that prohibits Health care facilities and third-party health care providers and medical creditors from pursuing collection actions, i.e., selling debt and filing lawsuits to collect medical debt, against patients who are determined to be indigent patients (with income at or below 200% FPL) over charges for health care services and medical debt. To avoid being sued or sent to collection, patients must request an "*indigency determination.*" To prove their household income, patients can choose to either submit an attestation or documentation. Senate Bill 71

provides a broad definition for third-party health care provider, which is*" a licensed health care professional or an entity with revenues of at least twenty million dollars ($20,000,000) annually, when billing patients independently for health care services provided in a health care facility."* In addition, medical creditor is defined as *"a person that provides health care services and to whom the consumer owes money for those services or the person that provided health care services and to whom the consumer previously owed money if the medical debt has been purchased by one or more medical debt buyers."* Finally, health care facility covered under Senate Bill 71 means most health care facilities licensed by the State Department of Health (including urgent care centers or freestanding emergency rooms, which might not be licensed by the Department of Health).

PRINCIPLE 4: INCLUSIVITY

To ensure that hospitals respond to the changing demographics, financial status, and health access trends in the communities they serve.

KEY MEASURES:

- Collect patients' feedback on hospital policies
- Partner with community-based organizations on outreach & education

STATE EXAMPLES: Inclusivity is an area in which states have not, to date, put as much attention in terms of clearly mandating health care providers to solicit feedback from patients on hospital financial assistance, billing and collection policies or partner with community-based organizations on outreach and education around hospital financial assistance programs.

However, it is encouraging to see that ***Colorado*** includes in its newly enacted law a provision that requires the state department of health care policy and financing to use feedback collected from patients and advocates to develop minimum standards on notifications of patient's rights. Under ***Maryland***'s newly enacted law, the Health Services Cost Review Commission is required to develop certain guidelines, with input from stakeholders, for an income-based payment plan. Stakeholders include *"the Maryland Hospital Association, Maryland Insurance Administration, Office of the Attorney General, labor unions that represent the health care sector, a statewide nonprofit consumer rights group; patients' rights organizations, legal service providers who work with patients who have experienced medical debt; and patients who have experienced medical debt."*

PRINCIPLE 5: ACCOUNTABILITY

To ensure that hospitals comply with state laws and regulations.

KEY MEASURES:

- Require data reporting disaggregated by race and ethnicity regarding FAP and debt collections
- Include a mechanism to monitor compliance & enforcement
- Require trainings for hospital staff on hospital assistance policies

STATE EXAMPLES: To ensure their state residents are effectively protected and that the newly enacted laws are properly implemented, most states ramp up oversight compliance and strengthen enforcement. In addition, states have taken steps to assess racial disparities and discrimination in hospital policies and practices by requiring health care providers to collect and report data disaggregated by race and ethnicity on patients receiving financial assistance and those whose unpaid medical bills are sent to collections.

Colorado and ***Maryland*** are taking the lead on requiring health care facilities to collect and report data on patient groups based on based on race, ethnicity, and primary language spoken to help evaluate hospitals' compliance with the required screening, discounted care, payment plan, and collections practices. In ***Illinois***, hospitals are required, under the new law, to include demographic questions in financial assistance application. However, to respect and protect patients' privacy, Illinois law requires that *"[demographic] questions shall be clearly marked as optional responses for the patient and shall note that responses or nonresponses by the patient will not have any impact on the outcome of the application."*

Enforcement is another important component in all the newly enacted legislation this year. For instance, in Illinois and New Mexico, the Attorney General is responsible for administering, monitoring compliance, and enforcing the newly enacted law. Additionally, the Attorney General is required to establish a complaint process whereby patients can file a complaint against a health care facility, third-party health care provider, medical creditor, or medical debt collector for violations. Colorado goes further, providing patients a private right of action with attorney fees as legal tools to enforce their rights to receiving discounts, screening, and other fair billing practices before being sent to collections. Under Colorado's newly enacted law, healthcare facilities and licensed health-care professionals are subject for a fine of up to $5,000 per week for every noncompliance infraction until corrective actions are taken. In California, under the newly enacted law, hospitals are subject to *"[an administrative penalty of] up to forty thousand dollars ($40,000) [for noncompliance]. This amount shall be adjusted every five years to reflect the percentage change in the calendar year average, for the five-year period, of the medical care index of the Consumer Price Index, as published by the United States Bureau of Labor Statistics."*

Key Considerations for a Winning State Campaign to Curb Medical Debt

The path to victory in recent state campaigns to curb medical debt is rooted in Community Catalyst's System of Advocacy. As illustrated in an accompanying series of case studies, advocates brought together six advocacy capacities to effectively challenge the powerful interests of hospitals and health systems to put statewide protections in place. Below are four key lessons we learned from our state and local partners.

Lesson 1: Analyzing disaggregated data on medical debt shines a light on inequities.

As discussed above, medical debt disproportionately affects communities of color and other historically oppressed and excluded populations. To develop effective policy recommendations that are centered on health justice and racial equity, many advocates heightened their efforts to highlight racial disparities in medical debt. Advocates in ***New York*** and ***Maryland***

looked at zip code data as well as data from the Urban Institute and the U.S. census to understand how medical debt lawsuits affect certain racial/ethnic and income communities. New York advocates went further, sending letters directly to hospitals' leadership detailing how many of their cases were filed in low-income communities of color and urged them to offer financial assistance in lieu of suing their patients. In ***Colorado***, advocates sharpened their analysis on how medical debt perpetuates the cycle of racial inequity to support Black and Latino legislators who have been increasingly effective in championing policies that aim to improve health and economic stability for communities of color.

Lesson 2: Using personal stories and public court records on medical debt cases makes a strong case for robust hospital financial assistance and medical debt protections.

Story collection is one of the most common and effective strategies advocates use to directly hear from the people affected by medical debt and bring their stories to the places where decisions are made – in community forums, hospital feedback sessions, legislative hearing rooms, on the floors of state capitols, in the media, and on social networks. Advocates in ***New York*** launched the We The Patients (WTP) social media platform in 2019 for community members to share their experience with the health care system. Within two years, the WTP posts have been placed in at least 1 million digital feeds and seen by over 500,000 users. While bringing to light the burden of medical debt through personal stories, New York advocates also reviewed online public court filings. They identified over 50,000 medical debt cases against low-income patients, which led to influential media coverage in the New York Times. Advocates in ***Maryland*** partnered with health economists at Boston University to conduct a research study looking at 145,746 medical debt lawsuits filed between 2009 and 2018. Advocates used the finding results to dispel myths from the opposition – the Maryland Hospital Association claiming that medical debt protections included in Senate bill 514 and House Bill 565 would jeopardize hospital hospitals' financial health and solvency.

Lesson 3: Community power — nurtured through public education, grassroots organizing and by building diverse coalitions — can overcome powerful hospital (or health entity) interests.

Building community power is recognized by advocates as a valuable and necessary strategy to improve health justice and racial equity. Advocates in ***Maryland*** emphasized that one of the keys to their success is their broad and diverse coalition – the End Medical Debt Maryland coalition made up of 59 organizations (including unions, churches and state and local community advocacy organization), the coalition represents approximately 400,000 Marylanders. Additionally, the coalition used their legislative expertise and mobilized community members – an *"inside-outside"* strategy – to push their medical debt protection legislation to the finish line. In ***Illinois***, advocates have built power through community education and dispelling fears within Spanish-speaking immigrant communities resulting from lack of knowledge of their health care rights. Partnering with community health worker organizations and organizations serving immigrant communities, Illinois advocates worked directly with individual community members to help them address hospital billing issues and apply for financial assistance. In addition, they provided a series of Facebook education sessions on various topics including immigrant health care rights and hospital financial assistance. In turn, these community members actively called for improvements and better protections.

Lesson 4: Engaging early with state agencies that are responsible for implementing the newly enacted law helps ensure smooth implementation of newly enacted laws.

This is an important step to ensure smooth implementation of any new law. In ***New Mexico***, for instance, immediately after Senate Bill 71 was signed into law, advocates turned their attention to the rule-making process. They worked closely with the Office of Superintendent of Insurance on draft regulations that clarify areas left unclear in the newly enacted medical debt protections. Specifically, including a screening process for public insurance coverage and hospital assistance, clarifying the process of indigency determination, and developing model financial assistance applications and notices. To engage community members, New Mexico advocates relied heavily on social media to educate community members of the new protections and organize them to deliver public comments. Similarly, in ***Colorado***, advocates worked with the Department of Health Care Policy and Financing (HCPF) to design an inclusive stakeholder process to draft proposed regulations and develop a uniform application and a statement of patient rights. Colorado advocates also provided a series of trainings to community partners outlining the major provisions included in the newly enacted law and worked with them to identify implementation priorities. Those trainings prepared community partners to engage in upcoming stakeholder meetings.

Conclusion

Medical debt has become a major concern in the U.S. The significant effect of medical debt on the physical, mental, and economic well-being of many families, especially historically oppressed and excluded populations, cannot be ignored. While the hospital/health care provider community are a strong force and lobby in nearly all states, advocates have prevailed in passing medical debt protections. Advocates, policymakers, and stakeholders, working together, can adopt measures that curb unfair medical billing and collection practices and improve economic stability for patients. This is most effectively done by building community power and utilizing effective advocacy strategies that ensure that the needs of those most vulnerable are being met.

For more detail on state medical debt protection efforts, read the series of case studies that highlight successful state campaign strategies to pass medical debt protections.

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